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At Issue
ICWA and MEPA/IEPA: Injustice Guaranteed

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The concept of race has no biological or genetic legitimacy. Yet, it remains a powerfully destructive social construct with a legacy of exploitation, degradation, and obdurate inhumanity. To a lesser degree today, racism and other destructive ethnocentric dynamics are part of interpersonal and systemic dynamics within our country. Race doesn't exist, but racism does. This has significant implications for adoptive placements of minority children within child welfare practice.

The children of most minority cultures can be expected to be frequently and morbidly subjected to both systemic and interpersonal prejudice and discrimination during their lifetimes. Such powerful psychological and emotional assaults can be destructive at any time but are especially so during the formative years of latency and adolescence. Minority children must be fortified with the cognitive and emotional competence necessary to develop resilience to the harmful dynamics of racism and other ethnocentric assaults. This should be considered a presumptive developmental need of all minority children, who can reasonably be expected to be subjected to systemic and systematic racism during their lifetimes.

The implication for public child welfare adoption policy and practice is that professionals have a moral responsibility to assure that potential adoptive placements have the capacity to educate minority adoptees about the reality of racism and to develop strategies to fortify them against its destructive dynamics. If we accept psychological and emotional fortification from racism as a presumptive developmental need of many minority children in our society, then this would appear to support strategies to assure that prospective adoptive homes have the willingness and capacity to meet these developmental needs of minority children in need of adoption.

For Native American children, cultural identity and the developmental need to cultivate resilience to racism are considered essential and codified in the Indian Child Welfare Act (ICWA). Major ICWA requirements specify preference for adoptive placement of Native American children with Native American adoptive families and within Native American communities (ICWA, 1978). There is no mention in ICWA of the potential for such cultural matching of children with prospective adoptive families and communities as a potential violation of prospective adoptive parents' or children's civil rights. In fact, such matching is encouraged, ethically justified, and in most cases, required. In many cases, this applies to children who are only a small percentage Indian by blood (ICWA, 1978).

For many other minority children within the child welfare system, including African American and Hispanic children, cultural identity and the developmental need for resilience to racism are *not* recognized as essential and codified in law to the same degree and with the same effect as ICWA does for Native American children. In fact, many contend that the Multi-Ethnic Placement Act, as amended by the Inter-Ethnic Placement Act (MEPA/IEPA, 1996), implies that for most minority children, cultural identity and developmental resilience are not essential and that MEPA/IEPA essentially prevents social workers from appropriately attending to important developmental needs of many minority children. MEPA/IEPA has provisions that prohibit discrimination on the basis of race or culture in the evaluation and selection of adoptive families for specific children (MEPA/IEPA, 1996).

The Indian Child Welfare Act, however, *requires such discrimination*. If one believes that either cultural identity or psychological resilience to racism is an important developmental need for minority children, it would appear to be essential to evaluate and select adoptive families to assure that prospective parents either have the capacity to facilitate and provide for these needs or are able and willing to develop these competencies. It would be important to differentiate among families who have the capacity to provide such cultural identity and psychological resilience for children and those who do not. For ICWA, that's the whole idea. Additionally, ICWA makes the commonsense presumption that same-culture parents are likely to have special competence in meeting these important developmental needs, and same-culture becomes a proxy for possession of this special competence. This is not the case for other minority children and MEPA/IEPA. MEPA/IEPA prohibits such discrimination, seeing it not only as bad social work but also a violation of civil rights (MEPA/IEPA, 1996). ICWA requires such discrimination, lauding it as developmentally essential and a triumph of not only individual civil rights but communal rights as well (ICWA, 1978).

At issue is the injustice inherent in the application of these conflicting legislative mandates. One set of rules for one group of minority children requires "placement in ... adoptive homes which will reflect the unique values of [that] culture" (Indian Child Welfare Act, 1978), while another set of rules for other minority cultures prohibits such directed placement.

Justice is a foundational ethic of our society. Its essential character is reflected in the ethical norms of most helping professions. Social work and law identify justice as a moral foundation of their respective professions. The Harvard philosopher John Rawls (1971, p. 76) conceptualized justice as fairness, suggesting that social inequities (such as, I suggest, the difference between ICWA and IEPA) should be instituted only if it can reasonably be expected to be to everyone's advantage to do so. That is clearly not the case here.

Aristotle, in the *Nicomachean Ethics*, stated that justice requires that we treat equals the same and unequals differently in proportion to their differences (Aristotle, n.d., Book V, Chapter III). In other words, if we as a society are going to treat large numbers of minority children in need of adoptive families differently from Native American children in need of adoptive families, then we must show clearly what differences between the two groups justify such unequal treatment.

Let's first consider the similarities among minorities in our country; they are many and clear. For example, let's compare the similarities between children from African American and Native American subcultures. Both groups of children are from cultures with a history of oppression, subjugation, displacement, family and cultural destruction, and more recently, institutional racism and economic marginalization. Both have the same developmental needs for care, nurturance, opportunity, and protection. Both can be expected to benefit from their subculture's adaptive and resiliency strategies, if they have the opportunity to learn and assimilate them. Both groups live in a country where the rule of law and the concept of justice are paramount. The similarities argue strongly for equal treatment, and I believe a comparison with Hispanic culture and many other minorities would reveal the same strong similarities and produce the same strong argument for equal treatment.

What are the differences that could justify the dichotomous approaches to same-culture adoptive placement between the laws guiding Native American and other minority groups? No significant differences seem readily apparent. I suggest that the biggest difference is in the degree of legal and political autonomy that has evolved for Native Americans. Native Americans are in a better position to promote and negotiate their interests than are most other minorities. This may explain some major differences between ICWA and MEPA/IEPA, but it doesn't justify them.

In conclusion, I would argue that there are no differences between the needs and circumstances of Native American and other minority children in need of adoption that justify the remarkably different laws and rules that guide our public social workers in their efforts to identify and develop adoptive homes for minority children. I would argue that minority children who will grow up in our society need minority-specific cultural and adaptive competencies and resiliency strategies.

In addition, children services agencies in the public sector should recognize these as presumptive developmental needs of minority children in need of adoption. We need to look to research to prove or disprove the commonsense assumptions of ICWA that minority culture adaptive strengths and resilience are highly likely to exist in same-culture adoptive placements, and moreover, that prospective adoptive parents from different cultures must be evaluated on their willingness and capacity to meet these developmental needs. Further, we should require and enable social workers to identify, assess, and prepare the best available prospective homes to meet the developmental needs of minority children. Same-culture adoptive homes and transculture adoptive homes with the capacity and willingness to develop these competencies should be considered strong and preferred resources, although all need to be involved in thorough adoptive family assessment.

Finally, standard-setting social work organizations, such as the National Association of Social Workers (NASW), the Council on Social Work Education (CSWE), and the National Association of Public Child Welfare Agencies (NAPCWA), must redouble their efforts to work through the complex issues and moral dilemmas that have perpetuated the dichotomous placement rules promulgated by ICWA and MEPA/IEPA, including children's rights versus parents' rights, protective services worker responsibilities versus adoptive parents' civil rights, individual interests versus group interests, and federal authority versus tribal authority. These organizations need to advocate for clear, consistent, and universally applicable guidelines for adoptive placement of minority children that are in their best interests and that are just for all.

References

Aristotle. (n.d.). Distributive justice. *Nicomachean ethics*. [W. D. Ross, Trans.] Access at: http://classics.mit.edu/Aristotle/nicomachaen.html

Indian Child Welfare Act (ICWA). (1978) U.S. Code: Title 25, Chapter 21. Online at: http://www4.law.cornell.edu/uscode/html/uscode25/usc_sup_01_25_10_21.html

Multi-Ethnic Placement Act (MEPA), as amended by the Inter-Ethnic Adoption Provisions of 1996 (MEPA-IEPA). (1996). 42 U.S.C. ß 622 (b)(9) (1998), 42 U.S.C. ß 671(a)(18) (1998), 42 U.S.C. ß 1996b (1998).

Rawls, J. (1971). *A theory of justice*. Cambridge, MA: Harvard University Press.

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Barriers to Services Among Women in Substance Abuse Treatment: Implications for Child Welfare

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In many localities, the child welfare system has become a *de facto* substance abuse treatment system due to the number of cases involving parental alcohol or drug abuse (Wells & Shafron, 2005). Consequently, parental substance abuse treatment is frequently a component of child welfare service plans. Women in the child welfare system often face a combination of risk factors in conjunction with substance abuse, including mental illness, exposure to violence, poverty, inadequate housing, and other environmental problems (Cash & Wilke, 2003; Nair, Schuler, Black, Kettinger, & Harrington, 2003). It is estimated that up to two thirds of women in treatment for substance abuse may also have a cooccurring mental health problem (McHugo et al., 2005), such as depression, anxiety, and post-traumatic stress disorder (PTSD) (Magura, Kang, Rosenbaum, Handelsman, & Foote, 1998; Center for Substance Abuse Treatment, 2005). This cooccurrence is clinically significant because, as compared with treatment for adults with only one disorder, dual disorders pose special treatment challenges in terms of accessing separate service systems, tend to be underserved by the substance abuse treatment system (SAMSHA, 2001), and are associated with a number of negative treatment outcomes (Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003). The purpose of this study was to document the extent and type of cooccurring disorders and to examine barriers to substance abuse and mental health services among women in residential and outpatient substance abuse treatment programs

Methods

Using a cross-sectional survey design, data were collected in face-to-face interviews from 41 women in residential and 45 women in outpatient substance abuse treatment. The response rate was high; 96.2% of the eligible women agreed to participate in the interview.

Mental disorders (generalized anxiety disorder, depression, dysthmia, and PTSD) were assessed using the Computerized Diagnostic Interview Schedule (C-DIS). The C-DIS has demonstrated reliability and validity and provides a DSM-compatible diagnosis (Robins, Cottler, Bucholz, Compton, North, & Rourke, 1999).

Substance use disorders were assessed using a structured Computerized Intake Assessment Instrument, the CIAIC-C, a uniform countywide assessment tool administered at treatment intake, also yielding a DSM-compatible diagnosis (University of Akron, 2001).

Perceived service barriers were measured with the Allen Barriers to Treatment Inventory (ABTI) (Allen, 1994), a scale originally developed to measure women's perceived barriers preventing them from receiving alcohol and drug abuse treatment. As adapted in this study, the ABTI consisted of 46 alcohol and drug and 39 mental health treatment barriers. Cronbach's alpha for the scales were .90 and .95, respectively. Self-reported use both of substance abuse and mental health services over the past 6 months was also collected.

Results

Women Participating in This Study: Respondents ranged in age from 21 to 55, with a mean age of 34 years. Eighty-one percent of the sample identified as African Americans. Forty-five percent of respondents had a high school diploma or GED. Over three fourths (78.7%) of the women were living with a partner at the time of study. At the time of interview, 40% (34) of the respondents had received welfare assistance in the past 6 months. Nearly all of the women (91%) had children. On average, the women had 3.1 children, with a range of 0 to 12. The mean age of the minor children was 8 years (SD 5.3 years). 5% (10) of the children were less than 1 year old, 34% (62) were between 1 and 5 years old, 29% (53) were between 6 and 11 years, and 31.3% (57) were between 12 and 17 years. In addition, 41.1% of the minor children lived with their mother at the time of the interview, 37.4% lived with a relative, and 15% lived with foster parents. In this sample, 68% of the women had experienced out-of-home placement of one or more of their children; 76% of these women had children in relative care (either formal or informal kinship care placements), 28% had children in formal foster care placements, and 8% had children placed with adoptive parents.

Mental and Substance Use Disorders: Fifty-six percent of the women (N = 48)) had a current cooccurring substance use and mental disorder, while 44% (N = 38) had a current substance use disorder only. Forty-one percent (N = 35) of all respondents met criteria for a current major depressive episode, 28% (N = 24) for *PTSD*, 21% (N=18) for manic episode and 14% (N = 12) for generalized anxiety disorder. Over half the women in this sample met the criteria for current alcohol and cocaine dependence (52% and 58%, respectively), and over one quarter (28%) met criteria for marijuana dependence.

Service Use: Forty percent of the women had used mental health services. Ten percent could not access mental health services, and 50% had not used or sought such services. Almost half (48%) of the women with a mental disorder had not used or sought mental health services.

Perceived Service Barriers: Table 1 shows the top 10 barriers to treatment services. "Fear of losing children" was the most frequently reported barrier to both substance abuse and mental health services. Other frequently reported barriers to alcohol and drug services were "need alcohol/drugs for stress relief," "unable to stay clean in the past," "community expects alcohol/drug use," and "poor treatment experiences in the past." Other frequently reported barriers to mental health services were "no health insurance," "feeling ashamed," "no transportation," and "waiting for opening." There were no differences in perceived barriers between the cooccurring disorder and substance use disorder groups with one exception: "Fear of losing friends if alcohol/drug free" was reported as a barrier more frequently

for the substance use disorder group than the dual disorder group (21% vs. 2%). While there were no overall differences in the mean ABTI score, t-tests indicated statistically significant differences in particular items between women in residential and outpatient settings (see Table 2), including "waiting for opening," "not knowing where to get info on treatment," "unable to stay clean in the past," and "need alcohol/drugs for stress relief." In addition, the women in residential treatment reported an overall greater number of barriers to substance abuse services, but not to mental health services, than the women in outpatient treatment.

Implications for Practice

The results of this survey indicate the multiple barriers that women may experience in accessing services. Barriers to treatment services reflected service delivery issues, individual characteristics, and social community factors. Treatment providers, particularly for those women in residential treatment who tend to experience more service barriers, need to be aware of and address these barriers to enable women to access services in the first place and then continue to maintain sobriety in the community posttreatment.

Table 1. Top 10 Barriers to Treatment Services—Percentage of Women Rating Barriers as 'A lot'

Barriers to Alcohol and Drug Treatment	%	Barriers to Mental Health Treatment	%
Fear of losing children	35.7	Fear of losing children	27.3
Need alcohol/drugs for stress relief	33.7	No health insurance	20.6
Unable to stay clean in the past	29.3	Feeling ashamed	20.6
Community expects alcohol/drug use	27.9	No transportation	20.6
Poor treatment experiences in the past	21.2	Waiting for opening	20.6
Length of treatment	20.9	Distance from home	15.2
No transportation	20.9	Not knowing the location	14.7
Waiting for opening	18.6	Responsibilities at home	14.7
Alcohol/drug problems are a sign of weakness	18.6	Not knowing whre to get info on treatment	14.7
Not knowing where to get info on treatment	17.4	Dealing with problems of family members	14.7

Table 2. Differences in Perception of Barriers

Mental Health Treatment Services	Residential% (n=14)	Outpatient% (n=20)
Group with men	15.4	0.0
No health insurance	42.9	5.0
Alcohol and Drug Treatment Services	**Residential% (n=14)**	**Outpatient% (n=45)**
Waiting for opening	31.7	6.7
Feeling ashamed	29.3	4.4
Unable to stay clean in the past	47.4	13.6
Unable to pay for treatment	47.4	13.6
No health insurance	24.4	2.2
Not wanting health to interrupt life	19.5	4.4
Fear of losing children	20.5	48.9
Community expects alcohol/drug use	39.0	17.8
Protected from bad results of alcohol/drug use	9.8	0.0
Need alcohol/drugs for stress relief	46.3	22.2
Not knowing where to get info on treatment	26.8	8.9
Poor treatment experiences in the past	30.0	13.3
Feeling situation is hopeless		

All values are statistically significant at $p<.05$

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The finding that "fear of losing children" was the most frequently reported barrier to both substance abuse and mental health treatment is consistent with other research suggesting that children may act both as a motivator and a barrier to treatment. Women in substance abuse treatment frequently cite parenting concerns as a reason for entering treatment (Office of Applied Studies, 2004). On the other hand, many women do not seek help for substance abuse problems due to fear of involvement with the child welfare system. Others drop out of treatment due to the competing demands of parenting (Daley & Gorske, 2000) or because they feel overwhelming guilt and shame for their substance use and the impact it has had on their parenting (Cox, 2000).

We have found in our previous research on women and their support systems that children are integral in the social networks of and are viewed as sources of social support to women in treatment. In fact, when women describe their support systems, children are frequently viewed as providing as much sobriety support to women as that provided by adults (Tracy & Martin, forthcoming). Therefore, when out of home care is used to ensure child safety, motivation to access and remain in treatment may be undermined. As part of our ongoing research agenda on treatment barriers of women with dual disorders, we will be examining the role of social networks and treatment motivation on facilitators and barriers to services. Findings from this study will hold significance for the development of enhancements that can be provided in substance abuse treatment and mental health programs to attract more of the underserved women in our community.

Some recent studies have found that substance dependence delays or prevents mothers from regaining custody of their children, and that current approaches to treatment do not adequately address both the extent and type of mental health problems that typically accompany substance abuse problems of women (Wells, 2006). Current permanency planning timelines also may not allow sufficient time for women to move toward recovery with the hope of regaining custody of their children in placement, particularly in light of the many issues involved and the recovery time needed for dual disorders. Therefore, maintaining contact with children while in treatment and inclusion of children in the women's treatment program, wherever possible, may be appropriate strategies to employ.

References

Allen, K. (1994). Development of an instrument to identify barriers to treatment for addicted women, from their perspective. *The International Journal of the Addictions, 29*, 429-444.

Cash, S. J., & Wilke, D. J. (2003). An ecological model of maternal substance abuse and child neglect: Issues, analyses, and recommendations. *American Journal of Orthopsychiatry, 73,* 392-404.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders. Treatment improvement protocol (TIP) Series 42* (Rep. No. DHHS, Publication No. SMA 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Compton, W. M., Cottler, L., Jacobs, J., Ben-Abdallah, A., & Spitznagel, E. L. (2003). The role of psychiatric disorders in predicting drug dependence treatment outcomes. *American Journal of Psychiatry, 160,* 890.

Cox, K. L. (2000). Parenting the second time around for parents in recovery: Parenting class using the twelve-step recovery model. *Sources, 10,* 11-14.

Daley, D., & Gorske, T. (2000). Improving treatment adherence for mothers with substance abuse problems. *Sources, 10,* 1-5.

Magura, S., Kang, S. Y., Rosenblum, A., Handelsman, L., & Foote, J. (1998). Gender differences in psychiatric comorbidity among cocaine-using opiate addicts. *Journal of Addictive Diseases, 17,* 49-61.

McHugo, G. J., Krammer, N., Jackson, E. W., Markoff, L. S., Gatz, M., Larson, M. J., et al. (2005). Women, co-occurring disorders, and violence study: Evaluation design and study population. *Journal of Substance Abuse Treatment, 28,* 91-107.

Nair, P., Schuler, M. E., Black, M. M., Kettinger, L., & Harrington, D. (2003). Cumulative environmental risk in substance abusing women: Early intervention, parenting stress, child abuse potential, and child development. *Child Abuse & Neglect, 27,* 997-1017.

Office of Applied Studies. (2004). *Results from the* 2004 National Survey on Drug Use and Health*: National findings* (Rep. No. DDHHS, Publication No. SMA 04-3964, NSDUH Series H-25). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Robins, L. N., Cottler, L. B., Bucholz, K. K., Compton, W. M., North, C. S., & Rourke, K. M. (1999). *Diagnostic interview schedule, version IV (DIS-IV).* St. Louis, MO: Washington University School of Medicine, Department of Psychiatry.

SAMHSA. (2001). SAMHSA position on treatment for individuals with co-occurring addictive and mental disorders. Online at: http://alt.samhsa.gov/reports/archive/001011april_1999.htm.

Tracy, E. M., & Martin, T. C. (Forthcoming). Children's roles in the social networks of women in substance abuse treatment, *Journal of Substance Abuse Treatment*.

University of Akron. (2001). *Computerized intake assessment instrument (version 2.0) user manual*. Akron, OH: Author.

Wells, K. (2006). *The impact of welfare reform on the child welfare system in Cuyahoga County, Ohio, 1995-2001.* Policy Brief 06-01, The Schubert Center for Child Development, College of Arts and Sciences, Case Western Reserve University, Cleveland, Ohio.

Wells, K., & Shafran, R. (2005). Obstacles to employment among mothers of children in foster care. *Child Welfare, 84,* 67-96.

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Delivering Parent Training to Families At Risk to Abuse: Lessons From Three Meta-Analyses

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Norma Harris, PhD

Introduction

The profound responsibilities of child welfare workers cannot be overstated because vulnerable children and adults are heavily influenced by the services these workers and other service providers deliver. Child welfare and other services can affect children's immediate and long-term physical welfare, emotional and social well-being, and opportunities for future success as well as parents' self-esteem, sense of competence, and satisfaction with childrearing. Although intervening with families who have multiple challenges provides an opportunity to support and strengthen these families, success is not guaranteed. In many communities, there are insufficient resources to meet the complex needs of these families. This reality underscores the importance of using empirically supported practice and intervention decisions to increase the likelihood of achieving desired outcomes (Gambrill, 2006).

Ideally, child welfare practitioners should provide a broad continuum of preventive and treatment services, such as child protective services, foster care, adoption, day care, emergency shelter services, intensive home-based services, respite services, and others. National standards and guidelines suggest that capable staff and multiple high-quality services are essential if we are to achieve desired outcomes for children and families. Thus, child welfare professionals who have appropriate education and training and have the necessary knowledge and skills to serve culturally and ethnically diverse client populations are needed at all levels of the child welfare system (APHSA, 1995).

Because of substantial problems affecting the ability of child welfare systems to meet the needs of children and families, these systems have been under considerable scrutiny in recent years. Studies suggest that child welfare systems are not able to provide effective services for a variety of reasons. Child welfare agencies have been faced with staffing issues, including inadequate educational requirements, lack of career ladders, salaries that are not commensurate with responsibilities, insufficient training opportunities, inadequate supervisor-caseworker ratios, and stressful work environments that lead to high staff turnover (GAO, 2003; Pecora, Whitaker, Maluccio, Barth, & Plotnick, 2000; Pecora, Briar, & Zlotnik, 1989; Graef & Hill, 2000). Even though many improvements have been made due to passage and implementation of laws and practice innovations, the child welfare system cannot and should not be solely responsible to address the needs of all vulnerable children and families and, therefore, must rely on the involvement of other stakeholders-including children's parents.

The entry point into child welfare is generally through child protective services. Recent innovations, such as early intervention and multiple service tracks that offer flexibility in response to maltreatment reports, have increased the overall responsiveness of child protective services (U.S. Department of Health and Human Services, 2003). In addition, the use of multidisciplinary teams, implementation of family-centered approaches, improved data tracking systems, and other factors also have been helpful in achieving positive outcomes for families in child welfare systems. Further, CPS agencies must conduct accurate assessments and provide timely services to families and children because many children are re-reported a number of times before decisions are made to substantiate the allegations, thereby bringing the families and children into the CPS systems. For many children who are re-reported, the effects of repeated exposures to maltreatment and harmful activities of the parents are cumulative. By the time CPS provides intervention, these families are often in crises and drastic measures may be needed to protect the children. Many CPS agencies are "incident driven," meaning the focus of investigations into family situations is based solely on the incident reported to officials rather than including other factors affecting children's safety. When needed services are delayed, children often experience developmental problems in physical, intellectual, emotional, and social domains.

In this article, we discuss factors associated with successful parent training. Our suggestions are based on two published and one unpublished meta-analytic reviews of parent training (Lundahl, Nimer, & Parsons, 2006; Lundahl, Lovejoy, & Risser, 2006; Lundahl, Risser, & Lovejoy, 2006). Prior to reviewing data that can guide intervention decisions, we provide a brief overview of parent training.

Parent Training

Two major findings support the use of parent training as a means of helping parents and children. First, volumes of research indicate parents play an important role in their children's psychosocial development through parenting practices and the environment they create for their children (Darling & Steinberg, 1993; Grusec & Goodnow, 1994). Second, research has shown that parent training can directly change the childrearing strategies parents use, as well as modify parents' attitudes and perceptions toward childrearing (Lundahl, Risser, & Lovejoy, 2006). Thus, parent training appears to be a valuable and needed intervention for both parents and their children.

Parent training includes a variety of interventions designed to increase the likelihood that parents will provide a nurturing, structured environment for their children while concurrently strengthening the parent-child relationship. Parent training programs specifically aim to decrease parents' use of coercive childrearing practices. Examples of interventions used by parent training programs include reviewing child development literature, teaching and helping parents practice specific parenting skills (e.g., attending, rewarding desirable behaviors, time-out), identifying maladaptive parent-child interactions, and supporting parents' ability to manage their own emotions, including responding in constructive ways to stress.

A number of manualized parent training programs have been developed (e.g., Barkley, 1997; Forehand & Long, 2002; Webster-Stratton, 1994). While many of these programs share common aims and strategies, there are differences. Programs may vary on dimensions, such as mode of delivery (e.g., individual, group, self-directed), theoretical orientation (e.g., behavioral or nonbehavioral), recipient (e.g., one parent, both parents, involvement of the child), instructional aids (e.g., video, actual practice with child), amount of

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material covered, and the number of sessions offered. In addition to variability in parent training programs, differences exist in the targeted populations, such as children's age (e.g., younger, older), identification of clinical difficulties in children (e.g., acting out behavior, ADHD), or parental risk factors (e.g., low socioeconomic status, history, child abuse). Consistent with knowledge that "one size does not fit all," there is a need to understand factors associated with successful parent training. To help clarify such factors, we describe three meta-analytic reviews conducted by the primary author that address the conditions under which parent training can be expected to be most helpful.

Meta-analytic Reviews

Meta-analysis is a research strategy that provides a quantitative summary of outcomes from primary and secondary studies focusing on a particular question (Cooper & Hedges, 1994; Lipsey & Wilson, 2001). In our case, three separate meta-analyses were conducted. These involved exhaustive literature searches for articles that employed parent training programs, coding these studies, and calculating their effect sizes. An effect size, known as Cohen's *d*, is a measure of the impact of an intervention. Values in the 0.20 are considered small, while values in the 0.50 and 0.80 range are considered moderate and large, respectively (Cohen, 1988). Negative values would indicate the intervention was harmful or less beneficial than no intervention. Within a meta-analysis, *d*s are calculated for each study and entered into a master database, which allows for a descriptive summary of the overall effectiveness of parent training. In addition, if a sufficient number of studies exist, meta-analysis allows for hypothesis testing. In our case, this was done by using the variability in characteristics of parent training programs and target populations as predictors or independent variables. Thus, interaction or moderator effects were tested. For example, we investigated whether delivery mode or child age influenced outcomes and, if so, under what conditions.

Parent training includes a variety of interventions designed to increase the likelihood that parents will provide a nurturing, structured environment for their children while concurrently strengthening the parent-child relationship. Parent training programs specifically aim to decrease parents' use of coercive childrearing practices.

These three meta-analytic reviews investigated parent training focused on (a) children with disruptive behaviors, (b) parents at risk of physical abuse or neglect of a child, and (c) the role played by fathers in parent training outcomes. The first meta-analysis investigated the results from 63 separate studies of parent training focused on children displaying behavioral problems. All studies in this meta-analysis compared control groups with experimental groups; this review will be referred to as the *general meta-analysis* (Lundahl, Risser, & Lovejoy, 2006). The second meta-analysis investigated the results from 23 separate studies of parent training programs targeting families identified as having physically abused or neglected a child, families at risk of doing so, or both. Some, but not all, of the studies in this sample employed a control group. This review will be referred to as the *parents at risk to abuse meta-analysis* (Lundahl, Nimer, & Parsons, 2006). The third meta-analysis, which is currently under review, investigated whether fathers and mothers experience similar outcomes from parent training and whether inclusion of fathers in parent training enhances outcomes. This review will be referred to as the *fathers in parent training meta-analysis* (Lundahl, Risser, & Lovejoy, 2006).

The goal of this article is to provide guidance to child welfare practitioners about how best to use parent training; therefore, we provide relatively little information about the methodology of each study, and we present only selected findings. Interested readers are encouraged to request the actual meta-analyses in print form from the primary author.

The three meta-analyses are similar in that they all examine three broad classes of dependent variables: positive changes in children's behavior (e.g., increased compliance, decreased noncompliance), positive changes in parents' behavior (e.g., increased sensitivity, decreased coercion, lowered risk to abuse), and improved parental perceptions related to childrearing (e.g., decreased stress, fewer cognitions associated with abuse, and increased sense of childrearing efficacy).

Findings

As a reminder and guide, "*d*" is a measure of the impact of an intervention, referred to as the effect size. Values in the 0.20 range are considered small, while values in the 0.50 and 0.80 ranges are considered moderate and large, respectively. The symbol "*k*" represents the number of studies used in a particular comparison.

In general, parent training was shown to have effect sizes in the moderate, significant range (i.e., *d*s ranged from .40 to .60) for all dependent variable categories across the general and at risk to abuse meta-analyses. Similarly, fathers and mothers showed no significant differences in the degree to which they were influenced by parent training. Thus, there is generic support for parent training programs in helping parents improve how they interact with their children and how they perceive themselves in the parenting role. Similarly, children whose parents were in training tended to show increases in positive behaviors, which can increase the likelihood of further positive parent-child interactions (Bell & Chapman, 1986).

While it is comforting to know that parent training tends to result in positive and meaningful outcomes, the generic findings do not tell the whole story of parent training. Rather, several factors related to parent training participants and how parent training was delivered significantly influenced outcomes. Understanding the optimal conditions under which parent training is presented provides critical information that can be used to make informed intervention choices. Next, we pose and answer questions that service providers often consider when making decisions about recommending or designing parent training programs.

Do characteristics of participants matter?

It depends. Not surprisingly, socioeconomic challenges are associated with significantly poorer outcomes from parent training. Data from the general meta-analysis showed that positive changes in child behavior in studies targeting disadvantaged families (d = .24, k = 18) were significantly lower compared with nondisadvantaged families (d = .54, k = 17), $p < .01$. This pattern held for positive changes in parental behavior (d = .34, k = 16 versus d = .75, k = 12) and parental perceptions linked to childrearing (d = .38, k = 7 versus d = .72, k = 14), ps < .01 and .05, respectively. In a related manner,

outcomes for children in studies that included a high percentage of single parents (d = .24, k =16) were significantly lower compared with studies with fewer single parents (d = .45, k = 29), p < .05, though this was not true for changes in parental behavior or perceptions. The results from the parents at risk to abuse meta-analysis were similar. Thus, special attention needs to be given to families facing socioeconomic challenge. As an example, individually delivered parent training is superior to group delivered parent training for families facing economic challenges (see section entitled "Does delivery mode matter?").

Contrary to predications that younger children would benefit more than older children from parent training because they are more malleable, no statistical differences were found, although the patterns did follow predictions. Similarly, children evidencing a broad range of acting out symptoms benefited from parent training; in fact, children who displayed greater degrees of difficulty prior to their parents' involvement in parent training changed their behavior more after the intervention.

Do the characteristics of parent training programs matter?

Yes. Children's service workers cannot directly influence the characteristics of the families they serve. Increasing a family's socioeconomic status, for example, usually goes beyond the scope of intervention options. Child welfare workers, however, can influence intervention characteristics to best meet the needs of individual families.

The goal of this article is to provide guidance to child welfare practitioners about how best to use parent training; therefore, we provide relatively little information about the methodology of each study, and we present only selected findings.

Should fathers/partners be included in parent training?

Yes. Results from the meta-analysis on fathers' role in parent training indicate that fathers or partners should be included. Specifically, desirable outcomes for children from mother-only studies (d = .23, k = 13) were significantly lower than studies involving both mothers and fathers (d = .49, k = 18), p < .01. Similarly, increases in desirable parenting behaviors were significantly higher in mother and father groups (d = .59, k = 16) compared with mother-only groups (d = .21, k = 7), p < .01. No significant differences were found for parental perceptions. It is important to note that this pattern held when the socioeconomic status of families and the percentage of single parents were statistically controlled. While these findings may seem intuitive, and some parent training programs openly advocate the involvement of both parents (Barkley, 1997), controversy about this issue does exist. Two early studies (Firestone, Kelly, & Fike, 1980; Martin, 1977) tested the hypothesis that including fathers in parent training did not enhance outcomes. The explanation for these findings was that the recipient of formal training would communicate the results to the untrained partner. Current estimates suggest that fewer than 20% of families participating in parent training include fathers (Budd & O'Brien, 1982; Coplin & Houts, 1991) and many programs do not actively recruit fathers or partners. Based on the findings from this study, we strongly encourage recruitment and involvement of fathers or partners in parent training efforts.

Does it help to involve children in their own therapy in addition to parent training?

Not necessarily; in fact, it might diminish outcomes when a child therapy component is added to a parent training program. Data from the general meta-analysis suggest that involving children in their own therapy in conjunction with parent training did not result in enhanced outcomes. For example, positive changes in parental behavior were lower from programs that included a child therapy component in addition to parent training (d = .18, k = 5) when compared with parent training only (d = .54, k = 37), p < .05. This same pattern held for changes in parents' perceptions of child rearing where parents who participated in a parent training program that also had a child therapy component experienced fewer positive changes about their parenting (d = .33, k = 6) compared with parents of programs without a child therapy component (d = .59, k = 31), p < .05. While including a child therapy component lowered desirable changes in parents' behavior and perceptions, there was no statistically significant benefit (or liability) on children's behavior.

The reasons the few studies that included a separate child therapy component evidenced poorer outcomes are not known. We speculate that inclusion of a therapy program for children may inadvertently communicate to parents that children have primary responsibility for parent-child interaction problems, which may reduce parents' engagement or motivation to change. Also, it could be that such programs are more complicated to conduct, which dilutes the effect of parent training. It should be noted that this finding was based on studies of programs targeting child noncompliance, not those that provided therapies directed at helping children who have suffered abuse, neglect, deprivation, or multiple attachment insults. Thus, this finding should not be used to dissuade referrals for child-specific therapy that is distinct from parent training.

Does including a home visitor or home visits help?

Yes. In the parents at risk to abuse meta-analysis we found that interventions that included a home visitor showed significantly higher improvements in attitudes linked to abuse (d = .76, k = 5) and in using desirable parenting practices (d = .64, k = 9) compared with interventions that did not (ds = .46 and .40 and ks = 6 and 4, respectively), p < .05. Similarly, interventions that provided a mixture of services in the family's home and an office setting produced significantly higher results for both attitudes linked to abuse (ds = .82 and .46, ks = 6 and 4, respectively), p < .05, and childrearing behaviors (d = .85 and .41, ks = 5 and 7, respectively), p < .05. There are many reasons why including a home visitor could potentially promote positive outcomes. Parent trainers may obtain a better assessment of what really happens at home, which could enhance their ability to design effective and individualized interventions. Involvement in home visits may also communicate the seriousness of problems to families, heightening their engagement. It may be that home visits increase the likelihood that parent training occurs, as it is more difficult for families to drop out prematurely. Or, it may be that home visits are an effective "transfer of learning" intervention that supports the integration of learned parenting skills into family life.

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Does theoretical orientation matter?

It depends. In the at risk to abuse meta-analysis, programs that involved only a behavioral component (d = .24, k = 3) were less likely to positively change parents' attitudes linked to abuse, when compared with those programs that involved nonbehavioral parent training only (d = .69, k = 4) or a mixture of nonbehavioral and behavioral components (d = .80, k = 3), $ps < .05$. By contrast, childrearing skills changed more when a behavioral component (d = .61, k = 6) was present compared with nonbehavioral only programs (d = .32, k = 2), $p < .10$. In the general meta-analysis, which involved many more studies, theoretical orientation did not influence outcomes, although there was suggestion that programs involving both behavioral and nonbehavioral components may provide parents with the best opportunities to change both their childrearing behaviors and their attitudes toward parenting. We hypothesize that behavioral programs are ideal for helping parents learn discrete parenting skills and that nonbehavioral programs may be better suited for changing parents' attitudes, consistent with the training program's stated objectives and methods. Thus, the question does not seem to be whether one orientation is better than the other, but how can both orientations be used best to support parents and their children.

Does length of parent training matter?

It depends. In the parents at risk to abuse meta-analysis, studies that included a larger number of sessions (d = .70, k = 7) showed significantly greater changes in attitudes linked to abuse when compared with those with a lesser number of sessions (d = .33, k = 3). Length of time in parent training did not matter, however, for childrearing behaviors. Although not reported in the general meta-analysis, time in treatment was not significantly related to outcomes. It makes sense to the author that extra time in the training helped to change parents' attitudes linked to abuse, because such attitudes are often not conscious and it may require more time to examine and challenge long-held beliefs.

One of the most salient findings across the general and parents at risk to abuse meta-analyses was that individually-delivered parent training outperforms group delivery. Furthermore, there is some evidence that the best mode might be a combination of individually-delivered and group-delivered parent training.

Does delivery mode matter?

Absolutely. One of the most salient findings across the general and parents at risk to abuse meta-analyses was that individually-delivered parent training outperforms group delivery. Furthermore, there is some evidence that the best mode might be a combination of individually-delivered and group-delivered parent training. In the general meta-analysis, individually-delivered parent training (d = .69, k = 13) was more successful in modifying children's behaviors when compared with group-only parent training (d = .34, k = 33). While significant differences were not found in the parent behavior and parental perception outcomes, the data pattern indicates that at least some form of individually-delivered parent training is superior to group-only parent training.

This finding was particularly salient for studies in the general meta-analysis involving low-income families, families who do most poorly as a result of parent training but who may need it the most. In the studies involving low-income families, it was found that children whose parents received individual parent training (d =.76, k = 8) benefited more than children whose parents received group parent training (d = .12, k = 10), $p < .01$. Similarly, parents evidenced more desirable behavioral changes from individual parent training (d = .70, k = 6) when compared with group parent training (d = .22, k = 8), $p < .01$. For parental perceptions, the difference between individual- (d = .59, k = 4) and group-delivered (d = .25, k = 3) training did not reach statistical significance, though the difference appears to be meaningful (Lundahl, Nimmer, & Parsons, 2006, p. 97).

Individually-delivered parent training may be superior because interventions can be tailored to the unique needs of each family; or, families may develop a close relationship with the person delivering parent training, which may encourage their adoption of newly learned skills. Proponents of group-delivered parent training suggest it is more efficient and also promotes social support, although our data provide compelling evidence that socioeconomically challenged families do best when at least some individually-delivered parent training is provided.

What are long-term outcomes?

The preceding results were based on outcomes immediately following completion of parent training. Although such results are promising, the durability of outcomes is critical especially when considering families served by the child welfare system. Results from the three meta-analyses suggest that the effects of parent training are durable, although considerably diminished across times periods ranging from 6 to 12 months. Clearly, families with multiple needs will not be sufficiently served solely by parent training programs, and a broad-based system of care is needed to promote the likelihood of success for these families and their children. However, parent training is a valuable intervention and, when applied concurrently with other service programs, certainly can be expected to improve outcomes for vulnerable families and their children.

Discussion

Child welfare practitioners play critical roles in providing assessments and appropriate service interventions for at-risk families. Of the many available intervention options, parent training is widely relied upon to benefit children by helping their parents use more effective parenting skills. Considerable evidence supports the use of parent training to address a wide variety of difficulties with various target populations (Ramey & Ramey, 2000: El-Mohandes, Katz, El-Khorazaty, McNeely-Johnson, & Shops, 2003: Huhn & Zimpfer, 1989; Huebner, 2002; Cheng, 2004). The pattern of findings from these three meta-analyses supports parent training as an effective intervention. However, many factors need to be considered when designing parent training interventions and when making referrals to such programs.

Families facing economic challenge and single mothers tend to benefit less from parent training compared with parents without economic challenges. More important, such single mothers and socioeconomically disadvantaged families do much better when parent training is delivered individually compared with group delivery. This finding provides a measure of hope because the mode of delivery, individual or group, is a factor that can be controlled by child welfare professionals. Moreover, our findings suggest that parent training providers should actively recruit fathers, partners, or both to

participate in parent training rather than assuming that having only a child's mother present is sufficient. Also, families considered to be at risk to abuse are more likely to show meaningful improvement when more sessions of parent training are offered. The attitudes and perceptions that contribute to parents being at risk to abuse are likely deeply engrained and, thereby, cannot be expected to change immediately. To decrease risk of future abuse, service providers should strongly consider using home visitors, as parent training programs that used such services tended to report improved outcomes for families. Our findings also suggest that programs that provide both behavioral and nonbehavioral instruction are likely to have broader effects for children and parents when compared with programs that rely on only one of these orientations.

It is our hope that the information provided in this review of three meta-analyses can help guide practice decisions. The primary articles provide more detailed information and should be consulted directly, since space limitations preclude inclusion of complete data.

References

American Public Human Services Association (APHSA). (1995). Guidelines for a model system of protective services for abused and neglected children and their families. Washington, DC: Author.

Barkley, R. (1997). *Defiant children: A clinician's manual for assessment and parent training* (2nd ed). New York: Guilford.

Bell, R. Q., & Chapman, M. (1986). Child effects in studies using experimental or brief longitudinal approaches to socialization. *Developmental Psychology, 22*, 595-603.

Budd, K. S., & O'Brien, T. P. (1982). Father involvement in behavioral parent training: An area in need of research. *Behavior Therapist, 5,* 85-89.

Cheng, S. (2004). Factors that influence the effectiveness of a parenting program for Asians and Pacific Islanders. Unpublished dissertation. Salt Lake City: University of Utah College of Social Work.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Cooper, H., & Hedges, L. V. (1994). *The handbook of research synthesis*. New York: Russell Sage Foundation.

Coplin, J. W., & Houts, A. C. (1991). Father involvement in parent training for oppositional child behavior: Progress or stagnation. *Child & Family Behavior Therapy, 13*, 29-51.

Darling, N., & Steinberg, L. (1993). Parenting style as context: An integrative model. *Psychological Bulletin, 113,* 487-496.

United States Department of Health and Human Services, Office on Child Abuse and Neglect. (2004). Emerging practices in the prevention of child abuse and neglect. Washington, DC: Author.

El-Mohandes, A., Katz, K., El-Khorazaty, M., McNeely-Johnson, D., & Shops, P. (2003). The effects of a parenting education program on the use of preventive pediatric health care services among low-income, minority mothers: A randomized controlled study. Elk Grove Village, IL: American Academy of Pediatrics.

Firestone, P., Kelly, M. J., & Fike, S. (1980). Are fathers necessary in parenting training groups? *Journal of Clinical Child Psychology, 9,* 44-47.

Forehand, R., & Long, N. (2002). *Parenting the strong-willed child: The clinically proven five-week program for parents of two- to six-year-olds*. New York: Contemporary Books.

Gambrill, E. (2006). *Social work practice: A critical thinker's guide* (2nd ed.). New York: Oxford University Press.

General Accounting Office (GAO). (2003). *GAO studies child welfare recruitment and retention.* Washington, DC: Author.

Graef, M., & Hill, E. (2000) Costing of child protective services staff turnover. *Child Welfare, 79*(5), 186-199.

Grusec, J. E., & Goodnow, J. J. (1994). Impact of parental discipline methods on the child's internalization of values: A reconceptualization of current points of view. *Developmental Psychology, 30,* 4-19.

Huebner, C. (2002). Evaluation of a clinic-based parent education program to reduce the risk of infant and toddler maltreatment. *Public Health Nursing, 19*(5), 377-389.

Huhn, R., & Zimpfer, D. (1989). Effects of a parent education program on parents and their preadolescent children. *Journal of Community Psychology, 17,* 311-319.

Lipsey, M. W., & Wilson, D. B. (2001). *Practical meta-analysis*. Thousand Oaks, CA: Sage.

Lundahl, B., Lovejoy, M., & Risser, H. (2006). Fathers in parent training: Two meta-analyses examining whether they should be included. Unpublished manuscript.

Lundahl, B., Nimer, J., & Parsons, B. (2006). Preventing child abuse: A meta-analysis of parent training programs. *Research on Social Work Practice, 16*, 251-262.

Lundahl, B., Risser, H., & Lovejoy, M. (2006). A meta-analysis of parent training: Moderators and follow-up effects. *Clinical Psychology Review, 26*, 86-104.

Martin, B. (1977). Brief family intervention. Effectiveness and the importance of including the father. *Journal of Consulting and Clinical Psychology, 45,* 1002-1010.

Pecora, P., Briar, K., & Zlotnik, J. (1989). Addressing the program and personnel crisis in child welfare: Technical assistance report. Washington, DC: National Association of Social Workers, Commission on Family and Primary Associations.

Pecora, P., Whittaker, J., Maluccio, A., Barth, R., & Plotnick, R. (1992). *The child welfare challenge: Policy, practice, and research*. New York: de Gruyter.

Ramey, C., & Ramey, S. (2000). Persistent effects of early childhood education on high-risk children and their mothers. *Applied Developmental Science, 4*(1), 2-14.

Webster-Stratton, C. (1994). *Troubled families, problem children: Working with parents: A collaborative process*. New York: Wiley.

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Journal Highlights

Judith S. Rycus, PhD, MSW

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 mailing a copy of current articles (preferably published within the past 6 months) along with a two- or three-sentence review to the editors of the APSAC Advisor *at the address listed on the back cover, or by E-mail to JSRycus@aol.com.*

In this issue of the *APSAC Advisor*, Journal Highlights summarizes the 12 highest scoring articles for the 2006 Pro Humanitate Literary Awards in child welfare. Together they represent a snapshot of some of the exceptional work produced by child welfare researchers, academicians, and practitioners during the past year. The three highest scoring articles—by Littell; Chaffin and Friedrich; and DeSena and colleagues—were selected to receive the award.

Multisystemic Therapy (MST)—A Systematic Review

This study reports the findings of a rigorous systematic review to synthesize the results of multiple studies of the effects of multisystemic therapy (MST) for youth with social, emotional, and behavioral problems. According to the author, because traditional narrative reviews of research are subject to many sources of bias, there is a "burgeoning body of literature on the science of research synthesis" (p. 445). In this article, the author presents her systematic review of MST to demonstrate how systematic review methods can promote more accurate conclusions about the effects of an intervention by synthesizing the findings of a diverse body of primary research and research reviews.

The systematic review was completed within the formal structure of the Campbell Collaboration, a nonprofit organization that develops standards for, conducts, and disseminates rigorous systematic reviews of effects of interventions in social welfare, education, and crime and justice. MST was selected for review because it is presented as one of the few empirically supported and effective treatments for youth and families, it has been widely disseminated in North America and Western Europe, and it appears to have a strong research base that includes multiple randomized controlled trials.

In this article, Littell describes the history and methodology of MST, presents the findings of prior reviews on the effects of MST, defines systematic reviews conducted through the Campbell Collaboration, presents the methodology used for the MST review, describes the particular problems encountered in reviewing MST research, and provides prelimnary results of the systematic review and possible explanations for the findings.

In contrast to other research reviews or meta-analyses, a systematic review uses transparent procedures to identify, assess, and synthesize research results. This includes developing explicit inclusion and exclusion criteria for study designs, interventions, populations, and outcomes to be included in the review. Failure to comply with these criteria results in exclusion of studies from the systematic review. Systematic reviews also require exhaustive computerized and hand searches to locate all relevant sources, including unpublished research; rigorous and detailed coding of primary studies by independent raters to increase reliability; and wherever possible, quantitative synthesis of results across studies (meta-analysis). Reviews include explicit statements about any conflict of interest and must be updated every 2-3 years to remain current (p. 449).

Although most prior studies of MST have concluded that it is "effective" or "successful," and produces positive outcomes for clients, the findings of the systematic review are at odds with these conclusions. According to the author, "Preliminary results...indicate that MST has few if any significant effects on measured outcomes, compared with usual services or alternative treatments" (p. 457), although additional data from trials now in progress can be added to the systematic review when it is updated.

The more important point, however, is that achieving evidence-based practice requires easy access to comprehensive and accurate research findings to underpin policy and practice decisions. Unfortunately, many existing research reviews are misleading or even biased, particularly when they consist of narrative summaries of convenience samples of published articles. Systematic reviews can provide relevant information about the effects and the effectiveness of social interventions that is up to date, free of allegiance effects, and the product of rigorously applied criteria and scientific method.

Littell, J. H. (2005). Lessons from a systematic review of effects of multisystemic therapy. *Children and Youth Services Review, 27,* 445-463.

SAFE Homes: Are They Worth the Cost?

The objective of this study was to evaluate Connecticut's SAFE Homes program, a short-term group care program for children between the ages of 3 and 12 entering care for the first time. The SAFE Homes program, operated by private agencies, was designed to improve case outcomes by consolidating resources to promote assessment and treatment planning. The researchers hypothesized that SAFE Homes would result in greater continuity of care for children, fewer placements, more frequent placements with siblings, more placements in communities of origin, more placements with relatives, reduced use of high-cost restrictive inpatient and residential care settings, and reduced rates of re-abuse through earlier detection and provision of services to meet child and family treatment needs.

The study used a sample of 342 children who received SAFE Home services, matched to 342 control children in traditional foster care. The 684 subjects had been selected from a larger pool of 909 children.

The study results determined that the SAFE Home program was no more effective than traditional foster care programs in achieving desired outcomes, yet the costs of SAFE Home care were significantly higher than traditional foster care. It must be cautioned, however, that during implementation of the SAFE Home program, significant improvements were noted concurrently in Connecticut's traditional foster care program, including reductions in the number of placements per child and an increased likelihood that children would be placed with siblings, and/or with relative caregivers, and in their home communities.

DeSena and colleagues suggest the SAFE Homes program represents one of many well-intended short-term interventions for families in the child welfare system, and they contend that such short-term "quick fixes" may be less effective than sustained, multifaceted interventions that consider child maltreatment as a more chronic condition in need of comprehensive assessment, concurrent case planning, multifaceted individualized treatments, and longer-term interventions (p. 640).

The authors also conclude that even though well-intentioned, the SAFE Homes program represents one of many examples in child welfare practice of widespread and costly implementation of service models that are untested prior to their proliferation. They recommend thorough and rigorous evaluation of child welfare programs to identify those with the greatest potential to improve outcomes at the most reasonable cost.

DeSena, A., Murphy, R., Douglas-Palumberi, H., Blau, G., Kelly, B., Horowitz, S., & Kaufman, J. (2005, June). SAFE homes: Is it worth the cost? An evaluation of a group home permanency planning program for children who first enter out-of-home care. *Child Abuse & Neglect, 29,* 627-643.

Evidence-Based Treatments in Child Abuse and Neglect

In their introduction, the authors quote Leonardo da Vinci as saying, "Those who are enamored of practice without science are like a pilot who goes into a ship without rudder or compass and never has any certainty where he is going" (p. 1097). The critical importance of underpinning child welfare practice with the best science possible is the thesis of this article.

Chaffin and Friedrich define *evidence-based practice* (EBP) as "the competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs)" (p. 1098). They contend there is more consistency in the clinical research community regarding what constitutes "demonstrated safe and effective" and considerably less consistency when considering issues of fidelity, competency, and implementation.

The article provides a thorough discussion of the concept of EBP and the state of its acceptance and implementation in contemporary child welfare practice. They describe the rationale for incorporating EBP in child welfare, summarize basic concepts of EBP, thoroughly contrast EBP with traditional clinical approaches to practice, describe sources of reticence or resistance to its implementation, and review the current state of evidence in several areas of child welfare intervention. The authors contrast EBP with "evidence-suggested" or "evidence-informed" practice (p. 1099), which is often driven more by "political, cultural, or entrepreneurial agendas" than by scientifically supported program efficacy (p. 1099). They suggest that while indirect evidence is often cited to support a program's effectiveness, it is of little value, as such evidence can be cited to support virtually any intervention, particularly those based on intuitively plausible theories. The authors contend that controlled outcome research is necessary to determine program outcomes to ultimately differentiate effective programs from those that are inert or even harmful.

The authors review types of evidence, the strengths and limitations of various study methodologies, and the importance of measuring the bottom-line outcomes that directly reflect ultimate program goals as opposed to measuring change in mediating variables. They also discuss the many challenges in disseminating and implementing even strongly supported practice models into field settings, including the structural, fiscal, personal, and training barriers that prevent EBP from becoming fully incorporated into direct practice.

Chaffin and Friedrich conclude by stressing that adopting EBP does not necessarily mean adopting only those practices that meet the highest possible criteria for scientific support, or for which a complete body of rigorous research exists for all possible outcomes and all potential population subgroups (pp. 1103-1104). EBP simply means favoring the best supported available practices and selecting interventions based on the strength and soundness of available empirical data.

Chaffin, M., & Friedrich, B. (2004, November). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review, 26,* 1097-1113.

Family Functioning in Gay/Lesbian, Heterosexual, and Special Needs Adoptions

This study attempted to identify possible predictors of family functioning among cohorts of families headed by gay and lesbian adults, families headed by heterosexuals, and families adopting a child with special needs.

The study grouped respondents into three data sets. The first included 86 parents who had adopted children with special needs through child protective services. *Special needs* was defined as being older than 3 years, having physical and/or mental handicapping conditions, having psychological or emotional problems, being part of a sibling group, or being from minority cultures. The second data set included 47 gay and lesbian adoptive parents, the majority of whom had adopted their children privately, through international adoption programs or through private nonprofit organizations. Only 19% had adopted through child protective services. The third data set included 25 heterosexual adoptive parents, most of whom had adopted internationally or by private adoption and only 7% of whom had adopted through CPS.

Stepwise multiple regression analysis was used to assess the relationship between the dependent variable (standardized family functioning score) and the independent variables, which included child behavior scores, special needs adoption status, gay/lesbian headed families, age at adoption and at interview, disabilities, availability of support, number of previous placements, prior abuse, and sibling adoption.

The authors suggest that the study findings were generally consistent with findings from current literature. Six variables were identified to contribute significantly to the prediction of standardized family functioning scores: age of child at adoption, child adopted as part of sibling group, child diagnosed with a disability, special needs adoption, number of previous placements, and interaction between homosexual adoptive parent and child's age at adoption. The study results indicated that there were no negative effects on family functioning associated with gay/lesbian sexual orientation of adoptive parents, and that family functioning was actually enhanced when homosexual families adopted older children. The study also suggested an association between lower family functioning and sibling adoption or child having been diagnosed to have a disability. Further, study findings indicated that special needs adoptions were as-

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sociated with higher levels of family functioning, possibly because of the special expertise of the placing agency and the availability of specialized postadoption services. Leung, Erich, and Kanenberg concluded by reviewing the limitations of convenience sampling, cross-sectional studies, and the use of self-report questionnaires and by cautioning against generalizing the study results to a larger population.

Leung, P., Erich, S., & Kanenberg, H. (2005, September). A comparison of family functioning to gay/lesbian, heterosexual, and special needs adoptions. *Children and Youth Services Review, 27*, 1031-1044.

Evaluating Family Preservation Services

This study attempted to evaluate the conditions under which family preservation services were successful at preventing the unnecessary placement of children into foster care. The author, aware of conflicting findings of prior research addressing the question "Are family preservation services effective in preventing out-of-home placement?" reframed the research question to "Under what service conditions are family preservation services effective in preventing out-of-home placement, and for which families?"

The study utilized a single group postmeasure only design, examining variables after families had received services. Data were derived from case files for 488 families who had received family preservation services in Los Angeles County. The source of the data in case files was the service provider, who recorded data both when families entered the program and as the cases were closed. A series of logistical regression analyses was used to test four models that addressed the research question.

Related to family characteristics, the only significant predictor was single parent status, indicating that single parent families were less likely to have a successful program outcome compared with nonsingle parent families. Contrary to the findings of prior research, in this sample, families with a history of child placement were one and a half times *more* likely to have a successful program outcome compared with families with no such placement history. This suggests that families with prior placement history may be no less likely to achieve successful outcomes than families without such a history. It was also found that while frequency of worker visitation was not significant, the total duration of services received was a significant predictor of program outcome. The longer the duration of services, the greater the likelihood of a successful outcome. However, this trend held only up to 12 months, and then the level of success began to decrease, suggesting there might be a threshold for provision of such services. The study also determined that families with mental health problems and who received services were not more likely to have a successful outcome than were families with mental health problems who did not receive services. However, families with mental health problems were less likely to have successful outcomes than those without mental health problems.

While not significant in predicting outcomes, being on public assistance did not decrease the likelihood of a successful outcome according to the findings, suggesting that poverty alone may not necessarily increase or decrease the odds of a successful outcome.

The authors noted that the lack of comparison groups of families receiving alternate or no services, which would allow for examination of program effects between groups, was a limitation of this study.

Bagdasaryan, S. (2005, June). Evaluating family preservation services: Reframing the question of effectiveness. *Children and Youth Services Review, 27*, 615-635.

Collaboration Between Police and Child Protective Services

This article examined coinvolvement by police and child protective services (CPS) workers in child maltreatment investigations. The study summarized the findings of a broad review of both practice and empirical literature, and it reports findings from a secondary analysis of data from the National Survey of Child and Adolescent Well-being (NSCAW).

The literature review identified differences in opinion about the benefits and liabilities of coinvolvement of police and CPS workers in child maltreatment investigations. Many sources contend that joint involvement improves investigations and also benefits children and families, largely because of the often complementary skills of law enforcement and child protection workers. Joint interviews can prevent separate, redundant interviews of children, and two investigators can gather and explore more and different information than if each worked singly. The literature suggests that police/social worker collaboration can potentially produce better evidence, promote more accountability, and when appropriate, result in more prosecutions, confessions, and convictions.

Conversely, a variety of sources report friction between these agencies, resulting from differences in philosophy and style. Often cited is the potential for each discipline to interfere with the other's job. While CPS workers are often concerned that police will antagonize families and use heavy-handed or punitive interventions, police are often concerned that CPS workers will inadvertently interfere with evidence collection in criminal investigations, at times even tipping off perpetrators. Law enforcement officers are accustomed to making independent, quick decisions in the field, while social workers typically must consult with supervisors and other consultants, sometimes delaying decisions.

The data analysis component of the study used a stratified random sample of 92 child protection agencies nationwide, comparing case outcomes for CPS cases with and without police involvement. The study used a multivariate procedure with a large sample to control statistically for a number of potentially confounding variables. The study determined that police investigation was a component in 45% of the cases reported to CPS agencies. Police involvement was not found to be associated with a reduction or inhibition of affirmative child protection activities. Although results of the analysis were diverse, a common theme was that coinvolvement of police and CPS was positively associated with a range of different CPS interventions, including increasing the likelihood that CPS finds allegations credible and provides needed services. Cross, Finkelhor, and Ormrod conclude that, "[o]verall, police do not appear to hinder CPS effectiveness and may, in fact, promote it" (p. 241). They recommend that law enforcement and CPS coordinate child maltreatment investigations in every community.

Cross, T., Finkelhor, D., & Ormrod, R. (2005, August). Police involvement in child protective services investigations: Literature review and secondary data analysis. *Child Maltreatment, 10*, 224-244.

Child Protective Services and the Juvenile Court

This study identified characteristics of both effective and problematic juvenile court processes in Louisiana. The research used a two-stage qualitative design that combined direct, systematic court observations to identify critical features of effective and problematic courts, and personal interviews with judges, child welfare agency attorneys, and staff to identify factors that facilitated or impeded timely safety and permanency decisions for children. For this research, *effective child welfare judicial contexts* were defined as case planning and court decisions that adequately addressed child safety and physical and legal permanence for children and families, while problematic judicial contexts did not (p. 341).

The study provided extensive descriptive data of the many factors that characterize both effective and problematic courts. According to the Ellett and Steib, the study results were not surprising. Effective courts were found to be orderly, maintain reasonably scheduled dockets, respect participants, focus on the best interests of children, hold parents accountable, and allow time for testimony and discussion of key facts. Problematic courts were found to be chaotic and noisy, have overcrowded dockets and long wait times, and have participants who often seemed motivated by self-interests that superseded those of the children involved (p. 343). While none of the courts observed was either exemplary or deficient in all identified categories, the use of an extreme contrasting cases method allowed clear contrasts between the more effective and more problematic courts.

The study findings also suggested that the goals of child welfare and court processes remain in considerable conflict, and that practices in the adversarial legal process appeared counterproductive when applied to child welfare. The data reflect a child welfare system driven largely by the desire of agency personnel, particularly caseworkers, to avoid sanctions and demeaning treatment in the courtroom. In no instances in the study were caseworkers sworn in as expert witnesses; rather, experts were almost exclusively external providers of clinical services who often provided testimony based on limited contact with family members. In many courts, cases were rushed through the court docket rather than allowing sufficient time to carefully review individual case circumstances. The study also identified "extreme variation in the knowledge, preparation, and performance of child welfare staff, attorneys, CASAs, and judges (p. 348) with often negative consequences for children and families.

The authors contend that change is needed to rebalance the roles of CPS and the courts to promote the best interests of children and families, and they recommend that child welfare agencies form alliances with judges, attorneys, and with legal, academic, standard-setting, and other types of organizations to improve both the child welfare and juvenile court systems.

Ellett, A., & Steib, S. (2005, September). Child welfare and the courts: A statewide study with implications for professional development, practice, and change. *Research on Social Work Practice, 15*, 339-352.

Obstacles to Employment for Mothers of Children in Foster Care

This study sought to identify barriers to employment faced by unmarried birth mothers whose children were in foster care. Legislative and practice changes associated with welfare reform have limited cash assistance payments while providing incentives and service support to promote employment and self-sufficiency. Since reunification of foster children depends upon parents' ability to meet their children's basic needs, parents without stable economic support are at a disadvantage. In spite of the importance of this issue in promoting permanence for foster children, the authors found no empirically- based investigations specific to this issue in the research literature.

The present study conducted standardized interviews with a criterion sample of 158 mothers whose children were in foster care. The research measured mothers' age, race, marital status, education, household composition, household size, and income. Several interview items assessed economic hardship and history of cash assistance use. Data were collected on barriers to employment, including educational limitations, lack of work experience, low job skills, inadequate understanding of workplace performance norms, perceived discrimination, lack of transportation, physical health problems, alcohol or substance abuse, physical abuse or domestic violence, severity of psychiatric symptoms, and child special needs or health problems. Employment outcomes were measured by work status and current income. Methodology included descriptive statistics to address the prevalence of barriers to employment and to document mothers' income levels and level of hardship. Regression analyses examined differences in outcomes for mothers with different barrier profiles.

The most prevalent barriers noted were lack of transportation (74.1%), lack of education (48.1%), substance use (48.1%), lack of job skills (32.9%), special needs child (31.6%), and mother's mental health condition (25.9%). The most common cooccurring barriers were mental health problems and substance use (14.6%). Mothers in the study sample appeared to be exhausting their allocations of cash assistance, yet only one third worked full-time and most did not work at all. In the year following children's placements, one third had no wages and almost half earned less than $500 per month. The authors recommend that income support be considered a critical child welfare intervention for this population and be provided in the form of cash assistance, payment for education or job training, or wage subsidies. Long-term income support may be necessary, given the prevalence and cooccurrence of many employment obstacles. Further, because 70% of mothers have substance abuse, mental health, or physical health barriers, employment is less likely, and child welfare agencies are increasingly required to provide services to address these conditions. Finally, given the time necessary to recover from these conditions, Wells and Shafran argue for flexibility in child welfare policy so mothers who are progressing toward recovery by the end of the children's first year in placement will not lose custody of their children permanently.

Wells, K., & Shafran, R. (2005, January/February). Obstacles to employment among mothers of children in foster care. *Child Welfare, 84*, 67-96.

Integrating Actuarial Risk Assessment and Clinical Judgment

The purpose of this article is to describe recent advances in child welfare decision making and to discuss how these advances can position the field to adopt evidence-based practice as its next progressive step.

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Shlonsky and Wagner first describe risk assessment and family in child protective services and draw distinctions between the two with respect to design, administration, and utility. Risk assessment instruments are designed to estimate the probability of reoccurrences of child maltreatment. The authors provide a comprehensive history of the development of actuarial risk assessment instruments in child welfare and offer a balanced review of the research literature. Their review presents a compelling argument for the superiority of actuarial risk assessment over consensus models in child welfare. The authors describe in depth the development and utilization of actuarial risk assessment instruments both to dispel common resistance to their use and to demonstrate their utility in classifying cases into varying levels of risk. They also describe the proper and essential integration of actuarial risk assessment and clinical judgment. Clinical judgment is shown to be an essential part of framing risk assessment questions and interpreting answers, and data from risk assessment instruments can inform clinical judgments about possible service interventions.

Contextualized assessments of child and family functioning are the essential means of collecting in-depth information for case planning purposes, including to identify goals and objectives and to inform selection of the most effective service interventions. The authors explain that risk assessment can not, and should not, be used for this purpose. They also show how family assessments, although clinical in nature, need to be carefully structured to provide a framework for data collection that promotes a uniform and comprehensive assessment, resulting in accurate and relevant data.

The authors conclude by describing what they believe to be the next step in the evolution of child welfare—the adoption of an evidence-based approach to practice. They contend that when actuarial risk assessment and structured family assessments are utilized, thereby improving the availability and quality of information about families, achieving evidence-based practice becomes more possible. This article describes evidence-based practice models used in medicine and suggests how these may be adopted or adapted, and it proposes a model for utilization in child welfare. Shlonsky and Wagner foresee a need for development of a variety of new technologies to allow rapid assessment and utilization of this information. These might include psychometrically sound rapid assessment instruments, information specialists who continually identify effective core services, and models of integrated program evaluation. The authors suggest that child welfare agencies must undergo a comprehensive reformation to provide systemic supports for activities to achieve evidence-based practice.

Shlonsky, A., & Wagner, D. (2005, April). The Next Step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management. *Children and Youth Services Review, 27*, 409-427.

Letter to the Editor:Time to Rethink Healthy Start/ Healthy Families?

Dr. Chaffin addresses critiques to his earlier article, entitled "Is It Time to Rethink Healthy Start/Healthy Families?" which reported findings of research studies that evaluated the effectiveness of home visiting programs such as Early Start/Healthy Start. The original article (*Child Abuse & Neglect, 28,* June 2004, pp. 589-595) generated considerable response from researchers and family home visiting program advocates, centered on whether the existing program evaluation research on Healthy Start/Healthy Families programs warrants a conclusion that these programs do not effectively prevent child maltreatment.

In the Letter to the Editor, the author restates and supports his contention that while primary prevention programs may have many positive outcomes for low income families and children, there is no convincing evidence that they actually prevent child maltreatment. To support this conclusion, he presents and discusses several methodological issues related to the purpose, utility, and quality of various types of research designs, including randomized controlled trials (RCTs) in producing valid outcome data. He also explains why the current body of evaluation research on home visiting programs fails to support a conclusion that such programs prevent maltreatment.

Although the author does not recommend exclusive reliance on randomized controlled trials as the sole method of conducting evaluation research, he does contend that "if you want to know whether or not a program achieves its intended bottom-line outcome, the fact remains that randomized trials are the fairest and most accurate way of doing so" and that many researchers consider RCTs to be the "gold standard" for evaluating an intervention's effectiveness (p. 241). Chaffin also debunks many of the objections commonly raised about the rigidity of RCTs and the difficulty of implementing them in field trials. He discusses the question of whether null findings represent failure of a program model in achieving intended outcomes or, rather, failures in implementation. He states there is sufficient data from exemplary studies of exemplary programs that are implemented with high degrees of fidelity, that have common null findings, strongly suggesting that failure to prevent maltreatment is more likely the result of the intervention itself rather than inconsistent implementation.

The author also addresses the criticism that preventing child maltreatment is the wrong outcome for judging program effectiveness. He responds that programs such as Healthy Families have "self-identified and marketed themselves to policy makers, legislators, communities, and professionals primarily as child maltreatment prevention programs" (p. 244) and if they advertise and receive funding for this purpose, they should be evaluated on this outcome. He recommends instead the programs be viewed and marketed primarily for the purpose of providing maternal and child health enhancement and their success be interpreted on achievement of outcomes that match this purpose.

Chaffin, M. (2005, March). Letter to the Editor. *Child Abuse & Neglect, 29*, 241-249.

Parent Training Programs in Child Welfare

Barth and colleagues cite statistics indicating that at least 400,000 child welfare services (CWS) recipients will participate in parent training programs annually and that another 450,000 of the referred cases not opened by CWS will have parenting classes provided or arranged for them. Parent training is a primary intervention by government to fulfill its responsibilities to provide reasonable efforts to preserve, maintain, or reunify families involved with CWS. In spite of the large number of CWS recipients of parent training, the authors contend that few parent training models or interventions have been tested with child welfare clientele. Those that have been tested have not shown robust effects in preventing the placement of children or reducing maltreatment, perhaps be-

cause of insufficient investment of time and resources.

In this article, the authors highlight existing evidence from parent training programs that show promise for audiences other than child welfare recipients, primarily mental health. The study examined peer-reviewed literature, state reports and unpublished findings, parent training program Web sites, and unpublished data from the National Survey of Child and Adolescent Well-Being (NSCAW) and the Caring for Children in Child Welfare Study. Their findings help to answer the following six questions: (1) What are the characteristics of parent training relevant to characteristics of families involved with CWS? (2) What are the current purposes of parent training programs? (3) What parent training and support efforts show the greatest promise? (4) What programs are now in use, and what are their characteristics? (5) What programs are most likely to be integrated into existing CWS service delivery programming? (6) How can we accelerate the development of evidence-based parent training programs? The data addressing each question are discussed. The authors also identify the leading evidence-based parent training programs with descriptions of ranking criteria and discussion of specific programs, their designs, and evidence support.

The authors conclude that for parent training programs to have positive outcomes for families served in CWS, better identification and assessment should be made of parents in need and parents most likely to benefit from such programs. Because the most effective programs are the most costly, wiser allocation of fiscal resources will be necessary. The programs with the best evidentiary support will also have to be adapted for better *fit* with child welfare recipients, but program fidelity must also be maintained. They suggest the need for measures other than attendance and punctuality to assess change in parent and child behaviors. Parent training programs should also be differentiated by their developmental efficacy for children of different ages, as some programs show good effects for children of certain ages and not others. Finally, the creative integration of evidence-supported *mini-interventions* that are not only effective but also efficient could be adapted into existing programs at limited cost.

Barth, R., Landsverk, J., Chamberlain, P., Reid, J., Rolls, J., Hurlburt, M., Farmer, E., James, S., McCabe, K., & Kohl, P. (2005, September). Parent-training programs in child welfare services: Planning for a more evidence-based approach to serving biological parents. *Research on Social Work Practice, 15*, 353-371.

Child Welfare Reform

This study was conducted in an effort to discern the impact of major recent legislative changes on child welfare practice. During the 1990s, the federal government promulgated an unprecedented amount of legislation in efforts to improve the child welfare and public welfare systems. Statutes included the Adoption and Safe Families Act of 1997 (ASFA), the Multi-Ethnic Placement Act of 1994 (MEPA) and its subsequent amendments, the Inter-Ethnic Adoption Provisions of 1996 (IEPA) and welfare reform legislation (the Personal Responsibility and Work opportunity and Reconciliation Act of 1996, or PRWORA), which replaced the Aid to Families of Dependent Children (AFDC) program with the Temporary Assistance for Needy Families (TANF) program.

Each piece of legislation was intended to improve outcomes in a variety of child welfare-related services. ASFA was promulgated to address criticisms of the child welfare system by emphasizing due process rights for parents, placement prevention, timely achievement of permanence for children, and subsidies for special needs adoption. The goals were to improve both child safety and permanence, while concurrently providing interventions to promote children's well-being. MEPA represented an effort to speed up permanence by reducing barriers to adoption based on the race or ethnicity of both prospective adoptive and foster families and children in need of care. The PRWORA legislation was intended to promote employment and self-sufficiency by imposing time limits on receipt of cash assistance as well as imposing work requirements on recipient families. Although not directly related to child welfare, the legislation was expected to affect many families served in the child welfare system.

The authors report on the findings of the Local Agency Survey (LAS) of the National Study on Child and Adolescent Well-Being (NSCAW), which was administered between 1999-2000. The researchers collected data from local child welfare administrators in two stages and weighted data proportionate to the size of the primary sampling unit. Data analysis identified high levels of implementation activities, particularly in urban areas and state-administered child welfare agencies. However, the degree of implementation varied for each of the major pieces of legislation. Considering the date range of the study data, these findings are noted to be early effects of this legislation. Researchers identified that ASFA had the most influence on child welfare service delivery, even though its impact was uneven. ASFA placed greater emphasis on ensuring children's safety, shortened time frames for decision making, increased the number of families not reunified, and increased emphasis on adoption of older children. Most surveyed agencies had implemented concurrent planning. TANF appears to have had much less effect, but there has been some increased coordination between children services and TANF staff. Of the three statutes, MEPA-IEP appears to have had the least effect on service delivery at the time of the survey.

Mitchell, L., Barth, R., Green, R., Wall, A., Biemer, P., Duerr Berrick, J., & Webb, M. (2005, January/February). Child welfare reform in the United States: Findings from a local agency survey. *Child Welfare, 84*, 5-24.

In Appreciation

We would like to extend our sincerest appreciation to Ernestine Briggs-King for her 9 years of service to APSAC as editor of the Journal Highlights section of the *APSAC Advisor*.

Dr. Briggs-King, Clinical Associate in the Department of Psychiatry and Behavioral Sciences at Duke University Medical School, recently resigned from the *APSAC Advisor* in response to increased personal and professional demands on her time.

We commend her for her exceptional work in keeping us informed and up to date regarding current research and new developments in the child maltreatment field.

Thank you, Ernestine… we wish you all the best.

Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

SENATE AND HOUSE MOVE TO EXTEND SAFE AND STABLE FAMILIES PROGRAM

With authorizing legislation for the Promoting Safe and Stable Families (PSSF) program due to expire at the end of the current fiscal year—September 30, 2006—the House and Senate have moved forward with legislation to reauthorize the statute. The legislation, first enacted in 1993, is the largest source of federal funds dedicated for prevention services with $434 million available to states in 2006 to use for family support services, family preservation services, reunification services, and adoption support services. Of the total amount available in 2006, $345 million is mandatory spending ($40 million more than 2005), and Congress has appropriated $89 million for discretionary spending this year out of $200 million authorized.

Fortunately, Congress appears intent on reauthorizing the PSSF program before the current statutory authority. On June 12, the House Ways and Means Committee approved H.R.5640, the Child and Family Services Improvement Act of 2006, to reauthorize the PSSF program through 2011, and to target the $40 million in newly authorized mandated spending to support monthly caseworker visits with children who are in foster care.

The recent House Ways and Means Committee action recognizes the importance of capturing the increase in mandated spending (newly provided in 2006 for the child welfare prevention services authorized by the Title IV(B)-2 program). The committee has developed a bill directing the new funds to be divided among all states, specifically to support activities to improve caseworker retention, recruitment, training, and ability to access needed technology to improve work capacity and quality

In the Senate, the Finance Committee voted out its version of a reauthorization bill, S.3525, the Improving Outcomes for Children Affected by Meth Act of 2006, which passed the Senate by unanimous consent on July 13. Like the House bill, the Senate's measure targets the newly mandated $40 million in spending. However, in the Senate version, the money would go for competitive grants to promote interagency partnerships within states. Grants would range from $500,000 to $1 million, to increase the well-being of children removed from their homes or who are at risk of being placed in foster care because of a parent's or caretaker's abuse of methamphetamines. Eligible services could include early intervention and prevention, parenting skills training, child and family counseling, and other comprehensive family-based services.

The bill responds to concerns expressed earlier this year by the Finance Committee's leadership, Senators Charles Grassley (R-IA) and Max Baucus (D-MT), at hearings focusing on the tremendous challenges facing child welfare services because of the prevalence of methamphetamine drugs and the dangers posed to children in the care of meth users.

Reauthorization of the Promoting Safe and Stable Families program in both bills would retain the four categories of service that states are required to address. In addition to extending statutory authority for services through FY 2011, both bills would reauthorize court improvement grants and the mentoring children of prisoners program. Once the House passes its reauthorization bill, a conference committee will have to work out a compromise version to reconcile the diverse approaches taken by each chamber to target the $40 million in newly authorized entitlement spending. With the House and Senate proposing two very different approaches to directing the use of these monies, the outcome for legislation to reauthorize the PSSF program is uncertain, except that the funding for the program will continue.

CONGRESS PASSES SEX OFFENDER BILL ASKING FOR NATIONAL CHILD ABUSE REGISTRY

Before adjourning for the August recess, and the unofficial start of the campaign season leading to the mid-term elections in November, Congress passed the Adam Walsh Child Protection and Safety Act of 2006. President Bush signed the bill into law on July 27, marking the 25th anniversary of the abduction of Adam Walsh. The thrust of the legislation is to mandate a national sex offender registry and to enhance federal criminal sentences for sex offenders. Both the House and Senate measures would also give child welfare agencies access to national crime information databases for the purpose of conducting background record checks.

However, the final bill contains two provisions—neither of which was in the Senate's original version of the bill—that raised the concern of child advocates. The provisions are (1) the inclusion of juveniles on the national sex offender registry and (2) the creation of a national registry of cases of child abuse or neglect. In the compromise legislation accepted by the House and Senate, juveniles would be included on the

national sex offender registry, but the measure appears to exclude a group of consensual offenses among juveniles as exempt from the registry provisions. Nevertheless, the legislation retains the House-passed provision requiring the Secretary of Health and Human Services to create a national registry of substantiated cases of child abuse and neglect.

When fully implemented over time, the national registry is intended to enable child protective service agencies to identify an adult perpetrator's past child maltreatment offenses in other states, without having to check the child protective service central registries in each individual state. To counterbalance the mandate for establishing a national registry and to proceed responsibly, the Senate demanded that the bill include provisions requiring HHS to conduct a study on the feasibility of establishing data collection standards for a national child abuse and neglect registry. Clearly, such a study should be completed before the federal government begins to create a registry and collect information from the states. The final measure authorizes $500,000 to fund the study, but no money has been authorized to manage the registry.

Moreover, the legislation does not provide new financial or technical assistance to states to improve or standardize their child protective services-substantiated case record keeping systems or to support states in the added burden of preparing for, and transferring data to, a new national registry. Not all states maintain the same registry information: Some states do not record registry entries by name of perpetrator, but rather by name of child; some states no longer maintain registries at all. Neither do most Native American tribes, which are included in the legislation, maintain registries. Without additional technical and financial assistance to the states, the quality of the information collected would likely be uneven and at times unreliable. Child advocates hope that Congress will correct this deficiency in the legislative mandate for the creation of a national registry of child abuse and neglect cases by targeting appropriations to help state child protective services agencies upgrade their central registries or comparable systems of case-specific data.

CONGRESS STALLS ON 2007 FUNDING BILLS

While the House and Senate Appropriations Committees have moved ahead with drafting the money bills for the 2007 fiscal year, the word from Capitol Hill is that none of the funding legislation will be decided until after the November elections, when Congress plans to return for a lame-duck session to complete work on appropriations legislation.

Already, the House Republican leadership has postponed floor action on the FY 2007 Labor-HHS-Education Appropriations Bill until later in the year in order for the House to vote on a Democratic proposal to increase the minimum wage. The money bill that funds labor, health, human services, and education programs was expected to move to the House floor after it passed the House Appropriations Committee on June 13. In the committee deliberations, Rep. Steny Hoyer (D-MD) successfully offered an amendment to raise the minimum wage from $5.15 to $7.25 an hour. That was enough to put the brakes on the process.

The HHS money bill voted on by the House and Senate Appropriations Committees leaves most child and family services funded at the 2006 level, including Child Abuse Prevention and Treatment Act (CAPTA) grants, following in step with the President's budget proposing a funding freeze on discretionary spending for almost all children's programs. An exception is funding for the Promoting Safe and Stable Families program previously mentioned: The House committee approved the Administration's budget request to add $40 million to total $345 million in mandatory spending for services to children and families at risk, while maintaining the PSSF discretionary spending at $89.1 million, for a grand total of $434.1 million for the program. Unfortunately, the companion bill approved by the Senate Appropriations Committee on July 20 would cut by $14 million the discretionary share of the PSSF funding.

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HHS ISSUES GUIDANCE ON CAPTA 2003 AMENDMENTS

The HHS Administration for Children and Families has issued new provisions to the CAPTA section of its *Child Welfare Policy Manual,* addressing a variety of issues. Special attention has been given to questions raised by the 2003 CAPTA amendments regarding the referral (1) to child protective services of infants affected by illegal substance abuse and (2) to the Individuals With Disabilities Education Act (IDEA) Part C agency of children under the age of 3 in substantiated cases of child abuse or neglect.

On questions regarding referral to CPS of infants exposed to illegal drugs, HHS comments:

- CAPTA requires that the health care provider must notify CPS of *all* infants born and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.
- Such notification need not be in the form of a report of suspected child abuse or neglect.
- It is ultimately the responsibility of CPS staff to assess the level of risk to the child and other children in the family and determine whether the circumstance constitutes child abuse or neglect under state law.
- Health care providers are required to notify CPS regardless of whether drug-exposure is defined as child abuse or neglect in the state's reporting statute.
- The inclusion of infants who are born with prenatal exposure to alcohol is not required by the CAPTA provision, nor is it prohibited.
- Since CAPTA does not specify which agency (such as hospitals or community-based organizations) must develop the plan of safe care, the state may determine which agency is responsible.
- The plan of safe care should address the needs of the child as well as those of the parent(s), as appropriate, and assure that appropriate services are provided to ensure the infant's safety.

On questions regarding the referral to the IDEA Part C agency of children under the age of 3 in substantiated cases of child abuse or neglect, HHS comments:

- CAPTA does not specifically require that every child under the age of 3 who is involved in a substantiated case of child abuse or neglect must be referred to Part C services. Therefore, states have the discretion whether to refer every such child for early intervention services, or to first employ a screening process to determine whether a referral is needed.
- "Primary referral sources" to Part C agencies include hospitals, physicians, and social service agencies, which can include CPS. Some state CPS agencies are using other primary referral sources to assist in screening a child (after substantiation), while other state IDEA Part C programs are working with CPS agencies and training CPS social workers to conduct appropriate screenings. Both approaches meet the CAPTA requirements.
- Under the CAPTA provision, the state is not required to refer other children in the household who are not the subject of the substantiated case of abuse or neglect. However, HHS encourages states to refer all children who are suspected of having a disability and warrant a referral to early intervention services.

The new guidance on the CAPTA amendments also addresses the following: training for guardians ad litem, required triage procedures for children not at risk of imminent harm, public participation in citizen review panels, notification of abuse or neglect allegations, and criminal background check requirements.

For a complete discussion of CAPTA provisions covered in the *Child Welfare Policy Manual*, see: http://www.acf.hhs.gov/j2ee/programs/cb/laws_policies/laws/cwpm/policy.jsp?idFlag=2.

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.

Message from the President

As APSAC increases in size and continues to develop new products and services, the need for active membership participation becomes critically important. We need your opinions about new and existing services. We need your help in planning and implementing those services. The major limiting factor in the growth of our organization, and in its ability to provide for its members, is a shortage of manpower to carry out new projects and sustain those already in existence.

APSAC has a number of committees that would greatly benefit from your involvement. Typically, committees regularly hold telephone conference calls and report to the Board semiannually. Most are active throughout the year, while a few, including the Nominations and the Awards committees, require only seasonal involvement. Committee members represent all disciplines related to child maltreatment, and they work in cities and rural areas all over the United States and in multiple other countries. This diversity provides a tremendous source of creativity and knowledge. Service on a committee is a good way to meet others who share your interests, to make professional contacts, and to give back to the organization. It is also a very good way to have a major impact on ASPAC activities.

The Professional Education Committee is responsible for planning the annual Colloquium and the Advanced Institutes in San Diego, as well as overseeing the Forensic Interview Clinics. Ideas for training opportunities and new programs are developed here and, ultimately, presented to the Board. If you are interested in education and training, this is the best committee to join. You may want to steer APSAC toward Web-based training, or single-day regional trainings on specific topics. Serving on this committee allows you to influence a major component of the organization. Please contact cochair Mike Haney (Mike_Haney@doh.state.fl.us) if you are interested.

The Membership and State Chapters Committee is another important group. Ideas about member recruitment and member services are developed here. If you've identified important gaps in our services, or have thoughts about how to attract new members, I invite you to join this committee. Please contact cochairs Pat Lyons (lyonsp@chi.osu.edu) or Walter Lambert (Wlambert@med.miami.edu). If you are interested in helping structure the relationship between APSAC and its state chapters, or in working directly with the chapters, we need your involvement. Please contact Mike Haney, vice president of APSAC (Mike_Haney@doh.state.fl.us). APSAC wants interested professionals who can help identify the needs of our members and design ways to most effectively satisfy them.

The Cultural Diversity Committee is dedicated to identifying new ways to ensure the cultural competency of the organization and to serve a diverse population of professionals. By its very nature, APSAC attracts people from widely differing geographic areas, professions, backgrounds, and ethnicities. As the organization grows internationally, we must find ways to offer training opportunities and resources in multiple languages and respond to the unique needs of professionals from multiple countries. This committee has an important influence on all of the activities of the organization. If you are interested in learning more, please contact the committee cochair, Toni Cardenas (Toni.Cardenas@bellevue.nychhc.org).

APSAC has other committees you may want to join, including those focusing on Long-Range Planning, Underrepresented Disciplines; Awards; Nominations; Public Affairs; Operations/Finance/Development; and Publications. One or more of these committees needs your ideas and your energy. APSAC will be a better organization because of your active involvement. To find out more and to become involved, contact Daphne Wright (apsac@comcast.net), who heads the operations team at the national office.

Jordan Greenbaum
APSAC President

APSAC Board Member Selection

APSAC has completed its recent call for nominations to the Board of Directors. The slate of members willing to stand for election for 3-year terms, beginning January 2007 and ending December 2010, will be selected early in September. Special thanks to all who submitted applications for consideration in the nomination process. A ballot of selected nominees will be sent to each paid member. Watch for your ballot to come by mail early in the fall.

To assist you in voting, remember that duties of Board members include, but are not limited to, the following:

- attending at least one Board meeting a year
- chairing a committee or subcommittee
- waiving speaking fees for a minimum of one APSAC-sponsored training event each year
- actively working to generate members and revenue for the association

Your vote is so important. PLEASE REMEMBER TO VOTE!

Nashville Colloquium Highlights

The 15th Annual Colloquium held in Nashville was a terrific success. Not only were the workshops and seminars of the highest caliber, the overall synergy of the gathering could be felt throughout the 4 days. Thanks to those who attended and helped create such a memorable event. See you next year at the 16th Annual Colloquium in Boston, Massachusetts, July 11-14, 2007!!

Presentations at Awards Ceremony

The Awards Ceremony, which were held during the Colloquium membership luncheon, recognized the following individuals for their professional accomplishments and their contributions to APSAC:

Outstanding Service: Cynthia Cupit-Swenson
Outstanding Professional: Eliana Gill and Cordelia Anderson
Frontline Professional: Bob Adams and Clare Sheridan-Matney
Research: Linda M. Williams
Outstanding Doctoral Dissertation: Michael R. McCart

The Friedrich Memorial Award, established in honor of Bill Friedrich, was presented to Lucy Berliner. Lucy received the award because of her commitment to advancing knowledge and promoting clinical excellence in the child abuse field, qualities that Bill exemplified.

Please take a moment to recognize these outstanding individuals who do so much in the field of child maltreatment

Annual Membership Survey

APSAC is about to launch the 2006 Membership Survey. This survey provides a direct way for members to influence the direction of our organization in the coming years. As a membership-driven professional society, APSAC is only as strong as the collective efforts of members. Please help set the direction of APSAC by completing the 2006 Membership Survey. For the first time, this can be completed on the Web. Visit the APSAC home page at www.apsac.org and click on Membership Survey.

Winners of the *APSAC Handbook*

During the Colloquium, both members and nonmembers who visited the APSAC booth in the exhibit area could enter a drawing to win a hardcover copy of *The APSAC Handbook on Child Maltreatment, Second Edition.*

Congratulations to the two lucky winners, Karene Harrison of Charleston, South Carolina, and Rebecca Swift of Nashville, Tennesee.

Thanks to those of you who stopped by the APSAC booth and made yourselves known to Andrea Wright and Daphne Wright, who represent APSAC operations at the national office. It is great to put a face to APSAC members' names. Contact the national office at any time with concerns or comments.

2007 APSAC Membership

It's difficult to believe that another membership year will soon be upon us. Annual membership is in effect from January1 to December 31. Watch for membership renewals in the mail early in October. Why not invite a colleague to join APSAC, too!

Please renew by January 1 to prevent interruption of your online access to *Child Maltreatment: Official Journal of the American Professional Society on the Abuse of Children*. The journal is included as a benefit to all paid members of APSAC. To receive a hard copy of the journal, however, you will need to pay an additional $20.00 fee. For instructions on how to access your online account of *Child Maltreatment,* contact the national office at 843-764-2905 or visit www.apsac.org.

APSAC Web Site Update

We have begun Phase 2 of the Web site structure and design operation. In the fall, APSAC will be able to offer online registration for membership and to attend future events. Watch the Web site for this new user-friendly feature.

APSAC State Chapter News

Currently, APSAC is participating in dialogues with state chapter leaders and representatives. Mike Haney, the vice president of the APSAC Board, is heading up this effort with Walter Lambert and Pat Lyons. If you wish to participate in a future chapter discussion via conference call, please contact the national office at 843-764-2905 or Mike Haney at 850-245-4217.

APSAC Child Forensic Interview Clinics

There are two APSAC Child Forensic Interview Clinics currently scheduled:

December 4- 8, 2006, Portsmouth, VA
May 7-11, 2007, Seattle, WA

This is APSAC's pioneering intensive week-long (40 hour) class for people responsible for forensic (investigative) interviews with children regarding suspected abuse. Registration information and details can be found on the APSAC Web site (www.apsac.org <http://www.apsac.org/>) or by E-mailing the Clinic Coordinator at apsacclinic@verizon.net.

Mark Chaffin, Bill Friedrich: 2006 Pro Humanitate Prize and Medal Winners

As we were heading to press with the Summer 2006 edition of the *APSAC Advisor*, the Center for Child Welfare Policy of the North American Resource Center for Child Welfare (NARCCW) announced this year's winners of the Pro Humanitate child welfare literary awards. The 2006 judges were Peg Hess, Alfred Kadushin, Alice Lieberman, Haluk Soydan, Bruce Thyer, and Ronald Hughes. They selected, as one of this year's winners, an article written by Mark Chaffin and Bill Friedrich, entitled "Evidence-Based Treatments in Child Abuse and Neglect," which was published in the December, 2004, issue of Children and Youth Services Review. The Pro Humanitate awards will be presented on October 3 at the annual Structured Decision-Making Conference, sponsored by the Children's Research Center of the National Center for Crime and Delinquency.

This year's Pro Humanitate awards presentation should be both poignant and celebratory for APSAC members. The event is to be joyous because two of APSAC's most committed and productive members are being recognized for possessing the "intellectual integrity and moral courage to transcend political and social barriers to champion best practice for maltreated children," the criteria for which the Pro Humanitate awards are given.

Mark Chaffin has demonstrated a long and enduring commitment to APSAC. He has served on the APSAC Board of Directors, served for many years as editor of APSAC's professional journal, *Child Maltreatment,* and has published in numerous journals in the field of child maltreatment and in the *APSAC Handbook on Child Maltreatment*. Mark's is one of the most articulate and intrepid voices energizing the field of child welfare's commitment to empiricism and evidence-based practice. With one foot planted firmly in real world practice and inservice education and the other foot planted just as firmly in research, Mark is one of a few renaissance child welfare professionals who can help lead us to the promised land of evidence-based practice.

Mark's coauthor on the winning article was Dr. Bill Friedrich. Bill's commitment to APSAC, to its members, to both empirical research and sound clinical practice in child maltreatment, and to children and families is legendary. He is best known and highly respected for his extensive efforts to further the knowledge base related to child sexual abuse and sexual behavior problems in children. He also served as cochair of the APSAC Research Committee for many years. I recently had the opportunity to testify in a child welfare case in which attachment therapy was an issue. Children were at risk of abuse from those who were supposed to be providing protective and therapeutic care. Dr. Friedrich's articles in the *Advisor,* in which he helped define the problematic issues related to attachment therapy, took center stage in the court proceedings. The case findings and legal conclusions from the court case were the impetus for legislative reforms in adoption practice in Ohio. Bill Friedrich's work continues to positively impact children and families.

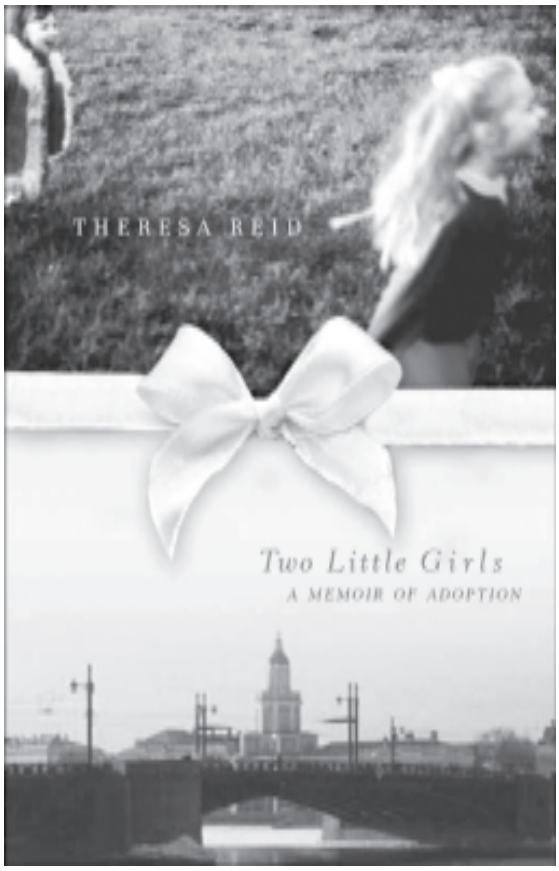
This Pro Humanitate awards ceremony will also be a time of sadness, as Bill died in September of 2005. This year's Pro Humanitate award will be the first posthumous presentation. When the Pro Humanitate medal and prize are given, we will not be able to shake Bill's hand and drape his medal, but we look forward to celebrating his tremendous spirit.

All of us at the *Advisor* are proud of our fellow APSAC members, Mark Chaffin and Bill Friedrich, for their exemplary work and their recognition as 2006 Pro Humanitate prize and medal winners.

Congratulations Mark and Bill.

Compelling New Book by Theresa Reid

As many of you will remember, Theresa Reid was the first executive director of APSAC and held that position for ten years, until she resigned in the spring of 1997 to become a mother by adoption. With physician husband Marc Hershenson, she first adopted a daughter from Russia and subsequently brought another daughter from Ukraine into the family. In April of this year, Theresa published *Two Little Girls: A Memoir of Adoption* with the Berkeley Publishing Group, a division of Penguin Group, Inc. Her true adoption story often reads like a suspense novel, but one with heart! It is a candid and deeply moving memoir of two international adoptions, a vividly detailed account of how Natalie and Lana became the daughters of Theresa and Marc.



Theresa's concern for the unfortunate children of the world has deep roots. After majoring in psychology, comparative literature, and women's studies, she received a master's degree in English from Ohio State University. She then attended the University of Chicago on a full academic scholarship, where she took courses toward a doctorate in English (she received her PhD in 2001). Her part-time job as managing editor of the *Journal of Interpersonal Violence* led her to take on the duties of a fledging organization called the American Professional Society on the Abuse of Children. APSAC had been founded a year or so before by some of the nation's leading lights in the field of child abuse and neglect. Because of her admiration for the founders and her enthusiasm for their work, Theresa became the indefatigable manager of APSAC's affairs and national office as the organization grew and expanded its scope of trainings and publications. She is also a coeditor of the first and second editions of *The APSAC Handbook on Child Maltreatment.*

Of Theresa's new book, Adam Pertman, executive director of the Evan B. Donaldson Adoption Institute, says, "A beautifully crafted, deeply insightful, painfully honest, and sometimes disturbing book…I couldn't stop turning the pages." Noelle Oxenhandler, the author of *The Eros of Parenthood*, commented, "Brings together a parent's longing, a traveler's harrowing journey, and a scholar's insight to explore the drama of foreign adoption. Written with passion, humor, extraordinary honesty, it is—above all—a fabulous read."

Two Little Girls has been favorably reviewed in *Adoptive Families, University of Chicago Magazine,* and *O, The Oprah Magazine*. Abigail Thomas's recent review in *O* included the following:

> Adoptive parents have to do more soul-searching than their biological counterparts, and Reid writes with remarkable honesty about what she discovered in herself—prejudice, jealousy, anger, doubt, and an endless supply of guilt. When Reid and her husband adopted the tiny Lana, they did so in spite of their worries about her health, her ability to bond, and how she would change the family. The two girls did not get along at first, and Reid does not gloss over her own anger at both children. Lana was affectionate but indiscriminately so, and Reid wanted to feel loved as a mother. One day Lana pulled another child away from Reid and planted herself firmly there. That small but unmistakable act of ownership changed their world. A powerful advocate of adoption, Theresa Reid and her husband cannot now imagine a happier life than the one they share with their daughters. Raw feelings, she shows us, are a normal part of the process. Because of the generosity displayed in her candor, she proves that if we can face our demons, we can stare them down. And when that happens, then joy is ours for the taking.

Two Little Girls is a compelling story for any reader, but especially for adoptive parents, people considering adoption, relatives of adoptive families, and those who work with foster or adopted children and their families. The hardcover edition is available at most major bookshops with a suggested retail price of $23.95 ($33 Canada). It is available online from Amazon.com, barnesandnoble.com (or bn.com), and us.penguingroup.com. Penguin will also release a trade paperback edition in April 2007. For more information, excerpts, photos, adoption resources, and reviews go to www.theresareidbooks.com.

First meeting with Lana

First day with Natalie

APSAC ADVANCED TRAINING INSTITUTES
January 22, 2007
Town & Country Resort and Convention Center
San Diego, California

The APSAC Advanced Training Institutes will be held in conjunction with the 21st Annual San Diego International Conference on Child and Family Maltreatment on January 23-26, 2007.

Registration information and forms for the following Advanced Training Institutes can also be accessed on the APSAC Web site (www.apsac.org) or by calling 843-764-2905. Or, see the registration form printed on the following page in this issue of the *Advisor*. Continuing Education Credits (CEUs) are offered for all Advanced Training Institutes.

APSAC PRE-CONFERENCE INSTITUTE #1
CHILD SEXUAL ABUSE MEDICAL EVALUATION: HOW WELL DO YOU AGREE WITH THE EXPERTS ON INTERPRETATION OF CASES?
Joyce Adams, MD & Lori Frasier, MD

Participants in this workshop will view images of medical examination findings on 20 children, then answer (on paper) questions regarding interpretation. Those who wish to participate in a research study will also complete a questionnaire detailing education and experience level. After the answers are turned in, the cases will be shown again and the experts' opinion will be presented, along with additional examples and the research base for their answers. Active participation by the audience will be encouraged.

APSAC PRE-CONFERENCE INSTITUTE #2
EVERYTHING YOU NEED TO KNOW ABOUT SERIOUS PHYSICAL ABUSE, HOMICIDE, AND NEGLECT OF CHILDREN
Rob Parrish, JD

Gain a different perspective from a former prosecutor and current Guardian ad Litem who presents and confronts expert testimony on a weekly basis. Learn to think "forensically" about injuries to children and recognize the "stupid stories" their perpetrators offer to account for these injuries. Examples of actual cases, photographs, computer animations, and other media help to identify the abuse and the perpetrator. Participants will receive a list of 20 different behaviors that help sort between the potential suspects when more than one adult was present when the injuries occurred. This institute is geared toward a multidisciplinary audience.

APSAC PRE-CONFERENCE INSTITUTE # 3
BASIC TRAINING IN TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY
Anthony P. Mannarino, PhD & Judith A. Cohen, MD

This is a review of the theoretical rationale for trauma-focused cognitive behavioral therapy (TF-CBT) and the basic components of the treatment model. These components include psycho education, parenting skills, relaxation skills, affective regulation, cognitive processing, trauma narrative, in vivo desensitization, conjoint sessions, and safety skills education. This Institute will incorporate numerous clinical examples and some complete case presentations.

2007 APSAC Advanced Training Institute Registration,San Diego

American Professional Society on the Abuse of Children

Information: The APSAC Training Institutes will take place on Monday, January 22, 2007, 8:00 AM to 3:00 PM at the Town & Country Resort and Convention Center, San Diego, California. The training is offered in conjunction with the 21st Annual San Diego International Conference on Child and Family Maltreatment, January 23-26.

Confirmation of registration will be e-mailed to each individual. Continuing education credits will be provided to participants verifying six (6) contact hours for submission to the appropriate entities.

Discipline (indicate one):

1. Child Protective Services	5. Medicine	9. Psychiatry	13. Victim Services
2. Education	6. Ministry	10. Research	14. Other
3. Law	7. Nursing	11. Social Work	
4. Law Enforcement	8. Psychology	12. Sociology	

Please print or type legibly and complete all sections of this form:

Name_____ Degree_____

Employer_____

Preferred Address_____

City_____ State/Providence/Country_____

Zip_____ E-mail_____

Day Phone_____ Fax_____

Home Phone_____

1st Choice Institute_____ Second Choice Institute_____ Based on availability
(Limited number of spaces)

Registration Fees (circle)	Before 12/16/06	After 12/16/06
Nonmembers	$150.00	$175.00
APSAC Members ($50.00 savings)	$100.00	$125.00
Join APSAC Now!	$100.00	$100.00
CEU Credit	**$10.00**	**$10.00**

Methods of Payment ☐ Check payable to APSAC (Federal ID # 93-0940608) ☐ PO # _____

TOTAL Payment_____ ☐ Credit Card $_____ to the following credit card: ☐ Visa ☐ MCard ☐ AmEx

Card Number _____Expiration Date_____(MM/YY)

Card Holder's Name_____ Sig._____ Date_____

Cancellation Policy: Registration cancellations must be made in writing. Cancellations postmarked on or before December 31, 2006, will be refunded in full, less a $50.00 administrative fee. Cancellation requests postmarked Jan.1–Jan. 15, 2007, will be refunded 50% of the registration fee. Refunds **will not be made** for cancellations postmarked **after January 15** or for participants who register and do not attend. Transfer of registration fees to another person may be made without penalty upon notification.

To Register:	SEND PAYMENT TO:	Questions:
Online information and registration form are available at: www.apsac.org	Mail to: APSAC PO Box 30669 Charleston, SC 29417	Call 843-764-2905 Toll free- 877-402-7722 Fax: 803-753-9823 E-mail: apsac@comcast.net

September 25, 2006
National Center for Victims of Crime
Training Institute NCVC
Seattle, WA
E-mail: KOBrien@ncvc.org

September 27-30, 2006
25th Annual Research and Treatment Conference
Association for the Treatment of Sex Offenders
Chicago, IL
Call: 503-643-1023

September 27-October 1, 2006
International Association of Forensic Nurse
14th Annual Scientific Assembly
Vancouver, BC
Visit: www.iafn.org

October 2-6, 2006
2006 Regional Training: Child Abuse and
Exploitation Team Investigative OJJDP
Houston, TX
E-mail: ojjdpmail@fvtc.edu

October 11, 2006
Legal Issues for Victim Advocates, Health
Care Professionals and SANE Nurses
Under SubpoenaTeleconference
Southwest Center for Law and Policy
Call: 520-623-8192

October 12-15, 2006
29th National Children's Law Conference of the
National Association of Counsel for Children
Louisville, KY
Call: 888-828-NACC or
E-mail: advocate@nacchildlaw.org

October 25, 2006
Group Facilitator Training for Those Working
With the Survivors of Sexual Trauma
Cleveland Rape Crisis Center
Cleveland, OH
Call: 216-609-6194 x 110

October 29, 2006
2006 National Conference on Sexual Assault in
Our Schools Safe Zone Society
Tampa, FL
Call: 841-870-4086

December 4- 8, 2006
APSAC Child Forensic Interview Clinic
Portsmouth, VA
Visit: www.apsac.org or
E-mail: apsacclinic@verizon.net

January 22, 2007
APSAC San Diego Training Institutes
San Diego, CA
Visit: www.apsac.org

January 23-26, 2007
21st San Diego International Conference
on Child and Family Maltreatment
San Diego, CA
Visit: www.chadwickcenter.org

May 7-11, 2007
APSAC Child Forensic Interview Clinic
Seattle, WA
Visit: www.apsac.org or
E-mail: apsacclinic@verizon.net

July 11-14, 2007
APSAC 15th Annual Colloquium
Boston, MA
Visit: www.apsac.org

APSAC ADVISOR

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Save these dates!!!!!

APSAC Child Forensic Interview Clinic
Portsmouth, VA, December 4- 8, 2006

APSAC Advanced Training Institute
San Diego, CA, January 22, 2007

15th APSAC Annual Colloquium
Boston, MA, July 11-14, 2007

For more information Visit: www.apsac.org

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