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IN THIS ISSUE

At Issue: Bridge Over a Philosophical Divide

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A deep philosophical divide exists between "strictly objective" researchers who believe that engaging in civic debate regarding their research and its implications undermines objectivity, and "citizen scientists" who believe that researchers can—and sometimes should—help decision makers develop policy that incorporates the best available empirical evidence. The authors argue that this divide can, and should, be bridged for an assault on the abuse of science. *At issue...* is the frequent abuse of science by politicians, entrepreneurs, and other special interests who, with impunity, fill the "vacuum of social discourse" caused by scientific detachment. This article details a need and an opportunity for all scientists and researchers to support civic engagement, to champion scientific objectivity in policy formulation, and to hold accountable those who abuse science. **2**

Constructive Uses of Risk: The Promise and Peril of Decision-Making Systems in Child Welfare

Aron Shlonsky, MSW, MPH, PhD
Liz Lambert, MSW

Recent evaluations of the Ontario Risk Assessment Model (ORAM)), used since 2000 by Ontario's child welfare agencies, determined that the risk assessment tool, which is the centerpiece of the ORAM, was neither reliable nor valid in estimating the likelihood of future recurrences of maltreatment. In response, the Ontario Ministry of Children and Youth Services partnered with the University of Toronto to consult child welfare caseworkers to determine the utility of alternative decision-making tools. After piloting several tools using their own case files, Ontario's caseworkers provided feedback in focus groups held throughout the province. When comparing the ORAM, a consensus-based model, with the California Structured Decision-Making (SDM) model, the caseworkers clearly favored the SDM, a comprehensive set of tools that incorporates both actuarial risk assessment and clinical assessment tools. While workers appreciated the speed and promise of enhanced predictive capacity using an actuarial approach, they often struggled to conceptualize the difference between risk assessment and clinical assessment, a fact that raises serious implementation challenges. Recommendations to facilitate successful implementation are considered within a broader debate about the utility and relevance of risk assessment instruments in a child welfare context. **5**

REGULAR FEATURES

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At Issue: Bridge Over a Philosophical Divide

Paul A. T. Higgins, Kai M. A. Chan, and Stephen Porder

Introduction

Each new generation of scientists debates the role that science should play in society (van der Vink, 1997; Myers, 1999; Ehrlich, 2003). This debate is often reduced to a passionate conflict between two apparently irreconcilable philosophical views. The 'strictly objective' scientists shun civic engagement out of concern that scientists remain objective and free from external influence (Wooster, 1998; Hsu and Agoramoorthy, 2004), while 'citizen' scientists encourage civic engagement to ensure that society can benefit from scientific understanding (Bazzaz et al, 1998; Ehrlich, 2003; Terborgh, 2004). There is a middle ground, but it is generally restricted to informing policy makers and the public about scientific findings through expert advisory panels and the activities of our most venerated institutions such as the Royal Society and the National Academy of Sciences. Here we suggest that the threat posed to scientific objectivity by the escalating politicisation of science provides a much larger, although limited, bridge between these competing philosophical views: a commitment to scientific objectivity requires a greater civic presence.

All scientists recognise the need for researchers to strive for objectivity, and to state assumptions clearly and openly. The pursuit of unbiased research is a cornerstone of the scientific method and a basic requirement for confidence in experimental results. Most scientists also recognise that our values, hopes and beliefs, our individual backgrounds and our societal context all influence our choice of research questions and hinder our efforts to achieve complete objectivity. Nevertheless, striving for objectivity in our experiments ensures that results and analysis remain as unbiased, replicable and credible as possible. Beyond this broad agreement over objectivity in research, however, a polarised disagreement rages between those who shun engagement in policy debates and those who embrace it.

The 'strictly objective' scientists consider the commitment to objectivity in research to include objectivity in the public domain. According to this view, knowledge need not lead to technological advancement or alter the policies that we as a society adopt. Instead, knowledge is valued inherently because it pushes back the darkness of ignorance. When scientific knowledge can more directly benefit society, the responsibility for exploiting the results and reaping the rewards lies with non-scientists. Furthermore, by remaining apolitical and as free from external influence as possible, the scientific community builds credibility with the general population and thereby increases the potential for widespread acceptance of scientific findings (Pielke, 2004). As a result, 'strictly objective' scientists eschew advocacy (Wooster, 1998; Hsu and Agoramoorthy, 2004).

At the other end of the philosophical spectrum, 'citizen scientists' believe that societal membership confers the right – and at times the responsibility – to engage in civic debate. Since the vast majority of policy makers and the general population lack scientific training, scientists are uniquely qualified to help promote policies that capitalise on scientific understanding. While citizen scientists acknowledge the need to strive for objectivity in research, they also encourage scientists to help society reap the gains and avoid the disasters that science reveals.

Citizen scientists also see an obligation to society that stems from the funding of research. The vast majority of 'objective' research – that which is pursued and published freely and without pressure from political or economic stakeholders – is funded through taxes paid by the public. Scientists therefore have a responsibility to ensure that society accurately understands and benefits from research as a reasonable return on the investment of its tax revenue (Lubchenco, 1998).

Politicisation of science

The debate between the 'strictly objective' and 'citizen' camps leaves many scientists unwilling to engage in civic discourse. Some are convinced by the argument for strict objectivity. Others recognise that it is professionally safe to focus solely on research and dangerous to advocate on behalf of anything, even science. The risk is especially paralysing for young researchers, who must consider the judgments of those who will influence decisions over hiring, tenure, publication and funding. Yet this professionally safe alternative may be the most dangerous for science and society because the resulting lack of civically engaged scientists creates a vacuum in social discourse that allows politicians and interest groups to abuse science with relative ease and impunity.

In the US, for example, the media largely ignored instances of scientific abuse by the Bush administration until scientists began speaking out (Association of Reproductive Health Professionals, 2004; Union of Concerned Scientists, 2004a; Chan et al, 2005). Increased public awareness and the response of some administration officials to the problem of scientific abuse (Marburger, 2004) following this relatively minimal civic engagement, demonstrate the potential power of scientific engagement. These are small victories, however, and the politicisation of science remains a problem (Union of Concerned Scientists, 2004b), as exemplified by the administration's approach to climate change and its championing of abstinence-only sex education. In the case of climate change, the administration has cited unrepresentative and poorly supported findings that contradict more widely accepted research. There is also a notable asymmetry between the administration's stress on scientific uncertainty in relation to climate change and its practice of ignoring scientific evidence that questions the plausibility of policies the President favours, such as missile defence (Barton et al, 2004; Gronlund et al, 2004). Similarly, the administration has gone beyond moral and ethical arguments for abstinence-only sex education, with claims of greater effectiveness relative to comprehensive sex education programmes. While morality lies outside the scientific realm, the empirical claim is contradicted by objective scientific research (Brückner and Bearman, 2005).

Scientific abuse for political, corporate or personal gain is certainly not unique to the US or its current administration and is generally not a partisan issue. There have always been advocacy groups, business interests and politicians on all sides who misrepresent science, either deliberately or through ignorance. Some policy makers, irrespective of political party, also champion science in the face of powerful political and economic pressure. Nevertheless, the current abuse of science for political gain is ubiquitous among fields as diverse as

public health, atmospheric chemistry, forestry, fisheries management and climate science, and increasingly occurs at the highest levels of government (Association of Reproductive Health Professionals, 2004; Union of Concerned Scientists, 2004a; Chan et al, 2005).

At times, scientists themselves contribute directly to the problem of abuse by overstating the certainty or implications of research findings or by downplaying contrary views that are also supported by research. Likewise, scientists can sometimes overreach by using their professional credibility to promote policy choices that depend upon ethical values and personal beliefs. Nor do scientists always recognise the knowledge and values found among non-scientific groups, which appropriately contribute to the processes of developing well-informed policy.

Therefore, concern over how scientists engage the public is legitimate. Unfortunately, when scientists recoil too far from the policy implications of research, they also contribute to the misuse of science. In their efforts to avoid making value judgments, scientists often avoid interpreting their results fully, because to do so would place their words in a policy context. In order to eschew value judgments, they avoid *technical* judgements that they are uniquely qualified to make (Failing and Gregory, 2003). Into this vacuum step politically motivated parties who offer their own interpretations of scientific results and, without credible opposition, mislead the public towards their own desired goals.

Recognising the need for scientists to guard against scientific abuse in their own actions, the misuse of scientific results by political partisans represents a great threat to both science and society. Science has historically been a source of objective information for policy making. Now, its pervasive misrepresentation through a biased selection of results and the suppression of unwelcome findings threatens to convert science into a subjective tool for advancing narrow political, corporate or personal interests.

Bridge over the divide

The politicisation of science creates a need for advocacy that differs fundamentally from the advocacy that occurs over policy on issues such as climate change and stem cell research. In this unique case, advocacy seeks only to restore scientific integrity and promote objectivity by exposing and ending abuse. Thus, politicisation links the commitment to unbiased science with limited civic involvement, and thereby bridges the philosophical divide between 'strictly objective' and 'citizen' scientists.

This bridge cannot fully reconcile the two competing philosophical views, however. Some researchers will never be comfortable with scientists advocating policy, which necessarily involves ethical, moral and value judgements. Others, who are eager to help society make wise decisions, may view those unwilling to do so as shirking responsibility. Broad agreement between the citizen and strictly objective philosophies is therefore unlikely, rendering this bridge a limited and conditional coalition that applies only to the abuse of science.

Even when faced with the politicisation of science, some may argue against civic engagement, believing that scientists are most effective when pursuing research exclusively (Hsu and Agoramoorthy, 2004). After all, we are trained to discover, not to engage in civic debates. But the politicisation of science – such as political litmus tests for funding reproductive health research and making appointments to panels on bioethics (Union of Concerned Scientists, 2004a, 2004b) – hinders our capacity to pursue research freely. It also denigrates science in the eyes of the public and thereby threatens funding and the value society places on scientific research. As a consequence, an exclusive focus on research fosters the politicisation that undermines science and limits our future research options.

A sizable fraction of the scientific community in the US is beginning to recognise the need to engage in public discourse. Recent efforts to characterise and criticise the politicisation of science by the Union of Concerned Scientists (UCS) (2004a, 2004b) and ScienceinPolicy have received significant support within the scientific community. For example, over 5,500 scientists endorsed a UCS statement calling for an end to the Bush administration's abuse of science, among them many of the world's top scientists including 48 Nobel laureates, 62 National Medal of Science recipients and 129 members of the National Academy of Sciences. Similarly, over 1,800 researchers endorsed a ScienceinPolicy statement criticising the administration's misuse of environmental science (Porder, 2004). Beyond these grassroots efforts by individual scientists and advocacy organisations, it is time for our traditional scientific institutions and reward structures to encourage responsible civic engagement (Chan et al, 2005). This willingness to publicly defend the integrity of science reflects a coming together of the 'citizen' scientists' desire for civic engagement with the 'strictly objective' scientists' wish to protect objectivity. But even the impressive number of scientists engaging on this issue constitutes a relatively small fraction of the scientific community, and many who endorsed these efforts will probably take no additional actions to directly engage with the broader society. Without an expansion of these efforts, the objective use of science in civic debates remains gravely threatened.

Conclusion

The pursuit of objectivity is a cornerstone of scientific research. Ironically, uncritical pursuit of objectivity leads to reticence among scientists to engage in civic debates. This allows less knowledgeable, more politically motivated individuals and organisations to become the voice for science in the public domain, which is in the interest of neither scientists nor the public. Scientists' weak public presence results in anaemic or non-existent challenges to scientific abuse and a lack of public accountability for the abusers. As a result, the politicisation of science has proven an effective tool for advancing narrow political, business and personal interests.

Solving this problem will depend on scientists' willingness to champion objectivity in civic debates and will not require inappropriate partiality. Scientists must be careful to maintain their own integrity when engaging in civic debates, but educating the public and policy makers – in this case about scientific abuse – differs from advocating policy options by promoting rather than undermining objectivity. Thus, 'strictly objective' and 'citizen' scientists can agree to champion scientific integrity in public discourse. In this coherence of goals, the abuse of science bridges the apparently irreconcilable philosophical views of 'strictly objective' and 'citizen' scientists. While there remains disagreement over the appropriate scope of scientist advocacy, we can protect the role of science in society by setting aside that philosophical debate whenever science gets politicised.

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Introduction

Child Protective Services (CPS) agencies are charged with investigating allegations of child maltreatment and, finding that such maltreatment has occurred or is likely to occur in the future, must choose a course of action that protects children from future harm. The former task requires an accurate assessment of the risk of future maltreatment, and the latter requires a comprehensive assessment of family dynamics and functioning (Shlonsky & Wagner, 2005; Hughes & Rycus, 2003). At both of these stages, organizational, environmental, and individual factors create multiple barriers to accurate decision making (Gambrill & Shlonsky, 2001). Organizational and environmental challenges include heavy caseloads, time pressures, chronic stress, the presence of incongruent and often conflicting case information, public scrutiny, and restrictive agency policies (Regehr et al., 2000). Individual factors, such as limited processing capacities, ineffective critical appraisal skills, and personal biases, also complicate accurate decision making (Gambrill & Shlonsky, 2001). Given the complex and multifaceted nature of decision making in a child welfare context, the unassisted clinician is unlikely to be able to accurately estimate the threat of harm in either the near or long term. In fact, there is a substantive body of research spanning diverse disciplines which suggests that workers are able to more accurately determine risk levels using a statistically-driven risk assessment tool rather than relying solely on clinical judgment (Dawes, Faust, & Meehl, 1989; Grove & Meehl, 1996).

Consensus-Based Tools Versus Actuarial Tools

In an effort to minimize the shortfalls of unassisted clinical decision making, researchers and other professionals have developed formal risk assessment tools, which generally fall into two categories: consensus-based and actuarial. Both are intended to improve clinical judgment by identifying specific characteristics to examine when one is assessing future risk of harm. Consensus-based models are derived from agreement among experts about a set of characteristics that contributes to future risk of maltreatment, whereas actuarial models are statistically driven and based on empirical relationships between risk factors and outcomes (Baird & Wagner, 2000). By and large, actuarial tools predict at least as well as, and usually far better than, unassisted clinicians (Grove & Meehl, 1996) and consensus-based tools (Dawes, 1994).

Few comparisons have been made among the various risk assessment instruments used in child welfare services. A notable exception is the Children's Research Center (CRC) study of the reliability and predictive validity of three commonly-used risk assessment instruments: one actuarial tool and two consensus-based tools (Baird et al., 1999; Baird & Wagner, 2000). These included Michigan's Family Risk Assessment of Abuse and Neglect (FRAAN)—an actuarial tool; the Washington Risk Assessment Matrix (WRAM)—a consensus-based tool; and the California Family Assessment Factor Analysis (CFAFA)—a consensus-based tool. The three tools were rigorously compared using a retrospective review of cases in California. Not surprisingly, FRAAN's actuarial approach substantially outperformed the other two tools in terms of both reliability and validity, more often consistently and accurately classifying high-risk families who later maltreated their children. In addition to being data-driven, the FRAAN largely comprises simple (yes-no) questions (making it easy to score reliably), separately estimates recurrences of both abuse and neglect (an acknowledgement that these are two very different forms of maltreatment with potentially different risk factors), and calculates an overall risk rating rather than relying on caseworker judgment to assign a level of risk.

Nonetheless, even the best risk assessment instruments do not estimate maltreatment well enough for use as the sole basis of decision making. Rather, these tools can be used to classify families into escalating degrees of risk (low, moderate, high, very high) with the greatest possible precision, and this information is then combined with clinical assessment skills to formulate a service plan (Shlonsky & Wagner, 2005). The hope is that actuarial approaches to such classifications will provide greater consistency and enhanced predictive validity of decisions through the optimal weighting of statistically valid risk indicators. Actuarial instruments and accompanying decision-making tools have been developed by the Children's Research Center (CRC), and these have been put into operation with some degree of success (Johnson, 2004; Wagner & Johnson, 2003; Wagner, Johnson, & Caskey, 2002)

However, the literature suggests that workers tend to rely more heavily on clinical judgment, which may be indicative of a general distrust of risk assessment instruments. Schwalbe (2004) pointed to a persistent belief in the efficacy of clinical judgment, a tendency for people to be more heavily influenced by narratives than numbers, and the depersonalized nature of statistical tools as the primary reasons for worker resistance to risk assessment instruments. Munro (2005) suggested that this resistance may stem from differences in human reasoning. Front-line workers have traditionally shown a preference for intuitive reasoning, whereas actuarial tools tend to be derived from an analytic reasoning model. Against this backdrop, the implementation of standardized, risk assessment instruments is wrought with many challenges, despite their greater predictive capacity, and training child protection workers to think differently is eminently more difficult than training them to use a tool. Most important, risk assessment (estimating the likelihood that a child will be reabused) is not so easily separated from clinical assessment (observing and understanding the many factors that contribute to and sustain maltreatment), and both are needed to make a viable service plan.

Study Background

In 2000, Ontario implemented the Ontario Risk Assessment Model (ORAM) to ensure a more comprehensive, standardized assessment process (Tuyl, 2000) and to "promote and support a structured and rational approach to case practice, without replacing professional judgment" (Ontario Association of Children's Aid Societies, 2000, p. 1). The ORAM was derived from an older system developed in New York and includes three major components: a screening in-

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strument to ascertain whether allegations should be investigated, a safety protocol designed to indicate cases where children are at risk of immediate harm, and a risk assessment tool (RAT) designed to predict both long-term risk of maltreatment recurrence and to gather important case information at several points in time. None of the instruments contained in the ORAM was statistically derived. Rather, these are consensus-based or expert-driven tools and have not been empirically validated.

The RAT comprises five-risk assessment domains, including the caregiver, the child, the family, the intervention (caregiver motivation and cooperation), and abuse/neglect circumstances. Within these domains, the RAT contains 22 individually rated risk elements that are thought to be associated with child maltreatment. Each of the 22 risk elements is evaluated on a scale of severity, ranging from 0 to 4. The risk assessment scales are defined using "anchors," narrative descriptive statements to help workers determine which rating (0–4) best fits the characteristics of the family they are investigating (Leslie & O'Connor, 2002). Space is provided at the end of each risk element for workers to expand upon or justify their selected rating in narrative form. After completing the risk assessment, workers consider all the risk elements present in a case and how these risk elements interact with one another (accounting for the presence of protective factors that may mitigate risk to the child), and then they choose an overall risk rating for the family based on a five-point severity scale (Leslie & O'Connor, 2002). The determination of the overall risk rating is based exclusively on the clinical judgment of workers, though supervisor input is encouraged. The RAT is completed for cases to be opened for ongoing services, every six months, and when a case is to be closed. The RAT is used as both an assessment of risk and a structured clinical tool, and the same set of risk factors is assessed repeatedly for the life of the case.

The three tools were rigorously compared using a retrospective review of cases in California. Not surprisingly, FRAAN's actuarial approach substantially outperformed the other two tools in terms of both reliability and validity, more often consistently and accurately classifying high-risk families who later maltreated their children.

Since the implementation of the RAT, professionals have raised questions about its predictive value, workload implications, and impact on casework. These concerns center on how the tool is used in practice and whether the data produced are informative and useful (Leslie & O'Connor, 2002). Confirming concerns expressed in the field, initial outcomes from the RAT evaluation study conducted at the University of Toronto suggest that it is neither a reliable nor a valid tool for estimating whether children will be reabused (Trocme et al., 2007). More specifically, the tool was deemed unreliable due to low internal consistency within categories, low inter-rater agreement for individual risk factors, and low inter-rater agreement for the Overall Risk Score. The study also suggests that the RAT has low predictive validity for almost every item, including the overall risk rating.

In light of these findings, the Ontario Ministry of Children and Youth Services (MCYS) partnered with the University of Toronto to investigate alternative risk assessment and contextual assessment tools for use in CPS. The Ministry researched a battery of tools used in the United States, the United Kingdom, and Australia as part of its movement toward a differential response system (i.e., diverting low-risk cases into preventive and family support programs and serving high-risk cases with core child protective services) that relies upon quickly and accurately classifying cases into varying levels of risk. Given the problems experienced by workers using the current risk assessment system and the difficulty of implementing new decision-making protocols, the MCYS decided to obtain input from the field prior to restructuring the current system. The Ministry chose eight tools to "test-drive" with intake and ongoing services workers from an array of Children's Aid Societies (CAS) in Ontario. Ninety-two child welfare workers and supervisors volunteered to review the tools, use them to assess a set of closed cases, and participate in focus groups held across the province.

The California Structured Decision-Making Model

As a result of its literature search and consults with several academic sources, MCYS concluded that the California Structured Decision-Making (SDM) system developed by Children's Research Center of Wisconsin represented the current best risk assessment system. California's SDM contains, as its centerpiece, a reliable actuarial risk assessment instrument with high levels of predictive validity in estimating the likelihood of subsequent child maltreatment reports, subsequent substantiated maltreatment, and child injury resulting from abuse or neglect (Wagner & Johnson, 2003; Johnson, 2004). This tool is used at the close of maltreatment investigations to help workers make difficult service decisions (e.g., whether and how to serve these families and long-term placement decisions). The risk assessment tool encourages the provision of more intensive services, mandated when necessary, to high-risk cases and less intrusive, voluntary services to lower-risk cases. Clinical skills are still of paramount importance for gathering the case-specific information required by the risk assessment form, understanding the issues that resulted in the family being investigated, and determining a reasonable course of action given this contextual information and the risk rating produced by the tool.

The risk assessment tool is accompanied by a safety assessment (which is completed within 24 hours of seeing the children) and, for families having continued involvement with the child welfare system, a structured clinical assessment tool (completed by the ongoing services worker), a risk reassessment, and a family reunification assessment. Risk assessment and clinical or contextual assessment are deliberately separated. That is, instruments designed to produce a risk rating are entirely distinct from instruments designed to gather critical case information that drives the case plan. The risk assessment tools are viewed as decision aids, simply to be used as another piece of information at key milestones during a family's involvement with child protection services (CPS). The SDM clinical assessment tool, the California Family Strengths and Needs, is designed to provide detailed, individualized information about the issues that brought the family to the attention of CPS, and it is structured in a way that facilitates case planning (see Table 1 for detailed descriptions of each tool in the California SDM system).

Methods

Intake and family service workers and supervisors from a wide range of Ontario's Children's Aid Societies (CAS) were solicited through the Ontario Association of Children's Aid Societies' Web site and mailing list to participate in what was called a "test drive" of risk assessment and clinical assessment tools that were being considered for use across the province. Participating workers were asked to com-

plete mock risk assessments using their own closed cases, examine of set of potential clinical assessment tools, and participate in a day-long focus group to gather feedback about each instrument.

Sample

There are 53 Children's Aid Societies in Ontario, varying in size and population. To maximize inclusion and variation, participation was limited to two volunteers from each agency. Focus groups were held in three locations: Ottawa (East); Sudbury (North); and Toronto (South and West). These locations were chosen to minimize travel for participants and to garner a sample that was representative of the province. The clear distinction in job description and types of decision-making needs between intake and ongoing services workers necessitated conducting separate focus groups for intake (Component I) and ongoing services (Component II) workers and supervisors. In all, 92 workers and supervisors from 34 Children's Aid Societies participated in the focus groups.

Procedures and Instruments

Prior to the focus groups, participants in both components were asked to volunteer to spend a day at their own offices familiarizing themselves and "testing" the two assessment instruments on three cases they had recently closed to insure that families with open cases were not affected by reevaluation of their case files. Participants were also asked to review four clinical or contextual assessment tools designed to structure information gathering for use in case plan development. These ranged in level of complexity, knowledge needed about the family, and time to complete. Volunteers then participated in focus groups centering on the instrumentation and viability of the risk assessment tools they had completed (morning session) and on their opinions about the clinical assessment tools they had been asked to review (afternoon session).

Front-line workers have traditionally shown a preference for intuitive reasoning, whereas actuarial tools tend to be derived from an analytic reasoning model. Against this backdrop, the implementation of standardized, risk assessment instruments is wrought with many challenges, despite their greater predictive capacity...

Intake workers and supervisors in Component I began by reviewing the California Safety Assessment and the California Risk Assessment. Ongoing workers and supervisors in Component II began by reviewing the California Risk Reassessment Tool and the California Family Reunification Assessment. All volunteers were then asked to select and review the charts of three of their own cases that had been closed in the last six months. Component I participants reviewed at least one case that had not been opened and one case where the child had been taken into care. Component II participants reviewed at least one case where the child had been reunified and one case where the child had received ongoing services without having been placed in foster care.

After participants had refamiliarized themselves with the cases, the volunteers from Component I were asked to complete a California Safety Assessment and a California Risk Assessment for each selected case. Volunteers for Component II completed a California Risk Reassessment Tool and a California Family Reunification Assessment. For each case, volunteers used only information that would have been available to them at each respective decision point. While completing this task, they were asked to take notes in relation to the following:

- Ease of use
- Availability of requested information
- Utility as a decision aid
- How the tool compared with the equivalent instruments in the ORAM
- Potential of the tool to work in concert with other, more detailed assessment tools
- Strengths of the tool
- Weaknesses of the tool
- Unintended consequences of its implementation

Volunteers then summarized their comments and turned in their completed instruments to the principal investigator.

Although the Ministry of Children and Youth Services had decided to pursue the risk assessment portions of SDM unless serious objections were raised in the field, there was considerable debate about which clinical assessment tool would be most beneficial for Ontario. The Ministry chose four clinical assessment tools, representing a range of depth and complexity, as potential candidates for use in the province. These included the Ontario Revised Risk, Strength, and Needs Assessment; California Family Strengths and Needs Assessment; Looking After Children Initial Assessment—Ontario Version; and Bristol Core Assessment Form.

The Ontario Revised Risk, Strength, and Needs Assessment is a tool derived largely from the RAT. This instrument was constructed and used so workers could, essentially, evaluate and ultimately choose a tool with which they were familiar. The California Family Strengths and Needs is a structured clinical assessment tool covering eleven caregiver and nine child domains. Each item is anchored and scored, but the scores are not summed to indicate risk. The tool also includes a prioritization of these strengths and needs as well as a section for additional elements not covered by the tool.

The initial assessment module of the Ontario Looking After Children (ONLAC) assessment system is a detailed, largely narrative assessment tool geared toward ascertaining children's developmental needs, a caregiver's parenting capacity, and family and environmental factors, all of which are used to develop a case plan that drives service provision. While the ONLAC is defined as a "brief" assessment tool, the level of detail is far greater than the previous tools and requires a relatively long period of time to complete, as well as substantial knowledge of the child and family being assessed. This tool was chosen since it is fairly comprehensive, includes an assessment of child developmental functioning, is used widely in the United Kingdom, and is already in use across the province (primarily for children residing in long-term foster care).

The Bristol Core Assessment Form is a more detailed and time-intensive version of the Looking After Children Initial Assessment, and it also includes a scale for each domain. Similar to the ONLAC, the domains comprise child developmental needs, parenting capacity, and family and environmental factors, but the anchors and discussion points are far more numerous and detailed. Also included are parent and young person perception of individual and family strengths and needs, as well as a detailed analysis of these strengths

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and needs by the assessor. Again, this information is used to develop a case plan that drives services provision. This tool was chosen because it is comprehensive and detailed, is used widely in the United Kingdom, and represents the high end of the continuum in terms of required training for use and the length of time and amount of client information needed to complete it (see Table 1 for further descriptions of each tool).

One week prior to the scheduled focus group, participants in both components received a package containing these four clinical assessment tools for their review, and the afternoon session of each focus group gathered the participants' opinions of these four measures.

Data Analysis

The principal investigator and research team reviewed the notes and completed risk assessment forms filled out by study participants. They analyzed the content of the notes and forms to identify commonly expressed concepts, including concerns or strengths of the tools and opinions regarding their possible implementation in the field. Research assistants coded and labeled these responses and identified themes that were common across participants. In the focus groups, the facilitator explored with child welfare staff members their perceptions about how these tools would enhance or detract from their ability to provide high-quality services to the children and families with whom they work. In addition, their opinions were elicited regarding their experience with the current decision-making system (ORAM).

The transcripts and recorder notes were initially reviewed using discourse analysis. Open coding was used to identify broad concepts and themes that emerged in each group. This was followed by axial coding to establish interconnections among the themes and create a coding framework (Strauss & Corbin, 1990).

As a result of its literature search and consults with several academic sources, MCYS concluded that the California Structured Decision-Making (SDM) system developed by Children's Research Center of Wisconsin represented the current best risk assessment system. California's SDM contains, as its centerpiece, a reliable actuarial risk assessment instrument with high levels of predictive validity in estimating the likelihood of subsequent child maltreatment reports....

Results

Overall, the participants favored the instruments in the California SDM system. Although they had not been trained on the proper use of these tools, caseworkers, by and large, appeared to understand their function and how to complete the tools. Nevertheless, there was some confusion around the separation of risk assessment and clinical assessment. The California Risk Assessment was well received by the vast majority of participants. They cited its ease of use, the speed with which it could be completed, and the consistency of its ratings as major benefits over the RAT in the ORAM. However, understanding how the contextual tools functioned with the risk assessment tool presented a challenge.

The contextual assessment tools sparked some discussion around the need to have a tool that would allow workers to effectively meet the needs of families while reducing, or at least not adding to, their paperwork. With this in mind, caseworkers tended to prefer the California Strengths and Needs Assessment. Participants expressed concern that the Ontario Revised Risk, Strength, and Needs Assessment was too deficit-focused and contained the same problematic issues present in the ORAM. Overall, participants perceived the ONLAC and Bristol assessment tools to be comprehensive and thorough but not feasible for use in daily practice. Although workers believed they had the skills to complete the tools, time constraints and high caseloads prohibited their use, and this was particularly true for investigation caseworkers. Some participants also pointed out that such detailed assessment tools may be too intrusive to engage families. That is, the generally intrusive and investigative nature of child protection work may not allow caseworkers to engage families sufficiently to complete a comprehensive clinical assessment tool.

Conceptualizing Risk and Context

The RAT in the ORAM required that workers use the ratings on the individual risk elements to inform their decision of the overall risk rating. In other words, workers use a combination of the risk ratings and their clinical judgment to determine the overall risk rating, which is then supposed to help determine an appropriate service plan for each family. In the California SDM model, risk and context are clearly separated, representing a paradigm shift that many workers struggled to grasp. The perceived disconnect and lack of integration between the risk rating and the more thorough family assessment posed the largest conceptual hurdle. Workers seemed skeptical about the predictive value of the California risk assessment tool because it did not include all of the 22 factors contained in the RAT, nor did it contain its narrative components (despite the fact that they did not trust the RAT either). They consistently highlighted that certain variables, such as a family's visibility in the community and a caregiver's mental health, seemed to be "missing" from the tool. The RAT framework appeared to bind workers mentally, limiting their ability to conceptualize risk without also completing a corresponding narrative that was generally used to provide a rationale for the risk rating and to more fully understand the family. Many participants expressed that the risk rating seemed meaningless, like a hollow number, because it was devoid of theory or context within which to situate it. This challenge speaks to one of the potential shortfalls of actuarial risk assessment instruments identified in the literature, namely, that they "indicate risk level without explaining the dynamic processes that might explain their findings" (Schwalbe, 2004, p. 573). That is, the risk assessment instruments use only the most predictive factors, and those factors may not be located at the beginning of the causal pathway leading to maltreatment.

A substantial portion of the focus groups was devoted to explaining how the tools functioned together because workers were not given any prior training in the use of the tools. After a more thorough discussion of SDM, they began to grasp that the California Risk Assessment tool is not meant to be a narrative tool; it is merely designed to trip an alarm bell that signals to workers that some families have a higher likelihood of future maltreatment than others, and it helps them make decisions about whether and where the family would best be served. Clinical expertise is still crucial in deciding how to use the risk rating to inform case planning. In other words, the actuarial risk assessment tool was not intended to help workers fully assess family functioning, understand clients' percep-

tions of their behavior, develop case plan goals, or choose treatment interventions. The SDM model generated a significant amount of confusion among workers primarily around the purpose of the risk rating and how it was intended to guide workers' decision making. For example, one worker's comment that "now if we have a high-risk case, we would transfer the file, but this is a different kind of tool" signals a lack of understanding of what to do with a risk rating. Another worker expressed that she was "having a hard time switching…maybe [use] a different name, like risk checklist?" Workers didn't understand when the risk assessment tool was meant to be filled out. Once workers understood that the risk assessment tool works in concert with a contextual assessment tool intended to capture family functioning and family dynamics, it was easier for them to process this new way of thinking.

The Perceived Relevance and Utility of the Risk Assessment Tool

Many workers expressed concern about the utility of the risk assessment tool as a decision-making aid. Even when it was communicated that numerous research studies have shown that actuarial models outperform clinical judgment and consensus-based tools in terms of estimating future harm to a child, workers remained skeptical. Probing around this issue revealed that many workers were dubious about the predictive value of the RAT in the ORAM and this, coupled with the length of time it took to complete, had made the RAT into a "recording tool" rather than a decision aid. One of the workers stated matter-of-factly that "most of these tools are completed when they have to be used and until then, they are a useless tool...this will not be a decision aid." That is, their assessment of overall risk, while informed by some of the general categories contained in the instrument, was clearly made after the workers had decided the risk level and made most of their casework decisions.

The contextual assessment tools sparked some discussion around the need to have a tool that would allow workers to effectively meet the needs of families while reducing, or at least not adding to, their paperwork. With this in mind, caseworkers tended to prefer the California Strengths and Needs Assessment.

In terms of a clinical tool, the RAT also did not seem to meet the needs of workers. One worker explained that trying to show family functioning using the RAT "was like putting a square peg in a round hole. It just didn't fit." In other words, with the ORAM, workers had become accustomed to relying chiefly on their clinical judgment because they did not believe in the merit of the tool. Other studies of decision making in child welfare echo that workers tend to use risk assessment instruments to merely verify, document, or justify decisions; in some cases, workers deliberately inflated risk ratings to ensure that families were classified as high enough risk to be given the services the worker thought appropriate (English & Pecora, 1994; Lyle & Graham, 2000).

Managing Risk Versus Promoting Child Well-Being

An ideological debate emerged among workers about the very nature of their role as child welfare workers and whether the pendulum had swung too far in the direction of risk management over more holistic approaches to child well-being. Some participants were concerned that relying on risk assessment tools intended to assess risk of physical abuse and neglect exclusively may encourage workers to minimize the importance of, or completely overlook, other kinds of maltreatment, such as emotional abuse or exposure to domestic violence. Critics of risk assessments in the field similarly argue that inadequate attention is afforded to the needs of the majority of children that come to the attention of child welfare who are "not likely to be physically endangered, but who are, nonetheless, at risk for a variety of long-term social, emotional and behavioral problems" (Knoke & Trocme, 2004, p. 37).

It became clear that workers' distrust of the ORAM as a useful decision-making aid had forced them to rely more heavily on their clinical judgment to make critical case decisions. For example, workers openly shared that they would frequently adjust risk ratings on the RAT if it did not match their intuitive reasoning. An unintended and unfortunate consequence of workers using the RAT, a tool with limited reliability and validity, was an erosion of their confidence in the ability of any tool to accurately estimate future maltreatment. The literature suggests this distrust may be attributable to a general perception among child welfare workers of risk assessment tools as mechanisms for controlling, monitoring, and formalizing their work to promote accountability, rather than as sources of consultation and support (Munro, 2004). In light of these findings, implementation concerns are of paramount importance lest good tools are used incorrectly in practice.

Discussion

The focus group participants' struggle to understand and appreciate the separation of risk and context in the California SDM and their resistance to risk assessments in general (as a result of bad experiences with the prior tool and the perceived incursion into clinical territory) signals the need for standardized, targeted, and comprehensive training prior to implementing new tools in the province.

Implementation Challenges

Training. For risk assessments to produce desired results, child welfare workers need to be trained to use the range of tools in the decision-making system correctly and consistently. Unnecessary risk can result from both the use of invalid instruments (as was the case with the RAT) and the misuse of a valid risk assessment tool (Gambrill & Shlonsky, 2000). More specifically, workers need to understand the accuracy and limitations of risk assessments. Knowing that risk assessments can produce two kinds of errors—false positives (where nondangerous families are determined to be at high risk) and false negatives (where dangerous families are determined to be safe)—will hopefully help remind workers to keep a critical mindset about the level of risk determined by a tool (Munro, 2004).

Furthermore, workers need to understand the intention of risk assessment tools and how they can function in harmony with clinical tools. Many workers expected the risk assessment instrument to provide guidance about the intensity and type of services that would help prevent future maltreatment. Training is necessary to explain that clinical judgment and expertise are needed to tap into these critical areas, and clinical tools can help workers structure this more detailed information. Perhaps, over time, more dynamic assessments can be developed that address both cause and consequence (Schwalbe, 2004), but these are not yet available for use in child welfare.

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Training needs to highlight specific ways in which the implementation of the California SDM system will add value to workers' daily responsibilities. Emphasizing that the tools in the California SDM are streamlined to enhance efficiency in recording will likely promote worker buy-in. Focus group participants were very vocal about their disdain for excessive and redundant paperwork that ultimately robs them of critical time that could be spent building relationships with families. Workers need training to help them better understand how front-end tools (e.g., screening, safety assessment, and risk assessment) fit into Ontario's new differential response initiative. Understanding these distinctions will not only help workers appreciate the merits of each tool but also help them understand the interaction among tools, which will minimize duplication in recording.

Accessibility. Accessibility may pose the greatest implementation challenge because the California SDM system represents a new paradigm for workers. The successful implementation of SDM will be thwarted if workers fail to fully conceptualize how risk and context are separated in the approach and how the different tools function in concert. The implementation of the California SDM model is an opportunity for trainers to dialogue openly with workers and supervisors about the strengths and limitations of the model and to jointly develop ways to address challenges faced by workers.

Organizational Culture. There is enormous pressure on child protection agencies to be accountable for errors made in their efforts to protect children from harm (Kanani, Regehr, & Bernstein, 2002). Munro (2004), in her examination of the organizational pressures in child welfare, argued that the pressure to be accountable for errors can lead to defensive practices, in which workers may be tempted to place an unwarranted amount of confidence in the results of risk assessment instruments as a means of escaping blame. She underlined that child welfare workers must be mindful that a risk assessment does not represent a certain truth; it is merely an informed hypothesis that may need to be changed in the presence of new information. She advocated that child welfare agencies, and supervisors in particular, foster an organizational culture that encourages workers to be self-reflective and critical of their reasoning.

Conclusion

Currently there is a dearth of empirical research exploring how risk assessment tools influence decision making. The viability of actuarial risk assessment systems in child welfare practice remains somewhat controversial. Accordingly, it is crucial that actuarial risk assessments are not presented as a panacea for the problems faced by the field. No instrument can determine with 100% certainty that maltreatment will recur. We are limited to finding the best predictive tool among many and then understanding and working within the limits of that tool. Actuarial risk assessment tools, while far from flawless, are the most predictive instruments of future maltreatment to date and, as such, can be useful decision-making aids (Shlonsky & Wagner, 2005). However, their predictive capacity, like many empirical measurements, is hindered by methodological issues, such as variations in definitions of child abuse and neglect (Gambrill & Shlonsky, 2000; Zuravin, 1999) and the fact that substantiation may not be the most valid measure of recurrence of harm (English, Marshall, & Orme, 1999).

As a rule, the actuarial tools should be developed and validated in the same jurisdiction to ensure that they are sensitive to the populations in which they will be used. Unfortunately, political and organizational needs may preclude such a long-term approach, as was the case in Ontario. Since one cannot determine in advance how the SDM tools will be used by workers and how they will interact with other factors (Munro, 1999), the risk assessment tools will be prospectively validated and recalibrated based on locally-specific findings. Given the complex and difficult nature of introducing new tools into any existing system, the tool developers have been, and will continue to be, consulted frequently and extensively to insure model fidelity. Interim data analyses and consultation with pilot agencies will also be conducted to ensure that the implementation of the tools is not causing dire unintended consequences.

Risk assessments and contextual assessments will be useful as decision-making aids only if implemented in a child welfare environment that supports transparency, consistency, constructive criticism, and accountability (Gambrill & Shlonsky, 2001, p. 830) and in which child welfare workers perceive the tools to be directly helpful and relevant to their daily work. The mere addition of new tools to child welfare agencies without sufficient training and organizational support is unlikely to improve workers' capacity for accurate decision making or increase the safety and well-being of children and their families. With the presence of conditions that support the effective use of these new tools, workers should be better equipped to use their clinical skills to assess, plan, and manage their cases.

Table 1. Risk and Clinical Assessment Tools

Instrument	Which Cases	Purpose	Description
California Safety Assessment	For a new referral For open cases in which family circumstances have changed	To assess the immediate safety concerns that may place a child in danger of imminent serious harm To provide structured information to guide workers' decisions about whether immediate protective interventions are necessary	Consists of safety items, safety interventions, and safety decisions
California Risk Assessment	Prior to a referral being opened for services	To assesses whether or not a family has a high likelihood of a future reoccurrence of child maltreatment Risk level helps guide case decisions about whether to close a referral, or open it as a child protective services case, or refer the family to alternative service providers.	Actuarial risk assessment tool consists of an abuse index and a neglect index
California Risk Reassessment	For cases in which children have remained in their own homes or been reunited with their families	Evaluates a family's progress toward case plan goals of risk reduction and child safety	Combines items from the original risk assessment tool with additional relevant items
California Family Reunification Assessment	For cases in which children are in placement and reunification with their families is being considered	To assess the family's readiness for reunification and to structure case management decisions around reunification to promote continued child safety and placement stability	Consists of reunification risk assessment, a visitation plan evaluation, a reunification safety assessment, guidelines for placement, and a recommendation summary.
Ontario Revised Risk, Strength, and Needs Assessment	For all cases open for services	To evaluate a family's presenting strengths and needs and to develop an effective service plan	Largely derived from the RAT contained in the ORAM. Each child is rated on 22 items arrayed in five subdomains (caregiver factors, child factors, family factors, intervention factors, and abuse/neglect factors). A space is provided for narrative explanation each factor.
California Strengths and Needs Assessment	For all cases open for services	Helps workers systematically identify and evaluate family strengths and needs and plan service interventions using this information.	11 caregiver factors and 9 child factors are rated on scales that identify and prioritize areas of need and identify relevant areas of family strength
Bristol Core Assessment	For all cases open for services	Gathers information useful for developing a case plan that drives services	Similar to Looking After Children (see next) but with more numerous and detailed anchors and discussion points
Looking After Children Initial Assessment — Ontario Version	For all cases open for services	Gathers information useful for developing a case plan that drives services	Largely narrative tool geared toward ascertaining children's developmental needs, caregiver's parenting capacity, and family and environmental factors

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Journal Highlights

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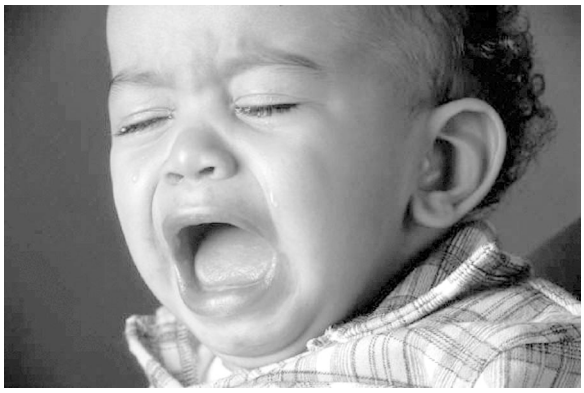
The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute by mailing a copy of current articles (preferably published within the past 6 months) along with a two- or three-sentence review to the editors of the APSAC Advisor at the address listed on the back cover, or by E-mail to JSRycus@aol.com.

The Impact of Trauma on Child Development

This article summarizes the growing body of research linking childhood experiences of abuse and neglect to serious, life-long consequences. The author delineates the negative impact of abuse and neglect on two fundamental developmental processes—neurodevelopment (the physical and biological growth of the brain, nervous, and endocrine systems) and psychosocial development (personality formation including morals, values, and social conduct). Putnam contends that "[s]uccessful prevention of child abuse and neglect will do more to eliminate its pernicious effects than any combination of treatments. Indeed, the mainstay of public health effects is that the prevention of disease is the most cost-effective intervention" (p. 7). He indicates that when abuse cannot be prevented, several empirically-supported treatment options can help mitigate its impact. Putnam provides research citations for several of these treatments, including cognitive behavioral therapy (CBT), trauma-focused CBT, and parent-child interaction therapy. In addition to making general recommendations for judges regarding child abuse and neglect cases, Putnam calls on policy makers and the general public to demand better services for children who have been maltreated, stating that, without such action, "this tragic legacy will continue across generations" (p. 9).



Putnam, F. (2006, Winter). The impact of trauma on child development. *Juvenile and Family Court Journal, 57*(1), 1-11.

Children's Disclosure Patterns—Summary of Research Findings

Olafson and Lederman provide an extensive and objective summary of critical research concerning children's disclosure patterns in child sexual abuse cases, and they summarize findings in a concise, 11-point chart. According to the authors, research concludes that most victims delay disclosure, often until adulthood. However, researchers disagree about rates of disclosure and of recantation among children. Gradual disclosures over time are common, and more than one interview may be necessary to achieve full disclosure. The rates and patterns of disclosure can be affected by whether there have been prior disclosures, the level of support to the child victim by nonoffending parents, the developmental level of the child victim, and the child's relationship to the perpetrator. The authors inform judges that simply knowing the law is often insufficient to deal effectively with child sexual abuse cases; a thorough understanding of the findings of sexual abuse research will "enhance their ability to make just decisions by applying the law to the facts" (p. 38). While the article was written primarily to update judges, the succinct, objective, and timely presentation of this article makes it relevant for anyone serving sexually abused children.

Olafson, E., & Lederman, C. S. (2006, Winter). The state of the debate about children's disclosure patterns in child sexual abuse cases. *Juvenile and Family Court Journal, 57*(1), 27-40.

Current Findings Regarding Medical Evidence in Child Sexual Abuse

This article reviews the historical evolution of medical knowledge and clinical expertise in child sexual abuse. Frasier and Makoroff outline research over the past 25 years that has expanded medical knowledge related to child sexual abuse and that has debunked many myths regarding female genital anatomy that were based largely on dogma combined with a lack of empirical research. Early child abuse specialists assumed that documentable physical evidence would be critical in enabling physicians to determine the facts in sexual abuse cases. Research has demonstrated that even in cases of alleged genital or anal penetration, physical evidence is rare and sexually transmitted infections are uncommon. This requires considerable medical interpretation. The authors stress that all "professionals involved in a sexual abuse case [must] understand that a child's credible history of sexual abuse should not be discounted because the child has a normal genital examination" (p. 45). An important feature of this article is a review of specific criteria to be used in evaluating expert witnesses who are testifying about medical findings in sexual abuse cases, including their knowledge regarding the current state of science and their recent training and clinical experience.

Frasier, L., & Makoroff, K. (2006, Winter). Medical evidence and expert testimony in child sexual abuse. *Juvenile and Family Court Journal, 57*(1), 41-50.

Diversity as a Variable in Child Maltreatment Research

In this article, Miller and Cross replicated a prior content analysis study by Behl et al. (2001)* that examined the ways ethnicity has been studied as a variable in child maltreatment research. There has been considerable concern about the disproportionate number of

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children of color served by the public child welfare systems. To address the complex issues inherent in this concern, the authors suggest that empirical research include a focus on ethnicity in all investigations. In this article, the authors studied the use of ethnicity in research by reviewing articles published in three child maltreatment specialty journals over a 20-year period from 1977 to 1998. The findings of the new study indicate that there have been recognizable but small increases in attention to ethnicity in child maltreatment research. The authors found that the percentage of articles focusing on ethnicity was still less than 10%. Fifty percent of the articles reported ethnic composition and 24% used ethnicity in data analyses. The latter showed the largest gain in use of ethnicity in research since the Behl et al. study. The authors encourage continued inclusion by researchers of ethnicity as a variable in child maltreatment research.

Miller, A., & Cross, T. (2006, January). Ethnicity in child maltreatment research: A replication of Behl et al.'s content analysis. *Child Maltreatment, 11*(1), 16-26.

* Behl, L., Crouch, J., May, P., Valente, L., & Conyngham, H. (2001, February). Ethnicity in child maltreatment research: A content analysis. *Child Maltreatment, 6(*2), 143-147.

Child Abuse and Bone Fractures

Multiple and unexplained fractures in infants and toddlers often indicate they are victims of child abuse. There are times when medical conditions can also cause multiple fractures. Many parents whose children have been diagnosed with metabolic or genetic bone disease have discovered the diagnosis as a result of allegations of child abuse. This article presents the differential diagnosis of multiple fractures and the diagnostic testing clinicians can use to assess the cause of multiple fractures in infants and toddlers. The article includes a discussion of bone diseases that affect children of this age including osteogensis imperfecta, rickets, osteomyelitis, copper deficiency, fractures secondary to demineralization from paralysis, and issues related to preterm birth. The authors suggest a careful review of the clinical history and a careful examination for other signs of abuse or neglect are essential when children come for treatment of multiple fractures.

Jenny, C., for the Committee on Child Abuse and Neglect. (2006). Evaluating infants and young children with multiple fractures. *Pediatrics, 118*, 1299-1303.

Burns and Child Neglect

This article describes the results of a retrospective study of 440 hospitalized pediatric burn patients during 2000–2002. The study employed a multidisciplinary team investigation of suspicious cases, which included a home assessment. Researchers identified 395 cases of accidental burning (89.8%) compared with 41 cases of neglect (9.3%). Several family conditions, including parental drug abuse, single parent families, delay to presentation, and lack of first aid were statistically more prevalent in the children identified as neglected than in the group of children accidentally burned. The children in the neglect group were also statistically more likely to have deeper burns and require skin grafting. Findings show that 82.9% of children whose burns were deemed to be due to neglect had a previous entry on the child protection register; 48.8% were transferred into foster care. The authors conclude that burning by neglect is far more prevalent than by abuse, and they advocate for a multidisciplinary investigation coupled with the use of home assessments to aid in diagnosis, which includes a goal of targeting preventive strategies for children with the above risk factors.

Chester, D., Jose, R., Aldlyami, E., King, H., & Moiemen, N. (2006, March). Non-accidental burns in children—Are we neglecting neglect? *Burns, 32*(2), 222-228.

Empowering Mothers Who Abuse Substances

Mothers who use substances constitute 80% of those involved in the child welfare system. The process of recovery from addiction is a difficult one, and the Adoption and Safe Families Act of 1997 created time frames that challenge recovery time for mothers whose children are in the child welfare system. Practitioners working with this population need to act quickly if mothers are to complete their recovery programs within time frames for reunification. This article discusses results of a qualitative study of women with substance abuse problems who are involved in the child welfare system. Thirty-four women participated in focus groups. The data analysis revealed several predominant themes, which the author organized into two categories: (1) obstacles to family reunification, including the infrequency of mothers' visits with their children, lack of communication among service providers, and limited services for children, and (2) recommendations for change, such as a stronger family focus in substance abuse treatment, more support for the family once treatment is completed and the children are returned home, and more training for child welfare workers on addiction and recovery issues. The author advocates for a strengths-based empowerment approach to working with mothers with substance abuse issues.

Smith, N. A. (2006). Empowering the "unfit" mother: Increasing empathy, redefining the label. *Affilia: Journal of Women and Social Work, 21(4)*, 448-457.

Standardizing Definitions of Child Maltreatment

The authors of this article tested whether they could develop more reliable definitions of child maltreatment and processes for substantiating maltreatment, and whether child welfare caseworkers would be comfortable with and accepting of this revised approach. Determinations from five field sites were compared with those made by master reviewers (made while listening to case presentations from the field sites). Agreement, sensitivity, specificity, positive predictive values, and negative predictive values were high overall and for each type of maltreatment. Agreement among raters was substantially improved. The revised definitions and determination process were well liked by caseworkers and other stakeholders. The authors contend that while implementing standardized definitions in a typical child protective services environment posed myriad political challenges, the study results suggest that achieving reliable substantiation determinations may be a feasible goal.

Slep, A., & Heyman, R. (2006, August). Creating and field-testing child maltreatment definitions: Improving the reliability of substantiation determinations. *Child Maltreatment, 11*(3), 217-236.

Influencing Child Maltreatment Policy

Noting that public policy can be a powerful tool to aid children and their families, the authors of this article address how psychologists and other child-oriented researchers can leverage this tool to ensure that child and family issues, specifically issues related to child abuse and neglect, receive adequate attention. They encourage a bidirectional relationship between policy makers and child maltreatment experts through which policy makers would solicit and employ relevant expertise provided by psychologists. Toward this end, this article offers practical guidance to psychologists on understanding the process of making policy, how to become familiar with relevant policy, communicating effectively with policymakers, and understanding the unique contributions psychologists can make to the policy development process.

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

Differential Outcomes of Different Forms of Maltreatment

The authors tested the hypothesis that different traumatic experiences contributed in variable degrees to different mental pathologies. A total of 223 young adult nonpatients were assessed with the help of self-reports. The role of six different trauma experiences (broken home, dysfunctional family, family violence, child sexual abuse, severe child sexual abuse, and adult sexual abuse) were assessed related to six different conditions or pathologies (depression, somatization, borderline, overall physical health, overall mental health, and alexithylmia [i.e., difficulty in recognizing and describing one's emotions and in defining them in terms of somatic sensation or behaviors.]) A series of multivariate analyses of variance and Roy-Bargmann stepdown analyses were used. The results confirmed that individual traumatic experiences were associated with different subsequent pathologies. Specifically, borderline pathology resulted from sexual abuse, somatization from severe child sexual abuse, and depression from dysfunctional or broken family constellations. Family violence was associated with poorer overall mental health and alexithymia. None of the trauma variables was associated with overall physical health. Most of these relationships have been reported in the literature based on results from different clinical samples.

Modestin, J., Furrer, R., & Malti, T. (2005, March). Different traumatic experiences are associated with different pathologies. *Psychiatric Quarterly*, 76(1), 19-32.

Home Visitation by Nurses and Child Maltreatment Recurrence

This study investigated whether home visitation by nurses with disadvantaged first-time mothers would reduce recidivism in samples of families in which children had previously been maltreated. In the study, 163 families with a history of one index child having been exposed to physical abuse or neglect were enrolled in a randomized controlled trial that compared standard treatment with a program of home visitation by nurses in addition to standard treatment. The primary study outcome was recurrence of physical abuse and neglect, based on a standardized review of child protection records. At 3-years' follow up, records were available for 160 of 163 families (98%); 139 (85%) completed follow-up. Recurrence of child physical abuse and neglect did not differ between the control and intervention groups. However, hospital records showed significantly higher recurrence of either physical abuse or neglect in the intervention group. There were no differences between groups for the other secondary measures. The authors conclude that this strategy does not seem to be effective in preventing recurrences of physical abuse and neglect in families associated with the child protection system, and they suggest more effort be made toward prevention.

MacMillan, H., Thomas, B., Jamieson, E., Walsh, C., Boyle, M., Shannon, H., & Gafni, A. (2005, May 21–27). Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: A randomised controlled trial. *Lancet, 365*(9473), 1786-1793.

Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

CONGRESS LEAVES FUNDING DECISIONS TO LAME DUCK SESSIONS

Members of Congress left town at the end of September after sending just two appropriations bills—defense and homeland security—to the President's desk before the start of the new fiscal year on October 1. As a stopgap, Congress passed a continuing resolution on September 29, which carries federal spending through to November 17 and provides funding for federal programs serving children and families essentially at the current FY 2006 levels.

When legislative work resumes on November 13, legislators will have to deal quickly with the ten outstanding appropriations bills, or buy additional time by passing another continuing resolution. Whatever the outcome, it seems very possible that FY 2007 funding for most federal agencies will be wrapped into an omnibus, catchall spending bill.

In negotiations on the final version of the Defense Department money bill, appropriators acquiesced to demands from the White House to restore defense spending that had been trimmed by Congress earlier in the year as a way to support domestic priorities. Under pressure from the threat of a White House veto, however, negotiators on the FY 2007 defense appropriations bill agreed to meet the President's demands to come in at levels higher than the Senate or House were proposing. That meant losing funding that had previously been committed to the Labor-HHS-Education Appropriations Bill.

Supporters of the domestic spending initiative are looking for redress. In the House, 24 moderate Republicans have signed a letter, dated September 27 and addressed to Majority Leader John Boehner (R-OH), urging commitment to the budget agreement passed earlier by the House, which had shifted over $6 billion from Defense and Foreign Operations Appropriations Bills into domestic discretionary spending, with approximately $4.1 billion added to the Labor-HHS-Education Bill.

The House letter, spearheaded by Rep. Michael Castle (R-DE), said that providing "$7 billion above the Administration's request…is equal to the funding enacted in FY06…plus a 2% inflationary increase." Castle and the others signing the letter said, "We appreciate your work to live up to this agreement and your willingness to incorporate these priorities in the federal allocation for the fiscal year 2007." The letter also reminded the House Republican leadership that these additional funds "will not come from mandatory programs such as Medicare, Medicaid, food stamps, foster care programs and others that serve the very people we are trying to help."

A similar letter in the Senate is being circulated by Senators Arlen Specter (R-PA) and Tom Harkin (D-IA). They are urging Senate leadership to allocate $7 billion for the Labor-HHS-Education Bill. In advance of voting on the bill, which was drafted by the appropriations subcommittee that he chairs, Sen. Arlen Specter (R-PA) was quoted in the *Congressional Quarterly*, complaining that the bill constitutes what he sees as "the disintegration of the appropriate federal role in health, education and worker protections." He lamented, "We don't have money to appropriate anymore."

PRESIDENT BUSH SIGNS BILL EXTENDING PREVENTION FUNDS

On September 28, President Bush signed into law 5 more years of funding for the Promoting Safe and Stable Families program, which supports prevention services. Called the Child and Family Services Improvement Act of 2006 (S. 3525), this bill had been sent to the White House after being approved in its final form by the Senate on September 20 and by the House on September 26.

The bill, which reauthorizes through 2011 the program of grants to states to prevent child abuse and neglect, retains the four categories of service the states are required to address in the basic program: family preservation, family support services, time-limited family reunification services, and adoption promotion and support. The statute also includes new

provisions targeting $40 million in newly authorized mandated spending to address issues proposed (1) by the House, for supporting monthly caseworker visits with children who are in foster care, and (2) by the Senate, for competitive grants to promote interagency collaborations to increase services for children in the child welfare and child protection system whose parents or caretakers abuse methamphetamines or other drugs.

By combining the allocations in these two diverse pieces of legislation, enacted separately by the House and Senate, the final legislative agreement would divide the $40 million annually between the two programs. Support for services to families with substance abuse would receive almost the entire share, with decreasing amounts to 2011, and support for improvements in caseworker home visits would receive the remainder, starting at $5 million in 2008 and increasing annually through 2011. The total 5-year funding authorization provides $345 million in mandatory spending each year (with $40 million set aside for the targeted activities) and $200 million in discretionary spending to be appropriated each fiscal year through 2011.

The funding aimed at addressing substance abuse in child welfare cases may be used for a variety of services, such as family-based comprehensive long-term drug treatment, early intervention services, child and family counseling, mental health services, and parenting skills training. The spending on caseworker support would focus on activities such as recruitment, retention, training, and access to technology.

The new legislation also increases the share of Promoting Safe and Stable Families grant allotments to Indian tribes from 1% to 3% of mandatory funds and from 2% to 3% of discretionary funds. In addition, the measure reauthorizes both the Court Improvement Program and the Mentoring Children of Prisoners program, including the creation of a new voucher program to offer mentoring support nationally where existing programs currently do not reach.

HOUSE BILL TO INCREASE AWARENESS OF SHAKEN BABY SYNDROME

Legislation was introduced on September 14 by Rep. Sue Kelly (R-NY) directing the Secretary of Health and Human Services to develop a public information and educational campaign targeted primarily to educate new parents and child care providers about brain injuries and other harm that may result from shaking infants and very young children, as well as healthy strategies to cope with a crying baby and related parenting frustrations.

The Shaken Baby Syndrome Prevention Act, H.R. 6070, would authorize $5 million for one year to support the creation of public service announcements and the dissemination of effective prevention practices to parents and care givers, maternity hospitals, child care centers, organizations providing prenatal and postnatal care, and parent education and support services.

The bill also directs members of HHS to meet twice yearly with a variety of groups concerned about shaken baby syndrome. They would provide support for the parents of surviving children who suffer serious brain injuries as a result of shaking, "especially during the traumatic period immediately following the shaking event, when parents most need support."

H.R. 6070, which came at the end of this year's Congressional session, has been referred to the House Subcommittee on Health and will likely receive no action. More attention may be seen next year, when a similar Senate measure is expected to be introduced.

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

Rejuvenation of State Chapters

The popularity of state chapters has waxed and waned over the years; currently, APSAC has 14 chapters and 8 more states that have an interest in starting a chapter. Over the past 12 months, the Board has taken a close look at the relationship between the national organization and the state chapters in an effort to better determine the needs of each, and identify the best ways to meet those needs. From this analysis has emerged a strong commitment to foster the relationship and reestablish strong state chapters. The effort is being led by Mike Haney, APSAC's vice president and chair of the State Chapter Committee.

To help increase communication between the national office and individual state chapters, Haney has organized a monthly conference call attended by representatives from various chapters and the APSAC Board. I have participated in these calls and found them very enlightening. Several points became clear almost immediately. Many of the chapters share similar problems, for example, difficulty keeping updated contact information for members and designing activities that will reach all members within a large state. A paucity of financial resources is a widespread problem. Technical difficulties can become disabling to a chapter. There have been active discussions of these challenges on the conference calls, and in several cases we have identified steps to help alleviate the problems. Participants on the call are creative and motivated. They are interested in sharing ideas and solutions. Not infrequently, one chapter has come up with an innovative plan to overcome a given problem, and members from other chapters on the conference call take this information back to their own group. The national office is encouraging state chapter members to share information on the APSAC Web site, as it is clear that increased communication among chapters is vitally important, especially to chapters in the early stages of development.

Major goals of the national organization and its state chapters include educating professionals working in child welfare and providing resources to APSAC members. The state chapters have developed a number of programs to accomplish this, and some of these will be described in future issues of the *Advisor*. The national office is exploring ways to help chapters in their efforts to sponsor conferences and seminars. We are soliciting input from chapter members on the monthly conference calls and will take that information back to the Board, with recommendations for action.

A stronger relationship between national and state organizations will help maximize the growth and development of each. The APSAC Board is committed to building that relationship and serving as a resource for chapter members. We invite you to join your state chapter and become involved. If your state has no chapter, then we encourage you to help start one. The national organization will be here to provide aid, as will other chapters. Using the monthly conference calls, the State Chapter Committee of the Board, the APSAC Web site, and informative articles in the *Advisor*, you can establish a chapter that will provide excellent resources to the professionals in your state.

Jordan Greenbaum, MD
APSAC President

2006 Membership Exceeds 2005

APSAC's membership grew in 2006, thanks to everyone who believes in the mission of the American Professional Society on the Abuse of Children. With your help, 2007 will continue to show steady growth, signaling a strong connection among professionals helping abused and neglected children and their families. We encourage you to reach across disciplines and invite your colleagues to also become a part of this great organization

APSAC Database

Growth provides opportunities to improve services for members. The national office is doing its best to streamline its operations while maintaining and improving the infrastructure of the organization, but we need your help. APSAC's database system (in progress) relies on accurate E-mail addresses for members. Notices, receipts, and membership-only log-ins all require a valid E-mail address for each member in the database. Because deciphering handwritten E-mail addresses can be an insurmountable task, we ask that you pay particular attention to your 2007 membership renewal form. **Please check the contact information carefully and print your E-mail address very clearly.** Even so, it is inevitable that some E-mail addresses will be incorrect. We ask for your patience as we respond to the issues and challenges resulting from this new data system. Please contact us if you have any questions or concerns, and we look forward to serving you in 2007.

San Diego Advanced Training Institutes

Don't forget to register early for the preconference Advanced Training Institutes to be held on January 22, 2007. The three Institutes are given as one-day, intensive workshops held prior to the International Conference on Child and Family Maltreatment in San Diego, January 23-26, 2007. The three preconference Advanced Training Institutes are as follows:

Child Sexual Abuse Medical Evaluation: How Well Do You Agree With the Experts on Interpretation of Cases?
Joyce Adams, MD and Lori Frasier, MD

Everything You Need to Know About Serious Physical Abuse, Homicide, and Neglect of Children
Rob Parish, JD

Basic Training in Trauma-Focused Cognitive Behavioral Therapy
Anthony Mannarino, PhD and Judith A. Cohen, MD

More detailed descriptions of these Institutes can be found on the APSAC Home page at www.apsac.org. For more information, contact the national office at 843-764-2905 or toll free at 877-402-7722. E-mail is always a choice at apsac@comcast.net.

APSAC Offers Special Pricing on Two Study Guides

For a limited time only, APSAC is offering a discount on two APSAC Study Guides. The reduced price for each volume is $24.95 for members, and $27.95 for nonmembers. This is a significant reduction off the retail price. The two available volumes are:

Volume 1. *Assessment of Sexual Offenders Against Children,* 2nd edition (2001)
Volume 4. *Psychological Maltreatment of Children* (2001)

For ordering information, please visit the APSAC Web site at www.apsac.org.)

Knowledge Bank Offered by the National Child Traumatic Stress Network

APSAC is increasingly getting calls from members seeking resources. And have we found a great one for you!!!

Through a collaboration with the National Child Traumatic Stress Network (NCTSN), APSAC now provides a direct link from the APSAC Web site to NCTSN's *Knowledge Bank*, an online database that provides up-to-date and scientific information on child and adolescent trauma. *Knowledge Bank* is an invaluable online research tool for professionals in a variety of disciplines, and APSAC is excited to provide this link both to members and to others visiting the APSAC Web site. A special thanks to the National Child Traumatic Stress Network!!

Highlighting Contributions of APSAC Members

The *Advisor* is initiating a new feature to illustrate the scope and types of work being performed by APSAC members on behalf of maltreated children. Because of APSAC's interdisciplinary focus, its members provide a wide array of services in a variety of organizations and settings. Our goal is to acknowledge the diverse contributions of APSAC members, while concurrently informing readers about the roles and responsibilities of different professional disciplines in the prevention and treatment of child abuse and neglect.

We encourage readers to submit short articles (approximately 500 words) describing the focus and contributions of an APSAC member who is doing unique, innovative, challenging, or exemplary work. Submissions should be E-mailed to Judith Rycus (JSRycus@aol.com) or mailed to the Editors at the address on the *Advisor* masthead.

APSAC Board Elections

Thanks to all APSAC members who voted in the 2007 board election to fill three vacant board positions. Kathy D. Johnson, MS, and Lori Frasier, MD, were elected as new board members, and current board member, Jon R. Conte, PhD, was reelected to serve another term.

Kathy Johnson is employed at the Jordan Institute for Families, School of Social Work, University of North Carolina. Lori Frasier, is associate professor in the Department of Pediatrics at the University of Utah School of Medicine. Jon Conte is professor at the School of Social Work, University of Washington.

APSAC would like to thank the members of the 2006 Board for their commitment and hard work to strengthen the organization and give a special thanks to Anthony Mannarino, PhD, past President, and to Pam Gosda, BS, treasurer, whose terms of service ended in 2006.

The members of the 2007 APSAC Board are

Jordan Greenbaum, MD, President
Michael Haney, PhD
Jon R. Conte, PhD.
Walter Lambert, MD
Elissa Brown, PhD
Pat Lyons, LISW
Susan Samuel, BS
Lori Frazier, MD
Sarah Maiter, PhD,
Rochelle Hanson, PhD
Toni Cardenas, LCSW
Sharon Cooper, MD
Rob Parrish, JD
Kathy Johnson, MS

APSAC Child Forensic Interview Training Clinics

APSAC pioneered its Forensic Interview Training Clinic model to address the training needs of a variety of professionals whose job responsibilities include interviewing child victims of alleged maltreatment. The Clinic is designed for a multidisciplinary audience that includes professionals from mental health, child protective services, law enforcement, social services, medicine, and law who lack forensic interviewing skills, or who would like to improve their skills.

The Forensic Interview Training Clinic is a 5-day (40-hour) training experience that combines didactic and experiential learning activities. Leading experts in the field of child forensic interviewing developed the Clinic curriculum and also conduct each Clinic training program. The curriculum emphasizes state-of-the-art principles of forensically sound interviewing, while providing a review of several effective interviewing models.

The Clinics are highly interactive in nature, which gives participants opportunities for extensive personal interaction with the presenters and with other participants. The training includes a practicum component that incorporates videotaping of trainee interviews, mock court testimony, and skill-based exercises, with constructive feedback given to individual participants.

Training topics include the following: how investigative interviews differ from therapeutic interviews; an overview of pertinent research; introduction to the use of several forensic interview models and methods; the impact of children's level of development and language capacity on interviews; types and design of interview questions; cultural considerations in interviewing; interviewing special groups such as adolescents, children with disabilities, or children who are reluctant to talk; eliciting details; law enforcement concerns; other legal considerations; and effective court testimony.

Because the Clinics are cosponsored by APSAC and the Institute for Continuing Education, continuing education credits are available to Clinic participants for an additional fee of $25, which is included in the registration payment. Continuing education credit is awarded separately for each day, contingent upon completion of the entire day of training. Professional continuing education credit is also provided by national certifying organizations for psychology, social work, marriage and family therapy, drug and alcohol counselors, and nursing.

Participants will receive a Clinic notebook, a resource CD, and four excellent reference books that can further enhance their knowledge and skills.

Training Schedule: 2006-2007

Clinics are currently scheduled in Portsmouth, Virginia, on December 4-8, 2006, at the Renaissance Portsmouth Hotel and Waterfront Conference Center, and in Seattle, Washington, on May 7-11, 2007, at the Washington State Criminal Justice Training Commission (CJTC).

Registration

Registration fees are $1099 for APSAC members and $1199 for nonmembers. The registration fee covers all training sessions, interview practicum and critiques, extensive course materials, daily continental breakfast and afternoon break, one closing luncheon, a videotape of one's own practice interviews, and a certificate of completion. Partial registrations are not permitted, and attendance is required at the entire clinic, including all practicum sessions, to receive a certificate of completion.

Additional information about registration or payment is available directly from APSAC by E-mail at apsac@comcast.net. Registration information and forms can be downloaded from the APSAC Web site (www.apsac.org) and may be returned via E-mail to apsac@comcast.net, by fax, or by mail. For more detailed information about the Forensic Interview Clinics unrelated to registration or payment, please contact Lori Ley at: apsacclinic@verizon.net, or phone/fax: (425) 483-8250.

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

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2007 Membership Renewal

Dear APSAC Colleague:
Thank you for your support throughout 2006. We hope that your membership has been beneficial to you and will continue to provide the most up-to-date research on child maltreatment. The membership cycle in the American Professional Society on the Abuse of Children is effective from January 2007 to December 2007. **As an added benefit to your membership, APSAC's peer-reviewed journal, *Child Maltreatment*, can be accessed electronically. However, if you wish to continue receiving hard copies, please note that an additional $20.00 fee is required with your membership renewal.**

To ensure that you receive APSAC's publications by mail, please attach your membership mailing label in the space provided below or include the requested information, making any necessary changes. Thank you for helping to improve the lives of children.

Daphne Wright, Operations Management

Renewal amount due for 2007: _____ Date:_____

(Select dues according to your income level)

Above $50,000	*$125.00*	_____
$30,000 - $50,000	*$100.00*	_____
Below $30,000	*$75.00*	_____
Student Membership	*$65.00*	_____ Verification required.

***No group discounts available on renewals.**

Child Maltreatment: Official Journal of the American Professional Society on the Abuse of Children
Hard copies: $ 20.00 Online Journal: No additional cost

Total Amount Due: _____

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Thank you for supporting APSAC! www.apsac.org

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN (APSAC)

Announces its

15TH ANNUAL COLLOQUIUM

Marriott Boston Copley Place, Boston, MA
July 11-14, 2007

APSAC's Annual Colloquium is a major source of education and research necessary for professionals in the field of child maltreatment, including mental health, medicine and nursing, law, law enforcement, education, prevention, and child protective services.
Colloquium seminars begin where seminars at other conferences end!

COLLOQUIUM FEATURES:

- *Institute on Cultural Considerations in Child Maltreatment*
- *Intensive interdisciplinary, skills-based Advanced Training Institutes on all aspects of child maltreatment*
- *Field-generated skills-based training, research, poster presentations, and symposia*
- *Networking opportunities with other professionals and APSAC members in your area*

The Boston Marriott Copley Place is Boston's most complete convention hotel in the heart of the Back Bay, just four miles from Boston Logan International Airport. The hotel is connected by a climate-controlled walkway to a dual, indoor shopping-mall complex featuring over two hundred shops and restaurants. You can walk to famous Newbury Street, see a game at Fenway Park, or take a trolley tour of the city. Many cultural and historic sites of Boston are nearby, and the Back Bay subway station on the orange line is a short walk from the hotel.

Rooms are available at the Marriott Boston Copley Place, 110 Huntington Avenue, Boston, MA 02116, at $163/night (single) and $179 (double), plus tax. For reservations, call 1-800-228-9290 and request the APSAC Colloquium rate. We urge you to make your hotel reservations early. The cut-off date to receive the conference rate is June 20, 2007.

Visit this Web page for more information about the hotel, travel, airport, and sightseeing in Boston: http://marriott.com/property/propertypage/BOSCO

For more information on the Colloquium, contact:
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Web site: www.apsac.org

WATCH FOR OUR FULL BROCHURE TO BE MAILED THIS FEBRUARY!

December 6, 2006
CBT Treatment for Posttraumatic Stress in Preschool Children
U.C. Davis CAARE Center Mental Health Training Division
Sacramento, CA
Visit: www.mentalhealthtraining.tv

January 8-12, 2007
Sexual Assault Nurse Examiners/ Forensic Nurse Training
Richmond, VA
Call: Bonnie Price 804-281-8574 or
E-mail: bonnie_price@bshsi.com

January 11-14, 2007
Society for Social Work and Research
Hyatt Regency, San Francisco
Register: www.sswr.org

January 22, 2007
APSAC Preconference Institutes
San Diego, CA
Visit: www.apsac.org or
E-mail: apsac@comcast.net

January 22-26, 2007
21st Annual San Diego International Conference on Child and Family Maltreatment
San Diego, CA
Visit: www.chadwickcenter.org or
E-mail: sdconference@chsd.org

February 26-28, 2007
Child Welfare League of America 2007 National Conference
Washington, DC
Call: 202-942-0308 or
Visit: www.cwla.org or
E-mail: register@cwla.org

March 4-7, 2007
34th NCJFCJ National Conference on Juvenile Justice
Call: 775-784-6012 or
Visit: www.ncjfcj or
E-mail: staff@ncjfcj.org

March 29-31, 2007
3rd Annual Assessing and Treating Child, Adolescent, and Adult Trauma Conference
Honolulu, HI
Call: 858-623-2777 ext. 393 or
E-mail: lmconradi@alliant.edu

April 12-13, 2007
SCAPSAC Conference
Greenville, SC
E-mail: delsey@dnlcc.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 or
E-mail: apsaccolloquium2005@charter.net

APSAC ADVISOR

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Save these dates!!!!!

APSAC Advanced Training Institutes
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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