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# Gang Prevention: A Collaborative Response

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## Introduction

"The American gang scene is poorly understood and is a great source of public concern, in spite of years of research and years of suppression and intervention efforts" (Esbensen & Osgood, 1999, p. 194). It is not clear how gangs intersect with the overall problem of juvenile delinquency. It is also unclear whether or not specific intervention and prevention techniques are needed to prevent gangs, or if prevention should be aimed at the broader goal of preventing juvenile crime.

The relationship between child maltreatment and juvenile delinquency is well established. While child abuse and neglect do not inevitably lead to delinquency, history of child maltreatment is associated with an increased risk of crime and violence as a child matures (Wiig & Widom, with Tuell, 2003). Specifically, children who have been abused or neglected have been shown to be 4.8 times as likely to be arrested as juveniles when compared with nonmaltreated youth, and they are 11 times more likely to be arrested for a violent crime than are nonabused matched controls. Further, child abuse and neglect are associated with an earlier onset of juvenile crime by about a year. Physically maltreated youth are 2.35 more times as likely to be involved in a gang than nonabused youth. For children who have experienced sexual abuse, the odds of gang involvement are 1.77 times higher (studies cited in Wiig & Widom, with Tuell, 2003).

A recent prospective longitudinal study of 574 children followed from age 5 to age 21 found that youth who had been physically abused in the first 5 years of life were at greater risk for being arrested as juveniles for violent, nonviolent, and status offenses. They were less likely to have graduated from high school, more likely to have been fired in the past year, to have been a teen parent, and to have been pregnant or to have impregnated someone in the prior year while not married (Lansford et al., 2007). Mersky and Reynolds (2007) followed 1,539 children from kindergarten and found that both physical abuse and neglect were associated with violent delinquency outcomes, as did Crooks et al. (2007) in a prospective study of 1,788 students in two schools. Lewis et al. (2007) found an association between maltreatment history and carrying weapons. Youth with a maltreatment history perceived a greater need to carry weapons.

As a result, prevention of juvenile delinquency and gang involvement by children who have been maltreated must be an important concern of child maltreatment intervention.

Gangs form when institutional offerings and social structures are weak. They serve a function—to respond to the needs of alienated youth. Youth join gangs for status, security, money, power, excitement, and new experiences. The question faced by communities throughout the nation is, how can we promote the transition from teenage years to young adulthood and assist youth in becoming productive members of society? In particular, how can communities promote this positive transition for ALL youth, not just those with strong families and other advantages?

This article explores youth gangs and describes what innovative communities are offering youth as alternatives to gang involvement.

## Defining Gangs

There is no single, accepted nationwide definition of youth gangs (NYGC, 2007a). The terms *youth gang* and *street gang* are often used interchangeably to refer to neighborhood or "street-based" youth groups comprising mainly individuals under age 24 who are jointly engaging in criminal activity (Lyddane, 2006; OJJDP, 2002). Most researchers use the age range of 12–24 (Esbensen, 2000). Eliminated from this definition are adult groups. Adult motorcycle gangs, prison gangs, or hate groups may be engaging in criminal behavior, but they are not the focus of this article.

Dewey Cornell, PhD, directs the Center for Violence Prevention at the University of Virginia. He noted (personal communication, 2007) that more formal and organized gangs are not simply juvenile groups but are operated mainly by young adults who use juveniles in subordinate roles. Thus, the more serious gangs are an adult problem that is secondarily hazardous to juveniles who are recruited into membership.

Gangs may be large or small. According to Esbensen (2000), there must be more than two youth in order to use the term *gang*. The group must also share a sense of identity. Identity can be shown by any combination of the following: a name, symbols, geography or "turf," colors, hand signs, logos, clothing style, bandanas, or hats. The group must also have some stability and permanence. Most important in the definition of *gang* is group involvement in a pattern of criminal acts (Esbensen, 2000; Howell, 1998; Howell & Lynch, 2000).

Studies of large samples show that gang members are responsible for a large proportion of all violent offenses committed by adolescents. In various studies, gang members (who comprised 14%–30% of the sample) were responsible for 68%–85% of the crimes (various studies cited in NYGC, 2007a). Compared with nongang at-risk youth, gang members are much more likely to engage in serious offenses, such as selling drugs or possessing powerful, lethal weapons, and they are more likely to have extensive criminal involvement (Huff, 1998).

Youth gang structure can vary considerably. Unlike organized crime groups, most street gangs are loosely structured with transient leadership and membership and have informal rather than formal roles for members. Very few youth gangs meet criteria for classification as organized crime. For example, it would be rare for youth gang members to manage or control drugs at the organizational level, but they may be involved in street-level distribution, or they could be used by adult-based distribution systems (Howell, 2007; NYGC, 2007a).

## Who Are Gang Members?

According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) (2002), youth gangs that are of concern to the

community generally consist of males who commit serious and sometimes violent crimes. As mentioned, the members range in age from 12–24 years. Youth typically begin associating with gang members by age 12 or 13 and join the gang between ages 13 and 15. Thus, gang membership will usually occur anywhere from 6 months to 2 years after the youth begins involvement with the gang (Howell, 2007; Huff, 1998). It is worth noting that youth gang membership is very dynamic and changeable, with most youth reporting gang affiliation of a year or less (NYGC, 2007a).

Typically youth who join gangs have low-income, minority background, may be recent arrivals to the area, and live in poorly educated and socially distressed families (Esbensen, 2000; Howell, 1998). Gang members may live in isolated or segregated parts of the community, and they may confine their activities to local neighborhoods. These may be neighborhoods where drugs and firearms are readily available and other youth are delinquent (NYGC, 2007a).

Youth who join gangs often have histories of delinquency, substance use, and little attachment to school, school failure, and school drop out. While there is a consensus about the high rate of criminal activity of gang members, it is important to note that youth who join gangs are generally delinquent prior to becoming a gang member. Joining a gang enhances a youth's rate of criminal activity dramatically, but criminal behavior was generally present prior to gang membership (Esbensen, 2000; Esbensen & Osgood, 1999; NYGC, 2007a).

Families of gang members may be large nuclear or extended families characterized by low-income and minority or recent arrival status. They have high levels of divorce, separation, family conflict and frequent crises. There is poor family management and problematic parent-child relationships. There may be high levels of substance abuse, child maltreatment, and inadequate supervision of children. Parents of gang members, especially fathers, are likely to have histories of arrest and incarceration and may also be actively involved in criminal activity. There may be older siblings or uncles and fathers who have themselves been gang members (NYGC, 2007a).

Researchers question whether youth involved in gangs are appreciably different from other delinquent youth. It is not clear if youth in gangs are a separate population, and whether special techniques or efforts are necessary for gang-involved youth, or if the same approaches that are effective for delinquency in general are also appropriate for gang intervention (Esbensen & Osgood, 1999; Esbensen, 2000).

## Girls in Gangs

In 2000, the National Youth Gang Center's survey of 3,018 law enforcement agencies indicated that only 6% of gang members were female. Respondents indicated that 39% of gangs had female members and only 2% of gangs were predominately female. These figures are similar to the 1998 Youth Gang Survey. Other researchers have offered estimates as well, ranging from 6% to 38% of gang members being female (studies cited in Howell, 1998).

Howell (2007) and Howell, Moore, and Egley (2001) claimed that more girls are joining gangs currently than in the past. During early adolescence, about a third of gang members are female (studies cited in NYGC, 2007a). Females appear to leave gangs at an earlier age than their male counterparts. Gender-mixed gangs are more usual than in the past.

Independent female gangs are generally affiliated with male gangs. Female gang violence is more likely to involve simple battery or assault rather than homicide, and female nonviolent crimes consist mainly of substance violations (studies cited in Howell, 1998).

## Community Conditions That Enable Gangs

There are several community conditions that enable gangs. First, the usual socializing agents (families and schools) are ineffective or even alienating. Adult supervision is largely absent. Second, youth have a great deal of free time that is not spent in positive, skill-building activity. Third, youth have limited access to careers or jobs. Finally, there is a defined place to congregate, usually a neighborhood (Moore, 1998, cited in NYGC, 2007a). The more risk factors youth are exposed to, the greater the likelihood of joining a gang (Office of National Drug Control Policy, 2007). Those with seven or more risk factors at ages 10–12 were 13 times more likely to join a gang than those with no risk factors (Hill, Lui, & Hawkins, 2001).

Howell (2007) emphasized that the process of joining a gang can be gradual. Youth start by spending time with gang members, sometimes when they are quite young, and they are later assimilated into the group. Other youth associate with gang members but never join.

Youth join gangs for social reasons (to be around friends or extended family members who are already part of the gang). Some seek a sense of belonging. Youth also join gangs for perceived protection. It is less frequent that youth join gangs to make money or because of coercion. Some youth seek excitement; others are looking for prestige (Howell & Egley, 2005; NYGC, 2007a; Office of National Drug Control Policy, 2007).

James C. Howell, PhD, Senior Research Associate with the National Youth Gang Center in Tallahassee, Florida, commented, "Gangs are often at the center of appealing social action—parties, hanging out, music, dancing, drugs, and opportunities to participate with members of the opposite sex. Gang members are often looked up to by other adolescents because of their rebellious and defiant demeanor (personal communication, 2007)"

Dr. Cornell agreed that gangs could enhance status for youth and offer the opportunity to intimidate others. He added, "There can also be coercive processes at work that pull youth into gangs and keep them there, even when they want to leave. Some gangs threaten injury or even death to members who leave the gang (personal communication, 2007)."

National data show that in communities with populations of less than 50,000, gang problems are intermittent. In areas with populations under 25,000, only 10% of localities report persistent gang problems (Howell, 2007). Permanent gang presence is more likely in schools and cities with larger populations. There is also a strong correlation between the presence of gangs and both guns

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and drugs in schools. Public schools are more likely to report gangs than are private schools (40% compared with 16%) (Howell & Lynch, 2000).

## History of Youth Gangs

Youth gangs are not a new phenomenon. Rather, youth gangs have been known throughout our country's history. Youth gangs may have first appeared in Europe or Mexico. No one is certain about when they emerged in the United States, although the earliest record places the time at the end of the American Revolution in 1783 (Howell, 1998). As the Industrial Revolution gained momentum in large cities in the northeast (such as New York, Philadelphia, and Boston), gangs began in those areas, and they flourished in Chicago during the industrial era when immigration and population shifts reached peak levels (Smith & Guerra, 2006).

According to Howell (1998), the United States has seen four distinct periods of youth gang activity: the late 1800s; the 1920s; the 1960s and the 1990s. In the early nineteenth century, youth gangs in the United States were predominately Irish, Jewish, and Italian (studies cited in Howell, 1998). Modern American gangs may have grown from difficulties of Mexican youth trying to adjust to a new way of life in the United States under stressful conditions in the Southwest (studies cited in Howell, 1998). Feelings of displacement and resentment fueled the first prison gang in California in the 1950s (the "Mexican Mafia") (Smith & Guerra, 2006).



Esbensen (2000) noted that in the 1960s, adolescents grew to 10% of the population, and this demographic likely contributed to the concern about youth gangs. There was a hiatus in the 1970s with gangs reemerging as a focus of concern in the 1980s and 1990s. The juvenile homicide rate doubled in the 1990s in spite of a general decline in juvenile violence (Esbensen, 2000). Dr. Cornell reported that the juvenile homicide rate declined drastically by the end of the 1990s and has continued to remain relatively low, compared with 30 years ago.

According to Howell (1998), there have been changes in gangs over time. Today's gangs are less concerned with territorial affiliations. They have increased mobility and much greater access to weapons. According to Esbensen (2000) and Esbensen and Osgood (1999), the easy availability of lethal weapons gives new importance to gangs. The use of firearms is a major feature of gang violence. Gang members are far more likely than other delinquents to carry guns and to use them (NYGC, 2007a). Today's gang members also use drugs and alcohol more extensively, and some gangs are involved in drug trafficking.

## Incidence

According to studies cited by Howell (1998), in 1980 there were gangs in an estimated 286 jurisdictions with more than 2,000 gangs containing nearly 100,000 members. By 1996, there were more than 31,000 gangs with approximately 846,000 members in 4,800 jurisdictions. An 11-city survey of nearly 6,000 eighth-grade students found that 9% were currently gang members and 17% said they had been involved in a gang at some point in their life (Esbensen & Osgood, 1997, cited in Howell, 1998).

Based on a nationwide survey, Gottfredson and Gottfredson (1999) estimated that 5% of schools and 36% of communities were experiencing problems with youth gangs. Of places with gang problems, most (65%) were urban centers with 16% being suburban and 19% being rural areas. The increase in rural gangs has been documented by others (Esbensen, 2000). In a 1998 national school survey (Gottfredson & Gottfredson, 2001), 7% of boys and 4% of girls said they had belonged to a gang in the past 12 months (cited in NYGC, 2007a).

The 2004 National Youth Gang Survey, conducted annually since 1995, estimated that approximately 760,000 gang members and 24,000 gangs were active in more than 2,900 jurisdictions in 2004. The percentage of law enforcement agencies reporting youth gang problems declined from 1996 to 2004 in all four area categories (rural counties, small cities, suburban counties, and larger cities) although there have been slight increases in some areas since 1999–2001. In 2004, 12.3% of rural counties, 28.4% of smaller cities, 40% of suburban counties, and 79.8% of larger cities reported gang problems (Egley & Ritz, 2006). This survey has some limitations due to the method of asking law enforcement to estimate the incidence in their local areas without the benefit of a standardized definition of youth gangs.

The 2004 National Youth Gang Survey found that a high percentage of homicides were considered to be gang-related. In two cities, Los Angeles and Chicago, more than half of the nearly 1,000 homicides were considered gang-related. In the remaining 171 cities, approximately one fourth of all homicides were thought to be gang-related. In 2004, this represented an 11% higher rate than the previous 8-year average. However, more than 80% of agencies with gang problems in smaller cities and rural counties recorded no gang homicides (Egley & Ritz, 2006). Others agree. NYGC (2007a) noted that gang-related homicides are concentrated mostly in the largest cities in the United States where there are longstanding and persistent gang problems and a greater number of documented gang members, most of whom are young adults.

## Demographics

The average age of gang members is between 17 and 18 years old with an age range of from 12 to 24 years (studies cited in Howell,

1998). Male members outnumber females by a wide margin (90% male, according to Esbensen, 2000, although in some gangs, females may be as many as one third of the members).

Gangs vary in size from large, enduring, territorial gangs (averaging 180 members) to small groups specializing in drug trafficking (averaging 25 members). In large cities, gangs may have much larger numbers (studies cited in Howell, 1998). Gangs can also be categorized according to the degree of structure. Structure can vary from a group of friends who band together to commit crimes to those that have a more rigid structure with rules.

A survey in the mid-1990s (Curry, 1996, cited in Howell, 1998) showed the ethnicity to be 48% African American, 43% Hispanic, 5% Caucasian, and 4% Asian. Another survey of 6,000 eighth-grade students in 11 locations found 31% of those claiming to be gang members were African American, 25% were Hispanic, 25% were Caucasian, 5% were Asian, and 15% were some other group (Esbensen & Osgood, 1999).

Researchers acknowledge that gangs are more likely to have disproportionate representation from minority groups (85%–90% in some studies). According to a 2001 National Youth Gang Center survey, nearly half (49%) of all gang members are Hispanic/Latino, 34% are African American/black, 10% are Caucasian/white, 6% are Asian, and the remainder are of other ethnicities (Egley et al., 2006, cited in NYGC, 2007a). It is important to note that the racial composition of gangs varies by locality and reflects the demographic composition of the larger community. Caucasians are 11% of gang members in large cities, but 30% of gang members in rural areas (Esbensen, 2000).

It is felt that minorities are overrepresented in gangs simply because minorities are more likely to live in areas and under conditions conducive to gang formation. Gangs proliferate in areas with social disorganization, so neighborhoods with this characteristic produce more gangs. Even though minorities are approximately one third of the U. S. population, minorities are more likely to be poor, to live in high-risk neighborhoods, and to be disenfranchised. The gang provides family-like relationships for adolescents who feel isolated and alienated from both their original and adopted cultures (studies cited in Howell, 1998).

According to Guerra and Smith (2006), studies conducted on gang involvement of ethnic minority youth point to a common set of risk factors. These include a sense of hopelessness, alienation, a need to belong, reaction against a negative ethnic identity, search for a positive identity, lack of family support and other family problems, peer pressure, fun, recreation, and economic gain. For some ethnic groups, there are limited opportunities for the development of protective factors, such as school achievement or involvement with prosocial groups.

There are efforts at both the state and the national level to confront disproportionate minority contact in the juvenile justice system and in the child welfare system. The Child Welfare League of America (CWLA) has an overview, vision, and proposed action steps on its Web site (www.cwla.org/programs/juvenilejustice/jjdmr.htm). The American Psychological Association has published a comprehensive volume, *Preventing Youth Violence in a Multicultural Society* (Guerra & Smith, 2006), to highlight the importance of creating culturally compatible interventions to stop violence among youth of diverse populations.

It is important to note that the majority of youth who are from poor, minority families or who have absent or single parents do *not* join gangs or engage in violent activities. There are some differences between disadvantaged youth who join gangs and those who do not. Youth who join gangs are more socially inept, have lower self-esteem, and are more antisocial. They are more impulsive, more risk seeking, show less commitment to school, have less attachment to their parents, and communicate less with their parents. They have lower levels of interaction with prosocial peers (Esbensen, 2000).

Only a few studies have followed gang subjects over a long period of time. These studies have shown that the average gang member is involved in the gang for less than a year (Esbensen, 2000; Howell, 2007; studies cited in Howell, 1998; NYGC, 2007a). There do appear to be some areas with longstanding gangs that are multigenerational and more hierarchically structured. These gangs may have patterns of more long-term membership. For members of these groups, leaving the gang is more gradual and difficult, and it is possible that the gang may threaten members who leave or impose sanctions (NYGC, 2007a).

## Consequences of Gang Membership

Prolonged gang membership can have devastating consequences for youth. The gang acts as a powerful social network, constraining the youth from prosocial behaviors and limiting contact with conventional activities. Gang members face other difficulties, such as doubling or tripling the likelihood of serious injury due to their criminal and aggressive behaviors. A cascading series of consequences includes school failure, school drop out, early parenthood, and unstable employment. Due to lack of skills and education, gang members face a lack of career opportunities. The strengthening of ties to criminal activity makes it likely that crimes will persist into adulthood (NYGC, 2007a).

Dr. Cornell (personal communication, 2007) commented about how gangs socialize their members. "Gangs isolate their members from nonmembers and from family who oppose gang membership. The process can have a strong psychological impact on the young members, bonding them to the gang and increasing their propensity to follow orders of other gang members. There are parallels between gangs and cults or other groups that exercise coercive control over members," explained Cornell.

## Prevention

Even though criminal activity escalates when a youth joins a gang, it is important to realize that criminal behavior occurs sporadically. Esbensen (2000) explained, "For the majority of the time, gang youth engage in the same activities as other youth—sleeping, attending school, hanging out, working odd jobs. Only a fraction of their time is dedicated to gang activity" (p. 2). Thus, prevention opportunities abound. However, there is little guidance about the best time for prevention activities and limited data about the effectiveness of intervention and prevention efforts.

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Should gang prevention efforts be offered to all youth or should at-risk youth be targeted for interventions? Gangs develop among socially marginal adolescents who are not engaged in either the school or the community. Should youth fitting these descriptors be targeted for help?

Should gang prevention efforts begin earlier than adolescence? Patterns of violence develop early and are longlasting. Violence does not simply appear, mysterious and full blown, when a youth enters adolescence (Slaby, 1998). Although patterns of violence can be altered through corrective treatment during adolescence and adulthood, interventions with younger children may be easier and more effective (Slaby, 1998).

The following sections review research on the known effectiveness of various gang prevention efforts.



### Police Prevention Efforts

The measurement of criminal activity is difficult under any circumstances. Experiments in police practices are fraught with problems. How does one, for example, measure the degree of respect police offer to citizens? Thus, according to Sherman (2007), only a few studies have produced strong scientific evidence about the effectiveness of police strategies. Sherman's analysis was supported by the National Institute of Justice, the research arm of the Office of Justice Programs in the U.S. Department of Justice.

After a comprehensive review of over 150 studies and sources, Sherman (2007) divided police interventions into practices with strong support, practices with little support, and promising practices. His focus included gang prevention but was larger in scope. Sherman noted that the effects of police on crime prevention are complex and often surprising. He also noted that there was not even one impact evaluation in the literature on the effect of police practices on gangs. Thus, the following literature relates to police efforts in areas broader than gang prevention and intervention.

According to Sherman (2007), more focused efforts are more likely to prevent crime. For example, increased directed patrols in street-corner "hot spots" are effective. The optimal length of a police patrol visit to a hot spot for the purpose of deterring crime is about 15 minutes. Proactive arrests of serious, repeat offenders and those driving under the influence are effective. Arrests of employed suspects for domestic violence (but not arrests of unemployed suspects) are effective.

Promising practices are also focused efforts. For example, there are preliminary data that support the effectiveness of police traffic enforcement patrols against illegally-carried handguns. In one study in Kansas City in 1995, officers were given training in detecting the carrying of concealed weapons. Gun seizures in the target area rose by 60%, and gun crimes dropped by 49%. A similar area in a different part of town showed no changes in guns seized or gun crimes. Adding additional police to assignments can be helpful, if the details are targeted. Problem-oriented policing, in general, is a promising approach (Decker, 2003; Sherman, 2007).

An innovative police tactic used traffic barriers to block automobile access to designated streets. The theory is that crime occurs partly because of opportunity, and blocking such opportunity can lower crime. The Los Angeles Police Department noticed that gang crime, such as drive-by shootings and street assaults, happened on the periphery of neighborhoods linked to major roadways. By reducing access to these areas through placement of traffic barriers, homicide and aggravated assault rates fell and were not displaced into other areas (Travis, 1998).

Community policing can be effective if focused on a crime risk-factor objective. For example, community policing can be effective if it is focused on improving police legitimacy. Modest but consistent scientific evidence supports that the more respectful police are toward suspects and citizens, the more people in their jurisdiction will comply with the law. Thus, making the "style" and the substance of police intervention legitimate in the eyes of the public, particularly among high-risk juveniles, can be an effective crime prevention strategy. Neighborhood block watches as a gang prevention technique, however, are not effective, according to Sherman's review. Sherman noted that the areas with the highest crime rates are the most reluctant to organize. Areas with effective organization often have little crime at baseline, making it difficult to document effectiveness.

Police storefronts are popular but have little data to show effectiveness. Likewise, newsletters show no effect on victimization rates. A less popular but more effective technique, according to Sherman, is door-to-door visiting by police for either seeking or giving information.

Another practice without research support is arrests of juveniles for minor offenses. Hiring additional police to provide rapid 911 responses, unfocused random additional police patrol, and reactive arrests do not, according to Sherman, prevent crime. Reduced response time is compromised by citizen delays in reporting crime and the small proportion of crimes that have direct victim-offender involvement.

An innovative effort is the use of civil injunctions barring gang members from "hanging out together" on street corners, cars, and other public places. The injunctions are aimed at disrupting gang activity before it can escalate. The injunctions also give police legal

reasons to stop and question known gang members who may have drugs or weapons. The injunctions can prohibit a range of gang activities, including carrying weapons, displaying gang symbols in certain areas, and even carrying spray paint. Civil injunctions were first used in Los Angeles in the 1980s. San Francisco, Fort Worth, Chicago. and Wichita Falls, Texas, are among municipalities using injunctions. The ACLU (American Civil Liberties Union) and others criticize the technique and favor community programs (Cities try…, 2007).

Dr. Howell believes that targeted gang suppression has shown some success. He stated, "A three-pronged suppression strategy of selective incarceration of the most violent and repeat older gang offenders; enforcement of probation controls on younger, less violent gang offenders; and arrests of gang leaders in 'hot spots' of gang activity proved somewhat effective in the TARGET program in Orange County, California. Another targeted program in Dallas, Texas, showed some success in using aggressive curfew and truancy enforcement while targeting geographical areas that were home to seven of the city's most violent gangs (personal communication, 2007)."

Decker (2003) emphasized that law enforcement efforts target proximate causes of gang violence (such as threats gangs generate, the availability of firearms, and criminal opportunity) rather than fundamental causes. Suppression strategies such as surveillance, arrest, or incarceration respond to immediate needs for control rather than long-term changes that lower risk for gang involvement. Police have little opportunity to target fundamental causes of gang involvement, such as racism, unemployment, and the lack of proactive activities for youth.

Decker (2003) and others have emphasized the need for further research and the limited nature of studies to date. Suppression interventions show a "mixed report card," but in reality, little is known about the impact of specialized police units and other targeted efforts.

### Community Prevention Efforts

Communities play an important role in establishing positive environments for teens, and a wide variety of interventions must be delivered at the community level. These include social work intervention, counseling and therapy, recreational activities, enrichment activities, and leisure activities. Despite the popularity of these and other interventions such as surveillance, mentoring, and tutoring, according to Gottfredson and Gottfredson (1999), the scientific literature does not offer support for any particular set of best practices for these interventions. The Office of National Drug Control Policy (2007), however, cited studies demonstrating that structured activities, volunteering, and after school programs can provide a safe haven for youth and are effective in lowering rates of violence, substance use, risky behaviors, and smoking as well as in improving success in school, both in terms of grades and behavior.

One program being piloted is Gang Prevention Through Targeted Outreach (Esbensen, 2000). This is a structured recreational, educational, and life skills program that targets youth at risk. A case manager keeps detailed records on the youths' school attendance, their participation in program activities, contact with the juvenile justice system, general achievements, and problems. Prosocial behaviors are rewarded and proactive measures are taken if a youth breaks curfew, skips school, or associates with delinquent friends. A process evaluation of 33 programs (Feyerherm, Pope, & Lovell, 1992 in Esbemsem. 2000) concluded that the Gang Prevention Through Targeted Outreach initiative by the Boys and Girls Clubs of America "is both sound and viable in its approach" (p. 5, cited in Esbensen, 2000). The program is rated as a Level 3 (promising) intervention by Helping America's Youth.

Another innovative response is the Los Angeles Homeboy Industries' Jobs for a Future project. Located in gang-afflicted East L.A., Homeboy Industries (OJJDP News, 2006) offers gang-involved and at-risk youth the opportunity to become productive members of society through a variety of employment opportunities. Their slogan is "Nothing stops a bullet like a job." To date, only anecdotal evidence is offered to support this program.

### Child Protective Services Intervention

Since not all maltreated youth will join a gang or become delinquent, a thorough assessment of children known to be maltreated can identify those with additional risk factors, such as hyperactivity, impulsivity, low self-control, aggressive behaviors, discipline problems, poor academic performance, rejection by peers, and exposure to delinquent peers and siblings. This individualized assessment can match children and youth with an intervention that is tailored to address each child's needs. According to a 2001 bulletin by OJJDP, use of Structured Decision Making™ (a system that systematically evaluates risk factors) in child protective services has promise for breaking the link between abuse and delinquency (Wiebush, Freitag, & Baird, 2001).

Wiig and colleagues (2003) concluded that the front line of delinquency prevention should be the prevention of child abuse and neglect itself. There should be a continuum of prevention programs starting with the prenatal period and continuing through the school years. The earlier the intervention begins, the greater the likelihood for success. Thus, providing services and positive activities to younger siblings of youth who are involved in the juvenile justice system or known to be gang-involved may deter them from later criminal involvement.

### School Prevention Efforts

There is a considerable number of gang prevention efforts within schools. Gottfredson and Gottfredson (1997) examined strategies nationwide in 848 schools and developed a taxonomy of 22 types of school-based gang prevention activities.

The most common gang prevention activity found in schools is the use of prevention curriculum. The second-most common strategy undertaken by schools is the control of school culture and school climate, which sets expectations for student behavior. About 12% of schools report using this type of strategy.

Most of the schools responding to Gottfredson and Gottfredson's survey reported that the major gang prevention efforts were directed toward the youth themselves. Efforts were less often aimed at parents and families to improve the supervision or management

Cont'd on page 8

of youth. Interventions directed toward known gang members included counseling, social work, and psychological or therapeutic activity.

According to Gottfredson and Gottfredson (1999), many of the gang-prevention efforts in schools did not follow best practices and were insufficient to be effective. The researchers outlined what a prevention curriculum, instruction, or training should cover. First, the training should provide youth with the skills to recognize, resist, and refuse gang involvement. The curriculum should teach problem solving, such as how to generate solutions and choose between alternatives. Self-management skills such as goal setting, self-monitoring, and self-reinforcement should be imparted, and there should be instruction on emotional control. Communication skills should be taught, as well as methods for understanding others' perspectives.

In addition to delineating the content of curricula, Gottfredson and Gottfredson (1999) also considered instructional methods that are likely to be most effective. Behavioral modeling, role playing, rehearsal, and skills practice were recommended.

Schools can target behavioral interventions toward high-risk youth as well. Gottfredson and Gottfredson (1999) offered some best practice methods for behavioral interventions. Schools should develop individualized plans for youth with specific written behavioral goals, and they should always monitor or track behavior. Tracking should be daily or more often. A baseline should be established prior to attempts at change. Specific rewards and consequences should be a part of the plan. If a student does not show change, then different reinforcement strategies or a different intervention should be tried. As a student improves, the reinforcement can be phased out or made more difficult to earn.

An example of a simple, low-intensity school-based program that can be delivered to as many youth as possible is G.R.E.A.T. (Gang Resistance Education and Training). This primary prevention program is implemented by law enforcement agencies. Modeled after the DARE (Drug Abuse Resistance Education) program, the 9-week, one-hour per week curriculum introduces students to conflict resolution skills, ways to resist peer pressure, and the negative aspects of gang life. The program targets middle school students, primarily seventh graders, and has goals of reducing delinquency and gang membership, developing more favorable attitudes toward police, and increasing awareness of the consequences of gang membership.

In contrast to suppression programs or programs for at-risk youth, G.R.E.A.T. is intended for all youth. The G.R.E.A.T. program contains a middle school curriculum, an elementary school curriculum, a summer program, and family training. Five regional training centers also provide training to sworn law enforcement officers, including nine lessons: introduction to crime, victims and rights, cultural sensitivity and prejudice, conflict resolution, meeting basic needs, drugs and neighborhoods, responsibility, goal setting, gangs and how they affect people's lives, and resisting peer pressure.

A one-year cross-sectional survey of 5,935 eighth-grade students compared students who had participated in the G.R.E.A.T. program during seventh grade to those who had not experienced the program. Students who received the training reported significantly more prosocial behaviors (lower levels of gang affiliation and self-reported delinquency, lower rates of drug use). Rates of selling drugs, victimization, and status offenses were similar (Esbensen & Osgood, 1999).

A number of differences were also found in students' attitudes. Students who had received the G.R.E.A.T. training showed more negative attitudes about gangs, reported having fewer friends with delinquency problems, had higher self-esteem, showed more commitment to success at school, and had more friends involved in prosocial activities. They also reported less impulsivity and higher levels of attachment to parents (Esbensen & Osgood, 1999).

Two years into the evaluation of G.R.E.A.T., however, students were not exhibiting the promising returns found in the one-year study. In response, a national team revised the program to offer more active learning. Booster sessions were incorporated to reinforce skills taught in prior years. Pilots of the revised program were tested in 14 cities in 2001 and then implemented in 2002–2003.

A 5-year longitudinal evaluation study of G.R.E.A.T. showed modest positive effects of adolescents' attitudes and delinquency risk factors (such as peer group associations and attitudes about gangs, law enforcement, and risk-seeking behaviors). However, there was no effect on actual delinquent behaviors or on youth involvement in gangs. The research on G.R.E.A.T. underscores the importance of making a realistic assessment of what a time-limited (in this case 9 hours) intervention can accomplish. While the program met important goals of developing favorable attitudes toward the police and educating youth about the consequences of gang membership, it did not reduce the incidence of gang membership, nor did it impact future delinquency (Esbensen, 2004, in Ashcroft, Daniels, & Hart, 2004).

An example of a secondary prevention effort is the Montreal Longitudinal Study, which targets at-risk kindergarten boys who display disruptive behaviors. The school offers help to the parents and training sessions to the boys. Significantly fewer youth who participated in the program were found to be gang members at age 15 (Tremblay et al., 1996, cited in Esbensen, 2000). This program is rated as "Level 1" (highest rating) by Helping America's Youth.

Drug abuse prevention programs can be linked to gang prevention. It is well-established that adolescents who use drugs are more likely to engage in violent behavior, be involved in criminal acts, and join gangs. Conversely, teenagers who participate in gangs are more likely than nongang youth to be involved with drugs (Office of National Drug Control Policy, 2007).

A recent study (Crooks et al., 2007) suggested that school climate can be important in mitigating risks for adolescent delinquency. Given the same individual risk profile, a student attending a school that was perceived by students as safe was less likely to engage in violent delinquency than was a student attending a school perceived to be unsafe.

**Improving Prevention Efforts**

Despite the multitude of programs and efforts, substantial work needs to be done. Youth violence and young gang membership are complex problems. Many of the programs considered the most promising produce rather modest effects, often of limited duration. Even well-designed programs will have little impact unless teachers and staff receive preparation and training to implement the program and unless the school climate supports the program (Farrell & Flannery, 2006).

Phelan Wyrick, PhD, recently left the position of Gang Program Coordinator for the Office of Juvenile Justice and Delinquency Prevention. He discussed how to improve prevention efforts in a recent article (2006). According to Dr. Wyrick, those engaging in prevention efforts must begin by identifying their communities' risk factors for youth gang involvement. The next step is making a determination about which factors in the locality are most amenable to change. Those factors can then be addressed by offering effective community, family, or individual services.

Dr. Wyrick (2006) stated that a balance of three components is needed for effective gang prevention: (1) attractive alternatives to gangs, (2) effective support systems for young people, and (3) accountability of young people to their parents, their schools, and their communities. He said, "Superior gang prevention efforts blend effective support systems with attractive alternatives to gangs, and target these services to adolescents who are most at risk for gang involvement" (p. 54).

Communities seeking guidance about effective approaches can consult Helping America's Youth, a broad nationwide effort of the Bush administration to engage all Americans in helping young people become healthy adults. Nine federal agencies worked together to rate programs and create a database describing effective interventions. Programs are rated "Level 1" (strong scientific evidence of effectiveness), "Level 2" (less strong scientific evidence), and "Level 3" (promising programs with some research support). The Web site currently lists 22 gang prevention efforts.

**Comprehensive Strategy**

Experts agree that a balanced and comprehensive approach to gang prevention is most likely to be successful. A comprehensive approach will feature prevention programs that target youth at risk of gang involvement to reduce the numbers who join gangs, will offer intervention programs and strategies to youth already involved in gangs to help them separate from the gang, and will include law enforcement suppression strategies to target the most violent gangs and older, more criminally active gang members (Howell, 2007).

The U.S. Department of Justice offers a comprehensive gang prevention model aimed at serious, violent, and chronic juvenile offenders (Coolbaugh & Hansel, 2000; Howell, 2003; Wilson & Howell, 1993). The model is based on findings from pilot studies in the late 1990s. The general idea is that communities should offer a range of options on a continuum so that each youth can be matched with the most appropriate intervention at a time of need. The model seeks to prevent youth from engaging in serious delinquency by focusing on the individuals at greatest risk, while also improving the juvenile justice system response. The continuum of interventions should include suppression, immediate interventions, immediate sanctions; community-based offerings, aftercare services, and prevention.

The key components of the Comprehensive Gang Model include the following: strengthening families, supporting organizations (schools, churches, youth-serving programs), belief in prevention as the most cost-effective approach, immediate intervention to prevent escalation of behaviors or chronic behaviors, a system of graduated sanctions that holds juveniles accountable and offers public safety while providing needed programs to juveniles, and identifying and controlling the small number of serious offenders.

The primary objectives of a community's comprehensive strategy are to unify and enhance existing programs, to develop new programs to fill gaps, to increase communication and information sharing, and to monitor and evaluate interventions. A risk-focused planning approach can identify both the risk factors and the protective factors in the community.



The U.S. Department of Justice (1999) has published a description of a five-part model for responding to gangs. This model includes the components of the comprehensive approach previously described.

First, community residents and leaders must join together and plan, strengthen, and create opportunities for youth. Both gang-involved and at-risk youth should be targeted. The next step is an objective, community-wide assessment to determine whether or not a gang problem exists and the dimensions of that problem. Without assessment, the nature of the gang problem, if any, will not be known (Howell, 2007). Guidelines for community assessment are available from the National Youth Gang Center and from Helping America's Youth.

It is recommended that prevention programs operate in the target community. The location could be a store front, or programs could be housed within an existing facility such as a Boys and Girls Club.

Cont'd on page 10

In some communities, key service employees meet weekly to discuss service needs.

Second, outreach workers should engage gang-involved youth. Outreach workers can encourage youth to attend school, help gang members obtain job training and seek employment, and link them with social services. Interventions should match the level of youth gang involvement with more intensive services and more restrictive sanctions for youth involved with more dangerous and entrenched gangs. Higher-risk youth should have individualized treatment plans (Howell, 2007).

Third, the interventions must provide and facilitate access to academic, economic, and social opportunities. Innovative projects include a graffiti "paint-out," community health fairs, recreational opportunities, and neighborhood activities. One program provided a computer literacy lab. Program efforts can include advocating for gang members when they are confronted by the criminal justice system, with the goal of transforming the gang from antisocial to prosocial activity. However, it should be noted that some efforts at advocacy have had unintended consequences of increasing gang cohesiveness and leading to an increase in gang crime. In general, projects based solely or primarily on community organization and detached workers have failed to reduce delinquency and gang activity (U.S. Department of Justice, 1999). Evaluations of more comprehensive programs that include detached workers have been more promising (Esbensen, 2000).

Fourth is gang suppression and holding gang-involved youth legally accountable for criminal actions. Efforts in this area include the Flying Squad in Chicago (which gave the impression of an omnipotent police force by saturating a 5-square-block area every night) and the Los Angeles CRASH program (Community Resources Against Street Hoodlums). This effort used uniformed officers, street surveillance, investigative follow through, and arrests. They also enacted new ordinances, such as curfew laws, anti-loitering legislation, and civil injunctions limiting the ability of certain groups to congregate. There have been legal challenges to some of these ordinances.

Last, the U.S. Department of Justice model advocates facilitating organizational change and development through a team "problem-solving" approach consistent with the philosophy of community-oriented policing. The model includes development of recreational activities and community improvement campaigns, such as better health care, sanitation, and education.

The Comprehensive Gang Model is rated at "Level 2" by Helping America's Youth, and a research summary is located on the Web site. The model has been piloted in at least six sites throughout the nation with mixed results (Spergel, Wa, & Sosa, 2004, cited in Howell, 2007). Two of the five sites involved in the national OJJDP demonstration project had positive outcomes while three sites did not. The sixth site was evaluated with a quasi-experimental design and showed positive results on several measures.

Communities should be prepared for considerable effort over a long period of time, based on lessons learned from other large-scale projects. For example, the Safe Kids/Safe Streets project designed to improve community responses to child abuse and neglect found that it took 9–12 months for project planning and collaboration building. The pace of progress varied depending upon numerous local factors, but the evaluation suggested that developers should expect that an initiative of system reform will require 8–10 years. Communities are urged to start with a few activities that have a strong stakeholder consensus and to operate as a learning community (Cronin, Gragg, Schultz, & Eisen, 2006).

## Conclusion

Esbensen (2000) noted that prevention strategies must include primary, secondary, and tertiary efforts. Primary prevention would include programs such as G.R.E.A.T., described earlier. Such programs are offered broadly to all youth and endeavor to convince youth to avoid joining or associating with gangs. Secondary prevention efforts are those that target at-risk children, generally using a more comprehensive intervention rather than a simple educative approach. Tertiary prevention works with individuals who are already gang-involved and offers alternatives to gang involvement.

However, overreliance on prevention is unlikely to impact youth gangs. A balance of prevention, intervention, and suppression tactics is likely to be far more effective (Howell, 2007; NYGC, 2007b; Wyrick, 2006). For example, the G.R.E.A.T. prevention program could help youth in gang-problem areas avoid joining a gang while an Intervention Team could work with active gang members. The most violent gangs and gang members could be targeted by a Gang Suppression Unit.

Efforts to prevent, intervene, or suppress gangs must be systematic, sustained, and based on both local knowledge and on up-to-date scientific research. An effective program model is likely to contain multiple components, such as prevention, social intervention, rehabilitation, suppression, and community mobilization supported by a management information system and rigorous program evaluation (Howell, 1998; Wyrick, 2006). Thus, a comprehensive model, such as advocated by the U.S. Department of Justice, is necessary. Piecemeal efforts are unlikely to be effective.

Implementation is also crucial. Even the most successful program model, if poorly implemented, will achieve disappointing results. "Implementation is our biggest problem," asserted Wyrick. "Solutions to gang problems require long-term commitment. Quick solutions tend to not have lasting impact (personal communication, 2006)."

Youth with strong, supportive, and caring families are unlikely to become delinquent or join gangs. For those youth who are lacking family support, and for youth who have experienced maltreatment, the community must find ways to offer them connectedness and caring; and the community must remain committed to ongoing efforts.

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# Substance-Exposed Infants: Current Issues and Responses

Nancy K. Young, PhD, Sidney L. Gardner, MPA

## Overview[1]

While the topic has not been on the front pages for quite some time, the issues related to substance-exposed infants still affect at least 400,000 babies born each year—and closer to a million infants, if exposure to tobacco and alcohol are included. When the numbers are expanded to include all children under the age of 18, the fact that more than seven million children were prenatally exposed to alcohol, tobacco, or other drugs is a national health concern of major import.

Yet, considering the total number of births, estimates of substance-exposed births, and births in which exposure has been detected with follow-up assessment and services, it is clear that 90%–95% of all children with prenatal substance exposure are not detected at birth and leave the hospital with their birth parent(s) without follow-up plans or services.

This article suggests a practice and policy framework to provide a comprehensive view of the issues related to prenatal substance exposure, including a brief review of estimates of the prevalence of the issue, a summary of state policies and programs to assist these families, and suggestions of needed interventions in policy and direct practice.

## A Policy Framework for Intervention

Since many substance-exposed infants are not identified prenatally or at birth, an approach that addresses all the stages of development for affected children is critical. Most previous work related to substance-exposed infants has focused on pregnancy and the birth event. However, a more comprehensive view is needed that takes into account multiple intervention opportunities, beginning with pre-pregnancy and continuing throughout a child's development.

The framework (Figure 1) developed by Children and Family Futures, Inc. (CFF) to organize practice and policy responses to these children asserts that there are five major time frames when intervention could reduce the potential longer-term harm of prenatal substance exposure:

1. **Pre-pregnancy** – This time frame offers the opportunity to promote awareness of the effects of prenatal substance use among women of childbearing age and their family members;

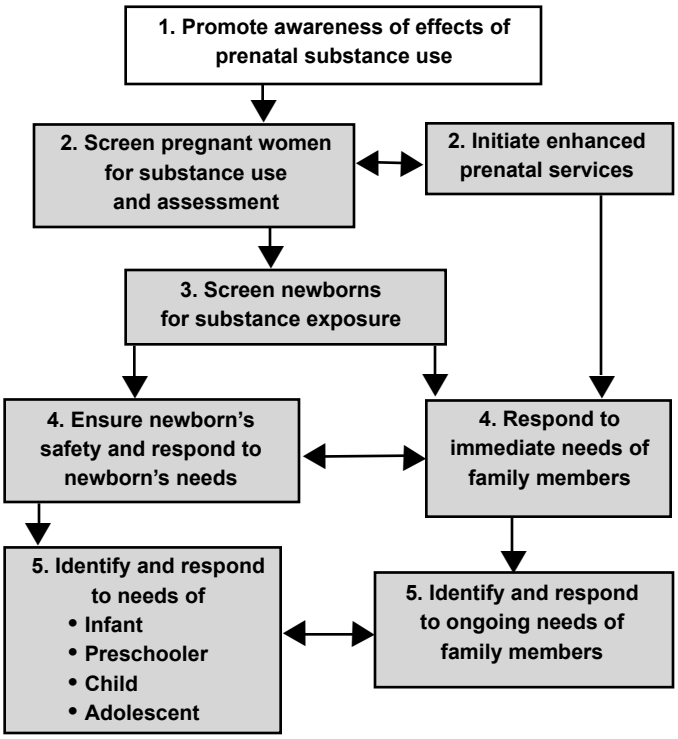
2. **Prenatal** – This intervention point encourages health care providers to screen pregnant women for substance use as a part of routine prenatal care and to make active referrals with follow-up that facilitates access to treatment and related services for women who need those services;

3. **Birth** – Interventions during this time frame incorporate screening newborns for substance exposure at the time of delivery and obtaining needed assessments—including safety assessments—and follow-up care for the family;

4. **Neonatal** – The emphasis includes developmental assessment and the corresponding provision of services for the newborn as well as the family immediately following the birth event; and

5. **Throughout childhood and adolescence** – This time frame calls for ongoing provision of coordinated services for both child and family.

**Figure 1: Framework for Analysis of the Five Time Frames for Prenatal Substance Abuse**




## The Problem

### History

The issue of substance-exposed infants first came to public attention in the United States during the 1980s and early 1990s because of the concern about infants affected by their mother's use of cocaine, particularly crack, during pregnancy. Earlier research on fetal alcohol syndrome was first published in the 1970s. National focus on the problem has reemerged over the past few years in response to several developments:

- In 2003, Congress passed amendments to the Child Abuse Prevention and Treatment Act (CAPTA) which require that substance-affected infants be referred to child protective services (see CAPTA side bar); this policy does not specifically mention alcohol, but refers only to illicit drugs, although several states have included alcohol in their testing and referral protocols:

- A growing body of research on fetal alcohol spectrum disorders (FASD) has included longitudinal studies documenting the long-term neurological effects of prenatal exposure to alcohol, leading to the development of new federally funded resource centers and the formation of a congressional caucus to address the issue;

- Concern has grown about the increasing number of pregnant women and children affected by the maternal use of methamphetamines, and households in which children are exposed to the dangers of methamphetamine manufacture;[2]

- Some states have recently enacted or proposed legislation directed at maternal substance abuse, including legislation in some states that has led to the incarceration of mothers of substance-exposed infants.

The focus on prenatal substance exposure is also intensified by increasing evidence that for substance-exposed infants and children, *early intervention makes a difference*. In the early 1990s, some practitioners and researchers held that prenatal drug exposure inevitably produced lasting damage, especially when the drug was cocaine. Others held that drug-exposed children were not significantly different from other infants who faced similar socioeconomic challenges. As information has accumulated over the past decade, both positions have been supported. There is growing evidence of the harmful effects of prenatal exposure to illegal drugs, alcohol, and tobacco. At the same time, it is clear that early intervention and nurturing home environments are important mediating factors that can lead to positive outcomes for substance-exposed children.[3]

In reauthorizing the CAPTA legislation in 2003, Congress responded to concerns about prenatal drug exposure by making three important changes in the law. To maintain their CAPTA grant funding, states must assure that they have the following:

- Policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants, except that such notification shall not be construed to establish a definition under federal law of what constitutes child abuse or require prosecution for any illegal action;

- A plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms;

- Procedures for the immediate screening, risk and safety assessment, and prompt investigation of such reports.

CAPTA also requires states to establish procedures to refer children under the age of 3 years who have substantiated cases of child abuse or neglect to early intervention services, funded under the Individuals With Disabilities Education Act (IDEA). While the CAPTA amendments regarding substance-exposed infants state that the identification of a substance-exposed infant shall not be construed as establishing child abuse or neglect in itself, these infants can be included in the group of children who can be referred for developmental assessments.

## Prevalence

Several different studies have estimated substance use by pregnant women and the number of infants exposed. Each of the studies varies in its estimates, due, in part, to differing methods of data collection, focus of the population included in the study, and different approaches used in the analyses. The following are some of the major studies.

*National Survey on Drug Use and Health (NSDUH)*

The most recent national data available from the NSDUH reports 2004–2005 annual averages of substance use by pregnant women (see Table 1). Prior studies based on this annual survey have found similar rates of substance use.[4] When these percentages are applied to the approximately 4 million infants born each year, the projections result in a wide range of estimated substance-exposed infants, depending on substance and trimester of use.

**Table 1: Substance Use by Pregnant Women by Length of Gestation, and Estimated Number of Infants Exposed**
(2004–2005 Annual Average)

| *Substance Used (past month)* | *1st Trimester* | *2nd Trimester* | *3rd Trimester* |
|---|---|---|---|
| Any Illicit Drug (3.9%) | 7.0% women | 3.2% women | 2.3% women |
| Alcohol Use (12.1%) | 20.6% women | 10.2% women | 6.7% women |
| Binge Alcohol Use (3.9%) | 7.5% women | 2.6% women | 1.6% women |

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The NSDUH also provides information beyond substance *use* to capture the number of individuals who need alcohol or drug treatment for substance *abuse* or *dependence*. Table 2 shows the results of an analysis using the 2005 NSDUH public use file on the percentage of females classified as needing alcohol or drug treatment, by pregnancy status.[5]

**Table 2: Percentage of Females Aged 15–44 Classified as Needing Treatment by Pregnancy Status: 2005**
(Source: Online Analysis of NSDUH Public Use File)

| *Needed Treatment in Prior Year for:* | *Pregnant* | *Not Pregnant* |
|---|---|---|
| Alcohol or Illicit Drug Use | 7.6% | 10.5% |
| Illicit Drug Use | 3.5% | 3.9% |
| Alcohol Use | 5.5% | 8.4% |

*Fetal Alcohol Surveillance Network (FASSNet) and State-Based FAS Prevention Program*
From 1997–2003, the Centers for Disease Control and Prevention (CDC) funded FASSNet, a statewide, population-based surveillance network, to determine the prevalence of Fetal Alcohol Syndrome (FAS) within a geographically defined area. CDC studies from FASSNet showed FAS prevalence rates ranging from 0.2 to 1.5 cases per 1,000 live births in different areas of the United States. Other prenatal alcohol-related conditions, such as alcohol-related neurodevelopmental disorders (ARND) and alcohol-related birth defects (ARBD) are estimated to occur about 3 times as often as FAS.[6]

*Screening During Pregnancy*
In a study of more than 7,800 pregnant women enrolled in prenatal care clinics in five communities who were screened for substance use with the *4P's Plus*©, approximately one third (32.7%) had a positive screen. Four of the communities conducted follow-up assessments on all women with a positive screen and found that 15% of those continued to use substances after learning of the pregnancy.[7]

*The Pregnancy Risk Assessment Monitoring System (PRAMS)*
The PRAMS, currently used in 32 states, collects data based on self-reported maternal behaviors and experiences that occur before, during, and shortly after pregnancy. Through cooperative agreements between the CDC and these 32 state governments, information on the use of alcohol and tobacco prior to and during pregnancy is compiled; questions on illegal drug use are included in the survey at the discretion of the state.[8] Seventeen states reported tobacco use in the PRAMS study and found that 6.2% to 27.2% of women smoked during last 3 months of pregnancy, and 1.8% to 8.2% used alcohol in last 3 months of pregnancy.[9]

The need for routine data collection and monitoring remains important, because the number of women with substance use disorders has not decreased significantly over the last few years. For example, the percentage of females aged 12 and older with illicit drug or alcohol dependence or abuse increased slightly from 6.1% in 2002 to 6.2% in 2003, and it remained steady at 6.2% in 2004.[10]

When these data are analyzed together, the following summary can be made:

- An estimated 10%–11% of the 4.1 million live births (in 2004) involved prenatal exposure to alcohol or illegal drugs;
- Prenatal exposure to alcohol rises to as high as one in five pregnancies during the first trimester;
- When tobacco data are included, the three data elements—prenatal use of alcohol, tobacco, and illegal drugs—are the basis for the statement that "more than one million" children are affected by prenatal exposure.[11] (This figure differs from the 400,000 stated at the beginning of this article; the 400,000 figure measures only prenatal use that can be detected at a point in time—birth—while the surveys that are the basis for the larger figure cover prenatal substance use during the entire period of pregnancy.[12])

## The Practice and Policy Responses

Based on our recent review of state-level documents and in-depth interviews in ten states, we believe that the current system of identifying these infants and responding to their needs is too often fragmented and fails to identify and serve most of these children. State efforts in each of the five areas set forth in the framework above are summarized next.

### Pre-pregnancy Awareness

Fewer than half of the states have public education campaigns that emphasize the potential harm done by using alcohol, tobacco, and illicit drugs during pregnancy. Some states have worked with institutions of higher education to disseminate this message. However, the national rates of use during the first trimester suggest that the message is not getting through to many pregnant women, especially those who are younger.

### Prenatal Screening

To reduce substance exposure during pregnancy and improve chances for a healthy birth outcome, there must be an effective link between screening and facilitating a woman's access to necessary treatment and related support services. Good model programs for prenatal screening operate in most of the ten states, but no state in the entire nation *requires* prenatal screening for substance use. In fact, few states have developed any policy that supports prenatal screening by private physicians, beyond a handful of pilot projects,

with Washington State a notable exception. At present, infants are tested for a large number of birth conditions, including some with an incidence far lower than prenatal exposure to harmful substances, but no state has mandated either prenatal testing or testing at birth to detect substance exposure. There are some efforts to move toward universal prenatal screening, and in some states and localities, a substantial portion of the most at-risk pregnancies are screened. State use of Medicaid funds provides one example of the disconnection between screening for substance abuse and screening by public programs for other medical conditions. Medicaid covers the cost of 37% of births nationally. Recently, Medicaid regulations were changed to include screening for substance use disorders among its covered benefits. Yet no state has used this as a policy option to ensure that the large percentage of births using this program require screening for substance use among pregnant women.

Further, no state has current prevalence data on substance use during pregnancy that covers the full range of substances. This lack of data regarding prenatal screening, referrals for treatment, and outcomes of treatment makes it difficult to assess the results of the model programs in place, or the states' overall policies.

### Testing at Birth

Hospital policies and practices vary widely regarding the testing of newborns for evidence of substance exposure, with very few hospitals using universal screening. Moreover, most testing that is conducted is based on somewhat subjective criteria. Hospitals do not usually provide child protective services (CPS) or other state agencies with data on the total number of infants tested at birth, the results of these tests, or referrals to CPS. However, recent legislation in some states has expanded the requirement that a CPS referral be made when drug exposure is detected. Fetal alcohol spectrum disorders have received increased attention in some states. As an example of the variance however, seven of the ten states interviewed considered prenatal exposure to be evidence of child abuse or neglect, while three others do not.

### Immediate Postnatal Services for Newborns and Families

Responses to the CAPTA legislation requiring that substance-affected infants receive a developmental assessment under the Individuals with Disabilities Act (IDEA) are still evolving. There are few estimates of referral trends resulting from the new federal policy. Of the ten states studied in depth, only two have strong links between IDEA referrals and child protective services agencies. The lack of uniformity in child welfare-referred developmental assessments that are utilized in most states makes it difficult to assess status in this area.

### Services for Children and Families

Ideally, services for an infant or child and the child's parents would be woven together in a comprehensive approach, although it is more commonly the case that the primary emphasis is on the child or the parents rather than both simultaneously. Some states have strong models of family-centered services. For instance, 19 states fund treatment services for mothers of substance-exposed infants (SEIs) with supplemental funds beyond the funding level required by the federal government. However, waiting lists for treatment persist, and admissions of pregnant women are a disproportionately small percentage of total admissions. Even where adequate treatment resources are available, other agencies may simply lack information or sufficient outreach regarding those resources and may conclude that treatment is not available.

In addition to the five listed areas, cross-cutting efforts are critical to assessing progress in addressing this issue.

### Data Systems and Interagency Organizational Efforts

Issues related to substance-exposed infants must be dealt with in a collaborative manner, since no single agency has the resources, the information base, or the dominant role to address the full range of needs of all substance-exposed or substance-affected newborns and their families. The lack of critically needed data that could be shared across agencies was noted to be a major barrier to collaboration. The information gaps at each of the hand-off points delineated in the framework are substantial, and these weaken the ability of the systems to work together to track children and families as they move from one agency to another. State policies and practices related to substance-exposed infants tend to develop within a complex system that includes diverse agencies within federal and state government. We found that states' interagency organizational efforts usually subordinate attention to substance-exposed infants in favor of other interagency activities.

Gaps in how substance-exposed infants are tracked by state data systems in terms of screening, assessment, and service delivery inhibit states' ability to measure whether they are making progress on addressing the problem. The need for routine data collection and monitoring remains important. Better tracking of data related to substance-exposed infants would support the case for developing more resources to serve these infants, and their mothers and families.

With respect to alcohol, the Substance Abuse and Mental Health Services Administration (SAMHSA) FASD Center for Excellence summarized state efforts in its 2004 report:

> Analysis of the data shows that state legislatures are responding to the societal cost of FASD by placing continually more emphasis on prevention and intervention services. State legislative actions range from calling for coordinated state FASD efforts to requiring FASD information to be given to persons applying for marriage licenses.[13]

As an example, in 2004 the Hawaii legislature adopted a proposal to address FASD more comprehensively and charged the Department of Health with developing a coordinated statewide effort to address the issue.[14] Also in 2004, the Minnesota legislature transferred funds from the Commissioner of Health to a statewide organization focused solely on prevention of and intervention with FASD. Shortly after, a contract was signed between the Minnesota Organization on Fetal Alcohol Syndrome and the Minnesota Department of Health to address issues of research on FASD, public education, professional education, and community grants.

Cont'd on page 16

## Options for Further Efforts

The states reviewed and highlighted in this report have shown that policy related to substance-exposed infants can be made effective, and that it can be taken to scale. In addressing the needs of these children, it is apparent that the connections across the five points discussed in this paper are as important as the interventions themselves. The handoffs from one point to the next and the linkages needed to coordinate services must become a comprehensive services framework, rather than a series of fragmented initiatives. The following action steps are needed to provide the proper foundation for this framework to result in better outcomes:

- ✔ States should make the most of Medicaid regulations and resources to influence hospitals and providers to adopt prenatal screening policies in their Medicaid schedules and reimbursements, given that Medicaid pays for 37% of births nationally, and well above that level in several states.

- ✔ Current statewide prevalence estimates of substance-exposed births are needed to establish baseline data for each state in order to understand the level of need and define the priorities for meeting that need sufficiently.

- ✔ The necessary statutory or administrative support must be in place to authorize the appropriate interagency coordinating bodies to address policy in a comprehensive and systemic manner as part of their mandates, and to establish and monitor interagency outcomes for programs serving substance-exposed infants annually, guided by a strategic plan that is supported by an inventory of all state programs that affect outcomes for substance-exposed infants.

- ✔ States need to augment the capacity of their existing information systems to collect data regarding how many parents of substance-exposed infants are referred, how many enter treatment, how many complete treatment, and how many succeed in continuing their recovery. This data are crucial to understanding the costs and cost-effectiveness of programs.[15]

- ✔ States must creatively use multiple funding sources to support the implementation and expansion of interventions for this target population. Comprehensive treatment is essential for substance-exposed infants and their families, and capacity-building for this level of service requires the strategic use of multiple funding streams. As one powerful example, states can take better advantage of Medicaid to finance mental and behavioral health assessments, therapies, wraparound services, and other interventions for children who are at high risk of emotional problems due to substance abuse by one or both parents.[16] Likewise, prioritizing an investment of funds in prevention and early intervention services to women results in significant cost-savings opportunities to the child welfare, health care, education, and criminal justice systems.

From this policy framework and model, it is possible to develop some concrete steps for hands-on practitioners in dealing with the problem of substance-exposed births. These include the following:

- ✔ *Work with hospitals, health clinics, and maternal and child health agencies to develop closer ties in serving families that may be affected by substance use disorders.*

In states such as Washington and Rhode Island, exemplary prenatal screening protocols have been developed by maternal and child health agencies and by hospitals. Child welfare workers need to know what their state's procedures are and how to respond to families by providing services rather than with punitive action that may worsen parents' incentives to seek treatment for their problems.

- ✔ *Understand the referral procedures from hospitals to child protective services, and from CPS to agencies that can conduct developmental assessments as required in the CAPTA legislation previously referred to.*

The required developmental assessments under CAPTA should seek to identify the specific neurodevelopmental delays that may be caused in part by substance exposure. Even when children do not assess at levels that ensure they will be admitted to the caseloads of Part C agencies that provide early intervention services for 0–2-year-olds, it is important to follow these children over time so that schools responsible for 3–5-year-olds are prepared to provide any needed special education services and parental support.

- ✔ *Work with medical staff who are familiar with the more subtle signs of fetal alcohol spectrum disorders.*

Considerable publicity has been given to the more visible facial and other aspects of fetal alcohol syndrome, but many children who do not show these visible effects may still be affected by the neurodevelopmental impact of prenatal exposure or the emotional impact of postnatal exposure in a family affected by a family member with a substance use disorder.

- ✔ *Develop an awareness of how to detect and record substance abuse in child abuse and neglect cases.*

The challenge is not to assume that parents are abusing alcohol or illicit drugs; the challenge is knowing how to detect abuse at a level that affects child abuse or neglect. Some states and localities have participated in online training for their front-line employees, using the tools developed by the National Center on Substance Abuse and Child Welfare (available at www.ncsacw.samhsa.gov). These tools have been developed in response to the findings that front-line workers often do not record substance abuse; for example, two adjacent states reported in 2000 that their foster care caseloads were affected by substance abuse in 62% and in 4% of the cases—suggesting strongly that the first state was doing a far better job of preparing its employees to detect and record the problem. The National Center on Substance Abuse and Child Welfare has also prepared a comprehensive review of screening and assessment tools—the SAFERR process—that are used by child welfare staff around the nation. This is available at www.ncsacw.samhsa.gov.

- ✔ *Ensure that child welfare agencies include staff with expertise in multiple funding sources for treatment and children's services, rather than assuming that child welfare funding will be needed for such services.*

Sometimes child welfare agencies are reluctant to diagnose and record problems with children out of fear that limited funding from the child welfare system would be the only way to respond to such diagnoses. But funding exists from multiple systems, and many children and their families are eligible for those funds.

The policy framework for intervention presented in this article along with the research from major studies and the action steps suggested for states, practitioners, and programs offer solutions toward more favorable policy actions in the area of substance-exposed infants.

**Notes and References**

[1] This article is the result of research and analysis sponsored in part by the federal government through its support of the National Center on Substance Abuse and Child Welfare, but the views expressed are those of Children and Family Futures (CFF) and do not represent those of the federal government of any funder of CFF.

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[4] In a 2003 study, Ebrahim and Gfroerer estimated that in 1998, 202,000 pregnancies were exposed to illicit drugs, 1,203,000 pregnancies were exposed to cigarettes, and 823,000 pregnancies were exposed to alcohol; the study used data from the 2000 National Household Survey on Drug Abuse.

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[10] Office of Applied Studies, Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health; due to changes in the methodology and data collection procedures for the NSDUH, trend comparisons with figures prior to 2002 are not possible.

[11] Chasnoff, I., & McGourty, R. (2003). *Power beyond measure.* Chicago: National Training Institute Publishing.

[12] A significant number of incidents of prenatal exposure to alcohol or illegal drugs take place in pregnancies that do not lead to a live birth (which totals 37% of all pregnancies). It should not be assumed, however, that the ratio of prenatal exposure in births is the same as that in pregnancies, given the harmful prenatal effects that lead to a disproportionate number of terminations of pregnancies and unintended pregnancies resulting from use of illegal and legal drugs. The American College of Obstetrics and Gynecology. (2000, February). *Alcohol and pregnancy.* Danvers, MA: Author. American College of Obstetricians and Gynecologists. (2000, February). *Repeated miscarriage.* [ACOG Education Pamphlet AP100]. Washington, DC: Author. DiFranza, Joseph D., & Lew, Robert A. (1995). Effect of maternal cigarette smoking on pregnancy complications and sudden death syndrome. *Journal of Family Practice, 40*(4), 385.

[13] Fetal alcohol spectrum disorder legislation by state, 2003–2004 legislative sessions. SAMHSA FASD Center, Washington, DC.

[14] The bill called for (1) Public awareness aimed at the general public, including awareness targeted at high-risk populations, as well as public education on how to prevent FASD, (2) professional education to teach professionals about FASD so they can recognize and identify FASD for referrals to diagnose, treat, and intervene, and teaching professionals to diagnose and screen and intervene using effective techniques, (3) screening high-risk populations, including both women of childbearing age and children already affected, (4) diagnosing high-risk populations, including children already affected and women at risk, (5) surveillance and data, including collecting and analyzing prevalence and incidence statistics to help define and describe the problem, and (6) intervening with high-risk populations, including treating women of childbearing age to reduce and eliminate the risk of an alcohol-exposed pregnancy and preventing secondary conditions in children already affected by FASD.

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# Mandated Reporting and Child Welfare Agencies: A Look at the Data

**Brett Drake, PhD, Melissa Jonson-Reid, PhD**

Mandated reporting is a cornerstone of the child protection system in the United States. Recently, some (Melton, 2005) have called for abolishing this policy, asserting that it is more harmful than beneficial. In addition to mandated reporting laws, other aspects of child welfare policy have drawn criticism, including concerns about unnecessary intrusiveness, low effectiveness, and general overreaching (Besharov, 1990; Melton & Thompson, 2001). It is only in the last 2 decades that we have begun to develop sufficient empirical data to effectively evaluate these concerns.

This brief report summarizes a larger article (Drake & Jonson-Reid, 2007) recently appearing in *Child Abuse & Neglect*. It addressed the following concerns relating to child welfare policy and practice:

- That reports are escalating due to overly broad mandates to report.
- That this escalation in reports is due to a "lowering of the bar," with less serious cases flooding the system.

This overloading is claimed to result in a series of negative outcomes, specifically,

- That child welfare agencies are overwhelmed by massive investigation caseloads.
- That these overwhelmed systems are therefore unable to provide preventative or protective services.
- That child welfare services are viewed negatively by clients and professionals alike.
- That with current reporting levels, case finding (identifying children who need protection) is no longer a problem.

In addressing the above concerns, we utilized a number of existing studies and publications, especially *Child Maltreatment 2003* (DHHS, 2005*)*, the annual publication tracking child maltreatment nationwide, as well as its precursor document from the mid-1970s, the *National Analysis of Official Child Abuse and Neglect Reporting:* 1977 (National Humane Association, 1979). The data from the 1970s provide an opportunity to understand child welfare reporting at a time when mandated reporting policies were new and when child maltreatment reports were far less common than they are today.

## Key Findings

### Escalation of Reporting (1977–2003)

Maltreatment reports were about 4 times as common (per 1,000 children) in 2003 compared with 1977. Reports from professional (mandated) sources were about 5 times as common, whereas reports from nonprofessional sources were about 3 times as common. It is unclear if this increase in reports from professionals is due to mandated reporting laws or from the larger number of professionals contacting children (e.g., school social workers, etc.). In any case, it is interesting to note that if the increase in reports from professionals had increased at *only* the rate of reports from nonprofessionals, then the total number of child maltreatment reports being received in 2003 would have dropped by less than 20%. *We found no evidence that mandated reporting laws were primarily responsible for overall increases in reporting.*

### Myth: Current Reports Are Less Severe Than in the Past (1977–2003)

We were able to track the proportions of cases that were reported and then substantiated, and we were also able to track the number of substantiated cases that were moved into foster care. These were the best data we could develop to give a sense of how many "serious" cases were being encountered. We were surprised to discover that the "throughput" (initial report to substantiation to foster care) was similar in both time frames (about 7% in 1977, about 6% in 2007). *We found no evidence that today's reports are less serious than reports from 3 decades ago.*

### Myth: Investigation and Intake Functions Are Overwhelming Child Welfare Agencies

We were able to find a number of sources that addressed this issue, notably the Urban Institute publication *The Cost of Protecting Vulnerable Children IV* (Scarcella et. al., 2004). This and other sources (including studies of worker time utilization) showed that investigation and intake functions probably consume between 5% and 10% of agency resources, with the lion's share of other resources being devoted to foster care. *The main factor burdening child welfare agencies is foster care, not intake or investigation.*

### Myth: Child Welfare Agencies Are Too Overwhelmed to Help Families

This is simply false. In 2003, most substantiated cases and about a quarter of unsubstantiated cases received post-investigation services (DHHS, 2005). Given the larger number of unsubstantiated cases, there are actually more unsubstantiated than substantiated cases served. As of 2003, 20 states had alternative response systems in place, providing a formalized means of intervening in less emergent or severe situations. The movement toward provision of preventative services and community collaboration is one of the bright spots in recent child welfare policy developments. *Although service provision could undoubtedly be increased, we found clear evidence that very large numbers of families, both substantiated and unsubstantiated, are currently being served.*

### Myth: Clients Have Negative Attitudes Toward Child Welfare Agencies

There is a large volume of literature in this area, from early work by Magura and Moses (1984) to more recent work based on the National Study of Child and Adolescent Well-Being (NASCAW) (Chapman, Gibbons, Barth, & McCrae, 2003) and including some detailed work from Washington State (English, Brummel, Graham, Clark, & Coghlan, 2002). Clients report satisfaction with child welfare services about 75% of the time. It is interesting to compare this with levels of satisfaction claimed by families using (voluntary) mental health programs. These levels of satisfaction are only slightly higher, varying from about 75% to about 90%. *In summary, we found that clients have generally positive views of child welfare agencies, and the commonly asserted characterization of families as generally disgruntled is simply wrong.*

### Myth: Providers Have Negative Attitudes Toward Child Welfare Agencies

A number of researchers have surveyed mental health professionals with regard to their views of child welfare agencies. Findings are consistent and show that service providers generally view child welfare positively and feel that child welfare intervention is more likely to help than to hinder therapy. They believe that child welfare interventions help keep children safe, and they strongly support mandated reporting laws. One study (Kalichman & Craig, 1991) found that 94% of service providers felt such laws were necessary.

### Myth: Case Finding Is No Longer a Problem

Many studies have determined that large numbers of maltreatment events are not reported to child welfare agencies. *While it may be easy to look at millions of reports per year and feel that we are getting "enough" reports, it is hard to morally justify such a judgment in the face of ongoing harm to children in situations that are not known to child welfare services.*

## Summary

Conventional wisdom sometimes characterizes child welfare services as intrusive, overburdened, and in a perpetual state of crisis. There is a familiar image of these agencies being flooded by new intakes and unable to respond in any way except to triage and then drop cases. The well-known escalation in reports has caused many to believe that child welfare agencies exist in a sort of perpetually besieged state. The data we found simply did not support these conclusions. We found that the child welfare system spends only a small part of agency efforts on intake and investigations, that it provides protective and preventive services to large numbers of families, and that it is generally well-liked by those individuals (both clients and providers) with whom it comes in contact. New policies for engaging families and communities, such as alternative response systems, may improve our ability to prevent future child maltreatment. The child welfare system is certainly not perfect, but by no means does it appear to be broken or under a desperate state of siege.



This article summarizes research previously reported in Drake, B., & Jonson-Reid, M. (2007). A response to Melton based on the best available data. *Child Abuse & Neglect, 31,* 343-360.

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# Journal Highlights

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

## Neighborhood Matters in Child Maltreatment Rates

Children of minority racial and ethnic backgrounds are overrepresented in the child welfare system. This study examined the relationship of various neighborhood characteristics with rates of substantiated child maltreatment for black, Hispanic, and white children within 941 neighborhoods (defined by census tracts) in three northern California counties. Independent variables included measures of population density, impoverishment, neighborhood instability, child care burden, neighborhood racial/ethnic composition, and alcohol outlet density.

Results indicated that the average substantiated maltreatment rates per census tract were 1 in 32 black children, 1 in 91 Hispanic children, and 1 in 167 white children. Percentage of poverty and number of off-premise alcohol outlets per 1,000 population were positively related to the rate of substantiated maltreatment cases for black children, while the percentage of black population and percentage of people moving in the past 5 years were negatively related. For Hispanic children, percentage of female-headed families, percentage of poverty. and percentage of unemployment were positively associated with rates of substantiated maltreatment, while percentage of black residents and population per square mile were negatively related. Finally, for white children, percentage of families in poverty, percentage of Hispanic residents, percentage of elderly residents, and the ratio of children to adults were positively associated with maltreatment rates.

The authors pointed out that rates of substantiated maltreatment differed when considering data from census tracts as opposed to counties. In this study, the disparity between rates of substantiated maltreatment noted between ethnic/racial groups was more pronounced at the level of the census tract. This finding, combined with the differences in neighborhood characteristics related to maltreatment rates among the racial and ethnic groups, suggests that the disparity may be a function of the areas in which the children live and that interventions should be aimed at addressing the relevant neighborhood characteristics for each group of children.

Freisthler, B., Bruce, E., & Needell, B. (2007). Understanding the geospatial relationship of neighborhood characteristics and rates of maltreatment for black, Hispanic, and white children. *Social Work*, *52*(1), 7-16.

## Occult Fractures in Burn Victims

While it is common practice for clinicians to obtain a complete skeletal survey on infants and children under 2 years of age who have suspected nonaccidental head injury or inflicted fractures, there is less agreement among professionals about the necessity of performing this procedure on young children with suspicious burns. This is because the frequency of occult fractures in burn victims is suspected to be low. In this retrospective study, the authors reviewed records from cases of suspected physical abuse evaluated by the Child Protection Team between 1989 and 2000. A total of 285 patients were diagnosed with physical abuse, 54 of whom were burn patients. Fifty-eight percent of burn and 85% of nonburn patients received a complete skeletal survey. To determine the frequency of occult fractures in these groups, the authors excluded patients who had no survey, and those in whom a fracture was obvious or suspected on presentation. A group of 169 patients remained, including 35 with burns and 133 with nonburn abusive injuries. Occult fractures were identified in 14% of the burn patients and 34% of nonburn patients. The most common site of occult fracture was the rib, followed by the femur. The average number of occult fractures was 8.8 in the burn group and 5.4 in the nonburn group. The authors concluded that while the frequency of occult fractures in patients with inflicted burns is lower than that in patients sustaining nonburn abusive injuries, it is nonetheless clinically significant, and a complete skeletal survey is warranted in the nonaccidental trauma evaluation of these patients.

Hicks, R. A., & Stolfi, A. (2007). Skeletal surveys in children with burns caused by abuse. *Pediatric Emergency Care, 23*(5), 308-313.

## Are Abusive Skeletal Fractures on the Decrease?

The authors of this study hypothesized that the incidence of serious physical abuse in the form of skeletal fractures in children had increased concurrently with the increase in reported incidents of child maltreatment. Using a retrospective design, they examined records and radiographs of all children less than 36 months of age who were evaluated for fractures at Yale-New Haven Children's Hospital from 1979–1983, from 1991–1994 and from 1999–2002. After excluding fractures related to metabolic bone disease or congenital disorders, they classified the injuries as abusive, accidental, or of unknown etiology. Ratings regarding etiology were made for each time period by two pediatric radiologists and two clinicians, one of whom was a child abuse expert. Weighted kappa statistics were calculated and indicated good agreement between raters, and between repeated ratings over time.

Results indicated that the proportion of cases rated as abusive decreased from 22.5% in the earliest period (1979–1983) to 10.0% in the middle period (1991–1994) and to 10.8% in the most recent period (1999–2002) ($p<.0001$). Multivariate logistic regression analysis revealed a significant association between the time period and the odds of a child presenting with an abusive fracture. When compared with children in the early sample, those in the middle sample showed a 69% decrease in odds (OR=0.31; 95% CI 0.15, 0.62), while those in the late group showed a 55% decrease in odds (OR=0.45, CI 0.0.23, 0.86). When children were classified according to age, a significant decrease in rates was found only in the 0–11-month age group. The percentage of cases rated as abusive in the youngest age group decreased from 38.7% to 22.8% to 23.6% over the three time periods. When location of fracture was studied, the proportion of abusive fractures of the humerus, tibia/fibula, and skull showed a statistically significant decrease over time. These findings did not support the authors' initial hypothesis, and they also stand in contrast to the increase

in number of CPS reports and substantiated cases of maltreatment occurring in the United States and in Connecticut during the same time period. The authors hypothesized that the increased recognition of maltreatment led to increased services for maltreated and at-risk children, which resulted in a decrease in the likelihood of serious injury such as fracture.

Leventhal, J. M., Larson, I. A., Abdoo, D., Singaracharlu, S., Takizawa, C., Miller, C., et al. (2007). Are abusive fractures in young children becoming less common? *Child Abuse & Neglect*, *31*(3), 311-322.

## Child Trauma and Sensory Modulation Disorders

This article focuses on the impact of exposure to both prenatal and postnatal trauma on child sensory modulation. According to the author, sensory modulation (i.e., the ability to regulate stimuli) "occurs within the central nervous system by balancing both excitatory and inhibitory sensory inputs that arise within one's sensory mechanisms, as well as those that occur external to the body" (p. 110). Research has consistently verified the link between child trauma and sensory modulation disorders. The author reviewed the literature and provided definitions and descriptions of sensory modulation disorder as well as the behavioral aspects of the disorders. He discussed the advances in research and, more specifically, recent assessment data from children who are served by the Southwest Michigan Children's Trauma Assessment Center (CTAC). The Center validates the prevalence of sensory modulation disorders among children who have suffered trauma, as well as children with both a history of trauma and a diagnosis of fetal alcohol spectrum disorder (FASD). This information is important for assisting professionals in recognizing and identifying behaviors related to sensory modulation disorders in children who have experienced maltreatment to ensure effective preventive and intervention services.

Atchison, B. J. (2007).Sensory modulation disorders among children with a history of trauma: A frame of reference for speech-language pathologists. *Language, Speech, and Hearing Services in Schools, 38*(2), 109-116.

## Educators as Mandated Reporters

The U.S. Department of Health and Human Services estimates that in 2002, 896,000 children were abused or neglected, many of whom were school-aged children. Research shows that the child abuse and neglect problem has serious consequences for children's physical, psychological, emotional, and educational well-being. In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was passed, requiring teachers to report cases of suspected abuse. It is important for teachers to know how to intervene when faced with this situation. This article provides three decision-making charts that outline options for teachers reporting child abuse or neglect. Teachers and administrators can use the charts to help them determine how to respond when they suspect a child has been abused or neglected. The charts can help teachers identify the type of action they need to take in particular situations, based on their observations of physical and/or behavioral symptoms. The charts can also be useful tools for educators in fully understanding their legal obligations as mandated reporters.

Pass, S.(2007). Child abuse and neglect: Knowing when to intervene. *Kappa Delta Pi Record, 43*(3), 133-138.

## Collaborative Tools for Speech-Language Pathologists

Speech-language pathologists are challenged by the increase in the number of children they serve who have been abused or neglected and/or have fetal alcohol spectrum disorder (FASD). The authors argue that it is important for speech-language pathologists to understand the child welfare laws that affect children and families and to understand the complexity of family histories and cultures. This article provides a short history of the child welfare system, an overview of the current system, and some related funding challenges. In addition, it reviews the research literature on effective tools for collaborative interventions for children with FASD and/or children who have been abused and neglected. The authors make suggestions about collaborative roles (e.g., participating in the interdisciplinary teams that plan interventions for children in the child welfare, legal, and educational systems) that speech-language pathologists can integrate into their interventions when they provide services to this population of children.

Rogers-Adkinson, D. L., & Stuart, S. K. (2007). Collaborative services: Children experiencing neglect and the side effects of prenatal alcohol exposure. *Language, Speech, and Hearing Services in Schools, 38*(2), 149-156.

## Mental Health as a Predictor of Placement Movement

In this study, Barth and colleagues used the National Survey of Child and Adolescent Well-Being to examine differences in patterns of out-of-home placement between children with (n=362) and without (n=363) emotional and behavioral disorders (EBD). The authors used baseline clinical scores from the Child Behavior Checklist to classify children into either group. They further classified children with EBD into two categories, those with fewer than four placements (n=224) and those with four or more placements (n=128) during their first 36 months of placement in child welfare.

Using predictive statistics, the study found that children with EBD were over twice as likely as children without EBD to experience four or more placements. Higher numbers of placements for children with EBD were predicted by children also having a diagnosis of depression and not being placed with siblings. Higher numbers of placements for children without EBD were predicted by older age (>11) and gender (female). No predictive relationship was found between children being placed in kinship care and number of placements. The authors suggest a need for training caregivers about EBD and increasing opportunities for placing siblings together.

Barth, R. P., Lloyd, E. C., Green, R. L., James, S., Leslie, L. K., &Landsverk, J. (2007). Predictors of placement moves among children with and without emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders, 15*(1), 46-55.



Cont'd on page 22

## Combat Deployment Impacts Child Maltreatment in Military Families

Gibbs and colleagues reported on a study in which they compared child maltreatment rates of enlisted soldiers' families during combat-related deployment and nondeployment. The sample included a total of 1,771 families identified in the Army Central Registry with at least one documented incident of child maltreatment from September 11, 2001 to December 31, 2004. Incidents included neglect, physical abuse, emotional abuse, and sexual abuse.

Predictive analyses generated a number of statistically significant differences. Female civilian parents experienced higher rates of maltreatment during deployment than male civilian parents. Non-Hispanic white parents had higher maltreatment rates than black or Hispanic parents. While neglect constitutes the highest percentage of maltreatment incidences during nondeployment, this rate doubled during times of deployment. For female civilian parents, the neglect rate was four times greater during deployment than nondeployment. Overall, child maltreatment was 42% higher during times of deployment. The authors reported that these findings are consistent with other research studies with military families. They further suggest that with the increased family stress brought about by deployment, affected Army families should receive both supportive and prevention services.

Gibbs, D. A., Martin, S. L., Kupper, L. L., & Johnson, R. E. (2007). Child maltreatment in enlisted soldiers' families during combat-related deployments. *Journal of the American Medical Association, 298*(5), 528-535.

## Therapists' Faulty Perceptions of Treatment Effectiveness

The authors described a small, cross-sectional study of mental health therapists treating children in foster care. The final sample for data analysis included 21 therapists, each providing in-home treatment as usual to one foster child. Treatment was provided for depression, anxiety, behavior problems, and self-esteem. The therapists consisted of licensed Marriage & Family Therapists (76%), social workers (14%), and licensed PhD Psychologists (10%).

Foster children were administered four standardized measures upon entry into treatment and 6 months later to measure the aforementioned emotional and behavioral issues. After 6 months of treatment, therapists completed a survey indicating the extent to which they believed a significant improvement had resulted from the intervention. Correlation analyses found no significant relationships (and in most cases, virtually no relationship) between the therapists' perceptions of improvement and actual change as indicated from the standard measures. The authors concluded that the therapists were unable to accurately evaluate the effectiveness of their own practice.

Love, S. M., Koob, J. J., Hill, L. E. (2007). Meeting the challenges of evidence-based practice: Can mental health therapists evaluate their practice. *Brief Treatment and Crisis Intervention, 7*(3), 184-193.

## Factors Impacting Evidence-Based Practice Implementation in Child Welfare

This article described the challenges to implementing evidence-based practices in child welfare, including the systems' structures, processes, and person factors. The authors noted that though the benefits of evidence-based case management, psychotherapeutic, and pharmacologic interventions are demonstrated, implementation of those interventions has not occurred in most child welfare settings. Many reasons exist for the gap between research and implementation. For example, researchers' design of efficacy and effectiveness in their research trials often do not consider the complexity of real-world service settings, which creates challenges as practitioners seek to implement those interventions. Practitioners do not have the time, resources, training, or incentives they need to become better informed and skilled in evidence-based interventions. Finally, there has not been enough attention given to developing infrastructures and systems to assist in translating EBP to real-world settings.

This study sought to depict the perspective of providers about the factors that influence the implementation of EBP in child welfare and how to modify those factors in order to facilitate implementation. A total of 15 case managers and 2 consultants participated in a statewide study, called SafeCare, which examined implementation and monitoring of ongoing fidelity of an intervention designed to reduce child neglect among at-risk parents. Semi-structured interviews, conducted over a 2-week period, were analyzed using a methodology of "Coding, Consensus, Co-occurrence, and Comparison."

The results identified six factors that affected the implementation of evidence-base intervention in this study: (1) Acceptability of the EBP to the caseworker and family, (2) suitability of the intervention to the needs of the family, (3) motivation of caseworker to implement the EBP, (4) EBP training experiences, (5) the degree of organizational support, and (6) the impact of the EBP on the process and outcome of services.

Aarons, G. A., & Palinkas, L. A. (2007). Implementation of evidence-based practice in child welfare: Service provider perspectives. *Administration and Policy in Mental Health and Mental Health Services Research, 34*, 411-419.

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# Washington Update

**Thomas L. Birch, JD**
**National Child Abuse Coalition**

## Federal Budget, Child Health Insurance Top Political Agenda

Back from summer recess, with the end-of-year adjournment nowhere in sight, Congressional Democrats have created a series of political confrontations with President Bush over spending priorities and the expansion of the State Child Health Insurance Program (SCHIP). They hope to draw attention to the Democrats' priorities on spending for education and health care in contrast to what Democrats see as excessive spending on the war in Iraq. Appropriations leaders in the House and Senate have pointed out, for example, that the dispute between the White House and Congress over the President's complaint that the annual spending bills, most of which he threatens to veto, exceed his proposed budget by some $22 billion in discretionary spending, while the President has asked Congress to increase spending by $46 billion, off budget, for the war effort.

In an attempt to embarrass the President and draw a bead on this dispute over spending priorities, Congressional Democrats plan to send to the President the Labor-HHS-Education appropriations bill for the 2008 fiscal year in a bundle with the funding measure for the Department of Veterans Affairs. In response, Bush has promised that a veto would even apply to the veterans' spending—which he favors—if packaged with domestic funds he considers excessive.

Senate and House appropriators have worked through October to resolve the differences between them in the spending measures headed for the White House. A conference committee report in the form of a final bill is expected to go to the House for floor consideration during the first full week in November. The timing would get the bill to the White House around Veterans Day, forcing Bush to exercise his veto on the veterans funding while attention is focused on those who have served the nation in the armed forces.

The House completed action on all 12 appropriations bills by the start of the August recess, but the Senate has voted on only 7 of the funding measures. With the Senate passage on October 23 of the Labor-HHS-Education money bill, it seems unlikely that the Senate will take action separately on the remaining 5 FY08 appropriations bills. With the appropriations bills bogged down on Capitol Hill, Congress may still be working on the Fiscal Year 2008 funding measures in December and January. Congress set a November 16 action deadline with the passage of a continuing resolution carrying funding through the week before legislators plan to break for the Thanksgiving holiday. That goal now seems unlikely to achieve. A second continuing resolution carrying federal spending for several more weeks at the 2007 levels is to be expected.

## Child Abuse Registry Study Funding in Senate Bill

During Senate floor votes on the Labor-HHS-Education spending legislation, the chamber adopted by voice vote an amendment offered by Sen. Dianne Feinstein (D-CA) with Sen. Jon Kyl (R-AZ) to provide $500,000 for a feasibility study for a National Registry of Substantiated Cases of Child Abuse and Neglect. The Adam Walsh Child Protection and Safety Act of 2006 authorized the creation of a national registry, and it also authorized spending on a study to determine the feasibility of such a registry. The Feinstein amendment would require the Department of Health and Human Services to complete the study within a year of the enactment of the appropriations legislation. Without specific funding earmarked for the feasibility study, HHS has been unwilling to proceed.

The national registry of substantiated cases of child abuse and neglect would be available to child protection authorities, not to the general public, to use as a resource in tracking previous instances of child maltreatment in order to enable child protection workers to be better equipped with relevant information in assessing cases. The funds for the feasibility study would be taken from the spending account already allocated in the appropriations bill for HHS general departmental management. The feasibility study is expected to address whatever problems and implementation concerns have been raised about the proposed child abuse registry. During last year's consideration of the registry provisions in the Adam Walsh bill, issues were raised about the ability of states to provide to the registry reliable and comparable reporting information—recognizing the variation among states in the standards for inclusion of information in central registries maintained by the various states—and concerns over due process involving case information maintained by state and county child protective service agencies.

## House/Senate Continue Efforts to Pass SCHIP

Democrats—with some significant Republican support—are intent on forcing the President's hand on legislation to extend and expand authorized funding for the State Child Health Insurance Program (SCHIP). On October 25, House Democrats forced a repeat vote on the legislation already vetoed by President Bush, and again they failed to gain the two-thirds majority needed to withstand a presidential veto. In fact, the bill, almost identical to that vetoed a week earlier by President Bush, lost two Republican votes the second time around. Republicans—even moderates who supported the $35 billion SCHIP expansion to increase health coverage to 10 million children—were angry at the Democrats for hastily scheduling the floor vote. When Republicans asked Democrats to postpone a vote on the bill for a week, they were denied.

Despite the posturing and partisan bickering, in the Senate, at least, the leadership of some prominent Republicans is attempting to craft a measure for SCHIP able to withstand yet another Bush veto. Sen. Charles E. Grassley (R-IA), ranking member on the Finance Committee, is intent on negotiating changes in the SCHIP bill aimed at boosting Republican support for the measure and ensuring a veto-proof majority in the House. To that end, it is reported that Grassley and other Republican and Democratic Senate colleagues have reached across the Hill to House Republicans to understand

Cont'd on page 24

what levels of changes would garner the votes needed for a secure passage of the SCHIP expansion.

Issues revolve around eligibility, whether it should be set at 300% of the federal poverty level ($60,000 for a family of four) or lower, say at 250%; coverage for adults, phasing out coverage for childless adults, but keeping enrollment for pregnant women; children of immigrants, requiring verification of citizenship; and targeting enrollment, encouraging states to enroll the poorest, Medicaid-eligible children ahead of others.

If the SCHIP measure passes both House and Senate with a veto-proof majority, Congress would send the bill to the White House with the message that changes had been made sufficient to garner support enough to override yet another veto.

The contested legislation would expand SCHIP by $35 billion over the next 5 years, to $60 billion, extending coverage to 10 million children. The expansion would be paid for with tobacco tax increases, including a 61-cent increase in the cigarette tax, to $1 per pack. The President proposed increasing current SCHIP funding by $5 billion, which analysts explained would not even pay health insurance coverage for the children already enrolled.

In addition to his objections to the overall cost of the bill, the President has held out a desire to advance his proposal to expand health insurance coverage through tax breaks, an idea he put forth in his State of the Union address at the beginning of the legislative session. A report from the Urban Institute suggests that the President's proposal, which Congress has rejected, to offer parents tax deductions to offset the costs of health insurance—rather than expanding SCHIP—would actually cost families earning between 150% and 300% of the federal poverty level much more than under SCHIP. The study concludes that the potential to decrease the number of uninsured children would be substantially greater under an SCHIP expansion than under the proposed tax deduction.[1]

## House Hearing Investigates Teen Boot Camps

In 2005, Rep. George Miller (D-CA), then the ranking minority member of the House Committee on Education and the Workforce, introduced legislation aimed at preventing the notorious cases of child abuse, and fatalities, in private residential treatment programs, sometimes called behavior modification programs, and commonly referred to as juvenile boot camps. Miller's bill never got a hearing. Last week on October 10, Miller, now the chair of the renamed Committee on Education and Labor, convened an investigative hearing on child abuse and neglect at private residential treatment facilities.

Leading off a panel of witnesses, including the parents of teenage children who met their horrifying deaths in these facilities, the managing director of forensic audits and special investigations for the Government Accountability Office (GAO), Greg Kutz, described a network of hundreds of residential treatment programs operating in the United States, ungoverned by federal laws or regulations and only a few operating in states under license or regulation. He cited cases of physical, emotional, and mental abuse, and ineffective program management leading to deaths resulting from abuse. Kutz explained that programs engage in misleading marketing practices, often through Web sites representing staff expertise when none exists. He told the committee members that untrained program staff members typically assume a child is faking symptoms when abuse causes harm. Kutz said that the GAO investigators found evidence of serious physical abuse and negligent operating practices leading to the deaths of teens whose parents had placed them in the boot camps.

In the GAO report, *Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth* (GAO-08-146T), released on the day of the hearing, the government investigators, asked by the House committee to examine the facts and circumstances surrounding selected closed cases where a teenager died while enrolled in a private program, "found significant evidence of ineffective management in most of the 10 cases, with program leaders neglecting the needs of program participants and staff. This ineffective management compounded the negative consequences of (and sometimes directly resulted in) the hiring of untrained staff; a lack of adequate nourishment; and reckless or negligent operating practices, including a lack of adequate equipment. These factors played a significant role in the deaths GAO examined."[2]

While the GAO report acknowledges "positive outcomes associated with specific types of residential treatment," Kutz explained at the hearing how GAO found programs that changed names and moved from state to state after serious abuse or the death of a teen was discovered. He said the GAO's investigation found little or no standards for employment or background checks on prospective staff in the programs investigated, which run an average daily cost of $300, generally paid out of the pockets of willing parents or sometimes paid with federal dollars, such as special education funds, but with no federal oversight. He questioned whether any level of due diligence was exercised even in those states with licensing agencies. Some programs operate on federal land, Kutz reported, even citing one which still operates though it owes the U.S. Forest Service tens of thousands of dollars in rent.

In an attempt to quantify the number of incidents of abuse in these residential programs, GAO turned to the federal National Child Abuse and Neglect Data System (NCANDS) study of child maltreatment. The NCANDS report identified 1,619 staff members

involved in incidents of abuse in residential programs in 33 states in 2005. Recognizing, however, that the NCANDS data collect reports about children known to child protective services, GAO in its report to Congress admitted, "Because there are no specific reporting requirements or definitions for private programs in particular, we could not determine what percentage of the thousands of allegations we found are related to such programs."

Kutz pointed out that that because no agency or registry tracked the industry, it was impossible to say how many programs existed, how much money they collected, how programs were financed, or how frequently abuse occurred. The GAO plans to release early next year a more comprehensive report on the abusive treatment of youths in these residential treatment programs. Miller signaled that he does not intend to introduce legislation until GAO has provided its complete findings, but he asserted his commitment to pursuing a "federal interest in the abusive treatment of these children" through continued investigations.

## Congressional Panel Urged to Invest in Early Childhood Programs

At a June 27 hearing before the congressional Joint Economic Committee, Dr. James Heckman, Nobel Prize-winning professor of economics from the University of Chicago, testified to the panel of Senators and Representatives that "major economic and social problems such as crime, teenage pregnancy, dropping out of high school and adverse health conditions" are traced to "adverse family environments [which] promote adult failure." The hearing, entitled "Investing in Young Children Pays Dividends: The Economic Case for Early Care and Education," was cochaired by Rep. Carolyn Maloney (D-NY), vice chair of the Joint Economic Committee, and Sen. Robert Casey (D-PA).

Leading off the panel of witnesses, Heckman advised the legislators, "If society intervenes early enough, it can affect cognitive and socio-emotional abilities and the health of disadvantaged children…, promote schooling, reduce crime, promote workforce productivity, and reduce teenage pregnancy….The longer we wait to intervene in the life cycle of the child, the more costly it is to remediate to restore the child to its full potential."

Maloney identified the hearing as one in a series planned by the Joint Economic Committee "as Democrats in Congress work to develop policies for the 21st century that help families balance the competing demands of work and family responsibilities." She referred to "a compelling body of research" presented at the National Summit on America's Children convened in May by House Speaker Nancy Pelosi (D-CA), making clear that "early intervention improves children's lives and eases the burden on public resources."

Another hearing witness, Democratic Kansas Governor Kathleen Sebelius commented that early childhood programs "cross traditional agency boundaries" as in her state, where the education department and social services agencies collaborate. "It's important," she said, "that any legislation promotes community-based programs as well as school-based efforts…because pre-K isn't just an education issue, but a social, health, and economic issue as well."

Douglas Besharov, director of the American Enterprise Institute's Social and Individual Responsibility Project and the first director of the federal National Center on Child Abuse and Neglect, testified about early childhood educational programs, with particular recommendations about Head Start. He suggested that Head Start should "go back to its roots, to search for ways to make a meaningful improvement in the lives of the poorest, most disadvantaged children. It might, for example, provide services to unwed teenagers [who] start during their first pregnancy."

Statements and testimony from the Joint Economic Committee hearing are available on the committee's Web site: http://jec.senate.gov/hearings.htm#062707.

Sen. Casey has introduced the Prepare All Kids Act (S.1374) aimed at helping states provide high quality pre-kindergarten programs, with an emphasis on serving low-income children. The legislation, also introduced in the House (H.R.2859) by Rep. Maloney includes an "Infant and Toddler Set Aside" to fund programs that serve children from birth through age 3.

The Joint Economic Committee has issued an Economic Fact Sheet, "The Economic Benefits of Investing in High-Quality Preschool Education," which concludes that investing in high-quality preschool "is a cost-effective method for improving the life circumstances of children, particularly those who are currently most at risk of failing in school." The paper cites research by Art Rolnick and Rob Grunewald from the Minneapolis Federal Reserve Bank asserting that "as much as 80 percent of the projected benefit of high-quality preschool for disadvantaged children goes to the public." Heckman's research referenced in the JEC fact sheet estimates an increase in gross domestic product by as much as 3.5% when high-quality preschool is available to all children The JEC's Economic Fact Sheet is available on Rep. Maloney's Web site at: http://maloney.house.gov/documents/workingfamilies/children/20070522_preschooleducation.pdf.

**Notes**

[1] Blumberg Linda J., & Genevieve M. Kenney. *Can a Child Health Insurance Tax Credit Serve as an Effective Substitute for SCHIP Expansion?* Posted to Web: October 18, 2007, Permanent link: http://www.urban.org/url.cfm?ID=411560, Urban Institute, Washington, DC

[2] Testimony Before the Committee on Education and Labor, House of Representatives. Posted to Web: October 10, 2007, Permanent link: http://www.gao.gov/news.items/d08146t.pdf. General Accounting Office, Washington, DC.

## 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.

# APSAC Advanced Training Institutes

The APSAC Advanced Training Institutes are being held in conjunction with the 22nd Annual San Diego International Conference on Child and Family Maltreatment. You ***must register separately*** for the APSAC Institutes and the San Diego Conference. Registration and housing information for the full conference can be found at www.chadwickcenter.org

## APSAC Preconference Institute #1

**Medical Evaluation of Sexual Abuse of Children and Adolescents**

Lori Frasier, MD, & Suzanne Starling, MD

Two morning sections will provide the novice and experienced sexual abuse examiners with an opportunity to increase their knowledge directed to their own skill levels. The afternoon session will bring all participants together for case-based format and discussion.

**Novice**—Will be able to recognize normal ano genital anatomy in children and adolescents, know how to culture and test for sexually transmitted diseases, depending on age and development of the child, and describe peer review and case oversight and how they differ.

**Experienced sexual abuse examiners**—Will be able to discuss three of the most current articles on medical aspects of sexual abuse of children, describe the three most common mimics of sexual abuse, develop an approach to screening and diagnosis of sexually transmitted diseases in children and adolescents evaluated for sexual abuse, and relate features of peer review and case oversight that differentiate these two processes.

## APSAC Preconference Institute #2

**Help for Families Involved in Physical Coercion or Abuse: Community Application and Supervision of Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)**

David J. Kolko, PhD, & Amy D. Herschell, PhD

This workshop provides an overview of the child, caregiver, and family components of AF-CBT and offers some ongoing programmatic development and clinical directions to facilitate community application. Examples of procedures designed both to minimize the psychological sequelae of the experience (e.g., aggression, social withdrawal) and reduce the risk of recidivism (e.g., anger, limited discipline) will be included. We will also describe the integration of child and caregiver work from recent case applications and discuss the incorporation of research/evaluation tools to document treatment course and outcome. Suggestions will be provided for addressing common implementation and systemic obstacles to treating this population effectively in diverse community settings, as well as for enhancing training and supervision of AF-CBT. Emerging developments regarding the assessment, treatment, and study of child physical abuse will be included.

## APSAC Preconference Institute #3

**Advanced Forensic Interviewing**

Illene Berson, PhD, Lynda Davies, BA, Michael Haney, PhD,Tom Lyon, JD, PhD, Julie Kenniston, LSW, & Kee MacFarlane, ACSW

This is an advanced-level forensic interviewing institute with emphasis on knowledge and performance, including providing feedback and critiques of forensic interviews. Updates on research and legal issues will be provided as well. It is recommended that participants have completed a week-long interview training, such as offered by APSAC, Finding Words, and so on. This institute will include both a didactic and an experiential process to increase comprehension and understanding of the dynamics of forensic interviewing.

## WIPSAC Opens Webinar Participation to All APSAC Members

WIPSAC, the Wisconsin state chapter of APSAC, has been sponsoring a series of monthly Webinars for its members, featuring discussion of articles from the *APSAC Advisor* and from the journal *Child Maltreatment*. The Webinars usually occur at lunch time, and the authors of the articles to be discussed are invited to help lead the discussion and answer questions about their work.

At a recent WIPSAC board meeting, the board voted to extend an invitation to any APSAC member who would be interested in participating in these sessions. The date will likely be the fourth Thursday of every month, beginning in January 2008.

Previous Webinars based on *Advisor* articles have included "Ethical Issues for Guardians *ad Litem* Representing Children in Dependency Cases" (Jennifer Renne), Summer 2007; "Constructive Uses of Risk: The Promise and Peril of Decision-Making Systems in Child Welfare" (Aron Shlonsky and Liz Lambert), Fall 2006; and "Delivering Parent Training to Families at Risk to Abuse" (Brad Lundahl and Norma Harris), Summer 2006.

The dates and topics of Webinars will be posted on the master calendar on the APSAC Web site (www.apsac.org) and include direct links to enable interested participants to register for a session online. Information will also be provided in the *Advisor* when published articles are slated for Webinar discussions.

APSAC expresses its appreciation to WIPSAC for making this educational opportunity available nationally.

## APSAC Task Force Report on Attachment Wins Pro Humanitate Literary Award

The final *Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems* has been selected to receive the Pro Humanitate Literary Award.

The report, published in *Child Maltreatment, 11*(1), February 2006, reviewed the controversy related to the use of potentially harmful attachment therapy techniques used by a subset of attachment therapists, and it formalized APSAC's position on assessment and treatment of attachment problems in children.

The report was written by task force members Mark Chaffin, Rochelle Hanson, Benjamin Saunders, Todd Nichols, Douglas Barnett, Charles Zeanah, Lucy Berliner, Byron Egeland, Elana Newman, Tom Lyon, Elizabeth LeTourneau, and Cindy Miller-Perrin.

The Pro Humanitate Literary Awards are presented annually by the North American Resource Center for Child Welfare (NARCCW). The awards celebrate outstanding literary achievement by authors from the United States and Canada whose work exemplifies the intellectual integrity and moral courage required to transcend political and social barriers to champion "best practice" in the field of child welfare.

The APSAC report is one of three articles selected by a panel of peer judges to receive the Herbert A. Raskin Pro Humanitate article award. Award winners will each receive a Pro Humanitate medal, and a cash award of $1000 will be presented to the authors of each winning article. The awards will be presented by Dr. Ronald C. Hughes, Director of NARCCW, on Thursday, January 31, at the 22nd Annual San Diego International Conference on Child and Family Maltreatment.

Congratulations to APSAC members for continued exemplary work.

## CONFERENCE CALENDAR

### 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, CA
Call: 877.402.7722, or Visit: www.apsac.org, or
E-mail: apsac@apsac.org

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

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

### March 10–14, 2008
**APSAC Child Forensic Interview Clinics**
Virginia Beach, VA
Call: 877.402.7722, or Visit: www.apsac.org, or
E-mail: apsac@apsac.org

### March 17–20, 2008
**24th National Symposium on Child Abuse**
Huntsville, AL
Visit: www.nationalcac.org, or
E-mail: ablalock@nationalcac.org

### April 20–23, 2008
**National American Indian Conference on Child Abuse and Neglect**
**National Indian Child Welfare association (NICWA)**
Minneapolis, MN
Visit: www.nicwa.org/conference, or
E-mail: isla@nicwa.org/conference

### May 12–14, 2008
**8th Annual Campbell Collaboration Colloquium**
Vancouver, BC, Canada
Visit: www.campbellcolloquium.org

### May 19–22, 2008
**2008 Prevent Child Abuse America National Conference**
Milwaukee, WI
Call: 312.663.3520, or
Visit: www.preventchildabuse.org?events/index.shmtl

### June 2–6, 2008
**APSAC Child Forensic Interview Clinics**
Seattle, WA
Call: 877.402.7722, or Visit: www.apsac.org, or
E-mail: apsac@apsac.org

### June 3–6, 2008
**2008 Conference on Family Group Decision Making**
**American Humane Association**
Tuscon, AZ
Call: 303.792.9900, or Visit:www.americanhumane.org

### June 18–21, 2008
**16th Annual APSAC Colloquium**
Phoenix, AZ
Call: 877.402.7722, orVisit: www.apsac.org, or
E-mail: apsac@apsac.org

# APSAC ADVISOR




## Save these dates!

**January 28, 2008**
**APSAC Advanced Training Institutes**
**San Diego, CA**

**March 1–14, 2008**
**APSAC Child Forensic Interview Clinics**
**Virginia Beach, VA**

**For more information visit: www.apsac.org**

## NEW APSAC Important Contact Information

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