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IN THIS ISSUE

Evidence-Based Practice: Identifying and Removing Barriers to Implementation
Denise E. Bronson, PhD

Evidence-based practice is now an established value and methodology in many of the disciplines involved with child maltreatment. The field of social work has recently embraced evidence-based practice, as a manifestation of both scientific and ethical reform. Its goal is to underpin direct practice with the best available empirical data to assure that interventions actually produce intended outcomes that are in clients' best interests. However, as this emphasis on empirical research is more widely implemented, the difficulties of interpreting research and integrating it into practice become clearly evident for the social work profession. Denise E. Bronson's article provides an overview of the challenges inherent in incorporating empirical data into social work practice. She reviews the essential elements of evidence-based practice, describes the organizational and user barriers that undermine evidence-based practice, and details a variety of strategies that can help establish evidence-based social work practice. 2

The Campbell Collaboration: A Reliable Source of Evidence for Practice
Julia H. Littell, PhD

The Campbell Collaboration is a new, international and interdisciplinary organization devoted to producing the highest quality systematic reviews of the effectiveness of interventions in the fields of social care, including child welfare. In this article, Julia H. Littell provides a history of the evolution of evidence-based practice in social work, reviews the limitations of various research designs and methods, and argues the importance of synthesizing large bodies of literature using methods of systematic review to determine the state of current "evidence." She also summarizes the formation and development of the Campbell Collaboration and describes the reasons for the organization's commitment to systematic reviews as a means of promoting evidence-based practice. She reviews the importance of transparency in research and outlines strategies to minimize bias and increase the accuracy of the evidence provided to practitioners by the research community. 7

REGULAR FEATURES

Journal Highlights 11
Washington Update 13
News of the Organization 17

ALSO IN THIS ISSUE

Message From the President 16
Conference Calendar 19

APSAC: Enhancing the ability of professionals to respond to children and their families affected by abuse and violence.

Evidence-Based Practice: Identifying and Removing Barriers to Implementation

Denise E. Bronson, PhD

Since the earliest days of the social work profession, debates over the extent to which science and research can, or should, inform practice have been common (Bronson, 2000). Various strategies to bridge the gap between research and practice have been proposed over the years, but the recent introduction of evidence-based practice (EBP) to social work may prove to be the best approach yet for linking the two; whether EBP succeeds in bridging the gap between research and practice will depend largely on anticipating possible barriers to using EBP and finding ways of eliminating or minimizing those obstacles.

EBP is a fairly recent development in social work. The model for evidence-based practices first appeared in medicine during the early 1990s to help health professionals select the most efficacious and effective treatment methods. According to Chaffin and Friedrich (2004),

> EBP was born out of the recognition that many common health care and social services practices are based more on clinical lore and traditions than on scientific outcome research. Practice traditions sometimes even run counter to outcome research evidence. EBP strives to bring services more into line with the best-available clinical science and promote practices which have been demonstrated to be safe and effective. (p.1097)

In the mid-1990s, literature touting the use of EBP in the social sciences began to appear and the movement to adopt this approach has quickly gained momentum.

In the simplest of terms, EBP is defined as "…the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual [clients]" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 2). While this definition focuses on micro-level services, some authors have also applied EBP to mezzo- and macro-level practice (McNeese & Thyer, 2004). Regardless of the level at which it is applied, EBP consists of five steps:

1. Translating practice problems/decisions into an answerable question;
2. Identifying the best available evidence to answer the question;
3. Critically evaluating the rigor and quality of the evidence and its applicability to the practice decision;
4. Appling the best available evidence to the practice decision; and
5. Evaluating the effectiveness and efficiency of the solution (Sackett et al., 2000).

Recent technological developments in electronic bibliographic databases, access to full-text online articles, indexing services, and reference management software now make it feasible to adopt EBP in most practice settings.

Engaging in EBP is more than simply following these five steps, however. It also requires that practitioners be willing to employ the best available research to guide practice decisions, abandon interventions that are found to be ineffective or less effective than alternative approaches, and accept a scientific approach to practice. Fortunately, these values are also consistent with the Social Work Code of Ethics, requiring practitioners to "fully utilize evaluation and research evidence in their professional practice" (National Association of Social Workers, 1996, p.12), and with the academic accrediting standards from the Council on Social Work Education, mandating that all social worker students acquire the skills to critically assess research findings and incorporate the knowledge gained from research and evaluation into their practice.

Yet, despite the professional obligations and good intentions of social workers, few are actively engaged in EBP (Howard, McMillen, & Pollio, 2003; Kirk, 1999; Lehman, Goldman, Dixon, & Churchill, 2004; McNeese & Thyer, 2004; Rosen, 1994; Rosen, Proctor, Morrow-Howell, & Staudt, 1995). This raises two critical questions: Why aren't practitioners embracing EBP? and What can be done to promote the use of EBP in social work? The remainder of this paper addresses these questions.

Why Aren't Practitioners Embracing Evidence-Based Practice?

Many proponents of EBP have offered hypotheses as to why social workers are not using EBP and have identified possible barriers to implementing this technology in practice settings. These barriers and hypotheses can be grouped into three categories (see Table 1). The first category deals with aspects of the EBP technology itself that make it difficult to implement, the second deals with characteristics of the users that frequently interfere with implementation, and the third category considers issues within the practice environment that hinder the use of EBP.

Table 1.
Barriers to Adopting Evidence-Based Practice

Technological Barriers
1. Adequacy of procedural guidelines and training materials for EBP
2. Skills required to implement technology (e.g., database searching, knowledge of research and statistics)
3. Access to required resources (e.g., electronic databases, systematic reviews, and citation management software)

User Barriers
1. The congruity (fit) between the user and the technology
2. Users' sense of ownership in EBP
3. Personal costs and benefits

Organizational Barriers
1. Organizational supports
2. Time constraints

Technological Barriers

EBP is a technology that helps practitioners to identify and use the best available evidence in their practice decision making. *Technology* in this sense refers to the procedures and methods that are used in EBP. Characteristics of the technology itself can either facilitate or hamper implementation (Munson & Pelz, 1981). Before we ask *if* social workers are using EBP in their practice, it is important to first assess whether they *can* use it. That is, is the technology ready to be implemented in practice environments?

To determine whether EBP technology is ready for implementation in practice settings, we need to assess the extent to which (1) clear, proceduralized training materials, guidelines, and courses are available to help practitioners learn the EBP technology (Thomas, Bastien, Stuebe, Bronson, & Yaffe, 1987; Robinson, Bronson, & Blythe, 1988), (2) practitioners have the repertoire of requisite technical skills to fully implement EBP (Robinson et al., 1988), and (3) practitioners have access to the technical resources that are required to use EBP, such as access to electronic bibliographic databases, full-text online articles, indexing services, and reference management software.

Availability of adequate training materials. Courses and training materials on how to use EBP in social services are still scarce (Hawley & Weisz, 2002). Only recently have classes started to appear in the curricula of social work programs (Gibbs, 2005; Howard, McMillen, & Pollio, 2003) that give students hands-on experience with using EBP. Textbooks are also beginning to appear (Gibbs, 2003) and recently a procedural guide was prepared on how to access social care research in the electronic databases (Macwilliam, Maggs, Caldwell, & Tiernery, 2003). Len Gibbs (2005), who has written extensively on this topic and teaches courses on evidence-based practice for social workers, observed that, "[p]resently, every research methods text in social work is woefully outdated. Amazingly, these texts do not include content regarding basic skills for translating research into practice (e.g., posing well-built practice questions, methodological filters, critical appraisal skills specific to different types of evidence, and databases specific to question types). These texts have essentially not yet adapted to the information revolution that will only increase in its potential as an aid to practice/research integration. Such skills need to be taught" (p. 10). Currently, the paucity of textbooks and other training materials on how to implement EBP is a significant barrier to using this technology in a practice setting. This situation is likely to change, however, as newer social work textbooks begin to include EBP content and schools add EBP to practice courses and continuing education offerings (Bilsker & Goldner, 2000). Written materials alone will not be enough, however. Training workshops, classes, and continuing education opportunities are also needed (Gotham, 2004).

Developing the technical skills to use EBP. The availability of courses, textbooks, and other training materials that focus on EBP will undoubtedly improve practitioners' abilities to engage in EBP. At a minimum, practitioners must know how to find relevant research and *apply* it to their practice (Gibbs, 2005). To do this, social workers need to be familiar with computers, know how to access Internet search engines and Web sites, and be able to conduct searches of electronic bibliographic databases to access systematic reviews of the research literature, such as those archived in the Web sites for the Cochrane Collaboration (http://www.cochrane.org/index0.htm) and the Campbell Collaboration (http://www.campbellcollaboration.org/), the What Works Clearinghouse (http://whatworks.ed.gov/), and other services that provide reviews of the best evidence available for various interventions. Without these fundamental skills, it is nearly impossible to use EBP to guide practice decisions.

There is some debate in the field as to whether practitioners should also have the ability to conduct a synthesis of the existing research. This can occur at two levels. The most comprehensive approach is a systematic review and meta-analysis of all research (published or not) on an intervention or practice problem. Completing a systematic review of the literature requires sophisticated knowledge of research methods and statistics to competently critique the quality of the identified research and to complete a meta-analysis of the research findings. This process can take months or years to complete depending on the extensiveness of the research. The skills and knowledge needed to conduct a systematic review are usually taught at the doctoral level.

A "quick but not dirty" version of a systematic review (rapid evidence assessment) has been proposed by Deaton (2005) as a more practice-friendly way of identifying and evaluating existing research for an intervention or practice problem. A rapid evidence assessment (REA) differs from a full systematic review by focusing on published research only and using fewer criteria on which to evaluate the rigor and quality of the research. And, unlike a full systematic review, rapid evidence assessments can generally be completed in less than six months.

Access to technical resources needed for EBP. Limited access to electronic bibliographic databases, full-text online articles, indexing services, and reference management software in practice settings is currently a major barrier to implementing EBP in many social service agencies. Gibbs (2005) acknowledged that "[s]tudents have access to bibliographic databases [at the university], but after they graduate they will not have access to them in their agencies. Therefore, they cannot apply EBP skills to answer questions in their agencies" (p. 10). Currently the cost of subscriptions to electronic bibliographic databases is prohibitive for most social service agencies and remains a significant barrier to the use of EBP in practice settings.

User Barriers

The literature on implementing new technology often focuses on user characteristics associated with the adoption of new social technologies (Munson & Pelz, 1981). Some of the key factors in this area include (1) the congruity between the user's personal goals and philosophies and the technology, (2) the user's sense of "ownership" in the technology, and (3) the user's assessment of the personal costs and benefits associated with adopting the technology.

Congruity between the user and the technology. The congruity, or fit, between the user and the technology can encompass many things. For example, in EBP there is an inherent assumption that research-guided practice is superior to that which is guided by practice experience. To the extent that social workers accept this assumption, they will be more likely to embrace the EBP approach; those who believe that research is antithetical to practice will find EBP to be incongruous with one of their core values (Addis, 2002; Rosen, 2003). Although some have argued that social workers have an ethical obligation to engage in research-guided practice (Gambrill, 2003; Gibbs & Gambrill, 2002; McNeese & Thyer, 2004), this view is

cont'd on page 4

not universal (Addis, Wade, & Hatgis, 1999; Carter, 2002). Other areas of incongruity that may exist include the following:

- Valuing "practice-based evidence" over evidence-based practice (Barkham & Mellor-Clark, 2003; Carter, 2002; Shaw & Shaw, 1997);
- Believing that research findings cannot generalize to the practice environment due to client dissimilarities, the changeable nature of practice (Carter, 2002), and the importance of the therapeutic relationship (Addis, Wade, & Hatgis, 1999; Levant, 2004; Wolfe, 1999);
- Thinking that proceduralized interventions are just a cookbook approach to practice and that they strip the practitioner of all creativity and flexibility (Gibbs & Gambrill, 2002; Carter, 2002); and
- Placing more value on flexibility and eclecticism than on following treatment manuals for empirically supported interventions (Carter, 2002).

Practitioners who adhere to any of these beliefs or values are less likely to adopt EBP.

User's sense of "ownership." The implementation literature is also filled with research showing that user participation in the design and development of an innovation leads to a greater sense of "ownership" and increased implementation. Although evidence-based practice methods were designed and developed in medicine, it may be possible to promote a sense of ownership for practitioners by involving workers in strategies to bring the technology into practice settings. The implementation literature is inconclusive as to when and how to involve users, but any participation in this process is better than trying to impose these methods on the practice community. Gibbs and Gambrill (2002) recently wrote an article countering many of the practice myths about EBP that reflect workers' perceptions that it is "an ivory tower concept" (p. 460), one that "ignores clinical expertise" (p. 459), and that "those who promote EBP simply adopt reverence for another authority: that of the researcher" (p. 469). Efforts like those of Gibbs and Gambrill to address misconceptions about EBP and to couch EBP in practice language are a first step toward addressing the practitioner concerns, but more efforts to foster a sense of relevance and ownership are needed to eliminate this barrier to widespread implementation.

User costs and benefits. The last user barrier to be discussed here focuses on the practitioner's perceived personal costs and benefits of using EBP in practice (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004). The introduction of any new technology is often accompanied by some anxiety and stress associated with the effort needed to learn a new way of practicing (Munson & Pelz, 1981). Practitioners may also fear being held personally accountable if they use an intervention that is based on research evidence but is not successful for their client (Shaw & Shaw, 1997). Or, practitioners may feel that their value as an experienced social worker is depreciated by letting research guide clinical decisions rather than practice wisdom (Robinson, Bronson, & Blythe, 1988). The perceived costs together with the real costs of using EBP (e.g., time needed to search databases and learning new treatment methods) must be outweighed by the benefits of EBP (e.g., improved client outcomes, greater client satisfaction with services, or professional recognition) if EBP is to be adopted by practitioners.

Organizational Barriers

Lack of organizational support may be one of the most critical barriers facing EBP. "Professionals who wish to adopt a technology in an agency that does not support their effort are less likely to implement it, in large part because their costs are so much greater than those of a professional in an agency that supports that technology" (Robinson, Bronson, & Blythe, 1988, p. 294). Supports can be tangible (e.g., in-service training, onsite consultants, access to electronic bibliographic databases, and adequate computer facilities) or intangible (e.g., incorporating EBP into supervision or public recognition for using EBP). The tangible supports are obviously essential for implementation, but the intangible factors will, over time, ensure the sustainability of EBP.

Lastly, when practitioners are asked why they don't use EBP, the typical response is that "[b]usy practitioners [do] not have the time to follow the EBP process in an agency" (Gibbs, 2005). In today's practice environment, this is probably true. Although Gibbs (2005) argued that, with training, undergraduate students can locate relevant research for a practice problem in less than 30 minutes, most practitioners would find it impossible to devote this amount of time to each practice problem or client issue that they encounter. When completed systematic reviews are more readily available, practitioners will be able to access relevant information quite quickly, but for now, systematic reviews for many practice problems have not yet been undertaken. As a result, to use EBP, workers must spend time searching the electronic databases, retrieving relevant studies, reading and evaluating the research reports, and translating the information into directions for practice. Quite simply, practitioners do not have the time to do all this. Creative solutions are needed to eliminate this barrier.

What Can Be Done to Promote the Use of EBP in Social Work?

The technological barriers impeding the use of EBP in social work will be the easiest to address. Ongoing advances in computer technology will undoubtedly enhance our ability to find and retrieve relevant research information. For example, advances in Internet speed, the availability of full-text online journals, and the development of sophisticated search engines, such as Google, will make it much easier for social workers with technological know-how to locate the relevant research information for evidence-based practice (Gibbs, 2005). Gaining access to the electronic bibliographic databases continues to be a barrier for those outside university systems, primarily due to the cost of subscriptions to these services. But, until subscription costs are reduced or eliminated, schools of social work can promote evidence-based practice in agencies by providing library privileges (including access to electronic databases) as part of collaborative research efforts, supports for student internships, alumni benefits, or through continuing education courses.

Training materials, textbooks, and courses on EBP are also becoming more prevalent. Step-by-step guidelines for how to efficiently search the electronic bibliographic databases are being developed (Bronson, 2005), textbooks that include content on evidence-based practice are available (Gibbs, 2005), and increasingly, social work programs are adding content on evidence-based practice to research and practice courses. Future graduates of social work programs are likely to know about evidence-based practice and to possess, at a minimum, the skills to locate completed systematic reviews and relevant research in the electronic databases.

When systematic reviews are not available, social workers will need more sophisticated skills to explore the electronic bibliographic databases and adequately assess the rigor and quality of the retrieved research. This will be far more time consuming and require advanced knowledge about research methods and statistics. Preparing all social workers to conduct this type of sophisticated systematic review is, at this time, probably unrealistic.

It is realistic, however, to develop a specialization within social work education that focuses on developing a small cohort of well-trained social workers with the skills to conduct sophisticated searches for research, undertake systematic reviews of the literature, and complete meta-analytic studies of various intervention strategies. These specially trained social workers will provide the information to practitioners and eliminate the need for all social workers to conduct their own searches for relevant research. This may offer a more efficient model for integrating EBP into social work.

In this model, evidence-based social work practice can be conceptualized according to three levels of activity, each requiring different levels of skill and knowledge (see Table 2).

Organizations that adopt evidence-based practice may find it useful to have an evidence-based retrieval specialist as part of the staff, or those with this training may serve as consultants to social service agencies. Finally, *systematic reviewers* will have the highest level of training (typically at the doctoral level) in literature retrieval, research methods, and statistics. In addition, they will know how to use meta-analytic statistics to prepare comprehensive, systematic reviews for distribution to the field through the Campbell Collaboration and similar organizations. This model reduces the time that direct service workers and administrators need to devote to collecting the "evidence" needed for evidence-based practice while still ensuring that they will have access to the best available research to guide their work.

Even if social workers have easy access to relevant research, their attitudes toward the scientific underpinnings of evidence-based practice may still present a formidable barrier to implementation. Training materials need to be developed that (1) help social workers recognize the relevance of EBP to practice, (2) describe the strengths and limitations of this method, and (3) show practitioners the importance of using evidence-based treatments. In addition, the philosophical fit between the practitioner and EBP is an important factor in fostering implementation, but bringing about changes in these areas can be a difficult challenge (Munson & Pelz, 1981). Revising course content in social work education to include the concepts and methods of EBP is a first step. Additional efforts are needed to reach practitioners in the field through continuing education workshops and in-service training. The misconceptions of EBP can be challenged when necessary (Gibbs & Gambrill, 2002) and studies conducted to demonstrate the benefits of engaging in evidence-based practice.

Table 2. Types of Evidence-Based Social Work Practitioners

	Activities	Required Skills and Knowledge
Evidence-Based Practitioners	- Seek out and use the best available research evidence to guide practice decisions	- Access research syntheses from the Internet - Search electronic bibliographic databases for relevant research - Have the ability to identify serious methodological problems with the published research
Evidence-Based Retrieval Specialists	- Develop advanced skills in searching electronic sources for research relevant to social work practice - Prepare research summaries, identify promising practices, and disseminate results to practitioners	- Use advanced knowledge and skill in electronic search strategies - Develop skills to critically evaluate research methods, designs, and statistical procedures used in research reports
Systematic Reviewers	- Conduct meta-analyses on interventions and policies - Disseminate research syntheses and analyses through the Campbell Collaboration and similar organizations	- Gain ability to search electronic databases and "gray" literature - Develop skills to critically evaluate research methods, designs, and statistical procedures used in research reports - Build knowledge of meta-analytic statistics

Evidence-based practitioners are social workers with BSW or MSW degrees who use the best available research evidence to make practice decisions. They will need fundamental computer skills to access available research syntheses and bibliographic databases. And, they should have enough knowledge about research and statistics to identify any serious methodological flaws or issues of bias in the published research. *Evidence-based retrieval specialists* are social workers with MSW degrees, a specialization in evidence-based practice, and advanced skills in identifying and retrieving research from the electronic bibliographic databases and the Internet. Social workers with this level of training will be capable of conducting rapid evidence reviews of the research literature and preparing summaries of the research findings for direct service providers or policy makers.

cont'd on page 6

Acceptance of EBP is likely to be slow and incremental, as it is for most other innovations. But technological advances, better education and training in EBP, and the increasing presence of evidence-based practice in social work organizations will all serve to infuse EBP into social work practice. Doing so may narrow the gap between research and practice in ways that were not possible before and thus insure that social work practitioners are using interventions based on the best available research in the field.

About the Author

Denise E. Bronson, PhD, is Associate Professor in the College of Social Work at The Ohio State University, specializing in research and evaluation and child welfare issues. She is a lead researcher on Ohio's University-Agency Research Consortium, promoting an evidence-based approach to child welfare practice.

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The Campbell Collaboration: A Reliable Source of Evidence for Practice

Julia H. Littell, PhD

Where can professionals find the current best evidence for practice with vulnerable children and families? Many look to published research reviews or the many summaries of "evidence-based practices" (EBP) produced by scholars, government agencies, and professional organizations. But, as I explain, the accuracy of these sources varies. How can we tell whether a research summary is accurate or whether it is an unbiased assessment of the evidence?

This article considers what constitutes "good" evidence and introduces helping professionals to The Campbell Collaboration, a new international organization devoted to producing the highest-quality systematic reviews of evidence on "what works" and what doesn't in the fields of social care. By way of introduction, let us examine the contexts in which the need for more reliable information on intervention effects emerged.

Evidence-Based Practice

For more than a century, there have been movements to use "scientific" evidence to inform practice and policy and to improve the health and well-being of vulnerable children and families. In the scientific charity movement of the late nineteenth century, practitioners looked to science to solve social problems. As the medical and social sciences evolved, attempts to link science and practice also emerged. In the scientist-practitioner movement in social work in the 1970s, practitioners were expected to generate scientific evidence and use it in practice. Many experienced a fundamental conflict between the faith required for practice and the skepticism required for research. The current movement toward evidence-based practice takes into account a division of labor in the helping professions (i.e., most practitioners are not researchers and vice versa), and it links practice and research in other ways.

Evidence-based practice derives from evidence-based medicine, which was developed in the early 1980s in Canada and has had its greatest impact in the United Kingdom. David Sackett, one of the founders of evidence-based medicine, defined it as "the conscientious, explicit, and judicious use of current best evidence in making decisions" about individual cases (Sackett et al., 1996, p. 71). EBP is *a process performed by clinicians*. The process of EBP involves formulating answerable questions, seeking answers, appraising the evidence, applying the results, and assessing the outcomes.

Although interest in EBP is growing (certainly much lip service is paid to it), current discourse includes considerable confusion about what EBP is and isn't. Some experts appear to favor a cookbook approach to EBP, linking certain diagnoses or conditions to practices that have been "proven" effective in similar cases and then promoting or even legislating the use of these treatments. That is certainly *not* what Sackett had in mind. Other oversimplifications include the classification of interventions as "effective," "promising," or "not effective," based on criteria that vary (considerably) from one classification schema to the next. Widespread misconceptions include the notions that the only evidence that matters in EBP is evidence about outcomes, and that the only credible evidence on outcomes comes from randomized controlled trials.

Evidence for Practice

Many sources and types of evidence are relevant for practice. Current models of evidence-based practice and policy (EBP) encourage professionals to seek and carefully consider credible information about clients' needs, values and preferences, contexts and constraints, and interventions effects. Practitioners may come up empty-handed, unable to find credible evidence on one or more of these topics; nevertheless, they must act. In these circumstances, EBP helps practitioners clarify what we *don't* know.

Scientific evidence is always tentative, constantly evolving, and incomplete. EBP practitioners can avoid ruts and fads by recognizing that the current best evidence is not the last word on the subject.

Next, let us focus on *one* type of evidence for practice—results of empirical research on intervention effects. This is not necessarily any better or more important than other types of evidence. However, if we are concerned about intervention effects, we ought to examine and synthesize this kind of evidence carefully.

How Do We Know What Works?

A range of evaluation methods is used to identify effects of interventions, and diverse review methods are used to synthesize results of multiple studies of intervention effects.

Effect Studies

Randomized controlled trials (RCTs) are generally considered the gold standard in evaluation research because RCTs are most likely to provide unbiased estimates of intervention effects. However, RCTs are not always appropriate nor are they foolproof. There are many alternatives to the RCT, some more reliable than others.

RCTs conducted under carefully controlled conditions, often in university clinics and in close collaboration with program developers, are sometimes called "efficacy studies." RCTs conducted under real world conditions are called "effectiveness" studies. In general, efficacy studies inform us about the *potential* impact of an intervention under ideal conditions, while effectiveness studies show the *likely* impact in practice settings.

An RCT can yield two different kinds of information. First, researchers can assess outcomes for all cases in the original treatment and comparison groups to provide an unbiased estimate of the overall impact of the treatment as it was implemented. This is called an "intent-to-treat" (ITT) analysis. This information is often what policy makers and agency administrators want. It tells us what effects we are likely to obtain if an intervention is implemented, even though participation levels vary and some people drop out.

Second, RCTs may yield an analysis of "treatment on the treated" (TOT). This includes only those cases that received the "full dose" of treatment. Because drop-outs are excluded (and attrition is often not random, i.e., people drop-out for various reasons) the TOT analysis does not follow the original experimental design. Hence, these results are essentially quasi-experimental.

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The validity (accuracy or credibility) of research results is not simply a function of research design or methods. Validity is a property of the inferences one can draw from a study. For example, characteristics of the sample and setting affect our ability to extrapolate results to other people and places. Characteristics of measurement instruments affect our ability to examine central ideas and associations between constructs. Competing explanations for differences between experimental and comparison groups affect our ability to identify intervention effects. Small studies often lack the statistical power necessary to detect clinically meaningful effects, and some studies are unduly influenced by extreme cases (outliers).

There is no such thing as a perfect study. Single studies, no matter how rigorous, have limited generalizability. Multiple studies are needed to enhance confidence in results, or modify or refute previous findings. Independent replications are necessary to counter "allegiance effects" that may appear when interventions are studied by their developers.

Synthesizing Results of Multiple Studies: Traditional Reviews

The most common method of synthesizing results of multiple studies is the traditional literature review. The traditional method involves finding relevant studies, describing them, and generating conclusions about what the weight of the evidence suggests. This approach is vulnerable to several types of bias.

Sampling bias. Reviewers tend to obtain a convenience sample of published studies. If I do a keyword search of the electronic bibliographic databases that happen to be available to me, my results will differ from those obtained by a colleague who uses the same keywords in a different location with access to different databases. Further, because journal indexing is fallible, relevant studies may be missed by electronic keyword searches.

Publication bias. Reports with positive, statistically significant findings are more likely to be submitted for publication and more likely to be published than those with negative or null results. This publication bias may suppress reporting of nonsignificant findings in studies that have mixed results. If a research review considers only published reports and there are many, relevant unpublished studies on the topic, positive effects will be overestimated.

Because journals limit the length of published articles, descriptions of intervention and research methods are often incomplete. Some are more tidy than accurate. If reviewers rely only on published accounts of studies, they may miss important implementation issues that affect the interpretation of results.

Confirmation bias. Researchers and reviewers who expect certain results are likely to find them if they use evidence selectively. People tend to accept evidence that confirms their expectations and dismiss that which does not.

The task of combining results of multiple studies is quite complex. No two studies are identical. Studies on the same topic may have different sample characteristics, designs, outcome measures, and results. Traditionally, reviewers have used their best cognitive algebra to sort out differences among studies and sum up results. This mental math is not very accurate. Studies have shown that reviewers' conclusions may be affected by irrelevant information (e.g., the wording of titles of research articles and authors' reputations or affiliations).

Further, what is being "counted" in the traditional literature review depends entirely on original study report. Since many small studies lack power to detect effects, adding them up can lead reviewers to underestimate intervention effects.

The Science of Research Synthesis

For the past century, statisticians and scholars have worked to develop methods to combat the biases inherent in traditional narrative reviews. Beginning with Pearson's work in medicine in 1904, researchers have created systematic approaches to synthesizing results of multiple studies. This includes meta-analysis and "systematic reviews."

Meta-analysis

Meta-analysis refers to the quantitative synthesis of findings from two or more studies. In a meta-analysis, original data from each study are converted to a common metric called an "effect size" (ES). There are several ES metrics, but the most common is the *d* index (also called the standardized mean difference), which expresses differences between treatment and control groups in standard deviation units.

Meta-analysis can be used to answer a number of different questions about a body of research. Usually we want to know whether all of the studies in our sample point to the same conclusion (heterogeneity tests address this issue). We may also want to estimate an average or overall effect across studies. Average ES are created by weighting study ES by their precision (inverse variance) and then averaging results across studies. This means that more precise studies (usually larger studies and those with more consistent results) "count" more in the overall average. This is as it should be. (We wouldn't want a study with 10 cases to count as much as one with 1,000; nor would we want a study with widely varying results to count as much as one with consistent results.)

Because meta-analysis includes data from all subjects in the original studies, many underpowered studies with statistically nonsignificant results can add up to an average ES that is statistically significant and clinically meaningful.

If many effect studies are available, meta-analysts can examine differences among them to address other questions relevant to policy and practice. For example, we might want to know whether a program tends to be more effective with younger children or older ones, whether low-income families benefit as much as wealthier families, whether more intensive programs have stronger effects, and so on.

Meta-analysis is not always possible or desirable. It does not make sense to combine studies that address different questions, and the quantitative synthesis of results of many weak studies is still weak. Further, meta-analysis attends to only one phase of the review process—the analysis. The science of research synthesis can be brought to bear on other aspects of the review process.

Systematic Reviews

Systematic reviews focus on the scientific aspects of *all* phases of research synthesis. Unfortunately, the term has been widely misused, and many so-called systematic reviews aren't.

A systematic review has explicit objectives, uses transparent procedures, and attempts to minimize bias in the identification, assessment, and synthesis of research results. Procedures are spelled out in advance and are documented so that others can critically appraise or replicate the review, or both. A systematic review follows the basic steps in the research process (further, while most studies sample people, families, organizations, and the like, a systematic review samples and analyzes prior studies). The steps are as follows:

First, explicit objectives are stated and eligibility criteria (inclusion and exclusion criteria) are formulated to specify the types of study designs, interventions, populations, and outcomes that will be included in the review.

Second, a systematic search strategy is designed to reduce bias in the identification of eligible studies. The search strategy specifies keyword strings and sources that will be used to find relevant studies in bibliographic databases and other electronic media. The search may be bounded by dates, journals, databases, and so forth, as long as the search procedures are transparent and replicable. The search strategy includes efforts to find "gray" (unpublished) literature; this usually involves contacts with experts in the field and careful scanning of relevant bibliographies. Many reviewers use hand searches of key journals to identify relevant studies that are not fully indexed.

Next, reviewers conduct the search and document results. Decisions about full text retrieval and study eligibility are usually made by two independent raters to increase reliability. Specific reasons are given for each study exclusion.

The data from eligible outcome studies are extracted by independent raters onto uniform paper or electronic forms. These data include characteristics of the study (e.g., design, attrition), interventions, samples, outcome measures, and findings. Again, coding is conducted by multiple reviewers to increase reliability; differences among coders are discussed and resolved (sometimes by a third person). Reviewers assess many qualities of eligible studies and seek additional information from primary authors as needed.

A systematic review *may* include meta-analysis if there are two or more similar studies that meet the eligibility criteria.

Finally, the review process and results are reported in a structured and detailed document.

Potential problems with systematic reviews. A systematic approach does not guarantee that a review will be free of bias, although transparent methods facilitate commentary and debate about the integrity of a review.

Systematic reviews are very labor intensive and, therefore, expensive. Costs depend on the duration and complexity of the review and range from $40K to $200K per review.

Once completed, systematic reviews may become outdated as results of new studies become available. To remain relevant, reviews must be updated every two or three years.

What do these problems mean for practitioners and policy makers? Many people underestimate the complexities of finding, assessing, and synthesizing evidence scientifically. Will practitioners and policy makers be able to do this and keep their day jobs? In the EBP framework, ultimate responsibility for the assessment and use of evidence lies in the hands of the practitioner and policy maker. Realistically, decision makers need help with this process. Reliable sources of evidence—a body of systematic reviews on topics relevant to practice and policy—will be enormously useful for policy and practice. Again, this will not be the last word on the issues, nor should it obscure other types and sources of evidence that practitioners need to consider in making decisions (i.e., evidence about the needs, preferences, contexts, and constraints present in individual cases).

Some systematic reviews find that there is no credible evidence on a topic. When this occurs, decisions must be made on other grounds. However, arming practitioners and policy makers with the knowledge that there is no good information on a topic helps them fulfill the EBP dictum to consider the current best evidence. In short, systematic reviews are merely a way of carefully compiling and making available one type of information for practice.

Where Is the Evidence That Is Needed?

During the past decade, important advances in the science and practice of research synthesis included improved methods of information retrieval, better understanding of relationships between research design and outcomes, and development of statistical techniques and software for meta-analysis. At the same time, many organizations and individuals made extensive efforts to compile and synthesize empirical evidence on intervention effects for specific conditions and problems. Practitioners and policy makers who want to know "what works" and "what works best for whom" can find many lists of empirically-supported programs on Web sites sponsored by government agencies, foundations, and professional organizations. More thorough treatments of these topics are available in government reports and peer-reviewed publications.

This said, with a few exceptions, advances in the science and practice of research synthesis have not been connected. As a result, putatively authoritative reviews and lists of effective practices have proliferated with little attention to the science of research synthesis. Ironically, while these lists and reviews are aimed at providing evidence for practice and policy, they are not themselves based on evidence about how to find, summarize, and synthesize research findings.

The Campbell Collaboration

Building on the successful, collaborative model of rigorous research synthesis pioneered by the Cochrane Collaboration in medicine (see www.cochrane.org), the Campbell Collaboration was created in 1999 to bridge the science and practice of research synthesis and produce the highest-quality systematic reviews of research on intervention effects in the fields of social care.

The Campbell Collaboration is an independent, nonprofit organization devoted to producing reliable information on effects of behavioral, social, and psychological interventions (see www.campbellcollaboration.org). Named for Donald T. Campbell, the Collaboration (fondly known as C2) strives to minimize bias and maximize the quality, relevance, timeliness, and accessibility of information for policy and practice.

C2 develops standards for systematic reviews, offers training in systematic review methods, provides technical assistance to review

cont'd on page 10

teams, ensures that C2 reviews meet C2 standards through a peer-review process, and provides Web-based access to C2 systematic reviews. C2 hosts annual colloquia and fosters international, interdisciplinary perspectives on social problems. In addition, C2 maintains a unique, electronic register of studies of the effects of psychosocial, behavioral, and educational interventions.

C2 is organized by a corporate Board, an international Steering Group, a Secretariat's office, and six Coordinating Groups. The Coordinating Groups cover three substantive areas (education, social welfare, and crime and justice) and three cross-cutting topics (methods, communication, and users). Some of the Coordinating Groups have subgroups (e.g., the Methods Group has subgroups on topics such as training, information retrieval, research design, and statistics). The Cochrane Collaboration and C2 relate to each other through overlapping steering groups and subgroups.

C2 has been supported by largely volunteer efforts from an international, interdisciplinary network of scholars, practitioners, and policy makers and by the work of other nonprofit organizations, government agencies, and foundations (particularly in the United Kingdom and Nordic countries). Recent support from the American Institutes for Research has allowed C2 to begin to build a more permanent infrastructure.

C2 Reviews

Like Cochrane reviews, C2 reviews are produced by independent review teams that follow certain policies and procedures (policy statements on information retrieval, research design, and statistics are available on the C2 Web site). C2 reviews are *not* limited to RCTs, but evidence from RCTs is analyzed separately from evidence from other kinds of studies.

The process begins when a review team registers a "title" for the review with a C2 Coordinating Group. The title declares the review team's objectives and outlines a preliminary approach to the review topic. Next, the team develops a detailed "protocol" or plan for the review. The protocol is vetted by substantive and methodological experts within and outside of C2, who comment on the relevance of the proposed review for practice and policy in a particular field, along with its methodological rigor. The protocol includes an explicit statement about any potential conflicts of interest. Completed reviews are also vetted by substantive and methodological experts within and outside C2. C2 reviews are expected to be updated every two or three years.

Once accepted by a C2 Coordinating Group, all products (titles, protocols, and completed reviews) are posted on the C2 Web site. Commentaries may be posted as well.

The C2 Social Welfare Coordinating Group

The C2 Social Welfare Group may be of interest to APSAC members because this group covers topics related to child abuse. Within the Social Welfare Group, the Developmental, Psychosocial, and Learning Problems (DPLP) Subgroup, which is coregistered with the Cochrane Collaboration, has produced systematic reviews on topics such as cognitive-behavioral interventions for sexually abused children and school-based programs for prevention of child sexual abuse.

To date, most of the interest, effort, and funding for systematic reviews in social welfare has been located in Europe; hence, the Social Welfare Group is only beginning to organize networks of scholars, practitioners, policy makers, and funders in North America. The group covers a wide range of topics, including child welfare, mental health, substance abuse, public health, aging, poverty, housing, welfare, work, and family life.

Using the Science of Research Synthesis

Practitioners and policymakers can use valid, up-to-date research syntheses to make informed decisions about the likely impacts of social and behavioral interventions. However, research reviews might be biased, particularly when they are not based on understanding of common problems and methods of research synthesis. Consumers should be wary of traditional research reviews that rely on narrative summaries of convenience samples of published studies. Valid summaries of available evidence are more likely to come from systematic reviews that use transparent methods and attempt to minimize bias at every step in the review process.

To illustrate the differences between traditional and systematic reviews, my colleagues and I recently completed a jointly-registered Cochrane/C2 review on effects of multisystemic therapy (Littell, Popa, & Forsythe, 2005). Results of this systematic review (available in the *Cochrane Library, Issue 4*, and on the C2 Web site) are not consistent with those of traditional, narrative reviews or partially-systematic reviews of the same body of evidence.

This suggests a need to reassess and update empirical evidence that has been reviewed by traditional methods. The Campbell Collaboration provides a platform for this purpose by bridging the science and practice of research synthesis, developing reliable syntheses of evidence on intervention effects in the fields of social care, and promoting open debate about the evolving evidentiary status of interventions. Practitioners and policy makers are welcome to join the Campbell Collaboration, suggest topics for systematic reviews, participate in review teams, and critique C2 products (contact: jlittell@brynmawr.edu).

About the Author

Julia H. Littell, PhD, is Associate Professor in the Graduate School of Social Work and Social Research at Bryn Mawr College, specializing in children and family issues and child welfare. She is a member of the editorial board of Children and Youth Services Review and a member of the Steering Committee of the Campbell Collaboration.

References

Littell, J. H., Popa, M., & Forsythe, B. (2005). Multisystemic therapy for social, emotional, and behavioral problems in youth aged 10-17 (Cochrane Review). In *The Cochrane Library, Issue 4, 2005*. Chichester, UK: Wiley.

Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal, 312*, 71-12.

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, Ph.D., 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

Developmental Differences in the Utility of Anatomical Dolls During Interviews

This study examined the impact of anatomical dolls on reports provided by 3- to 12-year-old alleged sexual abuse victims (N = 178). Children were split into two age groups (i.e., 3-6 & 7-12) to explore developmental differences. Children produced as many details in response to open-ended invitations with and without the dolls. In response to directive questions, the 3- to 6-year-olds were more likely to reenact behaviorally than to report verbally, whereas the 7- to 12-year-olds produced more verbal details than enactments when using the dolls. Younger children were also more likely than the older children to play suggestively with the dolls and to contradict details provided without the dolls, whereas the older children were more likely to provide details that were consistent. Children in both age groups produced proportionally more fantastic details with the dolls than without the dolls.

Thierry, K. L., Lamb, M. E., Orbach, Y., & Pipe, M. (2005). Developmental differences in the function and use of anatomical dolls during interviews with alleged sexual abuse victims. *Journal of Consulting and Clinical Psychology, 73*(6), 1125-1134.

CSA Linked With Elevated Risk Taking and Relationship Dissatisfaction

The links among childhood sexual abuse (CSA), women's adult sexual risk behaviors, and the quality of their intimate relationships were explored in this article. A model was tested among a household sample of women (n = 732), in which CSA predicted Wave 1 male partner sexual risk and aggression characteristics, resulting in lower relationship satisfaction and, ultimately, in higher numbers of Wave 2 sexual partners. These results were generally replicated among women who entered new relationships at Waves 2 and 3. The authors concluded that elevated sexual risk behaviors among CSA survivors reflect difficulty in establishing stable and safe relationships and may be reduced by interventions aimed at improving intimate relationships.

Testa, M., VanZile-Tamsen, C., & Livingston, J. A. (2005). Childhood sexual abuse, relationship satisfaction, and sexual risk taking in a community sample of women. *Journal of Consulting and Clinical Psychology, 73*(6), 1116-1124.

Relational Outcomes of African American CSA Survivors

This longitudinal study examined the effects of childhood sexual abuse (CSA) on the intimate and marital relationships of adult survivors from a sample composed primarily of African American women. The protective role of maternal support also was explored. Researchers interviewed 136 women, with documented histories of CSA, on the quality and nature of their current marital relationships and other interpersonal connections. Findings suggest that CSA survivors with poor maternal attachment are more likely to enter into marital or cohabiting relationships than CSA survivors with good maternal attachments. The severity of sexual trauma in childhood was correlated with greater marital dissatisfaction. Good maternal attachment during childhood, however, had a negative main effect on adult interpersonal problems and a buffering effect on the relationship between abuse and marital dissatisfaction.

Liang, B., Williams, L. M., & Siegel, J. A. (2006). Relational outcomes of childhood sexual trauma in female survivors: A longitudinal study. *Journal of Interpersonal Violence, 21*(1), 42-57.

PHYSICAL ABUSE

Is There a Link Between Physical Abuse and Perceived Social Isolation?

Using data from the National Youth Survey, this study examined the relationship between physical abuse and social isolation. Results strongly supported the hypothesis that adolescents who had experienced violence were likely to report more isolation than those who had not. Interestingly, males were more socially isolated than females and Hispanics more than Whites. Parental involvement, neighborhood safety, household density, and stressful life events were also linked to the degree of social isolation.

Elliott, G. C., Cunningham, S. M., Linder, M., Colangelo, M., & Gross, M. (2005). Child physical abuse and self-perceived social isolation among adolescents. *Journal of Interpersonal Violence, 20*(12), 1663-1684.

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Development of PTSD Among Bipolar Patients With Abuse Histories

The authors studied 100 patients, diagnosed as bipolar using DSM-IV criteria, who were evaluated for childhood physical, sexual and emotional abuse, traumatic events in adulthood, and lifetime PTSD. Adult comorbid PTSD was evident in 24% of subjects and was significantly associated with childhood sexual abuse, adult sexual assault, and adult survival of the suicide, homicide, or accidental death of a close friend or relative. Severe childhood abuse was reported by about half of bipolar patients, but only one-third of abused patients developed PTSD. Risk for PTSD rose in linear fashion to the number of childhood abuse subtypes present. The findings suggest that about one-third of bipolar patients with severe childhood abuse histories, particularly sexual abuse, manifest comorbid adult PTSD. Childhood sexual abuse, as well as severe interpersonal loss, may sensitize individuals who are predisposed to bipolar disorder also to develop eventual PTSD.

Goldberg, J. F., & Garno, J. L. (2005). Development of posttraumatic stress disorder in adult bipolar patients with histories of severe childhood abuse. *Journal of Psychiatric Research, 39*(6), 595-601.

Are There Divergent Pathways for the Intergenerational Transmission of Destructive Behaviors?

This study examined abuse during childhood as a potential mediator of the intergenerational transmission of externalizing behaviors in adulthood. Community participants, drawn from the National Comorbidity Survey (N = 5,424), underwent diagnostic and psychosocial interviews and reported on their own adult symptoms in several domains. Multiple group structural equation modeling revealed that (a) externalizing behavior in parents was associated with childhood abuse in offspring, particularly among mother-daughter dyads, (b) abuse had a unique influence on adult externalizing behaviors in offspring above parental externalizing behaviors, and (c) abuse accounted for the relationship between parental and offspring externalizing behaviors in female but not male participants. This article emphasized the importance of examining different environmental processes that may explain familial transmission of destructive behaviors in men and women and highlighted the importance of family interventions that target parental symptoms to ameliorate risk to offspring.

Verona, E., & Sachs-Ericsson, N. (2005). The intergenerational transmission of externalizing behaviors in adult participants: The mediating role of childhood abuse *Journal of Consulting and Clinical Psychology, 73*(6), 1135-1145.

OTHER ISSUES IN CHILD MALTREATMENT

Are School Counselors Reporting Abuse?

A sample of school counselors (N = 263) completed questionnaires to share their child abuse reporting behaviors, influences with regard to making a decision to report, and perceived barriers to the reporting process. Participants indicated reporting the majority of suspected cases, and elementary school counselors reported more cases than did high school counselors. Implications and recommendations are presented.

Bryant, J., & Milsom, A. (2005). Child abuse reporting by school counselors. *Professional School Counseling, 9*(1), 63-71.

Strategies for Conducting Bonding Evaluations

Involuntary termination of parental rights is one step the court can take in intractable child abuse cases. The court or the child protection agency frequently requires a psychological evaluation that includes an assessment of the child's psychological bond with various caretakers, sometimes referred to as a bonding evaluation. The principles underlying such psychological evaluations and accepted methods of conducting these evaluations are delineated in this article.

Barone, N. M., Weitz, E., & Witt, P. H. (2005). Psychological bonding evaluations in termination of parental rights cases. *Journal of Psychiatry & Law, 33*(3), 387-411.

Can Public Policy Be a Powerful Tool for Maltreated Children and Their Families?

This article addressed how psychologists and other child-oriented researchers can utilize public policy to ensure that child and family issues, specifically issues related to child abuse and neglect, receive adequate attention. The authors encourage the development of bidirectional relationships between policymakers and experts in child maltreatment. To facilitate such relationships, the article offered practical guidance to psychologists on understanding the policymaking process, gaining familiarity with relevant policy, communicating effectively with policymakers, and understanding the unique contributions that psychologists can make to the policy process.

Portwood, S. G., & Dodgen, D. W. (2005). Influencing policymaking for maltreated children and their families. *Journal of Clinical Child and Adolescent Psychology, 34*(4), 628-637.

Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

CONGRESS VOTES BUDGET CUTS, CHILD WELFARE FUNDING AT ISSUE

In December, Congress recessed for the holidays and left a major budget reconciliation spending cuts bill on the table. Fiscal conservatives had used the demand for relief to survivors of Hurricane Katrina as an excuse to pull out a wish list of long desired federal program cuts, many embedded in the legislation at the center of the budget reconciliation debate. Much of the debate focused on a range of cuts proposed in programs that help children and families. On February 1, the day after the House returned for the State of the Union address and the resumption of legislative business, the $40 billion budget cuts bill, which had passed the Senate in December, passed the House narrowly by a vote of 216-214.

Many of the bill's provisions hurt poor children and their families while purporting to set aside funds to support the poor in the devastated regions of the Gulf coast. Opponents of the budget cuts criticized the bill for applying the savings to upcoming tax cuts while scaling back programs that would help the people who need these most.

The contentious budget reconciliation bill compromises health care for the poor by allowing states to change the rules and impose new costs on Medicaid recipients. Cuts in Medicaid are likely to lead to states increasing health care co-payments on the poor and dropping preventive care. The Congressional Budget Office estimates that the increase in co-payments and premiums, and reductions in benefits, will total $16 billion over 10 years. The legislation cuts $5 billion in child support enforcement, which is estimated to deprive children of more than $8 billion in child support over the next 10 years. It restricts access to food stamps, causing an estimated 300,000 low-income families, many of them the working poor, to lose their food stamps.

In addition to these cuts, the bill takes aim at federally funded foster care services. The budget cutting measure harms abused and neglected children being cared for by their grandparents and other relatives. By overturning the *Rosales* decision, which extended federal foster care assistance to abused and neglected children in the care of relatives, the bill eliminates almost $600 million in foster care assistance over a 5-year period for at least 4,000 children who have been placed in low-income homes with relatives. The provision, which makes it less likely that states will place children with relatives, undercuts a preference for placement of children with relatives required by the Adoption and Safe Families Act.

Different versions of the Deficit Reduction Act have shuttled back and forth between the House and Senate. The budget cuts measure first passed the Senate in November by a vote of 52-47. At the same time in the House, Republican leaders were forced to pull their own version of the budget-cutting measure from the floor when it became clear that the budget bill lacked the votes for passage. To appease Republican moderates, their party leaders had agreed to drop the bill's provisions allowing oil drilling in Alaska's Arctic National Wildlife Refuge. Conservative Republicans who would support the Alaska oil exploration then got angry and threatened to withdraw their support. Moderate Republicans went further and said it wasn't enough to hold their votes either, objecting to other provisions in the bill that would hurt the nation's poor. A week later, the Republican leaders took a slightly trimmed version of the bill to the House floor and managed to squeak through with a 217-215 vote. Democrats held together and were joined by 14 Republicans voting against the measure.

On December 19, the House took up a House-Senate conference committee's agreement on a final version of the Deficit Reduction Act, passing it by a narrow margin of 212-206. The bill then went back to the Senate, where it barely passed, 51-50, on December 21, when the Vice President was brought back to Washington to cast the tie-breaking vote. The bill went back to the House for another vote because of slight changes in provisions made in the Senate on procedural grounds, and it passed on February.

Child advocates and others worked to hold back the budget cuts doing harm to children and low-income families. The outcome sadly reflects a lower priority to services for children and poor families over continued tax cuts for the wealthy.

FISCAL 2006 HHS APPROPRIATIONS BILL FINALLY PASSES

While legislators labored over the politics of budget cuts, Congress (for the first time in recent memory) managed to complete action on all appropriations legislation for the new fiscal year without resorting to enactment of an omnibus spending measure to pick up money bills too controversial to pass on their own. Even so, it wasn't easy.

The Labor-HHS-Education Appropriations Act for 2006 was the last of the appropriations bills. It was passed and signed into law by the President on December 30, 2005. The final conference agreement on the bill was first defeated, 209-224, in the House on November 17. In a significant setback for the House Republican leadership, Democrats hanging together with 22 Republicans defeated the conference committee's agreement on the appropriations bill. The Republicans were mostly budgetary moderates joined by conservatives angry over the leadership's decision to strip away funding earmarked by individual legislators for special projects.

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Provisions of the bill, such as cuts to education programs, a freeze on college financial aid, reduced spending for the Centers for Disease Control, and cuts in grants to states for prenatal care for mothers, were cited as reasons for opposition. A different version of the bill then barely managed to pass the House, 215-213, with a second vote on December 14, 2005. The Senate then adopted the bill by voice vote on December 21 and sent it to the President for signature.

Federal support for child welfare services comes up short in the fiscal 2006 Labor-HHS-Education money bill. While the overall funding for the Department of Health and Human Services is up by more than $94 billion over the 2005 level, none of that increase was given out in any significant way to services for protecting children and preventing harm to children at-risk of maltreatment. In fact, the overall budget for the HHS Administration for Children and Families is down in 2006 by $45.3 million. Almost all child welfare programs were left with level funding or were cut. With inflation up 2.33% over last year, a funding freeze amounts to a spending cut for these programs. On top of that, an across-the-board cut of 1% was applied to all federal programs by a provision included in the Defense Department's appropriations bill.

Significantly, all funds earmarked for special projects by individual legislators were eliminated in the final HHS appropriations and in all other appropriations bills as well. This unprecedented action was taken as a necessary step to control spending. In recent years, the Child Abuse Prevention and Treatment Act funding for discretionary grants has included between $5 and $8 million earmarked for local projects, on top of the funds for research and demonstration grants. With the elimination of the earmarks, CAPTA discretionary grants appear to have been cut. In fact, the basic level of funding remains the same.

WHITE HOUSE CHOOSES WHEN TO WITHHOLD INFORMATION

During the Senate confirmation hearings for Judge Alito, there was discussion regarding how much weight should be given to Presidential statements issued at bill signings, when courts must interpret legal intent. A recent *New York Times* editorial called the proposal that a President's statements during bill signings should have equal weight to Congressional intent an "outlandish idea" ("Judge Alito's Radical Views," January 23, 2006).

Apparently disagreeing with that editorial, the President made clear his disagreement, and differing intent with portions of the FY06 Labor-HHS-Education Appropriations Act, in his bill signing statement. The Senate Appropriations Committee report required

> [t]hat specific information requests from the chairmen and ranking members of the Subcommittees on Labor, Health and Human Services, and Education, and related agencies, on scientific research or any other matter, shall be transmitted to the Committees on Appropriations in a prompt professional manner and within the time frame specified in the request: Provided further, that scientific information requested by the Committees on Appropriations and prepared by government researchers and scientists shall be transmitted to the Committees on Appropriations, uncensored and without delay.

(Senate Report 109-103—Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2006: http://thomas.loc.gov/cgi-bin/cpquery/?&dbname=cp109&sid=cp109dHWBq&refer=&r_n=sr103.109&item=&sel=TOC_701922&)

In signing the FY06 Labor-HHS-Education-Appropriations Act, the President asserted in his statement that

> the executive branch shall construe provisions in the Act that purport to mandate or regulate submission of information to the Congress in a manner consistent with the President's constitutional authority to withhold information that could impair foreign relations, national security, the deliberative processes of the Executive, or the performance of the Executive's constitutional duties.

(Office of the Press Secretary, December 30, 2005, President's Statement on H.R. 3010, the Department of Labor, Heath and Human Services, and Education, and Related Agencies Appropriations Act, 2006, http://www.whitehouse.gov/news/releases/2005/12/20051230-6.html)

What the White House says is that Congress will get the information if the Administration feels like giving it. Perhaps the courts will decide at a later time the relative weight of Congressional and Presidential intent regarding such passed and signed legislation.

NEW DOMESTIC VIOLENCE LAW ATTENDS TO CHLD MALTREATMENT

On January 5, 2006, the President signed into law legislation reauthorizing the Violence Against Women Act (VAWA). The bill, which passed the Senate by unanimous consent on December 16 and passed the House by voice vote on December 17, adds new provisions to the VAWA statute. Many of these provisions have been proposed by child protection advocates before because the VAWA reauthorization process has stretched over several years and multiple sessions of Congress.

The new domestic violence statute recognizes the interconnections between child maltreatment and domestic violence through provisions to authorize the following:

- Services for children exposed to domestic violence. The statute authorizes the Justice Department's Office on Violence Against Women, in collaboration with HHS, to award competitive grants ($20 million each year of FY2007-11) aimed at mitigating the effects of domestic violence on children and reducing the risk of future victimization or perpetration of domestic violence, through direct counseling, advocacy, or mentoring.

- Training for programs that serve children, such as Head Start, child care, and after-school programs. The same competitive grant authority also supports training, coordination, and advocacy for programs that serve children and youth on how to identify children and families experiencing domestic violence and properly refer them to programs that can provide direct services to the family and children.

- Grants to home visitation programs to develop model programs to train home visitation service providers on addressing domestic violence. The statute authorizes a competitive grant program ($7 million for each of FY 2007-11) awarded by the Justice Department's Office on Violence Against Women in collaboration with HHS. The funds are targeted for home visitation programs (working with victim service providers) and to develop model policies and procedures to train home visitation service providers on addressing domestic violence. The cited goals of the training are to reduce the impact of violence on children, maintain safety, improve parenting skills, and break intergenerational cycles of violence. Activities would include training by domestic violence service providers of home visitation program staff to safely screen for domestic violence, to understand the impact of domestic violence on children, and to link new parents with existing community resources.

- Cross-training to address the relationship between domestic violence and child maltreatment. The statute authorizes $5 million annually for FY 2007 through 2011 to support efforts by child welfare agencies, domestic violence services, courts, law enforcement, and other community organizations to develop collaborative responses and services and provide cross-training to enhance community responses to families where there is both child maltreatment and domestic violence. Competitive grants will be awarded by the HHS Family and Youth Services Bureau in consultation with the Office on Violence Against Women, with attention to ensuring that grantee organizations have the capacity to respond appropriately to domestic violence in homes where children are present, to domestic violence in child protective cases, and to the needs of both the child and nonabusing parent. Activities include (a) the implementation of policies and practices for child welfare agencies and domestic violence victim services that are consistent with the principles of protecting the safety and well-being of children and nonabusing parents and caretakers, and (b) enhanced linkages and cooperation among child welfare agencies, domestic violence services, courts, law enforcement agencies, and other entities to provide more comprehensive community-based services to protect and to serve both child and adult victims.

HHS CLARIFIES FEDERAL POLICY: MANDATORY CHILD ABUSE REPORTING TRUMPS CONFIDENTIALITY IN FEDERAL PROGRAMS

Regardless of privacy rules and confidentiality of information under federal laws, mandatory reporters of child abuse and neglect are required, as an exception to these laws, to report suspected cases of child maltreatment, according to an information memorandum issued by the U.S. Department of Health and Human Services.

The memorandum, signed by Assistant Secretary for Children and Families Wade Horn, acknowledges instances in which "[f]ederal privacy rules are being cited as the rationale for mandatory reporters not to follow state laws regarding reporting child abuse and neglect." The memo cites explicit exceptions in federal laws requiring the confidentiality of health information that mandate compliance with state child abuse and neglect reporting laws.

The September 15, 2005, memorandum "to affirm the obligation of mandatory reporters to report child abuse and neglect under state and federal laws" refers specifically to exceptions to the confidentiality and privacy rules in the Health Insurance Portability and Accountability Act (HIPPA), the Public Health Service Act Title X family planning program, and the confidentiality rules relating to patient records in federally funded alcohol and drug abuse treatment services.

The HHS directive encourages state child welfare and child protective service agencies to work with their state's attorney general to notify all mandatory reporters of their legal obligations to report child abuse and neglect. Similarly, Horn's memorandum requests that all federal agencies overseeing health care programs inform their grantees of the memorandum's directive to mandatory reporting of child maltreatment (see full text of information memorandum on Children's Bureau Web site: http://www.acf.hhs.gov/programs/cb/laws/im/im0507.htm).

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 area of specialization in child welfare, human services, and cultural affairs.

A Message From the President

Jordan Greenbaum, MD

I'd like to welcome you to another year of APSAC growth and expansion. The organization began 2006 on an upbeat note, hosting three successful day-long pre-conference Institutes at the San Diego Conference on Child and Family Maltreatment in January. Over 300 participants attended the following workshops: Pediatric Sexual Abuse: Update on Medical Evaluation (Joyce Adams, MD, and Lori Frasier, MD), Basic Training in Trauma-Focused Cognitive Behavior Therapy (Anthony Mannarino, PhD, and Judith Cohen, MD) and Improving Your Knowledge and Skills in the Interview With Males and Children Who Have Developmental Disabilities (Deborah Davies, LCSW, Kee MacFarlane, MSW, and Martin Henry, PhD). The pre-conference institutes have always been popular with professionals, as they focus on practical techniques and recent, evidence-based advances in the various fields related to child maltreatment prevention, investigation and intervention. I, and members of the Board, want to keep these Institutes successful so we welcome your suggestions on appropriate topics for the future. Please let us know of topics you think we should address by contacting our Operations Manager, Daphne Wright, at 843-764-2905, or toll-free at 877-40-APSAC. Alternatively, you can e-mail Daphne at apsac@comcast.net.

APSAC is steadily growing in membership and popularity. Our membership stands at greater than 2000 and continues to increase as new professionals join the ranks and others renew their memberships or return to APSAC after a hiatus. To maintain this rapid acceleration in growth, we need to promptly respond to the needs of our members and continue to provide high quality training and educational materials, efficient service and helpful resources. We want to provide you with the tools you need to better tackle the challenges you face every day in your work with maltreated children. We want to help advance the field of child maltreatment by encouraging research and new practice techniques. We want to provide assistance to those just entering the field, and to those well-established and highly experienced. To do all of this we need active participation by our membership. We need you to tell us what you want from APSAC. We need your help in providing it.

One important way for APSAC members to become involved with the organization and to help fulfill its mission is to become a member of a committee. We are actively recruiting interested members to the following committees:

Organization Development	Membership
Professional Education	Cultural Diversity
Publications	Awards
Nominations	Public Affairs
Under-Represented Disciplines, and	Long-Range Planning.

We need your ideas, your experience, your energy. You may want to help update the APSAC Guidelines and Study Guides, you may want to contribute to the *APSAC Advisor*, or help plan the Colloquium. Perhaps you have ideas for new Guidelines or suggestions for Cultural Institute talks. We want to hear them. Committee members typically meet by phone conference every month or two (the frequency of meetings depends on the decision of committee members and the chairman). Members should expect to work on tasks outside meetings, but the amount of work required depends on the particular committee and on your ability to participate. All levels of expertise are welcome. If you would like to join a committee, or have any questions about them, please contact me at jordan.greenbaum@choa.org. I'd be happy to discuss them with you.

APSAC is looking forward to a successful Colloquium in Nashville this June. We are providing an extensive selection of workshops focusing on a variety of areas, including forensic interviewing, maltreatment investigation and prosecution, prevention, cultural diversity and maltreatment research. There are presentations designed for law enforcement and child protective service workers, as well as legal, medical and mental health audiences. Professionals at all levels of expertise will be able to find suitable workshops, from beginners to the field, to those professionals who have been shaping it. A pre-Conference Cultural Institute offers presentations on a multitude of subjects, ranging from child maltreatment intervention issues in Brazil, to a discussion of minority religions in the United States, to services for deaf victims of child sexual abuse. You can improve your skills in interviewing children from diverse backgrounds, and increase your ability to provide culturally competent services to a wide range of clients. We will also have day-long Advanced Training Institutes preceding the Colloquium. The National Child Traumatic Stress Network (NCTSN) will sponsor "Trauma-Focused Cognitive-Behavioral Treatment for Traumatized Children and Their Families," by Anthony Mannarino, PhD, and Judith Cohen, MD. A second Institute will target medical and legal professionals, addressing "Current Controversies in the Evaluation of Abusive Head Trauma Cases—Medical and Legal Perspectives." This will be presented by Brian Holmgren, JD, Betty Spivack, MD, and Christopher Greeley, MD. Finally, Jane Silovsky, PhD, and Lisa Swisher, PhD, will conduct the third Institute "Children With Sexual Behavior Problems: Identification, Assessment, Treatment, and Policy Issues." I encourage you to look at our brochure and take advantage of your membership discount to register for the Colloquium, the Cultural Institute and/or the Advanced Training Institutes.

APSACs mission is to enhance the ability of professionals to respond to children and families affected by abuse and violence. In keeping with this mission, we are striving to find new ways to bring you state-of-the-art information and resources. We have an expanded, updated website to help our members obtain key information regarding upcoming events throughout the country, and gain access to professional resources. Please visit our new Web site (www.apsac.org) and give us feedback on whether or not it is meeting your needs, and how you would like to see it expanded. We welcome your suggestions on how to make it a primary resource for you in your work.

As APSAC expands, the Board is actively looking for ways to increase the organization's visibility, and its utility to members. We need you to tell us what you think and what you need. To grow maximally, and to best serve our members, we need your constant input. Please contact me or Daphne Wright at jordan.greenbaum@choa.org or apsac@comcast.net, respectively. APSAC is your organization. We want you to use it.

Jordan Greenbaum, MD
APSAC President

APSAC Board Meeting Held in San Diego

The APSAC Board Meeting was held in San Diego, California, on January 22, 2006. The outgoing president, Tony Mannarino, called the meeting to order and handed the gavel to the new president, Jordan Greenbaum. The first order of business was the election of the other officers who form the Executive Committee, along with one member-at-large.

The new Executive Committee members are:

- Jordan Greenbaum, president
- Mike Haney, vice president
- Sarah Maiter, secretary
- Pam Gosda, treasurer
- Rochelle Hanson, member-at-large

The Executive Committee has a monthly teleconference to conduct APSAC business between the scheduled semiannual Board meetings—at the San Diego Conference and the APSAC Colloquium. All Board members are invited to participate in the monthly teleconferences, but only members of the Executive Committee vote on motions made during the teleconferences.

Treasurer Pam Gosda reported that APSAC's financial situation is good but reminded the Board that we must continue to watch expenses carefully to remain in a solid financial position. The Board agreed to make a goal of applying for grant funding to supplement income from memberships, donations, and professional education events.

Operations manager Daphne Wright reported that APSAC ended 2005 with 2,017 members. The membership is remaining very stable, and she expects a substantial number of new members to be added during 2006.

Committees and subcommittees chaired by Board members are the heart of the APSAC organization.
The committees are:

- Membership
- Professional Education
- Cultural Diversity
- Publications
- Operations/Finance
- Awards
- Colloquium Planning
- Public Affairs

Members of the committees do not need to be members of the Board. Any APSAC member with expertise and interest in any of the committees and who is willing to being actively involved should contact Daphne Wright, operations manager (phone: 843-764-2905, toll-free: 877-40-APSAC, fax: 803-753-9823; e-mail: apsac@comcast.net, or mail: P.O. Box 30669, Charleston, SC 29417).

The Board agreed that there will be two and not more than three APSAC Forensic Interview Clinics during 2007. The locations and dates of the clinics will be determined and announced in the near future.

A Practice Guidelines Subcommittee within the Publications Committee will be developing guidelines on additional topics for eventual publication by APSAC. New topics proposed include neglect, joint investigations, and child sexual exploitation. If you have suggested topics for other Practice Guidelines, please send them to Elissa Brown, Chair of the Publications Committee (phone: 718-990-2355, fax: 718-990-1586, e-mail: browne@stjohns.edu, or mail: Department of Psychology, St. John's University, 8000 Utopia Parkway, Queens, NY 11439).

APSAC 14th Annual Colloquium Drawing Near

We hope you save the dates June 21–24, 2006, for APSAC's 14th Annual Colloquium in Nashville, Tennessee. Nashville is not only the home of the Grand Ole Opry but also the major music center in the nation for country, gospel, and rhythm & blues performance and recording. There is much to see and do in friendly Nashville, and the Colloquium hotel offers Southern hospitality as well as first-rate accommodations at reasonable prices.

The Gaylord Opryland hotel is recognized around the world for its extraordinary service, luxurious accommodations, and first-class entertainment. Under majestic, climate-controlled glass atriums, you are surrounded by nine acres of lush indoor gardens, winding rivers and pathways, and sparkling waterfalls. Here you can unwind, explore, shop, dine, and be entertained. Highlights include a 44-foot waterfall, laser-light and fountain shows, and tours aboard the hotel's

APSAC 14th Annual Colloquium at the Gaylord Opryland Hotel

Front entrance to Gaylord Opryland

View from private balcony

Old Hickory Falls

cont'd on page 18

Delta Flatboats—all inside the hotel. The Gaylord Opryland offers a variety of restaurants, including the Cascades Seafood Restaurant, Old Hickory Steak House, Ristorante Volare, Breakfast at Rachael's, and Rusty's Sportsbar & Grill.

On the Opryland grounds, you can hear the legendary sounds of the Grand Ole Opry, golf at Gaylord Springs, Nashville's premier golf course, enjoy a lunch or dinner cruise aboard the General Jackson Showboat, or walk to nearby Opry Mills mall for shopping. The hotel also offers sightseeing tours of Nashville, better known as Music City USA.

In downtown Nashville, the District is an area along 2nd Avenue and historic Broadway where you can enjoy plenty of restaurants, speciality shopping, and entertainment. It is a must to visit the legendary Music Row, where aspiring singers, musicians, and songwriters congregate. The Gray Line and the Gaylord Opryland Hotel offer tours that drive past stars' homes and visit Music Row, the District, the Ryman Auditorium, and other attractions.

So make your plans now to attend APSAC's 14th Annual Colloquium at the Gaylord Opryland Hotel. For more information about the Colloquium, call 843-764-2905, or e-mail apsac@comcast.net, or visit www.apsac.org.

Delta Flatboat Cruises

Memorial Painting for Bill Friedrich Commissioned

A group of APSAC members, friends, and admirers of the late Bill Friedrich, have contributed to a fund to commission Bill's artist son, Karl, to do a large painting that will be prominently displayed at the Chadwick Center for Children and Families in the Children's Hospital in San Diego. The painting will also be displayed each year in January at the San Diego International Conference on Child and Family Maltreatment. Karl Friedrich toured the Chadwick Center during the January conference this year, chose a spot for the painting, and took measurements for the painting. Those interested in supporting this special memorial to Bill Friedrich should send their contribution to Charles Wilson, MSSW, Executive Director Chadwick Center for Children & Families, Children's Hospital–San Diego, 3020 Children's Way, MC 5016, San Diego, CA 92123. Checks should be made payable to San Diego Children's Hospital. All contributions, large or small, will be most appreciated.

William N. Friedrich Memorial Award and Lecture Established

The APSAC Board unanimously voted to establish a memorial award in honor of Bill Friedrich and his important contributions to research and practice in the field of child maltreatment. To receive the award, recipients must have demonstrated the qualities that reflect Bill's professional career, most important of which is commitment to research and clinical practice. Also, for the first year of the award, the winner needs to have sufficient knowledge to be able to talk about Bill's life and career. The recipient will present a lecture during the Awards Luncheon at the Colloquium. This award will be presented annually, if there is an appropriate candidate.

New APSAC Membership Cards

Within the next couple of weeks, membership cards will be sent from the National office. Your membership card provides your membership number for 2006. This number is your key to registering online for APSAC's professional journal, *Child Maltreatment,* through Sage Publications. Eventually, when phase two of the Web site is complete, it will also allow you to log-on to other "members only" benefits.

Lush Gardens

The Grand Ole Opry®

The Magnolia Lobby

Photos from www.gaylordhotels.com/gaylordopryland/tour/gallery.cfm

CONFERENCE CALENDAR

March 26–29, 2006
33rd National Conference on Juvenile Justice
National District Attorney's Association
Denver, CO
visit: www.ndaa.org

March 27–31, 2006
Critical Analysis of Victim Assistance
Joint Center on Violence and Victim Studies
Fresno, CA
call 800-910-4308

March 29–31, 2006
3rd Annual Assessing and Treating Child Adolescent and Adult Trauma Conference
Alliant International University, Institute on Violence, Abuse, and Trauma
Honolulu, HI
call 858-623-2777 ext. 393

April 1–4, 2006
25th National CASA Annual Conference
National CAA Association
San Diego, CA
call 888-805-8978

April 4, 2006
In Harm's Way: Preventing and Healing Childhood Trauma
Children's Institute, Inc
Los Angeles, CA
call 213-385-5100 x1672 or visit: www.childrensinstitute.org

April 6–7, 2006
Understanding Mental Health Issues of Survivors Michigan Coalition Against Domestic Violence and Sexual Violence
Lansing, MI
call 517-347-7000 x21

April 6–7, 2006
12th Annual South Carolina Professional Colloquium on Child Maltreatment
SCPSAC
Greenville, SC
call 864-284-9440
or e-mail: sschildgal@aol.com
or visit: www.scpsac.org

April 15, 2006
Race to Stop the Silence
Safe Shores—Children's Advocacy Center
e-mail: office@runwashington.com
or visit: www.stopcsa.org/race.cfm

April 20, 2006
National Observance and Candlelight Ceremony
National Crime Victims' Rights Week
Washington, DC
visit: www.ovc.gov/ncvrw

April 23– 29, 2006
National Crime Victims' Rights Week
Victims' Rights: Strength in Unity
visit: www.ovc.gov/ncvrw/welcome.html

April 24–28, 2006
APSAC Child Forensic Interview Clinic
Seattle, WA
call Lori Ley 425-483-8250
or e-mail: apsacclinic@verizon.net
or visit: www.apsac.org

May 1–5, 2006
OUR KIDS Training in the Evaluation and Management of Child Sexual Abuse
Nashville, TN
call Suzanne V. Petrey 615-341-4920
or e-mail: suzanne.v.petrey@vanderbilt.edu
or visit:: www.ourkidscenter.org

May 21–24, 2006
Prevent Child Abuse National Conference
Prevent Child Abuse America
San Diego, CA
visit: www.preventchildabuse.org/ConferenceEvents/conference.html

June 4–8, 2006
Child Abuse and Neglect Institute
National Council of Juvenile and Family Court Judges
Reno, NV
visit: www.ncjfcj.org

June 21– 24, 2006
APSAC 14th Annual Colloquium
Nashville, TN
e-mail: apsaccolloquium@charter.net
or visit: www.apsac.org

July 9–12, 2006
International Family Violence and Child Victimization Research Conference
Portsmouth, NH
call 603-862-1888
or e-mail: frl.conference@unh.edu

APSAC ADVISOR

EDITOR IN CHIEF
Ronald C. Hughes, PhD, MScSA
Institute for Human Services and
the North American Resource Center
for Child Welfare, 1706 E. Broad Street
Columbus, OH 43203
614-251-6000

ASSOCIATE EDITOR
Judith S. Rycus, PhD, MSW
Institute for Human Services and
the North American Resource Center
for Child Welfare

EDITORIAL ASSISTANT
Susan C. Yingling
Institute for Human Services and
the North American Resource Center
for Child Welfare

CONSULTING EDITORS

Child Protective Services
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School of SW Center for Child Welfare,
Arlington, TX 817-272-3535

Cultural Issues
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Treatment Center Medical
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Journal Highlights
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Evaluation Treatment & Research
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Law Center
Los Angeles, CA 213-740-0142

Medicine
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Primary Children's Medical Center
Salt Lake City, UT 801-588-3650

Mental Health/Perpetrators
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Merrill-Palmer Institute
Detroit, MI 313-872-1790

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San Francisco State University
School of Nursing
SanFrancisco, CA 415-405-3660

Washington Update
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National Child Abuse Council
Washington, DC 202-347-3666

Prevention
Neil B. Guterman, PhD
Columbia University
School of Social Work
New York, NY 212-854-5371

Research
David Finkelhor, PhD
University of New Hammpshire Family
Research Laboratory
Durham, NH 603-862-2761

Opinions expressed in the *APSAC Advisor* do not reflect APSAC's official position unless otherwise stated. Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence.

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Save these dates!!!!!

14th APSAC Annual Colloquium in Nashville, Tennessee, June 21–24, 2006

APSAC Forensic Interview Clinic in Seattle, Washington, April 24–28, 2006

For more information visit: www.apsac.org

APSAC Important Contact Information

Membership, Publications, Continuing Education
Daphne Wright & Andrea Wright
Operations
PO Box 30669
Charleston, SC 29417
843-764-2905 or toll free: 877-40-APSAC
Fax: 803-753-9823
E-mail: apsac@comcast.net

American Professional Society
on the Abuse of Children
PO BOX 30669
Charleston, SC 29417

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