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Promoting Successful Family Reunification: A Systematic Review of the Relevant Research

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Successfully reuniting abused, neglected, or unruly children in substitute care with their families and preventing their subsequent reentry into out-of-home care is a significant challenge. This article describes a systematic review of the research to identify programs, policies, and practices most likely to promote successful reunification and prevent reentry. The authors describe the methods used to complete the systematic review, summarize their findings, and discuss implications for policy, practice, and future research, particularly in light of a lack of strong empirical research on these topics. **2**

The Use of Paraprofessionals in a Prevention Program for Child Maltreatment: History, Practice, and the Need for Better Research

Lynn Rigney, PsyD
Elissa J. Brown, PhD

Although the peer-reviewed home visiting literature has provided little empirical evidence for the effectiveness of home visiting as a means of reducing the risk of child maltreatment, hundreds of such programs continue to serve at-risk families. Further, 76% of home visiting programs in the United States employ at least some paraprofessionals, in spite of a lack of empirical rationale and support for this practice. This article describes the historical emergence of paraprofessionals as service providers for the prevention of child maltreatment and is followed by a review of the empirical literature on home visiting programs that employ paraprofessionals. **13**

What's New and Who's Doing It? Southwest Ohio Early Learning Collaborative: Promoting Mental Health Wellness for Children Ages Birth to Six

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In 2006, Early Learning programs in four Ohio counties formed the Southwest Ohio Early Learning Collaborative. Its purpose was to determine the prevalence of preschool children exposed to family and community violence, child abuse, or emotional maltreatment and to develop resources to provide mental health services to these children in the preschool setting. This article reports the Collaborative's concerns about the increasing numbers of preschool-aged children with significant emotional and behavioral issues, and the challenges and successes of integrating mental health services into preschool education programs. **21**

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Promoting Successful Family Reunification: A Systematic Review of the Relevant Research

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One of the key challenges facing child welfare workers is how to successfully reunite families who have been separated due to abuse, neglect, or the parents' inability to handle unruly children. Each year approximately 500,000 children in the United States reside in out-of-home care (Administration for Children and Families [ACF], 2008) with foster parents, relatives, or in other residential settings. Approximately 54% of those children are reunited with their parents following separations that range from only a few days to several years (Child Welfare Information Gateway, 2008). For many families, the reunification is successful and there is no further need for intervention by the child welfare system. For other families, the children will reenter out-of-home care within 12 months following the family reunification. This process exposes children to further trauma, adds to the family disruption, and requires additional costly services for the family.

In 2000, the Children's Bureau of the U.S. Department of Health and Human Services initiated the Child and Family Services Review (CFSR) to evaluate each state's performance on a variety of outcome measures, including reunification and reentry to care. The CFSR established national standards for reunification and reentry to care, requiring that 76.2% or more of all children in out-of-home care should be reunified with their families within 12 months, and that no more than 8.6% of those who were reunited would return to foster care. Many states found themselves out of compliance on these two measures and began to look for effective methods for promoting successful family reunification.

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In Ohio, a decision was made to conduct a systematic review of the best available research literature to identify programs, practices, and policies that are likely to foster successful reunification and to decrease the number of children returning to out-of-home care. Despite numerous excellent literature reviews and books dealing with this topic (Barber & Delfabbro, 2004; Barth, Berrick, Courtney, & Albert, 1994; Berrick, Barth, & Gilbert, 1997; Dougherty, 2004; Haskins, Wulczyn, & Webb, 2007; Littell & Schuerman, 1995, 2002; Marsh & Triseliotis, 1993; Wulczyn, 2004; Wulczyn, Barth, Yuan, Harden, & Landsverk, 2005; Wulcyzn, Webb, & Haskins, 2007), a systematic review provides a concise summary of the best available empirical research. This article describes both the methods used to complete the systematic review and a summary of the findings pertaining to family reunification and reentry to care. It concludes with implications for practice and policy and recommendations for future research.

Systematic Review of Family Reunification and Reentry to Care

> The purpose of a systematic review is to sum up the best available research on a specific question. This is done by synthesizing the results of several studies. A systematic review uses transparent procedures to find, evaluate and synthesize the results of relevant research. Procedures are explicitly defined in advance, in order to ensure that the exercise is transparent and can be replicated. This practice is also designed to minimize bias. (Campbell Collaboration, 2009; http://www.campbellcollaboration.org)

A systematic review is based on a comprehensive examination and appraisal of the existing research, both published and unpublished. The objectives of a systematic review are to (1) conduct a comprehensive, unbiased review of the research literature, (2) describe the review process with enough specificity that it can be replicated or updated by others interested in the topic, (3) appraise the available research for quality and credibility, (4) identify "best practices" based on the best available evidence, and (5) disseminate the results of the review for use by practitioners and policy makers. When these procedures are carefully followed, any bias that might influence the conclusions is minimized.

Systematic reviews offer several advantages over traditional literature reviews and promise to be a useful tool in bridging the gap between practice and research. Systematic reviews begin with a practice or policy problem for which information is needed to guide decision making. With a focus on "what works," a search for relevant research is initiated using explicitly stated criteria to decide which articles will be included and which articles will be excluded from the systematic review. This is done to maximize the transparency of the process and to reduce possible bias that might have an impact on the conclusions that are drawn from the review.

Perhaps most important, in a systematic review, is that conclusions are not based on a single outcome study but on a compilation of all the available research, providing more valid information on which interventions and programs work for specific populations and under what circumstances positive outcomes might be expected.

Systematic reviews are completed in stages. In the first stage, a practice or policy problem is identified and is translated into a searchable question. The searchable question identifies the nature of the practice or policy problem and the target population, and it determines whether research on a specific intervention is sought or whether the search should look at research on any intervention or policy that has been applied to the problem.

In the second stage, an attempt is made to identify all research that is relevant to the search question. This includes articles published in professional, peer-reviewed publications as well as unpublished materials, such as those found in conference presentations or proceedings, unpublished dissertations, state or county evaluation monographs, or other unpublished research results.

The third stage focuses on evaluating the quality and rigor of the research and on compiling the results of all identified studies in order to assess the state-of-knowledge for the identified problem. A standardized critique is applied to each of the studies to reduce any possible bias that might influence the assessment of the research. The results are compiled to allow easier interpretation and to detect trends in the research that are not evident from the review of a single study.

The final stage of a systematic review is to summarize the current state of knowledge based on the best available research. This information is disseminated to practitioners and policy makers to assist in evidence-based decision making and planning. The stages are summarized in Table 1.

Table 1. Stages of a Systematic Review

Stage	Activities
Protocol Development	• Questions to be answered by the review are specified • Inclusion and exclusion criteria to identify relevant research are described • Methods for the review are made explicit • The protocol is discussed with users and modified as needed
Search and Screen Studies	• Methods for managing references are identified and set up • Search methods are explicated and implemented (i.e., electronic databases, hand-searches, reference mining, and snowball searching for unpublished studies) • Studies are screened for relevance, and reliability checks are completed on screening procedures • Descriptive mapping of the relevant literature is completed
Extract Data	• Articles passing the screening criteria are given a full review • Important data concerning the research methods, outcome measures, intervention, and outcomes are coded on a data abstraction form • Data are coded and entered into software for statistical and conceptual synthesis (e.g., SPSS, Access, NUDIST) • Quality and credibility assessment is completed for each study
Data Synthesis	• Numeric, categorical, and narrative data are summarized • Meta-analyses are completed if possible • Narrative empirical synthesis is completed • Conceptual synthesis is completed • Conclusions drawn from the syntheses are presented • Recommendations that are clearly linked to the analyses and synthesis are presented
Final Report	• Full technical report is prepared, including a detailed description of the search and analysis methods to promote transparency • Report is presented to the users for discussion of conclusions and recommendations • Plans are made for updating review

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Typically, systematic reviews are used to answer questions about the effectiveness of interventions and policies. However, when a strong body of experimental evidence is lacking, systematic reviews have also been used to identify trends and promising directions and areas requiring new research. Table 2 provides a summary of the questions guiding this systematic review.

Table 2. Search Questions

Topic	Question
Family Reunification	• What interventions or services result in increasing successful family reunification within 12 months of placement for abused, neglected, or unruly youth/children who are returning from out-of-home care?
	• What factors are correlated with successful family reunification?
	• What are "promising" practices for increasing successful family reunification for abused, neglected, or unruly youth/children?
	• What research is needed to develop more effective services and policies to increase successful family reunification for abused, neglected, or unruly youth/children who are returning from out-of-home care?
Reentry to Out-of-Home Care	• What interventions or services are effective in reducing reentry to out-of-home care for abused, neglected, or unruly youth/children?
	• What factors are correlated with returning to out-of-home care following family reunification?
	• What are "promising" practices for reducing reentry to care for abused, neglected, or unruly youth/children?
	• What research is needed to develop more effective services and policies to reduce reentry to care for abused, neglected, or unruly youth/children?

Table 3. Search Methods

Search Method	Description
Electronic Databases	• See full report (Bronson, Saunders, Holt, & Beck, 2008) for list of electronic databases searched.
Hand Searching of Child Welfare Journals	• The table of contents was reviewed for seven journals identified as most likely to contain relevant research.
Conference Presentations	• Conference proceedings for 2007 (Society for Social Work and Research, Council on Social Work Education, and the Campbell Collaboration) were reviewed for relevant references.
Citation Searches/ Reference Mining	• The bibliographies of all articles selected for full review were mined for additional articles. A search was done for any title that appeared relevant.
Contact With Identified Experts in the Field	• Phone calls and discussions with colleagues in the U.S. engaged in child welfare research, especially in the area of reunification.
Snowball Method	• All links and leads to additional material suggested by relevant Web sites or electronic databases were followed to locate additional resources.

Project Methodology

Between April 2007 and February 2008, the authors completed a systematic review of the research literature to identify strategies to promote successful family reunification and to reduce reentry to care for abused, neglected, and unruly children. This effort extended an earlier rapid evidence assessment (REA) of research dealing with reentry to care (Bronson, Helm, Bowser, & Hughes, 2005), which was completed to provide information on the factors associated with reentry into foster care. This earlier review included only published articles dealing with reentry to care for children who were in out-of-home placements due to abuse or neglect.

The current project is a systematic review that expands upon the work completed in 2005 by including the following:

- research on family reunification,
- studies that address services for unruly children and youth, and
- unpublished research reports ("grey" literature).

This effort is also more expansive than a typical systematic review. The inclusion criteria were broad and included all empirical articles (not just experimental or quasi-experimental studies) dealing with reunification or reentry. In many systematic reviews, only experimental or quasi-experimental research is included, but the research questions for this review demanded a broader perspective to identify important trends in the field, even if those trends are not based on rigorous quantitative research.

Search Strategies

Several methods were used to locate relevant research on family reunification and reentry to care. Table 3 provides a summary of the approaches employed (see on previous page).

Every attempt was made to identify all available research pertaining to reunification and reentry in child welfare services. The search included materials available as of February 2008 and earlier as well as English language resources in the United Kingdom, Scandinavia, Australia, and East Central Europe.

Keywords – The keywords used in the electronic database searches were developed to capture references that addressed (1) the problem question (issues of family reunification and reentry to care), (2) the population of interest (abused, neglected, or unruly children), and (3) type of service.

Review Process – The review process consisted of several steps, such as establishing clear criteria for including or excluding articles, assessing the quality and rigor of the research, and synthesizing the relevant research.

Inclusion and Exclusion Criteria – Each report considered for the systematic review had to comply with the criteria that were established for the project. To be included in the final empirical analysis the report had to

1. deal with family reunification following a foster care placement or reentry to out-of-home care following family reunification
2. be based on work with abused, neglected, or unruly children
3. report on (a) an empirical study evaluating programs intended to increase family reunification or decrease rates of reentry into out-of-home care after reunification, or (b) research to identify factors associated with reunification or reentry to care
4. be written in English.

Nonempirical materials (i.e., literature reviews and conceptual papers) that did not satisfy the inclusion criteria were used to identify common practices and trends in the field but are not included in this summary.

Assessing Research Quality

The quality and credibility of the research articles used in the systematic review were appraised in two stages. In the first, all empirical studies were rated on the rigor of the research using a standardized rating scale called the Maryland Scale of Scientific Methods (Sherman, 1998). The scores ranged from 1 to 5, and higher scores were associated with more rigorous research. Only studies given a rating of 4 or 5 (i.e., quasi-experimental or experimental studies) were included in the analysis of effective programs. Second, the articles were reviewed for any obvious biasing factors or conflicts of interest that could influence the research.

Results

Overview of Available Research

Eight hundred titles were initially reviewed for inclusion in the systematic review. Ultimately, only 71 articles reported on empirical research; 6 articles (reporting on five separate studies) were judged to be quasi-experimental or experimental and 65 articles reported on correlational or qualitative research. Table 4 shows the types of empirical articles that were identified.

Only Level 4 and Level 5 studies are able to provide some degree of causal analysis. The paucity of rigorous research on programs to increase successful reunification and decrease reentry to care limits the definitive conclusions that can be gleaned from the existing research.

Table 4. Frequency: Maryland Scale Ratings

Level 0: Qualitative studies	8
Level 1: Single group or correlational	40
Level 2: Group comparison (non- equivalent groups)	12
Level 3: Group comparison (equivalent groups)	5
Level 4: Quasi-experimental	3
Level 5: Experimental	3
Total	71

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Experimental and Quasi-experimental Research

Table 5 provides a summary of the experimental and quasi-experimental studies only. These are the most rigorous of the available studies.

Although these studies are the most rigorous available, each has significant limitations that interfere with being able to draw definitive causal conclusions about the effectiveness of the intervention.

While some significant weaknesses exist for each of these studies, they provide service models that appear to be promising. Three of the experimental or quasi-experimental studies evaluated the effectiveness of intensive family services to support successful family reunification, one examined the importance of matching services to need, and one highlighted the benefits of working with parents to improve their skills in dealing with their unruly children. Even though the results are somewhat inconsistent across studies, it is

Table 5.
Experimental and Quasi-Experimental Research on Reunification and Reentry

Authors	Treatment Model	Outcome Variables		Findings
		Reunification	Reentry	
Choi, S. (2006); Choi & Ryan, (2007)	Service matching and recovery coaches (services to substance abusing mothers)	Likelihood of reunification; Completion of substance abuse treatment		Matched services seemed to lead to a high likelihood of reunification. Mothers who received matched concrete services were more likely to achieve reunification than those with unmatched needs or no needs. Findings are correlational in nature.
Fisher, Burraston & Pears (2005)	Early intervention foster care program	Length of time incare; number of placements	Occurrence of reentry to care	Unable to draw conclusions regarding effectiveness of the intervention. However, children who did not receive the EIFC were more likely to have failed placements and reenter care.
Jones, Neuman, & Shyne (1976)	Intensive family preservation services	Length of time in care		No differences between group who received intensive family preservation services and group who received regular services. Conclusions can't be drawn about service effectiveness.
Stein & Gambrill (1979)	Intensive services to enhance parental decision making	Timely permanency decisions		Children who received the intervention were more likely to be leaving care at the end of the study. Unable to draw further conclusions from research.
Walton (1991, 1996, 1998) Walton, Fraser, Lewis, Pecora & Walton, 1993)	Homebuilders family preservation services	Number of days in home	Family functioning (parental attitudes, family assessment, and self-esteem)	Children who received the intervention were more likely to be in their biological home at the end of 90 days and at 12 months. However, results were somewhat inconclusive. The 6-year follow-up indicated that children who received the intervention were more likely to be stable at that time.

safe to conclude that these programs have some positive benefits for the participating families. The common characteristics of these programs include (1) increased contact between workers and parents (small worker to family ratios, 24-hour availability), (2) parent contacts with child, (3) parenting skills training (including cognitive-behavioral models), (4) mental health and substance abuse services to parents, (5) concrete services to the family (transportation, job training, housing, respite care, day care, home-maker assistance), and (6) social support networks. The research suggests that these services decrease the amount of time children spend in out-of-home care, improve family functioning, and increase family stability.

Correlational and Qualitative Research

The correlational and qualitative research findings tend to be consistent with the results of the more rigorous research. However, some additional factors that may be related to successful reunification were identified. Until more rigorous research is done, however, the causal connections between these factors and reunification outcomes are unknown. Some of the factors that were presented in these studies are shown in Table 6.

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Table 6. Factors Associated With Success or Failure of Family Reunification

Category	Specific Factors
Child Characteristics	**Age** – infants and children under 2 years of age and teenagers have higher rates of reentry and less successful reunification. **Race/Ethnicity** – minority children often remain in care longer or reenter care more frequently. **Type and Nature of Problems** – children with health or behavioral problems were less likely to reunify or were more likely to reenter care. **Gender** – contradictory findings.
Parent/Family Characteristics	**Parental Engagement** (i.e., involvement and contact) – frequent, positive contact is generally good, but involvement could be proxy for general parent-child relationship or parental ambivalence. **Parental Constellation** – children from single-parent families are more likely to reenter care. **Presence of Parental Problems** – substance abuse, disabilities, mental illness, incarceration or lack of adequate housing decrease chance of successful reunification. **Number of Children** – reentry is more likely when multiple children are reunited with family at the same time, and likelihood of reentry increases with the number of children in the family.
Service Characteristics	**Placement Characteristics** – time in placement and numbers of placements were suggested to increase the risk of reentry; treatment foster care increased the likelihood of reunification. **Types of Services** – reentry more likely if there is not adequate support network for families or if families with unmet service needs; kinship placements delay or decrease reunification

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A number of program models have been evaluated using nonequivalent comparison groups or no comparison group. More research using rigorous evaluation designs are needed before definitive conclusions can be drawn about the effectiveness of these programs. However, preliminary studies are promising. These models can be grouped into the following categories: (1) intensive family preservation/reunification programs, (2) recovery coaches and services matching, (3) early intervention foster care, (4) concurrent planning, (5) court-based services, (6) the Manatee model, and (7) an assessment and treatment model. Table 7 provides a brief summary of each of these models.

Table 7. Program Models for Improving Reunification and Decreasing Reentry to Care

Type of Model	Key Components
Intensive Family Preservation/ Reunification Services	• Rapid referral response and 24/7 availability • Home-based • Small caseloads • Increased worker contact with parents, family members, and children • Concrete services (e.g., financial assistance, medical services, housing assistance. day care, etc.) • Family preservation services prior to reunification and post-reunification • Use of cognitive and behavioral approaches with family • Less than 90 days of service • Continuous family assessments • Support team consisting of involved parties from the court system, CPS, the foster care agency, and other individuals • Participation from parents, foster care staff, and foster families • Behavior modeling and opportunities to practice new behaviors
Recovery Coach and Service Matching	• Use of supportive person assigned to work with mother through substance abuse recovery process • Use of services that were intended to match the specific needs of the mother from both agency and maternal perspectives
Early Intervention Foster Care Program	• Extension of the multi-dimensional treatment foster care program for adolescents designed for use with preschool-aged children • Preservice and in-service training for foster parents • Ongoing and intensive support from program staff • Counseling for children • Parent training • Emphasis on concrete encouragement for prosocial behavior • Close supervision of youth by caseworkers (daily) • Small caseloads (10–12) • Pre-service and in-service training for foster parents • 24-hour a day case worker availability • Relies on a points-based behavior management program for youth in the foster home • Use of treatment team with clearly defined roles • Close monitoring of peer associations
Concurrent Planning	• Assessment of reunification prognosis within 90 days of placement • Development of simultaneous reunification and permanency plans for the child • Placement with caregivers who are willing to adopt but also support the reunification process • Full disclosure to birth parents of the plans and effects of out-of-home care • Frequent parental visits • Timely permanency is the goal • Case conclusions are made based upon observed parental behavior

Table 7. Program Models for Improving Reunification and Decreasing Reentry to Care (cont'd)

Type of Model	Key Components
Court-based Services	• Increased court reviews from 180 days to 90 days
Manatee Model	• For children with emotional and behavioral problems • Case management • Long-term residential services • Placement counseling • Adoption
Assessment and Treatment	• Assessment of relationships to understand importance and dynamics occurs via 15–20 hours of face-to-face contact with child and family members • After assessment, conference is conducted to provide feedback to parents and offer recommendations to the court • Treatment plan is implemented with the primary goal that parents will achieve accountability for the maltreatment of their child • Additional goals are identified and services such as counseling, psychotherapy, medication, and crisis intervention are utilized to meet these goals

Conclusions

Without a body of conclusive research on effective reunification services, it is necessary to examine the entirety of the empirical literature for suggestions on promising practices and common themes. The following practices have been identified from the available empirical literature. None has yet been rigorously evaluated, but all have preliminary support from the existing research and suggest practices that promise to assist reunifying families. These are categorized as pre-reunification services, post-reunification services, strategies to reduce reentry to care, and special programs for unruly children/youth.

Pre-reunification Services

- Assess parental ambivalence about reunification and reunification readiness, using methods similar to those included in the North Carolina Family Assessment Scale for Reunification (NCFAS-R), and address the issues that are identified.
- Prepare a detailed service plan for families.
- Involve parents in case planning and arrange regular contact with the child.
- Schedule regular home visits for the child when possible to insure child's safety.
- Identify family needs and match them with available community services prior to reunification.
- Provide parenting skills training to prepare parents to deal with behavioral difficulties exhibited by the child.
- Develop training programs for workers on how to engage parents.
- Work with parents, children, kinship caregivers, and foster parents to prepare for reunification in a unified and consistent manner.

Reunification Services

- Offer intensive, in-home services with low worker-to-family ratios.
- Match services to client-identified needs for individualized programming.
- Offer multi-component services to address the complex issues presented by family reunification. These would include mental health services for the parents, stress management support, concrete services (e.g., housing, financial, job, and transportation), substance abuse programs, counseling, and homemaker assistance.
- Anticipate family issues and provide preventive services based on pre-reunification assessments of family strengths and needs. Services should be in place at the time of reunification to prevent the need for reentry to care.
- Provide special health care services (e.g., respite care, nurses and aides, and social supports) for children with health needs.
- Provide concrete services in an effort to minimize family stresses.
- Offer different services for families with children in care due to neglect than for families with children in care due to other types of abuse or dependence.

Reducing Reentry to Care

- Use assessment tools, such as NCFAS-R, to determine the appropriateness of and best timing for reunification.
- Identify family factors that have been correlated with reentry and provide specialized services. For example, develop programs for older youth who are reunifying and for parents with infants and young children.

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- Introduce cognitive-behavior programs to deal with child behavior problems and train parents in the use of behavioral parenting methods.
- Maintain reunification services for at least 12 months after reunification.

Special Considerations for Unruly Children

- Work with courts to create expedited review processes.
- Deal with parental ambivalence about reunification with unruly children.
- Provide services similar to the Multidimensional Treatment Foster Care program in Oregon and work with parents and foster parents to implement a consistent behavior management program.

Systematic reviews of the available research may not always provide clear-cut answers as to which programs are the most effective when there is limited rigorous research. But, as is the case in this review, a systematic look at the research can identify gaps in knowledge and suggest a starting point from which to design and evaluate new interventions and programs. This review clearly demonstrates the need for continued research into programs that will foster successful family reunification and decrease the likelihood of reentry to care for abused, neglected, and unruly children. It also suggests that a unitary approach (i.e., a one-size-fits-all program) will not be the best solution.

The existing outcome studies and other empirical work that identify factors associated with successful reunification provide the best starting point for developing reunification services that are tailored to the specific needs of individual families. Future evaluative research on reunification programs can also benefit from overcoming some of the limitations of previous research by using more rigorous research designs that lend themselves to better addressing issues of effectiveness and efficacy. As more rigorous outcome research becomes available, answers to the question “What programs work the best for which families and under what circumstances?” will be more easily attained. Until then, we must use the best available research to guide practice and policies for successfully reunifying families served by the child welfare system.

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The Use of Paraprofessionals in a Prevention Program for Child Maltreatment: History, Practice, and the Need for Better Research

Lynn Rigney, PsyD, and Elissa J. Brown, PhD

Although the peer-reviewed home visiting literature has provided little empirical evidence for the effectiveness of home visiting as a means of reducing the risk of child maltreatment (Gomby, 2000; McGuigan, Katzev, & Pratt, 2003; Sweet & Appelbaum, 2004), hundreds of programs continue to recruit and serve families. Further, 76% of home visiting programs in the United States employ at least some paraprofessionals (Chaffin, 2004; Duggan et al., 2004; Powell, 1993; Wasik & Roberts, 1994) in spite of lack of empirical rationale and support for the use of paraprofessionals within a home visiting treatment modality.

This review presents the historical emergence of paraprofessionals as service providers for the prevention of child maltreatment, and is followed by a summary of the empirical literature on paraprofessionals. We then review the research on home visiting using paraprofessionals. One of the challenges in evaluating this literature is that the majority of studies focus on outcome variables (particularly maternal attributes) instead of the seemingly crucial methodological factors regarding the delivery of services (i.e., internal validity). To address this issue, we highlight the large variability in paraprofessionals' job descriptions, training, supervision, and ability and willingness to adhere to specific protocols. We also present future research ideas with the goal of mobilizing the field to implement studies with clear rationales and associated methodologies, so that we can draw meaningful conclusions about maltreatment prevention programs.

History of the Emergence of Paraprofessionals as Home Visitors

The first large-scale home visiting program occurred in the late nineteenth century when private charity organizations dispatched "friendly visitors" (Weiss, 1993, p. 115) to the homes of the urban poor. The home visitors' assignment was to transform the families' character and behavior and, thereby, to attack the growth of urban poverty, class antagonism, and social disintegration. In the 1890s, more than 4,000 volunteer middle- and upper-class women were regularly visiting poor families in the tenements of major cities to provide guidance and to serve as models of how to "live right" (Weiss, 1993, p. 115). A thorough search of this literature revealed no studies of whether these visits had an impact in preventing the onslaught of poverty and its repercussions.

Home visiting reappeared as a remedy for social disparity during the 1960s when the war on poverty was renewed. Home visits were implemented as a way to connect families to community services that were being offered from state- and federally-funded programs. Although still seen as a bridge to the poor, these "friendly visitors" emphasized a personal and generalist helping relationship based on a less hierarchical, more holistic, and friendlier interaction between participant and professional (Halpern, 1993).

The premise of home visiting programs from the 1960s on changed from its earlier view of improving the character of individuals to an emphasis on the early development of children and the belief that it is necessary to intervene at home with parents to support and improve socialization, health, and education practices (Gomby, Larson, Lewit, & Behrman, 1993; Wasik & Roberts, 1994). Some programs relied on home visits as the exclusive or primary means of intervention, whereas others combined them with additional services, such as early-childhood centers. The level of training and education of these visitors is unclear from the literature (Hiatt, Sampson, & Baird, 1997; Roberts & Wasik, 1990). Many of the paraprofessionals were selected on the basis of their personal characteristics (Daro & Harding, 1993). Program efficacy was not studied.

With the social change of the late 1960s and 1970s came awareness that health service access and delivery were limited for poor, inner-city families (Gartner & Reisman, 1972). Health professionals were viewed as being insensitive to the cultural and economic issues of minorities. Paraprofessionals served as "professional-like" individuals with more "street level" experience (Powell, 1993, p. 25). They brought previously unavailable services to families in settings that were comfortable and convenient. The hiring of paraprofessionals in the 1970s became quite popular in the field of education, health, social services, family planning, drug abuse prevention, urban planning, police work, and corrections (Gartner & Reisman, 1974). In the mental health field, paraprofessionals provided a variety of therapeutic services, from peer counseling to suicide prevention (Tan, 1997).

In addition to improving service access, the training of people from the community to have professional skills was economically sound. Having the opportunity to work as paraprofessionals fulfilled a need for more jobs within the community. Paraprofessionals received less pay than professionals and required less job security (Pearl, 1974).

During the 1980s and 1990s, the services research field emerged. It maintained a focus on overcoming barriers to service delivery and increasing engagement with families (McCroskey & Meezan, 1998). Services researchers highlighted barriers to service access, including transportation difficulties, absence of child care, and distrust of the medical and mental health systems (Hiatt et al., 1997; Wasik & Roberts, 1994). They argued that paraprofessionals who conducted home visits were able to overcome these barriers. Home visitors actively sought out the families they served, rather than waiting for the families to come to a clinic or agency office. Paraprofessionals were perceived as being more connected and streetwise; they had more experience and knowledge of community services and how to negotiate them and, therefore, provided access to families-in-need more efficiently (Klass, 1996). In turn, paraprofessionals were accepted more readily by families than were professionals, particularly by those high-risk families who distrusted professionals and social agencies (Powell, 1993). There were mul-

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tiple additional advantages: home visitors served as links between the communities and families, addressing the issue of isolation that many of these families experienced; home visitors observed the individual needs of each family and helped parents change or improve their parenting skills, or both; and home visitors, if properly trained and supervised, monitored children's safety.

History of Application of Home Visitation to Child Maltreatment

Modern professional concern about child abuse emerged about 40 years ago with a 1962 publication, titled *The Battered Child Syndrome* (Kempe, Silverman, Steele, Droegenmueller, & Silver, 1962). The first author, pediatrician C. Henry Kempe, brought the medical profession into the movement to protect children and, together with other health professionals, formed a coalition to lobby governmental legislature for change. During the 1970s and 1980s, this coalition of professionals helped to enact child protection and mandatory reporting laws and to clearly establish the guidelines and definitions of child maltreatment.

The 1988 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) called for the creation of an advisory board to evaluate the nation's efforts to accomplish the purposes of the CAPTA and to make recommendations (Krugman, 1993). As a result, in 1991, the advisory board recommended a national home visiting program for children during the neonatal period as a strategy for preventing child abuse and neglect. Home visiting models focus on improving family functioning and parenting behavior (Duggan et al., 2004; Eckenrode & Runyan, 2004; Olds et al., 1997; Wasik, Bryant, & Lyons, 1990). Specifically, home visiting programs aim to prevent maltreatment by addressing the proximal targets of child abuse and neglect, including family characteristics such as conflict, social isolation, and socioeconomic stress as well as caregiver characteristics, such as the use of substances and harsh and inconsistent discipline (Grant, Cernst, & Streissguth, 1999; Guterman, 1999; Peterson, Tremblay, Ewigman, & Saldana, 2003).

The CAPTA recommendations did not specify who should be delivering the home visiting services. Many nonprofit agencies throughout the United States—some of whom are affiliated with the National Committee for the Prevention of Child Abuse and National Parent Aide Association—provide home visiting services using paraprofessionals. There was no definitive explanation for the preference for paraprofessionals over professionals found in the literature; however, it has been demonstrated that paraprofessionals work on a lower pay scale than professionals (Family Strengthening Policy Center, 2007).

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Home Visitors: A Complicated Job Description

Home visiting is not a single, specific, uniformly defined service but rather a strategy for service delivery (Powell, 1993). Thus, the home visitor's role is critical. Home visitors are the embodiment of the program for families; they draw families to the program, and they are the vehicles through which the service program is delivered. Home visitors must have a wide range of skills: personal skills to establish rapport with families; organizational skills to deliver the home visiting program, while still responding to family crises that may arise; problem-solving skills to address issues that families present in the moment when they are presented; and cognitive skills to do the paperwork that is required. These are not minimal skills, and there is no substitute for them if service programs are to be successful (Powell, 1993).

Public Health Costs of Home Visiting Programs

Due to ethical, empirical, and financial concerns, maltreatment experts have begun to question the efficacy and effectiveness of home visiting interventions (e.g., Chaffin, 2004). In a review of six home visiting programs, Gomby, Culross, and Behrman (1999) estimated that thousands of home visiting programs existed around the country, together serving over 550,000 families each year. Funding for these programs came from a variety of sources. In 2005, the Education Begins at Home Act (EBAH) was introduced in the U.S. Senate to establish the first federal funding dedicated to early childhood home visitation. The EBAH is a 3-year, 500 million dollar program to help states expand and deliver quality home visiting services. The average annual cost for a family involved with a home visiting program, such as Healthy Families America (HFA), is $3,348, with costs ranging from $1,950 to $5,768. The state-to-state allocations for HFA range from $350,000 to over 40 million dollars (http://www.healthyfamiliesamerica.org/home/index.shtml).

Home Visiting Programs for Child Maltreatment Using Paraprofessionals: Program Descriptions

Most articles on paraprofessionals refer to a review by Durlak (1979) as a seminal article. Durlak examined 42 studies that compared the efficacy of paraprofessionals with professionals, and concluded that paraprofessionals achieved clinical outcomes equal to or significantly better than those obtained by professionals. Additionally, Durlak argued that an effective therapist does not need mental health education, training, or experience. Nevertheless, qualifications such as level and type of education, quantity of training, necessity of certification, and presence/absence of supervision, were not evaluated as mediating/moderating influences on outcome. This analysis is warranted due to the vast differences in the definition of paraprofessionals used by the studies included in the review (Nietzel & Fisher, 1983). In fact, among the 42 studies reviewed, paraprofessionals were drawn from a wide variety of backgrounds, including psychiatric aides, nurses, college students, medical students, community volunteers, occupational therapists, psychiatric aids, adult counselors, public health officers, and speech pathologists (Durlak, 1979).

A number of prevention programs using paraprofessionals have been developed, implemented, and disseminated since the Durlak review. Few of these have focused on the prevention of child

maltreatment. Among those with maltreatment as an intervention goal, Olds' program has the strongest methodology (i.e., large sample sizes, multi-informant assessment, randomized controlled trials) and empirical evidence (Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Olds, Henderson, & Kitzman, 1994; Olds et al., 1997; Olds, Hill, Robinson, Song, & Little, 2000; http://www.evidencebasedprograms.org). In a review of home visiting programs for low-income families at risk for maltreatment, Olds and colleagues (2000) reported that only one study found significant effects for the prevention of child maltreatment (Elmira study; Olds et al., 1986). The Elmira study, in which nurses implemented the program, may have shown significant change because the sample was more severely impaired (i.e., pregnant teens at high risk), community was more limited in resources, and turnover of staff was lower than in other studies (i.e., regression to the mean).

Across multiple studies using professionals (i.e., nurses) and paraprofessionals, Olds' program has resulted in improvements in parenting and child outcomes (e.g., health). In the only trial comparing home visitation by nurses versus paraprofessionals, Olds and colleagues (Korfmacher, O'Brien, Hiatt, & Olds, 1999; Olds, 2002) randomly assigned 735 pregnant women to nurse visits, paraprofessional visits, or assessment-only conditions. Nurses completed more visits and focused more on physical health and parenting, whereas paraprofessionals conducted longer visits and focused more on environmental health and safety (Korfmacher et al., 1999). Nurse visits had greater impact on mothers' smoking and return to employment and on infants' emotional functioning and language development than assessments alone. The paraprofessional visits were not more successful than assessment-only on any of these variables. There were no significant differences on involvement with child welfare across conditions.

Other home visitation programs, using program evaluations, also have found limited (if any) efficacy in the prevention of child abuse and neglect. Despite utilizing sound experimental design of the use of randomized control groups, the variability in components and techniques used, as well as the lack of monitoring of fidelity, are problematic, limiting confidence in findings. The possibility of contamination within the randomized trials was present as well (e.g., St. Pierre, Layzer, Goodson, & Bernstein, 1999). There was an availability of community services to control families that was potentially similar to the treatment program. In addition, friendships developed between control and treatment families, introducing the potential for contamination. These home visiting programs are reviewed next.

The Parents-as-Teachers (PAT; Wagner & Clayton, 1999) program is a psycho-educational program designed to increase parents' knowledge of child development and parents' feelings of competence and confidence, and to develop home-school-community partnerships. The program originally emphasized the first 3 years of life, and it later expanded to target young parents of preschoolers, teenage parents, and parents of children attending child care centers. The demonstration project in Salinas, California, consisted of monthly home visits, starting prenatally or at birth, and was conducted by paraprofessionals with the title of parent educator. Out of the 10 parent educators for this project, 6 had bachelor's degrees. These individuals received one week of training in the program model, emphasizing the provision of age-appropriate information about child development and helping parents develop skills that promote children's intellectual, language, social, and motor skills development (Pfannenstiel & Seltzer, 1989). Recognizing their limitations, the PAT National Center (PAT-NC; Wagner & Clayton, 1999) recommended future hiring of parent educators with professional education and experience in the fields of education, health care, or social work. They also recommended that all parent educators receive one week of pre-service training in delivering the PAT model by trainers certified by PAT-NC staff. The PAT-NC now credentials the parent trainers annually, "contingent upon the local administrating agency's approval of their service to families and their completion of the required 10–20 hours of annual in-service training" (Wagner & Clayton, 1999, p. 180). The service model has undergone numerous changes since its onset and, therefore, requires more training of its parent educators. In 1996, 15 years after its inception, PAT-NC trademarked the "Born to Learn™" curriculum, which incorporates principles of neuroscience (Wagner & Clayton, 1999). We found no assessment of the frequency or quality of supervision included in the program evaluation.

The Home Instruction Program for Preschool Youngsters (HIPPY; Baker, Piotrkowski, & Brooks-Gunn, 1999), developed in 1969 at the National Council of Jewish Women's Research Institute for Innovation in Education of Hebrew University (Baker, Piotrowski, & Brooks-Gunn, 1998) is a 2-year program with a goal of empowering parents with limited formal education to prepare their preschoolers to attend school by fostering parent involvement in the school and community. Although the prevention of maltreatment is not stated directly in the program's goals, the research includes both parent and child outcome studies. HIPPY paraprofessionals were recruited from the parents' neighborhoods. Baker and colleagues thought that these paraprofessionals would be better able to deliver the program material in a manner consistent with the lifestyles and cultural systems of families, which, in turn, would encourage the families to learn and use the skills that were taught. Descriptive statistics of the paraprofessionals' background could not be found in any of the early demonstrations of the projects; in the 1999 program evaluation description, Baker et al. stated, "Some [of the paraprofessionals] had high school degrees, but few had any college experience" (p. 120). Paraprofessionals are described as having "…intensive, initial training and ongoing weekly training" (p. 193); however, no specific data on training are provided. Baker and colleagues argued that lack of training was balanced by having at each site a professional coordinator, who was "…typically an individual with a background in early childhood education, social work, or social service administration" (p. 120). The developers also did not delineate supervision methods and monitoring of integrity.

Hawaii's Healthy Start Program (HHSP) is a child abuse prevention program with the goal of helping at-risk families by teaching parenting skills that promote children's healthy development (Duggan et al., 1999). The program model is based on Henry Kempe's (1976) lay therapy program and the work of Selma Fraiberg (1980). The two primary components of this program have remained unchanged from its earlier prototypes: (1) the early identification (EID) of families with newborns at risk for child abuse and neglect, and (2)

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home visiting by trained paraprofessionals. "EID workers" (Duggan et al., 1999) screened medical records for at-risk families; no credentials of these workers were specified. Once families were identified and invited to participate in the program, home visitors were assigned to the families. These visitors were "…trained paraprofessionals recruited from the community, with qualities essential for working with vulnerable families: warmth, self-assurance, cultural sensitivity, and good parenting skills" (p. 68). Measurement of these characteristics was not described in the program evaluation. Upon the examination of the limitations of the pilot study, HHSP hired public health nurses and professional supervisors "…with formal training and experience in early childhood education, social work, or nursing" (p. 69) to direct the sites.

Healthy Families America (HFA; Daro & Harding, 1999) an extension of HHSP, was launched in 1992 by the organization Prevent Child Abuse America, whose main goals are to promote positive parenting and to prevent child abuse and neglect. Guided by the Hawaii Healthy Start Program, HFA focuses on enhancing parent-child interactions, fostering children's development, and improving family functioning in areas such as problem solving, social support, and use of community resources. Home visitors are hired based on their ability to engage families and establish trusting relationships; personal characteristics are considered to have more importance than level of education (Daro & Harding, 1999). None of these traits is formally assessed. Most HFA home visitors (82%) have attended or graduated from college, specializing in child development, social work, nursing, or education. HFA home visitors receive intensive, didactic training specific to their roles and receive ongoing supervision (of no specified frequency or intensity) to effectively assist families and "protect themselves from stress-related burnout" (p. 156).

The Comprehensive Child Development Program (CCDP; St. Pierre & Layzer, 1999) offers case management by home visitors for low-income children and their parents to enhance the social, emotional, and intellectual level of children and self-sufficiency of the families. The paraprofessionals who were hired initially had "life experiences…similar to those of the program's families" and "some familiarity with parenting, but very limited post-high school education" (p. 137). Reportedly, the severity of family crises hindered paraprofessionals' ability to engage families and implement the program, resulting in a new requirement of post-high-school education and training for the position. In addition, a management information system was put in place to help monitor the service provision and identify technical assistance needs.

Results From Child Maltreatment Programs Using Paraprofessionals: Lack of Internal Validity

An adequate evaluation of any intervention requires a clear description of each component (e.g., assessment tools, therapists, material provided to families, supervision methods) and consistent implementation of each component across participants (i.e., treatment integrity). Although the aforementioned home visiting programs may be theoretically strong and clinically informed, the methodological variability within and across programs is striking. Job requirements and the frequency and intensity of training and supervision of paraprofessionals differ across studies. In most studies, paraprofessionals were asked to provide support and information; techniques used (e.g., behavioral rehearsal, modeling) were unspecified. These programs also lack assessment of integrity to treatment protocols, particularly process and content of treatment delivery, yielding results that may be biased and inaccurate (Lichstein, Riedel, & Grieve, 1994). Thus, we cannot be sure whether the inability of these programs to prevent child abuse and neglect is due to the content of the programs or the method of implementation (i.e., use of paraprofessionals).

Among the many inconsistencies across home visiting prevention programs are the definitions of paraprofessionals. Lacking any standardized credentials or licensing, home visitors often are hired based on personal attributes thought to contribute to an effective helping relationship (Wallach & Lister, 1995). In a national survey of home visitation programs (Wasik, 1993), staff identified maturity, warmth, empathy, and a nonjudgmental orientation as essential home visitor attributes. HHSP (Duggan et al., 1999) defined paraprofessionals as "individuals from the community with qualities essential for working with vulnerable families: warmth, self-assurance, cultural sensitivity, and good parenting skills" (p. 68). CCDP defined paraprofessionals as individuals from the local community who have life experience with and report knowledge of parenting (St. Pierre & Layzer, 1999). For HFA (Daro & Harding, 1999), paraprofessionals were described as service providers selected on the basis of their ability to demonstrate a combination of personal characteristics, such as compassion, ability to establish a trusting relationship and empathy, and knowledge base. In PAT (Wagner & Clayton, 1999), paraprofessionals (i.e., parent educators) selected were an ethnically diverse group, mostly female, ranging in age from 22 to 60 years, with between 1 and 12 years of home visiting experience" (Wagner, Spiker, & Linn, 2002, p. 5).

Professional qualifications also differ among prevention programs. A home visiting survey found that 40% of programs serving low-income families required a bachelor's degree, whereas 60% did not (Roberts & Wasik, 1990). HHSP paraprofessionals (Duggan et al., 1999) were required to have at least a bachelor's degree. CCDP paraprofessionals were required to have a high school diploma (St. Pierre & Layzer, 1999). In the initial phase of its program, HFA paraprofessionals were described as having a wide range of education, experience, and expertise, from postundergraduate training to less than a high school diploma (Daro & Harding, 1999). PAT paraprofessionals had associate, bachelor, or advanced degrees.

There is also considerable variability with regard to the training and ongoing supervision of paraprofessionals. HHSP paraprofessionals received one week of pre-service training and ongoing supervision with a professional in a child-related field (e.g., nurse, social worker) and 30 hours of in-service training (Duggan et al., 1999). Following problems with paraprofessionals who received minimal training, HFA developers recommended one week of pre-service training, one day of continuing education each quarter, and 80 hours of additional training in the first 6 months (Gomby et al., 1999). PAT paraprofessionals received one week of pre-service training, one additional day of training during the first 6 months of work, 20 hours of in-service training, and opportunities for other trainings. CCDP paraprofessionals participated in extensive in-service training on conducting needs assessments, accessing services, and maintaining confidentiality (St. Pierre & Layzer, 1999). The

only program that incorporated ongoing supervision was HIPPY. HIPPY paraprofessionals received pre-service training in the HIPPY program plus weekly ongoing supervision.

Definitions and professional qualifications of paraprofessionals vary across home visiting programs, from individuals with high school equivalency to those with master's degrees in social work or early childhood education. Titles of the home visiting paraprofessionals include parent educators, case managers, and EID workers. Supervisors' credentials range from public health nursing degrees to experienced home visitors with associate or bachelor's degree. Training and supervision vary from one week of pre-training to "…training in areas such as conducting needs assessment, accessing services, and maintaining confidentiality" (St. Pierre & Layzer, 1999, p. 137). Given the diversity of personal qualifications, it is problematic that these constructs are not measured in any standardized manner that would allow for assessment of whether these attributes affect program retention and outcomes (McGuigan et al., 2003).

Efficacy of Use of Paraprofessionals

In two recent systematic reviews of the literature, differences in the measurement of decreased maltreatment of children are presented comparing paraprofessional and professional delivery of services. The Centers for Disease Control and Prevention (2003) found that the rate of maltreatment decreased when professionals conducted home visitation. In contrast, Sweet and Applebaum (2004) found that the impact was greater for programs staffed by paraprofessionals targeting at-risk families and focusing on child abuse prevention. That said, overall, neither direct measures of child abuse nor caregiver indicators of child abuse yielded average effect sizes significantly greater than zero.

More recent studies have compared the efficacy of paraprofessionals versus professionals for several mental health problems, including depression, substance abuse, and externalizing behaviors. Weisz and colleagues (Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995) conducted two meta-analyses and found differential effects for professional and paraprofessionals treating children on the basis of diagnostic category. Specifically, professionals were more efficacious with internalizing disorders, whereas paraprofessionals were more effective with externalizing disorders. In an updated meta-analysis of treatment outcome studies, Stein and Lambert (1995) found that level of training was a significant moderator of therapy outcome; well-trained therapists experienced fewer dropouts than less well-trained therapists, especially in outpatient settings. Kendall, Reber, McLeer, Epps, and Ronan (1990) found similar results favoring professional experience in the use of manualized interventions with conduct-disordered children (cf., Tan, 1997). Researchers compared the impact of 20 individual sessions of cognitive-behavioral therapy (CBT) with those receiving supportive/psychodynamic therapy in a day-hospital setting while using a crossover design. Greater therapist experience providing CBT was associated with more symptom reduction.

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Experiential Critique of Paraprofessionals

Experts have identified a number of limitations to the use of paraprofessionals, particularly when they are hired from the same community as those families who are serviced (Halpern, 1992). According to Halpern, "lay" workers are often still wrestling with the choices, issues, and problems they are to address with the families they visit. Korfmacher et al. (1999) have found that because paraprofessionals often have their own histories of housing problems, domestic violence, and substance abuse, they are unable to maintain a professional distance from their clients. Paraprofessionals may be unable to reconcile their own beliefs, experiences, and feelings in key areas with the demands of their helping role. As a result, supervisors reportedly spend a significant amount of time addressing counter-transference issues (Korfmacher et al., 1999).

When lay workers develop close connections with the families they work with, there can be negative consequences as well as beneficial ones, especially in small, closely-knit communities such as Mexican-American families. In the Migrant Project (Halpern, 1992), the home visitors lived in the same migrant labor camps as the program participants, and sometimes they found themselves players in the same family and community dramas. On one or two occasions, family feuds even forced individual home visitors to stop working with certain clients.

Another limitation relates to the closeness paraprofessionals develop with their families. Although paraprofessionals are hired specifically because they are thought to have the ability to build trust and rapport, the boundaries between the families and paraprofessionals often become blurred. Without proper supervision, many workers foster dependence with their families, preventing families from doing for themselves. They often became overinvolved with particular families, at times continuing to provide direct assistance rather than encouraging families to do for themselves when they are able. Overprotectiveness can pose serious problems if it results in reluctance to make referrals to other providers (Halpern, 1992). In a randomized trial of a multi-site HHSP home visiting program to prevent child abuse, Duggan et al. (2004) indicated that the home visitors often failed to recognize parental risks and seldom linked families with community resources. Further, the researchers found HHSP training programs to be underdeveloped in preparing staff to address risks and to link families with community resources.

The relatively limited training of paraprofessionals (i.e., lack of an advanced degree) also may result in lack of preparation for the complex issues experienced by families at risk for maltreatment. In an examination of home visiting programs, Gomby (2007) found that home visitors felt ill-prepared to address crises they might encounter and were not always willing or able to identify and respond

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to maternal depression, domestic violence, and substance abuse, the very risk factors that must be addressed to prevent child abuse and neglect. They also may have difficulty collaborating with team members who are established professionals (St. Pierre & Layzer, 1999). In a rare empirical examination of attributes associated with retention in a home visiting child abuse prevention program, McGuigan et al. (2003) found that giving staff more hours of supervision was associated with increased retention rates of “at risk” families. Not surprisingly, following initial implementation, some of the aforementioned programs have increased paraprofessionals’ job requirements.

Many paraprofessionals experienced difficulty in adapting to the professional environment in terms of time management, organization, and workplace social skills (Korfmacher et al., 1999). This factor may have both affected their ability to implement the intervention and contributed to the high rate of paraprofessional staff turnover. It is likely that this turnover also made it more difficult for families and paraprofessional visitors to form strong working alliances, which was the hypothesized value of using paraprofessionals.

The delivery of the intervention protocol is another area of concern. Paraprofessionals have not been sufficiently monitored with regard to fidelity of the proposed protocol. Programs that have examined the way paraprofessionals have administered the interventions have found that paraprofessionals may be uncomfortable promoting certain messages or intervening to address beliefs that contradict program messages when those are beliefs that they themselves still hold, such as the belief that one can spoil an infant by responding immediately to any bids for attention (Halpern, 1993).

An alternative explanation of findings is that home visiting is a model of service delivery, not an intervention in and of itself. In an invited commentary on the state of home visiting research, Gomby (2007) argued that home visiting as a mode of service delivery is associated with modest improvements in children’s cognitive development, behavior, and home environment, but not in maltreatment or risk for maltreatment. Based on extant research, Gomby concluded that program content, not method, drives program results.

Program content needs to be standardized (through manuals) and monitored (through integrity). Duggan and Caldera (Duggan et al., 2007) enrolled 325 families in a total of six HFA-Alaska sites, for which the program manual included descriptions of the home visitors’ responsibilities and curricula. To ensure integrity, an evaluation and self-evaluation of home visitors was conducted. They found that the degree of program success was associated with integrity to program content and goals measured using standard, consistent procedures. In turn, paraprofessionals’ training and ongoing supervision were related to integrity. That said, no overall effects were found for maltreatment prevention.

If the research shows that paraprofessionals require many hours of supervision by professionals to be more effective in retaining families and maintaining fidelity with implementation of the protocols, are paraprofessionals still the economically wiser choice? Programs that hire professionals, such as the Nurse-Family Partnership program (Olds et al., 1986), cost significantly more than programs that use paraprofessionals (e.g., HIPPY). In a cost-benefit analysis, the Family Strengthening Policy Center (2007) argued that the Nurse-Family Partnership saves the general public $17,180 per family due to fewer child protective services calls, fewer experiences with the justice system, and higher income for (and tax revenues from) caregivers. In contrast, HIPPY saves $1,476 per family. The benefits derived from the HIPPY program result from an increase of earnings and tax revenue among children served.

Remaining Research Questions

With the larger goal of establishing efficacious and effective prevention programs for child maltreatment, preventive scientists (e.g., Olds et al., 2000) encourage the field to expand its study of home visitors and to develop comprehensively designed programs staffed by paraprofessionals and professionals. Paraprofessionals are likely to be assets to prevention treatment programs, given the logic that the initial rapport with families may be easier when people share a common sense of community. Paraprofessionals may be better suited for certain portions of the preventative services, such as recruitment and retention. Nevertheless, assumptions that similarities in culture and ethnicity between paraprofessionals and families facilitate the delivery of the intervention need to be tested empirically. Measures of the constructs associated with some of the aforementioned challenges need to be developed (LeCroy & Whitaker, 2005). Given the minimum-to-moderate level of success of home visiting programs at this point, it behooves researchers to examine the effectiveness and efficacy of the ways in which services are being delivered. Remaining research questions include the following:

1. What are the professional (e.g., level of education, prior experience in mental health settings) and personal (e.g., maturity, empathy, good communication skills) qualifications necessary for home visitors?
2. What are the type and amount of training and ongoing supervision needed for home visitors?
3. Are there differences between paraprofessionals and professionals in their ability to engage and retain families?
4. Are there differences between paraprofessionals and professionals in their ability to assess risk and safety?5. What are the rates of maintaining integrity to established intervention protocols for paraprofessionals and professionals?

5. What are the rates of maintaining integrity to established intervention protocols for paraprofessionals and professionals?
6. Are there differences between paraprofessionals and professionals in their ability to identify and mobilize wraparound services?
7. What are the evidence-based preventive interventions for child maltreatment?
8. What are the relative outcomes achieved by paraprofessionals versus professionals?
9. What are the families' satisfaction ratings when served by para professionals versus professionals?
10. What is the cost-benefit ratio (e.g., salaries, cost and intensity of training, outcomes) of using paraprofessionals versus professionals?
11. Can enough paraprofessionals with the aforementioned characteristics be recruited, hired, trained, and retained in the home visitor role?

Conclusion

The use of home visitation as a preventive intervention continues to be under debate. Extant research is critical of the effectiveness of home visitation (Chaffin, 2004); nevertheless, a robust conclusion about the role of paraprofessionals is limited by lack of internal validity of the published studies. There is no cross-program consistency in hiring, training, and supervision practices; administration of intervention protocols; and measurement of outcomes. As a result, little is known about retention and efficacy. If we identify evidence-based prevention practices and training models, perhaps paraprofessionals are the cost-effective choice.

Based on this literature review, it remains unclear what role, if any, paraprofessionals should have in home-based programs to prevent child abuse and neglect. So, why should we continue to explore their utility? Given the era of high health insurance costs, limited mental health coverage, and cuts in public programs, the economic benefit of using paraprofessionals is compelling. In fact, the cost savings may motivate local, state, and federal agencies to fund the proposed empirical examination. Perhaps advocates for the prevention of child maltreatment need to better inform those in public office of the aforementioned limitations and needed research agenda.

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Southwest Ohio Early Learning Collaborative: Promoting Mental Health Wellness for Children Ages Birth to Six

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Family and community violence, child abuse, and emotional maltreatment are taking a toll on young children. More and more children participating in early learning programs are struggling with the lasting effects of these experiences. The Ohio Department of Mental Health has estimated that between 7% and 20% of preschool and early school-age children have behavior disorders that qualify for a mental health diagnosis. Children who are identified as *hard to manage* at ages 3 and 4 have a 50% chance of continued difficulties in adolescence and adulthood.

The Early Learning programs of Butler, Clermont, Hamilton, and Warren Counties represent over 5,000 at-risk children and their families in Southwest Ohio. This group formed the Southwest Ohio Early Learning Collaborative in 2006 to more aggressively learn about appropriate responses and treatment for these children and their families; to collect data to better understand the prevalence of these issues in Southwest Ohio; and to develop the funding, partnerships, and resources that would allow members to offer appropriate responses and treatment within their preschool programs. Representatives of these programs have shared their observations and concerns about the increasing numbers of preschool-aged children with significant emotional and behavioral issues, and their conclusion that the scope of the needs exceeds the resources available to address them.

Research

In 2006, the newly-formed Southwest Ohio Early Learning Collaborative conducted a pilot study to assess the prevalence of young children with challenging behaviors in Southwest Ohio. This rigorous, randomized study selected children from the eligible preschools in four county Head Start and Early Learning Initiative (ELI)-funded programs. Trained interviewers collected data on the children, which were provided by the children's teachers and parents. The study design was selected collaboratively by the counties' early childhood stakeholders (coordinators of special services for students, directors, school psychologists, and teachers), and The Childhood Trust and Child and Adolescent Psychiatry, divisions of Cincinnati Children's Hospital Medical Center. The major topic areas of this study were children's exposure to traumatic life events and victimization, their emotional and behavioral development, and family sociodemographic information. The study sought to understand the underlying reasons and potential causes for the increase in children's disruptive and potentially debilitative behaviors.

Standardized measures were completed by parents and early childhood education teachers and included the following: CCHMC's *Childhood Trust Events Survey* (CTES) (Baker, Boat, Grinvlasky, & Geracioti, 1998); the *Child Dissociative Checklist* (CDC) (Putnam, Helmers, & Trickett, 1993); and the *Child Behavior Checklist* (CBCL 1½–5 years of age) (Achenbach & Rescola, 2000). Data were collected on 141 children in late Spring 2006. A brief summary of the results included the following:

- Children in these preschool programs had a high level of exposure (28%) to child victimization and family violence.
- There was an increased level of symptoms of psychopathology among the children with increased (cumulative) exposure to traumatic life events—specifically four or more events (19%).
- There was a significantly high level of psychopathology (dissociation) among children exposed to specific types of child victimization, including witnessing family violence (prevalence 21%), emotional maltreatment (prevalence 16%), and sexual abuse (prevalence 4%).
- There were significantly higher scores across most CBCL behavioral dimensions among those exposed to sexual abuse (4% of the population sampled). (Sites, 2008)

The study identified one possible explanation for the high prevalence of emotional-behavioral issues that preschool teachers had witnessed, but the origins of which the teachers had not fully understood. The findings also narrowed the profile of at-risk children generally and highlighted the profile of those at highest risk: those children exposed to family violence, emotional maltreatment, and sexual abuse as well as 19% of children exposed to four or more serious traumatic events before age 5. Because of limited state, local, and federal resources and funding for early childhood programs, collaborative members agreed that having a clearer profile of the most at-risk children was a priority.

The study results also highlighted and described the early childhood mental health and behavioral issues for which teachers and parents needed help in understanding and treating: affect regulation problems, anxiety, depression, oppositional defiance, somatic complaints, aggression, and dissociation. The dramatic findings pointed to the need to identify at-risk children early and to provide trauma-informed services in schools, homes, and across the community. The research findings were clear that increased dissociation in children predicts longer-term emotional and behavioral problems.

The standardized instruments chosen for the study were found to be culturally sensitive, effective as child behavioral health screens, and research-based. This opened the possibility of including these types of instruments in traditional assessments of future young children entering early childhood programs. Most important, the study results strongly highlighted the need for the infusion of mental health and child welfare practices and services in early childhood, family friendly, natural settings, where the children spend a considerable amount of their time each day.

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Action Plan: 2007–2008 School Year

The study findings and the efforts of the Southwest Ohio Early Learning Collaborative built a momentum that transformed the research findings into action plans. The Collaborative quickly met to establish future action goals that included the following:

- Build mental health intervention capacity into early learning programs and children's homes.
- Promote evidence-based models that support the development of positive socio-emotional skills and mental health resilience in children.
- Develop funding models.
- Establish alliances and partnerships with providers of early childhood services.
- Create an integrated system of services for early childhood mental health.
- Provide training in prevention and treatment for teachers and parents to establish better sharing of resources and information networks.

In the 2007–2008 school year, each of the four counties identified a "best practice program" to initiate in chosen pilot classrooms. These projects offered a way to pilot nationally recognized successful intervention and prevention models that have been found to promote mental health wellness in early learning programs. Although the models varied in their approaches, they all included the following components: on-site mental health intervention in the preschool classrooms; parent and teacher training and support; evidence-based assessment tools and strategies; collection of outcome data; and professional development on the impact of violence and trauma on child development.

The hope was that the outcome data collected in the spring of 2008 would show positive changes in young children's social and emotional skills and improved resiliency and coping skills. In addition, it was anticipated that the pilot programs would highlight the infrastructure and building blocks necessary to integrate mental health interventions into preschool classrooms. This required examination of the system changes that were necessary to accomplish the operation of the new programs as well as changes in the preschool teachers' perspectives and skill levels when using mental health interventions with young students. A brief summary of the results of each county's pilot programs follows.

Results: 2008

Warren County, Ohio

The Warren County Community Services Early Learning Center selected two Early Learning Initiative (ELI) classes, each operating full-day and full-year programs and together serving 40 children, to pilot their mental health intervention model in the 2007–2008 school year. These classrooms were selected due to a high incidence of observable behavior concerns, specifically children with violent behaviors. The children and their families were surveyed to assess risk factors using CCHMC's *The Childhood Trust Events Survey*. Over 60% of the children in the target classroom had experienced two or more traumatic events before age 5 (compared with the 2006 random sample study, where 49% had experienced two or more traumatic events). The *Child Dissociative Checklist* was used to assess psychopathological behaviors in the target group of children. Fifty percent of the identified pilot classroom children scored above the subclinical threshold score (6) on this dissociative screening instrument (compared with 26% above the subclinical threshold score for the 141 children in the 2006 study).

Warren County partnered with the Warren County Mental Health and Recovery Centers (WCMHRC) to develop an intervention model that provided intensive on-site mental health consultation and that would serve high-risk children with an on-site licensed early childhood mental health therapist. The mental health consultant supported and trained the teaching staff and parents, and the mental health therapist provided individual therapy to children while they attended class. The teaching staff in the two pilot classrooms received 3 days of training on implementing the *Devereux Early Childhood Assessment* (DECA; Kaplan Early Learning Company at: www.kaplanco.com), using classroom guidelines, materials, and strategies to promote children's self-control, initiative, and attachment. Children with two or more protective factors scoring in the *concern* category on the DECA were referred for individual therapy (23 children). The DECA-C (a clinical assessment used for better assessment and diagnosis) was used with the 23 children to identify areas for specific clinical intervention by the trained mental health therapist. These children (58% of the total) received weekly on-site individual therapy, family counseling, the DECA classroom intervention strategies, and the mental health consultant's support for the teachers.

DECA songs and stories were used daily to support the development of attachment, initiative, and self-control. Children used "self-talk" and language from the DECA *Songs of Resilience* (Devereux Early Childhood Initiative at: www.kaplanco.com), such as "Stop and Think" and "I Can Do It," throughout the day during play activities with friends. Daily lessons included activities planned to encourage cooperation, communication, problem solving, and self-regulation. Parent involvement was supported through encouraging their participation in pre- and post-assessments of their children's behavior (80% success rate), training and support of home-based DECA activities and songs, and individual consultation for the 58% whose children received weekly private therapy at school.

The DECA pretest and posttest results in Warren County found a 23% decrease in behavioral concerns for the pilot intervention population of children and a 100% increase in the number of children possessing *areas of strength* (i.e., initiative, attachment, and self-control).

Warren County Early Learning Collaborative Pilot Program 2008 Results

	DECA pretest	DECA posttest
Behavior Concerns	40%	31%
Areas of strength: initiative, attachment, and self-control	20%	40%

Equally impressive was the increase in the number of children identified and served with individual mental health services. In the 2006–2007 school year, that number was 7, compared with 23 for the 2007–2008 school year. In the latter year, 10 out of the 40 children served in the intervention classrooms were identified as needing a "higher level of care" and were referred for additional mental health treatment, with 5 of these children (13% of the total) referred and treated by child psychiatrists.

Clermont County, Ohio

In Clermont County, Child Focus, Inc. administers the county's Head Start and ELI programs as well as mental health services for children ages birth–18 years in this county. Its new mental health pilot program for the 2007–2008 school year was called Child Focus Early Childhood Mental Health Best Practices (MHBP). Four classrooms were randomly chosen for the MHBP project, and these were matched with four comparison classrooms without the MHBP resources and training. Every child in the MHBP classrooms was assessed on a pre-session and post-session basis by teachers and parents using the DECA. This instrument was not used on the comparison classrooms because this process is part of the awareness training imbedded in the DECA program and would have biased the outcomes. In addition to the DECA curriculum and assessments, the pilot programs received the following resources:

- Pilot classroom teachers, their regional coordinators, and two mental health intervention specialists (licensed therapists) attended a 2-day DECA training.
- The pilot classroom teaching staff and the mental health intervention staff had weekly meetings to discuss intervention strategies used for the classroom as a whole and for individual treatment of children experiencing problems.
- A monthly "social-emotional wellness" newsletter was developed by the mental health intervention staff and was sent to parents and teachers.
- The pilot classroom teaching staff had access to the mental health intervention lending library to supplement and boost their parent and classroom activities.
- The pilot classroom parents and guardians were treated to a "kick-off" event in October 2007 to introduce the pilot project to parents. They were treated to a performance by David Kisor, the artist who created the DECA *Songs of Resilience* (CD). Thirty-six parents/guardians and their children attended (75% of the parents/guardians in the pilot project).

The Clermont County MHBP project used the *Early Childhood Environmental Rating Scale–Revised* (ECERS–R; Harms, Clifford, & Cryer, 1998) at the beginning of the school year to rate the pilot and comparison classrooms on the following dimensions: space and furnishings, personal care, use of reasoning language, child activities, staff-child interactions, program structure, and parent-staff communication. No significant differences on these measures were found.

Clermont County also piloted an *Early Childhood Mental Health Teacher Survey* that was originally developed by Child Focus, Inc. and revised in 2007–2008 by the Southwest Ohio Early Learning Collaborative. This short scale is an attempt to judge preschool teachers' knowledge and comfort level, as well as the barriers to

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implementation related to integrating a social-emotional curriculum into preschool activities and interactions with parents and children. A summary of the findings of this survey follows:

- Pilot teachers were 30% more comfortable providing social, emotional, and behavioral interventions in their classrooms.
- Pilot teachers felt 11% more knowledgeable about providing social, emotional, and behavioral interventions in their classrooms.
- Pilot teachers were 50% more capable of identifying four or more social, emotional, or behavioral activities to use in their classrooms.

On the Clermont County MHBP classrooms' pre- and postadministration of the DECA, 49 children received the pre-assessment (both parent and teacher ratings), and 38 (78%) children completed the project and received the post-assessment from parents and teachers. Areas of social and emotional wellness that were assessed included initiative, self-control, attachment, and behavioral concerns. According to the pilot teachers' assessments, 24 of the children in the pilot projects (63%) made significant behavioral changes in one or more of the DECA categories. According to the parents in the pilot projects, 47% of their children made significant behavioral changes on one or more of the DECA categories as assessed by the DECA and observed in their homes.

Hamilton County, Ohio

The Hamilton County Education Service Center Early Learning Program pilot mental health project used the DECA training, curriculum, and assessment system (e-DECA) in two pilot ELI classrooms. Two pilot teachers, their field supervisors, and the mental health consultant for the agency received 2 days of training on the e-DECA. Both teachers and parents completed pre- and post-DECA surveys for the children. The teachers met bimonthly with their supervisor and the mental health consultant to review the status of children and to discuss both classroom activities and specific intervention strategies for children exhibiting behavior difficulties. Two classrooms were chosen to participate as a comparison group. They used the DECA surveys to assess children but did not implement any particular DECA strategies or curriculum. The data from this pilot reflect trends that will impact a framework for future mental health services in this agency.

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The pre- and post-DECA assessments completed by teachers for the 28 children enrolled and maintained in the pilot classrooms showed the following results:

- 46% of the 26 children showed significant improvement in one or more of the DECA categories.
- Only 4% (1) of these children demonstrated a significant loss of skills in one or more DECA categories.

The results of teacher-completed pre- and post-DECA assessments on the 23 children enrolled and maintained in the comparison classrooms included the following:

- 61% (14) of the 23 children showed significant improvement in one or more DECA categories.
- 17% (4) of these children demonstrated significant loss of skills in one or more DECA categories.

These results might suggest that DECA provided more prevention of declining (problematic) child behaviors than intervention and improvement of positive social-emotional behaviors. Parent participation was problematic, and few parents completed the post-survey at the end of the year. The teachers also had problems with the e-DECA Web site (i.e., not functioning at times). Hamilton County ESC completed a teacher feedback survey on a post-intervention basis and noted that the pilot classroom teachers were more confident in their knowledge of how to incorporate social and emotional activities in their classrooms, particularly in regard to DECA child resiliency and protective skills.

Butler County, Ohio

Butler County's Early Learning Program chose to pilot Incredible Years training for children. This program is recommended for populations of preschool children who have exhibited the early onset of conduct problems. Children were given training by a licensed mental health therapist who had received certification from the Incredible Years training center in Seattle, Washington (www.incredibleyears.com). This program has been selected by the U.S. Office of Juvenile Justice and Delinquency Prevention as one of the "Blue Print Programs" and as an effective early violence prevention program.

The Dinosaur Curriculum in the Incredible Years program emphasizes training preschool children with conduct disorders in skills such as emotional literacy, empathy, perspective taking, friendship skills, anger management, interpersonal problem solving, and school rules for success. It is designed for use as a "pull-out" treatment program for small groups of children with behavioral conduct problems. After first securing parental consent for participation in the program, administrators sent weekly homework and parent letters to families. Two classrooms received this intervention program.

A community mental health therapist, who was trained in the Dinosaur Curriculum, conducted once-a-week, 40–50-minute small group work for children who were identified by teachers and the school psychologist as having potential conduct disorders. A total of 27 children in two centers (with multiple classrooms) were selected for the small group activities. Group size was approximately 6 children per session. A total of 18 children stayed engaged for the 10-week program. The identified target children received pre- and post-DECA-C assessments (a clinical diagnostic version of the DECA used in the other counties.)

Results on the DECA-C administered to the 18 fully engaged children in the Dinosaur Curricula were as follows:

- 17 children (94%) made clinically significant positive changes in one or more of the seven subcategories (initiative, self-control, attachment, withdrawal/depression, emotional control, attention problems, and aggression).
- 9 children (50%) demonstrated significant change in three or more subcategories.
- 3 children (17%) were identified for special needs and/or special education support from the local schools in cooperation with the Head Start program.
- 3 children (17%) required referrals for additional mental health support from the community.

These data led the Butler County Early Learning Program to continue and expand the Incredible Learning program to more children in the 2008–2009 school year. Also, professionals plan to include the full Training for Parents component along with the Dinosaur Curriculum offered by Incredible Years for children. The identification of the six children who required additional community support at a more specialized level of care was seen as a positive prevention outcome of the project.

Summary

The Southwest Ohio Early Learning Collaborative is well on its way to accomplishing its major goal to build mental health intervention into early learning centers and to promote mental health wellness for the preschoolers in their care. By forming this collaborative of concerned community professionals, the Collaborative has moved from initial surveys, screenings, and data collection to specific "first step" action plans in its communities to accomplish its goal. This group represents over 5,000 at-risk children and their families in Southwest Ohio.

Persistent advocacy, the collection of strong data, and the awareness campaigns directed toward mental health providers in their counties led to the building of alliances and partnerships with county mental health providers. Better trained teaching staff and school

psychologists led to better identification of children who needed social-emotional and behavioral help and support. This included children who needed a higher level of care to remain in their early childhood programs and to be effectively served.

The Collaborative built preschool mental health intervention capacity by piloting evidence-based models in their classrooms and in parents' homes that supported positive socio-emotional skills and mental health resilience in children. The outcomes of the initial pilot programs highlighted agency system changes that needed to be addressed to achieve their goals. Staff turnover, transient families, the need for mental health therapists to accommodate preschool schedules (naptime, mealtimes, outside playtimes, etc.), funding problems, and weekly staff schedule restraints were just a few of the barriers highlighted. The attitudes of parents and teachers and their acceptance of mental health assistance were not barriers, as both embraced the idea and activities. All programs wanted to enhance the in-home outreach and support activities for parents in future program efforts.

Warren, Butler, Clermont, and Hamilton Counties' Early Learning Programs now have increased the presence of on-site services provided by mental health therapists in their programs for the 2008–2009 school year. This alone is a remarkable achievement. Previously, with the exception of the specialized services offered by the Therapeutic Interagency Preschool programs (programs for children with serious maltreatment histories) in collaboration with CCHMC's Child and Adolescent Psychiatry Division (Sites, Wade, & Putnam, 2007) in three of the counties, no on-site mental health therapists offered school- and home-based services through these programs. Directors of the local mental health boards were presented with the data collected from the 2006 study and responded by saying they did not have personnel who were trained in early childhood mental health available to address the need of the early childhood programs. In addition, the mental health board directors reported that early childhood programs were competing with a growing demand for mental health services for the elderly. Yet, the momentum of the collaborative was sustained, and all four counties now have between one and four full-time therapists providing on-site mental health services that include prevention, consultation, and therapy. These newly developed resources, in addition to the expansion and use of the evidence-based models such as Incredible Years and DECA, put the Southwest Ohio Collaborative strongly on the path of promoting mental health wellness for children and families in their programs.

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MESSAGE FROM THE PRESIDENT

Dear Colleagues,

I'm sure it's an understatement, but 2008 has been quite a ride, and 2009 is looking to be very similar—that is, if all the pundits, prognosticators, and economic analysts are correct. From my perspective, most of them are wrong in their predictions, projections, and speculations about half the time, so with that history, I choose to look at the glass as half full rather than half empty. I know times are tough, but I believe in the resilience of this country.

I also believe in the commitment and resilience of APSAC members to confront the challenges ahead. As President of APSAC, I've had the privilege of meeting many wonderful people and have developed some great friendships. Many of these dedicated professionals toiled long and hard to guide APSAC through very difficult times. Without them and their dedication and commitment, APSAC may not have survived. But, they had a vision about serving professionals and increasing the competence of those who work with abused and neglected children and their families. That vision is apparent today through our Colloquiums, Clinics, Institutes, and Regional Trainings. APSAC also participates in the National Child Abuse Coalition, contributing to improved federal policies related to children, more comprehensive legislation, and increased funding for children's services, including those for children who are abused and neglected. Out of adversity a strong vibrant organization has emerged.

I've heard many of my friends and colleagues say they have "never seen it this bad," particularly economically. I grew up during the post-World War II boom listening to my parents and grandparents talk about the Great Depression and deprivations they suffered. I recall the gas rationing of the mid-1970s during the Carter White House years. While I'm told that what we are experiencing doesn't compare with the economic crash of '29 or the rationing required by a World War, I doubt that definitions or analysis, whether it's a recession or depression, make any difference to families who are losing their savings, their homes, and their jobs. We know that when families are stressed, child abuse rates increase. The more fundamental question confronting us is how do we help support families in need, while at the same time working with our partners to promote the safety of children? And, even more important, how do we prevent child abuse from happening in the first place!

I think 2009 will present ample opportunities to sort out the answers. We will all be challenged to do more with less, as many of you have been doing for years. However, even with the challenges we face, I believe that what you do every day makes a fundamental difference in the lives of children, and we must never lose sight of that, despite the circumstances. The leadership of APSAC is committed to exploring and developing ways to provide quality training in a fiscally sound manner that is accessible and responsive to your needs.

We are excited about our upcoming Forensic Interviewing Clinics slated for March 2009 in Virginia Beach, Virginia, and June 2009 in Seattle, Washington, as well as our annual Colloquium in Atlanta, Georgia, at the Omni Hotel at CNN Center June 17–20. I hope that you will have the opportunity to join us in Atlanta for an outstanding curriculum and networking opportunity. Please find more details about these and other APSAC activities on the APSAC Web site (www.apsac.org).

In addition, after some delay, we are restarting the dialogue with our partners around the country who train on forensic interviewing about establishing, for the lack of a better word, a Diplomate in Forensic Interviewing. This is an exciting project and many of you have already written expressing your interest and support. We met in San Diego on January 26 following the APSAC Institutes to brainstorm ideas and next steps. Our goal is to move this beyond talk to action. We'll update you on this discussion and other activities in future issues of the APSAC Advisor and on the APSAC Web site.

We continue to be a thriving, growing organization because of you and your work, and I thank each you for your contribution. Let me also take this opportunity to welcome our new members to APSAC. I hope all of you will become actively involved in your organization.

As we move forward into 2009, we will meet the challenges ahead with confidence and calm resolve; our mission is too important to do otherwise. My wish for each of you. despite predictions, is that 2009 will be a prosperous and Happy New Year!

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Journal Highlights

Patti A. Beekman, Susan Yingling and Judith S. Rycus

In this issue of the *APSAC Advisor*, "Journal Highlights" summarizes the eight high-scoring articles for the 2009 Pro Humanitate Literary Awards in child welfare. Together they represent a snapshot of some of the exceptional work produced by child welfare researchers, academicians, and practitioners during the past year. The four highest- scoring articles—by Chaffin; Dale and Alpert; Meezan and McBeath; and Nixon, Tutty, Weaver-Dunlop, and Walsh—were selected to receive the award.

Our Minds Are Made Up—Don't Confuse Us With the Facts: Commentary on Policies Concerning Children With Sexual Behavior Problems and Juvenile Sex Offenders

This article addresses well-intentioned but flawed child protection policies and practices that affect juvenile sex offenders and children with sexual behavioral problems. Author Mark Chaffin discusses four common misperceptions regarding teen and preteen sex offenders, contrasts these with long-standing and current scientific fact, and discusses the effect of these misperceptions on public policy and child welfare practice.

As Chaffin points out, one misperception relates to the level of risk for future sexual offending by youth with sexual behavior problems. Long-standing data indicate that as a group, children with sexual behavioral problems have a low long-term risk for future sex crimes. However, policy makers continue to ignore this finding, often because they have vested political and financial interests coupled with highly emotional child advocacy agendas and a need to legitimize the community's desire for retribution against sex crimes. The Adam Walsh Act's lifetime juvenile sex offender registration policy is one example of this agenda. While placing youth on lifetime public registries may make the community feel safe, it also stigmatizes youth and creates a cascading policy effect, resulting in social and psychological fallout for labeled individuals, whose youthful behavior will thus affect them for life.

Second, there is a prevalent misperception that youthful sex offenders are unique and special when compared with other juvenile offenders. Youth with sexual behavior problems are often lumped into a single group and are thought to be the only population of youth at high risk for committing future sex crimes, when in fact, they are at relatively low risk of reoffending when compared with youth demonstrating other potentially high-risk behaviors. Chaffin also pointed out that other serious juvenile justice offenses are handled much differently and do not create a permanent stigmatization and isolation from society as do juvenile sex offenses.

Third, youth with illegal sexual behaviors are viewed as a homogeneous group, when actually the term *juvenile sex offender* is more misleading than informative. Facts about the diversity of youth labeled as such and the differing nature of their sexual offenses are not reflected in policy and practice. The Adam Walsh Act applies to any youth age 14 or older whose sex offense is against a child under 12, but without consideration of other variables.

Finally, there is a prevalent perception that juvenile sexual behavior problems and sexually abusive behavior are difficult to change and require years of specialized treatment. These perceptions are borrowed from the adult sex offender service model and simply applied to broad populations of youthful sex offenders. This belief is contradicted by empirical data. Such long-term and harsh interventions, typical in treating adult sexual abuse perpetrators, are often unnecessary for youth and are potentially harmful to the majority of these youth.

The author does not suggest that juvenile sexual behavioral problems do not require intervention. Rather, when appropriate short-term treatment techniques are initiated with these youth, long-term outcomes become fairly typical of those experienced by youth with other types of juvenile offenses. The author concludes by challenging child protection advocates to educate lawmakers toward the goal of deriving policy and practice from scientific facts. In this way, fair and appropriate treatment approaches can be developed to benefit juvenile sex offenders instead of harming them. The author does not downplay the serious nature that juvenile sex crimes present, but he cautions that the many misconceptions about the future of the majority of these youth undermine both their treatment and their long-term well-being.

Chaffin, M. (2008). Our minds are made up—Don't confuse us with the facts: Commentary on policies concerning children with sexual behavior problems and juvenile sex offenders. *Child Maltreatment*, *13*(2), 110–121.

Hiding Behind the Cloth: Child Sexual Abuse and the Catholic Church

This article explores the factors that enable acts of child sexual abuse by priests in the Catholic Church. It also contends that priests who sexually abuse children differ little from child sexual abuse perpetrators in the larger community, a point not yet widely acknowledged in general psychological or psychoanalytic literature.

Dale and Alpert's analysis of historical literature indicates that child sexual abuse in the Catholic Church is not a modern phenomenon; however, protection by the church of priests who offend is a recent trend. The church has recognized sexual abuse as a crime for almost 2,000 years, and historically, penalties for priests were usually more severe than for lay offenders. In contrast, the contemporary church has often protected priest offenders from detection. Not until the advent of highly publicized cases in 1985, 2002, and later was the scope of child sexual abuse in the Catholic Church exposed. The authors note that strong public reaction to these cases marked the end of the church's power to conceal abuse, which ultimately empowered victims to disclose their abuse.

The authors explore five possible explanations for why priest offenders have been protected and how the church structure might promote vulnerability of children to be abused by their priests: (1) *Blaming society* and institutions the church could not control, including the media, increasing public discussion of sexuality, and

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general moral decay, (2) *Abuse of power* by the church by hiding abuse and coercing secrecy, (3) *Forgiveness* of deviant priests who are viewed as themselves victims in need of protection, (4) *Moral perfection* that compelled the church to maintain an image of infallibility, and (5) The *celibacy* requirement of priesthood.

The authors note that, because of the celibacy requirement of priests and the protection given to priests who offend, there are few studies of individual priest offenders or comparisons of priest offenders with other child sexual abuse perpetrators. However, the authors do identify some data suggesting many similarities between priests and community offenders. Both groups of offenders typically include well-educated and employed Caucasians who groom both child victims and their families, and who desensitize children to sexual advances and then blame their victims. They may sexually abuse many children, the majority of whom knew and trusted them. Both groups entice children by giving them time, attention, and friendship. Studies also identified cognitive distortions in both groups throughout their cycle of abuse, including perceiving that their child victims wanted and even initiated sexual activity, thereby allowing them to minimize or deny harm to their victims. Data also indicate that sexual abuse offenders often seek professions that give them access to children and an opportunity to develop trust with parents. The authors suggest that future research may study whether some child predators may be drawn to the priesthood because it provides access to both children and protection.

In conclusion, the authors make a strong case that there are similarities between priest offenders and child abuse perpetrators in the community. The authors recommend that society no longer consider priest offenders unique, but treat them as typical child predators and prohibit their access to vulnerable children. As long as priest offenders are protected, children will continue to be victims, and resolution for child victims will continue to be compromised.

Dale, K., & Alpert, J. (2007). Hiding behind the cloth: Child sexual abuse and the Catholic Church. *Journal of Child Sexual Abuse, 16*(3), 59–74.

Market-Based Disparities in Foster Care Outcomes

In this article, authors Meezan and McBeath examined the effects of market-based, managed care service contracting models on foster care outcomes. They found that neither their current study nor extant research is conclusive as to how market-based models affect outcomes for children in foster care.

Federal and state outcomes under the Safe Families Act (PL 104-89) and the Child and Family Services Review (CFSR) emphasize moving children out of foster care while maintaining their safety and well-being. The accompanying need for effective *and* cost-efficient foster care services has prompted some public child welfare agencies to forego traditional fee-for-service funding and instead adapt market-based business models for managed care provider contracts. Heretofore, most agencies used fee-for-service contracts and reimbursed providers individually for each service provided, thereby guaranteeing revenues only if contracted services were delivered. By contrast, market-based managed care providers receive a predetermined dollar amount per client or for a period of service and can maximize revenues by providing services at lower cost than the contract rate. Market-based contracting was expected to result in cost savings and improved child and family outcomes; however, some cited states have undermet outcomes and reduced services to foster children and their families, calling into question whether market-based models are appropriate for services to children in the child welfare system.

The authors' review of the literature includes analysis of demonstration projects by six states receiving Federal Title IV-E waivers to reorganize child welfare service delivery by using alternate financing models. Their data analysis provides mixed evidence regarding the relationship between market-based contracting and achievement of outcomes for children in foster care. The literature review also identifies covariates of foster care outcomes, including child, family, and caregiver factors; caseworker characteristics; and service provision.

Meezan and McBeath's study of foster care services in Wayne County (Detroit) Michigan analyzes the relative influence on placement outcomes of managed care and fee-for-service contracting mechanisms and the identified covariates. Placement outcomes included reunification with a biological parent, kinship care placement, termination of parental rights (TPR), and adoption. Multivariate analysis identified market-based disparities in outcomes of reunification and placement in kinship care. Controlling for child, family, and caseworker characteristics, the study showed that children served by agencies with performance-based, managed care contracts were less likely to be reunified and more likely to enter kinship placement when compared with children receiving fee-for-service contract services. However, contract type was not significant in either TPR or adoption, or in the proportions of children who did not have a dispositional outcome by the end of the study. In addition, children and families from fee-for-service agencies were assigned better-educated caseworkers and also received significantly more service contacts.

Study results suggest policy, practice, and research implications. The authors recommend that public child welfare agencies maintain their commitment to reunification when using market-based contracting and ensure that foster care placement decisions are driven by child and family needs rather than financial considerations. Services to reunify high-need families are more costly for managed care providers than kinship care placement or adoption, and research is needed on the effect of market-based models for provision of reunification services to parents. The authors contend that market-based contracting could change the focus of permanency planning by shifting attention away from reunification to less costly kinship placements. This shift could result in high-risk parents not receiving services they need for reunification and in more children being placed in kinship care rather than reunified. The authors present a compelling argument for child welfare agencies to address these concerns by including financial incentives for reunification in managed care and performance-based contracts.

Meezan, W., & McBeath, B. (2008). Market-based disparities in foster care outcomes. *Children and Youth Services Review, 30*(4), 388–406.

A Review of Child Protection Policies to Address Intimate Partner Violence

This article discusses the difficulty in determining whether children who are exposed to intimate partner violence should be included in legal or policy definitions of child maltreatment and, as a result, become subjects of mandatory reporting and child protective services intervention.

The authors describe how national and state-provincial governments have addressed this issue in their legislative, policy, and practice frameworks. A review of statutory and regulatory documents from the United States, Canada, Australia, the United Kingdom, and New Zealand illustrates the widely divergent and inconsistent ways this issue is addressed. The authors suggest this is not surprising, considering that the supporting research literature is itself inconclusive on the scope or type of harm experienced by children who witness violence between their parents, or the impact of child protective service intervention on the immediate and long-term safety of children.

Although many jurisdictions have not incorporated intimate partner violence in their child maltreatment statutes, many others have. The articulated benefits of such legislation include that it sensitizes front-line professionals to the potential of emotional harm to children who experience domestic violence, may prevent future harm, and may promote more rapid identification of children in domestic violence situations who are themselves being physically abused. One of the unanticipated negative outcomes of this approach is a substantial increase in the number of referrals received by child protection agencies, which, without commensurate increases in resources and funding, has the potential to paralyze the system and divert resources away from children determined to have been more severely abused or neglected. Another unintended consequence is that adult victims of domestic violence, concerned about the negative impact of intrusive involvement by child protective services, may be reluctant to disclose their abuse and seek help. Further, in practice, child protective service referral often results in holding adult victims responsible for failing to protect their children, rather than holding perpetrators responsible for their abusive acts.

Even in cases where statutory and regulatory language is clear, there is a lack of clarity at the policy and procedural levels to help caseworkers know when and how to intervene. The authors report discrepancies regarding what constitutes “exposure” to domestic violence; i.e., must children actually witness a violent act, or is exposure to a parent’s injuries and distress after a violent act sufficient to lead to emotional harm? Further, the data indicate that not all children experience harm from exposure to domestic violence, but it is not clear whether these differences can be attributed to constitutional differences in individual children, differential exposures to domestic violence, or some other factors. Finally, policies are inconsistent regarding whether a child must have experienced and been harmed by a prior act of family violence to warrant child protective services intervention, or whether an estimated risk of such harm in the future is sufficient to warrant opening a child protection case.

The authors conclude that there is little evidence to support the efficacy of including child exposure to intimate partner violence in child maltreatment statutes. Such inclusion may be both ineffective and harmful if the language is overly broad, if clear guidelines for implementation are not provided, and if requisite changes in the child protection service system are not made, such as providing additional resources, staff training, and clear internal protocols. The authors suggest a moratorium on legislation addressing children exposed to domestic violence until evaluations and reviews of both the intended and unintended consequences are completed. They also suggest that the best way to protect the safety and well-being of children in most cases of intimate partner violence is to support and protect the adult victim, while holding the perpetrator accountable.

Nixon, K., Tutty, L. Weaver-Dunlop, G., & Walsh, C. (2007). Do good intentions beget good policy? A review of child protection policies to address intimate partner violence. *Children and Youth Services Review, 29,* 1469–1486.

Gender Atypical Organization in Children and Adolescents: Ethico-Legal Issues and a Proposal for New Guidelines

Atypical gender identity organization (AGIO) is a serious medical condition in which children and adolescents feel their phenotypical appearance is alien to their self-perception as male or female. AGIO is a source of great distress to adolescents who are at high risk of suicide if not medically treated, and both mental health assessment and treatment may be indicated for these children/adolescents and their families.

There are currently no common international guidelines for the treatment of children and adolescents with AGIO. In this article, Giordano offers new guidelines consistent with ethical and legal principles accepted in the United Kingdom and worldwide for how minor patients should be medically, ethically, and legally treated. Those affected often face discrimination, abuse, and violence, making AGIO a public as well as medical issue. Giordano asserts that AGIO requires a broader view of gender identity beyond male and female. She contends that children with this condition deserve compassion and fair treatment, not discrimination.

There are three stages of medical treatment for AGIO; each intervention stage carries medical risks and previously established, albeit not universal, ethical-legal guidelines. *Fully reversible interventions* include administration of puberty-delaying hormones, giving an adolescent more time to experience life in his or her phenotypical state and to make an informed decision about further action. *Partly reversible interventions* involve hormone therapy for development of secondary sexual characteristics of the adolescent’s core gender identification. These are only partly reversible because some secondary atypical characteristics are very difficult to alter (voice change and beard growth cannot be changed; breast development can be removed only surgically). Hormones may be administered as early as age 16, but the older guidelines call for adolescents either to be emancipated or have both the minor patient’s assent and the written informed consent of a parent or legal guardian. *Irreversible interventions* refer to surgical procedures. Under the existing guidelines, surgical intervention should not occur before age 18 or prior to a real-life experience of at least 2 years in the gender role of the sex with which the adolescent identifies.

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Finally, the author discusses issues such as interfering with natural development, competence in minors, validity of informed consent, role of the family, and moral and legal responsibility of professionals for omission of treatment. She concludes by proposing new ethico-legal guidelines for treatment of AGIO that specify that children and adolescents should receive the medical treatment they request, if they are competent and if treatment will enhance their quality of life. The author also cautions medical professionals that refusing or deferring treatment until adulthood may also result in ethico-legal challenges.

Giordano, S. (2007). Gender atypical organization in children and adolescents; Ethico-legal issues and a proposal for new guidelines. *International Journal of Children's Rights, 15*(3-4), 365–390.

Teaching Evidence-Based Practice: Strategic and Pedagogical Recommendations for Schools of Social Work

The new standard for evidence-based practice (EBP) in social work is evident in topical articles, texts, and conference presentations, as well as in newly established journals and research organizations. However, pedagogical approaches in schools of social work do not largely reflect this emergence of evidence-based practice. To foster the integration of EBP principles into direct practice, this article calls for schools of social work to adopt an educational philosophy that ensures research-related experiences for students and teaching that is consistent with evidence-based practice.

The authors propose a model for implementing a pedagogy of evidence-based practice to prepare practitioners who can evaluate scientific literature and recommend interventions that are best supported by research. Schools can begin by reviewing curriculum and incorporating information and resources for EBP into course offerings and by discouraging the use of interventions that lack empirical support. Teaching methodology should focus on problem-based learning, including field experiences that enable students to use practices that are supported by research evidence.

The authors also contend that MSW education needs to become more specialty-focused to develop professionals with skills to deliver evidence-based interventions; and curricula should teach students the ethical importance of transparency in social work practice. They advocate testing before graduation to ensure students' consistency with the tenets and methods of EBP.

To maintain momentum of the pedagogic focus, each school of social work should appoint faculty members to track current research and educational innovations, thereby creating a national resource of EBP experts. Emergent issues for this transformation include determination of what constitutes "evidence" and how field education can reinforce evidence-based practices. Finally, the authors accentuate the need for schools to institute ongoing EBP training programs to strengthen the knowledge and skill of current professors and to provide continuing education on research-supported practices in the field. When adopted, this complement of strategic recommendations will foster a shift to a more scientific and research-based approach to social work education, and it will enhance public value of the social work profession.

Howard, M., Allen-Mears, P., & Ruffalo, M. (2007). Teaching evidence-based practice: Strategic and pedagogical recommendations for schools of social work. *Research on Social Work Practice, 17*(5), 561–568.

Caseworker Assessments of Risk for Recurrences of Child Maltreatment

This article describes a study designed to determine the effectiveness of caseworker risk assessments in estimating the likelihood of recurrences of child maltreatment. The study sample was derived from the National Survey for Child and Adolescent Well-Being (NSCAW) and included a nationally representative sample of youth and families who had been subjects of allegations of child maltreatment and were subsequently investigated by child protective services agencies. The national scope of the NSCAW data and inclusion of a large representative sample attempted to address many of the methodological issues encountered in prior risk assessment research. The study sample was a subset of children and youth who had remained in their homes following a CPS investigation for alleged child physical abuse or neglect (N=2,139). Data were collected at baseline, at 12 months, and at 18 months.

The researchers examined the association between caseworkers' knowledge of risk factors and the use of these factors in their risk assessments. The authors also examined the degree to which caseworkers' classifications of risk concurred with subsequent reports of maltreatment in these families. The study also examined families whom caseworkers had inaccurately rated "low risk" to determine what factors might have been overlooked and to identify decision-making errors and biases.

The study found that caseworkers' assessments of risk were largely based on parent-level risk factors, but their assessments were more accurate for low-risk than for high-risk cases. However, the overall findings suggest a complex picture of risk assessment in which there were few patterns of risk factors (other than prior reports of maltreatment) that consistently were associated with caseworker classification of risk. In general, there was a low level of agreement between caseworkers' assessments of risk and actual subsequent reports of child maltreatment. The authors conclude that correct identification and classification of families at highest risk enables limited agency and service resources to be utilized more effectively. Given the significance of mistakes in classification identified in the study—threats to child safety when cases are inappropriately classified as low-risk, and excessive cost expenditures on services for families who are not truly high-risk—increasing the accuracy of risk classifications is critical. The authors suggest that one means of improving the accuracy of risk assessment is to increase utilization of data regarding risk assessment from the research literature, most likely through training and the adoption of actuarial risk assessment measures.

Dorsey, S., Mustillo, S. A., Farmer, E., & Elbogen, E. (2008). Caseworker assessments of risk for recurrent maltreatment: Association with case-specific risk factors and re-reports. *Child Abuse & Neglect, 32*, 377–391.

Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

New Congress Convenes

The 111th Congress convened on January 6 with the swearing-in of the House of Representatives and newly elected Senators. It then set to work on the economic stimulus package proposed by then President-elect Barack Obama. House and Senate leaders met their self-imposed deadline in passing the measure by mid-February, the outlines of which were in negotiations during the year-end holidays. Congress has yet to vote on an omnibus appropriations bill combining all 12 funding measures, which were left as unfinished business at the end of the 2008 legislative session.

Economic Stimulus Package

Just before leaving for a week of President's Day recess in mid-February, the House and Senate voted final passage of the economic stimulus legislation—H.R.1, the American Recovery and Reinvestment Act. The compromise version of the bill offers tax breaks and spending that total $789 billion, much less than the initial bill passed by the House at $819 billion and the version first approved by the Senate at $838 billion.

The House-Senate conference committee agreement on the stimulus package includes $1 billion for Head Start and $1.1 billion for Early Head Start. The Senate bill had allocated only half this amount for each program. In addition, the Child Care and Development Block Grant makes available $2 billion for child care assistance for low-income families, as provided by both the House and Senate bills.

Grants for Temporary Assistance for Needy Families (TANF), funded at $2.5 billion in the House and $3 billion in the Senate, are set at $3 billion in the conferees' report. Funding for the Social Services Block Grant, stipulated in the Senate bill at $400 million, was dropped in the final agreement.

Formula grants under the Individuals with Disabilities Education Act (IDEA) Part C, which helps states serve age 2 and younger children with disabilities and special needs, receives $500 million in the stimulus bill. The Child Abuse Prevention and Treatment Act (CAPTA) requires states to refer all children under age 3 who are involved in a substantiated case of abuse or neglect to Part C-funded early intervention services.

Child welfare advocates also scored a victory in the economic stimulus package, which mandates a temporary increase of an estimated $1 billion for foster care payments to states, including an increase of 6.2% for the Medicaid matching rate to extend to children in foster care.

Opposition to the final stimulus legislation and to earlier versions of the bill centered on the additional spending that fiscal conservatives suggested was better dealt with through the regular appropriations process than as emergency spending. Critics also balked at supporting provisions they considered unnecessary in a bill aimed at the current financial crisis and rising unemployment.

Omnibus Appropriations

Prior to adjourning in October for election campaigning, Congress approved a continuing resolution that carries funding for federal agencies until March 6, 2009. The only appropriations bills passed by Congress last year were those providing full-year funding for defense, homeland security, veterans, and military construction. The remaining nine spending bills total about $410 billion. The Labor-HHS-Education Appropriations Bill, which contains funding for child protective services, child abuse prevention, and other child welfare services, never passed consideration by the committees in either chamber.

The Democratic leadership on Capitol Hill was intent on avoiding a replay of last year's confrontation with the President over the budget's bottom-line spending. President Bush had made known his intention early in 2008 to veto any spending bill with total dollars above the amounts proposed in his FY09 budget plan sent to Congress in February.

Appropriators in the House had been set on adding $14 billion in domestic spending for such programs as cancer research, student aid, and home heating assistance. A budget stalemate between Congress and the Bush administration created by the insistence of legislators to set their own spending priorities, as well as a continuing debate in Congress about off-shore oil drilling tied to spending legislation, left the appropriations bills far from enactment as the new fiscal year drew closer.

While almost all programs remain funded at the 2008 levels, some adjustments were made in special circumstances, such as an additional $600 million in the money bill for disaster relief above the 2008 funding level of $1.7 billion for the Social Services Block Grant (SSBG). Congress voted the extra SSBG funds to pay for health services (including mental health services) and for repair, renovation, and construction of health care facilities, child care centers, and other social services facilities. This was stipulated for those states directly affected by the 2008 hurricanes, floods, and other natural disasters, as well as for continuing relief from Hurricanes Katrina and Rita. (The Bush administration had proposed cutting $500 million from the $1.7 billion funding for SSBG.)

The deadline is fast approaching for passage of a proposed omnibus legislation that would encompass the unfinished spending bills for the fiscal year that began October 1, 2008. The House had tentatively scheduled consideration of the omnibus spending measure in early February, but the bill was pulled when it became clear that legislators would be focused on the economic recovery package. It remains uncertain whether the final funding bill will keep federal spending at the same levels for the remainder of the 2009 fiscal year or make some mid-year adjustments.

Meanwhile, looking ahead to FY 2010, the Obama administration expects to submit a summary budget by the end of February, including a full FY10 budget for congressional consideration in April.

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President Signs Bill to Expand SCHIP

On January 14, the House voted 289–139, largely along party lines, to reauthorize and expand the State Children's Health Insurance Program (SCHIP), which provides health insurance to lower-income children whose families earn too much to qualify for Medicaid, but who still struggle to afford health insurance. The Senate passed the measure on January 29, by a vote of 66– 32, and President Obama signed the legislation into law on February 4.

The bill will expand coverage for an additional 4 million children through FY13 at a cost of $32.3 billion, bringing the total number of children covered under the program to around 11 million. The costs of the SCHIP bill will be paid for largely by an increase of $.61 in the federal cigarette tax.

Smooth passage in the Senate was not certain initially, with objections raised to provisions in the House bill removing a 5-year waiting period for children who become legal residents to receive coverage under the federal insurance program. Opponents also claimed that the expansion of SCHIP would shift children who are currently covered by private medical insurance onto the federal health insurance program, straying from the intent of the program to pay for health insurance for lower-income families.

Congress twice passed an enlargement of the children's health program in 2007. Both times President George W. Bush vetoed it. President Obama had expressed the wish during his campaign that the SCHIP measure—with expanded eligibility to cover more children—would be among the first he would sign into law on becoming President.

Election Results: What Do They Mean for Children?

Not since the 1994 elections, when Republicans won the majority of seats in the House of Representatives for the first time in 40 years, have the Democrats controlled both the House and Senate and the Presidency. The election of Barack Obama as President and the gain of additional seats in both chambers of Congress give Democrats total control of the federal government with a strengthened position from which to pursue their legislative agenda. With the Obama campaign's attention to early childhood education and early intervention services shared by many in the Democratic leadership, advocacy for children may find powerful support.

Democrats convened the 111th Congress with their largest majority in 15 years, holding a net gain of 21 seats in the November elections: 256 seats for the Democrats and 178 for the Republicans, with one vacancy—the seat left open by Rep. Rahm Emanuel (D-IL), who serves as the new White House chief of staff.

One challenge Republicans faced this year was the number of seats left open by retirements—seats harder to defend than those occupied by incumbents. Republicans had 29 vacant House seats; Democrats had only 6.

While the new majority gives Democrats an advantage in advancing their agenda, the sizable loss of moderate Republicans to retirement and defeat on Election Day makes bipartisan agreement more difficult. Among the dozen or so Republican incumbents who lost their seats to Democratic challengers, about half would be considered moderates.

In the Senate, the Democrats hold 59 seats, counting the election of Al Franken (D-MN) to succeed Sen. Norm Coleman (R-MN), who has contested the results of the voting. Among the new Democrats joining the Senate in 2009, two of them, Mark Udall (D-CO) and Tom Udall (D-NM), moved from their House seats with 100% ratings on their voting records on children's issues, as compiled annually by the Children's Defense Fund Action Council Congressional Scorecard.

Four other new Democratic Senators come to Washington from state government. Kay Hagan (D-NC), criticized by her opponent for a liberal voting record in the North Carolina state senate, defeated Sen. Elizabeth Dole (R-NC), who rated a 40% on the CDF scorecard. Mark Warner (D-VA), the former governor of Virginia, brings an interest in support for early learning, as does apparently the newly elected Democratic Senator from Oregon, Jeff Merkeley, a former state legislator and Speaker of the House. Jeanne Shaheen defeated Sen. John Sununu (R-NH), who scored a moderate 60% on the CDF ratings. Shaheen served three terms as governor of New Hampshire, where she established the state's children's health insurance program.

In addition to his pledge to expand the State Children's Health Insurance Program (SCHIP), Obama's campaign agenda included support for early childhood education and early intervention services for children, an interest he shares with Speaker Nancy Pelosi (D-CA) and Rep. George Miller (D-CA), who might be expected to push the early intervention agenda as he continues in his position as chair of the House Education and Labor Committee.

Despite changes in the make-up of Congress brought about by the election, the legislative leadership with which child advocates have worked in the 110th Congress will stay essentially in place on the authorizing committees: in the Senate Finance Committee and the Health, Education, Labor, and Pensions (HELP) Committee, and in the House Education and Labor Committee and on the Ways and Means Committee. The leadership of the Appropriations Committees and subcommittees remains much the same in both chambers as well, except for the loss in the House of moderate Republicans from the Labor-HHS-Education Appropriations Subcommittee—Reps. James Walsh (R-NY) and Ralph Regula (R-OH).

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.

APSAC Board Meets in San Diego

APSAC's Board of Directors met January 24–25 in San Diego, California. On Saturday, the Board participated in a cultural diversity workshop presented by Kathy Germann. Kathy Germann Consulting is composed of a group of facilitators and consultants based in Madison, Wisconsin, offering customized training and consultation in diversity issues, conflict resolution, team development, and training design for educational, human service, healthcare, governmental, and business organizations.

The Board also recognized the election of new members and elected its officers for 2009. Board members elected to 3-year terms are as follows:

Monica Fitzgerald, PhD (1st term), a licensed clinical psychologist and Assistant Professor at the National Crime Victims Research and Treatment Center (NCVC) in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina (MUSC), Charleston, South Carolina;

Julie Kenniston (1st term), LSW, Director of Training and Education, Butler County Children Services, Hamilton, Ohio;

Robert Parish (2nd term), Deputy District Attorney, Salt Lake County District Attorney's Office, Bountiful, Utah; and

Susan Samuel (2nd term), Cloudcroft, New Mexico, who has worked 3 decades in the child abuse arena and advocates for the interests of field professionals.

Officers elected to serve are as follows:

President-Elect ***Ronald C. Hughes***, PhD, MSCSA, Director, North American Resource Center for Child Welfare / Institute for Human Services, Columbus, Ohio;

Vice President ***Viola Vaughan-Eden***, PhD, LCSW, Vaughan-Eden Counseling Services, Newport News, Virginia;

Secretary ***Kathy D. Johnson***, MS, Clinical Instructor, Jordan Institute for Families, UNC-SW, Chapel Hill, North Carolina;

Treasurer ***Vincent Palusci***, MD, MS, Loeb Child Abuse Center, New York, New York; and

Board Member on the Executive Committee ***Jon R. Conte***, PhD, Consultant, Mercer Island, Washington.

Michael L. Haney, PhD, Director for Prevention and Intervention, Florida Department of Health, Children's Medical Services, Talahassee, Florida, will complete his second year as APSAC's President.

A complete list of the association's Board of Directors is housed on the Web site www.apsac.org.

Forensic Interview Training Clinics This March and June

Consistent with its mission, APSAC presents the Forensic Interview Training Clinics, which are focused on the needs of professionals responsible for conducting investigative interviews with children in suspected abuse cases. Interviewing alleged victims of child abuse has received intense scrutiny in recent years and increasingly requires specialized training and expertise.

This comprehensive clinic offers a unique opportunity to participate in an intensive 40-hour training experience and to have personal interaction with leading experts in the field of child forensic interviewing. Developed by top national experts, APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing, including a balanced review of several models.

Training topics include the following:

- How investigative interviews differ from therapeutic interviews.
- Overview of various interview models and introduction to forensic interview methods and techniques.
- Child development considerations and linguistic issues.
- Cultural considerations in interviewing.
- Techniques for interviewing adolescents, reluctant children, and children with disabilities.
- Being an effective witness.

The 2009 Clinics will be held March 9–13 in Virginia Beach and June 1–5 in Seattle. Details and registration are available on the Web at www.apsac.org.

APSAC Advisor Library to Be Expanded

The *APSAC Advisor Library*, powered by OmniPress, provides members with direct access to the vast amount of knowledge that has been published in the association's quarterly newsletter, the *APSAC Advisor*. This benefit came online in 2008 in conjunction with the Annual Conference.

In the coming weeks, the library will expand to include articles published in the *APSAC Advisor* prior to 2002.

The *APSAC Advisor Library* is exclusively available to APSAC members. Simply login with your username and password and visit the Members Only section for access.

Plan Now to Attend APSAC's Colloquium This June in Atlanta

APSAC will host its 17th Annual Colloquium June 17–20, 2009, at the Omni at CNN Center, Atlanta, Georgia.

The Colloquium will feature Advanced Training Institutes, the Cultural Institute, and nearly 100 seminars from which to choose. In addition, the Colloquium offers ample networking opportunities, poster presentations, exhibits, and an awards ceremony.

The educational goal of APSAC's Colloquium is to foster professional excellence in the field of child maltreatment by providing interdisciplinary professional education.

Upon completion of this activity, participants should be able to

- Apply state-of-the-art treatment methods when working with abused and neglected children.
- Identify the most up-to-date information concerning working with abused and neglected children.
- Prepare and report quality testimony in court cases, both as experts and as witnesses.
- Identify physical abuse, sexual abuse, and neglect in children.
- Apply model examination and treatment techniques for abused and neglected children.

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

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 17th Annual Colloquium is cosponsored by APSAC and the Institute for Continuing Education. Continuing education credit is offered for a variety of disciplines and is awarded on a session-by-session basis with full attendance required at the sessions attended. Representatives from the Institute will be on site to accept applications for continuing education credit and to assist conference attendees. A separate processing fee is required.

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

Job Opportunities and Free Resume Posting Available Online

The APSAC Career Center, powered by JobTarget, was constructed to help connect our members and associates with new employment opportunities. Visit the Career Center on the APSAC Web site to begin your job search or employee recruitment process. Job seekers will also have access to tools designed to help them be successful. The Career Center is open to APSAC members and the public. Members receive significant discounts when posting job openings. Resume posting is free.

APSAC Expands Training to Serve States and Regions

APSAC plans to pilot two innovative state-level training events in 2009 to promote evidence-based practice in the field of child maltreatment. Designed by the Education Committee of the APSAC Board, the pilots are intended to make APSAC's commitment to disseminate empirically-supported practices in child maltreatment more strategic, substantive, and visible. Taking APSAC training "on the road" allows for broader dissemination of information about child welfare interventions that have strong empirical support but which, for many reasons, have not yet found their way into mainstream direct practice. State, regional, and local APSAC-sponsored training events also make it possible for professionals who cannot attend APSAC's Annual Colloquium to participate in the same high-quality educational opportunities, which are led by experienced APSAC presenters.

In Ohio, APSAC is collaborating with OHPSAC, Ohio's State Chapter of APSAC and the Public Children Services Association of Ohio (PCSAO) to provide a keynote address and six 3-hour training workshops on empirically supported interventions at PCSAO's annual child welfare conference in September 2009. This statewide conference normally draws 500+ direct-service child welfare professionals and other participants from related disciplines. Collaboration with Ohio's statewide child welfare inservice training system will facilitate the training of local trainers and the subsequent provision of ongoing training in these key program areas as a means of promoting their broader implementation.

In Gaston County, North Carolina, trainers from Duke Medical Center and UNC-Chapel Hill will conduct a workshop on providing treatment for traumatized children and their families. The full-day training is designed for a multidisciplinary audience and will present information on empirically-supported interventions for children who have experienced trauma, including trauma-focused cognitive behavioral therapy (TF-CBT) and parent child interaction therapy (PCIT). The workshop—arranged jointly by APSAC, the North Carolina State Chapter of APSAC, and the Gaston County Interagency Child Abuse Prevention Council—will also highlight the activities of the North Carolina Child Treatment Program.

APSAC Members Receive Pro Humanitate Literary Awards

Two APSAC members were awarded the 2009 Pro Humanitate Literary Awards for their exemplary contributions to the child maltreatment literature.

Dr. David Finkelhor, Director of the Family Research Laboratory, Crimes Against Children Research Center at the University of New Hampshire, received the Daniel D. Schneider book award for his recent publication *Childhood Victimization: Violence, Crime, and Abuse in the Lives of Young People* (Oxford University Press, 2008).

Dr. Mark Chaffin, psychologist and Professor of Pediatrics at the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center, won the Herbert A. Raskin article award for "Our Minds Are Made Up—Don't Confuse Us With the Facts: Commentary on Policies Concerning Children With Sexual Behavior Problems and Juvenile Sex Offenders (*Child Maltreatment, 13*(2), May 2008).

The Pro Humanitate Literary Awards are given annually by the North American Resource Center for Child Welfare to authors in the United States and Canada who exemplify the intellectual integrity and moral courage to transcend political and social barriers to champion best practice in the field of child welfare. The awards were presented at the 23rd Annual San Diego International Conference on Child and Family Maltreatment on January 29, 2009.

CONFERENCE CALENDAR

APSAC-Sponsored Training Events

June 1–5, 2009
Forensic Interview Training Clinic
Seattle, WA
Call: 877.402.7722, or Visit: www.apsac.org, or
E-mail: apsac@apsac.org

June 17–20, 2009
APSAC's 17th Annual Colloquium
Atlanta, GA
Call: 877.402.7722, or Visit: www.apsac.org, or
E-mail: apsac@apsac.org

Conferences

March 23–26, 2009
25th National Symposium on Child Abuse
National Children's Advocacy Center (NCAC)
Huntsville, AL
Visit: www.nationalcac.org, or
E-mail: mgrundy@nationalcac.org

March 30–April 4, 2009
17th National Conference on Child Abuse and Neglect
Children's Bureau, Office on Child Abuse and Neglect
Atlanta, GA
Visit: www.pal-tech.com, or E-mail: 17conf@pal-tech.com

April 6–7, 2009
Children's Justice Conference
Department of Social and Health Services/Children's Administration and the Children's Justice Task Force
Seattle, WA
Visit: www.dshscjc.com, or E-mail: jamt300@dshs.wa.gov

April 19–22, 2009
27th Annual Protecting Our Children National American Indian Conference on Child Abuse and Neglect
National Indian Child Welfare Association (NICWA)
Reno, NV
Visit: www.nicwa.org, or E-mail: isla@nicwa.org

April 22–26, 2009
American Adoption Congress 30th Annual Conference
Cleveland, OH
Visit: www.americanadoptioncongress.org/national_conferences.php

May 3–9, 2009
National Foster Parent Association 39th Annual Education Conference
Reno, NV
Visit: www.nfpainc.org, or E-mail: info@NFPAonline.org

May 14–16, 2009
2009 Biannual Center on Children and the Law National Conference
American Bar Association (ABA) Center on Children and the Law
Washington, DC
Visit: www.abanet.org/child/, or
E-mail: childlaw2009@abanet.org

May 26–29, 2009
9th Triennial International Child and Youth Care Conference
Fort Lauderdale, FL
Visit: www.icycc2009.com/abouttheconference.html, or
E-mail: registrations@icycc2009.com

June 2–5, 2009
American Humane's 2009 Family Group Decision-Making Conference
American Humane Association
Pittsburgh , PA
Visit: www.americanhumane.org, or
E-mail: info@americanhumane.org

June 2–4, 2009
The National Summit on the Intersection of Domestic Violence and Child Welfare
The National Council of Juvenile and Family Court Judges and the Family Violence Prevention Fund
Jackson Hole, WY
Visit: http://endabuse.org/content/features/detail/1081/
or E-mail: llitton@ispconsults.com

June 3–5, 2009
One Child, Many Hands: A Multidisciplinary Conference on Child Welfare
The Field Center for Children's Policy, Practice, and Research at the University of Pennsylvania
Philadelphia, PA
Visit: www.sp2.upenn.edu/onechild, or
E-mail: fieldctr@sp2.upenn.edu

June 3–5, 2009
The 12th National Child Welfare Data and Technology Conference
The National Resource Center for Child Welfare Data and Technology
Washington, DC
Visit: www.nrccwdt.org, or E-mail: nrccwdt@cwla.org

August 2–5, 2009
23rd Annual Conference on Treatment Foster Care
Foster Family-Based Treatment Association
Atlanta, GA
Visit: www.ffta.org, or E-mail: shorowitz@ffta.org

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