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IN THIS ISSUE

REGULAR FEATURES

ALSO IN THIS ISSUE

At Issue: Ethical Issues for Guardians *ad Litem* Representing Children in Dependency Cases

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As the legal community continues to evaluate the effectiveness of various models of representation for children in abuse and neglect (dependency) cases, the debate has intensified over whether guardians *ad litem* (GALs) can uphold their ethical obligations under the rules of professional conduct.[1] Many states are transitioning from a GAL (substitute judgment) model to a model where children in dependency cases are appointed an attorney who will advocate for them under a traditional attorney/client model. Some states have adopted a hybrid approach where factors such as the age and desires of the child determine which model of advocacy is used. When attorneys are advocating under the GAL/substitute judgment model, *At Issue* is whether and, if so, how, they will uphold their ethical obligations under the rules of professional conduct.[2]

GAL Versus Traditional Role of Lawyer

The traditional role of a lawyer is that of advisor, advocate, negotiator, and intermediary. The lawyer is bound by the profession's rules of ethics to "abide by a client's decisions concerning the objectives of representation. . . ."[3] Thus, the role of traditional counsel in representing a child, in contrast to the role of GAL, prohibits the lawyer from independently determining and advocating the child's "best interests" if contrary to the child's preferences. A GAL, on the other hand, is appointed to advocate what she determines is in the "best interests" of the child. The GAL often faces ethical dilemmas that the Model Rules do not resolve because the rules do not consider the GAL's unique role in the litigation. The dual role of the GAL as lawyer for the child and, in general, lawyer for the child's best interests makes applying some of the ethics rules to traditional ethics problems difficult, if not impossible. Some of these rules and the dilemmas they create for the GAL are discussed below.

Case Scenario:

> Assume you are appointed as the GAL to represent three children: Jason (age 15), David (age 7), and Angela (10 months). The allegations are that their mother is abusing drugs and has left David and Angela home alone on several occasions. Sometimes Jason is home, but more often than not he is out with friends. Jason has not really gotten into a lot of trouble, but he has begun skipping school frequently, and his grades have recently dropped. During your interviews with the children, Jason and David consistently tell you they would like to go home and live with their mother. Further, Jason tells you that he has seen his mother use drugs, but he asks you not to tell anyone because he knows if this information comes out, he might be sent to a foster home.

This case raises several ethical issues that routinely confront GALs appointed in dependency cases. Because the role of the GAL differs from that in a traditional lawyer/client relationship, GALs are often uncertain how to handle ethical situations under the applicable ethical rules. In raising the inherent conflict between the role of GALs and certain ethical obligations, this article suggests how GALs can analyze common ethical problems—loyalty, confidentiality, and conflicts of interest—to represent what they determine to be the child's best interests, while fulfilling their ethical responsibilities.[4]

Role of the GAL in Dependency Cases

In 1996, the American Bar Association passed Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases (ABA Standards).[5] The ABA Standards advocate a traditional lawyer/client approach to representing children in which the lawyer represents the child's "expressed wishes." However, the drafters of the ABA Standards recognized that in some states, a GAL is appointed to advocate the "best interests" of the child as opposed to the child's "expressed wishes." The ABA Standards define a GAL as an "officer of the court appointed to protect the child's best interests without being bound by the child's expressed preferences."[6] In those states, the GAL is usually statutorily charged with representing the child's best interests. To fulfill that duty, the GAL is entitled to receive relevant reports and to be advised of significant developments in the case. The GAL must investigate matters she deems necessary and should talk with or observe the child client. In exercising those responsibilities, the child's GAL draws a conclusion about what is in the best interest of the child and advocates that position to the court.

Representing the child while simultaneously representing her assessment of the child's best interests can create a conflict for the GAL in terms of compliance with the ethics rules. Some jurisdictions have separated these roles by statute or declared the role of a GAL a "hybrid," excusing strict adherence to *some* Rules of Professional Conduct.[7] Some states provide for the appointment of a lawyer for the child in cases where the child's wishes diverge from what the GAL thinks is best. However, even in states where the law provides a separate lawyer for the child, this often does not occur, either because of the prohibitive cost of appointing both a lawyer and a GAL for one child or the GAL simply does not ask the court to appoint a lawyer for the child.

Model Rule 1.2: Scope of Representation

As mentioned, the GAL is not bound by a child client's expressed wishes, but by his assessment of the child's best interests. That fundamental duty of the GAL conflicts with the traditional role of the lawyer as advocate for the client. It is also inconsistent with a lawyer's fundamental responsibility under MR 1.2 to abide by a client's decisions about the objectives of the case. GALs are required by statute to present to the court what they think is in the child's best interests, as well as the reasoning and facts that support this conclusion, regardless of the client's expressed wishes.

This is further complicated because a GAL must consider the child's position when assessing the child's best interests. In the case above, Jason (age 15) and David (age 7) have told their GAL that they want to return home. The GAL may determine that it is in Jason's best interest to return home because a change in school may be too disruptive, especially given Jason's recent school problems. Also, since Jason is 15 years old, the mother's drug use may not place him at as much risk as it does the younger two children. The GAL may feel that David's best interests are served by remaining out of the home. Advocating "best interests" thus may be at odds with MR 1.2, which says the client determines the objectives of the case.
Because the GAL's duty of loyalty as the lawyer for the child under MR 1.2 is contrary to the GAL's statutory duty to the court, some

states confronted with a similar conflict have amended their versions of the rule to exclude GALs from complying with MR 1.2.[8] In the absence of an express exception to MR 1.2 for the GAL, when the child's view and the GAL's view conflict, the GAL should inform the court of the child's view and the GAL's assessment of best interest. The GAL may also ask the court to appoint a lawyer to represent the child.[9]

Model Rule 1.6: Confidentiality

Applying the confidentiality rules to GALs under the Model Rules can be confusing. The difficult issue is *whether and to what degree to keep confidential certain communications between the GAL and the child*. Confidentiality normally required in the lawyer/client relationship and by MR 1.6 might prevent a GAL from carrying out the statutory responsibilities of her appointment. This is because MR 1.6 prevents the lawyer from disclosing confidential information that may be an important component of the GAL's position. Consequently, a GAL generally must disregard the restrictions of MR 1.6 in order to disclose relevant and necessary information provided by the child to the court and others. There is no satisfactory way to resolve this ethical dilemma.[10] It is always best to seek the child's consent before divulging information about the representation to the court. In some states, a GAL is prohibited from disclosing client communications to the court absent client consent.

As legal counsel representing the child's best interests, the GAL must explain to the child, if possible, that the GAL is charged with advocating the child's best interests and that information otherwise deemed confidential may be provided to the court. What should the GAL do if the child informs the GAL of relevant facts that the child does not want to be divulged? This occurs in the case scenario where Jason reveals that he's seen his mother use drugs, but he asks his GAL not to tell anyone. Jurisdictions have devised a variety of approaches to guide the GAL to ethically discharge her duty to the client and the court. In some states where a GAL is appointed to represent the child's best interests, lawyer/client confidentiality still applies because state statute or case law prohibits disclosure.[11] Other states make clear that confidentiality does *not* apply.[12]

Even within a state, there may be a wide range of views regarding how the confidentiality issue is addressed. A recent ABA survey in Michigan identified several ways GALs handle the disclosure of information that the child does not want divulged.[13] Some GALs felt the confidentiality rules strictly applied to their representation of children, and they would not reveal certain information even if they felt revealing it would be in the child's best interest. Others felt it was their duty to present the client's best interest to the court and overrode a strict application of the ethics rules on confidentiality.[14]

In the case example previously cited, the GAL must decide whether to reveal Jason's disclosure that he has seen his mother use drugs. When confronted with such a situation, a GAL may attempt to avoid the ethical dilemma by saying that disclosing Jason's mother's drug use is unnecessary because that fact would become known through other means. However, what if this is not the case? Drug screens can be inconclusive, and the agency may have no other eyewitnesses or mechanisms to prove the mother's drug use. Suppose, as well, that Jason confides in the GAL because one thing he knows about lawyers is that "they keep their clients' secrets."

Considering these same facts, the Michigan study reported that some GALs would not reveal information because they felt disclosure was ethically prohibited. Other GALs believed their role required them to present to the court all relevant information, including statements made by the child, and believed that such disclosure was not prohibited.

Perhaps the only solution to a GAL's dilemma is to prevent the possibility that the issue will arise. Consequently, if a GAL plans to reveal client communications, including those the child does *not* want to be revealed, the GAL should advise the child, before soliciting information, that the information will not be confidential. The child then can make informed decisions about what to disclose.

This advisement is especially important when representing older children who often have a sophisticated understanding of what characterizes a lawyer/client relationship. Many young people see lawyers in movies, television, and other media. They, or people they know, often have personal experience with the legal system. They may assume their lawyer will keep information confidential. To make sure the GAL does not violate the trust of these young people, it is critical to let child clients know that the GAL's role is to tell the judge what the GAL thinks is best for the child and why. The GAL also should inform the child that he might have to reveal matters they will discuss to the judge, the social worker, or to other parties.

Some states *require* the GAL to inform the child, before any interview, of the GAL's role and responsibility. This includes telling the child that the GAL may provide information to the court or other parties, including communications that otherwise would be protected by the ethical rules governing the lawyer/client relationship. Although this advisement may lead children withholding information from the GAL, the alternative is that a child's trust may be betrayed. Being clear with children about the GAL's role, and to what degree information will or will not remain confidential, helps maintain children's sense of trust and confidence that the system will protect them.

Model Rule 1.7: Conflicts of Interest

MR 1.7(a) prohibits advocacy on behalf of one client that will be "directly adverse" to another client. An example of such a conflict of interest occurs when an agency brings a petition to obtain custody of an infant whose underage teenage mother is in foster care and under the legal custody of the agency. This may be a conflict for a GAL if what she believes is in the young mother's best interests may be inconsistent with what she believes is best for the baby. Most conflicts typically arise for GALs when representing sibling groups.[15]

In our case example, the GAL's representation of Jason, the 15-year-old, may conflict with the representation of David, the 7-year-old, or of Angela, the 10-month-old child. Suppose, for example, that Jason is bonded with his mother, and although he is experiencing some behavioral problems at school, educational stability is recommended. Removing him from his mother's home would mean a change of schools. Suppose, further, that because of his age, his mother's occasional drug use does not affect his safety and well-being to the same degree that it does the younger children. Given these and other considerations, the GAL might conclude that Jason's best interests would best be met by remaining at home, but that removal of Jason from the home would be in Angela's, and possibly David's, best interests.

Cont'd on page 4

In this situation a lawyer performing the traditional role of counsel would have to withdraw from representing Angela and David and, perhaps, Jason as well. Under the traditional model, the lawyer's conflict analysis would require evaluating whether pursuing Jason's objectives would be adverse to pursuing Angela's and David's best interests, either directly or indirectly. Moreover, a lawyer in the traditional role would need to assess whether representing the younger children would compromise the duties of loyalty and confidentiality the lawyer owes to Jason.

These conflicts, however, are viewed differently by the GAL, whose duty is to protect the interests of the children, even if they are contrary to the children's wishes. From the GAL's perspective, there may be no conflict of interest because seemingly contradictory arguments for placing the children ultimately serve their best interests. Therefore, the GAL would not need to withdraw from representing one or all of the children. Nevertheless, representing the best interests of multiple clients by a GAL is not without potential conflicts. Suppose it is in Jason's best interests to continue to be placed with his younger siblings. Jason's therapist says that his sibling bonds are his strongest familial ties; therefore, he should remain with them. However, what if the younger children's treatment providers think otherwise? They say Jason is a negative influence on the younger children, especially David. The GAL faces a quandary. Advocating for the best interests of one sibling may compromise the best interests of another sibling. In this case, the GAL should ask the court to appoint a different GAL for the younger children.

Model Rule 3.7: Lawyer as Witness

Many lawyers and judges are confused regarding whether a GAL should be a witness in the proceeding to which he is appointed. MR 3.7 addresses whether a lawyer may testify on behalf of (or against) his client.[16] The rule generally requires withdrawal if the testimony is on substantive issues. The rationale is that (1) combining the roles of advocate and witness can prejudice the opposing party, and (2) testifying for or against one's client potentially creates a conflict of interest between the lawyer and client.[17] When applying this prohibition to GALs, however, it must be applied with consideration of the purpose of the legal representation. Because the purpose of GAL representation is to advocate for the GAL's assessment of best interests of the child, rather than the traditional expressed wishes of the child, it may not be unethical for the GAL to provide substantive evidence on behalf of the bests interests of the child.

To avoid this dilemma, the GAL should understand the difference between *advocating* and *testifying* for a child client. The comment to MR 3.7 provides some guidance. "A witness is required to testify on the basis of personal knowledge, while an advocate is expected to explain and comment on evidence given by others."[18] It may not be clear whether a statement by an advocate-witness should be taken as proof or as an analysis of the proof. A Colorado court clarified the role of a GAL as a witness:

> Insofar as the guardian *ad litem* chooses to present his or her recommendations as an opinion based on an independent investigation, the facts of which have not otherwise been introduced into evidence, the guardian functions as a witness in the proceedings and, thus, should be subject to examination and cross-examination as to the bases of his or her opinion and recommendation. If, on the other hand, the guardian *ad litem*'s recommendations are based upon the evidence received by the court from other sources, then they are analogous to arguments made by counsel as to how the evidence should be viewed by the trier of fact. Opinions and recommendations so based and presented are not those of a witness, but are merely arguments of counsel and examination and cross-examination concerning these should not be permitted.[19]

The critical issue is whether the GAL is providing evidence (in which case it should be subject to cross-examination, and testimony may be appropriate) or whether the GAL is analyzing evidence. Some states have resolved this complex issue by way of an advisory ethics opinion.[20] Some states have statutes that address this issue. Some states allow the GAL to testify under the theory that the GAL acts as an investigative arm of the court, and the content of the GAL's investigation, as well as the basis for any recommendations, should be subject to cross-examination by attorneys representing the agency and parents.

Conclusion

The unique role of GALs in helping the court reach the best decisions for children raises ethical considerations that are not easily reconciled under the Model Rules. The GAL's ethical obligations to the child, court, and opposing parties often conflict because the GAL serves as an advocate for the child, one who assesses what she believes to be in the child's best interests. Several important ethical issues affecting the role of the GAL should be addressed through legislation, case law, court rules, or ethics opinions. These include the following:

- The relationship of the GAL to the client
- Whether and, if so, how the child's preferences affect the position that the GAL advocates
- The extent that confidentiality and privilege attach in that relationship, and what disclosures are required if there is no confidentiality or privilege
- When a conflict of interest analysis applies
- Whether a GAL can be called as a witness

Clarifying these ethical issues would help GALs more concretely define their role as counsel. It also provides children with a clearer understanding of what to expect from GALs, including what, if any, information will remain confidential. Finally, resolving these issues will provide uniformity in the practice of law and much-needed guidance to GALs.

Notes

[1] Most states require GALs to be attorneys. Some states permit laypeople to serve as GALs. This article is about ethical obligations of attorneys, so it applies only to lawyer-GALs.

[2] This article analyzes the ethical issues under the ABA Model Rules of Professional Conduct (Model Rules). Forty-one states have modeled their state rules of professional conduct on the Model Rules. Most of the remaining states have based their rules on earlier versions of the ABA Model Code.

[3] Model Rule 1.2.

[4] Some states have resolved these ethical problems by clarifying that the GAL does not represent the child but represents the child's "best interests."

[5] *ABA Standards of Practice for Lawyers Representing a Child in Abuse and Neglect Cases, A-2,* "Lawyer Appointed as Guardian *Ad Litem*." See http://www.abanet.org/child/rep-define.html.

[6] Ibid; see also *ABA/NACC Revised Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases,* NACC Revised Version (NACC Children's Law Manual Series, adopted Oct. 13, 1996): http://www.naccchildlaw.org/documents/abastandardsnaccrevised.doc or http://www.naccchildlaw.org/training/standards.html.

[7] In re J.P.B., 419 N.W.2d 387, 391-92 (Iowa 1988); in re Rolfe, 699 P.2d 79, 86-87 (Mont. 1985), aff'd 766 P.2d 223 (Mont. 1988).

[8] E.g., in Wyoming, a recent proposed amendment to MR 1.2 reads, "Contrary to the ethical rules, the lawyer/guardian is not bound by the client's expressed preferences, but by the client's best interests. . . ." In Iowa, the Supreme Court has modified the Rules of Professional Conduct so that GALs "give priority to the paramount goal of discerning the child's best interest while enabling the lawyer to advocate an opposing viewpoint without fear of ethical violation."

[9] A dichotomy exists between the lawyer as guardian and the lawyer as advocate, and the lines become very easily blurred. Courts and legislatures have not provided much assistance and have often required attorneys to assume dual and potentially inconsistent roles." Haralambie, Ann. "The Role of the Child's Lawyer in Protecting the Child Throughout the Litigation Process," *North Dakota Law Review 71* (1995), 939, 941.

[10] *See* Stuckey, Roy T. "Guardians *Ad Litem* as Surrogate Parents: Implications for Role Definition and Confidentiality," *Fordham Law Review 64* (1996), 1785, 1786. ("Role definition and confidentiality issues can arise whenever attorneys are appointed to serve as guardians *ad litem*; however, they become even more complex when an attorney is appointed to serve as both the attorney and the guardian *ad litem* for a child").

[11] E.g., New Hampshire enacted a statute creating lawyer-client confidentiality between GAL and child. See *N.H. Rev. Stat.* § 458.127-a-110 (1992).

[12] To determine whether confidentiality applies, it first must be decided what or who is being represented. Representing the "best interests" of the child is distinct from representing the child. A loose analogy is made to the corporate arena where, under MR 1.13, the corporate lawyer represents the organization, not the individuals within the organization. Although some communications by corporate officers are protected, in performing his or her fiduciary duty to protect the best interests of the corporation, the corporate lawyer may have to reveal certain communications.

[13] The Michigan report is available from the ABA Center on Children and the Law, available by calling (202) 662-1746.

[14] See generally *NACC Recommendations for Representation of Children in Abuse and Neglect Cases,* NACC Program Committee, 2001, at http://www.naccchildlaw.org/training/standards.html.

[15] See Moore, Nancy J. "Conflicts of Interest in the Representation of Children," *Fordham Law Review 64*, (1996), 1819, 1842. ("[A] more common example of a possible conflict arising from duties . . . is the lawyer in a child custody . . . case who serves *both* as the child's lawyer *and* as guardian *ad litem*.")

[16] Model Rule 3.7.

[17] MR 3.7, cmt. 1.

[18] MR 3.7, cmt. 2.

[19] In re J.E.B., 854 P.2d 1372 (Colo. Ct. App. 1993).

[20] See, e.g., North Carolina Ethics Advisory Op. 2251 (Feb. 2000).

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Integrating Mental Health, Education, and Child Welfare Interventions for Preschoolers With Severe Maltreatment Histories: Ohio's Therapeutic Interagency Preschool (TIP) Model

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In this article,[1] we describe the Therapeutic Interagency Preschool (TIP) program, a comprehensive, promising program that has operated in Ohio for the past 18 years. TIP is a county-level, collaboratively funded, intensive, integrated Head Start day treatment program developed specifically to target highly disadvantaged children who have experienced various and/or multiple forms of sexual abuse, physical abuse, emotional abuse, neglect and domestic violence. The four Ohio communities and county agencies operating TIP programs recognize that seamless, interagency pathways and policies are essential if young, severely maltreated children are to escape the lasting consequences of abuse (Haugaard & Freerick, 2002). This article describes the TIP treatment model and outlines the results of this program for the children it serves.

The Need for Integrated Treatment

Traditional mental health treatment programs that serve families with young children in which domestic violence and child abuse are co-occurring are expensive and rare, in spite of high levels of need. Further, trauma-based, therapeutic intervention programs that are integrated into the family's natural caregiving environment (e.g., home and preschool/child care setting) are virtually nonexistent (Joseph & Strain, 2003; Egeland, Yates, Appelyard, & Van Dulmen, 2002). Very few local and state programs have centered on early interventions in an effort to reduce prevalence and poor long-term outcomes among the youngest victims of child maltreatment (Kotch et al., 1997; Kotch et al., 1995; Kotch, Browne, Dufort, Winsor, & Catellier, 1999; McGuigan & Pratt, 2001; Zelenko, Lock, Kraemer, & Steiner, 2000; Papin & Houck, 2005). Children and families with complex, co-occuring needs require innovative, complex, and individualized service systems to address those needs (Marks & Lawson, 2005).

Involving Early Childhood Education

In children's early years, social and emotional competence is a better predictor of academic performance than are cognitive skills or family background (Ladd & Burgess, 1999; McClelland, Morrison, & Holmes, 2000). Children exposed to severe maltreatment are most likely to exhibit social and emotional problems, such as problems with conflict management, social skills, emotional regulation, and making friends (Joseph & Strain, 2003). These children also have high levels of classroom behavior problems, they disrupt the learning environment for other children, and they learn less and attend school less than other children (Shonk & Cicchetti, 2001). Preschool teachers report that children's disruptive behavior problems are the most important challenges they face (Joseph & Strain, 2003). Research has demonstrated the effectiveness of early intervention and preschool services for improving children's language and cognitive skills, in decreasing behavior problems, and in promoting future academic success among these children (Martin, Ramey, & Ramey, 1990; Lee, Brooks-Gunn, & Schnur, & Liaw, 1990; Reynolds, Temple, Robertson, & Mann, 2001).

Head Start revised its performance standards in 1997 to emphasize the importance of early detection of vulnerable preschool children with psychological adjustment problems. Yet, most research contends that this population of children and their families are the most vulnerable and "difficult to engage" (Burns et al., 2004). While many of these children may be identified early, delays in providing intervention by several years undermine any potential benefit inherent in intensive early interventions (Forness et al., 2000). And, because emotional and behavioral problems in children are less amenable to intervention after the age of 8 (Huesmann, Eron, & Dubow, 2002), service delays often precipitate the long-term negative life course trajectories of these children. However, by reorganizing county-level services, the TIP program has demonstrated its capacity to engage this population to consistently participate in early childcare programs and has shown evidence of significant improvement in children's academic, language, social, emotional, and behavioral skills, as well as increased family stability and reduced subsequent incidents of abuse and neglect.

The Therapeutic Interagency Preschool Model

The TIP model was originally established in southwest Ohio in the greater Cincinnati area, and it is now operating in four counties across Ohio. The program holds great promise as an effective early intervention treatment model to serve young children with histories of severe maltreatment and high-environmental-risk factors. TIP is a county wraparound program that combines integrated, interagency service coordination and treatment management (Dunst & Brady, 2006; McWilliam, 2006) with the placement of children in enhanced, existing community programs such as Head Start.

While effective early childhood interventions for these "difficult to engage" children and families legally must exist in most counties (U.S. Dept. of Justice), these services often remain unused or underused due to the severity of families' personal and environmental risk issues. Had these children attended other preschools, many would likely have been expelled for reasons such as extreme violence, severe mental health issues, and sexual acting out. Other typical child and family problem areas include parental addiction, legal problems (incarceration, open warrants), low-cognitive functioning of parents, transient housing or homelessness, absence of reliable transportation, and failure to comply with entry-level criteria for early childhood programs, such as immunizations and assurances that children are free from communicable diseases and infestations.

The prevalence of developmental and behavioral disabilities in this population of children recently challenged schools and child welfare agencies to share information and to coordinate their service plans (Bowen & Bowen, 1998; Crozier & Barth, 2005). Schools contend that they need to know the trauma histories of children in their care because these factors strongly influence educational outcomes. The challenge for professionals is to adopt clear, ethical, program guidelines that will allow agencies to fully share information about the maltreatment and violence histories faced by these children and their families (Crozier & Barth, 2005).

Using many recommendations made by Schonkoff and Phillips (2000) in *From Neurons to Neighborhoods*, the TIP program has successfully engaged this targeted population by providing a model that blends both funding and service delivery mandates of key county agencies. The TIP Quality Assurance Service Guidelines (Table 1) reflect a seamless, interagency, family-friendly, one-stop model needed by young, severely maltreated children to escape the consequences of abuse (Haugaard & Freerick, 2002). Enrollment in TIP requires applicants to meet one or more of the following presenting problems: developmental, emotional, or behavioral problems, placement instability, a court mandate, or need for a more intensive level of service than is available in traditional community preschool treatment models. These criteria are potent identifiers of children who may benefit most from the long-term, year-round, multimodal, and interagency intense intervention services of a TIP model.

Program Description and History

The opportunity to develop this community-based, comprehensive treatment program came in 1989 in the wake of a local political backlash, when two young preschoolers in active care and custody of a county children's services department died within days of the home placement made by the agency. The community was outraged with what was perceived as a failure to protect these children. Through the collaborative efforts of Cincinnati Children's Hospital and county agencies, the first interagency-funded "community safety net" TIP model started in April 1989. This marked the beginning of continued, new collaborative partnerships within the county that led to a community-wide response to tragedy. This Ohio county realized that one agency, alone, is unable to assume the responsibility for protecting the safety of vulnerable children and their families (Austin, 2005). In 1991, the TIP model was merged with the county's Head Start model, thereby enhancing the program's ability to expand services to an additional county site, improve salary

Table 1

Cincinnati Children's Hospital Medical Center TIP Model Guidelines

TIP Quality Assurance Service Guidelines

- Referral of preschool aged children and their families by children services agency on issues of (1) developmental, (2) behavioral, or (3) placement instability concerns
- Interagency participation/agreements: preschools, children's services, early intervention, mental health, for collaborative program development and funding
- Low-number-of-children to staff ratio (recommended 4:1) with a classroom of no more than 12 children
- Full-year program operation (with seasonal and holiday breaks)
- Eighty-five percent attendance of TIP children (assistance from all partnership agencies, even juvenile court if necessary)
- Interagency-funded, blended services, coordinator position with fiscal and outcome data responsibilities to all contributing community agencies
- Increased home visits (Head Start, family service worker, TIP coordinator, TIP mental health therapist, daily bus monitor, teachers), minimum of one visit per month
- School-based provision of mental health, speech therapy, special education, and other services
- Child and family TIP assessments (pre- and post-9–12 months of programming)
- Mental health screening and consultation in the home and at visitations with families as requested by children's services or court
- Daily transportation for children, with informed staff on the bus and communication of observations to TIP staff
- Transportation of parents and children to appropriate appointments (MFE/IEP, immunizations, clinics, etc.) (caseworker, GAL, Head Start family services worker)
- Monthly reports and documentation of client observations and contacts shared with all participating agencies, with guardian's consent
- Access to and communication with all current community service providers with the parent/child, with use of a universal release form for all community agencies.
- Minimum of monthly treatment plan reviews and reports on family/child (includes staff, community professionals, parents as appropriate)
- Program credibility and visibility in the community: frequent contact and sharing of data with community service providers; well-trained staff, court appearances as requested
- Access to crisis-related treatment assistance: hospital emergency rooms, names and phone numbers of all emergency contacts (GAL, children's services, approved family and friends, doctors, etc.)
- Ongoing consultation and training from knowledgeable professionals (forensic centers, juvenile court, therapists, physicians, educators, etc.)
- Program evaluation: fiscal accountability and evidence-based outcomes on TIP and agency partners' guidelines

Model Variations (not known to change anticipated outcomes)

- Interagency agreements regarding funding, service provision, and coordination requirements to achieve above guidelines
- Full-day or half-day classroom program design for children
- Choice of preschool model: federal Head Start sites, Title I preschools, community preschools, special education preschools, and day care.

Source: Adapted from Sites and Cooper (2006).

Cont'd on page 8

and personnel structure, and add the full Head Start components to TIP programming. From 1996 to 2006, neighboring counties requested to be replication sites of the TIP model. Today, TIP exits in six sites across four counties in Ohio and the program serves around 110 preschoolers and their families, all of whom have open cases in the county children's services departments. All enrollment eligibility and service criteria are maintained for all the collaborative agency partnerships, including the Head Start 85% attendance requirements. Fifty-five percent of the children and families participate in one full year of programming and 38% continue for more than a year of service. Only 7% of the children leave the program before completing the recommended one-year service.

What makes TIP unique is that through minor policy changes, it is able to integrate already existing county-based services and funding to address children's service, mental health, and school readiness concerns. Each of the three major contributing agencies spends essentially the same amount per family or child for the TIP model as it typically would spend on traditional single agency delivered services. Each financially committed agency (children's services, Head Start, and mental health) contributes to the TIP pool of money, which is then used to finance interagency TIP staff salaries and expenses through one fiscal cooperative agency, usually Head Start.

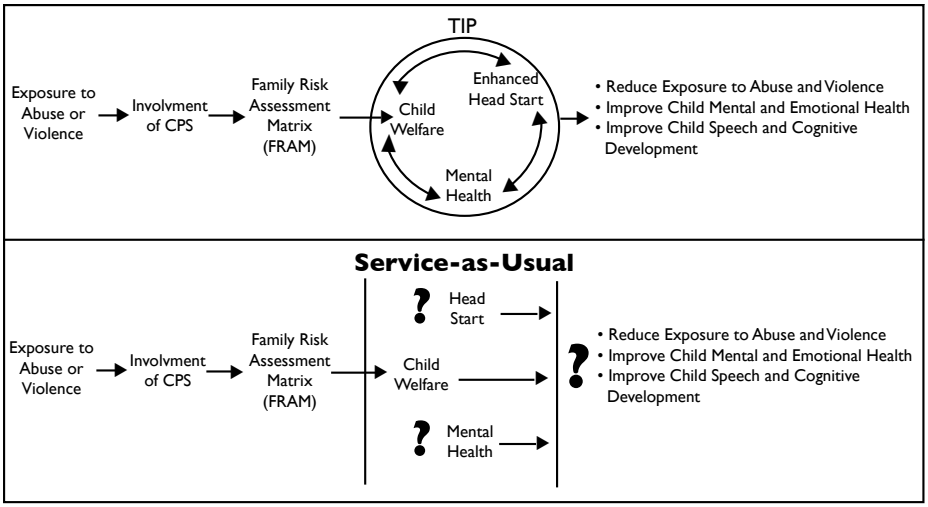
The county agency partnerships agree to a core set of integrated TIP model guidelines (Table 1) that provide the framework for the integrated community child and family wellness model (Figure 1), where safety is the number-one priority. The TIP program's goals are to help children with histories of and resulting disorders from abuse and neglect (1) to experience sustained, safe, nurturing environments and relationships, (2) to accept and interact with positive adult and peer role models, (3) to become stabilized both physically and mentally, and (4) to make significant developmental and social-emotional progress.

An essential aspect of TIP is the seamless, cost neutral integration of child protection, mental health, and Head Start preschool resources both in terms of services and dollars (1) to ensure and monitor the continued safety of the child's environment, (2) to provide intensive home and preschool mental health services, and (3) to enhance developmental and cognitive outcomes through a Head Start preschool curriculum. While each of these services already exists in most counties, each is generally funded by various sources of federal or state dollars, or both, and often works separately.

The TIP program operates as a year-round, interagency, center-based therapeutic preschool with school and home-based services, including assessments (e.g., speech, special education, and mental health), diagnosis and treatment, home-based parent education services, center-based classroom services, daily client transportation, and interagency treatment coordination and case management. Because of the community-based TIP interagency agreements (Table 1), all referrals are initiated by children's services departments. The children are initially screened for developmental and behavioral problems and for concerns about placement stability. For all children enrolled in TIP, there are weekly phone calls with a parent and caseworker, a minimum of one home visit a month, daily staff scrutiny of the home situation when the school bus picks-up and drops-off the child, weekly individual sessions with mental health staff, and semi-monthly case review and planning. The Childhood Trust, the Department of Psychiatry, and the Division of Developmental and Behavioral Pediatrics, all affiliated with Cincinnati Children's Hospital, provide administrative leadership and oversight for training and replication of the model to assure fidelity.

Interdisciplinary treatment teams, guided by mental health therapists and developmental specialists, are assigned to each family and provide assistance to the parents or guardians and other significant adults in the child's life. The treatment team coordinator (an interagency-funded position) cultivates and maintains a seamless approach to intervention in the face of interagency challenges between child welfare, school, family, and law enforcement agencies (Marks & Lawson, 2005). Further, since many families have difficulty accessing or engaging in outpatient therapy, TIP offers daily transportation, as well as intensive home-based and school-based treatment for developmental delays, behavioral problems, and trauma-related symptoms for the children, and supportive, mental health screenings and parental education treatment for the parents. TIP merges an early intervention or preschool curriculum for children with mental health treatment goals. This promotes psychological and developmental functioning in ways that other agencies and comprehensive treatment programs do not.

Figure 1
The 'TIP' Model vs. 'Service-as-Usual'



The classroom program curriculum used by the TIP program is established by the Federal Head Start Performance Standards on Early Childhood Development and Health [1304.21 Education and Early Childhood Development and 1304.21(a) Child Development and Education Approach for All Children (Early Childhood Quality Network, www.ecqnet.org)]. The early childhood mental health interventions used by TIP adapt cognitive-behavioral therapy and victim trauma approaches with traditional early childhood supportive mental health therapy (Bahl, Spaulding, & McNeil, 1999; Cohen & Mannarino, 2003; Cohen & Kaufman, 2000; Donahue, Falk, & Provet, 2000; Saunders, 2003; Hewitt, 1999; Wickham & West, 2002).

Qualified mental health staff in social work, counseling, or psychology are governed, supervised, and monitored by their respective county mental health departments or agencies. Intense mental health services (early childhood relationship-based intervention) are infused into the child's daily school and home environments to address typical diagnoses of children in the TIP program, including reactive attachment disorder, posttraumatic stress disorder, oppositional defiant disorder, depression, anxiety, sexual reactive behaviors, and dissociation. The children are seen both privately and in small group settings each week by their therapists. Evidence exists that children's social and emotional competence (more cooperation and less aggressive behavior) is strongly linked to their cognitive and academic competence, leading to success at school (Raver & Knitzer, 2002).

The program's administrative success is partly a result of its cultural sensitivity. Cultural sensitivity and program flexibility are core requirements for any program that seeks to establish itself successfully in a variety of settings. TIP has been implemented successfully at six sites whose enrollment ranges from 18% African American and 81% Caucasian to 80% African American and 20% Caucasian, with ethnicity of participants having little effect on program results. Because TIP utilizes established services that have already been shaped by the culture within each community, it does not impose outside values and curricula, nor does it compete with existing services. Implementation of TIP involves promoting cultural competence through unique community adaptations to the fidelity requirements in the TIP model guidelines. The evaluation measures, program fidelity process, twice-monthly peer review, and interagency treatment plan revisions address staff and client desire, cultural awareness, knowledge, skill, and personal encounters (Camphina-Bacote, 2002). The comprehensive system of care TIP provides is based on each community's common vision, the seamless delivery of child and family services, easy access to all supportive and required services, and accountability to the community through appropriate outcome and performance measures that provide continuous quality improvement efforts (Papin & Houck, 2005).

Process Evaluation Data and Findings

Participation Rates

One of the central strengths of the TIP model is its ability to increase family participation, access to services, and utilization compliance through a one-stop, integrated system. After one year in TIP, only half of the 50%–60% IEP-eligible children remained eligible for special education. Head Start attendance of TIP children averages 95%, exceeding the 85% class attendance goal set by Head Start, even though prior to their enrollment in TIP, fewer than 5% were engaged in any preschool or educational program. Of the few children who had been enrolled prior to TIP referral, two thirds were in the process of being expelled from their preschool program at the time of their enrollment in TIP for behaviors such as extreme recklessness, aggression, sexual acting out, extreme harm to themselves or others, and/or noncompliance with attendance or health standard guidelines. Moreover, fewer than 10% were engaged in any mental health services prior to TIP, and of those referred and receiving services, the average compliance rate was about three sessions.

Demographic Characteristics

In 2000, the Ohio Department of Mental Health (ODMH) Children's Services and Prevention Division funded an internal, prospective, longitudinal outcome evaluation of the four TIP sites in Greater Cincinnati. The Cincinnati Children's Hospital Medical Center (CCHMC) successfully gathered baseline and one-year postdata on 168 program participants over a period of 5 years (4 one-year, pre-post cycles). Data were collected from multiple sources, including official children's services case records, parent/guardian proxy assessments, speech and language pathologist evaluations, and preschool teacher observations. All parent/guardian assessments of the child were administered by TIP coordinators, who had been trained by CCHMC to complete these tools. TIP coordinators read the questions aloud to all informants to rule out attention deficits or limitations in reading skills of the caregiver. The CCHMC Institutional Review Board approved the use of these program evaluation data for subsequent analysis and publication.

The TIP population comprised 59.1% males and 40.9% females, of whom 40.5% were 3 years old, 43.5% were 4 years old, 13.1% were 5 years old, and 2.4% were 6 years old at the time of referral to TIP. Of these children, 50.6% were Caucasian and 48.7% were African American. At baseline, over 77% of these children had been previously removed from their biological homes. These children had at least one out-of-home placement, and 13.1% had three or more placements. At the time of follow-up, home placement stability had improved, and only 44.2% had an additional placement, with most of those to achieve permanence. Further, at baseline, 42.2% of the children were currently living with one or both biological parents, while 37.9% were living in foster care and 19.9% were living with relatives, such as grandparents and aunts, or with friends of the family. At year one, 43.8% were with one or both biological parents, 28.9% of the children were in foster care, and 27.3% were with other relatives or family friends. The data reflect a reduction in the number of children in foster care and an increased number of children placed in relative care.

Exposure to Maltreatment

All of the children included in the evaluation had an open case file with children's services. A chart review of the children's services caseworker files (made available through a standing universal release of information agreement that TIP programs have with sponsoring county agencies) provided information on alleged and substantiated abuse and neglect. In addition, at the time of program referral, each child's current legal guardian completed an inventory of traumatic events, the Childhood Trust Events Survey (CTES), identifying serious child abuse issues and other typical traumatic events. The format and questions were developed and first used in a study by Baker, Boat, Grinvalsky, and Geraciotti (1998). These two data sources identified children who had an indicated occurrence of a particular type of abuse (provided that the children's services caseworker had reported any alleged or substantiated event in the child's file), or this fact was provided by the caregiver in the CTES, that had been administered by trained TIP coordinators. The combination of the children's services case reports and the CTES inventory provided a more comprehensive representation of the children's abuse histories, with more incidents of violence and assaults reported. At baseline, 89.3% of the children who had completed 9–12 months of programming had previously experienced at least one form of type-specific victimization, with 15.5% having indicated sexual abuse, 25.6% having indicated physical abuse, 38.1% having indicated witnessing domestic abuse, and 54.8% having indicated neglect. In addition, 53.0% had indicated exposure to at least two types of substantiated/indicated victimization, 23.8% had indicated at least three types, and 7.1% had indicated exposure to all four major, reportable types.

Cont'd on page 10

Outcome Evaluation Data and Findings

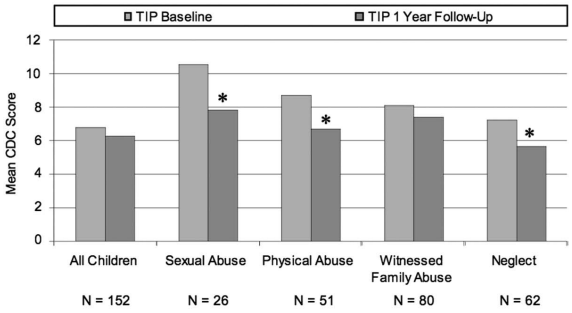
Behavioral and Mental Health Assessments

Assessment of changes in children's behavior and mental health problems were measured using the caregiver-administered Child Dissociative Checklist (CDC), Child Behavior Checklist (CBCL), and Social Skills Rating Scale (SSRS) (Putnam, Helmers, & Trickett, 1993; Kisiel & Lyons, 2001; Macfie, Cicchetti, & Toth, 2001; Hornstein & Putnam, 1992; Achenbach & Rescorla, 2000; Gresham & Elliot, 1990).

Tables 2 to 4 present the results of the pre-post outcome evaluation for all children, which are disaggregated across exposure to type of maltreatment for the CDC, CBCL, and SSRS measures. The overall pattern reveals significant improvements across most behavior and mental health assessments for all children and across all children by specific abuse exposure.

Table 2

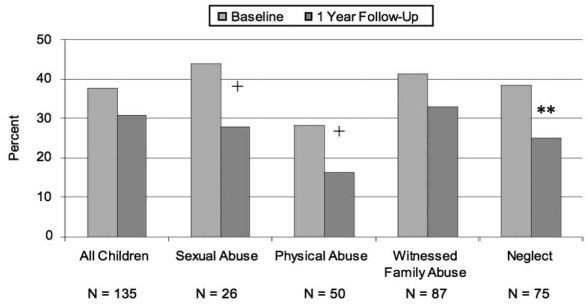
Change in Average Child Dissociative Checklist Score Over 1 Year Among TIP Children by Exposure



* p < .05; ** p < .01; *** p < .001 (two-tailed)

Table 3

Change in Percentage of Children Scoring Above Clinical Level on CBCL Total Scale Over 1 Year Among Children in TIP Programs by Exposure



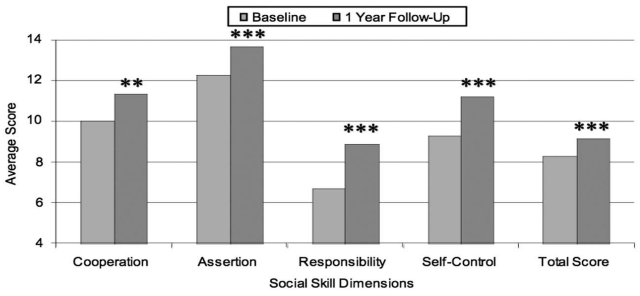
+ p < .10; * p < .05; ** p < .01; *** p < .001 (two-tailed)

Cognitive and Language Development

For two subsamples, we also completed speech and language assessments and a preschool teacher assessment of children's cognitive development. For speech and language, children were evaluated by a speech pathologist using the *Preschool Language Scales: Fourth Edition* (PLS-4) (Zimmerman, Steiner, & Pond, 2002), or the *Clinical Evaluation of Language Fundamentals: Fourth Edition* (CELF-4) (Semel, Wiig, & Secord, 2003) and the *Goldman-Fristoe 2: Test of Articulation* (GFA-2) (Goldman & Fristoe, 2000). While all children receive the articulation assessment, the use of the *Preschool Language Scales* or the *Clinical Evaluation of Language Fundamentals* is dependent on the child's baseline levels of skills, as one is more sensitive to lower skill levels than the other. For cognitive development, children were evaluated by the preschool teacher using the *Galileo Preschool* (Galileo Technology, 2002-2006), a standardized, observational assessment that gauged improvement across various dimensions of language and cognitive development.

Table 4

Improvements in Various Social Skills Over 1 Year Among Children in TIP Programs

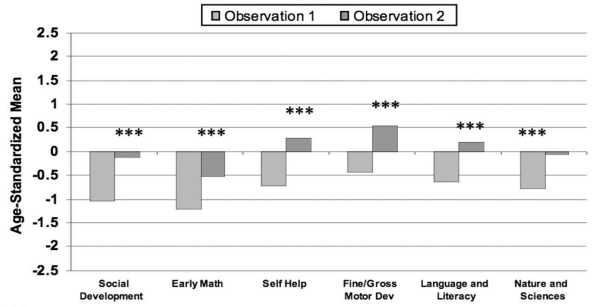


N = 150
* p < .05; ** p < .01; *** p < .001 (two-tailed)

The results of the cognitive/school readiness and language assessments are presented in Tables 5 to 6. Overall, the results show a significant improvement in language and articulation regardless of type of exposure to maltreatment. Moreover, improvement across all dimensions of cognitive development and school readiness, as measured using the *Galileo* through preschool teacher observations, was also significant for the total TIP population of children as well as for all children grouped by type of exposure to abuse.

Table 5

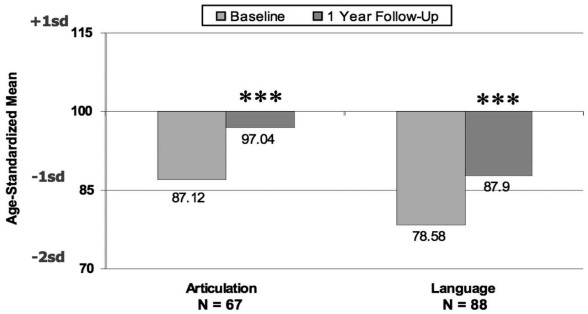
Change in *Galileo* Individual Development Scores Over 2 Observation Points Among Children in Cincinnati TIP



N = 58
* p < .05; ** p < .01; *** p < .001 (two-tailed)
Note: Data confined to Cincinnati TIP program from Summer 2001 to Summer 2003

Table 6

Change in Average Age-Standardized Speech and Language Assessment Scores Over 1 Year Among Children in TIP Programs



* p < .05; ** p < .01; *** p < .001 (two-tailed) Note: Data confined from Fall 2004 to Fall 2006

Discussion

Children enrolled in the TIP program are at an extremely elevated risk for adverse outcomes as a result of their experiences, including developmental disabilities, emotional disorders, and behavioral problems, all of which affect school readiness. Moreover, adverse childhood experiences that include abuse, neglect, and severe family dysfunction have been found to influence the origins of behaviors that underlie the leading causes of disability, social problems, health-related behaviors, and causes of death in the United States (Felitti et al., 1998).

The preliminary results of the internal evaluation show that TIP holds promise as an effective intervention for these most difficult-to-engage children and families. Why does TIP potentially work? TIP appears to be succeeding on two levels: programmatic and administrative. First, it is producing significant improvements over a one-year time frame in the social, emotional, and cognitive competence of severely maltreated preschoolers with complex co-occurring service needs who were not being served by preschool education or mental health agencies, regardless of their eligibility. We argue that programmatic success can be attributed to the intensity and integration of services and interagency policies. The intensity of services arises from the degree of engagement elicited and requested by all involved organizations, such as courts, children's services, schools, and mental health providers; the continual and intense monitoring of child safety and family stability; and the full year, one-stop, inclusive nature of the program. The TIP program development guidelines for evidence-based quality assurance (Table 1) (Sites & Cooper, 2006) conform to each agency's best standards of practice with only slight changes in agency policies. However, collectively, they present a collaborative model for services that integrates mental health treatment, early childhood education, and child/family safety (Schmitz & Hilton, 1996).

Administratively, in the counties where TIP has been implemented, it has successfully secured and sustained 18 years of administrative and financial support. TIP offers the simplicity of combining current funding streams and utilizing existing services, while providing safety, mental health treatment, and academic preparation for the least engaged, most emotionally disturbed and disruptive preschool children and their families. TIP services are integrated administratively and fiscally, as well as through the interdisciplinary nature of the program and extensive cross-training of staff. It removes barriers associated with cross-agency referrals and enrollments. For example, a key requirement of the TIP Guidelines is the existence of on-site, full-year mental health services and consultation, which are funded through each child's insurance or through Medicaid (Yoshikawa & Knitzer, 1997). On-site mental health consultation provides a continuum of care within the classroom as well as supports teachers, parents, and related staff (bus drivers, daycare providers, etc.). The involvement of the family is vital and develops the critical parent-teacher linkages and shared responsibility essential to addressing each child's social and emotional problems (Sheridan, Eagle, Cowan, & Mickelson, 2001).

Limitations and Future Steps

While the outcome evaluation indicating program success has been conducted with a high level of rigor, it is not definitive with respect to the limitations of its one-group, pre-posttest design. Because it involves following only those children participating in TIP, we cannot say unequivocally that these improvements would not have occurred without the intervention or in a usual-care model. However, a study with a control group at this point is untenable because of ethical and liability constraints. Specifically, county agencies are not willing to identify high-risk families and note their children's developmental and mental health issues without providing care, solely for the purpose of assigning a comparison group. A second consideration is that a selection bias may exist for referrals to TIP. Any bias, however, would likely be toward inclusion of the children most seriously involved with the county's children's services agency, as children referred to TIP are triaged by virtue of presenting problems, such as legal issues, custody decisions, and the severity of children's behaviors.

To conclude, TIP is feasible, fundable, and sustainable at a county level. Once implemented, it is essentially cost-neutral, representing a new way of organizing existing resources rather than requiring new ones. It produces strong results promoting school readiness and enhances the social potential of children and their families who are severely disadvantaged. The model encourages local choices for stakeholders at a financial comfort level regarding development and policy changes necessary to achieve the comprehensive goals and guidelines of the program. TIP offers the simplicity of combining funding streams currently available in all counties in the United States to help children who are most vulnerable—no new funds are necessary. The desired result is an effective service delivery model and a pooling of community resources that are necessary to assist children with histories of severe abuse and neglect.

Notes

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Responding to Methamphetamine Use, Abuse, and Addiction in Families[1]

Diane DePanfilis, PhD, R. Anna Hayward, MSW

Introduction

Methamphetamine manufacture, use, and addiction, and their effects on children and families, are serious problems confronting child welfare professionals across the nation. Similar to the crack epidemic of the 1980s, the "meth problem" increases the risk of child maltreatment, impacts family functioning, and seriously threatens the safety and well-being of children.

Child protective workers in particular, and child maltreatment professionals in general, are responsible for (1) recognizing methamphetamine or other drug related symptoms; (2) collecting information about methamphetamine use, abuse, addiction, and/or manufacture as part of risk assessment and safety evaluation; (3) developing and managing safety plans to address the safety influences that jeopardize a child's immediate safety; (4) conducting family assessments that evaluate the specific effect of methamphetamine use, abuse, or addiction and manufacture on parenting adequacy and assessing the effects of these circumstances on children; (5) developing change-oriented case plans that address the impact of methamphetamine use, abuse, or addiction; (6) selecting and coordinating meaningful interventions provided by addiction counseling and other agencies; and (7) evaluating progress of parents and children in recovery.

This article focuses on item 6 in this list by reviewing promising or acceptable interventions that may be useful in work with families once methamphetamine use by a caregiver has been identified. It acknowledges that safety plans need to first be developed to assure that children are safe and that appropriate interventions may be selected only after a comprehensive family assessment has been completed.

Conducting the Family Assessment and Assessing the Effects of Methamphetamine Use, Abuse, or Addiction on Parenting Adequacy and on Children

The primary purpose of conducting a comprehensive family assessment is to gather and analyze information that will guide the intervention change process with families and children. Targeting change strategies to the unique risk and protective factors present in families affected by methamphetamine will lead to increased safety, permanency, and well-being of children and families.

During the assessment, the family is engaged in a process to understand its strengths and needs and, in particular, to understand the way in which methamphetamine is affecting parenting and the children. It is assumed that a safety plan is in place and the focus of the assessment is on the factors that need to be addressed through change-focused intervention strategies.

Information about risk and protective factors related to the child, parent, family, and environment should be identified and assessed. Outlines for assessment of families (e.g., DePanfilis & Salus, 2003) are useful and should be supplemented by assessing the specific ways in which methamphetamine affects parenting, family functioning, and children.

Three areas of assessment are important: (1) assessing the degree of use, abuse, or addiction to methamphetamine; (2) assessing what specific effects are evident for the individual who uses, abuses, or is addicted to methamphetamine; and (3) assessing the specific ways in which this use, abuse, or addiction affects children in the family.

Assessing Use, Abuse, or Addiction

As with all substances, the first task of the practitioner is to understand whether the methamphetamine problem is one of use, abuse, or addiction (Zuskin & DePanfilis, 1995).

Use. Use of alcohol or other drugs involves the ability to use drugs in a responsible way. Use may be experimental, occasional, recreational, or social. Users experience no psychosocial problems and maintain control over the amount, time, place, and duration of their use (Griffin, 1993). Methamphetamine may be used initially for practical reasons: to stay up for extended hours for work or school or to lose weight. Women especially may initiate methamphetamine use for appetite control and weight loss (Rawson, Anglin, & Ling, 2002). Because methamphetamine is less expensive than other stimulant-type drugs (such as cocaine), it may be more likely to be used for these reasons.

Abuse. Substance abuse refers to the use of drugs in an irresponsible manner, which results in psychosocial problems; or, substance abuse refers to the use of a drug for the purpose of intoxication. Psychosocial problems experienced may be directly related to the abuse of substances, or may result from exacerbation of existing problems. The substance abuser retains control over drug usage, and there is no progression of the disease process (no abnormal tolerance, withdrawal, or pathologic organ damage) (Griffin, 1993). Substance abuse is most typically seen in adolescents; although many parents at risk of maltreating their children may be substance abusers, careful assessment may reveal that many are more likely to be chemically dependent or addicted. This is particularly true with methamphetamine (see Appendix).

Dependency or addiction. Dependency, or addiction, refers to a physiological disease process that can be identified behaviorally. In addition to psychosocial problems, the chemically dependent person loses control over use with regard to amount, time, place, and duration (Griffin, 1993). A progression of the disease process is evident and includes abnormal tolerance, perhaps from the onset of usage, withdrawal, and pathologic organ changes in late stages of addiction. The addicted person demonstrates a compulsion to use drugs, disregarding any negative consequences and exhibiting tolerance to the drug and withdrawal symptoms when he or she cannot have the drug. Preoccupation with acquiring and using the drug results in poor judgment. For example, drug-dependent parents may leave an infant unsupervised while they seek the next "fix." In their denial, these individuals often believe that their drugged state is normal and strive to sustain it. Such psychological dependence is difficult for the drug-dependent individual to overcome. These persons are unable to control their drug use and their addiction usually has negative effects on their day-to-day functioning (Griffin, 1993).

Cont'd on page 14

Assessing Effects on the Individual

If parental use of methamphetamine is suspected, it is important that the parents undergo a specific assessment of the effects of this use, abuse, or addiction on their everyday functioning (see examples of effects in the Appendix). The practitioner may observe physical, behavioral, cognitive, and psychological consequences. Physical problems include skin lesions (SAMHSA, 1999a), dental problems (Brandjord, 2006), increased risk of stroke and heart problems (Maxwell, 2005), and potential long-term damage to neuron cells (NIDA, 2005; SAMSHA, 1999). In terms of behavior, the parent may be observed with periods of heightened energy and feelings of euphoria (NIDA, 2005); impulsivity (Simons, Oliver, Ghaer, Ebel, & Brummels, 2005); and episodes of violence, aggression, and agitation (Maxwell, 2005). Impairments to cognition, memory, and attention, including ADHD, may also be observed (Maxwell, 2005; Simon et al., 2000). Finally, some parents may experience depression and anxiety, especially with withdrawal (Cretzmeyer, Sarrazin, Huber, Block, & Hall, 2003; NIDA, 2005).

Assessing Effects on Children

Because of the range of serious effects on the user, methamphetamine affects children in multiple ways, including increasing the risk of child abuse and neglect. The specific ways in which this translates to concern for children need to be understood as part of the assessment process. Once the specific ways in which the problem is affecting children are understood, safety and change-oriented strategies need to be tailored to the specific needs of each family. Examples of these effects follow:

Prenatal effects. Infants exposed to methamphetamine prenatally may experience delays in physical and neurobehavioral development (Lester et al., 2006). Research in this area is ongoing. Children with these effects may need specific treatment to address these consequences.

Household safety. Exposure to environmental toxins (arsenic, lye, mercury, lead) during the manufacture process is especially risky for young children (USDOJ, 2003). A complete assessment of household safety must be conducted with a specific eye to potential household hazards associated with methamphetamine manufacture and use.

Childhood supervision and neglect. Parents may sleep for excessive periods of time following drug binges and during periods of withdrawal. This may lead to a lack of supervision and to other forms of child neglect. Because methamphetamine use suppresses appetite, it is also possible that users may not regularly purchase or prepare food, leaving children at risk of nutritional neglect (Rawson, Anglin, & Ling, 2002).

Physical abuse. Agitation and violent behavior associated with withdrawal may increase risk for physical abuse.

Sexual abuse. When parents are using methamphetamine, children may be exposed to sexualized behavior in adults, which may also put them at risk for sexual abuse.

Lack of positive social support systems. Parents involved with methamphetamine may have few positive support systems and only be associated with others involved with methamphetamine. These conditions increase concern for child safety and make it more difficult to change negative behaviors.

Using Results of the Family Assessment to Target Outcomes

At the conclusion of the family assessment, the practitioner should target client outcomes that if achieved will reduce the risk of future maltreatment and address effects of child maltreatment. This usually means selecting risk factors and protective factors uniquely relevant to each family and then selecting interventions that will help parents, children, and families achieve these intermediate outcomes. An example of how this all comes together is provided in a sample logic model (see Figure 1). Each service plan should be unique and interventions should be selected that have the best chance of helping families achieve their individually targeted outcomes.

Selecting Evidence-Based Practices

Because methamphetamine addiction treatment is relatively new, an exhaustive search of the literature was unsuccessful in finding treatment programs with extensive research support of their effectiveness. As an alternative, this article identifies promising or acceptable practices that may be useful with families affected by methamphetamine.

The selection of programs or interventions was partially based on recommendations offered to child welfare administrators for selecting evidence-based interventions (Wilson & Alexandra, 2005) and by the California Evidence-Based Clearinghouse for Child Welfare (CEBC). This CEBC hierarchy suggests the following classification of programs:

1. Well-supported, proven effective practice
2. Supported efficacious practice
3. Promising practice
4. Acceptable emerging practice (effectiveness is unknown)
5. Evidence fails to demonstrate effect
6. Concerning practice

A series of efforts are underway to classify the degree of effectiveness of evidence of programs relevant to families served by child welfare agencies (e.g., CEBC, 2006). Readers are encouraged to continue to search for interventions with the best research support available. Other hierarchies (e.g., Gambrill, 2006) may also help practitioners select programs relevant for families affected by methamphetamine, based on acceptable, promising, efficacious, or effective results.

Based on this review of promising or acceptable programs, it is recommended that intervention for methamphetamine-affected families include the following three components: (1) substance abuse treatment for addicted parents, (2) parent and family-focused interventions, and (3) child-focused interventions. Since other papers in this series focus on safety, this paper focuses on promising or acceptable practices across the other three domains.

Substance Abuse Treatment

Substance abuse treatment, preferably treatment with some promise of effectiveness with individuals addicted to methamphetamine, is required in order to reduce the risk of maltreatment in affected families. While methamphetamine users share some of the same needs as users of other stimulant-type drugs such as cocaine, there are also differences. In particular, methamphetamine users may function adequately in their work or social lives before methamphetamine results in obvious consequences (Cretzmeyer et al., 2003; Rawson et al., 2002). In addition, methamphetamine users may be more likely to

be poly-drug users (Brecht, O'Brien, Mayrhauser, & Anglin, 2004; Stoops, Tindall, Mateyoke-Scrivner, & Leukefeld, 2005), have high rates of psychiatric disorders (Semple, Grant, & Patterson, 2004), and experience serious depressive symptoms during withdrawal (Rawson, Huber, et al., 2002; Sweben et al., 2004).

During the beginning stages of treatment, cognitive problems and ADHD may become worse and increase the likelihood of relapse (Maxwell, 2005; Zweben et al., 2004). To increase motivation, the CPS worker and drug treatment provider should provide education about the consequences of methamphetamine, interpret any apparent cognitive problems as related to the recovery process, and help the parent get through this stage of the treatment process.

Promising or acceptable models for treatment of parents with methamphetamine problems are reviewed next. The same treatment models that have shown effectiveness in the treatment of cocaine seem to also have promising outcomes in the treatment of methamphetamine (Huber et al., 1997; Maxwell, 2005; SAMHSA, 1999a) and methamphetamine treatment may actually be associated with more favorable criminal justice outcomes and higher rates of treatment completion (Luchansky, Kruspki, & Stark, 2006).

Motivational interviewing. First developed for use with problem drinkers, motivational interviewing may be used in combination with other interventions or to successfully engage clients in other specific treatment strategies. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence about making changes in behavior (Rollnick & Miller, 1995). Motivational interviewing has demonstrated effectiveness in improving outcomes for alcohol or other drug users (Hettema, Steele, & Miller, 2005) but has not been tested specifically with parents addicted to methamphetamine. Usually implemented as a group intervention, motivational interviewing has been classified by the California Evidence-Based Clearinghouse for Child Welfare (2007a) as a well-supported, effective practice.

Community reinforcement approach. First developed as an effective treatment with alcohol addiction (Myers & Smith, 1995), it has more recently demonstrated positive outcomes for cocaine addiction (Budney & Higgins, 1998). The community reinforcement approach is a comprehensive cognitive-behavioral intervention that creates environmental contingencies, such as familial, social, recreational, and occupational events, to support a client to change drug-using behaviors. The community reinforcement approach has been classified by the California Evidence-Based Clearinghouse for Child Welfare (2007b) as a promising practice.

The Matrix intervention. This model is considered an effective outpatient treatment for methamphetamine addiction (SAMHSA, 1999a). The Matrix intervention is recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT). This intervention includes the following components:

- outpatient treatment,
- information/education,
- relapse prevention,
- family involvement,
- cognitive-behavior–based individual therapy,
- group sessions,
- self-help (12-step program participation), and
- urine toxicology monitoring (Obert et al., 2000).

The Matrix treatment model acknowledges the impact of cognitive changes that may result from extensive methamphetamine use; these changes may result in impaired decision making and impulse control that can inhibit treatment (Obert, London, & Rawson, 2002). Evaluation of Matrix program participants' relapse rates suggests that longer treatment decreases the risk of relapse. Factors that increase the risk of relapse include the following: (older) age of user, Hispanic ethnicity, involvement with drug sales, and previous treatment episodes (Brecht, Mayrhauser, & Anglin, 2000). Comparisons between methamphetamine and cocaine users in Matrix treatment indicate similar positive benefits of treatment, but depressive symptoms are generally higher for methamphetamine users at admission and may be slower to change over time (Rawson, Huber et al., 2002).

Family-focused substance abuse treatment. Research with other drug use confirms that substance abuse outcomes (program retention, lower rates of relapse) are enhanced when social and health needs of parents and their children are addressed (Smith & Marsh, 2002). The Substance Abuse Mental Health Services Association (SAMHSA) recommends that family-related substance abuse treatments include:

- parent education on child development,
- attention to early adverse experiences in the client in an attempt to "break the cycle" of child maltreatment,
- development of social support networks, and
- focus on treatment issues and parent-child relationships and family dynamics (SAMHSA, 1999b).

Studies of cocaine-addicted parenting women suggest benefits of treatment programs that focus on a range of needs, including recovery from trauma, life skills, parenting education, and family engagement (Magura & Laudet, 1996). Furthermore, allowing children to enter care with addicted parents may have positive benefits for parenting, child behavior, family functioning, employment, substance abuse, and criminal justice involvement (Jackson, 2004; Sowers, Ellis, Washington, & Currant, 2002). Involving families in treatment seems to result in better outcomes than routine drug treatment. Comparing a methadone maintenance treatment enhanced with a family program to treatment as usual, participants in the family program achieved greater benefits in the areas of problem solving, family factors, social network, decreased drug use, and parental involvement with children (Catalano, Gainey, Fleming, Haggerty, & Johnson, 1999). This trend suggests that family-centered methamphetamine treatment could have better outcomes than methamphetamine treatment focused only on the addicted individual, but evaluation of this premise has yet to occur.

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Parent- and Family-Focused Interventions

Separate from substance abuse treatment, other types of parent- and family-focused interventions are needed to address the effects of methamphetamine on families and to reduce other risk factors for child maltreatment.

Social support interventions. Social isolation and/or connections with drug-using social networks may increase risk for continued substance abuse and child maltreatment. Positive social support may increase treatment retention and prevent relapse (Dobkin, Civita, Paraherakis, & Gill, 2002). Social support intervention may consist of individual support (in the form of parent-aides, or home visitors), may be a component of parent education and support groups, or may be provided as part of a multi-service intervention (DePanfilis, 1996). Cont'd on page 16

Network therapy, for example, uses the therapeutic relationship to help families develop positive social networks and stresses the use of social network members to support recovery (Galanter, Dermatis, Keller, & Trujillo, 2002). Preliminary findings suggest that participants may maintain abstinence when they have a supportive network (Galanter et al., 2002).

Parenting skills interventions. Many families involved with child protective services are mandated to attend parenting skills education and training (Barth et al., 2005). While not universally needed, parenting skills interventions may benefit some parents affected by methamphetamine. Based on a review of effectiveness of parent training programs for use with biological parents involved with child welfare services, research by Barth et al. (2005) stresses the need for tailored interventions for specific populations (e.g., age-specific, child- or parent-problem–specific, and population-specific interventions). Bringing together parents of children with disruptive behavior problems in multi-family groups shows some promise for improving parenting skills and child behavioral problems (McKay, Gonzales, Quinana, Kim, & Abdul-Adil, 1999). This approach may be an appropriate alternative to traditional parenting classes, which do not tend to focus on the unique needs of children who have mental health or behavioral problems. Because of the importance of understanding which parenting programs are most promising for working with parents involved with the child welfare system, a review of parenting skills programs is among one of the first types of interventions reviewed by the California Evidence-Based Clearinghouse (2006).

Experts suggest that interventions to increase positive parenting behavior should be selected on a case-by-case basis in order to match parenting needs, child behavior problems, and interventions (Barth et al., 2005, p. 368). Parenting programs developed for substance-abusing families, such as Focus on Family (FOF), have demonstrated lower rates of drug use, more positive parenting, and lower rates of child behavioral problems up to 24 months after participation when compared with a nontreatment group (SDRG, 2000).

Interventions to address concrete needs. Parents who use methamphetamine often have multiple needs beyond substance addiction (e.g., employment, child care, housing, employment, and medical care) (SAMHSA, 1999a). The multiple needs of methamphetamine users may be related to the multiple problems they sometimes face, such as poverty, risk- taking behaviors, and psychiatric disorders (Semple et al., 2004). Therefore, SAMHSA recommends that substance abuse treatment be enhanced with other services such as mental and physical health care, housing assistance, and job training. In addition, because a drug-using lifestyle may have taken resources away from a parent meeting other basic needs, it is very important to respond to the concrete needs of families for food, clothing, housing, etc. before family functioning issues can be successfully addressed.

Child-Focused Interventions

It is the role of CPS and other professionals both to reduce the risk of future maltreatment and to address the effects of maltreatment on children, thereby enhancing the well-being of children. Living with a methamphetamine-using parent may result in a range of consequences for children, including problems with their physical and mental health, development, and social skills.

Interventions to address physical health and developmental needs. Because of the serious health risks associated with methamphetamine exposure, a comprehensive medical examination for children should be conducted to assess any effects of exposure to drugs or toxic chemicals. Accidental ingestion or exposure may result in side effects for children, including breathing difficulties, heart palpitations, vomiting, irritability, and agitation (Hohman, Oliver, & Wright, 2004). Ongoing medical care will likely be necessary if toxic exposure has resulted in these symptoms.

Services for children may also be needed to address developmental delays. Since studies of children of parents in substance abuse treatment reveal that children have high rates of cognitive impairments (69%), speech and language delays (68%), emotional or behavior problems (16%), and medical problems (83%) (Shulman, Shapira, & Hirshfield, 2000), developmental evaluations of children of methamphetamine users are a necessary part of any intervention. If specific delays are detected, then appropriate intervention and treatment must be provided.

Services to Address Child Mental Health and Behavior Problems

Children of methamphetamine-addicted parents, as with children of other substance-abusing parents, may exhibit behavior problems at home and school and other socioemotional challenges, including aggression and antisocial behaviors. Antisocial behaviors (including lying and stealing) may be evident even when children have been removed from drug-using environments (Haight et al., 2005). Both individual and group interventions may be used to model and rebuild social skills to increase prosocial and decrease antisocial behavior.

Social skills interventions. Social skills interventions provided to children as part of parent training models or delivered in child-focused (individual or group) cognitive-behavioral therapy have consistently shown to be effective in helping children achieve a range of positive outcomes, such as decreasing aggressive and antisocial behaviors, increasing problem-solving and conflict management skills (Corcoran, 2000), and decreasing internalizing and externalizing behaviors (Harrison, Boyle, & Farley, 1999).

Individual or family therapy. Often conducted in school-based settings, child-focused therapy can also help children increase social competence, improve peer relations, and enhance problem-solving skills (DeMar, 1997). Individual or family-focused therapy, such as Brief Strategic Family Therapy, has also been shown to be effective in not only decreasing substance use in adolescents but decreasing behavior problems and increasing family functioning as well (Austin, Macgowan, & Wagner, 2005).

Finally, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been identified by SAMHSA as a model program. Children who have been exposed to traumatic life events and receive TF-CBT may experience a reduction in depressive symptoms, oppositional defiant behaviors, and anxiety and experience positive increases in social competency (SAMHSA-CSAP, 2005). Children exposed to maltreatment, drug abuse, or criminal activity (and/or parent arrest) may benefit from interventions that address PTSD reactions as well as other mental health needs.

Summary and Conclusions

The ongoing responsibility when working with methamphetamine-affected families is to control for safety, address the effects of child maltreatment and methamphetamine use on children, and to imple-

ment change strategies that will help to increase protective factors and reduce risk factors for continued maltreatment. Assessments must address the unique needs of these families, and the practitioner must select interventions that best match those needs in order to increase child safety and child and family well-being. Whenever possible, interventions should be selected based on the best available evidence of their effectiveness.

Interventions must be comprehensive, intensive, and long-term to prevent relapse, strengthen family functioning, and address serious child mental health and behavioral consequences that may present as a result of parental use, abuse, or addiction to methamphetamine. Because of the complex needs of these families, interdisciplinary collaboration is required to manage changes in conditions and behaviors over time. Safety should be continually assessed, as relapse is common. Continued opportunities for support should be available to reinforce and maintain the risk reduction process.

Appendix: FAQs About Methamphetamine and Its Effects on Children and Families

What Is Methamphetamine?

Methamphetamine, also known by the street terms "speed," "meth," "crank," or "crystal," is a stimulant drug that is produced either in a powder (similar to cocaine) or crystallized form. Depending on the form of the drug, it can be snorted, injected, smoked, or dissolved in water and swallowed. The crystallized form (also sometimes referred to as "ice") is thought to be more addictive and destructive, although all forms of the drug are extremely addictive. Methamphetamine is as addictive as cocaine, and the effects last much longer (from 6 to 8 hours after administration). Methamphetamine is usually produced in small-scale operations in homes, trailers, or abandoned buildings; these locations are usually in isolated rural areas. Over-the-counter cold medicines containing pseudophedrine or ephedrine are the base ingredients with car starter fluid, fertilizer, drain cleaner, hydrochloric acid, mercuric chloride, sodium hydroxide (lye), and a variety of other toxic and highly explosive chemical solvents also included as ingredients in methamphetamine "recipes" (NIDA, 2005).

How Extensive Is the Problem?

In 2003, 5.2% of adults in the United States had tried a form of methamphetamine at least once in their lives (NIDA, 2005), and in 2004, 1.4 million people over the age of 12 had used the drug in the past year (SAMHSA, 2005); most users are young adults (18-34 years old). Methamphetamine use grew substantially during the 1990s; between 1993 and 2003, treatment admissions increased by close to 600% (from 21,000 to 117,000) (SAMHSA, 2005). Females in particular may initially use the drug to help with weight loss and to increase energy (Brecht et al., 2004).

How Does the Problem Affect Children and Families?

Use of methamphetamine can be detrimental on individual users, their children, and entire family systems.

- Methamphetamine can be manufactured in homes where children live, introducing the risk of exposure to toxins,
- Use is associated with promiscuous sexual behavior, putting children at risk for both prenatal exposure and sexual exploitation,
- Withdrawal can be characterized by long periods of sleep after binge use, leading to lack of supervision of children, and
- The drug can lead to violent and paranoid side effects,which may increase risk of child maltreatment and threaten child safety.

Individual Effects

Individual effects impact the entire bio-psychosocial system of an individual.

Effects of Methamphetamine Use on Individuals

- Heightened energy and feelings of euphoria (NIDA, 2005);
- Personality changes, violence, aggression and agitation (Maxwell, 2005);
- Depression and anxiety (Cretzmeyer et al., 2003), especially with withdrawal (NIDA, 2005);
- Impairments to cognition, memory, and attention, including ADHD (Maxwell, 2005; Simon et al., 2000);
- Possible long-term damage to neuron cells (NIDA, 2005; SAMHSA, 1999);
- Increased risk for stroke and heart problems (Maxwell, 2005);
- Dental problems caused by dry mouth and grinding teeth (Brandjord, 2006);
- Skin lesions (SAMHSA, 1999).

Effects on Children and Families

All of the individual effects previously listed in turn may impact the ability of the parent or caregiver to meet the basic needs of children.

- Exposure to environmental toxins (arsenic, lye, mercury, lead) during the manufacture process, especially risky for young children (USDOJ, 2003).
- Risks from prenatal exposure including developmental and neurological delays (Lester et al., 2006).
- Exposure to sexualized behavior in adults may put children at risk for sexual abuse.
- Agitation and violent behavior associated with withdrawal may increase risk for physical abuse.
- Long periods of sleep after drug binges may lead to neglect of children's basic needs (Cretzmeyer et al., 2003; USDOJ, 2003).
- Chronic drug use has long been associated with increased rates of child abuse and neglect, inadequate nurturance, and increased rates of associated problems, such as depression and violence, which affect parenting and child development (Zuckerman, 1994).
- May compromise support systems especially in small, isolated communities (Haight et al., 2005).
- Some estimates find that as many as 35% of methamphetamine labs are homes to young children (CADEC, 2005).

What Factors May Protect Against These Negative Impacts?

- Temperament of child
- Positive early childhood experiences
- Positive and accessible positive role models within the extended family network
- Positive school experiences—school may be a refuge from chaotic home environment and allow opportunities for helping professionals to identify and intervene with affected families and provide alternate role models (Haight et al., 2005)

Drawing on factors thought to contribute to these protective factors, while providing effective interventions for the known effects of the methamphetamine culture on children, may reduce the impact of this drug on children and families.

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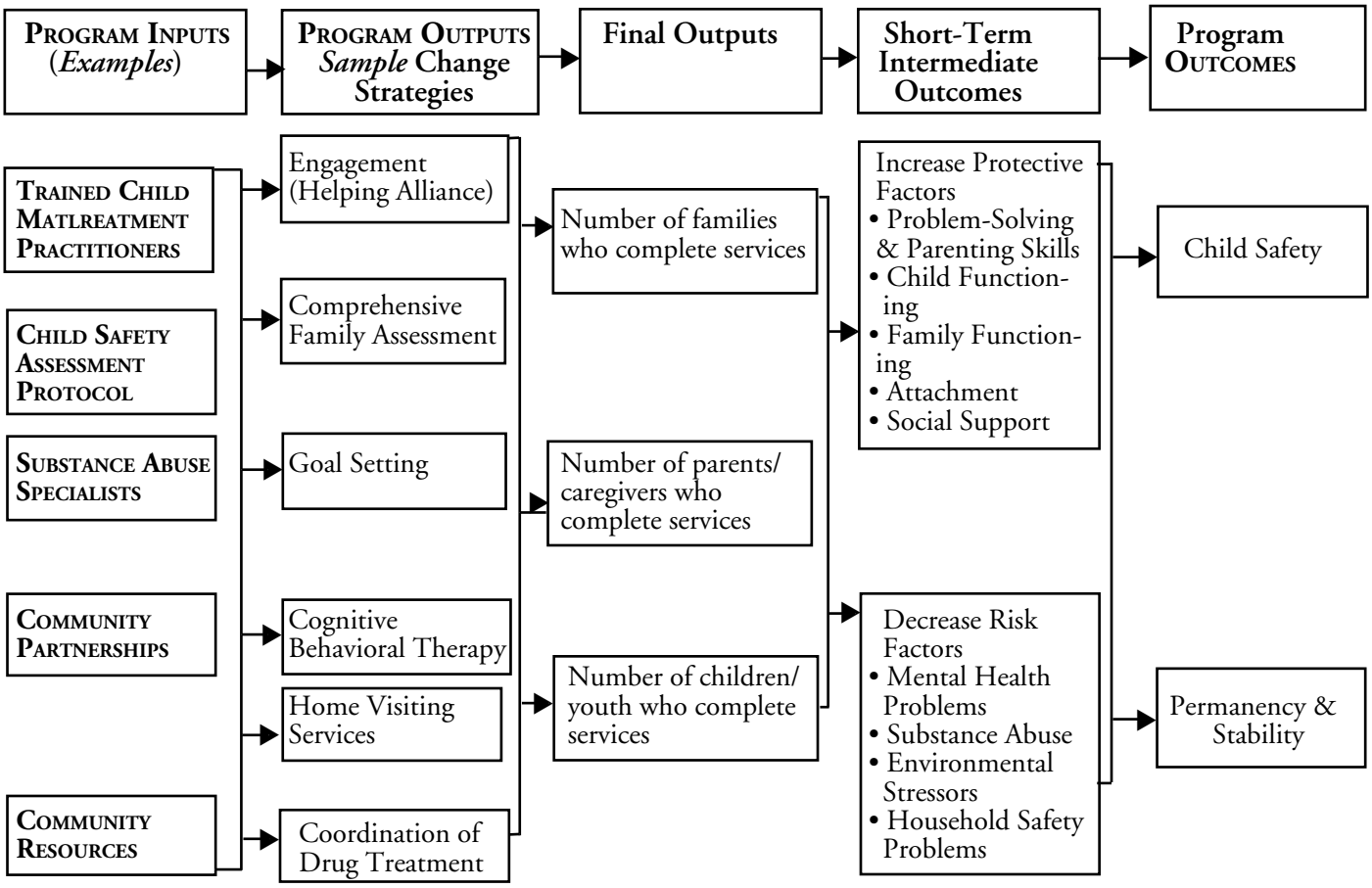
Figure 1. Sample Logic Model for Work With Methamphetamine-Affected Families
Assumptions: Providing or facilitating change strategies that enhance protective factors and decrease risk factors will eventually increase safety and permanency for children



Notes

[1]Adapted with permission from the National Resource Center for Child Protective Services: DePanfilis, D., & Hayward, R. A. (2006). *Ongoing child protective services (CPS) with methamphetamine using families: Implementing promising practices*. Prepared for the National Resource Center for Child Protective Services, a program of the USDHHS, Children's Bureau. Available at: http://www.nrccps.org/PDF/Ongoing_CPS_with_Meth_Using_Families_Implementing_Promising_Practice10302006.pdf

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WHAT'S NEW AND WHO'S DOING IT?

The Trauma Treatment Training Center: Disseminating Evidence-Based Trauma Treatments in Community Settings

Erica Pearl, PsyD, Erna Olafson, PhD, PsyD, Barbara Boat, PhD, Lisa Connelly, MA, Lacey Thieken, BA, Frank W. Putnam, MD

The Trauma Treatment Training Center (TTTC) is a collaboration of the Mayerson Center for Safe and Healthy Children and the Childhood Trust at Cincinnati Children's Hospital Medical Center (CCHMC). The Mayerson Center is a child advocacy center dedicated to prevention, evaluation, treatment, and research in child abuse and neglect. The Childhood Trust offers training and consultation on the assessment and treatment of child abuse and family violence. Originally funded under a SAMHSA grant in 2002 as part of the National Child Traumatic Stress Network (NCTSN), the TTTC was reconfigured after the grant expired in 2005.

The primary focus of the TTTC is to develop and disseminate trauma-informed, evidence-based, and evidence-informed treatments for children and their caregivers in formats that are viable for use in community agencies. Our replication cycle utilizes continuous quality improvement to improve the replication at each cycle. We select an evidence-based treatment (EBT), prepare training materials, train community providers and provide them with ongoing consultation, and collect feedback from trained providers and agency administrators to adapt models to meet the unique needs of each user. Trained clinicians also make use of the pre- and posttreatment outcome measures that we recommend, and they transmit results to the TTTC.

The TTTC currently provides training on the following six evidence-based or evidence-informed interventions:

Parent-Child Interaction Therapy (PCIT)

PCIT is a dyadic (caregiver-child) evidence-based treatment supported by more than 20 years of research and practice (Herschell, 2002). Originally developed in the 1970s to treat children's behavioral disorders, it has been increasingly utilized and found to be effective with a variety of other populations, including children with developmental delays, children in foster care, and children who have been maltreated or exposed to domestic violence (Eyberg, 2005; Urquiza, 1996). The therapist observes through a one-way mirror while the caregiver practices PCIT skills with the child and coaches the caregiver through a "bug-in-the-ear" device, or one may observe sitting with the caregiver and child in the room. Research shows that PCIT's repeated live coached practice, together with 5 minutes of daily home practice, is significantly superior to other parent training methods in enhancing parent-child relationships, improving children's behaviors, and replacing negative parenting and physical discipline with consistent, noncoercive limit setting (Chaffin, 2004). Sessions are generally held weekly for 1 hour and average 1420 weeks. Data collected by our trained clinicians on 41 families show excellent results in alleviating children's symptoms, reducing their disruptive behaviors, and decreasing parental stress. Measures used include the Child Behavior Checklist, Eyberg Child Behavior Inventory, Parenting Stress Index, Child Dissociative Checklist, and Trauma Symptom Checklist for Children.

Child-Adult Relationship Enhancement (CARE)

CARE is a trauma-informed, field-initiated modification of specific Parent-Child Interaction Therapy (PCIT) skills for use by adults who work with traumatized children and adolescents. This promising approach is a separate intervention developed by the TTTC in collaboration with therapists and service providers whom we had trained in PCIT. In response to feedback from the children and families they served, therapists adapted PCIT to serve special circumstances and then used the TTTC's structured conference call and listserv platforms to share successful adaptations. CARE thus reflects a cocreation between our training center and a range of community agencies and their consumers.

CARE contains three core components: (1) child-adult relationship enhancement; (2) child behavior management; and (3) psychoeducation about the behaviors and problems exhibited by many traumatized children. Because basic CARE skills can be taught in 3-6 hours, CARE is well suited to community agencies with limited time and resources. CARE has been found to be successful with foster parents, foster care caseworkers, child protection workers, staff in battered women's shelters and homeless shelters, advocates for child victims, staff in residential treatment centers, day care providers, Head Start teachers, medical care providers, staff in partial hospitalization programs, social service case managers. home visitation providers, and staff providing international adoptions. CARE can also be taught to parent groups, and a protocol is also available for families with adolescents.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is an evidence-based treatment developed by trauma experts at the National Child Traumatic Stress Network (NCTSN) to help children, from ages 3 to 18, and their parents overcome the negative effects of traumatic events, such as child sexual abuse, natural disasters, or domestic violence (Cohen, 2006; Cohen, Mannarino, & Deblinger, 2006). TF-CBT is a clinic-based, short-term treatment (12-16 weeks) for the child and parent and provides joint parent-child sessions as appropriate. TF-CBT targets the posttraumatic stress disorder symptoms, depression, anxiety, and behavioral problems commonly experienced by children who have been traumatized.

Cognitive Behavioral Therapy for Childhood Traumatic Grief (TG-CBT)

TG-CBT was also developed by NCTSN experts and draws from a variety of evidence-based treatment models that deal with traumatic grief. TG-CBT is based on a specific sequence that includes a trauma-focused phase and a grief-focused phase. It includes between 12 and 16 individual sessions for the child and for the parent, with joint parent-child sessions at appropriate times (Cohen, Mannarino, & Deblinger, 2006).

Psychological First Aid (PFA)

PFA was developed by the Terrorism and Disaster Branch of the NCSTN and the National Center for PTSD. PFA is an evidence-informed approach for assisting children, adolescents, and families in the immediate aftermath of disasters and terrorism. It is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning for children and their families, and it is intended for children and adults of all ages who have experienced disasters or terrorism. This 3-6 hour training is intended for mental health professionals who provide assistance to children and families as part of an organized disaster response.

Cognitive Processing Therapy for Sexual Abuse (CPT-SA)

CPT-SA is an adaptation of Cognitive Processing Therapy that has been used to effectively treat individuals aged 12 to adulthood who have experienced various traumas. CPT and CPT-SA reduce PTSD and other posttraumatic symptoms in veterans, rape survivors, child sexual abuse survivors, and others. CPT-SA includes sections specifically designed to focus on the areas of concern for sexual abuse survivors, including safety, trust, power/control, communication, intimacy, and social support. It is typically conducted in 17 50-minute sessions.

Figure 1. TTTC Training Timeline: May 2006–May 2007

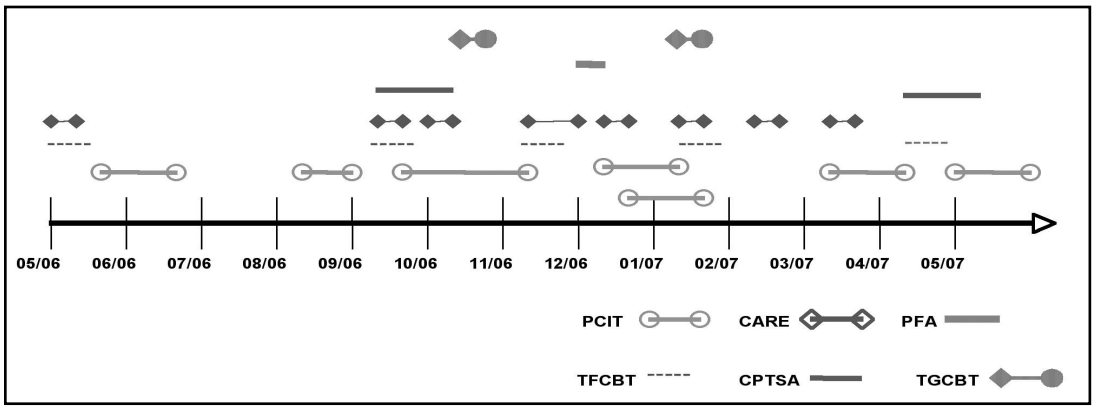


Figure 1 shows the numbers of trainings for all models as an example of the training output of the TTTC over the last year.

The TTTC has worked with 89 agencies in 18 states, Canada, and Japan and has trained 558 therapists and service providers. Forty trainees have been trained in two or more of our trainings, and 60 providers from 31 agencies have trained with us to become trainers. Figure 2 shows the increasing number of therapists trained per year by the TTTC.

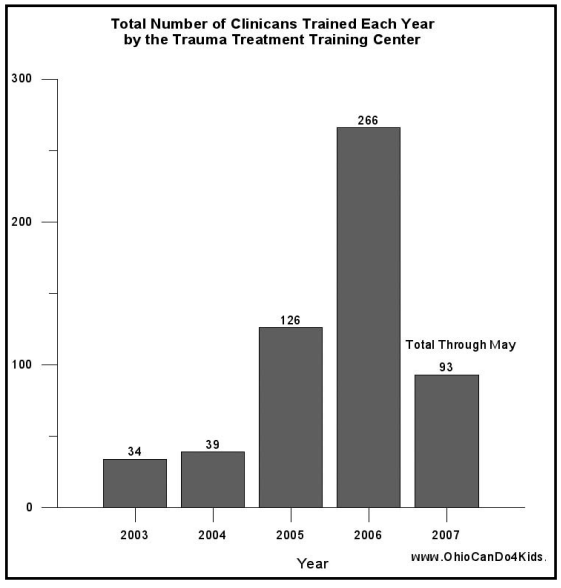
The TTTC has completed 18 replication cycles of PCIT, 6 replications of TF-CBT, 21 replications of CARE, 3 replications of TG-CBT, 2 replications of CPT-SA, and 1 replication of PFA. As a result, we have full sets of training materials for each model and experience working with a wide range of agencies.

In each model, trainees are required to formally demonstrate mastery of specific skills before progressing to the next skill. We continue to work with trainees as they apply what they have learned in their communities, through regularly scheduled conference calls, during which time our trained clinicians apply each new model with their initial clients. Four to six therapists from multiple agencies generally participate in each call and often provide important suggestions to each other. We have learned the most from these ongoing consultations about adapting and revising interventions to address the many complexities faced by therapists in the real world of community mental health services. In collaboration with our consumers, we have revised our trainings, protocols, and implementation materials to create clinical adaptations and modifications for special circumstances and diverse populations. We incorporate these adaptations into subsequent replication cycles, thus creating a continuous quality improvement loop for effective translation of evidence-based treatments real world of community agencies.

In addition to training and providing follow-up consultation to clinicians, the TTTC works with agency supervisors to preserve model fidelity during implementation and to ensure sustainability by training trainers within agencies. To ensure agency reimbursement, the TTTC collaborates with agency administrators around issues of fiscal management and sustainability, and it works with third-party payers to authorize models as billable therapies.

The TTTC has also developed a structured train-the-trainer approach to support both model fidelity and sustainability within agencies. After clinicians are trained in a model and supervised until they demonstrate competence on representative cases, selected clinicians are invited to work with our staff as co-trainers through a full replication cycle. As trainers in training, these clinicians attend at least one training, co-present didactics, and coach small group exercises, while our training staff supervises their training skills and helps them achieve mastery on our structured trainer criteria. These trainers in training then conduct training at their agency, which is attended by our staff. Trainees who meet competency criteria

Figure 2. Numbers of Therapists Trained by Year



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then receive the full Implementation Toolkit materials necessary to conduct their own independent trainings.

In 5 years of training and dissemination, we have learned much about agency characteristics that foster the embedding of effective trauma-informed interventions. We have learned that we can help with organizational readiness, provide critical information, and require that each agency commits to training a "critical mass" of therapists (a minimum of two for a small agency) to provide mutual support and clinical coverage in each model. We have had the greatest success in agencies where supervisors took part in the trainings with their staff. Most important, low staff turnover, good clinician morale, and visionary agency leadership are crucial to success.

For more information on the TTTC, please visit www.OhioCanDo4Kids.org.

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Journal Highlights

Tamara Davis, PhD,
Beth Ann Rodriguez, MSW,
Jordan Greenbaum, MD

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.*

Psychology Research Increases Focus on Physical Abuse and Neglect

The dominant types of maltreatment found in children and families in the child welfare system remain the same as a century ago. Physically abused and neglected children disproportionately come from families in poverty, with 61% of child welfare cases involving child neglect, 19% involving physical abuse, and 10% involving sexual abuse (USDHHS/ACYF, 2005). Yet, historically, both research and practice in the fields of psychology and mental health have focused their child maltreatment efforts on child sexual abuse. Further, during the 1980s and 1990s, between 13% and 38% of child abuse studies in psychology included participants from the child welfare system. Most studies assessed child sexual abuse in populations of women from college campuses, or involved in outpatient psychotherapy, or both.

In this article, Chaffin discussed historical trends and emerging changes to achieve a broader focus in child maltreatment research and the implications of these changes for future research and practice. Though attention to child sexual abuse remains substantial in the field of psychology, it is decreasing as a percentage in overall child maltreatment research. One contributor to this change is the increase in governmental health and mental health agency funding of research in physical abuse and neglect. Other factors include influential initiatives, such the Child Abuse and Neglect Working Group, whose 1998 report identified key knowledge gaps in the field of child maltreatment research, especially in the area of child neglect.

Chaffin discussed possible implications for psychology research and practice as a result of the expanding focus to include maltreatment and other social problems affecting children. For example, research demographics will expand to include characteristics such as gender, relationship to perpetrator, socioeconomic status, and cultural differences. Further, the causes of child maltreatment will be more differentially explored. Psychology researchers and practitioners will become more aligned with the social work profession and child welfare practice field as psychologists increasingly contribute to intervention science in the field of child welfare. This may mean that the changing roles of mental health professionals in child welfare will provide psychology with a greater opportunity to contribute in a multidisciplinary environment.

Chaffin, M. (2006). The changing focus of child maltreatment research and practice within psychology. *Journal of Social Issues, 62(*4), 663-684.

Family and Child Characteristics as Risk Factors for Re-referral

The federal Child and Family Services Review (CSFR) process has incorporated recurrence of maltreatment as an outcome indicator of the functioning of the public child welfare system. Child welfare research has typically focused on the specific risk of recurrence of abuse or neglect in children with substantiated maltreatment, rather than factors contributing to risk of re-referral in a broader population of unsubstantiated cases.

This Rhode Island study examined the rates of re-referrals for all cases between 2001 and 2004 using data on all closed CPS investigations that did not result in removals (22,584 children). The study's hypothesis was that child, family, and case characteristics would be significantly related to risk of re-referral. Child characteristics thought to create a higher risk were younger age of children, children with previous substantiated maltreatment incidents, and children with physical, emotional, or behavioral disabilities. Family characteristics included poverty or financial hardship, alcohol or drug problems, and domestic violence. Children previously neglected were also thought to be at higher risk for re-referral to CPS.

Results from this study indicated that approximately 40% of cases that were investigated and closed were re-referred to CPS within 3.75 years of the initial investigation. One third of these re-referrals occurred within the first 6-month period after the initial case closure. The most significant family characteristic affecting re-referral for maltreatment, particularly neglect, was poverty and its associated circumstances. Parental history of substance abuse and child disability status were other strong predictors of re-referral.

Implications from this study suggest greater attention to risk in cases that are investigated and closed without having been substantiated. The authors recommended development of more programs to support families with the identified risk characteristics. They further suggested that the child welfare field should also target prevention services to high-risk cases during the initial 6 months after CPS investigation.

Connell, C. M., Bergeron, N., Katz, K. H., Saunders, L., & Tebes, J. K. (2007). Re-referral to child protective services: The influence of child, family, and case characteristics on risk status. *Child Abuse & Neglect, 31*, 573-588.

Cont'd on page 24

Deconstructing Culture in Child Welfare Research

Ethnicity and culture have received more attention by researchers in recent years, primarily because of increased awareness of disparities in health and mental health for ethnic minorities. In the field of child maltreatment, disparities can also be found in the rates of reported maltreatment, the numbers of children in foster care, and the frequency and intensity of services received. These considerations have prompted child maltreatment researchers to study ethnic and cultural factors that impact children and families. The authors reviewed and provided a critique of this body of research and made recommendations to improve the effectiveness of culturally focused research in the field of child maltreatment.

The article defines *ethnicity* as "membership in a group based on common ancestry, heritage, culture, or history" (p. 788), and it defines *culture* as "shared values, behaviors, beliefs, norms, traditions, customs, and ideas of subgroups of individuals" (p. 788). The authors contend that a primary challenge for many researchers studying disparities in child welfare is their inability to deconstruct ethnicity and culture. Research has typically compared child maltreatment across broad ethnic groups, but as culture is not synonymous with ethnicity, focusing on broad groups may obscure important underlying cultural factors.

In this article, the authors made four recommendations for future research: (1) further study and expansion of the definition of culture, (2) identifying and examining cultural correlates that are proximal to the experience of child maltreatment, (3) increased collaboration among researchers in different practice fields to increase the effectiveness of child maltreatment research efforts, and (4) child maltreatment research must recognize the dynamic and complex nature of culture and the challenge this brings to researchers as they attempt to quantify and analyze data using simple experimental techniques.

Elliott, K., & Urquiza, A. (2006). Ethnicity, culture, and child maltreatment. *Journal of Social Issues, 62*(4), 787-809.

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Foster Children's Perspectives on Out-of-Home Care

More than a half million children across the nation reside in out-of-home care. Yet, historically, child welfare research literature and day-to-day child welfare practice do not provide children with many opportunities to voice their perspectives in order to provide a better understanding of the out-of-home care system. Emerging literature is exploring children's experiences in out-of-home care.

The authors of this study reviewed current literature on foster children's views regarding out-of-home care in relation to four child welfare goals: (1) protecting children from harm, (2) fostering children's well-being, (3) supporting children's families, and (4) promoting permanence. Several themes emerged. Many children in out-of-home care felt safe in their caregiver's home but not necessarily safe in the neighborhoods where they lived. Relationships mattered for children in care; in interviews, they verbalized the ways they have been positively influenced by certain relationships and how these contributed to their feelings of safety, well-being, family, and permanence. Another prominent theme was the changing definition of *family* for children in care. Family may refer to a child's birth family, extended family, and new families. It is important for the system to recognize and support inclusive definitions of family in order to meet the social and emotional needs of these children. Finally, the authors noted that too often, children in care are excluded from participating in permanency decisions. The literature strongly suggests that systems should do a better job of including children's voices in their permanency decision making.

Fox, A., & Berrick, J. D. (2007). A response to no one ever asked us: A review of children's experiences in out-of-home care. *Child and Adolescent Social Work Journal, 24*(1), 23-51.

Child Maltreatment and Mental Health: Age Matters

It is well documented that childhood maltreatment can affect the later mental health functioning of victims. Much has been theorized about the impact of a child's age at the onset of maltreatment, but it remains unclear whether maltreatment that occurs at certain ages or stages of development is associated with more harmful long-term consequences than others. This study tested the hypothesis that children maltreated earlier in life are at greater risk for poor psychopathology in adulthood than those maltreated at a later age. Data came from historical public criminal records of 496 juveniles and adults with substantiated cases of physical abuse, neglect, and sexual abuse prior to age 12.

For the study, the age-of-onset variable was classified in three ways: (1) continuous (ages 0-11), (2) dichotomous (early, ages 0-5, vs. later, ages 6-11), and (3) developmental (infancy, preschool, early school age, and school age). Results of the study indicated that an earlier onset of maltreatment, measured dichotomously and developmentally, predicts more symptoms of anxiety and depression in adulthood (while controlling for gender, race, current age, and other abuse reports). Later onset of maltreatment, measured continuously or developmentally, predicted more behavioral problems in adulthood.

The authors asserted that this study has important implications because it suggests differential effects of child maltreatment based on the child's age at the onset of maltreatment. This information

can be used to better individualize interventions for young children. For example, children who have been abused between the ages of 0-5 are at high risk for anxiety and depressive symptoms in adulthood. It is important to help these children establish effective coping and emotion-regulation skills. The findings also suggest that future research should use a developmental model to classify age of onset, since it was found to be the most promising of the three classification systems used.

Kaplow, J. B., & Widom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology, 116*(1), 176-187.

A Continuum for Reunification of Children in Long-Term Foster Care

The provisions of the Adoptions and Safe Families Act, which mandated shorter time frames for permanency for children in foster care, has not shortened length of stay in foster care for many children. One third of the children in foster care today have been in care for 3 or more years, some for 5 or more years. The authors contend that the system must explore alternative strategies to provide permanence for children in long-term foster care.

The Replacement with Birthfamilies Project (Replacement) was initiated in Texas in 1997 to explore the potential of birth families and extended kin as permanency options for children in long-term foster care. One of the primary values of the project is the belief that it is possible for families to change. Parents and kin and/or their situations can change and make it possible for them to have a relationship with their children. Early in the project, the team determined that its goal was too narrow and hindered engagement with birth families and family members who wanted contact but who could not provide a home. The team reframed the goal, and reconnection became an equally valued outcome for the project as part of the reunification continuum.

The Replacement project reviewed the case records of 281 eligible children and initiated assessments with relatives of 158 children, although not all the identified families completed the process. Sixty children were reconnected with relatives, including birthparents, grandparents, siblings, extended family, and stepfamily. The family connections were established at different levels of the reunification continuum, from writing letters and making phone calls, to visiting, and to permanent placement for 18 of the children.

The authors made several program-related recommendations to child welfare agencies. Good collaboration between child protective services and the project agency is very important. Reunification must be seen as a continuum. Any kind of reconnection with birth family can be of value to a child. It is also important that project staff maintain a nonjudgmental attitude when working with the birthfamily. Continuity in the relationship between the project staff and the family is essential and expedites replacement or reconnection. Finally, the authors noted the importance of understanding that the biological or historical bond between a child and the birth family will not necessarily lead to quick development of family bonding.

Mapp, S. C., & Steinberg, C. (2007). Birthfamilies as permanency resources for children in long-term foster care. *Child Welfare, 86*(1), 29-51.

Challenges to MEPA-IEP Implementation

In this article, McRoy and colleagues explored the background of the Multiethnic Placement Act of 1994 and the Interethnic Adoption Provisions of 1996 (MEPA-IEP) and described disparate outcomes for minority children, especially African American children. Minority children make up the largest number of children in the child welfare system awaiting adoption. MEPA and IEP are controversial laws that were originally created to remove barriers to permanency for children of color. These laws have been much debated, legally examined, widely interpreted, and misinterpreted. The authors argued that central to the debate is whether the intent of these laws was to reduce the length of waiting for adoption for children of color, or an effort to find children for white adults seeking to parent whomever they might select.

An essential part of MEPA that receives little attention is the mandate for diligent efforts to recruit foster and adoptive families who represent the racial and ethnic backgrounds of children in foster care. Enforcement efforts to date focus on the "no delay" provision with no regulations issued for recruitment requirements. The authors provided tools for successful recruitment of families of color in a MEPA-IEP world. They describes the need to focus on workforce development and training, especially in the area of identity development and the impact of adoption on children's sense of identity.

McRoy, R., Mica, M., Freundlich, M., & Kroll, J. (2007). Making MEPA-IEP work: Tools for professionals. *Child Welfare, 86*(2), 49-66.

Training Foster Parents to Meet the Needs of School-Aged Children

Foster children are 3 to 10 times more likely to have developmental delays and physical, social, emotional, and academic problems. Clinical researchers agree that the time children spend in foster care can be better utilized to help children learn new skills, modify maladaptive aspects of their behavior, and enhance the factors that promote resilience. The focus of interventions is often on family

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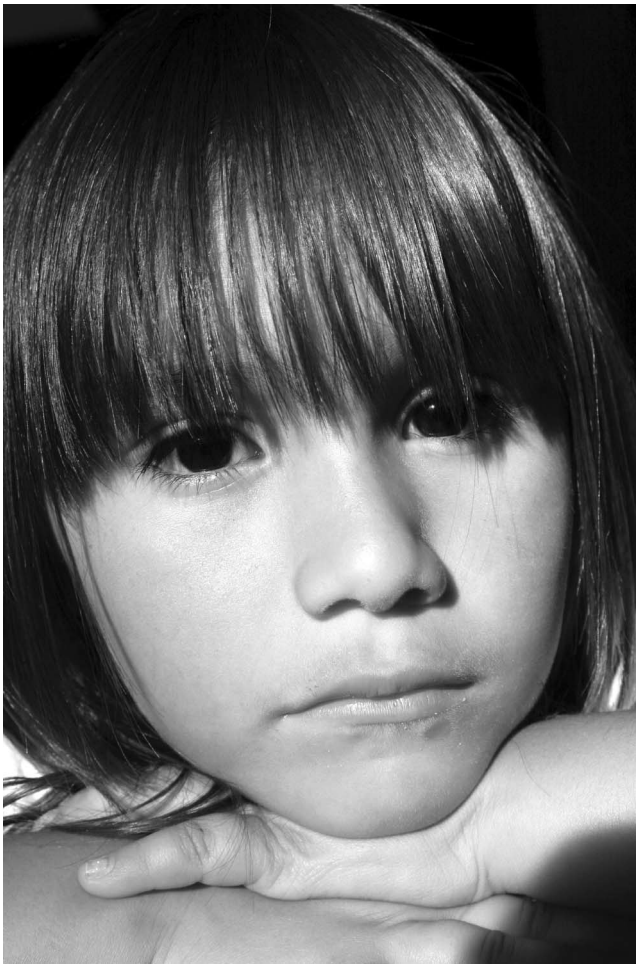
reconciliation or preservation, overlooking the potential therapeutic opportunities in the foster home. Most children who enter the child welfare system are of elementary school age, and most disruptive behaviors in foster care are seen in this group of children. Thus, more attention is needed in training caregivers who work with this age group.

This small study of 18 families tested a pilot intervention to improve parenting and reduce disruptive behavior in elementary school-aged children in foster care. It adapted an existing evidence-based intervention, *The Incredible Years*, developed for birth families, and used it to train a group of foster caregivers. Foster parents participated in a 12-week training program that focused on parenting skills and caregiver-child interaction; psychoeducation specific to the foster care system; and social support for foster caregivers. Results indicated that symptoms of conduct disorders and externalizing behaviors were significantly lower for children whose foster caregivers had participated in the training program. There were no significant changes in parenting attitudes or stress experienced by foster families. Foster parents did report high levels of satisfaction and acceptability with the program and its outcomes. Based on these findings, the authors suggested that more examination and evaluation of foster caregiver training programs for preadolescent children, using larger samples and randomized control trials, is needed.

Nilsen, W. (2007). Fostering futures: A preventive intervention program for school-aged children in foster care. *Clinical Child Psychology and Psychiatry, 12*(1), 45-63.



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Placement Stability and Child Behavioral Well-being

The Adoption and Safe Families Act of 1997 ensured a focus on permanency and adoption as a priority for all children in foster care. Despite this focus, nearly half of children in the child welfare system continue to live in foster care for more than 18 months, and many for several years. This study analyzed data from the National Survey of Child and Adolescent Well-being (NSCAW) in an to attempt to explain the relationship between a child's well-being and placement history, by applying a propensity score analysis on a cohort of children who were continuously in foster care for at least 18 months. Out of the 5501 children in the database, 729 met selection criteria. A composite behavioral well-being variable was constructed from two behavioral assessment tools, the Child Behavior Checklist (CBCL) and temperament scores for infants. The combination of both tools allowed the researchers to include children with ages from birth to 15 years. The goal was to identify the inherent contributions of a child's placement stability toward her or his risk for behavioral problems 18 months after entering foster care.

This study found compelling evidence that children in foster care experienced placement instability unrelated to their baseline problems, and this instability had a significant impact on their behavioral well-being. The authors suggested that this finding supports the development of interventions that promote placement stability as a means to improve outcomes among youth entering care.

Rubin, D. M., O'Reilly, A. L. R., Luan, X., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics, 119*(2), 336-344.

The Academic Vulnerability of Children in Foster Care

Child welfare policy makers and advocates are increasingly concerned about the academic vulnerability of maltreated children. This concern is reflected in the inclusion of child educational progress as an outcome for state performance in the Adoption and Safe Families Act. The National Conference of State Legislators reported that only 11 states have "substantively achieved" education outcomes.

This article reviewed research conducted since 1990 on educationally-related issues and outcomes for maltreated and foster youth to describe the nature, extent, and factors related to academic vulnerability of maltreated foster children. The review focused on child and family factors as well as on organizational, institutional, and policy-contextual factors within the educational and child welfare systems. Research has consistently found links between poor educational performance and child maltreatment and out-of-home care but has offered much less insight into how and why these links occur.

The authors contended that existing research suffers from substantial methodological limitations. Few studies examine factors that place students at risk for maltreatment and entry into the child welfare system as they relate to academic risk factors and educational progress. Little attention is given to potential moderating and mediating influences that are important for targeting policies or services to youth. The authors note an additional need for more longitudinal studies of foster youth's educational vulnerability, such as the impact of school transitions on foster youth.

Existing literature suggests that youth are academically at risk prior to and after entry into the child welfare system. There is a set of variables that may link maltreatment and educational outcomes. It is important to clarify the nature and quality of those variables and their effect in order to begin to identify gaps and points of interventions.

Stone, S. (2007). Child maltreatment, out-of-home placement and academic vulnerability: A fifteen-year review of evidence and future directions. *Children and Youth Services Review, 29*, 139-161.

Knowledge, Attitudes, and Confidence Regarding Child Maltreatment in Prehospital Emergency Medical Service Personnel

Prehospital medical providers (emergency medical service personnel) have a unique opportunity to recognize and report child maltreatment. They are able to evaluate the child and caretaker in the home environment, gain historical information during the earliest stages of the process, and directly view scenes of reported traumatic events. This study evaluated the knowledge and confidence of prehospital providers in recognizing, managing, documenting and reporting suspected maltreatment. Results of a questionnaire completed by a random sample of providers (1237 responders) indicated that 44% had received no continuing medical education on child protection within the past year, and 78% felt they needed additional education. There were major deficiencies in knowledge of core concepts in child maltreatment and in patient assessment, with a large proportion of questions answered incorrectly regarding assessment of maltreatment (91.3% answers incorrect), developmental abilities in children (88% incorrect), history (79.9%), and family management (79.7%). Nearly 50% of questions related to the level of certainty needed to report child maltreatment were answered incorrectly, typically with responders indicating a greater level of "proof" needed than is actually the case. Years of experience, initial hours of child maltreatment education, and CME were associated with correct answers on the questionnaire. Responders indicated a lack of confidence in assessing sexual abuse relative to physical abuse (47.8% vs. 10.1% expressed discomfort in identifying and managing sexual vs. physical abuse). Study results indicate a need for greater education of prehospital medical providers in the recognition and reporting of child maltreatment.

Markenson, D., Tunik, M., Cooper, A., et al. (2007). A national assessment of knowledge, attitudes, and confidence in prehospital providers in the assessment and management of child maltreatment. *Pediatrics, 119*(1), 103-108.

Healing of Hymenal Injuries in Prepubertal and Adolescent Girls

Clinical research over the past 25 years has demonstrated that the vast majority of children evaluated for sexual abuse have no diagnostic abnormality on anogenital exam (see extensive reference list in this article). This retrospective, multicentered study added to this literature by examining the healing process of hymenal trauma sustained by 239 prepubertal and adolescent females. Generally, small subgroups (patients varied in type of injury, age group, and time interval between injury and follow-up) limited the conclusions to be drawn regarding the time required for injury resolution, except that petechiae (pinpoint areas of bleeding) were consistently noted to resolve within 48-72 hours (consistent with petechiae in other regions of the body). Blood blisters were found as late as 34 days after injury. In both prepubertal and adolescent girls, evidence of a *recent* injury (bruising, abrasion, swelling) disappeared within 2 weeks in the vast majority of cases. The depth of a hymenal laceration (tear) changed during the healing process, in some cases becoming more shallow and in other cases, deeper (as the swelling subsided). Changes in the overall shape and depth often continued for up to 3-4 weeks. The outcome and final appearance of a hymenal laceration depended on the severity, but in the majority of cases (except the most severe), the membrane recovered a smooth, continuous rim.

There was no difference in the healing process between prepubertal and adolescent females with hymenal trauma. Frequently, there was little or no evidence of the injury when healing was complete. No hymenal scarring was noted in any child.

McCann, J., Miyamoto, S., Boyle, C., & Rogers, K. (2007). Healing of hymenal injuries in prepubertal and adolescent girls: A descriptive study. *Pediatrics, 119*(5), 1095.

Methamphetamine Exposure Presenting as Caustic Ingestions in Children

Caustic ingestion among young children and methamphetamine use among adult caregivers constitute two discrete health problems. This case report describes co-occurrence of these entities in two young children (2 and 5 years of age), who sustained severe caustic burns from ingesting the sulfuric acid contained in drain- opening substances being used in methamphetamine production. Both children sustained significant skin and oral burns (one child required skin grafts after experiencing burns to the neck, chest and abdomen). The 5-year-old sustained significant damage to the esophagus and stomach. He developed an esophageal stricture (narrowing of the opening due to extensive scarring), which ultimately required removal of the diseased portion of esophagus and replacement with a section of colon. Both children tested positive for methamphetamine (hair sample in one case and urine sample in the other). The authors discussed the dangers of accidental ingestion of toxic materials used in methamphetamine production and included a table of common materials used in labs. They pointed out that children in meth labs are at risk of multiple types of maltreatment, including supervisory neglect and physical violence. The children may also test positive for methamphetamine secondary to living in a home contaminated with the drug residue.

Farst, K., Duncan, J. M., Moss, M., et al. (2007). Methamphetamine exposure presenting as caustic ingestions in children. *Annals of Emergency Medicine, 49*(3), 341-343.

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Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

Congress Set to Challenge Bush on Fiscal 2008 Spending

The end of the Memorial Day congressional recess signals the start of essential budget deliberations on Capitol Hill as Congress begins drafting the appropriations bills for the coming fiscal year. This year, for the first time in 12 years, the Democrats are calling the shots and pushing for substantial increases in domestic discretionary spending.

The budget resolution spending plan passed by the House and Senate in May sets a cap on domestic discretionary funds across all federal agencies at $21 billion more than the White House requested for fiscal 2008. (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.) In allocating the additional spending across the 12 federal appropriations bills, Congress has provided more spending than the President sought for 8 of the 12 annual money bills. The President has threatened to veto any spending bill that exceeds the administration's budget request for that specific measure, which is certain to create challenges for the Democratic leadership.

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Aiming for the first time in 12 years to pass all spending measures by the beginning of the new fiscal year in October, appropriations leaders in the House plan to complete passage of 11 of the 12 spending bills in June and leave the defense appropriations measure for vote in July. The Senate hopes to begin drafting its bills in mid-June. Among the bills scheduled for early action is the Labor-HHS-Education appropriations measure. This bill is typically a center for controversial policy riders on social issues—with family planning and abortion services often at the top of the list—and this year is expected to be no exception. Moreover, the bill's total is set at $6.6 billion in new money above the 2007 allocation, and additional funds will be aimed at education, social services, and job-training programs. The President's budget request cut total spending in the bill by $3.6 billion from the 2007 level.

The additional funding for domestic programs allocated by the Democrats comes from cutting $3.5 billion from the President's defense request and cutting smaller amounts of no more than $700 million from three other bills: Financial Services, Legislative Branch, and State-Foreign Operations appropriations.

Home Visitation Bill Introduced Again in the House and Senate

Legislation to expand federal support for home visitation services was introduced in the Senate earlier this year by the original author of the measure, Sen. Christopher Bond (R-MO), with cosponsorship by Sen. Hillary Clinton (D-NY). The Education Begins at Home Act (S. 667), similar to the legislation Bond introduced in the last Congress, authorizes $400 million over 3 years in grants to states for programs of early childhood home visitation. The funds are intended to secure positive outcomes for children and families, including promoting positive parenting practices, reductions in child maltreatment, improved child health and development, and readiness for school. A companion bill, H.R. 2343, has been introduced in the House by Rep. Danny Davis (D-IL) with Rep. Todd Platts (R-PA).

Funds for services to support pregnant women and parents of children from birth until kindergarten entry would be allotted based on a state's proportionate share of the total number of children aged birth to 5 years. Home visiting services would extend to other primary caregivers of a child, including grandparents, other relatives, and foster parents. A portion of the funds would be set aside for payments to Indian tribes and tribal organizations applying for support of home visitation services.

The voluntary, early childhood home visitation services, required to occur no less frequently than once a month—and more often for families with "additional needs"—would also support referral of families to other community resources, such as child care, health and mental health services, literacy programs, employment agencies, and other social services.

As in earlier versions of the Education Begins at Home Act, S. 667 includes separate funding authorized at $50 million over 3 years for the Department of Health and Human Services, in collaboration with the Department of Education, to expand early childhood home visitation programs to serve families with English language learners. In addition, the bill authorizes another $50 million for 3

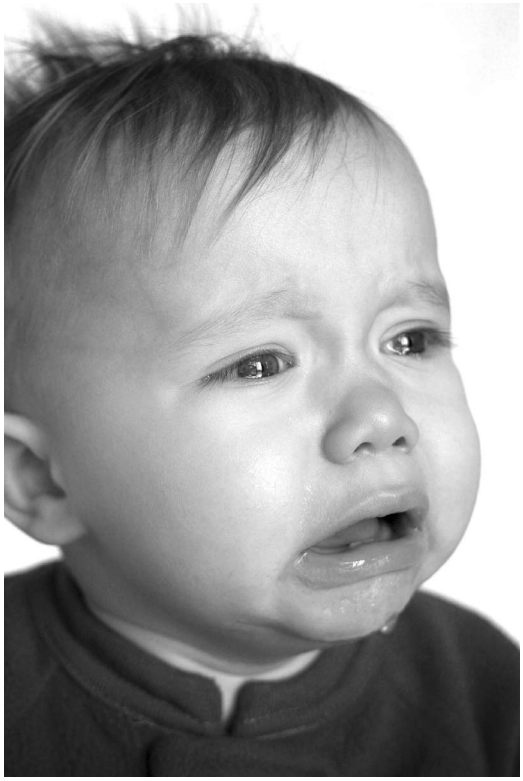
years to allow the Department of Defense, in collaboration with the Department of Education, to make grants on a competitive basis to support early childhood home visitation programs serving military families.

Finally, new provisions in the Senate bill, not included in previous versions of the Education Begins at Home Act, would authorize "such sums as necessary" for HHS to develop a public education and awareness campaign on the proper care of infants and young children. These services would be offered primarily through hospitals, which would offer parenting classes on caring for newborns. Special attention would be given information about the vulnerability of infants and young children to abusive head trauma and other injuries.

Dodd/Lowey Bills to Prevent Shaken Baby Syndrome

Senator Christopher Dodd (D-CT) introduced legislation in April aimed at focusing federal efforts on public awareness and education about the risks and dangers associated with shaken baby syndrome (SBS). The bill, the Shaken Baby Syndrome Prevention Act of 2007 (S.1204), would establish a national public health campaign to encourage prevention programs for frustrated parents and caregivers and would provide support to families affected by incidents of abusive head trauma. Companion legislation (H.R. 2052) was introduced in the House by Rep. Nita Lowey (D-NY).

Shaken baby syndrome refers to the serious, often permanent brain injury or death that results from the vigorous shaking of an infant or young child. SBS is often triggered by an episode of attenuated crying by an infant.



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This legislation authorizes $10 million in annual spending for 4 years to the U.S. Department of Health and Human Services for development of a National Action Plan to

- Identify effective, evidence-based prevention efforts,
- Establish a cross-disciplinary national advisory council to work with HHS to develop the campaign and coordinate national efforts to inform the general public, parents, child care providers, health care professionals, and others about the dangers of shaking as well as offer healthy approaches to parenting for frustrated parents,
- Offer support for families and caregivers struggling with infant crying and related frustrations to prevent SBS, as well as for survivors and grieving families who have suffered loss due to SBS, through a 24-hour hotline and an informational Web site and through the establishment of new programs,
- Disseminate effective prevention practices and techniques to parents and caregivers through maternity hospitals, child care centers, organizations providing prenatal and postnatal care, and other organizations providing support to parents, and
- Conduct training to ensure that persons involved in the care of young children, home visitors, primary care providers, foster parents, child care providers, and health care providers are aware of ways to prevent SBS and the need to secure immediate medical attention in cases of head trauma.

Speaking on the Senate floor on the introduction of the legislation, Dodd explained that SBS, the leading cause of death of physically abused children, results in the severe injury, disability or death of hundreds of children each year. He referred to a 2003 report in the Journal of the American Medical Association estimating that an average of 300 children die each year because of shaken baby syndrome and that 600 to 1,200 are injured—two thirds of them under age one. Prevention programs have proven successful in significantly reducing the number of SBS cases.

House Panel Hears Child Welfare Reform Challenges

A new proposal to reform the federal financing of child welfare services was presented at a congressional hearing on May 15 before the House of Representatives Ways and Means Subcommittee on Income Security and Family Support. The proposal would allow states to retain unused federal foster care dollars and to reinvest those funds in a range of services that prevent child abuse and neglect.

The three-part proposal, developed through a partnership of child advocacy and family and child-serving organizations, would (1) allow unused federal foster care subsidy funding to be used for preventive services rather than returned to the federal treasury, as is now the case, (2) guarantee services for every child who is at risk of being or has been abused or neglected, (3) promote program effectiveness by allowing federal child welfare training funds to be used for training staff of private and public agencies, as well as staff in health, mental health, and substance abuse and domestic violence services, and (4) enhance accountability by requiring annual reports from states on funds spent on particular services.

In opening the hearing, Rep. Jim McDermott (D-WA), the subcommittee chair, explained that the witnesses had been asked to focus on the obstacles encountered by states in their efforts to achieve positive outcomes for abused and neglected children. Those cited include too

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few available services, too few caseworkers, and "too little attention by government at every level." McDermott went on to say, "We need a system that focuses on preventing abuse, not just responding to it. We need qualified and experienced caseworkers who are not forced to oversee twice as many children as recommended."

Testifying at the hearing on challenges facing the child welfare system, Mary Nelson, administrator of the Iowa Division of Child and Family Services, put forth the reform proposal—not yet introduced in legislation—on behalf of the American Public Human Services Association; the American Federation of State, County and Municipal Employees; Catholic Charities USA; the Center for Law and Social Policy; Child Welfare League of America; Children's Defense Fund; National Child Abuse Coalition; and Voices for America's Children.

Another hearing witness, William Bell, president of Casey Family Programs, identified specific challenge areas needing attention and resources, including the following: implementation of a standard caseload for all child welfare caseworkers; improved supervision over decisions made by caseworkers in child welfare services; and the development of comprehensive community services for children and their families.

Cornelia Ashby, Director of Education, Workforce, and Income Security Issues at the Government Accountability Office (GAO), testified about the findings of a survey of states that found the most important challenges to improving outcomes for children as the following:

- Inadequate mental health and substance abuse services,
- High average number of child welfare cases per worker, and
- Difficulty of finding foster care homes for children with special needs.

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In addition, states identified challenges expected over the next 5 years: a growing number of children exposed to illegal drugs, increasing numbers of children with special needs, and changing demographic trends requiring greater multicultural understanding in providing services to children and families.

Faith-Based Initiatives Challenged in Court

On February 28, 2007, the U.S. Supreme Court heard arguments in a case questioning whether a group concerned with the constitutional guarantee of the separation of church and state can mount a First Amendment challenge to the Bush administration's faith-based initiatives.

The issue before the court in *Hein v. Freedom of Religion* is whether taxpayers have standing to initiate this kind of suit. In many cases, taxpayers are not allowed to sue to challenge government actions. Before the court can consider the constitutionality of the faith-based programs, the justices must decide whether the plaintiffs have the right, in this case, to sue. The Supreme Court has previously held, when, for example, allowing taxpayers to challenge congressional spending for private religious schools, that they do have standing to allege violations of the Constitution's Establishment Clause. If the court rules that the group does not have standing, it will be much harder to sue when taxpayers believe that the government is undermining the separation of church and state.

U.S. Justice Department lawyers argued before the Supreme Court that taxpayers can challenge the financing of religious activity only when a congressional statute expressly authorizes the spending. There is no statute behind the faith-based initiative, which was established by the President through executive order in various cabinet-level agencies, such as the Departments of HHS, Justice, Education, and Labor.

According to the plaintiffs in *Hein v. Freedom of Religion*, the number of federal grants to religious groups increased 38% between 2003 and 2005. They claim that these faith-based initiatives favor religious applicants for grants over secular applicants, in violation of the First Amendment prohibition of government support for religion.

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.

15th Annual Colloquium Is Major Success

Terry Hendrix, MA

APSAC's 15th Annual Colloquium was held at the Marriott Copley Square in Boston, Massachusetts, July 11–14, 2007. Both professionally and financially, the 4-day conference was most successful with attendees finding the training first-rate, the hotel accommodations excellent, and Boston hospitality welcoming. The preconference sessions on Wednesday attracted record numbers, with about 100 registered for the Cultural Institute and some 200 attending the four Advanced Training Institutes. The Thursday through Saturday conference had a registration of 812 participants representing all 52 states and nine other nations.

In addition to the intensive training sessions, the attendees enjoyed the Opening Reception and Poster Session late Thursday afternoon, with a delicious hors d'oeuvre buffet, a variety of libations, and live music by an excellent combo. There was considerable interest in the poster presentations and a fine opportunity for networking with colleagues. At noon on Friday, the registrants were treated to a fine meal at the Awards Luncheon during which the annual APSAC awards were presented and Dr. Anthony Mannarino delivered the William N. Friedrich Memorial Lecture. Dr. Mannarino's presentation was exceptionally interesting, appropriate, and accessible.

Following the excellent Boston conference, the 2008 Colloquium will move west to the relaxing vacation mecca of Arizona. The 16th Annual Colloquium will be held June 18–21, 2008, at the beautiful new Sheraton Wild Horse Pass Resort in Phoenix, Arizona. For a preview of the fabulous facilities of the Wild Horse Pass Resort go to www.SheratonWildHorsePassResort.com and make your plans to attend!

Mike Gardner, Gracia Alkema, and former Board member Tricia Gardner with daughter Alexandra at the Opening Reception

Colloquim attendees enjoying the Opening Reception and Poster Session

APSAC Awards Presented at 15th Annual Colloquium in Boston

Jordan Greenbaum, MD, Judith S. Rycus, PhD, MSW

At a special awards luncheon at the recent 15th Annual Colloquium in Boston, APSAC honored the outstanding achievements of several professionals in the field of child maltreatment. The 2007 APSAC annual award winners were as follows:

Award for Outstanding Service
Terry Hendrix, MA

Terry Hendrix is a long-time member and advocate of APSAC who also served as a member of the APSAC Board. Terry was instrumental in the founding, maintenance, and continuing success of APSAC's two primary publications, *Child Maltreatment: Official Journal of the American Professional Society on the Abuse of Children* and the organization's newsletter the *APSAC Advisor.* Terry was working at Sage Publications when APSAC originally launched *Child Maltreatment,* and he played a pivotal role in helping the journal become the prominent international publication it is today. Terry also chaired the APSAC publications committee for many years and has provided invaluable technical assistance and support to several generations of *Child Maltreatment* and *APSAC Advisor* editors.

Award for Outstanding Professional
David Corwin, MD

Dr. David Corwin, one of a small number of child forensic psychiatrists in the country, serves as Medical Director for the Child Protection Team at Primary Children's Medical Center University of Utah. Dr. Corwin was one of the founding members of APSAC and has worked for the past 25 years to help prevent, identify, and treat child maltreatment. He has authored numerous articles, book chapters, reviews, and teaching tools about and has made significant contributions to increasing the knowledge and skill of professionals working in the child maltreatment field. He spearheaded and obtained funding for Utah's efforts to prevent shaken baby syndrome by partnering with the National Center on Shaken Baby Syndrome

Cont'd on page 32

to educate new parents about the dangers of shaking their infants. He serves as a forensic evaluator, reviewer, and consultant on child maltreatment-related cases throughout North America.

Award for Research Achievement
Dr. John Landsverk

Dr. John Landsverk is Emeritus Professor of Social Work at San Diego State University, Research Director of the Chadwick Center for Children and Families, and Director of the Child and Adolescent Services Research Center at Rady Children's Hospital in San Diego. A tireless advocate of the scientific method and its application to direct practice, he has played a primary role in bringing evidence-based practice to the child welfare system. He has a gift for identifying critical research questions and innovative approaches to address them, and he demonstrates a strong commitment to the translation of research into direct practice. He routinely provides consultation and advice to other researchers and has served as principal investigator or coprincipal investigator on a variety of important research initiatives, including 23 such projects in the past 7 years.

Award for Outstanding Front-Line Professional
Moira Szilagyi, MD, PhD

Dr. Moira Szilagyi is a pediatrician from Rochester, New York, who works as an advocate, an educator, and a researcher to improve the care of children in foster care placement. Her medical home model of foster care treatment is well known by foster care and child welfare researchers throughout the country. Dr. Szilagyi has developed a variety of innovative foster care health programs that have been selected by the Institute for Health Improvement as models for foster care health programming around the country. She is a standing member of the American Association of Pediatric's foster care and adoption steering committee, and she has worked as a consultant to projects headed by the Annie E. Casey Foundation and the Child Welfare League of America. She also developed several foster care health programs in her home county, including the REACH medical evaluation center for suspected maltreatment and the CATCH mental health assessment for children entering foster care.

Award for Outstanding Achievement of Cultural Competency in Child Maltreatment, Prevention, and Intervention
Dolores Subia Bigfoot, PhD

Dr. Bigfoot is Assistant Professor of Research at the Center on Child Abuse and Neglect, University of Oklahoma, and she is Director of the Center's Native American Division, which provides oversight and administration for all programs with Native American emphasis. Dr. Bigfoot also directs the Indian County Child Trauma Center, a program that develops trauma-related treatment protocols, outreach materials, and service delivery guidelines adapted for use with American Indian and Alaskan native children. She also directs Project Making Medicine, a national training program for mental health providers in the treatment of child physical and sexual abuse. She is coauthor of Honoring Children, Mending the Circle, an intervention that integrates cultural traditions with treatment components of the cognitive behavioral therapy approach. Dr. Bigfoot is a member of the Caddo Nation of Oklahoma.

Award for Outstanding Research Article
Dante Cicchetti, PhD, Fred Rogosch, PhD, and Sheree Toth, PhD

Drs. Cicchetti, Rogosh, and Toth authored the winning article, "Fostering Secure Attachments in Infants in Maltreating Families Through Preventive Interventions," which was published in the journal *Development and Psychopathology* in 2006. This seminal article demonstrates the high rate (90%) of disorganized attachment in maltreated children and its stability in the absence of adequate intervention. The article demonstrates that children's attachment status can be significantly altered with behavioral or relational interventions during infancy, and it stresses that by the time children are preschool age, treatments that directly target the parent-child relationship are necessary to directly affect attachment quality.

The article provides evidence that child-parent psychotherapy is an effective intervention for improving the quality of attachment of maltreated children.

Award for Outstanding Article in *Child Maltreatment*

The award for Outstanding Article in *Child Maltreatment: Official Journal of the American Professional Society on the Abuse of Children* was given to Mark Chaffin, Rochelle Hanson, Benjamin Saunders, Todd Nichols, Douglas Barnett, Charles Zeanah, Lucyh Berliner, Byron Egeland, Elana Newman, Tom Lyon, Elizabeth Letourneau, and Cindy Miller-Perrin for "Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems."

This article reviews the issues related to attachment disorders and attachment therapy in maltreated children and makes recommendations for assessment, treatment, and direct practice. A wide variety of attachment-based treatment and parenting approaches have been purported to help children whose behavior is described as "attachment disordered" and their families. The authors contend that the field of attachment therapy is young and that the benefits and risks of many treatment interventions remain scientifically undetermined and, in some cases, controversial. The article presents the findings of the APSAC Task Force and represents APSAC's formal position on this issue.

2007 APSAC Awards recipients David Corwin (Award for Outstanding Professional), Terry Hendrix (Award for Outstanding Service), Rochelle Hanson (Chair of the Awards Committee), John Landsverk (Award for Research Achievement), Fred Rogosch (Award for Outstanding Research Article coauthored with Dante Cicchetti and Sheree Toth), and Jordan Greenbaum (President of APSAC).

APSAC State Chapters Renewed Commitment and Opportunities

Michael L. Haney, PhD

APSAC has a formidable mission to enhance the ability of professionals to respond to children and families affected by abuse and violence. To promote its mission, APSAC offers multiple opportunities for continuing education and interdisciplinary networking through a variety of events, including its annual national colloquium, training institutes offered yearly at the San Diego International Conference on Child and Family Maltreatment, and many specialized national and regional training institutes and clinics. APSAC is also one of the leading national training organizations on child forensic interviewing.

However, APSAC is reaching only a small percentage of the child protection professionals who could benefit from networking or attending training with other professionals, and from participating in forums to share ideas and "best practices" with other dedicated individuals committed to the principles set forth by APSAC.

I occasionally meet with professionals around the country who, when APSAC is mentioned, offer a vacant stare or reply, "Oh yeah, I was a member years ago," or, "I've heard of them, but somebody told me they went under." It's always with mixed emotions that, on one hand, I'm delighted to tell them that APSAC is alive, well, and thriving but, on the other, I'm frustrated that we're not getting our message out to colleagues who may have been members in the past, or to potential new members.

APSAC continues to be a growing and changing organization with boundless potential and ability to affect national policy and to shape the future of child maltreatment prevention and education. Because of a diverse membership that includes mental health practitioners, physicians and nurses, child protection workers, state and local attorneys, law enforcement personnel, psychologists, child interviewers, researchers, and many others, APSAC is in a unique position to lead the way at many levels. It is estimated there are over 40,000 child protection workers in the United States alone, which does not include members of the many other disciplines involved in child protection. APSAC's membership is just under 2,100. We need to do a better job of outreach. APSAC members live, work, and identify with their own state or region. This is where we need to support them.

State chapters can play a vital role in local networking and developing professional relationships that ultimately enhance the mission and objectives of APSAC. The importance of state chapters in recruiting and involving new members from the multiple disciplines involved in child protection work cannot be overstated. Many APSAC members initially learned about APSAC from their state chapters, as well as from attending training programs at either the local or national level.

APSAC's relationship with its state chapters has been inconsistent over the years. For much of APSAC's existence as an organization, state chapters were viewed as the "face of APSAC" and were recognized as a vital resource for the national organization. State-level chapters served as a training ground for the development of leaders who could ultimately serve APSAC and its members at the national level, in addition to being a conduit for the recruitment and retention of APSAC members.

However, in spite of the many benefits of maintaining strong state chapters, approximately 3 years ago the APSAC National Board voted to suspend financial subsidies to state chapters. These subsidies had been computed using a formula related to the number of paid APSAC members from each state. At the time, the Board also debated the relevance of state chapters, the value of maintaining relationships with them, and whether state chapters should be eliminated. This latter position resulted from the inherent difficulties of sustaining ongoing reciprocal relationships with state chapters and the concurrent need for APSAC to focus on internal organizational and financing issues to assure that the national organization remained on solid footing. The result was a period where attention was diverted to pressing national issues, and the state chapters were left to function on their own with minimal interaction or direction. Some state chapters did well during this period, while others struggled due to lack of leadership and support and were eventually dissolved.

In January 2006, after much debate, reflection, and advocacy, the APSAC Board reversed its earlier direction and reestablished both the Board's State Chapter Committee and formal state chapter agreements. The Board's decision to reinstate support to state chapters validated the inherent value of having organized, functioning professional groups who could carry out activities at the local and state levels for the betterment of the national organization. State chapter coordinators and officers were reaffirmed to be an important conduit of information between the national office, the Board, and APSAC members at the local and regional levels. APSAC Board members also looked to state chapter members for nominations for Board elections and awards, for feedback on new ideas, for assistance in disseminating information to members, for participation on task forces, and for member input on new initiatives, membership benefits, and critical issues.

The Board also committed to support the development and enhancement of local chapters by providing direction and technical assistance, and to reinstate financial support. The APSAC Board members' commitment to support state chapter development has gone a long way in reestablishing trust and credibility on behalf of both groups.

APSAC's state chapters are independent, incorporated nonprofit entities with formal affiliations to the national APSAC organization. Each state chapter is governed by its own Board of Directors and officers, and each operates in accordance with local chapter bylaws, the laws of the state in which it is incorporated, and APSAC's national bylaws. State chapters are typically organized within individual states, although some smaller states may join together to form a regional chapter. APSAC membership is a prerequisite to becoming a member of a state chapter, and national APSAC membership conveys automatic membership in a state chapter.

Beginning in January 2006, APSAC initiated monthly conference calls with state chapter leaders and members. These conference calls are held the second Monday of each month between 12:00 noon and 1:00 p.m. Eastern time. Over the course of 2006 and through July 2007, an active dialogue has occurred among state chapter members, and between state chapter representatives and the national

Cont'd on page 34

APSAC organization. The conference calls have reengaged many states that do not currently have an active chapter but are seeking information, ideas, guidance, and suggestions for how to proceed in developing one. The conference calls also generated input from all state chapters regarding revision of state chapter agreements and promoted the subsequent signing of new agreements by existing state chapters. There has also been active group discussion of strategies to provide training and education to explore new ideas for outreach, recruitment, and retention of members.

State chapters are involved in a variety of activities. Some examples of current state chapter activities are as follows:

- The California Chapter of the American Professional Society on the Abuse of Children (CAPSAC) is an active and dedicated group of professionals who were very helpful in shaping the discussions about how the national organization should interact with its chapters. As cochair of the State Chapter Committee, I attended a CAPSAC Board meeting that proved to be a very valuable experience. CAPSAC members asked many questions about the functioning of the national APSAC organization and showed considerable interest in finding better ways to improve state-national communications and relationships.

- The Wisconsin Chapter of the American Professional Society on the Abuse of Children (WIPSAC) has implemented a great innovation called "Lunch at Your Desk and Learn"—a Web- and telephone-based inservice training program for which participants can earn CEUs. These sessions often focus on discussion of articles from *Child Maltreatment* or the *APSAC Advisor,* with article authors invited to be present on the call. It is a novel way to educate and reach multiple participants using modern technology. More information about WIPSAC activities can be found on their Web site, http://wipsac.topcities.com/index.htm.

- The Michigan chapter was also very helpful as we worked through revising the state chapter agreements. Members' insights and suggestions were invaluable in arriving at the final agreement, and the Michigan chapter was the first to sign the revised agreement and submit a funding request to the State Chapter Committee, which was subsequently approved by the Board of Directors.

- North Carolina also has a very active chapter, which provides training and communication with APSAC members in the state. One of APSAC's newest national Board members, Kathy Johnson, hails from the North Carolina chapter as its former President.

- Florida has a very active chapter that has focused on training and outreach in local communities and has sponsored several trainings on interviewing children and on shaken baby syndrome (SBS). A Web site is under consideration to create a mechanism to communicate more rapidly with the membership and to provide child abuse information in Florida.

Other states that have current active state chapter membership include Ohio and New Jersey, and additional states have expressed interest in reinstating a state chapter or starting a new one to connect with other colleagues. These are West Virginia, Louisiana, Alaska, South Carolina, Illinois, Alabama, Oklahoma, Washington, Colorado, Rhode Island, Pennsylvania, Georgia, New York, New Jersey, Tennessee, and Texas.

If you are interested in becoming involved in an existing state chapter, or would like to consider joining with colleagues to form a chapter for your own state, please contact us. Your Board and the State Chapter Committee stand ready to assist you. If you'd like more information, contact Kathy Johnson, Chair of the State Chapter Committee, at kdwoodco@email.unc.edu, or Michael L. Haney, PhD, Vice President for APSAC and Cochair of the State Chapter Committee, at mike_haney@doh.state.fl.us. If you provide us with your E-mail contact information, we'll add you to our state distribution list and invite you to participate in the monthly state chapter conference calls, where you can get advice and technical assistance from your colleagues. We will also be publishing revised guidelines in the fall of 2007, which we hope will assist new chapters negotiate the intricacies of forming a new nonprofit organization, creating bylaws, and forging a new relationship with the national organization through signing a state chapter agreement.

APSAC is a viable professional organization that affords many opportunities for professional development, sharing ideas, and exploring differences of opinions on ways to achieve our common mission. Our biggest challenge is to reach out and recruit our fellow colleagues to help achieve the mission of preventing child abuse and mitigating its reoccurrence. It seems to me that we have our work cut out for us.

That said, to each of our current APSAC members, for everything that you do to make a difference in the life of children—THANK YOU!

A young Colloquim attendee, Miss Alex Gardner, directs the combo playing for the Opening Reception and Poster Session

About the Author

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September 15–20, 2007
12th International Conference on Violence, Abuse and Trauma
Institute on Violence, Abuse and Trauma (IVAT)
San Diego, California
Call: (858) 623-2777, or
Visit: www.ivatcenters.org

September 19–22, 2007
20th Annual National Independent Living Conference
Daniel Memorial Institute
Denver, Colorado
Call: (904) 296-1055, or (800) 226-7612, or
Visit: www.danielkids.org/sites/web/content.cfm?id=276

September 29–October 3, 2007
2007 National Staff Development and Training Association (NSDTA) Professional Development Institute
Dallas, Texas
Call: (202) 682-0100, or
Visit: http://nsdta.aphsa.org/pro_dev_inst.htm, or
E-mail: DGross@aphsa.org

October 17–20, 2007
15th Annual Scientific Assembly
"Imagine a World Without Violence"
International Association of Forensic Nurses
Salt Lake City, Utah
Visit: www.iafn.org/

October 27–30, 2007
2007 Annual Program Meeting
Council on Social Work Education (CSWE)
San Francisco, California
Call: (703) 683-8080, or
Visit: www.cswe.org, or
E-mail: info@cswe.org

November 14–16, 2007
2007 Conference on Differential Response in Child Welfare
American Humane Association
Long Beach, California
Call: (303) 925-9440, or
Visit: www.americanhumane.org, or
E-mail: candyl@americanhumane.org

December 10–12, 2007
National Adoption and Foster Care Training Conference
Child Welfare League of America
New Orleans, Louisiana
Visit: www.cwla.org/conferences

January 17–20, 2008
Society for Social Work and Research (SSWR)
"Research That Matters"
Washington, DC
Visit: www.sswr.org/conference.php

January 28, 2008
APSAC PreConference Advanced Training Institutes
San Diego, California
Call: (877) 402-7722, or
Visit: www.apsac.org, or
E-mail: apsacinc@comcast.net

January 28–February 1, 2008
22nd Annual San Diego International Conference on Child and Family Maltreatment
San Diego, California
Visit: www.chadwickcenter.org/Conf

February 25–27, 2008
2008 National Conference "Children 2008"
Child Welfare League of America
Washington, DC
Visit: www.cwla.org/conferences

May 12–14, 2008
8th Annual Campbell Collaboration Colloquium
Vancouver, British Columbia, Canada
Visit: www.campbellcolloquium.org/

June 18–21, 2008
16th Annual APSAC Colloquium
Phoenix, Arizona
Call: (877) 402-7722, or
Visit: www.apsac.org, or
E-mail: apsacinc@comcast.net

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Save these dates!

January 28, 2008
APSAC Advanced Training Institutes
San Diego, California

June 18-21, 2008
16th APSAC Annual Colloquium
Phoenix, Arizona

For more information visit: www.apsac.org

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