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At Issue: Child Welfare by Fad

David Stoesz, PhD

If the past is prologue in child welfare, the next program fad may be deployed as early as 2007, and successors are sure to follow. But what will they be? More important, will they demonstrably benefit abused and neglected children?

Varied approaches have evolved to address child maltreatment. The Child Abuse Prevention and Treatment Act of 1974 mandated reporting of abuse and neglect as well as establishing the first national database on the maltreatment of children. The 1980 Adoption Assistance and Child Welfare Act introduced permanency planning to stabilize children in foster care. In 1993, Family Preservation became the intervention of choice. With the 1997 Adoption and Safe Families Act, protection of children once again became paramount. Currently, nurse home visiting is being queued up by child welfare reformers, with emboldened Democrats and a humbled White House possibly uniting around this innovation during the 110th Congress. If so, the nation will begin another crusade to help vulnerable children, but absent convincing data that their circumstances will be significantly improved.[1]

This chronology suggests that a novel approach to child welfare coalesces approximately every 7 years, quite regardless of solid evidence of its superiority. The absence of optimal data upon which to guide future child welfare has been conceded by leaders in the field. Indeed, the authors of a recently acclaimed book, *Beyond Common Sense*, admitted the most glaring of omissions: "There is not a single intervention that has generated a published peer-reviewed article based on a study in which [researchers] accepted referrals from a child welfare agency, randomly assigned them to a treatment condition, and evaluated the outcomes" (Wulczyn, Barth, Yuan, Harden, & Landsverk, 2005, p. 155).

This admission follows a critique of the field by Mark Chaffin (2004), who noted that randomized, controlled trials (RCTs), while conventional in approving health interventions for children, were inexplicably absent in evaluating programs to mitigate child maltreatment. "Absent hard outcome data about intervention content," he wrote, "child abuse prevention programs and other psychosocial initiatives have been based more on advocacy, theory, weaker program evaluation designs, fashion, guesswork, and hope" (p. 589).

That efforts to ameliorate child maltreatment should consist of inferior research methods is paradoxical, especially in light of contemporaneous studies on welfare reform. In the early 1980s, states were offered waivers from Aid to Families With Dependent Children (AFDC) on two conditions: their innovations could not be more costly than AFDC *and* they demonstrated their outcomes through state-of-the-art research. By the time AFDC was cashiered and replaced by Temporary Assistance for Needy Families, most states had not only abandoned the welfare entitlement for poor families but also mounted field experiments documenting the efficacy of their innovations. The results of these studies now constitute a sizeable literature on welfare reform, comparing the outcomes of competing strategies, such as Work First versus Human Capital Development (Stoesz, 2000). Regardless of one's sentiments about the 1996 welfare reform (Personal Responsibility and Work Opportunity Reconciliation Act), there is little question that we understand its consequences through reasonably good data.

Compared with welfare reform, data on child welfare range from the absurd to the dismal. State reports of child maltreatment, for example, simply defy credulity. Between 1998 and 2001, the states as a group reported reassuring reductions of –1% and –4% in reported and confirmed cases of child maltreatment, respectively. But mischief lurked beneath the data. For 2001, Kansas and Maryland failed to provide any data at all on allegations of abuse and neglect. For those states reporting, in 1998 allegations ranged from Kentucky's high of 159.5 per 1,000 children to Pennsylvania's low of 7.9. In 2001, founded cases ranged from Alaska's high of 82.6 per 1,000 children to Pennsylvania's low of 1.6. Lest Pennsylvania be characterized as a paragon of child welfare, it should be mentioned that the data indicated North Dakota as deserving that honor for having reported the fewest victims of maltreatment in 1998: *zero* (House Ways and Means Committee, 2004, pp. 11-76).

By way of another illustration, the Child and Family Service Reviews (CFSRs) released in 2005 determined that of the 50 states and the District of Columbia evaluated on seven standards of child welfare, not one state was able to assure that maltreated children had a permanent and stable living arrangement; not one state was in compliance with regard to families having improved their ability to care for their children; only one state demonstrated that it adequately met a child's physical and mental health needs (Department of Health and Human Services, Administration on Children and Families, 2005). In December 2005, the Office of the Inspector General of the Department of Health and Human Services reported that "only twenty states demonstrated their ability to produce statewide reports detailing the extent to which [foster care] visits occurred during FY 2003; seven of the twenty statewide reports indicated that fewer than half of children in foster care were visited monthly in FY 2003" (Department of Health and Human Services, Office of Inspector General, 2005). Data such as these support an Annie E. Casey Foundation report that portrayed the human service workforce in less than flattering terms: "Millions of taxpayer dollars are being poured into a compromised system that not only achieves little in the way of real results, but [also] its interventions often do more harm than good" (Annie E. Casey Foundation, 2003, p. 2).

The antidote to child welfare by fad is evidence-based practice (EBP), the use of empirical evidence to demonstrate the outcomes of various interventions along an array of indicators of child well-being. Optimally, RCTs are the preferred research method since they screen-out external influences. Yet, RCTs in child welfare are a novelty, perhaps because the field experiment on the Illinois Families First initiatives cast doubt on the efficacy of family preservation. In the absence of field experiments, child welfare professionals rely on surveys, which are often retrospective studies of case records, a notoriously unreliable source of information. The Northwest Foster Care Alumni Study, for example, examined the case records of 659 alumni of foster care and interviewed 479 of them with respect to several indicators of psychosocial well-being. The study found that foster children suffered from alarming rates of mental health problems; most poignantly, their rates of posttraumatic stress disorder (PSTD) were twice that of U.S. war veterans (Pecora et al., 2005). Certainly, such findings are of concern, yet the research cannot attribute psychological harm to adolescents to foster care alone,

since there may have been external factors that traumatized foster youth. Moreover, the study has little to offer about remedying such trauma. If the study's researchers and sponsor had mounted an RCT to evaluate alternative interventions for children aging out of foster care, these problems could have been isolated and addressed. Such an option should have been conceivable since the children in the study would probably have entered foster care during the late 1980s, the very period when field experiments in welfare reform were being conducted.

Fortunately, local child welfare advocates have come to appreciate the value of EBP. For 20 years, the Chatham/Savannah Youth Futures Authority has collected data on a range of psychosocial, developmental, and community variables related directly to child and family welfare. These have been incorporated in local social service planning (http://www.youthfutures.com). In New York City, the CompStating method of crime reduction, pioneered by Dennis Smith (2005), has been advocated as a means for reducing child maltreatment in high-incidence neighborhoods. Accordingly, child welfare professionals concerned about improving the validity of the services they offer should contact local universities to identify faculty willing to work with them to optimize programming consistent with EBP. In this regard, schools of social work should be required to provide such research assistance to private and public child welfare agencies in exchange for the $240 million they receive for Title IVE training each year.

In the absence of sound data to guide child welfare, future initiatives will continue to be based on what is essentially well-credentialed common sense. Assuming that nurse home visiting or one of its variants captures the imagination of Congress and the White House, it may well emerge in 2007 or 2008. If so, this next innovation in child welfare will be hailed by child welfare advocates as rectifying the nation's chronic neglect of needy children and their families. Tens of millions of dollars will be passed to the states, further confounding their already Byzantine welfare bureaucracies, those very agencies that have already demonstrated their inability to report on the use of billions of dollars previously allocated to them for other well-intended ventures.

Having gained some momentum in a more favorable policy environment, child welfare advocates are already preening their next initiatives. Kinship care appears slated for roll-out after nurse home visiting, perhaps as early as 2010. The enormous surge in immigration and the commensurate demands on child welfare will certainly generate support for an Immigrants' Child Welfare Act not long thereafter (Jacoby, 2006).

At issue is whether these efforts will actually benefit maltreated children or, as so many programs before, they will become accretions to a lumbering bureaucracy that already employs the legions of managers necessary to keep track of a labyrinth of programs, all intended to address the immediate and long-term consequences of child abuse and neglect. Absent the accountability that EBP can bring to child welfare, it is not hard to imagine a future President who, confronted with the intractable morass that child welfare programming will have become, simply elects to cut the Gordian Knot and devolve children's services to the states as a block grant. If welfare reform is pretext, that President may well be a Democrat.

A Child Welfare Block Grant would leave child welfare advocates scrambling since the focus of activity will have shifted from Washington, D.C., to state capitals. The centrality of national organizations, such as the Child Welfare League of America and the Children's Defense Fund, will diminish accordingly. This will be a boon to state and local advocacy organizations, of course, but the readjustment will take years. As important, the status of both traditional programs (foster care, family preservation) and innovations (nurse home visiting, kinship care) will be up for grabs, suddenly pitted against each other for resources at the state level. Such an eventuality would prove dismaying for child welfare professionals and advocates who have dedicated their careers to the most vulnerable of Americans: maltreated children. In response, some will opt for early retirement, others will stay at the helm trying to steer the wreck in a more promising direction. In moments of despair, veterans of child welfare with sufficient experience to comprehend the moment will look back on decades of program development and wonder how such good intentions had come to this.

But then, we all know what the road to hell is paved with.

[1] Although the nurse home visiting program has generated important outcomes secondarily related to child maltreatment, these have not been its focus. The evolution of this important community health initiative serves as a model for how field experiments of interventions designed to mitigate child maltreatment could be conducted. See Robert Wood Johnson, *The Story of David Olds and the Nurse Home Visiting Program*, downloaded November 28, 2006, from: www.rwjf.org. For an assessment of nurse home visiting and related initiatives, see also Deanna Gomby, *Home Visitation in 2005: Outcomes for Children and Parents* (Washington, DC: Committee on Economic Development, 2005), online at: www.ced.org.

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About the Author

David Stoesz is Professor of Social Policy at Virginia Commonwealth University and the Executive Director of policyAmerica. He is a former caseworker and welfare department director. Among his books are *The Politics of Child Abuse in America* (with Lela Costin and Howard Karger) and *Quixote's Ghost: The Right, the Liberati, and the Future of Social Policy*, which won the 2006 Pro Humanitate Literary Award. He can be contacted at davestoesz@aol.com.

Implementation: The Missing Link Between Research and Practice

Dean L. Fixsen, Sandra F. Naoom, Karen A. Blase, Frances Wallace

For the past two decades, an international experiment has been underway to make better use of research-based prevention and treatment interventions in human service settings, such as child welfare, employment, health, juvenile justice, mental health, and substance abuse. So far, the results of this national experiment are not promising. Although the federal government spends over $95 billion a year to fund research to help create new interventions, and over $1.6 trillion a year to support services to citizens (Clancy, 2006), this research has had little impact on human services. The Institute of Medicine (2001) found that human services remain typically inconsistent, often ineffective, and sometimes harmful to consumers. These conclusions have been echoed in reviews by the Surgeon General (U.S. Department of Health and Human Services, 1999; 2001) and the President's New Freedom Commission on Mental Health (2003).

In 1983, *A Nation at Risk* (National Commission on Excellence in Education) declared that American schools faced a "rising tide of mediocrity" and that America was in danger of falling behind its international competitors because of the poor performance of its students. More than 20 years later, after billions spent on educational research, the National Assessment of Educational Progress showed the achievement of U.S. students was virtually identical to what it was in the early 1980s (Grigg, Daane, Jin, & Campbell, 2003). Given the lack of progress in making better use of research findings in delivering human services, in 2003 the U.S. Congress asked, "Is the bench to bedside transition becoming more effective?" The tentative conclusion from these efforts is that the findings of high-quality research are not being applied in sufficient quantity to have a demonstrable impact on human services, and they have not provided the intended benefits to consumers and communities.

Implementation: The Missing Link

Given the disappointing results of trying to move science to service, there has been renewed interest in the practice and science of implementation. Implementation has been lurking in the shadows since the 1960s, when it first received considerable attention in relation to the Great Society programs that were intended to benefit children, families, and communities nationally. Evaluations found that Great Society programs often had little or varied impact on individuals or communities. These poor results raised questions about why that might be, questions similar to those being asked today with respect to the limited effect of evidence-based programs. Lack of attention to implementation was a major factor in such failures both then (Pressman & Wildavsky, 1973; Hough, 1979) and now (Elliott & Mihalic, 2004).

Implementation can be defined as the art and science of incorporating innovations into human service settings to benefit children, families, and communities. We use the term *innovation* to include programs and practices that have a strong research base (e.g., *evidence-based programs*) as well as other programs and practices that have potential benefit to consumers, communities, or provider organizations (e.g., data-based decision support systems, electronic record systems, targeted fund-raising approaches, skill-based hiring methods). Although interest in implementation waned with the demise of the Great Society programs, some activity continued (e.g., Backer, Liberman, & Kuehnel, 1986; Blase, Fixsen, & Phillips, 1984; Bond, 1991; Fairweather, Sanders, & Tornatzky, 1974).

Recently, the authors completed a comprehensive review of the implementation evaluation literature and produced a synthesis of that literature, providing new ways to view the methods needed to make better use of science in human service settings. In this article, we summarize our findings and highlight some effective implementation practices found in our review (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Blase & Fixsen, 2003; Blase, Fixsen, Naoom, & Wallace, 2005). The goal is to help readers make better use of knowledge about implementation science to enable them to use the products of research more rapidly and more effectively to benefit children, families, and communities.

The *Science* in *Science-to-Service*

During the past two decades, researchers and policy makers have focused considerable attention on how to define an *evidence-based* program. A common definition now requires two or more randomized group designs, preferably done by two or more groups of investigators, that examine the outcomes of a program (Chadwick Center on Children & Families, 2004; Cohen, Mannarino, Berliner, & Deblinger, 2000; Elliott, 1998; Lonigan, Elbert, & Johnson, 1998; Saunders, Berliner, & Hanson, 2004; Wilson, 2005). Well-researched programs that meet these standards for scientific rigor are deemed to be *evidence based*, while those that fall short but demonstrate some preliminary positive outcomes may be called *promising practices* or *not yet effective*. Thus, *evidence-based programs* currently are defined by research methodology, and multiple experiments employing randomized group designs are considered the "gold standard" for defining *evidence* (e.g., Campbell Collaboration, www.campbellcollaboration.org.)

The *Service* in *Science-to-Service*

All human services could potentially benefit from science, including prevention and intervention services in child welfare, education, health, mental health, and substance abuse. Unfortunately, research-based program improvements in human services lag far behind improvements in other industries. We believe the reason is that the field of human services is far more complex than any other industry. With products such as computers, automobiles, pharmaceuticals, and other manufactured items, the latest science and high levels of quality can be built into the products themselves. The *product is, in fact, the intervention*, and its performance depends very little on the user of the product. Tens of thousands of pills that incorporate the latest scientific breakthroughs can be manufactured under the supervision of highly trained specialists working under carefully designed conditions to produce safe and reliable products. A license may be required to use the product, but the product itself produces largely uniform outcomes regardless of who dispenses it or uses it.

By contrast, in human services, the *practitioner is the intervention*. Science and quality must be incorporated into the performance of tens of thousands of practitioners situated in a variety of provider organizations that function within uniquely configured local, state, and federal service systems—a difficult task, considering the vagaries of life. Thus, in human services, the challenge in making best use of

science is to find the most effective means of integrating the findings of science and quality of performance into the daily work of hundreds of thousands of practitioners across the nation. In child welfare, this includes more than 500,000 social workers (www.bls.gov/oco/ocos060.htm), over 400,000 foster parents and group care workers (www.childwelfare.gov/pubs/factsheets/foster.cfm), and tens of thousands of associated psychologists, psychiatrists, and legal and medical professionals.

The *to* in *Science-to-Service*

As a profession, we are coming to realize that the *to* in *science-to-service* represents a whole new set of activities, which collectively are called *implementation*. For many years, science-to-service has been viewed as a passive process that involves the *diffusion* and dissemination of information whereby this information will somehow make its way into the hands of enlightened champions, leaders, and practitioners who will then put these innovations into practice (Rogers, 1995; Simpson, 2002). In this approach, researchers do their part by publishing their findings; it is then up to practitioners to do their part by reading the literature and making use of the innovations in their work with consumers.

This passive process is widely accepted and serves as the foundation for most federal and state policies related to making use of evidence-based programs and other human service innovations. For example, federal technical assistance (TA) grants allocate funds for information gathering, for publications and meetings to share information, and for training sessions to provide more detailed information in a lecture-discussion format. Federal TA efforts communicate this information to state TA representatives, who then pass the information along to provider groups and other potential users. Using this process, the professions spend hundreds of millions of dollars each year on the diffusion and dissemination of research information in child welfare, education, health, mental health, and other human service domains.

Over the past four decades, some practitioners have followed a more active and effective approach to translating science into service (e.g., Blase et al., 1984; Chamberlain, 2003; Fairweather, Sanders, & Tornatzky, 1974; Havelock & Havelock, 1973; Schoenwald, Brown, & Henggeler, 2000; Slavin & Madden, 1999). Further, other practice fields have been evaluating their attempts to use science in service settings. Thus, our review of the implementation evaluation literature (1970–2004) included practice fields such as agriculture, business, child welfare, engineering, health, juvenile justice, management, manufacturing, medicine, mental health, nursing, social services, and substance abuse, among others (Fixsen et al., 2005). To be included in the review, the literature needed to have some empirical evidence related to implementation.

Analysis and synthesis of the results of this review revealed some interesting findings and provided some frameworks that illuminate *what works* with respect to implementation. Additional information related to these strategies was identified through face-to-face meetings with successful purveyors of evidence-based programs (Blase et al., 2005).

In this article, we review two major theoretical frameworks that can guide efforts to move science-to-service more effectively and efficiently. The first framework describes the typical stages of implementation, and the second provides an overview of the core components of an implementation initiative. The final section of this article briefly explores the implications of these frameworks for improving the quality of child welfare services in the next decade.

Stages of Implementation

Implementation does not occur all at once. It is a process that takes 2 to 4 years to complete in any provider organization. It is a recursive process that includes steps focused on achieving benefits for children, families, provider organizations, human service systems, and communities. It appears that there are six functional stages of implementation: exploration, installation, initial implementation, full implementation, innovation, and sustainability. While we describe these in linear fashion, the stages are not linear in practice because each impacts the others in complex ways. For example, sustainability factors are very much a part of exploration, and exploration directly affects sustainability. Or, an organization may regress from full implementation to initial implementation as a result of unusually high levels of staff turnover. The stages should be viewed as components of a tight circle with two-headed arrows from each component to all others.

Exploration Stage

The passive processes of diffusion and information dissemination are important parts of the exploration stage. Information sharing in various formats is essential to increasing awareness of innovations and prompting professionals to consider the need to make changes in current practices and services. Prochaska and DiClemente (1982) described this process as moving from pre-contemplation to contemplation, preparation, and action. Drug companies and other manufacturers advertise their products to help potential users transition from awareness to action. In human services, information most often is shared through professional publications and at conferences. Rogers (1995) noted that the diffusion literature provides information about the factors associated with making a decision to adopt an innovation, but it says little about what to do next to implement that innovation with fidelity. Rogers observed that fewer than 30 of the more than 1,000 articles he reviewed pertained to implementation. Twenty years later, Greenhalgh, Robert, MacFarlane, Bate, and Kyriakidou (2004) stated that the most serious gap in the diffusion, dissemination, and implementation literature pertained to the processes by which implementation occurred in service delivery organizations. Thus, diffusion and dissemination play an important role in starting the implementation process but should not be confused with implementation itself.

Sustainable and effective implementation efforts are firmly rooted in the activities that occur during the exploration stage (Panzano & Roth, 2006). Critical questions at this phase include the following: What problem exists? What innovations exist that might help solve that problem? What changes will be needed in the provider organization to allow full and effective use of the innovation? What changes must be made in partner organizations, including federal, state, and local bureaucracies, to make full and effective use of the innovation? What are the costs of start-up and ongoing support of the innovation, and what sources of funding are available to pay for start-up and to support implementation? What data systems must be in place to monitor intended changes in consumer outcomes and organizational and bureaucratic supports?

The process of collecting and analyzing all of this information is a critical part of the exploration stage. Early in the exploration stage, an *implementation team* should be formed (e.g., Barratt, 2003). The

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implementation team members need to have direct access to people in the power structure and should be freed of other responsibilities to allow them to spend the time and resources needed to collect and analyze essential information. Team members must ultimately determine the problem to be solved, the innovation that might help solve it, and the most likely strategies to implement the innovation with fidelity and with clearly articulated benefits to consumers.

In some cases, innovations with a strong evidence base will have formed a *formal purveyor* group for the sole purpose of helping provider organizations, human service systems, and communities to consider the challenges and implications of implementing the innovation. As an example, Chamberlain (2003) described the purveyor group formed to help communities implement Multidimensional Treatment Foster Care. Purveyor groups have special expertise in the innovation itself *and* also have expertise in how to implement the innovation successfully. Implementation teams that have the benefit of experienced purveyors will find their jobs much easier to perform. However, most evidence-based innovations have no established purveyor group to support their implementation.

The exploration stage officially *ends* when the decision is made to implement a particular innovation. (As previously noted, implementation is not linear, so stages are never "over" in some final sense.) The time required to carry out exploration tasks seems to vary widely from a few months to several years; from 6 to 15 months seems to be a fairly common time frame for most organizations. However, this time frame is usually shorter when the help of an experienced purveyor group is utilized.

Installation Stage

The installation stage officially begins with the decision to implement an innovation and ends when the innovation is used for the first time with the first consumer. The installation stage has been largely ignored in human services, but it is routinely planned for in other practice domains, such as manufacturing, engineering, management, and forestry. Starting up any innovation requires time and resources, and the lack of planning for these costs has doomed many implementations attempted in human services. Start-up often requires hiring new staff and the associated activities of preparing job descriptions, developing salary scales, and special recruiting and interviewing, while concurrently redeploying existing staff, arranging office space, purchasing communications equipment such as cell phones and computers, creating new referral mechanisms, securing new funding sources, arranging initial training for staff, and preparing for responsible supervision and coaching. All these are essential components of the installation stage, and considerable resources often must be expended to accomplish these before the first consumer is seen and before any revenues are realized. Implementation teams must anticipate and consider the installation tasks as much as possible during the exploration stage to assure that adequate resources are available to support installation. Experienced purveyors can help potential implementation sites consider these tasks and their associated costs during the exploration stage.

The time required for installation varies widely, depending upon the nature of the innovation and the quality of the implementation support, but between 2 and 6 months represents an average amount of time required for installation for many attempted implementations.

Initial Implementation Stage

This stage is where the "rubber meets the road." During the initial implementation stage, practitioners, supervisors, managers, system partners, and others involved in the innovation must learn how to perform and relate to this new way of doing things. It is called the *initial* implementation stage to acknowledge that practitioners and managers in the provider organization, system administrators, and ongoing policy makers are not likely to be proficient in their new roles at the beginning of the implementation process. Learning any new skill does not generally go smoothly in the beginning, whether learning to play a musical instrument, master a sport, work in a new way with a distressed child and family, provide skill-based coaching, or revamp the methods used by the human resources department. Successful implementation usually requires people to acquire new skills and approaches, individually at first and then in unison or collaboration with others.

Because of the inherent challenges and difficulties in implementation of new innovations, this phase may not go well in the beginning. Change is often hard on everyone, and doing new things, especially when just learned, is difficult at best. For organizations to survive this stage and for the innovation to be successful require both determination and skill. Organizations that have the assistance of an experienced purveyor group have a considerable advantage, as the purveyors can guide and sustain an organization through this challenging change process. If a purveyor group is not available, the implementation team will need to find or develop the necessary expertise to help practitioners, organizations, and systems through this process.

Most attempts to implement innovations fail during this stage because the requirements for successful implementation are both poorly understood and inadequately supported. If organizations can survive the initial challenges and stresses, completion of the initial implementation stage may require from 9 to 24 months.

Full Implementation Stage

Full implementation of an innovation is reached when at least 50% of the currently employed practitioners simultaneously perform their new functions acceptably, that is, when measured by criteria that denote fidelity to the original innovation in their replication. This requirement may appear easy to meet, but it is not. One challenge, staff turnover, is a common occurrence not only at the practitioner level in human services agencies but also at supervisory and administrative levels. For each staff person who resigns, a replacement must be selected, trained, and coached, and the new practitioners' performance in their jobs must be assessed one or more times to assure their performance meets standards of fidelity. This sequence of activities takes considerable time. Further, there is no assurance that meeting fidelity criteria once means that the same practitioner will meet fidelity criteria the next time he or she is assessed as part of an ongoing process of quality assurance. Staff turnover also occurs in positions of interviewer, trainer, and coach. Learning to be a competent interviewer, trainer, or coach is itself a challenge, and practitioners who are supported by inexperienced trainers and coaches may not achieve fidelity criteria readily. Similarly, practitioners, interviewers, trainers, coaches, and performance assessors may not receive the guidance and support they need if managers and directors also are inexperienced, thus further affecting staff's ability to achieve compliance with fidelity criteria.

In the estimation of the authors, for these and other reasons, few attempts to implement innovations ever reach the full implementation stage. For those that do, the process from the exploration stage to the point of first achieving full implementation may take from 2 to 4 years to complete.

Innovation Stage

Useful innovations typically occur only after full implementation has been achieved. The advice from successful purveyors is "first do it right, then do it differently." That is, learn the intervention, learn how to do it with fidelity, do it long enough to learn the nuances of its applications, and then work on how to improve the intervention itself. In this manner, innovations will be thoroughly based on a solid mastery of the knowledge and skills that define the intervention, and therefore, they will be useful to other users of the same intervention.

This premise is a distinct departure from the advice of those who say that adaptation is necessary to adoption of innovations. Rogers (1995) and others claimed that the adoption of innovations *requires* adaptations that the individual user can make to help assure a better *fit* for the innovation within the adopting organization. However, a decision to adopt an innovation cannot be considered implementation of that innovation. On the one hand, a growing body of evidence shows that implementation with fidelity produces benefits to consumers, while adaptation (or reinvention) leads to poor outcomes for consumers (e.g., Panzano & Roth, 2006; Lipsey & Wilson, 1998). On the other hand, evidence-based programs need to continue to evolve if they are to maintain and improve their effectiveness over the years. Constructive change can occur in such programs provided that improvements are based on data derived from attempts to implement innovations with fidelity in real-world human service settings (Dusenbury, Brannigan, Falco, & Hansen, 2003). Thus, adaptations based on solid data that demonstrate improved benefits to consumers are the heart of the innovation stage.

Sustainability Stage

As we mentioned, activities related to sustainability must be incorporated into every stage, and they never end. Creating understanding of the innovation and building a constituency to support it begins during the exploration stage, and the scope and depth of support must be expanded at every opportunity in every ensuing stage (Khatri & Frieden, 2002). Early decisions about how to access external expertise to assure a quick and successful start-up, and how to make use of that external expertise to build local capacity, will impact sustainability over the long term. Developing and maintaining ongoing quality assurance systems that include practical measures of outcomes will positively impact sustainability. The conditions under which human services are delivered are in a constant state of change, and the sustainability of innovations depends upon staying tuned in to the changes, anticipating the next set of changes, and continually maintaining high fidelity services even in the midst of continual change.

Core Implementation Components

What goes on during the initial and full implementation stages? Based on the commonalities among successfully implemented programs, several core implementation components have been identified (Fixsen et al., 2005). The goal of implementation is that practitioners, such as foster parents, caseworkers, therapists, teachers, and physicians, will use innovations effectively. To accomplish this, practitioner behavior must be shaped and supported by several core implementation components, which are also referred to as *implementation drivers*. As shown in Figure 1, these core components are staff selection, preservice training, ongoing coaching and consultation, staff performance evaluation, data systems that support decision making, facilitative administrative support, and systems interventions. These interactive processes must all be *integrated* to maximize their influence on both staff behavior and organizational culture. The interactive core implementation components also *compensate* for one another, in that a weakness in one component may be overcome by strengths in other components.

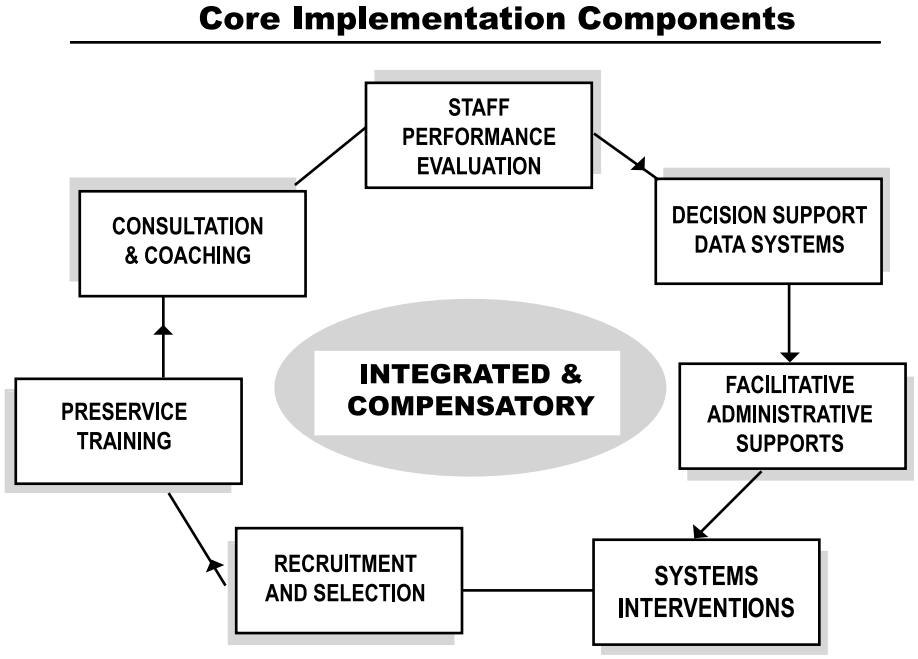

Figure 1. Core components that work together to implement and sustain the effective use of innovations, such as evidence-based programs.

Staff Selection

Effective staffing requires consideration of several questions. Who is qualified to carry out the evidence-based practice or program? What are the best methods for recruiting and selecting practitioners who possess necessary qualifications? In addition to prerequisite academic qualifications and experience factors, certain practitioner characteristics may be difficult to impart in training sessions, so they must be included in selection criteria. These include a broad knowledge of the practice field, basic professional skills, common sense, sense of social justice, sound ethics, a willingness to learn, a willingness

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to intervene, good judgment, and empathy. Some programs are purposefully designed to minimize the need for careful selection. An example might be a reading tutoring program designed to be staffed by volunteers (Baker, Gersten, & Keating, 2000). Other programs require more specific and complex qualifications for practitioners (Chamberlain, 2003; Phillips, Burns, & Edgar, 2001; Schoenwald, Brown, & Henggeler, 2000) as well as specific methods for assessing competencies (e.g., Blase et al., 1984; Maloney, Fixsen, Phillips, Wolf, 1975; Reiter-Lavery, 2004). In a qualitative study of the capacity of evidence-based program developers to help others implement their programs, many program developers stated that selection of staff was critical to the delivery of their model, but few program developers had established staff selection criteria or interview protocols to guide provider organizations in the selection of staff (Naoom, Blase, Fixsen, Gilbert, & Wallace, n.d.).

Staff selection also intersects with a variety of larger system variables. General workforce development issues, the overall economy, organizational financing, salaries and benefits, and the demands of the innovation in terms of time and skill can all affect the availability of qualified staff for human service programs. The focus on evidence-based practices and programs in human services has created concern about advanced education, the availability of a qualified workforce, and sources of funding to enable hiring of highly skilled practitioners (Blase & Fixsen, 1981; O'Connell, Morris, & Hoge, 2004).

Preservice and Inservice Training

Evidence-based practices and programs often represent novel ways of providing treatment and support to clients. Direct service practitioners and others at an implementation site need to learn when, where, how, and with whom to use new approaches and new skills. Preservice and inservice training are efficient ways to provide knowledge of background information, theory, philosophy, and values; to introduce the components and rationale for key practices; and to provide opportunities to practice new skills and receive feedback in a safe training environment. However, classroom training by itself is not sufficient to assure that staff will develop the capacity to effectively implement an innovation (Azocar, Cuffel, Goldman, & McCarter, 2003; Schectman, Schroth, Verme, & Voss, 2003; Stokes & Baer, 1977).

Coaching and Consultation

Most skills needed by effective practitioners can be introduced in training but must be practiced and mastered on the job with the help of a coach. A coach provides specific information about the application of an intervention in a clinical setting as well as advice, encouragement, and opportunities to practice and use skills specific to the innovation. The implementation of human service innovations usually requires behavior change at the practitioner, supervisory, and administrative support levels. Training and coaching are the principal ways in which behavior change is brought about for carefully selected staff in the beginning stages of implementation and also throughout the life of evidence-based practices and programs.

Staff Performance Appraisal

Evaluation of staff performance is designed to assess the application and outcomes of the skills that are reflected in the selection criteria, that are taught in training, and that are reinforced and expanded in coaching processes. Assessments of practitioner performance and measures of fidelity also provide feedback useful to interviewers, trainers, coaches, managers, and purveyors regarding the progress of implementation efforts and the usefulness of selection, training, and coaching.

Decision Support Data Systems

Other measures such as quality improvement information, organizational fidelity measures, and consumer outcomes assess key aspects of the overall performance of the organization and provide data to support decision making to assure continuing implementation of the core intervention components over time.

Facilitative Administration

Facilitative administration provides leadership and makes use of a range of data inputs to inform decision making, to support the overall processes, and to keep staff organized and focused on the desired intervention outcomes. In organizations with this advantage, administrators give special attention to policies, procedures, structures, culture, and climate to assure alignment of these organizational components with the needs of practitioners. Practitioners' interactions with consumers are key to successful intervention. It is the responsibility of administrators to make sure that practitioners have the skills and supports they need to perform at a high level of effectiveness with every consumer.

Systems Interventions

Systems interventions are strategies to work with external systems to ensure the availability of the financial, organizational, and human resources required to support the work of the practitioners. Again, alignment of these external systems to support the work of practitioners is an important aspect of systems intervention (see Mihalic & Irwin, 2003), for examples of the interaction of administrative and external system variables with successful implementation and benefits to consumers).

Integrated and Compensatory Core Implementation Components

The importance of integrating these core implementation components was illustrated by a meta-analysis of research on training and coaching carried out by Joyce and Showers (2002). They summarized several years of systematic research on training public school teachers. The study found that training consisting of theory and discussion coupled with demonstration, practice, and feedback resulted in only 5% of the teachers using the new skills in the classroom. These findings are similar to those of Rogers (2002) who reviewed the business literature and estimated that only about 10% of what is taught in training is actually transferred to the job. In the Joyce and Showers analysis, when on-the-job coaching was added to training, large gains were seen in both knowledge and the teachers' ability to demonstrate the skills. Most important, about 95% of the teachers used the new skills in the classroom with students. Joyce and Showers (2002) also noted that training and coaching can be done only with the full support and participation of school administrators (facilitative administration) and works best with teachers who are willing and able to be fully involved (staff-selection factors).

The integrated and compensatory nature of the core implementation components represents a challenge for implementation and sustainability. Organizations are dynamic, so ebb and flow affect the relative contribution of each component within overall outcomes. The feedback loops are critical to keeping the evidence-based program "on track" amid continuing change. If formal feedback loops (staff performance evaluations and decision support data systems) indicate

needed changes, then the integrated system needs to be adjusted to improve effectiveness or efficiency (see Bernfeld, 2001, for a more complete description of these interactive variables). That is, any changes in process or content in any one of the core implementation components require adjustments in other core implementation components as well.

The descriptions of the core implementation components provide a template for analyzing and attending to implementation. A given practice or program may require more or less attention to any given core implementation component for the practice or program to be implemented successfully, and some practices may be designed specifically to eliminate the need for one or more of the core implementation components (e.g., Baker, Gersten, & Keating, 2000; Embry, 2004). In addition, the compensatory nature of the core implementation components helps to assure that there are multiple systems, procedures, and opportunities to support high-fidelity implementation. For example, in an implementation infrastructure that has minimal training opportunities for practitioners, intensive coaching with frequent feedback may compensate for the lack of formal training. Or, careful selection of personnel and well-designed staff performance evaluations, coupled with strong incentive systems, may compensate for less training and coaching.

Sources of Core Implementation Components

Successful implementation requires identification of persons responsible for carrying out functions related to the core implementation components. For instance, who will select, train, coach, and evaluate staff at an implementation site? Who will provide administrative support services? Who will intervene with external systems when needed? Will this be done by people who work within the organization, or will it be contracted to individuals or groups outside the implementation site? For example, implementation sites using multisystemic therapy (MST) participate in a complex mix of core implementation components. Practitioners working in new MST implementation sites are selected by staff at the implementation site based on criteria provided by MST Services, Inc., are trained by MST Services, Inc. at a central location in South Carolina, are coached by local consultants who are themselves trained and coached by MST Services, Inc.'s consultants, are evaluated via monthly submissions of fidelity results to the MST Web site, and are administratively supported by staff employed by the implementation site (Schoenwald et al., 2000). At least initially, MST Services, Inc. and staff at the implementation site jointly carry out interventions in larger systems (e.g., referrals, funding streams, and interagency collaboration).

For multidimensional treatment foster care (MTFC), the implementation site identifies a core group (including an administrator, a supervisor, a therapist, and a foster-parent trainer/recruiter) who then participate in a 3-day session in Oregon, which includes training and exposure to the important aspects of a fully operational program (Chamberlain, 2003). Next, two trainers from Oregon go to the implementation site to train the first cohort of foster parents, to conduct additional training with the core staff group, and to introduce them to the parent daily report (PDR) Web site. After youth are placed in program foster homes, the Oregon staff monitor the PDR data and provide weekly telephone consultation to the on-site program supervisor and therapist. During the first year of implementation, the Oregon staff provides three additional 2-day training sessions at the implementation site.

In the systems described in these two examples, external contractors are actively involved in the ongoing operations of an implementation site. While these hybrid systems probably retain the compensatory benefits we mentioned, ongoing integration of functional treatment components and core implementation components may be difficult to achieve and maintain over the years. A different approach is to develop regional implementation sites that have the full capacity to provide all of the core implementation components within their own organizations. These are sometimes called "intermediary organizations." For example, in the teaching-family model, carefully selected staff members employed by an implementation site are trained and coached to conduct staff selection, training, coaching, evaluation, facilitative administration, and systems interventions for treatment programs within easy driving distance (Blase et al., 1984; Wolf, Kirigin, Fixsen, Blase, & Braukmann, 1995). In this approach, each implementation site becomes the source of its own core implementation components without continuing reliance on outside contractors. For these implementation sites, fidelity is measured at the practitioner level to assure competent delivery of the core intervention components, and it is also measured at the implementation site level to assure competent delivery of the core implementation components. Purveyors of a system called functional family therapy also work to develop self-sufficient implementation sites (Sexton & Alexander, 2000) and, recently, MST Services, Inc. has begun to develop organizations, called "network partners," to provide training and support services at the local level. A concurrent challenge for these "intermediary" arrangements is the development of procedures to monitor and assure fidelity to the implementation processes and outcomes at an organizational level.

Next Steps

In this article, we have summarized stages of implementation and core implementation components. As the review of the current literature and implementation best practices has demonstrated, there is nothing really new about either the implementation stages or any of the core implementation components. What is new, however, is an understanding that both the stages and components are highly integrated parts of a whole new entity that is identifiably "implementation." Thus, now we can see that the missing link in the science-to-service chain is implementation. And, when implementation teams and purveyors are doing their work effectively, we can identify their stage in the implementation process and exactly which core implementation components they are using.

To affect outcomes for children and families significantly, we must learn how to utilize well-researched programs and practices on a national scale. In their report of findings from the Blueprint Replication Initiative, Elliott and Mihalic (2004) stated that although ten Blueprint programs studied had completed the necessary efficacy and effectiveness trials and had met the rigorous evaluation standards required for certification as a Blueprint program, they were not necessarily prepared to deliver their programs on a large scale. Only four of the ten programs had the organizational capacity to deliver their program to ten or more sites a year. According to the authors, "Although we have taken giant strides in determining what works and promoting the use of science-based programs, we have lagged behind in building the internal capacity of designers to deliver their programs" (Elliott & Mihalic, 2004, p. 48).

As noted in the introduction to this article, the challenge in making use of science is in building science and quality into the daily performance of hundreds of thousands of practitioners across the

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nation. In the area of child welfare, this includes more than one million social workers, foster parents and group care workers, and associated psychologists, psychiatrists, and medical professionals. How many experienced and skillful purveyors will that take? How will we know if the purveyors are doing a good job? How can we help federal and state human service systems keep up with the changing landscape at the evidence-based practice level?

These questions relate to three seminal issues that must be resolved if we truly wish to close the science-to-service gap:

1. We need to develop measures of both the implementation stages and implementation components to provide practical signposts for policy makers and funders, useful feedback systems for purveyors, and common outcomes that can be assessed through continuing research.
2. We need to design training academies to develop—systematically, effectively, and efficiently—a whole generation of purveyors who have the requisite knowledge and skills to competently perform implementation work.
3. We need to engage policy makers and politicians in a determined effort to defragment human service systems and fully align funding, licensing, accreditation, monitoring, and bureaucratic functions with the needs of effective practitioners working in the context of facilitative provider organizations. Current state and federal systems are "legacy systems" that typically are more attuned to the past than to the future.

The practice and science of implementation have improved to the point where more is known, but to bridge the gap between research and practice, and to foster the science of implementation, we must be as empirically sound in choosing our implementation strategies as we are in choosing our interventions.

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About the Authors

The authors are codirectors and associate directors of the National Implementation Research Network.

Karen Blase developed and directed service programs in child welfare, domestic violence, and juvenile justice; developed one of the first national evidence-based program implementation efforts, and is past president of the Teaching-Family Association and the Foster Family-based Treatment Association.

Dean Fixsen has conducted research on program development and implementation, developed and operated residential and home-based treatment services, and led policy initiatives at state and federal levels.

Sandra Naoom has investigated prevention and health promotion, has studied the role of culture on health, currently leads a qualitative study exploring implementation practices and strategies utilized by evidence-based program developers, and is codirector of an implementation study of a teen dating violence prevention program.

Frances Wallace recently has focused on investigating factors that influence the success of attempted implementations of evidence-based practices and programs in systems of care, evaluating state behavioral health systems for children as well as the provision of implementation technical assistance.

The authors may be contacted by E-mail at: nirn_usf@fmhi.usf.edu or visit their Web site at: nirn.fmhi.usf.edu.

The Impact of Domestic Violence on Infant Health Factors and Child Maltreatment

William McGuigan, PhD

Introduction

A recent review conservatively estimated the lifetime prevalence of violence against women by their domestic partners to be between 25% and 30% with over half of female victims living in households with children under the age of 12 (Tjaden & Thoennes, 2000). Research has established that domestic violence not only affects women across their lifespan but has a profound impact on the lives of their children as well. To date, the majority of research has focused on the effect of domestic violence on school age or preschool age children, and it is acknowledged that young children and adolescents exposed to domestic violence are likely to experience many adverse outcomes (Kitzmann, Gaylord, Holt, & Kenny, 2003; Mahony & Campbell, 1998; Wolfe & Korsch, 1994). Similarly, two decades of research provide overwhelming evidence that domestic violence often cooccurs with the abuse and neglect of younger children (Appel & Holden, 1998; McGuigan & Pratt, 2001).

A review of the domestic violence literature reveals a noticeable paucity of empirical studies examining the effects of domestic violence on infants, and particularly the effect of domestic violence on infant health factors and subsequent child maltreatment. More research is needed on the relationship between domestic violence and infant health outcomes, as it is during pregnancy or immediately after childbirth that many women first experience domestic violence (Saltzman, Johnson, Gilbert, & Goodwin, 2003; Tjaden & Thoennes, 2000). During the first years of parenting, couple relationships are the most discordant (Belsky & Rovine, 1990), and the risk of child maltreatment is highest (Leventhal, 1988; National Research Council, 1993). Likewise, it is during the child's first year that domestic violence can have a profound influence on the child's future psychological development (Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006) and physical health (Alessi & Hearn, 1984).

Violence within the home interacts with many demographic and social factors that can influence infant health, development, and subsequent maltreatment. For example, a recent study using data from 16 states found that domestic violence was higher around the time of childbirth for women who were younger, unmarried, had fewer than 12 years of education, and who received Medicaid or other state medical assistance (Saltzman et al., 2003). The limited available research shows that mothers who experienced domestic violence were more likely to smoke, abuse drugs, receive late prenatal care, give birth prematurely, have infants with low birth weight or medical problems at birth, and utilize emergency room visits for well-baby check-ups (Campbell, 2001; Dietz et al., 1997; Huth-Bocks, Levendosky, & Bogat, 2002). Recent studies report that domestic violence increased the odds of poor infant nutrition (Kearney, Haggerty, Munro, & Hawkins, 2003) and contributed to poor mother-child bonding (Quinlivan & Evans, 2005). It is understood that many of these same factors have been associated, directly or indirectly, with the risk of child maltreatment.

Two infant health factors that have received little attention in the domestic violence literature are breast feeding and passive smoke exposure. Research shows that breast feeding reduces the risk of infections and may protect infants against SIDS, diabetes, allergies, asthma, and digestive diseases (American Academy of Pediatrics/ Work Group on Breastfeeding, 1997). Passive smoking is associated with higher rates of ear, sinus, and respiratory infections; sore throats; colds; and asthma (Richter & Richter, 2001) as well as higher rates of infant crying (Reijneveld, Brugman, & Hirasing, 2002).

Methods

Study Design

To examine the relationships between domestic violence, infant health factors, and child maltreatment, the current exploratory study reviewed 4 years of archived data (1997–2000) from the Oregon Healthy Start (OHS) program (see Katzev, Pratt, & McGuigan, 2001). Oregon Healthy Start continues to be a voluntary, home-visiting program designed to assist families at risk of poor family functioning in giving their firstborn infant a "healthy start" in life. The OHS program was modeled after Healthy Families America (HFA), a national initiative adopted in 1992 by the National Committee to Prevent Child Abuse (1996), now known as Prevent Child Abuse America. In addition to addressing child maltreatment, OHS was mandated by the Oregon legislature to improve the health outcomes of the parents and children they served (i.e., increased use of preventive health care and improved immunization rates). At the time of this study, OHS was operating in 21 Oregon counties, overseen by the Oregon Commission on Children and Families. County health departments were active collaborators in the OHS program, and in many counties, the OHS program was physically housed within the public health building.

Participants

The current study used archived data obtained from 1,106 (n = 1,106) at-risk families who were actively engaged in OHS for 12 consecutive months at some time between January 1, 1997, and January 1, 2001. To identify at-risk families, OHS used an extensive two-stage screening and assessment process. Mothers with firstborn children gave permission to be screened for family risk factors. The screening was initially done in the hospital by hospital nurses or trained Family Assessment Workers (FAWs) shortly before or after the child's birth. Mothers provided yes/no answers to the 15-item Hawaii Risk Indicator (HRI) checklist (Hawaii Family Stress Center, 1994).

Mothers who were unmarried, had inadequate or no prenatal care, or who had any two other risk characteristics (e.g., history of substance abuse, fewer than 12 years of education, inadequate income) were further assessed using the Kempe Family Stress Inventory (KFSI). The KFSI is an in-depth interview that assesses 10 psychosocial factors related to poor family functioning and the risk of child abuse (Korfmacher, 2000; McGuigan & Pratt, 2001). Healthy Start Family Assessment Workers (FAWs) conducted KFSI interviews after receiving extensive training in the interview protocols. Interviews took approximately 1–1/2 hours and were conducted in the hospital or in the family's home shortly after the child's birth as part of a

"welcome baby" visit. Based on KFSI scores, families considered at risk for poor family functioning were offered weekly home visiting services. Although a majority (92%) of mothers assessed as at risk on the KFSI initially accepted OHS services, high attrition rates during the first year (approximately 60%) followed the well-documented pattern found in most home visiting programs (McCurdy & Daro, 2001; McCurdy, Hurvis, & Clark, 1996; McGuigan, Katzev, & Pratt, 2003).

To improve the health and welfare of Oregon families, OHS Family Support Workers (FSWs) provided weekly visits to participating families for the first few months and gradually reduced to biweekly or monthly visits, depending on the families' needs. Visits could continue until the child was 5 years of age. All OHS home visitors received at least 96 hours of initial training and over half (58%) had college degrees in health and human service-related fields (e.g., nursing, public health, social work, human services). Home visits focused on infant health, child development, parenting education, and referrals to needed services, such as primary care physicians or mental health counseling.

The FSWs completed intake assessments after visiting the family for 3 months, and a subsequent assessment was completed at 12 months. Only those mothers with complete data at 3 and 12 months were included in the current study (n = 1,106). Mothers resided in semi-rural or small metropolitan areas, and the majority (70%) had never been married. Most mothers were white (69%) or Hispanic (26%); 5% were African American, Native American, Asian, or of other ethnicity. This closely matched the ethnic make-up of the Oregon counties being served. On average, mothers were 21.4 years of age (SD = 5.0) when their child was born, and most (79%) did not work outside the home. Over half (51%) of the mothers had less than a high school education and 81% were enrolled in the Oregon Health Plan, a state medical plan for low-income families. The majority (56%) lived with their husband or partner; over one third (35%) lived with parents, relatives, or friends (which might include the husband or partner); and the remaining 9% lived alone with their newborn child.

Measures

All measures of infant health were dichotomous (yes or no, except where indicated). Data were gathered from multiple sources, thus limiting single informant bias. Hospital records confirmed whether or not the child had been born prematurely (gestation < 37 weeks), was of low birth weight (≤ 2500 grams), was drug affected, or had medical problems. Shortly before or after the child's birth, FAWs used maternal self-reports to establish whether the mother had a history of substance abuse, had smoked tobacco during pregnancy, and was breastfeeding. In addition, the KFSI was used to assess whether the mother was having problems bonding with her infant.

After 3 months of home visitation, FSWs completed an intake assessment of family functioning that included an appraisal of domestic violence. For this study, domestic violence was strictly defined as "any act of physical aggression between partners with the intent to do harm that occurred during the first three months following childbirth." There is evidence that domestic violence is more common during pregnancy (Saltzman et al., 2003; Tjaden & Thoennes, 2000), and it is likely that many of the mothers assessed as experiencing domestic violence during the first 3 months of child rearing were initially victimized either prior to or during their pregnancy. Research has established that different types of domestic violence exist, but the majority involves the male partner as the perpetrator or both partners in mutual couple violence (Appel & Holden, 1998; Johnson & Ferraro, 2000). In the current study, no distinctions were made regarding the initial date that domestic violence began or the level, frequency, or typology of the violence. The conceptual basis of this study focused on how any type of physical aggression between partners confirmed during the first 3 months of child rearing would impact infant health factors during the child's first year.

The FSWs were trained to recognize signs of relationship volatility. The frequent home visits with observations of family interactions increased the likelihood that domestic violence would be detected. If domestic violence was suspected, mothers were asked privately if their mate had been physically aggressive toward them. Questioning the mothers in private insured their safety and promoted open disclosure. Victims were informed of their options regarding shelter services, legal action, and counseling. Of the 1,106 mothers in this study, 114 (10.3%) were assessed as having experienced domestic violence during the first 3 months after the birth of their firstborn child.

After 12 months of OHS services, the FSWs completed another assessment with several items related to infant health. These included whether the mother or others, or both, smoked tobacco inside the home, whether the infant received adequate nutrition (rated by FSWs as poor or fair vs. good), whether the infant was linked to a primary health care physician, whether infant immunization records were up-to-date, whether the infant received regular well-child check-ups, and whether the family relied on hospital emergency rooms for routine services.

Official child maltreatment data were obtained from Oregon's child protective services agency. These data were available for all children in the study and included any confirmed incident of child maltreatment that occurred from January 1, 1997, to January 1, 2002. In this way, maltreatment data were available for all children up to age 1, and for some children, up to age 5. Of the 1,106 children in this study, 41 (3.7%) had some form of child maltreatment confirmed by the state agency. The majority of cases (68%) were confirmed during the child's first year with the remainder (32%) confirmed before the child was 3 years of age. Of the 114 families assessed as experiencing domestic violence, 11 (9.6%) had child maltreatment confirmed by the state, specifically 3 cases of neglect and 8 cases of mental injury/threat of harm. Of the 992 families assessed as not experiencing domestic violence during the first 3 months of childrearing, 30 (3%) had child maltreatment confirmed by the state. These included 2 cases of physical abuse, 15 cases of neglect, and 13 cases of mental injury/threat of harm. There was no confirmation of sexual abuse in any of the study families.

Statistical Analysis

A sample size of 114 mothers assessed as experiencing domestic violence and 992 assessed as not experiencing domestic violence provided sufficient statistical power to detect any significant differences in outcome variables between the two groups. Since all of the health outcomes were dichotomous, chi-square tests were used to compare mothers who were assessed as experiencing domestic violence during the first 3 months of childrearing with mothers who were not. Comparisons were expressed as the percentage of mothers within each group. Next, the 12 infant health factors found to be significantly associated with domestic violence (see Table 1) were

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combined to create an overall index of infant health, with higher scores indicating the presence of a greater number of poor infant health factors. A logistic regression model examined whether higher scores on the infant health index increased the likelihood of confirmed child maltreatment after controlling for demographic factors and the direct effect of domestic violence (Table 2).

Table 1.
Chi-square tests of associations between domestic violence and infant health factors

	% of DV Families n=114	% of Non-DV fam n=992
Hospital Records		
Infant born prematurely (gestation<37 weeks)	5.3	3.5
Infant born drug affected^{ns}	3.5	1.6
Infant born low birth weight(≤2500 grams)***	5.3	.08
Infant born with medical problems*	8.8	3.7
FAWS Assessments Following Birth		
Mother has history of substance abuse^{ns}	37.1	28.1
Mother smoked during pregnancy**	30.7	17.4
Mother chose not to breastfeed infant***	54.4	34.9
Mother had difficulty bonding with infant***	25.4	13.2
FSWs Assessments at 12 Months		
Mother smoked at 12 months**	28.1	16.0
Others in home smoked at 12 months***	56.1	29.5
Infant received poor or fair nutrition**	24.6	13.4
Infant not linked to primary health care provider**	7.0	2.5
Infant immunizations not up-to-date***	16.7	7.0
Infant missing regular well-child check-ups**	14.0	5.9
Family relied on emergency room for care**	31.6	20.2
Child Maltreatment Confirmed by the State		
Child maltreatment	9.6	3.0

^{ns}non-significant, *p<.05, **p<.01, ***p<.001

Table 2.
Odds ratios and confidence intervals for variables predicting confirmed child maltreatment

Variable	Odds Ratio	95% CI	
		Lower	Upper
Mother's age^{ns}	.988	.915	1.07
Mother's years of education^{ns}	1.06	.895	1.25
Mother has never been married^{ns}	.623	.297	1.30
Family receives Oregon Health Plan^{ns}	.644	.241	1.72
Domestic Violence*	2.29	1.06	4.97
Index of infant health factors***	1.30	1.11	1.53

N=1,106
^{ns}non-significant, *p<.05, ***p<.001

Results

Chi-square analyses showed significant differences in the majority of infant health factors when comparing the 114 mothers who were assessed as experiencing domestic violence with the 992 mothers who were not (Table 1). Hospital records showed that infants born to mothers who experienced domestic violence were significantly more likely to be born with low birth weight ($p < .001$) and medical problems ($p < .05$). While hospital records showed that a higher percentage of mothers who experienced domestic violence gave birth prematurely and gave birth to infants who were drug affected, these substantive differences were not statistically significant.

The FSW assessments completed shortly following birth showed that mothers who experienced domestic violence were significantly more likely to have smoked during pregnancy ($p < .01$), had chosen not to breastfeed ($p < .001$), and had difficulty bonding with their infant ($p < .001$). There was no significant difference among these mothers in the category mother's self-reported history of substance abuse. (Note: The overall history of substance abuse was high since it was one criterion used for OHS program inclusion).

Family Support Workers' assessments at 12 months showed that the 114 mothers who experienced domestic violence were significantly more likely to smoke tobacco ($p < .01$) and to allow others to smoke in the home ($p < .001$). One-year-olds living in families that experienced domestic violence were more likely to have received only poor or fair nutrition ($p < .01$), were less likely to be linked to a regular primary health care provider ($p < .01$), and were more likely to be behind on childhood immunizations ($p < .001$), to have missed regular well-child check-ups ($p < .01$), and to have been seen in the hospital emergency room ($p < .01$).

The 12 infant health factors that were significantly associated with domestic violence were combined to create an index of infant health factors with higher scores indicating a greater risk for poor infant health. A logistic regression model was used to test the relationship between the index of infant health and confirmed child maltreatment after controlling for maternal demographics and any direct effect of domestic violence. A mother's age and education were entered in years. Marital status was entered as never married or other marital status, and membership in the Oregon Health Plan (yes or no) was used as a proxy for low income.

Results of the logistic regression showed that none of the demographic variables was significantly associated with confirmed child maltreatment. After controlling for the effects of the demographic variables, families assessed as experiencing domestic violence during the first 3 months of child rearing were over 2 times (OR = 2.29) as likely to have child maltreatment confirmed by the state ($p < .05$). Important to this investigation, the logistic regression showed that with the presence of each additional infant health factor, the likelihood of confirmed child maltreatment significantly increased 1.30 times ($p < .01$).

The sizes of the odds ratios were modest, but it is understood that in logistic regression analysis, the additive log-odds of significant predictors are multiplicative. This means that the addition of each infant health factor "multiplied" the likelihood of child maltreatment. Consequently, a mother who experienced domestic violence (OR = 2.29) and had any 2 of the 12 indices of poor infant health (OR = 1.30) was nearly 4 times (2.29 x 1.30 x 1.30 = 3.87) more likely to have child maltreatment confirmed by the state than were mothers with none of these conditions present.

Discussion

This exploratory study investigated the impact of domestic violence on multiple infant health factors and child maltreatment in a large sample of at-risk mothers with firstborn children. Independent sources were used to assess infant health factors, careful observations within the home confirmed the presence of domestic violence, and child maltreatment was documented by official child protection records. Among at-risk mothers with firstborn children, domestic violence during the first 3 months of childrearing was associated with many infant health factors across the infants' first year. When these health factors were combined, they had a significant effect on confirmed child maltreatment beyond the direct effect of domestic violence.

This suggests that violence within the family system may have an indirect effect on the maltreatment of infants via a higher likelihood of factors that are detrimental to infant health. While the methodological limitations of this exploratory study preclude causal conclusions, the findings provide support for the possible mediational role of infant health factors. Identification of these factors provides researchers, social service workers, health care professionals, and policy makers a better focus for coordinating future research and intervention efforts.

Implications

The research, social service, and health care communities should act collaboratively to improve our understanding of (1) how domestic violence affects infant health and maltreatment and (2) what prevention efforts may be effective. Researchers should broaden study populations to include at-risk families with infants, perhaps targeting families served by prenatal clinics, pediatricians, and multisite managed health care organizations. Data obtained from these alternate sources could assist researchers in identifying the specific health needs of infants living in homes with domestic violence.

Swift intervention is necessary when families with infant children experience domestic violence. It is essential that practitioners realize that infants raised in a violent household are victimized without being the direct target of the violence. Since women of reproductive age report higher rates of domestic violence than women of other age groups (Greenfeld et al., 1998), protocols for domestic violence screening should be in place at all pediatric and reproductive health care facilities. The American Academy of Pediatrics (1998) has recommended screening for domestic violence, but "best practice" methods of screening have yet to be identified. Some barriers to screening that must be addressed include lack of staff training, large caseloads, lack of time for screening, and absence of supportive staff.

Optimally, all human service practitioners should be trained to identify and respond to domestic violence and to promote safety for the entire family. Communities should cross-train domestic violence shelter, child welfare, health care, and social service personnel. New joint service models should be developed to address the possible harm to infants and children of all ages, and the effectiveness of such models must be thoroughly evaluated.

Health and social service practitioners serving new parents must realize that violence in the home creates a dysfunctional domestic environment that may reduce the capacity of new parents to care for their infant. Some research has shown that even without resorting to abusive discipline, first-time parents in violent relationships developed a more negative view of their infant (McGuigan, Vuchinich, & Pratt, 2000). These changes in parental cognitions could contribute to neglectful health practices and subsequent child maltreatment. Through cognitive restructuring techniques, such as discussions with concrete examples and role playing, new parents could learn how their behaviors impact their infant's health. Group treatment and home visitation have been suggested as effective methods of delivery for cognitive restructuring programs (Azar, 1997).

Study Limitations

The findings of this study are based on an at-risk sample of primarily white, non-Hispanic, and Hispanic families from semi-rural areas in one state. Likewise, all of the mothers were motivated to remain in an intervention program, limiting the ability to generalize the findings. Child maltreatment was limited to only those cases brought to the attention of the public child protective services system, which is likely an underestimation of actual maltreatment. Direct observations were used to assess domestic violence and reduce the social desirability bias of self-report questionnaires. However, formal measures of rater reliability were not possible.

Despite these limitations, this study provides information to better understand the impact of domestic violence on infants. Knowledge of infant health risks can be used to develop and support intervention strategies. Clearly, more research is needed to examine the causal connections between domestic violence, infant health factors, and subsequent maltreatment.

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About the Author

William M. McGuigan, PhD, is Assistant Professor of Human Development and Family Studies at Pennsylvania State University, Shenango Campus. His areas of interest are adolescent development, family development, family disorganization, and leadership and technology in the human services.

Dr. McGuigan may be reached by E-mail at: wmm11@psu.edu, by phone at: (724) 983-2914, or by mail at: 309D Sharon Hall, 147 Shenango Ave., Sharon, PA.

NCTSN: Working for the Future of Traumatized Children

Staff of the National Center for Child Traumatic Stress

Trauma is pervasive in the lives of American children. It often comes in the form of chronic sexual or physical abuse, or neglect, but trauma may also result from natural disasters, accidents, school and community violence, the sudden death of a loved one, or life-threatening illness. To address the serious and often underestimated significance of traumatic events on the lives of children, their families, and society, Congress established the National Child Traumatic Stress Network (NCTSN) in 2000.

Administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Network now consists of 44 grantee centers in 29 states, a coordinating National Center based at UCLA and Duke University (codirected by Robert S. Pynoos, MD, and John A. Fairbank, PhD), and a number of active centers not currently receiving SAMHSA grants. The NCTSN's unique collaborative structure brings together two major communities: (1) academic centers that are dedicated to conducting research and developing scientifically validated interventions and (2) community-based treatment and service providers who serve on the frontline of care. Together they work to fulfill the Network's mission of raising the standard of care and improving access to services for traumatized children, their families, and communities.

Raising the Standard of Care

To meet its mission, the NCTSN raises public awareness of the scope and serious impact of child traumatic stress through outreach to media, a comprehensive Web site, training of professionals from multiple disciplines, and creation of educational and informational products aimed at diverse audiences, including parents, school personnel, physicians, child advocates, first responders, and others. The Network also develops, disseminates, and evaluates clinical interventions whose efficacy and effectiveness are supported by scientific research, while striving to ensure that these interventions are culturally competent, developmentally sound, and adaptable to the needs of diverse groups. Along with improving clinical practice, NCTSN works with other established systems of care, such as education, law enforcement, child welfare, and juvenile justice to develop and promote trauma-informed practices.

Improving Access to Services

An essential part of NCTSN's mission is to increase access to services. The NCTSN strives to identify and confront the barriers that prevent children and families from receiving the care they need. Many NCTSN centers provide services in settings other than practitioners' offices and mental health clinics. Such nontraditional sites include schools, hospital emergency rooms, emergency/homeless shelters, and families' homes. The Network's members also bring care to those who cannot or do not ask for it through the usual clinical referral channels. Underserved populations, such as impoverished or homeless persons, individuals from minority ethnic or cultural groups, children with disabilities, persons living in rural areas, and refugees often suffer from high levels of traumatic stress, yet they may have limited access to services through formal organizations. The NCTSN has made it a priority to reach these populations and has formed groups and partnerships with other organizations to overcome barriers to services and to develop culturally competent interventions. Network members work across disciplines and geographic boundaries to address the full range of traumatic events, such as child abuse and neglect, traumatic loss of a parent or sibling, natural disasters, and school violence. Each quarter, NCTSN's combined efforts serve more than 10,000 children and families and train about 20,000 professionals.

Partnering With APSAC

NCTSN recognizes that it cannot meet its mission alone and is proud to join in partnership with APSAC to improve clinical practice, to share information and advance knowledge, and to pursue our common goal of saving children from the deleterious and potentially life-long effects of child abuse and neglect. NCTSN and APSAC share not only goals but also many leaders who are among the nation's preeminent researchers and trainers in the field of child maltreatment and child trauma. Barbara Bonner, PhD, Mark Chaffin, PhD, John Briere, PhD, Charles Wilson, MSSW, David Corwin, MD, Lucy Berliner, MSW, Anthony Mannarino, PhD, Lori Frasier, MD, Connie Carnes, LPC, Cheryl Lanktree, PhD,

NCTSN The National Child Traumatic Stress Network

NCTSN KNOWLEDGE BANK

The NCTSN Knowledge Bank (KB) (kb.nctsn.org) is a Web-based tool that allows public access to resources developed by members of the NCTSN, its partners, allies, and related organizations. The KB is easily accessed from the Network's Web site, and it links users to such diverse resources as training manuals, videos, DVDs, and CD-Rom products and handouts designed for parents and families. The Knowledge Bank also attempts to capture and catalog the expertise of the centers and individuals who make up the NCTSN. It provides descriptions and contact information for NCTSN sites, project directors, principal investigators, and staff of the National Center for Child Traumatic Stress.

The Knowledge Bank also directs users to relevant resources from government agencies, commercial publishers, and nonprofit organizations. Much of the print and multimedia material described in the KB is available online by clicking on the links provided. For those resources not available electronically, the KB provides additional contact information.

NCTSN.ORG: The Nation's Source for Up-to-Date and Scientific Information on Child and Adolescent Trauma

The NCTSN Web site (nctsn.org) is a virtual library of information about child traumatic stress and the children who have experienced it. Characterized by the breadth as well as depth of its content, it is designed to be rich—complex but not complicated.

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The Web site is organized by both audience and topic. The site's resources address mental health and other professionals, parents and families, policy makers, physicians, educators, researchers, and other readers. Topics cover a range of types of trauma, professional training and education, cultural issues, special populations, assessments, treatments, and more. The site is listed as a resource on child trauma by numerous organizations, including the National Institutes of Health's MedlinePlus (www.nlm.nih.gov/medineplus).

An important example of the resources available on the Web site is the recently released *Measures Review Database* (www.nctsn.org/measures). Although a number of important child trauma assessment and screening tools exist, clinicians have not always had clear information about which one to use in a particular situation. The *Measures Review Database* is a searchable collection of reviews of the various assessment and screening tools available to measure children's experience of trauma, their posttraumatic reactions, and the impact of trauma. These reviews are presented in easy-to-read, Web format, and the database can be browsed or searched easily in various ways, including by the age of the child in treatment. Each review of an assessment provides the same information, such as the age range for which the instrument is designed, the domains assessed, its format, administration, and scoring, pros and cons for its use, and the evidence base that supports it. This allows users to compare one assessment with another using the same criteria. Some of the assessment and screening tools reviewed can be downloaded directly from the database; for others, contact information is provided.

Other tools on www.nctsn.org include the following:

Parenting in a Challenging World (www.nctsn.org/nccts/nav.do?pid=ctr_aud_prnt_chlg) is an interactive video introduction to child trauma for parents and caregivers.

Cops, Kids and Domestic Violence (www.nctsn.org/nctsn_assets/acp/dv/nctsn_dv_rev1.htm) is a training video

Judith Cohen, MD, Esther Deblinger, PhD, and Benjamin Saunders, PhD, are just a few of the professionals who bridge APSAC and NCTSN.

Many of our joint efforts center on developing and disseminating trauma-focused interventions geared to helping abused and maltreated children. For example, NCTSN has sponsored both precolloquium institutes and a track at several APSAC colloquia, and it has promoted colloquia attendance by NCTSN members. Links to the NCTSN Knowledge Bank and other downloadable materials about NCTSN on its Web site were recently added to the APSAC site, and materials about NCTSN were distributed during APSAC's membership renewal drive. Discussions have begun about NCTSN members' participation in the revision of *APSAC Guidelines* and the *APSAC Handbook on Child Maltreatment, Second Edition*.

Promoting Evidence-Based Interventions

Developing and disseminating trauma-focused interventions is critical to NCTSN's mission. Over the past 5 years, NCTSN has taken a leading role nationally in promoting the development, evaluation, and dissemination of evidence-based mental health treatments. Evidence-based treatments are those that have been shown to have efficacy and effectiveness for alleviating those symptoms and/or conditions under study. Evidence-based interventions typically include (1) a treatment manual that lays out the therapy in clear-cut steps to ensure consistent implementation by practitioners in different settings, (2) standardized assessment batteries to guide and inform clinical practice, (3) systematic staff preparation and training, which includes ongoing consultation and supervision, and (4) ongoing evaluation to increase the effectiveness and efficacy of the treatment.

Although the federal government, major organizations, and many practitioners have been strong proponents of evidence-based interventions, the adoption of these approaches in "real world" settings has lagged behind. There have been barriers on both the organizational and individual clinician levels. Some clinicians believe that the available manualized evidence-based treatments do not adequately take into account the great variety and complexity of clients' individual histories and circumstances. They have questioned, for example, whether client populations in controlled studies match the client populations they serve. The children suffering from traumatic stress seen in direct practice settings often have complicated histories. Many have endured multiple traumatic events over the course of their lives and suffer ongoing disadvantages and adversities. Other critics of evidence-based treatments argue that interventions do not effectively consider the cultural differences in clients' understanding of trauma and their strategies to respond to and cope with trauma.

The NCTSN's collaborative framework provides a rare opportunity to understand and address these issues, and to bridge the gap between the professionals who develop these interventions and the practitioners who use them to deliver direct services. NCTSN brings together the developers of interventions, who are often from academic settings, with community-based clinicians to adapt, field test, evaluate, and refine interventions to better meet the needs of children suffering from traumatic stress. For example, Network centers are adapting cognitive behavioral treatments for use with various ethnic populations and with different types of trauma, and they are field testing these adaptations in a variety of practice settings. NCTSN has also addressed the organizational and implementation barriers to adoption of new interventions through a number of innovative projects and initiatives, such as learning collaboratives and the Breakthrough Series (see the following section, "Learning Collaboratives").

One important trauma-focused intervention disseminated widely by both NCTSN and APSAC is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Developed by NCTSN members Judith Cohen, MD, Anthony Mannarino, PhD, and Esther Deblinger, PhD, this treatment model has a particularly strong empirical base, having been evaluated in five large-scale controlled studies that included more than 500 sexually abused children. In the largest of these studies, over 80% of the children who received TF-CBT showed significant improvement in PTSD symptoms. These children also experienced significant improvement in depression, anxiety, behavior problems, and sexualized behaviors over 12 to 16 weeks of treatment, with gains sustained at follow-up.

TF-CBT is a structured treatment that involves the child's parent or supportive caregiver. It begins with *psychoeducation* about common trauma reactions. This helps to normalize the experience for children and their families and reduces shame and stigma. Another step,

affect regulation and relaxation training, helps the child cope with the unpleasant physical responses to traumatic stress (e.g., pounding heart, churning stomach) and emotional symptoms (e.g., fear, anxiety, jumpiness) and enables the child to talk more freely about the trauma without fear of these reactions. *Desensitization* is used when children continue to have intense reactions to the things, places, and people that remind them of the trauma. One of the most important elements of TF-CBT is the *trauma narrative*. By writing or drawing a coherent account of what happened, how it felt, and what it meant, children are more able to recover after a traumatic event. As part of this process, the therapist helps children identify and correct distorted and unrealistic ideas and beliefs about what happened. Often, in the case of abuse, these include self-blame, shame, and anger.

In addition to TF-CBT, the NCTSN is disseminating a number of other trauma-focused interventions. These treatments include the following: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (developed by David Kolko, PhD) and Life Skills Life Stories, an intervention for adolescent girls who have experienced multiple and/or sustained trauma in childhood or adolescence (developed by Marylene Cloitre, PhD). Parent-Child Interaction Therapy is a coaching intervention for parents with a history of physically abusing their children and was developed by Sheila Eyberg, PhD. The Component Therapy for Trauma and Grief Program is a manualized intervention that can be delivered in either individual or group modalities and in school-based or community clinic settings. Developed by Christopher Layne, PhD, Bill Saltzman, PhD, and Robert S. Pynoos, MD, for traumatized and/or traumatically bereaved youth ages 11-20, this intervention has been widely implemented around the world in such diverse settings as New York City following 9/11, postwar Bosnia, and multiple school districts in California. Outcomes have shown significant reductions in PTSD, depression, and complicated grief as well as improvements in children's school and social functioning. Another intervention, Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), developed by North Shore University Hospital in New York, is a group intervention for adolescents who have been exposed to chronic traumatic stressors. Cognitive Behavioral Interventions for Trauma in Schools (CBITS), which was developed by the RAND Corporation, the Los Angeles Unified School District, and UCLA, is a skills-based group intervention designed for school-based treatment. It is designed to relieve symptoms of PTSD, depression, and general anxiety among children ages 10-15. To help very young children whose traumatic stress often goes untreated, the NCTSN is disseminating Child-Parent Psychotherapy, a dyadic treatment approach for parents with infants, toddlers, and preschoolers who have witnessed domestic violence. It was developed by the Early Trauma Treatment Network at the University of California, San Francisco. (For more information on treatments that have been used by the NCTSN, see the fact sheets on Empirically Supported Treatments and Promising Practices at: www.nctsn.com/nccts/nav.do?pid=_top_trmnt).

Learning Collaboratives

After early efforts to train a variety of practitioners in TF-CBT and other evidence-based interventions and promising practices, the NCTSN recognized that training needed to address not only the learning needs of individual practitioners but also the organizational culture and barriers that interfered with effective implementation of an intervention. The NCTSN needed strategies to promote transfer of training so new learning would be fully and correctly utilized in the trainees' own direct practice.

The learning collaborative model is a novel strategy that enables organizations to make necessary changes to deliver and sustain effective practices. The NCTSN adapted this approach from a model developed by the Institute for Healthcare Improvement (for more information, see: www.ihi.org). The IHI model has been used in other healthcare milieus around the world to help organizations close the gap between the evidence base and everyday practice.

In February 2005, with support from SAMHSA, the NCTSN began a very ambitious and large-scale learning collaborative, the National Breakthrough Series on Trauma-Focused CBT. The Breakthrough Series was designed to enhance the speed and fidelity with which TF-CBT could be implemented, and to ensure that the knowledge and skills taught in training actually were used in service organizations. The Breakthrough Series represented the first time that learning collaboratives had been used to disseminate a mental health intervention, and it was the first use of this methodology in the field of child trauma.

to help law-enforcement officers respond effectively to domestic violence calls in which children are involved.

The Courage to Remember
This Web page (www.nctsn.org/nccts/nav.do?pid =typ_tg) includes one interactive video for general audiences and another (with a printable curriculum guide) for clinical professionals who work with grieving children and families.

Training and Education Opportunities
The NCTSN Web site contains information about numerous training opportunities (see: www.nctsn.org/training). Among them are upcoming learning collaboratives in which centers outside of the NCTSN may participate. For free online training in TF-CBT, you can also go to TF-CBTWeb at: tfcbt.musc.edu.

As part of its distance-learning program, NCTSN presents the Master Speakers teleconference series (www.nctsn.org/training/masters), in which the leading thinkers in the field of child trauma present lectures, share slides, and offer live answers to questions. Master Speakers teleconferences are open to the public (participants must register), and CEUs are available. The 2007 series on Trauma and Culture began in late February. Past lectures are also archived and can be downloaded.

Additional Web site resources include the following:

- Information about the NCTSN mission, vision, and history
- Contact information for NCTSN member sites
- Information on the types of traumatic stress
- Events calendar
- Doc Store, for ordering and shipping NCTSN-produced materials
- Materials on trauma and culture
- Spanish-language materials

If you have any questions or require any assistance with resources on the Web site, please contact: info@nctsn.org.

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Teams from 12 NCTSN grantee organizations across the country participated. During the course of the 9-month project, they received multiple, intensive, in-person training sessions, follow-up consultation, and technological support to facilitate sustained learning and sharing of progress. Each participating organization made rapid and significant changes in its organization, not only to adopt the intervention but also to ensure that once implemented, the new intervention would be supported and sustained over time.

For example, in some organizations, clinical supervision was reorganized into a group format to be more structured and specific to different treatment models. In others, productivity requirements were adjusted to allow additional time for training and supervision. Other organizations systematically educated their referral sources about the availability and benefits of evidence-based treatments. In all cases, changes were critical in creating organizational cultures that supported innovation and embraced evidence-based treatments.

Over the course of the Breakthrough Series, more than 400 children received TF-CBT. About 60 clinicians from participating sites continue to provide this intervention with fidelity to the model, and about 30 supervisors from the participating sites were trained and are now supervising other clinicians using the intervention. Leaders in several of the sites now provide ongoing incentives for staff to acquire competence and to use evidence-based trauma practices.

NCTSN has refined the framework used for the Breakthrough Series and customized it for subsequent learning collaboratives on both TF-CBT and other evidence-based and promising practices. Organizations within and outside of the NCTSN are now participating in these collaboratives.

Finding Common Threads

Training clinicians in specific evidence-based treatments is one way that the NCTSN works to improve the standard of care for traumatized children. Another approach is to look for the common therapeutic elements that have been shown to be effective across interventions and theoretical frameworks. Intervention developers now recognize that although many of the trauma and grief-focused interventions are unique in some respects, many also share common elements.

For example, a common *component* of evidence-based interventions is reliance on validated assessment measures to provide an accurate understanding of children's needs and circumstances, thereby allowing treatment to be tailored for each child served. Another common component of trauma-focused interventions is focus on skill building to increase children's emotional self-regulation and problem-solving skills. Many evidence-based interventions also include some form of systematic exposure to memories of what happened, which allows children to increase their ability to tolerate thinking and talking about the traumatic event and, ultimately, to react less intensely to trauma reminders.

The search for common elements of interventions can also extend to identifying common *concepts* that skilled interventionists should understand as they carry out their professional roles. Examples of these core concepts include developing an understanding about what posttraumatic stress and other common distress symptoms feel like to children and how they can interfere with daily life. Clinicians should also understand how difficulties with emotional regulation may influence children's behaviors and ability to function, and how trauma reminders may bring to mind upsetting memories of past experiences and unexpectedly evoke distress. Core concepts and core components are logically connected. For example, when clinicians understand that children exposed to trauma often experience difficulty with emotional regulation, they can incorporate into treatment plans specific strategies to teach children self-regulation skills.

The NCTSN plans to develop a core-concepts and core-components curriculum that will link the essential components of effective interventions and the essential competencies of effective professionals. Although still in its early stages, this project will ultimately provide training curricula for professionals in a variety of service sectors.

Acute Intervention for Terrorism and Disaster

Psychological First Aid is an example of a promising practice intervention being actively disseminated by the NCTSN. It was produced by the NCTSN and the National Center for PTSD and was developed by Melissa Brymer, PsyD, Anne Jacobs, PhD, Christopher Layne, PhD, Robert S. Pynoos, MD, Josef Ruzek, PhD, Alan Steinberg, PhD, Eric Vernberg, PhD, and Patricia Watson, PhD. The *Psychological First Aid Field Operations Guide, Second Edition*, is now available and can be downloaded from the NCTSN Web site. Psychological First Aid is an acute intervention delivered by mental health and other disaster-response workers who provide early assistance to affected children, families, and adults as part of an organized disaster-response effort. It is based on sound research as well as practical experience from the developers' years of work in disaster settings. The intervention is designed to reduce initial distress and foster healthy adaptive functioning. This approach has already been used successfully by professionals responding to Hurricane Katrina's displaced and traumatized children and their families, and data on this intervention are now being collected.

Reaching Out

Child trauma has consequences that extend far beyond the individual child and family's life. The long-term effects of unrecognized childhood trauma reverberate throughout society. And yet, the significance of child traumatic stress has been underrecognized and inadequately addressed. In partnership with APSAC, the NCTSN must reach beyond the usual borders of the mental health field to policy makers, child advocates, juvenile court justices, parents, activists, and members of the public who can help effect broad-scale change. Only then can the NCTSN fully meet its mission of bringing trauma-focused services to every child who needs them.

The following staff members contributed to this article:

Melissa Brymer, PsyD, Director of Terrorism and Disaster Programs, National Center for Child Traumatic Stress.

Christopher M. Layne, PhD, Director of Treatment and Intervention Development, National Center for Child Traumatic Stress.

Deborah Lott, MFA, Product Development Consultant and Writer for the National Resource Center.

Jenifer Maze, PhD, Managing Director of the National Center for Child Traumatic Stress.

Cybele Merrick, MA, MS, Project Manager for the National Resource Center.

Chris Siegfried, MSSW, Network Liason, National Center for Child Traumatic Stress

Jo Sornborger, PsyD, Postdoctoral Fellow, National Center for Child Traumatic Stress.

Steve Williams, MA. Executive Editor for the National Resouce Center.

Journal Highlights

Beth Ann Rodriguez, MSW
Tamara Davis, PhD
Judith S. Rycus, PhD

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute by 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 E-mail: JSRycus@aol.com.*

Child Welfare Practitioners' Engagement in Evidence-Based Intervention

This study was an effort to better understand the willingness and readiness of practitioners who are working with families involved in child physical abuse to engage in evidence-based practice. This small study of 77 practitioners from nine agencies used a combination of quantitative and qualitative methods to provide an overview of primary characteristics of child welfare practitioners that influence their acceptance of evidence-based interventions. The profiles included caseworkers' attitudes and beliefs, their treatment preferences, and how these might impact the implementation of evidence-based treatment in child maltreatment. Practitioners typically used family/systems therapy techniques and focused on family issues. Practitioners were not always clear in their understanding of treatment manuals or how to implement treatments guided by formal manuals. Although practitioners thought treatment manuals were important, respondents reflected a mix of attitudes toward actual use of manualized interventions. The study also attempted to relate elements of organizational climate to practitioners' engagement in evidence-based interventions, but findings were inconclusive. The researchers conclude that researchers and community agencies providing services to maltreated children must collaborate if evidence-based treatments are to be effectively disseminated and implemented.

Baumann, B. L., Kolko, Collins, K., & Herschell, A. D. (2006). Understanding practitioners' characteristics and perspectives prior to the dissemination of an evidence-based intervention. *Child Abuse & Neglect, 30*(7), 771-787.

Neighborhood-Based Foster Care

In this article, Berrick challenges the notion that placing foster children back into their local communities is always in the children's best interest. She provides a review of the empirical literature describing the effect of high- versus low-poverty neighborhoods on the well-being of children, and she critically discusses the significance of neighborhoods in terms of child abuse and neglect risk factors and ultimate placement outcomes of children and youth. While acknowledging the benefits of neighborhood-based foster care, which include minimizing disruptions in education and peer friendships, maintaining cultural connections, and increasing potential for parental visitation, the author also argues that research suggests that these factors appear to be less critical for younger children and are more relevant for older children and youth. The author further suggests that neighborhood-based placements are less important for the 50% of children in foster care who are never reunified with their families because their chances of returning to their neighborhoods are lower. The author notes additional research suggesting there may be some benefits for children who move from higher- to lower-poverty neighborhoods. The author argues for a more balanced approach to neighborhood-based placements, whereby placement decisions should be more concerned with the characteristics of the family with whom the child is placed than with the particular location of the placement.

Berrick, J. D. (2006). Neighborhood-based foster care: A critical examination of location-based placement criteria. *Social Service Review, 80*(4), 569-583.

Using Intensive Family Preservation With Adoptive Families

The Adoption Assistance and Child Welfare Act of 1980 and the Adoption and Safe Families Act of 1997 have contributed to an increase in the number of adoptions of children with special needs, including older children, sibling groups, children from minority races and/or ethnicities, and children with behavioral, emotional, and/or medical needs. This study explored the use of intensive family preservation services with adoptive families of children with special needs in Missouri. The authors studied factors that influenced the ability of adoptive families to remain intact after the termination of formal agency services. The researchers used multiple regression analyses to determine which factors contributed to the intactness of families at 6 and 12 months posttermination of services, thereby offering insights into the characteristics of children and adoptive families that impact adoption outcomes. Their prediction model included four factors: child characteristics, family characteristics, child's previous placement history, and service characteristics. At the 6-month postservice interval, the researchers found that the strongest predictors of a family remaining together were child and family characteristics (i.e., ethnicity of child, employment of parent) and child's initial reason for placement. At the 12-month interval, all four factors of the model contributed significantly to family preservation, but service characteristics were the greatest predictors of the family's ability to remain together.

Berry, M., Propp, J., & Martens, P. (2007). The use of intensive family preservation services with adoptive families. *Child and Family Social Work, 12*(1), 43-53.

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Child Neglect and Poverty

Child neglect is the most prevalent form of child maltreatment in this country. The authors of this article used data from the 1994 *National Study of Protective, Preventive, and Reunification Services Delivered to Children and Their Families* to approximate the effects of parental characteristics on both child neglect and on several poverty indicators that have been previously linked to substantiated physical neglect. In this study, physical neglect was defined as "a parent or caregiver not providing the child with basic necessities (e.g., adequate food, clothing, shelter, and hygiene)" (p. 111). The correlational analyses found associations between poverty and substantiated physical neglect, but logistic regression analyses showed that none of the poverty-related variables was statistically significant in predicting physical neglect. The study also found that families who were involved in the WIC program were less likely to physically neglect their children. This finding was attributed to the success of the WIC program in achieving positive child health outcomes and behavioral changes in mothers to engage in child wellness practices. Finally, the study found that primary caregivers with substance abuse or mental health issues were twice as likely to have their cases substantiated for physical neglect. Although some associations between poverty and child neglect were suggested in correlation analyses, none of the poverty variables was a statistically significant predictor of child neglect.

Carter, V., & Myers, M. R. (2007). Exploring the risks of substantiated physical neglect related to poverty and parental characteristics: A national sample. *Children and Youth Services Review, 29*(1), 110-121.

Parent Mentors in Child Welfare

In this article, Cohen and Canan describe the Parent Partner Program in California, which was designed to integrate parent mentors into the routine process of serving families in the child welfare system. Parent Partners are individuals who have personally experienced involvement of the child welfare system in their families. They are assigned to work with the birth parent(s) of children at the time of the initial placement hearing. The Parent Partners Program is modeled after other peer support and advocate programs, wherein peers play a key role in helping families successfully navigate the complexities of a social service system. This article describes the program's structure and its implementation in one region of the state. Discussion includes both the challenges and positive influences of the program on child welfare workers, parents, parent mentors, and the organization itself. The program's relationship to improved child and family outcomes is noted as an area in need of future research. Information gathered to date indicates the program offers promise for improving the interaction between child welfare agencies and families.

Cohen, E., & Canan, L. (2006). Closer to home: Parent mentors in child welfare. *Child Welfare, 85*(5), 867-884.

Effective Helping Relationships in Child Welfare

This article reports the findings from a qualitative study conducted in Canada which was designed to identify key attributes and practices of child welfare workers that contributed to positive relationships with their clients. The study was based on prior research findings that established the importance of the helping relationship in child welfare practice. Six worker-client dyads, which had been identified as having good relationships, participated in five semistructured interviews, resulting in a total of 30 interviews. Researchers used a back-and-forth interview process that allowed workers and clients to respond to each other's input, thereby eliciting "co-authored stories" of their relationship development process and its perceived impact. The analysis revealed two primary themes about attitudes and actions of workers that contributed to positive worker/client relationships: "(1) soft, mindful and judicious use of power; and (2) humanistic attitude and style that stretches traditional professional ways-of-being" (p. 35), which included going beyond responsibility to simply assure child safety by providing personal emotional support for the family, working with parents after termination of parental rights, and finding material resources for families, The authors conclude by suggesting three specific considerations for identifying, hiring, and training child welfare workers. First, individuals must possess abilities to develop relationships with clients. Second, workers must be trained in how to maintain good helping relationships with clients of the child welfare system. Last, child welfare supervision should include assessments of worker relationships with clients and incorporate monitoring and accountability of worker capacities in maintaining supportive, positive helping relationships with clients of the child welfare system.

de Boer, C., & Coady, N. (2007). Good helping relationships in child welfare: Learning from stories of success. *Child and Family Social Work, 12*(1), 32-42.

Wraparound Services in Child Welfare

As the title suggests, this article provides a descriptive and contextual understanding of the development of wraparound services in child welfare. The author first discusses the history and definition of wraparound as it was initially developed in the field of children's mental health. Key legislation and publications leading to systems change efforts describe the context for simultaneously implementing wraparound in children's mental health care, while also working to change systems to better integrate all of the public children's service systems. Noting that mental health and child welfare systems share similar service populations and a common philosophical focus on family-centered services, the author discusses how changes in child welfare legislation and resulting program development provide a good fit and fertile ground for wraparound's emergence in child welfare services. The author describes wraparound as part of a continuum of the established Family Support, Family Based Services, and Intensive Family Preservation Services. Wraparound is distinguished as an approach that emphasizes informal services, flexible funding, a "less prescriptive" service process, and unlimited length of participation. In the California example used in the article, wraparound also assumes a more child-centered than family-centered approach. The

author notes only two controlled studies of wraparound in child welfare and suggests that wraparound's sustenance in child welfare will be determined by further demonstration of its effectiveness.

Ferguson, C. (2007). Wraparound: Definition, context for development, and emergence in child welfare. *Journal of Public Child Welfare, 1*(2), 91-110.

Social Work Education and Child Welfare

This article describes a study across human service-related disciplines to determine which baccalaureate educational program appears to best prepare graduates to assume jobs as public child welfare case managers in Indiana. Research methods included surveys and focus groups, and content analysis of Indiana's child welfare policies and training competencies. The state's child welfare policies and training competencies were reviewed, and data from both line staff and supervisors were gathered to identify the skills necessary for case managers. Baccalaureate program directors were then engaged in matching identified competencies against their respective educational programs. Findings indicate that social work programs were the best fit with the values, theory, knowledge, and skills required for child welfare case managers. The applied nature of social work programs, which use more structured and supervised practicum experience in the child welfare setting, better prepared graduates and promoted mastery of the requisite competencies to do the work.

Folaron, G., & Hostetter, C. (2007). Is social work the best educational degree for child welfare practitioners? *Journal of Public Child Welfare, 1*(1), 65-83.

The Community Norms of Child Neglect Scale

In 2004, the U.S. Department of Health and Human Services reported that child neglect has the highest incidence rate of all types of child maltreatment. The first step in addressing the issue is to discern the perceptions of individual community members about child neglect, but little attention has been given to identifying these perceptions. This article describes the development and validation of an instrument called the Community Norms of Child Neglect Scale (CNCNS), which was developed to measure individuals' perceptions of child neglect. The measure was developed based on a classification approach recommended by Barnett, Manly, and Cicchetti (1993), in which they identified four types of child neglect: "failure to provide, physical neglect-lack of supervision, emotional maltreatment, and moral, legal, or educational maltreatment" (p. 69). The authors tested the instrument with practitioners and lay community people in rural and urban areas. The results suggest that this scale may be helpful in eliciting and comparing perceptions of child neglect among individuals and communities.

Goodvin, R., Johnson, D. R., Hardy, S. A., Graef, M. I., & Chambers, J. M. (2007). Development and confirmatory factor analysis of the Community Norms of Child Neglect Scale. *Child Maltreatment, 12*(1), 68-85.

Children's Perspectives of Kinship Care Placements

"Kinship care is a living arrangement in which a relative or another person who is emotionally close to a child takes primary responsibility for raising that child" (p. 1415). According to the 2000 U.S. Census, 6 million children are being raised by grandparents or other relatives in formal and informal kinship care. Informal kinship care has been a part of the tradition in this country for many years. In recent years, however, the child welfare system has recognized the value of kinship care resources within the foster care system. This small research study provides a descriptive analysis of kinship care from the perspectives of 40 children placed in kinship care. The researchers held eight focus groups in which children offered and discussed their perspectives on transitional issues, family relationships, the stigma of being in care, and stability of their placements. Transitioning into kinship care did not appear to bring about substantive challenges to children's adjustment. While they expressed fear of entering the child welfare system, children described what the author termed "fluidity" in their families and expressed that living with a relative reduced the stigma they felt in being separated from their biological parent(s). They expressed comfort in being legally tied to their guardians. At the same time, children expressed anger and disappointment, especially toward their mothers, for not showing up for visits and for unsatisfactory visits. Children further verbalized disappointment in their biological parents' inability to care for them but maintained hope for living with their parent(s) again in the future.

Messing, J. T. (2006). From the child's perspective: A qualitative analysis of kinship care placements. *Children and Youth Services, 28*(12), 1415-1434.

Substance Abuse Treatment in Child Welfare

Nearly half of the children found to be abused and neglected in 1995 had caregivers who abused alcohol or other drugs. Substance abuse has a negative effect on parenting practices and increases the risk of child maltreatment. Children of substance abusing caregivers are more likely to stay in foster care for long periods of time and are less likely to be reunified with their caregivers. Child welfare agencies have begun to explore the integration of child welfare services and substance abuse services to better meet the needs of children and families. This study used an experimental design to examine the effectiveness of a service integration model that used intensive case management to integrate substance abuse services and child welfare services. Over 700 families were randomly assigned to either the experimental group (receiving regular services plus intensive case management and a recovery coach) or a control group (treatment as usual—substance abuse assessment, referrals for services, and monitoring compliance and encouraged ongoing treatment participation). The study focused on two specific outcomes: family reunification and substance abuse services. The study found that the recovery coach program goal of moving participants into treatment more quickly was met with a significantly greater number of recovery participants gaining quicker access to substance abuse treatment than the control group. The study found that, overall, 12% of the families who received the recovery coach model of services were better able to access substance abuse treatment and were more likely to achieve family reunification compared with 7% of families in the control group who achieved reunification. It further found that the cost for implementing the recovery coach program was cost neutral when compared with services as usual.

Ryan, J. P., Marsh, J. C., Testa, M. F. & Louderman, R. (2006). Integrating substance abuse treatment and child welfare services: Findings from the Illinois Alcohol and Other Drug Abuse Waiver Demonstration. *Social Work Research, 30*(2), 95-107.

Message From the President

One of the goals of the APSAC Board has been to encourage members' involvement in the organization. We have approached this in a number of ways, including working hard to foster and support state chapters, soliciting input from a membership survey, and encouraging members to tell us about their needs and expectations regarding APSAC. We have also actively sought volunteers to participate on APSAC committees.

These efforts have been successful, and we continue to seek active membership participation and input. Our newest effort involves the *APSAC Advisor*. We are interested in letting our members know about other members—their work, their challenges, and their achievements. Communication "within the trenches" helps spread innovative ideas, define specific problems related to work, and combat the isolation many of us experience as we struggle with our daily challenges and frustrations. Professionals all over the country experience similar, as well as unique, problems as they tackle the varied aspects of child maltreatment work. Although communication among professionals certainly occurs at national and state conferences, these opportunities are relatively limited, and for those not able to attend meetings elsewhere in the country, they are not available at all. When I talk to colleagues, I am constantly surprised and encouraged to learn of programs, strategies, and innovations developed by individuals, groups, agencies, and states. I will often take these ideas and try to apply them in my own community (with or without success). This type of information exchange is invaluable in making others and myself more effective in our work. The *Advisor* provides a convenient vehicle to spread such information, accessing a large organization with geographically and culturally diverse members.

With this in mind, I ask you to submit a description of some aspect of your work or that of a colleague. You may want to describe a newsworthy accomplishment—a new program being developed by your office, or a community protocol recently completed, for example. Perhaps there is an ongoing challenge within your community for which local professionals have not been able to identify a solution. Chances are the same problem has affected other communities, and someone may have come up with a solution (which we can publish in the next *Advisor*). Submissions can be short (a single paragraph) or long (up to 1,000 words).

We also plan a regular *Advisor* column to highlight a professional within the organization who is doing particularly good work. This person need not be someone with a national reputation. Perhaps she is an extremely dedicated therapist, or he is the most diligent investigator in the squad. Maybe that person is you. We need you to help us identify those people and tout their achievements. Let us know by sending information you think best portrays this person and his or her contributions to child maltreatment work. Photographs are always welcome, of course.

Please submit your pieces to Ron Hughes, Editor of the *Advisor*, at: rhughes@ihs-trainet.com

Jordan Greenbaum, MD
APSAC President

Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

BUSH BUDGET PROPOSES FREEZE IN FY08 CHILD WELFARE FUNDING

The President's fiscal 2008 budget, sent to Congress on February 5, freezes funding for most services for children and families at the 2006 levels. (One week after receiving the Administration's budget proposal, Congress finally completed action on a fiscal 2007 spending resolution to fund federal programs for the rest of the current fiscal year at the 2006 spending levels.) With the exception of $10 million in additional spending proposed by the President for Child Abuse Prevention and Treatment Act (CAPTA) discretionary grants directed at a new initiative to fund nurse home visitation services, most federal child welfare programs directed toward prevention of child maltreatment are being held at 2006 funding levels. In the administration's funding request, CAPTA's basic state grants are held at $27 million, and the Community-Based Child Abuse Prevention Grants remain at $42 million.

This budget request also freezes funding for Title IV-B(1) child welfare services and Title IV-B(2) Promoting Safe and Stable Families at current levels. The Title XX Social Services Block Grant has been cut by $500 million in the budget proposal. Over 40% ($700 million) of Title XX money goes for child welfare services, including programs to prevent and treat child abuse and neglect.

Other children's programs fare no better. The State Child Health Insurance Program (SCHIP) is tagged with a proposed increase of $4.2 billion over 5 years, which actually would have the effect of reducing the number of children who are covered. An estimated $15 billion over the next 5 years would be needed just to maintain the current levels of coverage for half of the 12 million children who lack health insurance, without extending benefits to the 6 million not now included. Medicaid and Medicare are also proposed for spending reductions.

For the sixth year in a row, President Bush is proposing a hold on child care funding. At the current spending level, only one in seven eligible children will get child care assistance. When inflation is added to the spending freeze, reduced funds would mean that 200,000 fewer children would be covered by child care assistance in 2008, on top of 150,000 lost since 2000 due to the pressures of inflation.

Likewise, the budget request from the White House would freeze Head Start funding in 2008. Head Start currently serves only about half the eligible preschool children; Head Start serves fewer than 3% of eligible infants and toddlers.

Defense spending in the President's budget would increase by 11% over 2007 and would be 60% more than the defense budget President Bush inherited in 2001.

The House and Senate budget committees will develop their own budget proposals expected for floor action in March. The congressional budget resolution, which does not require the President's signature, provides the broad spending guidelines for the individual funding decisions to be made by the appropriations committees later this spring.

MID-TERM ELECTIONS: IMPACT ON CHILD PROTECTION ISSUES

The November 7 election results produced significant changes in Congress with the Democrats gaining majorities in both the House and the Senate. Although the impact of these changes on the politics of child protection remains to be seen, it is worth observing that the voting records of the new Democratic leadership elected in the House and Senate score considerably higher on children's issues than those of their Republican predecessors. The same is true for those Democratic Representatives and Senators who have assumed the chairs of committees and subcommittees charged with making decisions on policy and funding for programs serving children and families.

What's more, a significant number of the newly elected federal legislators ran campaigns focused on improving the lives of America's children. Some of the new faces in the House—such as Rep.-elect Gabrielle Giffords (D-AZ), Kathy Castor (D-FL), Heath Shuler (D-NC), and Nick Lampson (D-TX)—ran on issues important to children, especially children's health care. The same is true for two of the newly elected Senators, Amy Klobuchar (D-MN) and Bob Casey (D-PA). Sen.-elect Claire McCaskill (D-MO) comes to Washington with experience as a board member of the CASA (court-appointed special advocate) program. One new House member, Rep.-elect Carol Shea Porter (D-NH), is a former social worker.

Still, much will depend upon contacts made by constituents with their Representatives and Senators to impress upon them the important role played by federal policies and funding in serving children and families back home.

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SENATE PANEL APPROVES HEAD START BILL WITH ATTENTION TO CHILD ABUSE PREVENTION

Legislation to reauthorize Head Start services was approved on February 14 by the Senate Committee on Health, Education, Labor, and Pensions. The Head Start for School Readiness Act (S. 556), introduced by committee chair Sen. Edward M. Kennedy (D-MA) with Sens. Christopher Dodd (D-CT), Mike Enzi (R-WY), and Lamar Alexander (R-TN), would extend funding for Head Start for the next 3 years, that is, through 2010.

The measure was introduced with the bipartisan support of the authorizing HELP Committee leadership, and it includes a group of amendments drafted and proposed by the National Child Abuse Coalition. The amendments recognize that abused and neglected children and children at risk of maltreatment and in need of preventive services can benefit from Head Start and Early Head Start services. Reflecting the role that Head Start can, and does, play in this regard, the amendments address the following themes:

- Greater attention to serving children who have been mal treated or are at risk of abuse or neglect
- Greater attention to the training needs of parents (especially in Early Head Start)
- Improved coordination with existing home-based services
- Improved collaboration with the state agency responsible for child welfare services and child protective services

The Coalition's Head Start amendments have also been proposed to the House Committee on Education and Labor for consideration in drafting its version of the Head Start reauthorization legislation.

MENTAL HEALTH PARITY BILL PASSED BY SENATE COMMITTEE

At its meeting on February 14, the Senate HELP Committee also voted approval of S. 558, the Mental Health Parity Act of 2007, sponsored by Sen. Pete V. Domenici (R-NM), to require equal treatment for mental and physical health conditions covered by health insurance plans. Sens. Kennedy and Enzi joined Domenici in introducing the legislation.

The measure, which has been introduced in previous Congresses but never passed by both House and Senate, would require insurers who offer mental health coverage as part of their health insurance packages to make such coverage in their plans equal to the coverage for physical illnesses.

Some 30 states already have mental health parity laws. The Senate bill would exempt from the law those businesses with fewer than 50 employees. In addition, the bill would allow insurers to opt out if they found their costs rising significantly. It is estimated that the legislation would provide mental health parity for about 113 million Americans.

The bill would also provide parity for financial requirements such as deductibles, co-payments, and annual and lifetime limits, as well as parity for treatment limitations such as the number of covered hospital days and visits.

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.

In Memoriam: Jay M. Whitworth, MD

Jay M. Whitworth, MD, one of the pioneers in child abuse, passed away suddenly September 9, 2006, while in London after attending a conference of the International Society for the Prevention of Child Abuse and Neglect. Jay was one of the top forensic pediatricians in the world for nearly three decades—noted as much for his mentorship and modesty as his expertise. His death, in his favorite city and just as he was characteristically finishing up E-mail at an Internet café, ended a superb career.

Born May 11, 1938, in Pendleton, Indiana, Jay was a graduate of Indiana University School of Medicine. He completed his pediatric residency and a fellowship in Pediatric Nephrology at Johns Hopkins Hospital in Baltimore. He came to Jacksonville in 1969 and was initially in private practice, but he then joined the University of Florida-Jacksonville as Chief of Pediatric Nephrology, where he developed the first renal dialysis program in Northeast Florida. Having an agile mind and multiple interests, he served in many departmental roles.

In the mid 1970s, he developed an interest in protecting children who were sexually and physically abused, which became his professional passion for the rest of his career. His initial introduction to child abuse was as hospital consultant—the community physicians' theory being that if sexual abuse involved the genitals, these were at least close to the kidneys. Thin logic or not, Jay became increasingly fascinated by the complexities of such cases and the harm suffered by the children. Ray Helfer provided additional personal inspiration to Jay, as was true for a number of pediatricians of the era.

Jay was one of the first in the country to bring together multidisciplinary teams of professionals to better diagnose and make recommendations for abused children. With the support of the Florida Pediatric Society and the Florida Medical Association, Jay sought legislation to begin a pilot multidisciplinary program in Jacksonville in 1978. He developed this concept into Florida's statewide Child Protection Team system and served as the Statewide Medical Director until 2004. The Child Protection Team system now consists of 23 medically led teams who review all child abuse reports and who interview and medically examine those at highest risk. The CPT system in Florida is considered to be the premier statewide approach to child abuse with sophisticated quality assurance review, the most advanced telemedicine system, and a large number of medical child abuse providers. Unique among the states is that the Florida CPT system is located within Children's Medical Services—reflecting Jay's belief that child abuse is primarily a health problem with profound implications for health at all ages. Jay was awarded, among many other honors, a Lifetime Achievement Award by the American Academy of Pediatrics in 2004.

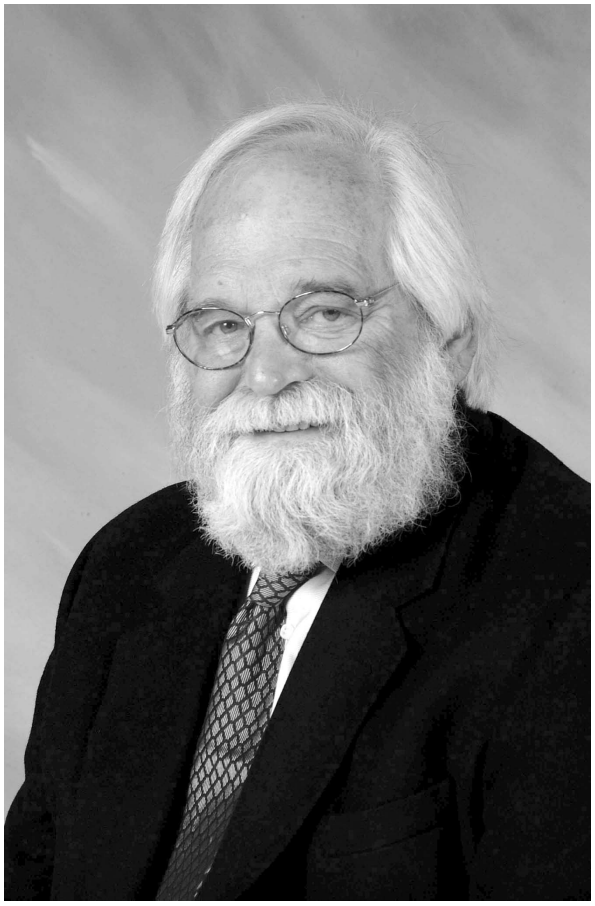
Jay trained physicians and other medical professionals, as well as nonmedical professionals, extensively within Florida, the United States, Europe, Asia, and South America on child abuse issues. He introduced child abuse prevention to China and lectured in Colombia, England, and Ireland. In addition, he served on a number of national child abuse committees, including those of the American Academy of Pediatrics, where he did considerable work to develop child abuse as a new pediatric subspecialty.

Jay was the author of nine textbook chapters on child abuse, multiple other publications, and coauthor of the national guidelines for evaluation of child physical and sexual abuse for the American Medical Association and the American Academy of Pediatrics. For the last 10 years, he was a national leader in the development of telemedicine for child abuse assessments.

Jay will be remembered as a gentle mentor with high standards, one of the most innovative thinkers in the field, and an untiring champion for children who are hurt and helpless. While he often joked that part of his success in obtaining state funding was that legislators couldn't easily say "no" to "Santa Claus"—it is clear to those who knew him that Santa Claus once walked among us.

In appreciation of Dr. Whitworth's tireless efforts and his endless contributions to children, Florida's statewide Child Protection Team system, and the community, a fund has been established in his name. Donations may be made to the J. M. Whitworth Memorial Fund, 1650 Prudential Drive, Suite 100, Jacksonville, Florida, 32207. The proceeds of this fund will be used to help underserved, abused children and to further the causes to which Dr. Whitworth dedicated his life.

Randell Alexander, MD, PhD



STATE CHAPTER NEWS
Web Meetings Make Continuing Education Accessible for WIPSAC Members

Raelene Freitag, PhD, MSW

Continuing education (CE) is essential for many APSAC members to maintain professional licenses. More important, APSAC members' commitment to professionalism demands that we keep abreast of the latest research affecting our practice. However, CE can be costly and require time away from our clients. The Wisconsin chapter of APSAC, called WIPSAC, recently began a series titled "Lunch at Your Desk and Learn," which provides brief (60 minute) CEU-eligible sessions that professionals can access without leaving their offices. WIPSAC's continuing education is offered at no cost to participants.

Lunch at Your Desk and Learn is modeled on WIPSAC's longstanding and very successful "Lunch and Learn" series. Two locations in Milwaukee and one in Madison have provided CE sessions for several years. This series reaches hundreds of Wisconsin professionals and provides excellent professional education. WIPSAC is organized around the principal mission of being a resource for CE. The current year will offer over a dozen sessions, such as "Quality Standards for Licensing Foster and Adoptive Homes" and "Matter in Motion: Abusive Head Trauma."

The new Lunch at Your Desk and Learn series is offered in addition to existing Lunch and Learn sessions. The new series is unique in several key ways. Lunch at Your Desk and Learn is accessible to professionals throughout the state, even in distant rural areas. All that is needed is a telephone and a computer with Internet access. Lunch at Your Desk and Learn also focuses on research. Each session references one article from a recent APSAC publication, either from the journal *Child Maltreatment* or the *APSAC Advisor*. Each individual session provides an overview of the article, a 5-minute *stat review*, which features one design or analytic methodology employed in the article, and a discussion period. Whenever possible, the author(s) of the selected article are invited to participate in the session.

Lunch at Your Desk and Learn accomplishes several key objectives:

- Increases accessibility to research, which in turn supports evidence-based practice
- Strengthens practitioners' skill as consumers of research literature through the 5-minute stat review
- Increases awareness of APSAC, WIPSAC, and APSAC's fine publications
- Provides convenient CE opportunities for participants

The most recent Lunch at Your Desk and Learn featured a recent article from the *APSAC Advisor*, entitled "Delivering Parent Training to Families at Risk" (Spring 2006). Primary author Brad Lundahl graciously agreed to participate and was available to respond to questions from participants. The 5-minute stat review discussed methods for conducting meta-analysis.

The technology for Lunch at Your Desk and Learn is surprisingly affordable and easy to use. WIPSAC uses GoToWebinar. WIPSAC collaborates with a nonprofit organization, the Children's Research Center in Madison, which holds licenses for GoToWebinar. As a result, there is no direct cost to WIPSAC to offer the series. Once access to a Web-meeting service is secured, the meeting organizer arranges the meeting. GoToWebinar automatically generates an E-mail announcement and manages registration. Participants simply click a link in the E-mail to register. They are then provided with instructions to access a conference call number and to log-in to a designated Web site at the appointed time. There is no cost to participants other than any cost associated with the log-in telephone call.

WIPSAC's experience with Lunch at Your Desk and Learn is new, and certainly the series will evolve as WIPSAC learns how to make the most of this exciting technology. Early experience indicates that there is tremendous potential for using Web meetings to reach members, to provide continuing education, and to increase interest in APSAC and its state chapters.

For information on GoToWebinar, visit: www.GoToMeeting.com.

WIPSAC invites APSAC members to be our guests for the next Lunch at Your Desk and Learn.

Take this opportunity to see what it's like, and maybe decide to start one for your state chapter.

DATE: Friday, April 27, 2007
Time: 12:00-1:00 CST

This Webinar will feature the article "Constructive Uses of Risk: The Promise and Peril of Decision-Making Systems in Child Welfare" from the *APSAC Advisor, 18*(4), Fall 2006. The authors, Aron Schlonsky and Liz Lambert from the University of Toronto, will be online for discussion. We have applied for CLE.

To register, go to:
www.gotomeeting.com/register/436353565
and follow the instructions.
After you register, you will receive an E-mail and can log-in to the session.

About the Author

Raelene Freitag, PhD, MSW, is Executive Director of the Children's Research Center (CRC) in Madison, Wisconsin. CRC uses research to develop empirically-based tools to improve decision making in child welfare and juvenile justice. CRC's many products include the Structured Decision Making (SDM™) model of safety and risk assessment and the JAIS assessment protocol for use in juvenile justice.

APSAC 15th Annual Colloquium to Be Held in Boston

The Annual Colloquium is APSAC's premiere training and networking event. Scheduled every summer, the colloquium brings together child advocates and child maltreatment professionals from a variety of practice perspectives and disciplines to present and share up-to-date information on research, practice, and education related to child abuse and neglect.

The 15th Annual Colloquium will be held in historic Boston, Massachusettes, at the Boston Marriott Copley Place Hotel. This year's colloquium offers a wide variety of events, including APSAC's Advanced Training Institutes, the 10th annual Cultural Institute, the William Friedrich Memorial Lecture, a membership luncheon and awards ceremony, poster presentations of exemplary and innovative work in research, practice, and program development, and over 100 individual workshop sessions with topics that span the entire spectrum of child maltreatment.

This year's Pre-Conference Advanced Training Institutes are full-day workshops presented by highly skilled and respected professionals in the field of child maltreatment. The primary sessions are *Trauma-Focused Cognitive Behavioral Treatment for Traumatized Children and Their Families* (Anthony Mannarino, PhD & Judith A. Cohen, M.); *Child Abuse in a Medical Setting/Current Controversies in the Diagnosis of Abusive Head Trauma* (Carole Jenny, MD, MBA, Thomas Roesler, M.D. & Peter Evangelista, MD); and *Integrating Directive and Nondirective Approaches in Treatment for Traumatized Children: One Size Does Not Fit All* (Eliana Gil, PhD).

Reflecting the diversity of APSAC members, many of the workshop presentations are cosponsored by other national organizations involved in the prevention, identification, and treatment of child abuse and neglect, including the National Child Traumatic Stress Network (NCTSN), the International Society on the Prevention of Child Abuse and Neglect (ISPCAN), and the Office of Juvenile Justice and Delinquency Prevention (OJJD).

Further reflecting APSAC's interdisciplinary focus, Continuing Education Credits (CEUs) will be awarded for psychology, counseling, social work, marriage and family therapy, drug and alcohol abuse counselors, nursing, play therapy, law, law enforcement, and continuing medical education (CME). Certificates of attendance for nonlicensed professionals are available free of charge at the conclusion of the conference.

As if the conference didn't offer enough to keep participants sufficiently occupied, the historic city of Boston offers a multitude of opportunities for both pleasure and learning. Conference attendees can experience the birthplace of colonial America and the American Revolution by visiting colonial sites such as Boston Harbor (of Tea Party fame) or the Old North Church, where lanterns hung in the steeple signaled the direction of the advancing British troops. History buffs will also appreciate that the church houses the oldest church bells in North America. Visit Paul Revere's home. Walk the Freedom Trail. See Boston Common, New State House, Park Street Church, Granary Burying Grounds, King's Chapel, the first public school site, the Old Corner Bookstore, Old South Meeting House, Old State House, Boston Massacre Site, and Faneuil Hall.

15th Annual APSAC Colloquium

July 12-14, 2007
Boston Mariott Copley Place Hotel

Colloquium Features:

- *Wednesday, July11th - Institute on Cultural Considerations in Child Maltreatment*
- *Wednesday July 11th -Advanced Training Institute*
- *Field-generated skills-based training, research, poster presentations, and symposia*
- *Networking opportunities with other professionals and APSAC members in your area*

For more information on the Colloquium, contact:
APSAC Colloquim/Jim Campbell
123 Main Street, Box 119, Sun Prairie, WI 53590
Phone: 608-772-0872, or E-mail: apsaccolloquim@charter.net, or Visit: www.apsac.org

Cont'd on page 30

Key Moments in Boston's History

1620 - Puritans arrive at Plymouth, MA

1630 - Boston established as capital of Massachusetts Bay Company's colony, John Winthrop, Governor

1635 - Boston Latin School established, the first public high school in America

1636 - Harvard College founded

1640 - Population of Boston 1200

1706 - Benjamin Franklin born in Boston on January 17

1770 - The Boston Massacre

1773 - Boston Tea Party – colonists angered over taxes dump 342 containers of tea into Boston Harbor

1775 - Paul Revere dispatched to warn colonists of pending British attack, "shot heard round the world" on Lexington Green begins American Revolution

1822 - The Town of Boston becomes the City of Boston

1826 - Doors open at the Union Oyster House, which is the oldest restaurant in Boston, and the oldest restaurant in continuous service in the US

1838 - Founding of Boston Police Department, the oldest in the country, and the first paid, professional public safety department

1862 - The Oneidas of Boston established as the first organized soccer club in America

1872 - The Great Boston Fire destroyed 776 buildings

1912 - Opening of Fenway Park, built especially for the Red Sox

1918 - Red Sox win the World Series for the second year in a row, led by baseball great, Babe Ruth

1942 - Coconut Grove fire, resulting in the death of 490 people and injury to 166

1950 - Famous Brink's robbery in the Brink's Garage on Commercial Street

2000 - Population of Boston: 589,141

2007 - APSAC's 15th Annual Colloquium to be held in Boston

Hungry? Boston is unsurpassed for its fine eateries, and particularly for world-renowned seafood restaurants. Thirsty? Try touring the Samuel Adams Brewery.

For art and science aficionados, there's always the Museum of Fine Arts, one of the country's oldest and finest, with a large, diverse collection and a unique representation of art from the time of the American Revolution. The Museum of Science offers the Charles Hayden Planetarium, the Theatre of Electricity, a dinosaur exhibit featuring an updated 39-foot long T-Rex and her scaly-skinned friends, and a Van de Graaff generator that creates a lightning storm so intense you can reportedly smell the ozone. Bringing the kids? They'll be occupied for hours at the many exhibits designed especially for children, leaving their professional parents to immerse themselves without guilt in child maltreatment education.

There's a great deal to discover nearby as well—Cambridge and Harvard University across the Charles, Lexington Green, the quaint fishing village of Rockport, and of course, Cape Cod and Martha's Vineyard. July is a great time for a family vacation…

For a complete program description, registration instructions, and lodging information, you can download the conference brochure in PDF format from the APSAC Web site (www.apsac.org). The link is located on the home page in the top right corner. Or, E-mail apsac@comcast.net and request a copy.

For those of us old enough to remember Dave Loggins, or young enough to know who Kenny Chesney is, "Please come to Boston…" says it all. Hope to see you there—it will be well worth your while.

April 15-18, 2007
Reconciliation in Child Welfare: Touchstones of Hope for Indigenous Children, Youth, and Families
National Indian Child Welfare Association
Oklahoma City, OK
Call: (503) 222-4044, or Visit: www.nicwa.org
or E-mail: info@nicwa.org

April 16-21, 2007
16th National Conference on Child Abuse and Neglect
U.S. Department of Health and Human Services, ACYF
Portland, OR
Call: (703) 528-0435, or E-mail: 16conf@pal-tech.com

May 2-4, 2007
The 14th Annual National Foster Care Conference
Daniel Memorial Institute
St. Petersburg, FL
Call: (904) 296-1055, or (800) 226-7612 or
Visit: www.danielkids.org/sites/web/content.cfm?id=275

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

May 14-16, 2007
7th Annual International Campbell Collaboration Colloquium
London, England
Visit: campbellcollaboration.org

June 6-9, 2007
2007 Conference on Family Group Decision Making
Washington, DC
Call: (303) 792-9900
or Visit: www.americanhumane.org/site/PageServer

June 9-12, 2007
National CASA's 30th Anniversary Conference
National CASA Association
Orlando, FL
Call: (800) 628-3233
or Visit: www.casanet.org/conference/index.htm

July 11-14, 2007
APSAC 15th Annual Colloquium
Boston, MA
Visit: www.apsac.org
or E-mail: apsaccolloquium2005@charter.net

July 15-17, 2007
23nd Annual Symposium: The Power of Prevention
Prevent Child Abuse Georgia
Atlanta, GA
Call: (404) 870-6588, or Visit: www.pcageorgia.org
or E-mail: jeanettem@pcageorgia.org

APSAC ADVISOR

Save these dates!

APSAC Child Forensic Interview Clinic
Seattle, WA, May 7-11, 2007

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

For more information, visit: www.apsac.org

APSAC Important Contact Information

PO Box 30669
Charleston, SC 29417
Toll free: 877-40-APSAC
Fax: 803-753-9823
E-mail: apsacinc@comcast.net
Web Site: www.apsac.org

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

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