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**_At Issue_: Musings on Policy**
Jerry Friedman

This *At Issue* column considers the ways that policy makers in the human services may overlook the primary purpose of helping clients achieve better outcomes. The author describes how well-meaning policy developers can, in fact, interfere with direct practice and suggests strategies for policy development that enable us to remain mission focused and effective. **2**

**SPECIAL ISSUE ON CHILD NEGLECT**

**Guest Editors:**
Diane DePanfilis, PhD, MSW
Maria Scannapieco, PhD, MSW

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**Defining _Child Neglect_: Principles for Practice**
Howard Dubowitz, MD, MS

This article reviews the many challenges in deriving a consistent and uniform definition of *neglect*, given complexities of context, disparities in personal and professional perspectives on parenting, and discipline-specific variations in approaches to working with children and families. While a consistent definition of *neglect* could potentially increase consistency in practice, such a uniform definition may not be possible. The author reviews the relevant issues in defining *neglect* and implications for direct practice. **3**

**Developmental Outcomes of Child Neglect**
Maria Scannapieco, PhD, MSW

Child neglect can have pervasive negative consequences on all aspects of children's development. These effects are exacerbated when children are neglected during their first 3 years of life. This article discusses the consequences of neglect on children's development and the characteristic short-term and long-term outcomes for children who have been neglected. **7**

**Project SafeCare®: An Evidence-Based Approach to Prevent Child Neglect**
Debra B. Hecht, PhD, Jane F. Silovsky, PhD, Mark Chaffin, PhD, John R. Lutzker, PhD

Project SafeCare® is a manualized in-home intervention program designed to prevent occurrences or recurrences of child abuse and neglect in multiproblem families involved in the child welfare system or at high risk for child welfare involvement. The SafeCare® program works to develop parental capacity in strengthening attachment, home safety, and infant and child health. This article describes the SafeCare® program model, its intended applications, and its supporting empirical base. **14**

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# *At Issue*: Musings on Policy

## Jerry Friedman

Dean Atchison once wrote that "the purpose of memos is seldom, if ever, to inform the reader. Rather, they are almost always intended to protect the writer." I think the same could be true for much of the policy development activity that occurs in human services today. *At Issue* is why so much of our policy work is focused on federal rules compliance and program protection that we sometimes run the risk of overlooking our primary purpose of helping clients achieve better outcomes.

Over the past couple of years, the National Policy Council of the American Public Human Service Association (APHSA), which comprises state CEOs, has been working on a more proactive approach to identifying social issues, establishing policy priorities, and developing formal policy positions that will strategically guide us toward achieving our program goals. Effective legislative relations are a core competency of APHSA, and I often hear from our members that it is one of the functions that they value most about the association. However, moving from a primary focus that includes legislative tracking, analysis, informing, and commenting to actually proposing and promoting new legislation requires different tools and skill sets. As we move toward this activity in preparation for a new administration in Washington, we have spent considerable staff time aligning our resources and identifying those elements that contribute to more effective public policy development. I would like to share some of our observations.

First, it is important to make the distinction between compliance and policy development. In either case, policy must be grounded in operational reality. Ultimately, policy is what you do, not what you write. Therefore, policy should be an operational tool, and effective communication between policy and practice functions is essential to good programming. This implies a participatory process involving all parties affected by the change. Based on my observations, too often critical functions such as training, evaluation, finance, and information system changes are an afterthought—not the primary considerations—to a good policy idea. I would contend that if you can't teach it, account for it, measure it, or automate it, policy expectations are unlikely to be met.

Second, policy should be data driven to the extent it is possible, both in terms of making the case for change and in evaluating effectiveness. A former policy colleague of mine used to declare "In god we trust, but for all else give me data." Recent events in TANF and child welfare have demonstrated the perils of relying primarily on federal data reporting to define program success. Rather, human service planners should identify those data elements essential to measuring client outcomes and then extract or add the data necessary for reporting compliance. We cannot have the federal reporting requirement tail wagging the program outcome dog.

Third, policy changes must be clearly understood by the end users. We must declare what problem we are trying to solve and try to fine-tune our product through field testing. The large volume of policy transmittals and lack of clear instructions, especially complex eligibility manuals, have extracted a huge toll in resource deployment, intake accuracy, program credibility, and staff morale. Ultimately, policy should be a tool for workers, and therefore, simple English works fine. It is also important that policy remains contemporary and that obsolete and obscure rules be purged. I worked in a state that catalogued over 35,000 separate program rules. The volume alone made it impossible for workers to keep track of policy or for computer professionals to effectively automate them. Like a garden, policy must be periodically weeded and pruned.

If possible, policy development should also consider a means to mid-course correction and adjustment based on program experience rather than theory. This is needed to balance a tendency toward rigidity and to create a program safety valve against unanticipated consequences. We do not need to reinvent the wheel. Capturing best practice and lessons learned is efficient and mitigates risk. One of the misnomers about welfare reform is that it started with legislation. It didn't. It evolved from the wisdom and experience gained from over 40 waivers where states felt that they could offer a better and more effective solution. These "laboratories of democracy" had a profound impact on social policy and contain an important lesson on the virtues of policy flexibility and empowerment.

There is one other policy consideration that is paramount—we must always focus on our clients. Behind all of the rules, regulations, manuals, and forms is a real person who needs help, guidance, and support. We can never lose sight of our central purpose or why we chose to work in human services in the first place. I really look forward to working with APHSA's revitalized Policy Council as it pursues a policy development course that is pro-active, analytical, politically astute, and empowers public human service agencies to do the right thing the right way.

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# Defining *Child Neglect*: Principles for Practice

Howard Dubowitz, MD, MS

Neglect is the most frequently identified form of child maltreatment (U.S. Department of Health and Human Services, 2007), but a lack of agreement on its definition and difficulties assessing neglect have impeded clinical work and research on this problem (Zuravin, 2001). A clear definition of *neglect* is not an academic exercise. How we think about a problem influences our practice. Several issues pertaining to defining *neglect* are presented, together with suggestions for applying these ideas in practice.

## One or Several Definitions?

It is possible that there will never be a single definition of *neglect* given the multiplicity of purposes for defining *neglect*. For example, a pediatrician focused on optimizing children's health may have a low threshold for considering a situation as neglect; a child protective services (CPS) worker with safety as the priority usually has a higher threshold, guided by state law and limited agency resources. A prosecutor is likely to have the highest threshold, pursuing only the most egregious cases of neglect. Alternatively, one can imagine a single, broad definition of *neglect* that takes into account the differing purposes it may serve, while allowing for varying responses. Specific criteria could be established, for example, for subsets of cases where CPS involvement or criminal prosecution is appropriate.

## A Parent-Focused Versus a Child-Focused Definition of *Neglect*

Some have argued that neglect should be viewed as occurring when a child's basic needs are not adequately met, resulting in actual or potential harm (Dubowitz, Black, Starr, & Zuravin, 1993). This child-focused perspective is in contrast to prevailing CPS definitions of *neglect*, based on parental omissions in care (DePanfilis, 2000). There are several advantages to the child-focused approach. It fits with a primary goal of helping to ensure children's safety, health, and development. A child-focused definition is less blaming and more constructive, a key issue as practitioners try to work with families. (It helps to be able to say "This is why I'm worried about your child" rather than "Here's what you did wrong.") The child-focused definition also draws attention to other contributors to neglect that are frequently present, in addition to parents, and encourages a broader response to the underlying problems.

Clearly, not all circumstances within this broad view of children's unmet needs will meet criteria for CPS involvement; alternative interventions must be considered. For example, a child may not receive medical treatment because the pediatrician did not clearly explain the plan or the family lacked funds to buy the medicine. Again, it is possible to develop criteria for a subset of neglect circumstances where CPS involvement would be appropriate. This happens currently in direct practice. Pediatricians and other practitioners frequently address situations of inadequate care, generally referring only the most severe or persistent cases to CPS.

## How to View Parental Responsibility

Parents *are* primarily responsible for meeting their children's needs. However, an ecological framework for understanding child neglect recognizes that there are usually multiple and interacting contributors. For example, a single mother who has lost her job and health insurance and is feeling depressed and stressed may not buy the medicines for her daughter's asthma. Some situations are mostly beyond parental control, such as inadequacies in a school system that fails to meet children's educational needs. And over nine million children without health insurance can be construed as a form of societal neglect. In general, CPS personnel become involved only when the parental omission in care is a major contributor to the child's need(s) not being met.

## What Are Children's Basic Needs?

Over time and across societies, views have evolved of what are considered "basic" needs of children. However, the United Nations Convention on the Rights of the Child attests to a remarkable degree of agreement, as do a number of studies in the United States that contrast views of whites and African Americans, low- and middle-income groups (e.g., Dubowitz, Klockner, Starr, & Black, 1998). *Basic* refers to a critical need that, if not met, would likely result in significant harm (e.g., inadequate food). Basic needs are distinct from wants or luxuries. Empirical evidence supports several needs as basic, including having adequate food, health care, shelter, education, supervision/protection, and emotional support and nurturance (e.g., Asser & Swan, 1998; Grantham-McGregor & Fernald, 2002; NICHD Early Child Care Research Network, 2001; Scaramella, Conger, Simons, & Whitbeck, 1998; Stoneman, Brody, Churchill, & Winn, 1999). Other concerns may emerge from a broad societal consensus, such as concerning inadequate hygiene or sanitation and inadequate clothing. These are typically considered neglect, particularly when persistent patterns exist that have harmful consequences to children. As children develop, their needs change. Several have noted the need for different *neglect* definitions that take into consideration a child's age or developmental level (Barnett, Manly, & Cicchetti, 1991, 1993). In addition, there is normal variation among children of the same age, and their specific needs may differ substantially. For example, a child with a chronic health problem such as diabetes clearly has special needs.

It is noteworthy that with advances in knowledge, our awareness and understanding of children's needs increase. For example, there are ample data to document the benefits of using car seat restraints (Klein, 1991), and a child not so protected could be considered neglected. Similarly, not long ago, treatment for some medical conditions, such as HIV and AIDS, was experimental. Today, the benefits are well established (Thorne & Newell, 2003), and not receiving essential care could prove fatal; therefore, this should be viewed as neglect. A third example is that of exposure to secondhand smoke, especially for children with underlying respiratory disease (Nelson, 2002). Asthmatic children regularly exposed to smoke are in a situation in which their health needs are not being adequately met.

In sum, the first question for practitioners in identifying neglect is "What is known about the harm or risks associated with this condi-

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tion or circumstance?" It is also important to apply the question to the specific child, who may have special needs. This helps answer whether or not neglect is a concern. It is also a good segue to the related question in the next section.

## When Is It Neglect? The Quest for an Evidence-Based Definition

The primary goal shared by all disciplines addressing neglect is to help ensure the adequate care of children. Ideally, a definition of *neglect* would be based on empirical data demonstrating the actual or probable harm associated with certain circumstances (e.g., not receiving adequate emotional support). Although evidence-based definitions are a good goal, they can be difficult to achieve for most types of neglect.

Children's health, safety, and development occur within a complex ecology with many and interacting influences, making it difficult to study the impact of a single risk factor, such as inadequate emotional support. The context of children's experiences also influences the possible impact of a given circumstance; a mature 9-year-old, for example, may do well alone at home for a few hours, whereas an unsupervised child with a fire-setting problem is a scary proposition. In some areas, however, it is questionable whether evidence is really needed to document harm (e.g., hunger, homelessness, being abandoned). It seems very clear that these conditions impair children's safety, health, and development.

In practice, we need to apply the best available knowledge, albeit often less than we would like, to clarify whether an unmet need is contributing to actual or potential harm to a child. Situations where the likelihood of harm is equivocal are best *not* considered to be neglect, even though that does not preclude efforts to improve care—a category of *possible* neglect. Research may help elucidate whether and when these *possibly* neglectful circumstances should warrant concern.

## Neglect and a Continuum of Care

The adequacy of care a child receives exists on a continuum from optimal to grossly inadequate, without natural cut points. A crude categorization of situations as "neglect" or "no neglect" is simplistic. Seldom is a need met perfectly or not at all. Usually cut-points are quite arbitrary. This makes it difficult to determine at what point inadequate household sanitation, for example, is associated with harmful outcomes. And, with relatively few extreme situations, the gray zone is large. This often makes it difficult to assess neglect. Even a relatively concrete area such as establishing the daily requirement for key nutrients is not straightforward, and it is difficult to measure the extent to which these are met.

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Clinical practice is often based on categorical approaches, determining that a specific circumstance constitutes neglect. Practitioners need to consider the aspects of neglect covered in this article, and they should use their best judgment as to whether the term *neglect* applies. Even if it does not, it may fall into a category of *possible* neglect, and interventions other than CPS could be beneficial.

## Actual Versus Potential Harm

Most state legal definitions of *neglect* include circumstances of potential harm in addition to actual harm. However, approximately one third of states restrict their practice to circumstances involving actual harm (Zuravin, 2001). The issue of potential harm is of special concern because the impact of neglectful circumstances may be apparent only years later. In addition, the goal of prevention may be served by addressing neglect even if no harm is apparent. However, it is often difficult to predict the likelihood and nature of future harm. In some instances, epidemiological data are useful. For example, we can estimate the increased risk of a serious head injury from a fall off a bicycle when not wearing a helmet compared with while being protected (Wesson, Spence, Hu, & Parkin, 2000). By contrast, predicting the likelihood of harm when an 8-year-old is left home alone for a few hours is difficult. Such circumstances may come to light only when actual harm ensues. And, even when we can estimate the risk, opinions may vary as to how seriously to weigh the risk. For example, some might view a certain risk as unacceptable while others may regard it less seriously.

In addition to the likelihood of harm, the nature of the potential harm should be considered. Even a high likelihood of minor harm (e.g., bruising from a short fall) might be acceptable. Life is not risk free. Indeed, child and human development requires taking risks (e.g., learning to walk and falling). In contrast, even a low likelihood of severe harm (e.g., fatal drowning) is not acceptable.

The inclusion of potential harm substantially broadens the scope of child neglect, and many families may be investigated, further overwhelming CPS resources. Alternatively, specific criteria can be established for CPS involvement, and other community interventions may be more appropriate for less severe circumstances. This approach is very much in keeping with the alternative response systems being developed. In sum, *neglect* can be defined as occurring when a child's basic need is not adequately met, resulting in actual or potential harm.

## Further Refining the Definition of *Neglect*: A Heterogeneous Phenomenon

It is evident that the different types of unmet needs children may experience represent a wide range of circumstances. In addition to characterizing different types of neglect (e.g., Sedlack & Broadhurst, 1996), it is useful to describe other aspects of child neglect—the severity, the duration (or chronicity), number of

incidents (frequency), intentionality, and the context in which neglect occurs, such as the socioeconomic climate. An example is the Illinois criminal law on abandonment that considers the time of day or night, temperature in the home, duration of home alone, proximity of parent or caregiver, and whether there was food, along with several other contextual factors.

**Severity** is viewed in terms of the likelihood and seriousness of harm. Some have tried to differentiate between the severity of the act (or omission) and that of the consequences, actual or potential (Barnett et al., 1993). This appears to be an artificial distinction in that our concern about acts or omissions is inherently tied to its implications. Hence, a severe form of neglect is one in which a child's inadequate care is associated with serious harm, actual or potential. And, the greater the likelihood of such harm, the more severe is the neglect.

One effort involved rating four or five levels of severity for several types of neglect. An expert panel of professionals was asked to rate the severity of each level (Magura & Moses, 1986). A scale of 0–100 was developed for each type of neglect, with 0 representing the most severe neglect. Another example is the Maltreatment Classification System (MCS; Barnett et al., 1993), in which the severity of each type of maltreatment was rated, based on the authors' views of what appeared to be a more harmful experience. Litrownik and colleagues (2005) utilized the severity ratings in the MCS to examine four strategies for measuring severity when assessing all types of maltreatment and in multiple reports: (a) maximum severity within each of five types of maltreatment, (b) overall maximum severity across the five types, (c) total severity or the sum of the maximum severity for each of the five types, and (d) mean severity or the average severity for the types of alleged maltreatment. The first approach was most strongly related to children's later functioning at age 8. Dubowitz and colleagues (2005) counted the number of times neglect was coded from CPS reports as an admittedly crude proxy measure of severity, a similar approach to that of McGee, Wolfe, Yuen, Wilson, and Carnochan (1995).

**Chronicity**, a pattern of needs not being met over time, is challenging to measure. Some experiences of neglect are usually only worrisome when they occur repeatedly (e.g., poor hygiene or sanitation). Thus, chronicity may be important in considering *whether* a particular experience constitutes neglect. Separately, it can be a dimension of the neglect experience. English, Graham, Litrownik, Everson, and Bangdiwala (2005) found that chronicity of maltreatment was related to child outcomes.

The challenge of assessing chronicity is clear; caregivers seldom disclose socially undesirable information. Older children, however, may be helpful. A crude proxy of chronicity is the duration of CPS involvement, or the time between the first and most recent reports. The problems are obvious. A CPS report reflects only when problems were identified; it is highly speculative to assume what transpired before and between reports.

**Frequency** is similarly difficult to assess. Caregivers or older children may disclose the information. The number of CPS reports offers a very crude proxy.

**Intentionality** is a question that arises regarding neglect, albeit less often than with abuse—implicitly or explicitly. In this author's opinion, intentionality does not apply to most neglectful situations. The Merriam-Webster dictionary defines *intentional* as "done by intention or design." I think that, in the vast majority of cases, parents do not intend to neglect their children's needs. Rather, there are problems that impair their ability to fulfill these needs adequately. Even the most egregious cases, such as those where parents appear to willfully deny their children food, probably involve significant parental psychopathology, and labeling such instances *intentional* may be simplistic. In clinical practice, as we strive to strengthen families, viewing their shortcomings as intentional may be counterproductive, especially if it fosters a negative stance toward parents. Finally, as a practical matter, it is difficult to assess intentionality, short of a caregiver acknowledging that he or she intended the omission in care. In sum, I think practitioners will be most effective if they do not incorporate intentionality in their consideration of neglect.

It should be noted, however, that in criminal law there are different and nuanced variations of the word *intentional.* Some acts are done *purposefully* to bring about a particular result. Other acts might be done *knowingly*, where an outcome is not intended, but one is aware of the anticipated outcome. A variation of this is when one acts *recklessly*, despite being aware of the high degree of risk. Finally, there are *negligent* acts, where one may not be aware of the risk, although one should be. Only the first circumstance fits well with what is commonly understood by the word *intentional*, and, as suggested, this appears to be rare in neglect cases. These legal considerations should not, however, diminish efforts to protect children by involving CPS or other clinical interventions.

**Cultural context** is another area in which *neglect* is defined. For example, in many cultures, young children help care for their younger siblings. This is both a necessity and is considered important in learning to be responsible. Yet, others may view the practice as unreasonably burdensome for the child caregiver and too risky an arrangement. There is no easy resolution to such a debate, and there can be awkward clinical dilemmas concerning new immigrants to the United States. Clearly, the risks and supports here might be very different from those in the country of origin. We need to recognize the importance of cultural context and how it influences child rearing practices and the meaning and consequences of experiences for children. It is, however, also important to recognize that just because a certain practice is normative within a culture does not necessarily mean that it will not harm children (Korbin & Spilsbury, 1999). One needs to be careful to avoid glibly accepting or respecting all culturally accepted practices; some may be clearly harmful and should not be sanctioned. At the same time, good practice should always involve understanding the culture and engaging the family respectfully.

**Poverty** is strongly linked with child neglect. For example, in the Third National Incidence Study, neglect was 44 more times likely to be identified in families earning less than $15,000 a year compared with those earning over $30,000 (Sedlack & Broadhurst, 1996). There are also ample data demonstrating that poverty per se jeopardizes children's health, development, and safety (Parker, Greer, & Zuckerman, 1988). Poverty can thus be construed as a

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form of societal neglect, particularly in a country with enormous resources. The child protection system, however, focuses narrowly on parental or caregiver omissions in care (i.e., fault); 11 states and D.C. laws explicitly exclude circumstances attributable to poverty in their neglect definitions.

A suggested approach is to have not only a broad definition of *neglect* that includes conditions associated with poverty but also one that identifies a subset of circumstances appropriate for CPS involvement. Alternative strategies, other than for CPS, should be more appropriate for other types or levels of neglect (e.g., homelessness). There is a challenge in the many situations of neglect with multiple and interacting contributors. The burdens of poverty are, for example, linked to parental mental health and substance abuse problems, impeding the care children receive. Good practice attempts to clarify the circumstances underpinning the neglect, and it tailors the response to best meet the individual needs of the child and family. Good policies seek to develop ways to help ensure children's needs are adequately met. In addition to their important clinical work, practitioners can play a valuable role in the policy realm. For example, one might help improve policies both within one's agency and at the local, state, and national levels by offering specific suggestions. APSAC participates in the National Coalition Against Child Abuse, a consortium of about 25 professional associations aiming to shape federal policies. APSAC members should forward their ideas to the leadership to bring to the Coalition.

In sum, a definition focused on children's basic needs not being adequately met appears more constructive than one based on caregiver omissions in care. Potential harm is a concern; attention to such circumstances may play a valuable preventive role. A broad perspective of neglect should encourage practitioners to intervene in a spectrum of circumstances, not all requiring CPS involvement. Recognition of the continuum of care children receive means there are no simplistic cut-points or formulae for determining neglect; each circumstance needs to be viewed individually. The nature and context of neglect are also important in addressing the specific needs of a child and family. Finally, most practitioners will work primarily with families, but attention to the societal contributors to neglect is also important.

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# Developmental Outcomes of Child Neglect

Maria Scannapieco, PhD, MSW

## Introduction

In 2005 in the United States, 62% of all confirmed victims of child maltreatment were victims of neglect (USDHHS, 2005). Neglected children are more likely to be younger, and the highest rate of victimization is in the 0–3 age group (USDHHS, 2005). The most devastating consequence of neglect is death, and in 2005 the majority of deaths due to maltreatment were due to neglect (USDHHS, 2005). Overall, the rate of child fatality due to neglect ranges from 32% (Delambre & Wood, 1997) to 42% (USDHHS, 2005; Wang & Daro, 1998) of all reported child death cases.

One aspect of neglect that separates it from physical abuse or sexual abuse is its tendency to be chronic rather than episodic. That is, neglect is often a lifestyle rather than an event. An impoverished parent-child relationship is at the core of the definition of *neglect*. Children aged 0–3 need a consistent and responsive caregiver to meet their physical, cognitive, and emotional needs. Infants have few outlets from which to receive nurture and care other than their caregiver(s). As a result, the consequences of neglect in young children span all areas of a child's development (Scannapieco & Connell-Carrick, 2005).

This argument of neglect may seem somewhat extreme given that the scope of neglectful behaviors is broad. Not all neglect is characterized by extreme deprivation; some neglect *may* be more benign, such as the case with incidents of neglectful supervision or merely a dirty house. The majority of children who live in dirty homes is well cared for. Some caregivers may be excellent caregivers but forgetful or preoccupied at times. A well-cared for child living in a dirty home would not show many or any developmental manifestations.

This discussion of neglect focuses on developmental consequences to the child when lack of care of an infant or toddler is central to the maltreatment. The article also centers on the impoverishment of care inherent in serious child neglect, which may be a devastating occurrence in a young child's life.

## Some Characteristics of Child Neglect

Child neglect is experienced most by infants and toddlers 0–3 years of age. Seventy-three percent of maltreatment victims ages 0–3 were victims of neglect (USDHHS, 2005) as compared with 64.6% of those ages 4–7, 60.3% of those ages 8–11, 53.8% of youth ages 12–15, and 57.1% of those 16 and older. Neglect is characterized by lack of care regardless of income. As a result, separating cases of neglect from poverty requires an examination of the relationship between parent and child.

Although several different subtypes and definitions of *neglect* exist, neglect is primarily the result of an impoverished relationship between parent and child. Typically, the parent fails to meet the needs of an infant through lack of care and nurture, which results in developmental consequences (Scannapieco & Connell-Carrick, 2005) and even death (USDHHS, 2005) for the child. Children who experience neglect in the first 3 years of life usually experience problems with attachment, resulting in physical, behavioral, cognitive, and social developmental consequences through the lifespan. In the cycle of neglect, parental behavior affects attachment, which then affects child behavior, ultimately increasing the possibility of child neglect and putting children at continued risk of harm.

Child neglect affects all areas of human development not only at the time of the incident but also across the lifespan. Research shows approximately two thirds of maltreated children have insecure attachments, and most have disorganized-disoriented attachment patterns (Crittenden, 1988; Carlson, Cicchetti, Barnett, & Braunwald, 1989; Egeland & Sroufe, 1981; Main & Solomon, 1986).

### Effects on the Brain

In the first 3 years of life, the brain is developing rapidly. Babies' brains grow and develop as they interact with their environment and learn to function within it (NCCAN, 2001). Chronic neglect in infancy and toddlerhood can have a devastating effect on the development of the child's brain. For appropriate neural pathways to develop, a child must have a stimulating environment. Pathways not stimulated decrease, whereas pathways stimulated flourish. When a child is ignored or without proper stimulation for growth, the brain may focus only on day-to-day survival and may fail to develop other important areas, such as cognitive and social growth (NCCAN, 2001). When neural pathways die, the child may not be able to achieve the expected developmental milestones, which is often seen among chronically neglected children (NCCAN, 2001).

Children must be provided the opportunity to develop their neural connections during infancy and toddlerhood. Babies who are not spoken to may not develop language at the same rate as other children. When a child's cries are not responded to or are met with hostility, the child learns early on that crying does not elicit a desired response and may fail to cry. Consequently, when a child is not offered attention or positive interaction, she or he may not then know how to deliver comfort and kindness to others. Such capacities often fail to develop because the child lacked the environmental, and thereby neural, stimulation necessary for such pathways to develop (NCCAN, 2001). In extreme cases of neglect in which the child experiences overall sensory deprivation, the brain may be smaller, fewer neural pathways may exist, and the child may be damaged intellectually forever (Greenough, Black, & Wallace, 1987; Perry & Pollard, 1998).

One of the most significant tasks of infancy is the development of attachment. The ability to form attachments may also be a function of early brain development. Lack of appropriate affective experiences in early life results in the inadequacy of attachment capabilities (Perry, 1999). Early neglect may result in lack of empathy because the part of one's brain that understands connectedness to others fails to develop. Lack of empathy or the lack of connectedness one feels to others may have tremendous consequences to the

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child as well as society. Perry (1999) maintained that the ability to feel empathy, remorse, and sympathy are experience-dependent capabilities. A child who experiences a lack of comfort and care may fail to develop such emotions.

In addition to affective difficulties seen in many neglected children, neglect has a profound influence on a child's cognitive capability. Cognitive stimulation allows the brain to develop critical neural pathways. Conversely, a lack of stimulation may result in brain size and capability differences. The cortex regulates the functioning of lower parts of the central nervous system. Its growth and ability to make synaptic connections is dependent upon the type, quality, and quantity of sensory experience (Chisholm, Carter, Ames, & Morison, 1995). When a child lacks sensory stimulation and cognitive experience, as is often the case with neglect, the cortex may be smaller in size and have fewer neural pathways, resulting in long-term negative consequences for the developing child (Perry, 1999).

## Developmental Outcomes of Neglect

Elevated prevalence of maltreatment for infants and toddlers suggests that a significant number of such children will experience negative developmental outcomes. It is important to assess the attachment relationship of all victims of maltreatment, but it is paramount for infant and toddlers who are suspected of being victims of neglect. One reason for this distinction is that neglect is often difficult to identify because it requires the measure of an omission of behavior. In the first 3 years of life, a child experiences enormous growth in all the developmental domains. Therefore, it is important to know the following developmental consequences in order to identify delays, presuming the developmental delays are a possible consequence of neglect.

### Cognitive-Behavioral Effects

A child who has been neglected may be delayed in cognitive development. One specific subclass of neglect, failure to thrive, has specific manifestations on an infant's cognitive development. Children with low weight who have been hospitalized for failure to thrive have been shown to have poorer cognitive functioning than normal weight children (Singer, 1986), although recent studies have shown this is confounded by psychosocial variables (Chatoor, et al., 2004). The cognitive deficits of nonorganic failure to thrive infants who have been given psychosocial intervention still persist at 3 years of age (Singer, 1986).

The cognitive deficits of neglected children seem to accumulate with time (Gowen, 1993). Infants and toddlers are generally interested in their surroundings and enjoy looking at human faces and hearing noises. By contrast, a neglected child may appear apathetic and disinterested in her environment. Children have beginning forms of mental representation even by 6 months of age, but this may be lacking in a neglected child who has failed to receive environmental stimulation. For example, if you make an "O" with your mouth to 5-month-old children, you should see them looking intently at your face and trying to imitate your facial expression. While they may not actually make the "O," they should begin moving their mouth in an attempt to mimic your expression.

Children at 3 months of age begin to anticipate events. If a 3-month-old child wakes from a nap, he may begin to cry. When his mother (caregiver) comes into his room, he will stop crying because he knows he is going to be picked up. However, neglected children may either fail to cry or cry indiscriminately to events. The child may not cry because he has learned crying elicits no response. Or, the child may cry without trying to convey a message to a caregiver. A child who has experienced neglect, even at 3 months, has already learned he cannot rely on others to meet his needs.

Between 6 and 12 months, infants begin to have goal-directed behaviors, and they can coordinate specific activities that are deliberate (e.g., thumb sucking). As children mature, they become increasingly interested in their environment, but this may not be apparent in neglected children (Scannapieco & Connell-Carrick, 2005). They may not have self-soothing intentional behaviors and may appear indifferent to their surroundings.

Children at 6 months also should be babbling, and there should be a progression from first words to phrases during the first 3 years. Severe neglect has been related to a number of language delays (Culp, et al., 1991). Neglected children show declines in both expressive and receptive language skills (Gowen, 1993). Maltreated toddlers develop and use language differently than nonmaltreated toddlers. They use language less frequently for social or affective exchanges than nonmaltreated toddlers (Cicchetti & Lynch, 1994). Neglected children will likely babble, but their language development afterward may fail to develop as expected. They may fail to use gestures to convey wants from 6 to 12 months, and they may not understand simple dialogue (e.g., "Where is your nose?"). One way the caregiver facilitates language development in a child is to attach a word to the gesture; neglected children may not have a caregiver who is responsive to their needs in this way, and language development may be delayed. From 12 to 24 months, and especially around 18 to 24 months, language development should be markedly apparent and increasingly rapid, which does not often occur for neglected children.

By the time children who are developing normally reach 24 months, they should have a vocabulary of approximately 200 words, but neglected children may already be behind in their language acquisition. At 24 months, neglected children may not use two-word sentences, and their conversational skills may be poor.

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Further expected developmental indicators include changes in play. Toddlers from 12 to 18 months repeat actions with variation, provoking new effects; their approach to the world is exploratory. Children between 12 and 18 months who have been neglected may not exhibit an exploratory approach to the world with trial and error learning. They may appear indifferent and lethargic in a room full of toys. With the greater mental representation expected in children between 18 and 24 months, children are able to recall people, places, and events better, and neglected children may not be able to do this. For example, a child who is 30 months should be able to recall where you keep crayons in your office after a few visits if you allow her to use crayons every time she visits you; a neglected child may not do this. The neglected child, if accustomed to one-command statements, may have great difficulty understanding more complex sentences.

## Socio-Emotional Effects

Broadly, maltreated children are more likely to have attachment problems than other children, which can range from mild interpersonal difficulties to the loss of capacity to form any meaningful relationship. While infants and toddlers who have been physically abused tend to develop insecure-avoidant attachment relationships, infants who have been neglected tend to develop insecure-resistant (Ainsworth, Blehar, Waters, & Wall, 1978) and anxious attachment patterns (Erickson & Egeland, 2002). Erickson and Egeland (2002) also found that by the age of 2, children who had experienced neglect displayed avoidant or unaffectionate behaviors toward their mothers. With increased age, both physically abused and neglected children are eventually likely to be classified as disorganized-disoriented because both groups have been found to display resistant and avoidant behaviors in the presence of their caregiver (Erickson & Egeland, 2002). Attachment should also be viewed in its cultural context since attachment behavior may vary depending upon the type of care-giving arrangement the family uses or the child's frequency of contact with strangers or separating from the caregiver.

***Consequences of an impaired attachment.*** The consequences of an impaired attachment relationship in early childhood have both immediate and long-term effects. The cost to the individual ranges from the most severe loss of the capacity to form any meaningful relationships to mild interpersonal, social, or emotional problems. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) indicates lack of adequate care can lead to reactive attachment disorder (RAD) of infancy or early childhood (American Psychiatric Association, 1994). It is important to note that the diagnosis of RAD is controversial. This is primarily because the diagnosis of such pathologies in children and the treatment for RAD lack empirical support (Werner-Wilson & Davenport, 2003). However, at this time RAD is still a diagnosable condition in the DSM-IV. At any rate, even with the provision of basic nourishment to an infant, the absence of tactile and cognitive stimulation will impede healthy child development, which is why focusing on the relationship between child and parent is so vital.

An impaired attachment relationship in infancy can have long-lasting consequences, primarily because of the relationship's influence on the child's internal working model. Children with secure attachments feel confident the world will meet their needs; they trust the world is a place for them to explore through physical and emotional means. However, children with insecure attachment do not have that same understanding of the world. Thus, a child with an insecure-avoidant attachment might interpret "neutral or even friendly behavior as hostile and show inappropriate aggressive behavior" (Widom, 2000, p. 351). Research has shown the experience of physical abuse in childhood may lead to aggressive behavior because the individual's internal working model includes a tendency to process information through deficient and hostile-influenced mechanisms (Dodge, Bates, & Pettit, 1990).

In the same way, children with insecure attachments cope with their environments less well than do children with secure attachments. They often behave more impulsively and lack problem-solving skills (Erickson & Egeland, 2002). Children, depending on their age, will use various coping behaviors to escape from a current abusive environment. Infant and toddler coping behaviors range from depression (Harrison, Hoffmann, & Edwald, 1989; Kazdin, Moser, Colbus, et al., 1985; Yamaguchi & Kandel, 1984) to self-soothing behaviors (Cavaiola & Schiff, 1988; Harrison, Hoffmann, & Edwall, 1989), such as head bumping and rocking oneself. Nonetheless, it is difficult to ascertain the actual causes of maladaptive coping and behavioral patterns since an impaired attachment affects all aspects of development.

While smiling is reflexive during the first few weeks of life, it eventually becomes socially constructed. By the sixth to tenth week, smiling is elicited by a human face; someone smiling at the infant, or the visual recognition of a caregiver. Neglected children are often not offered the stimulation to evoke a social smile, and the neglected child may fail to smile. Moreover, neglected infants may not laugh, which also requires active stimulation.

Nearly all infants experience stranger and separation anxiety, but many neglected infants fail to do so, especially around 7 to 10 months, respectively. If the neglected toddler does not have a real understanding of who is supposed to take care of him, he will respond indiscriminately to any stranger or being left with any person. The neglected child will not expect someone to meet his needs. The degree to which stranger and separation anxiety is seen is multiply determined, however, by culture, the child's temperament, past experiences with strangers, and the situation in which the infant meets the stranger. Neglected children are often not cared for consistently by a caregiver, and therefore, they do not experience anxiety when separating from their caregiver. Stranger and separation anxiety serves a self-preservation function for infants because this induces fear. Fear keeps children close to those who are supposed to protect them. Children should become more skilled at social referencing and looking to a known person for information on how to respond in an uncertain situation. Neglected children may not have a specific person to give them such information, and they may not have a social reference at all.

It is important, however, to assess attachment, separation, and stranger anxieties within a cultural context. The manner in which the infant is raised may affect the child's reaction to separation from a caregiver and interaction with strangers. For example, children who are taken to child care while their parent works may not demonstrate the same level of anxiety at their caregiver's departure and return. They may have become accustomed to the separation

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and reunion with their caregiver and seem to be unaffected by it. Similarly, children raised in a multiple caregiving format also run the risk of being mislabeled with regard to attachment. In the African American community (Jackson, 1993; Scannapieco, 1999), children traditionally become accustomed to multiple caregivers, who may be both blood and nonblood relatives. Therefore, the responses seen from such children at separation and reunion do not typically conform to Eurocentric and single-dual caregiver patterns of behavior.

Children who have been neglected may also show developmental delays between 24 and 36 months. Such children may lack the vocabulary to talk about emotions and lack the ability to regulate one's emotions in general. The behavioral expression of emotions is also expected and may not be evident in neglected children. They will not hang their heads when ashamed or hide their faces when embarrassed, or even have an understanding of such emotions.

Neglected children may have problems interacting and playing with others. They may fail to extend their knowledge of emotions to others, as is expected of children 24 to 36 months. Instead, they may become angry (Erickson & Egeland, 2002) and act aggressively, such as behaving forcefully toward a hurt and crying child on the playground, indicating a lack of empathic behavior. They may have general problems in relating and playing with peers and fail to demonstrate make-believe play. Neglected toddlers also tend to be easily frustrated, impulsive, and able to show little enthusiasm toward play (Erickson & Egeland, 2002).

Emotional abuse is often linked with neglect because neglect cannot occur in infancy and toddlerhood without some emotional consequence to the child, although the link between emotional abuse and maltreatment is equally relevant to any discussion of physical abuse and sexual abuse. Equally noteworthy is an infant or toddler witnessing the abuse of a parent, such as with domestic violence. Children understand language far earlier than they can speak it, and witnessing fights, whether physical or verbal, between one's caregiver and another can be traumatic to the infant and toddler. Children respond with more posttraumatic stress (PTSD) symptomatology when a caregiver is threatened, including fears, aggression symptoms, and hyperarousal (Scheeringa & Zeanah, 1995). While a caregiver may feel like he is protecting an infant during a domestic disturbance, often the child will fear harm from her caregiver and exhibit PTSD symptomology.

### Physical Effects

The most disturbing physical consequence of neglect is death. In 2005, the highest percentage of deaths related to maltreatment, 42.2%, resulted from neglect (USDHHS, 2005). The clearest signs of development in infancy and toddlerhood occur with physical maturity, but neglected children are often smaller and weigh less than other children. Neglected children experience inadequate physical care (Gowen, 1993). Failure to thrive is one of the most devastating physical manifestations of neglect in infancy and toddlerhood. Nonorganic failure-to-thrive infants (NOFTT) are generally below the 5th percentile of relative growth for infants at a given age, and the diagnosis places children at significant risk of poor developmental outcomes (Casey, Bradley, & Wortham, 1984). While one would expect a child to increase in both height and weight, neglected children with NOFTT may decrease and fall down the growth curve. Neglected children often fail to get round and plump, as is normal for children until the age of 9 months. The more severe subclass of neglect, failure-to-thrive infants, often fails to gain weight at all and will continue to be smaller and weigh less even as it matures (Kristiansson & Fallstrom, 1987). The skin of children who have been neglected may also appear dull, and their hair may be thin.

Children who have been neglected may fail to develop their gross motor skills as well as other children do (Scannapieco & Connell-Carrick, 2002). The neglected infant may not be able to keep her head erect, as is expected at 6 weeks. Neglected infants may not elevate themselves by their arms, sit with support, or roll over or crawl as expected. Some neglected infants are placed for long periods in one position, and their body develops differently or abnormally. For example, a child who virtually lives in a car seat will have an extremely flat head; a child who is placed in a bouncing swing will develop only leg muscles and be unable to sit because of poorly developed back muscles. The neglected infant may not be walking on time, and the child may be behind in gross motor development with no medical explanation. The toddler who has chronically experienced neglect may not be running or jumping, as is expected when there is a progression from walking to more sophisticated gross motor behaviors. When children are neglected, fine motor skills, such as grabbing, reaching, and picking up objects may not be developed at the rate of nonmaltreated children. At 6 months, neglected children may be unable to hold an object, such as their bottle or rattle, or at 12 months, something larger, such as a book. Children between 12 and 23 months may be unable to hold a crayon, throw a ball, or pick up small objects. The child who is neglected may not be able to use a fork or dress oneself in the second year of life, as is expected and developmentally appropriate for a toddler.

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## Identifying and Responding to Infants and Toddlers Who Have Been Neglected

In the context of the previous discussion of the three main developmental domains affected by child neglect, the following appraisal suggestions (Table 1) assess a child's cognitive-behavioral, socio-emotional, and physical behavior. As mentioned, child neglect is difficult to assess because it is indicated by the absence of behavior and therefore, a challenge to measure. Table 1 provides an assessment tool based on behavioral indicators within each developmental domain as a means of overcoming some of the hurdles in identifying child neglect in very young children. These indicators, in the overall context of the assessment, may provide support that the child is being neglected.

## Table 1. Assessing Neglect in Children Ages 0–3

| | Cognitive-Behavioral | Socio-Emotional | Physical |
|---|---|---|---|
| **0–6 months** | • Does the child imitate adult's facial expressions?<br>• Does the child repeat chance behaviors that produce pleasure for the child?<br>• Can the child recognize people and places?<br>• Does attention become more flexible with age?<br>• Does the child babble by the end of this period? | • Does the child show a range of emotions including happiness, sadness, and fear?<br>• Does social smiling and laughing emerge?<br>• Can the child imitate adult emotional expression during interactions?<br>• Does the infant begin to distinguish self from others (the emergence of an "I")? | • Does the child have rapid height and weight gain?<br>• Can the child hold her/his head up, roll over and reach for objects?<br>• Can the child hear sounds, with increasing sensitivity to sounds of own speech with age?<br>• Does the child begin to habituate toward fixed stimuli?<br>• Is the child sensitive toward motion? |
| **6–12 months** | • Does the child have goal-directed and intentional behavior?<br>• Can the child find hidden objects?<br>• Can the child imitate adults' actions?<br>• Can the child combine sensory and motor activities?<br>• Does the child babble, including sounds in the child's spoken language?<br>• Does the child show preverbal gestures, such as pointing? | • Does the child show stranger and separation anxiety?<br>• Does the child use the caregiver as a secure base?<br>• Can the child engage in social referencing?<br>• Does the child show definite attachment to caregivers? | • Can the child sit alone, crawl, and walk?<br>• Can the child organize stimuli into meaningful patterns? |
| **12–18 months** | • Does the child sort objects into catagories?<br>• Can the child find hidden objects by looking in more than one place?<br>• Does the child show trial and error learning in play?<br>• Does the child have an improved attention span?<br>• Can the child talk, at least saying the first words?<br>• Does the child use overextension and underextension of the words she/he knows?<br>• Can the child take turns when playing interactive games (peek-a-boo)?<br>• Does the child experiment with different behaviors to see the result and find new ways to solve problems? | • Does the child recognize and image of oneself?<br>• Does the child play with siblings and familiar adults?<br>• Does the child show signs of empathy?<br>• Does the child engage in turn-taking behaviors when playing?<br>• Does the child understand simple directives? | • Does the child continue to grow, but less rapidly than during the first year?<br>• Can the child walk better with more coordination?<br>• Can the child stand alone in one place?<br>• Can the child manipulate and play with small objects, improving coordination?<br>• Can the child use a spoon or cup? |
| **18–24 months** | • Can the child find objects that are out of sight?<br>• Does the child try to fully imitate adults' actions?<br>• Does the child engage in make-believe play?<br>• Does the child move objects into catagories during play? | • Does the child express self conscious emotions, such as shame and embarrassment?<br>• Does the child have a vocabulary that includes emotional terms?<br>• Does the child use vocabulary in order to emotionally regulate oneself? | • Can the child jump, run, and climb?<br>• Can the child manipulate small objects with good coordination?<br>• Is the child walking alone?<br>• Is the child able to push or pull something while walking?<br>• Can the child feed herself or himself? |

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### Table 1. Assessing Neglect in Children Ages 0–3 (cont'd)

| | Cognitive-Behavioral | Socio-Emotional | Physical |
|---|---|---|---|
| **18–24 months (cont'd)** | • Does the child recall people, places or objects better than before?<br>• Does the child use two-word phrases?<br>• Can the child scribble with crayons and pencils?<br>• Can the child point to and name body parts? | • Can the child increasingly tolerate the absence of a caregiver?<br>• Does the child use own name as labeled image of oneself? | • Can the child partly undress herself or himself? |
| **24–36 months** | • Is make-believe play less self-centered and more complex?<br>• Does the child have a well-developed memory recognition?<br>• Does the child have a more developed vocabulary?<br>• Can the child use sentences with increased usage of grammar?<br>• Does the child display conversational skills?<br>• Is the child able to follow simple directions?<br>• Can the child tell simple stories?<br>• Is the child able to answer questions? | • Can the child distinguish one's intention and unintentional actions?<br>• Can the child understand causes and consequences of behaviors?<br>• Does the child exhibit cooperative or agressive behaviors?<br>• Is the child beginning to engage in parallel play? | • Can the child get dressed or undressed partly by oneself?<br>• Can the child use a spoon or fork?<br>• Can the child run, jump, hop, and throw objects?<br>• Can the child pedal a tricycle/big wheel?<br>• Does the child gain weight and height but less so than during the first 2 years? |

**Source: Scannapieco & Connell-Carrick (2005)**

Assessment is a process in which information is gathered and analyzed to determine the origin and extent of critical risk-related problems, the strengths that will enhance the potential for change, and the barriers that will hinder this potential. The physical indicators are variables that are easier to act upon and, thus, are more clearly indicative of increased risk. These are the cases in which we most often do a good job in protecting children. The behavioral and relational variables are more difficult to act upon but are just as indicative of increased risk. Because they are often more difficult to recognize, however, they are likely to be overlooked or to be considered insufficient for protective action. It is important to consider the combinations of soft and hard indicators that are indicative of child neglect.

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## Summary

Early childhood is a critical developmental stage for intervening with families. Children aged 0–3 are at the highest risk of experiencing devastating consequences of child neglect. Assessment measures need to focus on the interaction between the infant or toddler and the caregiver. During this stage of the child's development, the practitioner must rely heavily upon observations of the child's behavior and the interaction between the child and the caregiver.

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# SafeCare®: An Evidence-Based Approach to Prevent Child Neglect

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Services within the child welfare system have been described as based primarily on practice ideologies and practitioner experience rather than on scientific evidence of efficacy (Chadwick Center on Children and Families, 2004). This issue is hardly unique to child maltreatment or child welfare practice, and over the past decade there has been a shift in favor of an evidence-based practice philosophy. Randomized clinical trials have demonstrated efficacy of treatments for children affected by sexual abuse and physical abuse, as well as for physically abusive parents (e.g., trauma-focused cognitive behavior therapy (TF-CBT), parent child interaction therapy (PCIT), physical abuse focused cognitive behavior therapy, and a variety of parent training models for disruptive behavior disorders in children). Services for child neglect, by far the most prevalent form of child maltreatment, have seen fewer developments (see Chaffin, Bonner, & Hill, 2001; Littell & Schuerman, 2002; and USDHHS, 2002). Promising models exist, although none have been classified as well supported. In this paper, we briefly describe one model, SafeCare®, and its promise for preventing child neglect.

## Overview of the SafeCare® /12-Ways Model

SafeCare® is a derivation of the original Project 12-Ways model developed by Lutzker and colleagues (Lutzker, 1984; Lutzker & Bigelow, 2002). This model has been used and evaluated in university-based projects in rural Illinois since 1979, in university-based projects in Los Angeles (Lutzker, 1984; Lutzker, Tymchuk, & Bigelow, 2001), and currently in Kansas, Michigan, Georgia, and in two field trials in Oklahoma. The model has been described in over 60 publications, covering the model itself, research, and outcome evaluations, and in more than 100 presentations.

The SafeCare® model is designed for use with multiproblem families involved in the child welfare system or who are at high risk for child welfare involvement due to neglect, physical abuse, or both, with the main goal of reducing subsequent maltreatment. It focuses directly on behaviors constituting child neglect, particularly neglect of young children, and is designed as a home-based service that can be delivered by paraprofessional staff. The name, Project 12-Ways, stemmed from the original twelve services offered to prevent or treat child maltreatment. Initial research and practice indicated that many involved families did not have needs in all areas, and it was difficult for paraprofessional staff to achieve competency, and/or efficient delivery in all twelve areas. The service was streamlined by selecting the three most prevalent parental behaviors associated with child neglect, when a foundation grant was funded to systematically replicate the model in California. This derivation became SafeCare® (SC). The components of SC are home safety and organization skills, child health and nutrition management skills, and child behavior management skills (Lutzker, Wesch, & Rice, 1984).

SC is based on the ecobehavioral model (Lutzker, 1984). The *eco* prefix refers to intervention targets at different levels within the concentric ecological model of maltreatment. The behavioral component reflects which targets are emphasized (proximal skills and behaviors), as well as technical aspects of how change is pursued (ongoing measurement of observable behaviors, skill modeling, practice and feedback, and training of skills to criterion; Lutzker, Wesch, & Rice, 1984; Lutzker & Bigelow, 2002). The model is rooted in the behavior analysis field. Behavioral theory conceptualizes child neglect in terms of skill deficits, particularly those skills that are most proximal to neglect and that form the objective basis of the family's involvement in the child protection system—failing to provide a safe and healthy home environment; inadequate parent-child involvement, bonding or supervision; and inappropriate parenting or child-management skills. In other words, the model focuses on neglectful behaviors directly, rather than on presumed underlying factors. This perspective does not preclude addressing possibly contributory, underlying, or co-morbid disorders such as parental substance abuse or depression, nor does it preclude recognizing the role of poverty and the need many neglecting families have for concrete supportive services (e.g., WIC, TANF, housing, etc.). However, these co-morbid or contributory areas are addressed by identification and referral to specialized services or benefits on a case-by-case basis, and they are not direct service components of the model beyond identification, referral, and support of service utilization to address them.

The SC model is structured, manualized, and prescribed. All SC components involve three structured processes—baseline assessment, intervention, and follow-up assessments to monitor change. Home visitors conduct observations of parents' knowledge and skills for each component, using a set of observation checklists. Parents are trained using a general 7-step format: (1) describe desired target behaviors; (2) explain the rationale for each behavior; (3) model or demonstrate desired behaviors; (4) ask the parent to practice the behavior during the visit; (5) provide positive feedback (point out positive aspects of performance); (6) provide constructive feedback (point out aspects of performance needing improvement); (7) review parents' performance, have them practice areas that need improvement, and set goals for the week. Using this format, parents are trained so that skills are generalizable across time, behaviors, and settings. In the Los Angeles replication, each component was implemented in approximately five sessions and was followed by a social validation questionnaire to assess parents' satisfaction with their training. Staff worked with parents until they met a set of skill-based criteria that were established for each component.

## Content Modules of SafeCare®

### Infant and Child Health

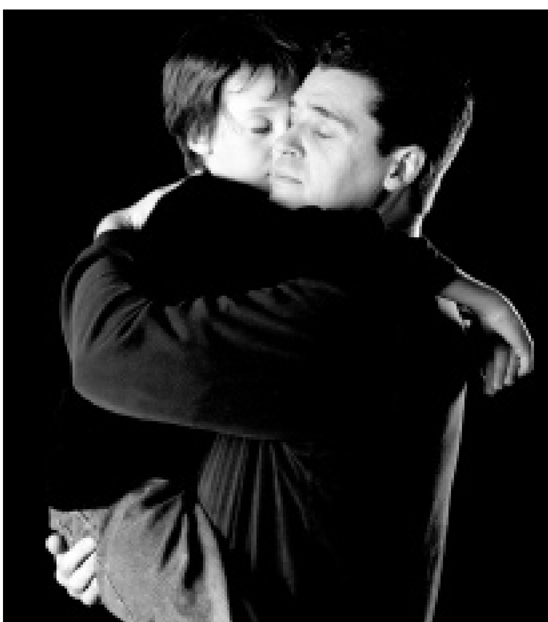
The goals of the infant and child health care module are to train parents to use health reference materials, prevent illness, identify symptoms of childhood illnesses or injuries, and provide or seek appropriate treatment by following steps of a task analysis (Bigelow & Lutzker, 2000). Parents role-play medical scenarios and decide whether to treat the child at home, call a medical provider, or seek emergency treatment. Parents are provided with a validated health manual that includes a symptom guide, information about planning and prevention, caring for a child at home, calling a physician, and emergency care. Parents are also provided with health recording charts and basic health supplies (e.g., thermometer).

### Home Safety

The home safety component involves the identification and reduction or elimination of accessible hazards, dangerous and unhealthy filth, and clutter by making them inaccessible to children. The parent and home visitor jointly assess each room in the home using a detailed checklist, and then skill training is delivered to help the parent reduce the number of hazards by making them inaccessible. Safety latches are supplied to the families. This includes working with parents on specific household management and cleaning practices.

### Parent-Child Bonding

The parent-child bonding component consists of parent-infant interaction training (birth to 8–10 months) and parent-child interaction training (8–10 months to 5 years). The purpose of this component is to teach parents to provide engaging and stimulating activities, increase positive interactions between parents and their children, and prevent troublesome child behavior (Lutzker, Bigelow, Doctor, & Kessler, 1998). Parents learn skills to structure play and daily living activities and increase bonding and attachment opportunities with their child. The primary method used is planned activities training (PAT) (Sanders & Dadds, 1982). Positive behaviors are reinforced and coached, and problematic behaviors are addressed and modified. Home visitors teach parents to use PAT checklists to help structure the child's activities and day, encourage time for positive parent-child interactions, and encourage selective use of positive reinforcement to manage child behavior.



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## SafeCare® Evidence Base

A number of lines of research support the efficacy of the model. These are summarized by category of methodology.

### Single Case Studies of Behavior Change

Given the roots of the model in behavior analysis, there have been a number of multiple-baseline and single-subject repeated measure design studies examining changes in coded observed behaviors and home environment criteria related to the initiation and sequencing of particular skill training modules. In these designs, measures were taken for several baseline periods, during training periods, and at follow-up. Lutzker and colleagues have reported patterns of changes in appropriate and inappropriate parent-child interaction skills, child behavior, percentage of correct steps in role plays of emergency health situations, and changes in home safety and organization as a function of module sequence among a range of families from at-risk parents to parents who have been referred for neglect related child fatalities (Bigelow & Lutzker, 1998; Lutzker, Bigelow, Rice, & Kessler, 1998; Lutzker, Bigelow, Doctor, Gershater, & Greene, 1998; Rosenfield-Schlichter, Sarber, Bueno, Greene, Lutzker, 1983; Tertinger, Greene, & Lutzker, 1984). High levels of correspondence have been reported between initiation of focused modules and expected changes in corresponding behaviors.

### Within-Subjects Group Studies of Behavior Change

In these studies, group within-subject changes on observed and coded behaviors corresponding to the same target areas used in single-subject designs were compared from baseline to posttreatment. Improvements have been noted consistently and have been reported across a range of provider types (i.e., research assistants, nurses, caseworkers) (Campbell, Lutzker, & Cuvo, 1982; Campbell, O'Brien, Bickett, Lutzker, 1983; Lutzker, Bigelow, Doctor, Gershater, & Greene, 1998; Tertinger, et al., 1984). Within-subjects group findings support a conclusion that the changes in observed parent behaviors noted in the single-subject studies are not limited to a small number of individual cases but are broad, aggregate effects.

### Quasi-Experimental Recidivism Studies

These studies have compared recidivism outcomes of 12-Ways/SafeCare participants with those of families who received alternative services. Gershater-Molko, Lutzker, and Wesch (2002) compared recidivism rates for families receiving SC services with rates of families receiving standard in-home family preservation services in Los Angeles. At 24-month follow-up, there was a significant difference between the groups, with SC completers having a 15% cumulative failure rate compared with 44% for family preservation services as usual.

In Illinois, Lutzker and Rice (1984) randomly selected 50 families with active child welfare cases enrolled in 12-Ways, and matched them to a comparison sample of families drawn from active cases at the same child welfare field offices. Child maltreatment recidivism was found in 10% of 12-Ways cases versus 21% of comparison cases. In an extension of this research, Lutzker and Rice (1987) compared 5-year recidivism results for families receiving 12-Ways and a matched comparison group. For each of the follow-up years, the 12-Ways group had lower rates of recidivism than the comparison group, with the greatest differences occurring immediately after service completion, and differences diminishing, but not to insignificance, over follow-up. Also in Illinois, Wesch and Lutzker (1991) compared families served by 12-Ways with a field-office matched group of families receiving services as usual. The 12-Ways families had fewer re-reports (42% vs. 56%) and fewer child placements (13% vs. 25%) than the arguably less severe comparison cases, as suggested by data that the 12-Ways families prior to treatment had significantly more contacts with the CPS than the comparison families prior to their treatment.

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### Randomized Trials of Behavior Change

Lutzker, Tymchuk, and Bigelow (2001) reported outcomes for the SC model among a group of primarily young parents with intellectual disabilities who were identified as high risk for child neglect in the UCLA Wellness Project. Families (N = 160) were randomly assigned to either modified SC or a comparison condition in which they received only didactic materials from the modified SC model, without the home visitor. Participants receiving the SC model showed significantly more improvement in the usual SC target skills and behaviors than those who received materials only.

### Studies in Progress

***SafeCare® high-risk prevention trial.*** Now entering its fourth year, this study is a randomized field trial comparing SafeCare® delivered by bachelor's-level home visitors with home-based mental health services delivered by licensed master's-level therapists. Both conditions are operated within a large community-based family preservation services provider agency, which is also a community mental health center in Oklahoma. The study population involves families who are considered to be at very high risk of imminent child welfare involvement and who have a young child and at least one of the following: parental substance abuse, serious parental depression or mental illness, domestic violence, or intellectual disabilities. Results suggest that compared with usual in-home mental health services, caregivers who were randomized to SC were less depressed, had greater reduction in child abuse potential scores, self-reported greater improvement in social support, and were engaged with a broader variety of community support services. A second randomized trial is also underway to examine implementation issues in rural populations.

***SafeCare® statewide trial for neglect.*** This study is a large field trial involving the migration of a statewide family preservation system to the SafeCare® model. Regions of the state were assigned to deliver SC versus usual care (unstructured case management and social support model). In addition, provider teams were randomly assigned to receive either a live-coached implementation approach (having a consultant/coach accompany the home visitor to directly coach practice techniques) or the more customary didactic training plus post hoc consultation. Thus, the study uses a 2 x 2 (model by implementation approach) design. Preliminary examination of downstream child welfare recidivism outcomes suggests that the coached SC teams are obtaining positive results. Preliminary results suggest that simply providing SC training without subsequent in vivo coaching results in very little or no downstream maltreatment reduction relative to usual care.

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***Additional studies.*** The Centers for Disease Control (CDC) has funded two research studies examining the potential efficacy of technological enhancements to the SC model. In Kansas, cell phones are being used to increase dosage (i.e., more frequent contact with therapists) with the parent-child training component of SC. In Michigan, computer-assisted SC training is being evaluated.

### Summary of Research Evidence

There is a pattern of evidence to support a conclusion that SC produces in situ behavior changes in behavioral domains directly proximal to child neglect (i.e., the same behaviors that occasion child neglect reports). The effect of the program and associated behavior changes on reducing subsequent recidivism of child maltreatment is supported by a pattern of findings, including both liberal and, more important, conservatively biased quasi-experimental comparison studies. Improved benefits have been documented compared with services as usual delivered by paraprofessional staff and compared with usual services delivered by more highly credentialed mental health professional staff. There are two published trial studies supporting efficacy, and there are encouraging preliminary findings in two other randomized studies. Preliminary data are available that support feasibility in large-scale real-world settings using usual field provider staff. Success of the model probably relates also to its in situ nature, and as is true with other evidence-based models, the focus on structured skills training. Improvements in parents is predictable because generalization of skills is known to be enhanced by frequent practice and training in real-life situations.

## Lessons Learned in Implementing SafeCare®

Our experience conducting the two Oklahoma field trials has yielded some initial lessons about the keys to implementing SafeCare®, and possibly other evidence-based models for child neglect, within the context of the large family preservation or family reunification service networks that service these cases. First, we believe it is critical that there is strong organizational leadership and commitment to bringing in and adopting the evidence-based practice, both financially and structurally. Second, our experience and emerging data have led us to reformulate traditional training approaches (workshop training and *post hoc* consultation), which we have found, and which a variety of evidence suggests, are largely ineffective. We believe uptake is far more effective when the initial training is done in small, intact practitioner teams (3–5 home visitors at a time), focuses on clear and specific skills, is broken up into manageable doses rather than massed, and is followed by periodic live modeling and direct observation of in situ practice. Adopting this sort of implementation approach requires a radical rethinking of how service systems conduct training. Finally, we believe it is important to understand that introduction of a new evidence-based model is likely to be met with mixed responses from front-line providers, even when they have been involved as stakeholders in the implementation process. Some will embrace the new model. Others will find it at odds with deeply held practice ideologies and habits. New staff members, who have fewer preexisting ideologies or habits, may find uptake easier than some more experienced staff. We believe that key next steps with research into SafeCare®, or any other evidence-based models relevant to child welfare, is to learn not only what works or how to improve the model itself but also how to transport these models into the unique systems serving child welfare clients.

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# Journal Highlights

Tamara Davis, PhD, Beth Ann Rodriguez, MSW

## Domestic Violence and Child Neglect

The cross-sectional study presented in this article focuses on the coexistence of child neglect and domestic violence (DV) in Jefferson County, Kentucky. Of 2,350 families investigated for child neglect during 1999, 29% also experienced DV. The authors found that within this sample, more substantiated neglect cases without DV were opened for ongoing services (57%) than the percentage of cases with co-occurring neglect and DV (45%).

A secondary systematic random sample of 100 families was taken from the original sample to further examine how this co-occurrence affects child welfare workers with regard to assessing risk and problems in child functioning, the relationship between risk assessment factors and DV, and how workers respond to the presence of DV in developing case plans and taking legal action. In their original case documentation, caseworkers used a consensus-based risk assessment tool (for which no reliability and validity data are available) to assess the level of risk for each child. For this study the researchers developed a case evaluation form to gather information from the intake, investigation, assessment, and case planning forms included in case records.

The researchers found that workers more often rated families experiencing DV at significantly higher risk for severe neglect/environmental conditions and limited social support than families without DV. Likewise, the presence of DV was significantly associated with lower child interpersonal and physical functioning. Children exposed to both child neglect and DV were found to be at higher risk of specific kinds of maltreatment, including physical abuse, lack of safety, and refusal of treatment (mental health and medical care), respectively.

The study further revealed that in many of the families where case records indicated DV was an ongoing issue, only 47% of such cases were previously reported to the authorities. In such cases, child welfare workers assigned a significantly higher assessment of risk to the family than when there was no evidence of previously unreported DV. Workers subsequently took legal action related to the DV in 65% of the cases. However, issues of DV were incorporated into case plan objectives for only 36% of the families.

The findings led the authors to suggest that child welfare workers need to be trained for the potential for co-occurring child neglect and domestic violence and the related "detrimental effects" on children so that appropriate assessment, legal action, and case planning can be implemented. The authors further recommended that states review laws around DV reporting to ensure they are working in the best interest of children. Finally, the authors suggested there is a need for developing specialized services to serve multiproblem families who demonstrate risk or who are substantiated for child neglect and who are experiencing domestic violence.

Antle, B. F., Barbee, A. P., Sullivan, D., Yankeelov, P., Johnson, L., & Cunningham, M. R. (2007). The relationship between domestic violence and child neglect. *Brief Treatment and Crisis Intervention, 7*(4), 364-382.

## Child Neglect and English Law

This paper describes issues related to child neglect cases in England and Wales. Specifically the article discusses tensions between the social work and legal professions in the intervention and resolution of neglect cases. The Children Act 1989 outlines the legal criteria that must be considered by courts in deciding whether to issue an order to intervene with a family in cases of neglect. Challenges in determining sufficient evidence to meet the "threshold criteria" for a court to issue a care or supervision order in such cases is the primary focus of this study. The two main criteria for order determination are existence or potential for significant harm to the child's health and development and what is reasonable to expect of a parent.

This qualitative study conducted in 2001–'02 includes interviews with social workers and lawyers in six local authorities in England and is intended to examine how the two professions work together in cases of child neglect. Social workers cannot remove children from home against parents' wishes without first going to court and working with lawyers. Separate interviews were conducted with the social worker and lawyer working together on 23 concluded cases or 46 interviews. An additional 6 interviews were conducted with social services managers and 2 with legal managers. The cases were selected by staff in the six local authorities and represented a wide range of cases and interprofessional relationships. A range of neglect was a factor in 19 of the 23 cases.

The researcher found that the ambiguity of the law surrounding the threshold criteria is a main source of conflict between social workers and lawyers. Though the law does not stipulate the occurrence of a specific event to "catapult" a case into receiving a court order, lawyers often want social workers to clearly articulate why the intervention needs to happen now as opposed to some earlier time in the history of the family. In addition, the court requires a comprehensive care plan be established before it will agree to intervene with a family. Thus, social workers feel they must be able to fully satisfy the demands of the lawyers and the court before they begin to start proceedings for cases of neglect. When a particular event cannot be identified to serve as the tipping point, delays in processing neglect cases occur. Other delays are precipitated by changes in family circumstances or in cases where families cooperate just enough to get by.

Both social workers and lawyers believe the courts give little credibility to the evidence presented by social workers. Instead, expert assessments are typically sought, which adds to the delay of the case and diminishes the value of the social worker. Likewise, lawyers often believe the social workers' evidence lacks quality and is not critically evaluated. This appears to be in large part why lawyers seek a catapult event on which to present a case of neglect.

The author concluded that cases of child neglect bring rise to a number of fundamental issues related to social work policy and practice. He suggested that improved dialogue between social workers and lawyers may offer some solutions to the dilemmas faced in cases of child neglect. In addition, he suggested that social work

needs to raise its standards for credibility and better communicate the complex nature of working with families to the courts. As well, the legal profession needs to improve its listening skills and recognize the differences and similarities from social work in professional mandates and desired outcomes for children and families. Finally, the author suggested that acknowledging their interdependency will contribute to working together more effectively.

Dickens, J. (2007). Child neglect and the law: Catapults, thresholds, and delay. *Child Abuse Review, 16*,(2), 77-92.

## Family Parental Structure and Child Neglect

Child neglect is the most common and the least studied form of child maltreatment. It appears to be most prevalent in families that are single-parented and female headed by women who are socially isolated and fraught with health and social problems. It has been argued that fathers are much more involved in neglectful families than past research has suggested. This research study seeks to address the significant gap of knowledge about the father's role in child neglect.

The researchers analyzed data using a random selection process of 1,266 Canadian neglectful families (outside of Quebec) taken from the *Canadian Incidence Study of Reported Child Abuse and Neglect—2003*. Their objectives were, first, to describe the characteristics and structure of families struggling with neglect issues in order to identify the parental structure of the families. Second, they did an intergender and intragender comparison of the sociodemographic characteristics (age of parent, level of education, and employment status) and personal problems (alcohol/substance abuse, criminal activity, cognitive impairment, mental and physical health issues, social supports, maltreated as a child, and victim of domestic violence) of the parents of the neglectful families.

The study found some subtle differences in the profile of families struggling with neglect from what is usually found in scientific literature. Almost half of the families were single-parent families headed by a female with multiple needs. However, men were often present in situations of neglect, whether residing in a two-parent family (38%) or by maintaining a link with their biological children (35% of the single parent-, female-headed families). The study also found that neglecting fathers and mothers struggled with different personal problems based on family structure. For example, fathers in nuclear families were less likely to have alcohol and substance abuse problems and single parent fathers were more likely to be unemployed. In contrast, women struggled with more problems, and the problems they faced explained many of the differences observed between the different family structures. For example, single-parent mothers tended to be younger, unemployed, and to have alcohol- and mental health-related issues. Overall, combining all family structures, single-parent women scored higher than men in all personal problem categories except criminal activity, and women were more likely than men to have been maltreated in childhood. With respect to intragender differences, surrogate fathers faced more problems than biological fathers, and in contrast, biological mothers faced more problems than surrogate mothers.

Based on the results of the study, which indicate that fathers experience fewer problems and that families in which the father is present seem to be less vulnerable to neglect, the researchers concluded that it is crucial to consider fathers from the initial moment of intervention when dealing with child neglect cases. The researchers also concluded that it is clear that parents who struggle with child neglect, especially single mothers, have many personal needs that must be addressed if intervention is to be effective. Finally, the researchers express the need for new studies to explore the impact of the presence of a father related to different types of neglect.

Dufor, S., Lavergne, C., Larrivée, M., & Trocmé, N. (2008). Who are these parents involved in child neglect? A differential analysis by parent gender and family structure. *Child and Youth Services Review, 30*(2), 141-156.

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## Predicting Prevention Program Completion

Many prevention programs have been developed in recent years to reduce risk factors and improve protective factors associated with child abuse and neglect. The results of evaluations of prevention programs are mixed and have led researchers to look at the process of service provision, paying particular attention to problems of client participation and to the circumstances that help and hinder program completion. This article uses a random assignment research design to examine the factors that predict program completion among families enrolled in a social work child neglect prevention program called Family Connections (FC).

The researchers selected 154 families who had participated in the FC program between 1997 and 2001. The eligibility criteria for the program were the following: (1) family referred by a person concerned that at least one of 19 neglect subtypes was occurring at a low level (too low for CPS investigation), (2) concern that at least two additional risk factors for neglect related to the child or the caregiver/family existed, (3) there was no CPS involvement, and (4) the caregiver was willing to participate in the program. Eligible families were randomly assigned into four conditions. Only two of the conditions were included in this article: FC intervention for 3 months (70 families) and FC intervention for 9 months (84 families).

A model was developed from the literature and program data to explore and identify the predictors of service completion. A total of 136 families with predata and postdata were included in relevant data analyses. Bivariate analysis compared differences between families who completed the services and those who did not, and differences between 3-month and 9-month intervention groups

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in completion status. In addition, logistic regression analysis was used to determine predictive variables.

The study was successful in predicting the families who completed services, but it was not as effective in predicting which families did not complete services. Some of the findings were consistent with findings from other research, but others were not. For example, similar to previous research, results from this study provide some support for the idea that even clients with difficult problems such as drug use and depression can complete preventive services. However, the authors suggested that this finding warrants further research. Other findings from this study include the importance of positive worker and family interaction and impact of the length of intervention on predicting completion of preventive services.

Girvin, H., DePanfilis, D., & Daining, C. (2007). Predicting program completion among families enrolled in a child neglect preventive intervention. *Research on Social Work Practice, 17*(6). 674-685.

## New Measure of Child Neglect

This article reports the results of testing a new scale measuring child neglect, the Community Norms of Child Neglect Scale (CNCNS). The study was conducted in a Midwestern region of the United States. After initial development of the scale with undergraduate and graduate students from two universities, the scale was administered via telephone survey in 50 communities across one state. A two-stage sample strategy was used to initially select 10 CPS office areas and then oversample rural, ethnically diverse, and low-income communities. The final survey sample was 96.7% white. A total of 3,826 adult interviews were completed for a 59% response rate. The CNCNS includes 21 scenarios that are rated on a 0–5 scale of neglect severity.

Confirmatory factor analyses were used to determine that the measure represents specific types of neglect: emotional neglect, physical neglect, failure to provide, lack of supervision, and educational neglect. Overall the scale was found to be reliable and valid among professional and nonprofessional participants and across both rural and urban communities.

Goodvin, R., Johnson, D. R., Hardy, S. A., Graef, M. I., & Chambers, J. M. (2007). Development and confirmatory factor analysis of the community norms of child neglect scale. *Child Maltreatment, 12(*1), 68-85.

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## Mental Processes Influence Maternal Neglect

The cross-sectional study reported in this article compares a convenience sample of neglectful mothers (n=34) to non-neglectful mothers (n=33) on how they processed information related to child emotions and behaviors. Approximately 85% of mothers in both groups were white. Three measures were administered to all participants to assess their perceptions of infant emotions and behaviors and the mothers' ability to recall important child-related information. A measure of depression was used as a control variable to further assess differences between groups.

Overall the study found neglectful mothers were less able to appropriately judge infants' emotions and more likely to make negative attributions to infants' behavior than non-neglectful mothers. After controlling for depression, there was no difference between neglectful and non-neglectful mothers in their abilities to recall important caregiving information. The findings appear to support previous research cited by the authors showing cognitive differences between neglectful and non-neglectful mothers.

Hildyard, K., & Wolfe, D. (2007). Cognitive processes associated with child neglect. *Child Abuse & Neglect, 31*(8), 895-907.

## Systematic Review of Primary Prevention Programs

This article presents the results of a systematic review of primary prevention programs for child abuse and neglect. The purpose of the review was to identify gaps and future directions for the development and evaluation of interventions from a public health perspective.

The reviewers used literature published in 9 different databases from 1980 to 2004 and identified 7,208 abstracts; 369 abstracts met the retrieval criteria of describing an intervention or reviewing the literature. Publications chosen described interventions implemented before maltreatment in over half of the studies' populations in an effort to prevent child maltreatment. A total of 140 publications that described 188 programs were reviewed and coded. The variables coded included the following: type of abuse targeted by the programs; whether the program targeted the entire community or only those at high risk; targeted risk factors, program content, and components; providers delivering the program; and if applicable, evaluation design and findings on impact of risk factors or abuse observed.

The reviewers found several notable gaps in the programs reviewed. Only one fourth of the programs reviewed had been rigorously evaluated; therefore, it is unknown whether they were effective for preventing child maltreatment. Additionally, many of the evaluated programs measured only the risk factor hypothesized to lead to maltreatment but did not measure occurrence of child maltreatment. The authors contended that it is important to measure both. Another major gap found by the reviewers was that only 3 of the 188 programs targeted neglect, which is the most common form of child maltreatment in this country. Finally, the review found limited program efforts to modify certain risk factors that prior research has indicated to be prevalent and significant to the public health perspective. These risk factors include parental physical discipline of children, family poverty, partner violence, and teenage pregnancy.

Based on their review, the authors concluded that there are many primary prevention programs for child maltreatment that address various risk factors, but many of those programs have not been rigorously evaluated. Most of those evaluated did not produce results indicating an impact on risk factors or child maltreatment. The authors also suggested that new low-cost interventions be developed that focus on the previously noted prevalent risk factors.

Klevens, J., & Whitaker, D. J. (2007). Primary prevention of child physical abuse and neglect: Gaps and promising directions. *Child Maltreatment, 12*(4), 364-377.

## Neglect of Neglect

The author's review of the literature indicated that child neglect is the most prevalent form of child maltreatment and has profound developmental implications. Yet, it is also the most understudied and least understood type of maltreatment. The author of this article examined why child neglect is so poorly understood and researched and made suggestions about how to address the "neglect of neglect."

The commentary noted the difficulty in setting a standard definition of *child neglect* because it can take many forms and occurs in diverse contexts. The definitions used vary from state to state based on the many different perspectives of professionals and nonprofessionals about what constitutes child neglect. The lack of consistency in the definition makes it difficult to target and study. One of the major obstacles is determining what minimally adequate levels of care are, especially when considering cultural differences.

The author further stated that neglect is also difficult to substantiate except for severe cases. Sometimes it is difficult to determine whether neglect is due to omission or absence of social, economic, or psychological resources, or whether it can be blamed on a parent, the environment, or both. Another challenge is that neglect tends to be "a long-term developmental issue rather than an event-specific crisis" (p. 609). Issues of poverty also create challenges in substantiating child neglect. Nonetheless, the increasing volume of allegations of child maltreatment has forced many child protection agencies to set up policies of prioritization. Physical abuse tends to be prioritized over neglect, even though the long-term harm of neglect can be more damaging to children. Neglect cases are often minimized until a particular incident of abuse occurs.

The author makes three suggestions to help raise awareness and understanding of child neglect. First, it is vital to define *child neglect* in clear and succinct terms so practitioners can develop a clear picture of the different types of neglect and be able to more effectively substantiate allegations. Second, intensive training should be provided to staff members who specifically deal with neglect cases. Finally, in recognition of the damage neglect inflicts on children, a critical timeline for dealing with cases of neglect may need to be developed to prevent the continual cycle of neglect.

McSherry, D. (2007). Understanding and addressing the 'neglect of neglect': Why are we making a mole-hill out of a mountain? *Child Abuse & Neglect, 31*(6), 607-614.

## Using Neuropsychological Tests to Profile Effects of Neglect

This study used a neuropsychological perspective to examine whether cognitive functions can contribute to distinguishing neglected children with or without physical abuse from comparison participants. It also sought to demonstrate an increased detrimental impact to children who are victimized by a combination of different types of maltreatment. Previous studies focused on the negative effects of neglect on overall developmental delays, language, and intellectual functioning. A growing body of scientific literature indicates that there is a link between child neglect and cerebral development. Neuropsychology studies cognitive functions such as motor performance, short-term and long-term memory, spatio-temporal orientation, language/vocabulary, language/expression and comprehension, and intelligence. In this study, a total of 79 children, ages 6–12, receiving child protective services (CPS) because of neglect (28 children) or a combination of neglect and physical abuse (56 children) were compared were a control group of 53 children of the same age, gender, and annual family income who were not involved with CPS. All children received a neuropsychological assessment that covered seven domains, including attention, memory and learning, visual-motor integration, motor performance, language, intelligence, and frontal/executive functions.

MANOVA analyses found significant differences among the three groups on all tests combined. Univariate and *post-hoc* analyses were then applied and found significant differences between groups. Finally, a discriminant analysis noted significant first- and second-order functions. Function 1 included capacities related to auditory attention, flexibility and response inhibition, and visual-motor integration. Function 2 included capacities for problem solving, abstraction, and planning. This analysis confirmed the hypothesis that neuropsychological tests can distinguish children based on their membership in the three defined groups. Neglected and physically abused children indicated cognitive deficits in Functions 1 and 2. Neglected children without physical abuse showed lower scores than the control group on Function 1 but showed greater capacities on Function 2 than children in both the neglected physically abused group and the control group. The authors suggested that neglect and physical abuse combined are more likely to result in poor cognitive functioning than neglect without physical abuse. The researchers conclude that neuropsychological tests can identify the cognitive effects that differing levels of child maltreatment have on children.

Nolin, P., & Ethier, L. (2007). Using neuropsychological profiles to classify neglected children with or without physical abuse. *Child Abuse & Neglect, 31*(6), 631-643.

## About the Authors

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# Washington Update

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

## Budget Politics to Dominate Election-Year Congressional Session

Congress returned in mid-January from its year-end recess to face a legislative agenda enlivened by the politics of an election year. In his State of the Union address on January 28, President Bush outlined themes for his last year in office. He promised to send Congress a budget proposal on February 4 for the 2009 fiscal year that would eliminate or reduce funds by more than $18 billion in 151 "wasteful and bloated programs," signaling a fairly tight spending plan from the Bush administration. Another round of budget disputes with the President is sure to dominate the legislative session this year.

The budget battle for 2008 funding was a tough one. Congress, still in session the week before Christmas, finished up the appropriations legislation for President Bush to sign into law on December 26. The omnibus funding measure combined spending for 11 of the 12 appropriations bills still awaiting final action at the end of the year. A series of veto threats by the President had blocked Congressional efforts from passing individual appropriations bills—except for the Defense Department spending measure signed into law in November. The President demanded that spending not exceed the overall total for the administration's budget sent to Congress last February. In the final funding measure, appropriations leaders in Congress agreed to meet the President's budget total, while setting many of their own spending priorities within that amount.

Much of the federal government's domestic discretionary spending ended up with level funding or cuts. Appropriations for most child and family services programs were held at the 2007 funding levels, minus an across-the-board cut of 1.747%, resulting in cuts below last year's spending. For example, the Child Abuse Prevention and Treatment Act (CAPTA) programs were hit with a loss of $1.746 million, not counting funds earmarked for special projects at $1.888 million or the new discretionary funds at $10 million requested by the White House, which the bill directs to go for support of "a range of home visitation programs…that have met high evidentiary standards." The final budget leaves CAPTA State Grants at $26.535 million, CAPTA Discretionary Grants at $37.135 million, and the CAPTA Community-Based Prevention Grants at $41.689 million for 2008.

A handful of Department of Health and Human Services (HHS) programs providing support for children and families were singled out for increases. Among them, the Head Start budget increased by $14 million to $6.9 billion, against the President's proposal to cut Head Start by $100 million. Likewise, the Community Services block grant, which the Bush administration has regularly sought to eliminate altogether, was funded again this year and given an increase of $35 million to total $653.8 million.

Other bills fared poorly. Funds for the Promoting Safe and Stable Families program—the largest federal funding source for child maltreatment prevention—were cut by $25.789 million. With the mandatory funds held at $345 million, the cut to the PSSF discretionary funds left the FY08 total at $408.311 million compared with $434.1 million in FY07.

While much of the political formula remains unchanged from 2007—except for the volatile chemistry of an election year—some factors will come into play to make the year ahead a bit unpredictable at the outset.

First, early last year, President Bush and Congressional Democrats drafted blueprints for balancing the budget by fiscal 2012. Those plans could change with an economic downturn. The legislative rush to push through an economic stimulus package is only the immediate response.

Second, Congress must deal with the reality of an annual budget deficit expected to grow by at least 34% this year due to an eroding economy. The Congressional Budget Office (CBO), in its annual budget and economic outlook report issued in January, projected the fiscal 2008 deficit will be $219 billion, up from a deficit of $162.8 billion in 2007. When figuring the cost of the new economic stimulus package and more funding for military operations in Afghanistan and Iraq (not included in the CBO report), estimators put the deficit total closer to $350 billion for the year.

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Those numbers and the slowing economy are sure to become part of the debate shaping the decisions legislators will make over the next couple of months in developing the Congressional budget resolution, which serves as the blueprint for the appropriations bills to come early in the summer months.

Finally, there lurks the possibility that Congress might not send any appropriations bills to the President for him to veto. It is common in a Presidential election year for the House and Senate to hold off on final passage of spending legislation. In the current instance, Congressional Democrats might like to wait for the chance of a new President from the same party to sign those appropriations bills.

## Head Start Bill Enacted With Child Abuse Prevention Provisions

On December 12, close to 5 years after Congress first took up a bill to reauthorize the Head Start program, President Bush signed into law the Improving Head Start for School Readiness Act of 2007, reauthorizing the early childhood development program for low-income preschoolers.

The measure, which extends the Head Start funding authority for 5 more years through 2012, includes new provisions that address the following:

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

In signing the measure, the President cited the "improved coordination of early childhood delivery systems…to help ensure our investments are better aligned and more effective." The President, however, was not supportive of the increased funding authorized by the bill. In his statement at the signing ceremony, Bush said, "I am concerned that the bill authorizes spending levels higher than those proposed in my budget. Approval of this legislation is not an endorsement of these funding levels or a commitment to request them."

The President also expressed disappointment "that the bill fails to include my proposal to protect faith-based organizations' religious hiring autonomy." The provisions, which would have allowed employment discrimination in Head Start hiring on the basis of religion (included in previous bills to reauthorize Head Start while Republicans still controlled Congress), had been a major point of controversy blocking passage of the legislation until this year.

The report on the Head Start bill filed by the Senate HELP Committee included extensive discussion acknowledging the important role played by Head Start and Early Head Start programs. These have been made possible through the comprehensive services provided to young children and their families in preventing the abuse and neglect of children and in protecting children and ameliorating the affects of maltreatment they may have already suffered.

## SCHIP Veto Vote Fails Again

Voting on January 23 to override the President's second veto of legislation to expand the State Children's Health Insurance Program (SCHIP), the House once again failed in its attempt to take the government-sponsored health insurance coverage to an additional four million low-income children. The override vote, 260 to 152, fell 15 votes short of the two-thirds majority required—no closer than the vote last October when the vote to override Bush's first veto failed by 13 votes.

Because Speaker Pelosi (D-CA) and the Democratic leadership in Congress appear to consider the expansion of SCHIP as a powerful political issue, there may be other attempts before the November elections to force Congressional Republicans to vote again on the SCHIP expansion measure. The bill, which already enjoys considerable bipartisan support in the Senate, would expand SCHIP by $35 billion over 5 years to $60 billion, financed by an increase in tobacco taxes, taking the cigarette tax to $1.00 per pack. In his last veto message, Bush objected to using an increased tobacco tax to fund the SCHIP expansion, and he claimed that the new bill would cover children in families with incomes above the national median.

Despite the President's veto of the SCHIP expansion bill, the program remains funded. On December 29, President Bush signed legislation extending SCHIP with enough money to provide states with the ability to cover through March 2009 those children currently enrolled. States had been pressuring Congress to abandon attempts at an expanded program because of worries that time would run out and SCHIP money would come up short, forcing states to remove recipients from their rolls if the current funding level continued. The Congressional Research Service in October reported that 21 states would face combined shortfalls of $1.6 billion in their children's health insurance programs.

House Republican leaders were willing to support the inclusion of the extra money to help the states facing shortfalls in their programs. House Democrats had been pushing to extend SCHIP funding until September 2008, in order to force another debate on what they see as a winning political issue. The extension until 2009, which finally passed and was signed by the President, made the legislation more palatable to Republicans who might not want to deal with the issue again during the 2008 election cycle.

## 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 Institute Shines in San Diego, Membership Grows

A total of 196 individuals participated in APSAC Advanced Training Institutes on January 28 in San Diego, California. They presented at the 22nd Annual International Conference on Child and Family Maltreatment, sponsored by the Chadwick Center at Rady Children's Hospital in San Diego.

APSAC Sponsored Three Institutes:

- Medical Evaluation of Sexual Abuse of Children and Adolescents, presented by Lori Fraser, MD, and Suzanne Starling, MD
- Help for Families Involved in Physical Coercion or Abuse: Community Application and Supervision of Abuse-Focused Cognitive Behavioral Therapy (AF-CBT), presented by David Kolko, PhD, and Amy Herschell, PhD
- Advanced Forensic Interviewing, presented by Lynda Davies, BA, Michael Haney, PhD, Thomas Lyon, JD, PhD, and Julie Kenniston, LSW.

APSAC also exhibited at the conference with good results. Thirty new members joined on site, and many individuals indicated that they would join in the future.

## APSAC Board Meets in San Diego, New Directors and Officers Elected

APSAC's Board of Directors met February 2 in San Diego, California. One agenda item was to ratify the election and appointment of new Board members and officers. Board members elected to serve 3-year terms were **Arne Graff**, MD, Medical Director, Child and Adolescent Maltreatment Services, MeritCare Health Systems, Fargo, North Dakota; and **Vincent Palusci**, MD, MS, Loeb Child Abuse Center, City of New York.

Additionally, in accordance with the bylaws, the Board voted to temporarily expand Board membership by appointing **Viola Vaughan-Eden**, PhD, LCSW, Vaughan-Eden Counseling Services, Newport News, Virginia; **Maria Gallagher**, MSW, Project Outreach Coordinator, Northeast Regional Children's Advocacy Center, Oakdale, Connecticut; and **Ronald C. Hughes**, PhD, MScSA, Director of the North American Resource Center for Child Welfare and the Institute for Human Services, Columbus, Ohio, to serve 3-year terms.

The following Board members were elected to serve as Officers: President **Michael L. Haney**, PhD, Director for Prevention and Intervention, Florida Department of Health, Children's Medical Services, Tallahassee; Vice President **Patricia Lyons**, The Center for Child and Family Advocacy, Columbus, Ohio; Secretary **Kathy D. Johnson**, MS, Clinical Instructor, Jordan Institute for Families, UNC-SW, Chapel Hill, North Carolina; Treasurer **Jon R. Conte**, PhD, Consultant, Mercer Island, Washington; and Immediate Past President **Jordan Greenbaum**, MD, Child Protection Center, Children's Healthcare of Atlanta, Georgia.

## APSAC Annual Colloquium Set for June

APSAC will host its 16th Annual Colloquium June 18–21, 2008, at the Sheraton Wild Horse Pass Resort & Spa in Phoenix, Arizona.

This year's Colloquium promises to deliver the very best in education. It features Advanced Training Institutes, the Cultural Institute, and nearly 100 seminars. The Colloquium also offers ample opportunities for networking, including welcome reception, poster presentations, and a membership luncheon and awards ceremony.

## Message From the President

Dear Colleagues,

I was honored to be elected President of APSAC by the Board of Directors at the Boston Colloquium, and I took the formal reigns at our recent February 1–2 Board meeting in San Diego. I want to take this opportunity to write a small note of introduction and share with you a few thoughts on APSAC.

I have worked in the discipline of child abuse and mental health for almost 25 years, and like many of you, I found my life's calling in this work. Of my many years of experience, my years involved with APSAC have been the most rewarding and productive. Looking back, APSAC has come a long way since it was originally founded by a small group of professionals who created a vision of service to children, which still applies today. As members, we owe a debt of gratitude to all those who have served this organization in the past 21 years. Yes, 21 years of working on behalf of children! APSAC has accomplished much in that time; however, there is still plenty of work left for us to do, and together we can do it.

It has been my pleasure getting to know many of you during my past 2 years of service on the Board, and I look forward to meeting many more of you at the Phoenix, Arizona, Colloquium and other future APSAC events. I'm humbled by the trust placed in me by you and my colleagues on the Board, and I look forward to seeking your thoughts and ideas on how we can continue to grow and improve our organization.

Best wishes,

Michael L. Haney, PhD, President
Director for Prevention and Intervention
Florida Department of Health, Children's Medical Services, Talahassee, Florida

Seminars are designed primarily for professionals in mental health, medicine and nursing, law, law enforcement, education, prevention, research, advocacy, child protective services, and allied fields. All aspects of child maltreatment will be addressed, including prevention, assessment, intervention, and treatment for victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect.

To help attendees select their seminars, the Colloquium is divided into convenient tracks: administration, cultural diversity, child protection, interdisciplinary, interviewing, law, mental health, medicine and nursing, prevention, and research.

The 16th Annual Colloquium is cosponsored by APSAC and the Institute for Continuing Education. Continuing education credit will be offered on a session-by-session basis, with full attendance required at a session to earn CEUs. Representatives from the Institute will be on site to accept applications for continuing education credit and to assist conference attendees. A separate processing fee will be required.

Complete details and registration information are available on the Web at www.apsac.org. The site also features a downloadable/printable PDF version of the conference brochure.

## "New APSAC Practice Guidelines..."

APSAC is currently in the final review process for new Practice Guidelines on Child Neglect. Sections include the following:

- Immediate and Short-Term Risk in Child Physical Neglect
- Long-Term Adverse Effects
- Multidisciplinary Assessment
- Role of Child Protective Services (CPS) Worker
- Role of Law Enforcement
- Role of Forensic Interviewer
- Role of Medical Provider
- Role of Criminal Prosecutor and Child Protection Attorney

## APSAC Hires New Management Firm

APSAC recently named Bandy & Associates, Inc. (B&A), Elmhurst, Illinois, as its association management company. B&A was selected because of the firm's focus on providing senior-level, experienced management for a select group of clients, as well as its commitment to helping APSAC develop and enhance its services. B&A is managed by Michael Bandy and Dee Dee Bandy, who together bring more than 40 years of association management experience to their customers.

Founded in 1985, Bandy & Associates is an association management, project, and consulting firm that focuses on providing services for the association market. Other clients include the American Forage and Grassland Council, Chicago Compensation Association, Medical-Dental-Hospital Business Associates, and Response Custom Publishing.

APSAC's new contact information is listed at the top of the next column. *Please be sure to update your records and to notify your accounts receivable department.*

**APSAC New Contact Information**
American Professional Society on the Abuse of Children
350 Poplar Avenue, Elmhurst, IL 60126
Phone: (877) 402-7722 Fax: (630) 359-4274
E-mail: apsac@apsac.org

## New Web Site Features Online Directory and Profile Update

APSAC recently unveiled its new Web site at www.apsac.org. In addition to streamlined navigation, the site features a Members Only area that includes a directory of APSAC members, the ability to edit your member profile, and auto-fill with online event registration.

To access the Members Only area, you'll need to log-in to the system with your username and password (contact APSAC if you don't have it). While you can complete registration for APSAC events without logging in, the association recommends that you log-in first because the form will pre-populate with your member demographics (name, title, address, etc.), saving you time during the registration process. The APSAC directory is viewable only by members, and sensitive information (e.g., member ID, user name, password, etc.) is viewable only to the profile owner.

If you haven't renewed your membership for 2008 or updated your online profile, APSAC urges you to do so as quickly as possible. To receive discount pricing on APSAC seminars and events, and to continue your subscription to the *Child Maltreatment* journal and the *APSAC Advisor*, dues must be paid. You can check your renewal status by contacting the office or by logging in to the Web site and going to My Profile under the Members Only tab.

## APSAC Child Forensic Interview Clinics

Two sessions of APSAC's Child Forensic Interview Clinics have been scheduled on the following dates:

March 10–14, 2008
Turtle Cay Resort
Virginia Beach, Virginia

June 2–6, 2008
Washington State Criminal Justice Training Commission
Seattle, Washington

APSAC has led the way in pioneering training in child forensic interviewing. These 40-hour clinics provide intensive training for professionals responsible for investigative interviews with children in suspected abuse cases, including law enforcement and social service investigators. The clinics are also appropriate for specialized child interviewers and persons interested in learning more about forensic child interviewing.

APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing, as set forth in the *APSAC Practice Guidelines for Investigative Interviewing in Cases of Alleged Child Abuse*. The training incorporates a balanced review of several prominent interview approaches and models, and it is designed for audiences with variable levels of pre-existing skill.

Cont'd on page 26

Each Clinic provides presentations and practice interview critiques from well-known experts; videotaping of participant practice interviews; and a mock court experience. In addition to the Clinic notebook, participants receive a resource CD containing a wealth of resource material and articles related to child interviewing, as well as several excellent books that will enhance an interviewer's knowledge and ability to defend the interview in court.

For additional information, contact Patti Toth at ptoth@cjtc.state.wa.us. To register, please go to the APSAC Web site at www.apsac.org.

## APSAC Events Online

Recently, APSAC added information for its 2008 events (including the Advanced Training Institutes, Child Forensic Interview Clinics, and the 2008 Colloquium) to the Web site at www.apsac.org. To access information, select the Event List under the Events & Meetings tab. Each event features program details, housing information, and online registration (activated several months in advance). Additionally, the event can be conveniently added to your Outlook calendar by selecting the "Add this event to Outlook" link.

## WIPSAC Opens Webinar Participation to All APSAC Members

WIPSAC, the Wisconsin State Chapter of APSAC, has been offering Web-based continuing education for its members, known as Lunch at Your Desk and Learn (LAYD&L). WIPSAC's board has voted to make these opportunities available to all APSAC members. The focus of LAYD&L is to make important new research information easily available to professionals in the field. Each LAYD&L selects one article from either the *Child Maltreatment* journal or the *APSAC Advisor* and discusses the content of the articles, with a brief "refresher" on methodology and/or statistics during the first portion of the session. A discussion of the implications of the article followed by a question-and-answer period complete the one-hour session. The article authors are invited to participate, and they may present their own material or respond to questions from participants, or both.

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

The dates and topics of Webinars will be posted on the master calendar on the APSAC Web site (www.apsac.org) along with direct links to online registration. The Webinars are normally scheduled the fourth Thursday of each month at 12:00 noon CST. 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 Undertakes Long-Range Planning

APSAC is undertaking an ambitious long-range planning process. Much of the work will take place via E-mail and internet questionnaires. APSAC members are encouraged to participate. If you are willing to serve on the ad hoc long-range planning committee, please contact Jon Conte at contej@washington.edu. Please put "long-range planning committee" in the subject line and your E-mail address as the only message.

## Fifth Annual National Race to Stop the Silence

Stop the Silence, Inc., a charitable, nonprofit organization dedicated to the comprehensive prevention and treatment of child sexual abuse (CSA), will hold its 5th Annual International Race to Stop the Silence: Stop Child Sexual Abuse on Sunday, April 13, 2008, at 8:30 am EST in Anacostia Park in Washington, DC.

According to Dr. Pamela Pine, founder of Stop the Silence, the race gives a voice and support to the victims of the horrors of child sexual abuse. "This silent epidemic is everyone's problem, creating long-lasting and negative impacts on our society and the victims," she adds. "The statistics speak volumes. Approximately 73% percent of prostitutes overall and 95% of teen prostitutes were sexually abused before the age of 18; over 32% percent of convicted killers were sexually abused as children; 60% of teenage mothers; and 73% of runaways. Most children are abused by someone they know and who have access to the child—in other words, the children are abused primarily by community and family members. The National Race to Stop the Silence helps bring the issue out to the light so that we can address this as a society in our individual communities."

This event has grown each year, attracting more than 1,200 people in 2007. Pepsi Bottling Company (PBG) is a primary supporter and contributor, and Ms. Foundation for Women is presenting the race and is contributing support for the fifth year. Many other sponsors have promoted the success of the race, including Gallup Organization, the Calvert Group, Comcast, The Walking Company, ClearChannel Radio, and Safeway.

To register for the race or for more information, please visit: www.stopcsa.org/race. Race entry fees are $20 by March 15, 2008, $25 until the day of the race, and $30 at pre-race packet pickup. Commemorative t-shirts will be available to all entrants.

## Conference on Creative Solutions to the Challenge of Chronic Child Neglect

The New York Center for Children, in association with Prevent Child Abuse America and the Administration for Children's Services, recently sponsored a conference on Creative Solutions to the Challenge of Chronic Child Neglect. The conference presented speakers from around the country and from New York who provided information about the connection between chronic neglect and poverty.

Speakers included Alfonso Wyatt, Vice President of the Fund for the City of New York; Dee Wilson, Director of the Northwest Institute for Children and Families in Seattle; Toby Herr, Executive Director of Project Match in Chicago; Raysa Rodriguez, Senior Advisor, Youth and Community Programs, Office of New York's Deputy Mayor of Health and Human Services, and Michael Bosnick, Deputy Commissioner, New York Administration for Children's Services. For a summary of the presentations, E-mail Christine Crowther, Administrative Director at the New York Center for Children, cacny@att.net.

**March 26–28, 2008**
**Eastern Conference on Child Sexual Abuse Treatment**
Arlington, VA
Visit: www.dcs.wisc.ed/pda/eastern/default.htm

**March 31–April 1, 2008**
**National Conference on Strengthening Families: Trends and Practices**
St. Louis, MO
Call: 800.942.0326, or Visit: www.e-mcca.org/training.php

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

**April 21–22, 2008**
**6th Annual Children's Justice Conference**
Seattle, WA
Call: 360.902.7966, or Visit: www.dshscjc.com

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

**May 14–16, 2008**
**Pathways to Adulthood 2008: National Independent Living/Transitional Living Conference**
Pittsburgh, PA
Call: 918.660.3700, or Visit: www.nrcys.ou.edu/conferences.shtm

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

**May 21–23, 2008**
**15th Annual National Foster Care Conferences "Footsteps to the Future"**
Orlando, FL
Call: 904.296.1055, or Visit: www.danielkids.org

**May 28–31, 2008**
**45th Association of Family and Conciliation Courts (AFCC) Conference**
Vancouver, BC, Canada
Call: 608.664.3750, or Visit: www.afccnet.org

**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**
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, or Visit: www.apsac.org, or
E-mail: apsac@apsac.org

**July 10–11, 2008**
**First National Research Conference on Child and Family Programs and Policy**
Bridgewater, MA
E-mail: jstephenson@bridgew.edu

**July 16–20, 2008**
**Training Institutes 2008 "Developing Local Systems of Care for Children and Adolescents with Mental Health Needs and Their Families"**
Nashville, TN
Call: 202.687.5000, or Visit: http://gucchd.georgetown.edu, or
E-mail: Institutes2008@aol.com

**July 21–23, 2008**
**11th National Child Welfare Data and Technology Conference**
Washington, DC
Call: 703.263.2024, or Visit: www.nrccwdt.org, or
E-mail: nrccwdt@cwla.org

**July 31–August 2, 2008**
**34th North American Council on Adoptable Children (NACAC) Conference**
Ottawa, Ontario Canada
Call: 651.644.3036, or Visit: www.nacac.org, or
E-mail: info@nacac.org

**August 3-6, 2008**
**31st National Juvenile and Family Law Conference**
Savannah, GA
Call: 888.828.NACC, or Visit: www.nacchildlaw.org, or
E-mail: advocate@NACCchildlaw.org

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

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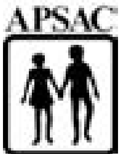



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