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Academic Gains by Youth in Residential Treatment

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Children entering residential treatment often present with significant mental health and behavioral problems (Child Welfare Information Gateway, 2009). For example, in 2005, the Child Welfare League of America (CWLA) evaluated the characteristics of 1,321 youth living in 19 residential care facilities. Mental health records revealed that 93% had been given a psychiatric diagnosis, 40% were on antipsychotic medication, over half had experienced previous psychiatric hospitalizations, and on average, youth reported 5.4 prior placements. Behavioral records indicated that nearly one third had multiple school suspensions, over half had criminal histories, and a large percentage exhibited clinical levels of internalizing (40%) and externalizing (60%) behaviors (CWLA, 2005; Connor, Doerfler, Toscano, Volungis, & Steingard, 2004; James et al., 2006; Baker, Kurland, Curtis, Alexander, & Papa-Lentini, 2007).

While behavioral and mental health risks are often the primary concern for youth at program entry, recent studies have also revealed significant levels of co-occurring deficits in academic functioning (Trout, Hagaman, Casey, Reid, & Epstein, 2008; Griffith, Trout, Epstein, & Garbin, in press; Wurtele, Wilson, & Prentice-Dunn, 1983). Specifically, in a 2008 investigation of 127 youth (mean age = 15.3 years) at the time of intake into a residential facility, results revealed youth scores of approximately two thirds of a standard deviation below mean on overall academic performance, with the lowest scores on measures of general academic knowledge, applied problems, calculation, reading fluency, and passage comprehension (Trout, Hagaman, Chmelka, et al., 2008). Similarly, in a study of 211 youth with emotional and behavioral problems placed in residential settings across Alabama, Wurtele, Wilson, and Prentice-Dunn (1983) revealed that 66% were rated by program administrators as functioning at least one year below grade level upon program entry, and nearly one third were rated as functioning more than two years behind. These findings are consistent with the results of a comprehensive literature review on the academic performance of children and youth in out-of-home care, which revealed that youth in residential settings often performed below grade level and scored in the low- to low-average range on academic measures (Trout, Hagaman, Casey, et al., 2008).

Though it is well documented that youth enter care with academic concerns, little is known about academic progress made by youth while in treatment. In a search of the published literature, researchers found little information about academic gains made while in care or the types of education provided in these settings. Given the considerable negative short- and long-term impact of poor academic performance, this knowledge gap is a problem for service providers and researchers who are developing and implementing comprehensive treatments for youth in care.

The importance of academic achievement to a youth's future is well documented, and it is known that academic failure can lessen the chances of long-term success. To illustrate, youth who lack basic academic skills such as reading, writing, and math are less likely to complete high school, to attend postsecondary school, or to become gainfully employed (National Assessment of Educational Progress, 2006). For those who also present co-occurring histories of behavior problems and mental health issues, the risks for school dropout, criminal activity, antisocial and delinquent behavior, substance abuse, and pregnancy are even greater (Ary et al., 1999; Baker et al., 2007). In contrast, studies reveal that youth who complete high school are more likely to find and keep employment over time and to continue their education beyond secondary school, and are less likely to be economically insecure or become involved with illegal activities (U.S. Department of Education, 2005, 2007).

Given the significant negative repercussions of school failure and, conversely, the protective influence of academic success, the academic abilities of youth need to be systematically evaluated while in care and interventions made that may improve their educational outcomes. This study sought to address some of the limitations in the literature by examining the academic gains made by youth from intake to one-year follow-up at the Boys Town Treatment Family Home Program, a large-scale residential treatment program in the Midwest.[1]

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Program Description

Boys Town residential group homes use a modification of the teaching family model, called the Boys Town Treatment Family Home Program, in which married couples (known as family teachers) live with up to eight youth in a home environment (Davis & Daly, 2003). The Boys Town teaching model is a behaviorally-based treatment model that incorporates five critical elements: (1) teaching skills, (2) building healthy relationships, (3) supporting moral and spiritual development, (4) creating a positive family-style environment, and (5) promoting self-government and self-determination (Davis & Daly, 2003). Positive support systems are in place for every youth in order to create an environment that will provide treatment for a youth's behavior problems (Larzelere, Daly, Davis, Chmelka, & Handwerk, 2004).

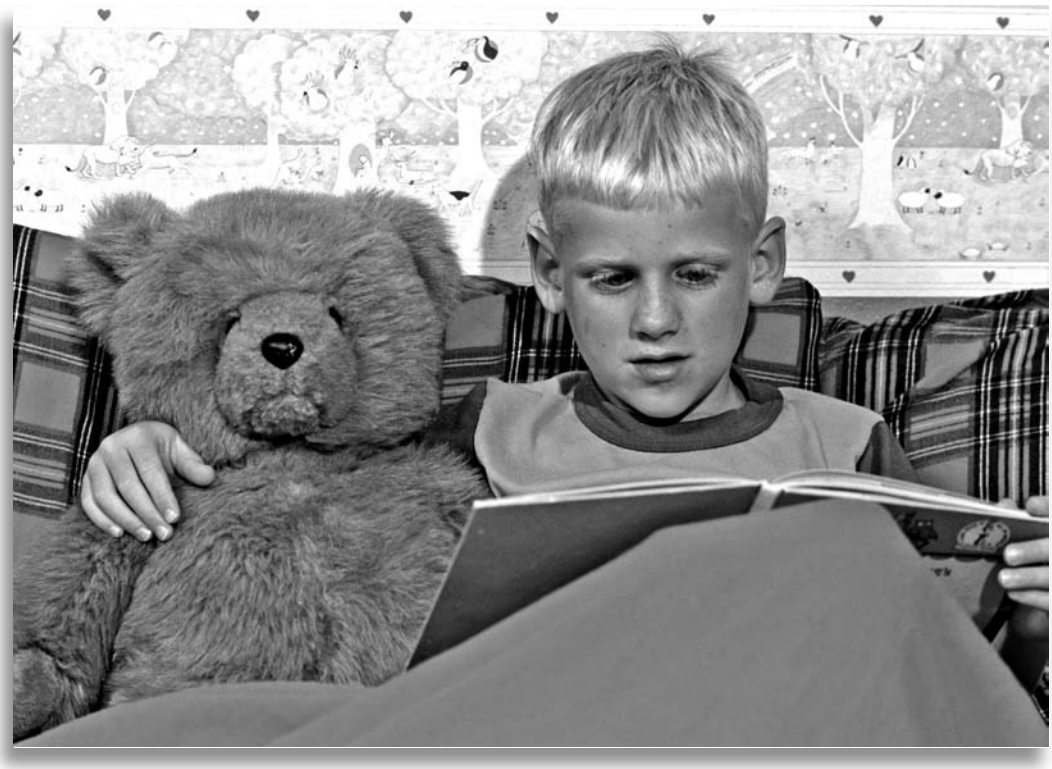
In addition to family, peer, and neighborhood support systems at Boys Town, the Boys Town educational model (BTEM) is integrated into the Treatment Family Home Program (Connolly, Dowd, Criste, Nelson, & Tobias, 1995). The BTEM comprises four components: (a) social skills curriculum, (b) teaching interactions, (c) motivation systems, and (d) administrative intervention. The social skills curriculum includes 16 social behaviors targeting adult relations, peer relations, school rules, and classroom behaviors. The teaching interactions component allows for a brief interactive instructional sequence with a student when a behavior occurs (Connolly et al., 1995). The third component, motivation systems, encourages behavior change in youth by allowing access to privileges and tangible items using a token economy that results in point rewards for positive behavior, or conversely, consequences when a student exhibits negative behavior. Finally, the administrative intervention component allows school administrators to act as change agents for students who have been removed from the classroom by using teaching interactions and behavioral rehearsals to teach alternative ways of responding to stressful school situations (Connolly et al., 1995).

The process of identifying and meeting individual academic needs of youth occurs through communication and instruction. Frequent communication through the use of school notes between school staff and family teachers helps to identify specific academic and social skills the youth are learning. This communication also helps assess if youth generalize these skills to different settings (Davis & Daly, 2003), ensures high rates of attendance as dictated by a stringent attendance policy, and facilitates collaboration between the school and the family home. Youth are screened for reading, writing, and math difficulties upon entrance to the school and are grouped according to ability level in a fluid system that permits movement among groups based on individual needs. To evaluate progress, youth are assessed using curriculum-based measurements (CBM) and receive feedback on their strengths and areas of need. Approximately one third of the instructors at the Boys Town schools have special education endorsements, and all are specifically trained in the Boys Town teaching model (Davis & Daly, 2003), Boys Town educational model (Hensley, Powell, Lamke, & Hartman, 2004), the elements of effective instruction, and cooperative learning to ensure that each classroom is consistent with others. Classrooms have a student-to-teacher ratio of 8:1, and youth receive systematic, explicit instruction in all academic subjects. To assist in after school studying, youth are provided with a mentor at school to help youth practice skills and participate in a homework/study hour in the family home each afternoon.

Method

Participants

Participants included the first 64 youth (33 boys and 31 girls) admitted to the Boys Town home campus Treatment Family Home Program between October 2006 and May 2007. Youth were primarily Caucasian (56.3%) and were an average age of 15.1 years old (SD=1.61; range = 11 to 18 years). At entry, participants had 1.65



(SD = 2.61) prior placements and an average age at first placement of 13.2 years (SD = 3.15). Nineteen participants (29.7%) were wards of the state. Over a quarter (26.6%) of the youth had been prescribed psychotropic medication, 53.4% had received one or more mental health diagnoses on the Diagnostic Interview Schedule for Children-IV (DISC-IV), and just over a third (n = 23; 35.9%) had been given a special education diagnosis.

Measure

The Woodcock-Johnson Test of Achievement, 3rd Edition (WJ–III; Woodcock, McGrew, & Mather, 2001) was used to measure the academic achievement of youth at intake and again at 12 months into treatment. The WJ–III is a psychometrically sound, individually administered, norm-referenced assessment with a mean of 100 and standard deviation of 15. To obtain a comprehensive, yet efficient, indication of youth academic competence, youth completed seven subtests of the WJ–III: (1) Reading Fluency, (2) Passage Comprehension, (3) Writing Fluency, (4) Spelling, (5) Calculations, (6) Applied Problems, and (7) Academic Knowledge. These subtests have a reliability coefficient range of .77 to .94 (Woodcock et al., 2001). Scores on the WJ–III are interpreted as follows: 69 and below = very low, 70–79 = low, 80–89 = low average, 90–110 = average, 111–120 = high average, 121–130 = superior, and 131 and above = very superior.

Procedure

Intake Assessment

Within four weeks of arriving at the Boys Town Treatment Family Home Program, youth were referred to one of four graduate students for assent to participate in the study, and to complete the initial WJ–III screening. Testing time varied between 45 minutes and two hours.

Prior to data collection, the four graduate students completed standardized training. Training included a week-long seminar led by experienced data collectors on (a) obtaining consent and assent, (b) confidentiality, (c) data collection procedures, and (d) administration and scoring of the WJ–III. Students were required to demonstrate 90% fidelity prior to administering the WJ-III to youth. Following the start of data collection, an outside evaluator familiar with the WJ–III administration procedures conducted follow-up fidelity checks every three months to ensure fidelity was maintained.

Data Analysis

Paired sample t-tests were conducted to establish mean differences between intake and follow-up assessment scores. Hedge's *g* effect sizes were calculated to determine the magnitude of differences between the mean academic achievement scores at intake and one year later. According to Cohen's standard (1988), 0.2–0.49 is a small effect size (ES), 0.5–0.79 is medium, and ≥ 0.8 is large.

Results

Academic Gains

Table 1 presents means, standard deviations, total change, t-test values, and effect sizes (*g*) for the seven subtests of the WJ–III at intake and one-year follow-up. All subtests showed positive changes from intake to follow-up (total change range = .22 to 5.29). The Reading Fluency, Writing Fluency, Calculation, and Academic Knowledge subtests revealed statistically significant positive changes with medium to large effect sizes (ES range = .55 to .93). Spelling was statistically significant with a small effect size (ES = .47). While not statistically significant, youth demonstrated positive gains on Passage Comprehension and Applied Problems subtests.

Discussion

Results indicate that youth who were served in the home campus Boys Town Treatment Family Home Program demonstrated significant academic gains over a one-year period. Overall, youth improved their academic performance in all basic skills, with greater significant gains in reading fluency, writing fluency, math calculation, and academic knowledge. Youth also revealed improvements, albeit smaller ones, in applied areas such as spelling, passage comprehension, and applied problems. Because little work has been done previously to evaluate the academic growth of youth served in residential settings (Trout, Hagaman, Chmelka, et al., 2008; Thompson et al., 1996), these results are an important first step in the investigation of changes over time and provide a base for the further evaluation of factors that may aid in youth academic growth during placement in care.

While the results of this study were found in a unique setting that offers supports that may not be representative of all residential programs, the approaches used are evidence-based and could be replicated in other settings. For example, while living in a family style home, youth were enrolled in the on-campus schools that implement the Boys Town education model (Thompson et al., 1996). This model, successfully implemented in hundreds of schools and districts across the nation (Bishop, Rosen, Miller, & Hendrickson, 1996), incorporates basic behavior management practices, relationship-building techniques, and social skills instruction, strategies that each have decades of empirical support for youth with and at risk of behavioral disorders. Second, the Boys Town Treatment Family Home encorporates a model that relies heavily on a point card system and token economy that is used during the academic school day and throughout the residential program. Previous research with similar populations of children who had or were at risk of behavioral disorders has found the use of token economies to be powerful behavioral change agents, which may significantly affect the academic achievement of high-risk youth (Gable & Strain, 1981). Third, in the academic setting, the whereabouts of youth were monitored closely, and school attendance rates were exceedingly high (on average 97%). These high attendance rates, coupled with the broad, evidence-based engagement and curricular

approaches that are also core to the BTEM (e.g., low student-to-teacher ratios, frequent progress monitoring through the use of curriculum-based measurements, a daily study hour, and daily home-school communication), likely influenced youths' academic gains over the one-year treatment period.

Limitations

As with any other study, there are several limitations that should be noted. Perhaps the most significant limitation was lack of a comparison or randomly assigned control group. Without a comparison group, we were unable to determine if the academic gains were greater than what would be found with youth served in other residential settings for the same duration of time. Similarly, random assignment of youth to treatment and control groups would allow for the systematic evaluation of the effects of this particular educational model. Second, due to the limited size of the sample, we were unable to evaluate possible differences between subgroups of youth in care. Specifically, given the heterogeneous nature of youth served in residential settings (Hagaman, Trout, Chmelka, Thompson, & Reid, in press), we would expect that youth who enter with co-morbid academic disabilities or special education diagnoses might present different patterns of gain. Finally, although the WJ–III is a well known and widely used method for examining academic knowledge, this was the only type of assessment used to measure academic performance.

Future Research

Future research should focus on four areas. First, a randomly assigned control or comparison group is needed to identify a relationship between academic gains and the academic intervention. In doing so, researchers may be able to link academic gains of youth in residential treatment programs to a specific intervention, such as the Boys Town Treatment Family Home and Boys Town educational model. Second, in addition to random assignment, a larger sample size would allow for more complex analyses, such as comparisons across groups, behavior incidents, and potential differences across subpopulations of youth in care (e.g., youth identified with disabilities, differences between males and females). Third, this study focused on gains made by youth over a one-year period. Given this time frame, we were unable to determine the gains made by youth who were served in this setting for longer or shorter durations. Future studies might employ more frequent measures of academic functioning to determine if there is a linear correlation between time in care and academic performance. Finally, in addition to a standardized assessment for overall academic performance, the use of curriculum-based measurements may be valuable in identifying and elaborating on a youth's strengths and limitations across time.

Implications

The findings reveal that youth with elevated levels of academic, behavioral, and mental health risks living in a residential program can make significant academic gains over a one-year period. These findings suggest several implications for practice. Establishing comprehensive supports for positive behavior in the treatment and educational settings may allow for an approach that continually reinforces positive behavior and extinguishes negative behavior. Further, consistent communication between the treatment home and school could allow for continuous and accurate monitoring of youths' academic progress and school engagement behaviors. Youth who receive academic screeners for the purpose of identifying their

Table 1. Academic Gains as Measured Using the *Woodcock-Johnson Test of Academic Achievement, Third Edition:* Intake and One-Year Follow-up

	Intake	Follow-up	Total N= 64		Effect Size N= 64		Change	*T*	*g*
	M		SD	M	SD				
Reading Fluency	91.61		14.07	96.64	15.75	5.03	5.27**	.93*	
Passage Comprehension	90.86		12.17	92.56	12.01	1.70	1.81**	.32*	
Writing Fluency	94.14		16.24	99.17	14.56	5.03	3.72**	.66*	
Spelling	98.86		14.86	100.95	13.45	2.09	2.65**	.47*	
Calculation	91.19		12.61	96.48	12.77	5.29	4.13**	.73*	
Applied Problems	91.31		8.80	91.53	9.08	0.22	0.33**	.06*	
Academic Knowledge	85.33		13.32	87.97	11.74	2.64	3.12**	.55*	

Note. * $p \leq .01$, ** $p \leq .001$

specific strengths and limitations may allow better placement in classes that meet their individual needs. Finally, monitoring homework and providing a study hour should be considered for youth in residential treatments programs. Access to homework assistance might help establish accountability for the youth as well as monitor and address difficult concepts with which youth are struggling. We suspect that these strategies, while comprehensive, may reveal a significant impact on the academic functioning of this high-risk population who too often fail in the system and too frequently demonstrate dispiriting long-term educational outcomes.

References

Ary, D. V., Duncan, T. E., Biglan, A., Metzler, C. W., Noell, J. W., & Smolkowski, K. (1999). Development of adolescent problem behavior. *Journal of Abnormal Child Psychology, 27(2),* 141–150. doi:10.1023/A:1021963531607

Baker, A. J. L., Kurland, D., Curtis, P., Alexander, G., & Papa-Lentini, C. (2007). Mental health and behavioral problems of youth in the child welfare system: Residential treatment centers compared to therapeutic foster care in the Odyssey Project population. *Child Welfare, 86*(3), 97–123.

Bishop, G. B., Rosen, L. A., Miller, C. D., & Hendrickson, J. (1996). Evaluation of the Boys Town motivation system in a U.S. school setting. *School Psychology International, 17*(2), 125–131.

Child Welfare Information Gateway. (2009). *Out-of-home care.* Retrieved from: www.childwelfare.gov/outofhome/overview.cfm

Child Welfare League of America (CWLA). (2005). *The Odyssey Project: A descriptive and prospective study of children and youth in residential group care and therapeutic foster care.* Washington, DC: Author.

Cohen, J. (1988). *Statistical power for the behavioral sciences* (2nd ed.). New York: Academic Press.

Connolly, T., Dowd, T., Criste, A., Nelson, C., & Tobias, L. (1995). *The well-managed classroom: Promoting student success through social skills instruction.* Boys Town, NE: Boys Town Press.

Connor, D. F., Doerfler, L. A., Toscano, P. F., Volungis, A. M., & Steingard, R. J. (2004). Characteristics of children and adolescents admitted to a residential treatment center. *Journal of Child and Family Studies, 13*(4), 497–510. doi:10.1023/B:JCFS.0000044730.66750.57

Davis, J. L., & Daly, D. L. (2003). *Boys Town long-term residential program training manual* (4th ed.). Boys Town, NE: Father Flanagan's Boys' Home.

Gable, R. A., & Strain, P. S. (1981). Individualizing a token reinforcement system for the treatment of children's behavior disorders. *Behavioral Disorders, 7(1),* 39–45.

Griffith, A. K., Trout, A. L., Epstein, M. H., Garbin, C. P., & Pick, B. (in press). Predicting the academic functioning of youth at entry to residential care. *Journal for At-Risk Issues.*

Hagaman, J. L., Trout, A. L., Chmelka, B., Thompson, R., & Reid, R. (in press). Risk profiles of children entering residential care: A cluster analysis. *Journal of Child and Family Studies.*

Hensley, M., Powell, W., Lamke, S., & Hartman, S. (2004). *The well-managed classroom* (2nd ed.). Boys Town, NE: Father Flanagan's Boys' Home.

James, S., Leslie, L. K., Hurlburt, M. S., Slymen, D. J., Landsverk, J., Davis, I., Mathiesen, S. G., & Zhang, J. (2006). Children in out-of-home care: Entry into residential or restrictive mental health and residential care placements. *Journal of Emotional and Behavioral Disorders, 14*(4), 196–208. doi:10.1177/10634266060140040301

Larzelere, R. E., Daly, D. L., Davis, J. L., Chmelka, M. B., Handwerk, M. L. (2004). Outcome evaluation of Girls and Boys Town's Family Home Program. *Education and Treatment of Children, 27*(2), 130–149.

National Assessment of Educational Progress. (2006). *The nation's report card: Reading 2006.* Jessup, MD: ED Pubs.

Thompson, R. W., Smith, G. L., Osgood, D. W., Dowd, T. P., Friman, P. C., & Daly, D. L. (1996). Residential care: A study of short- and long-term educational effects. *Children and Youth Services Review, 18*(3), 221–242. doi:10.1016/0190-7409(96)00002-3

Trout, A. L., Hagaman, J., Casey, K., Reid, R., & Epstein, M. H. (2008). The academic status of children and youth in out-of-home care: A review of the literature. *Children and Youth Services Review, 30*(9), 979–994. doi: 0.1016/j.childyouth.2007.11.019

Trout, A. L., Hagaman, J., Chmelka, B. M., Gehringer, R., Epstein, M. H., & Reid, R. (2008). The academic, behavioral, and mental health status of children and youth at entry to residential care. *Residential Treatment for Children & Youth, 25*(4), 359–374. doi:10.1080/08865710802533654

U.S. Department of Education. (2005). *National assessment of educational progress.* Washington, DC: Author.

U.S. Department of Education. (2007). *National Center for Education Statistics: Dropout and completion rates in the United States.* Washington, DC: Author.

Wiederholt, J. L., & Bryant, B. R. (2001). GORT 4 Gray Oral Reading Tests *examiner's manual.* Austin, TX: Pro-Ed.

Woodcock, R. W., McGrew, K. S., & Mather, N. (2001). *Woodcock-Johnson test of academic achievement, 3rd edition*: Itasca, IL: Riverside Publishing.

Wurtele, S. K., Wilson, D. R., & Prentice-Dunn, S. (1983). Characteristics of children in residential treatment programs: Findings and clinical implications. *Journal of Clinical Child Psychology, 12*(2), 137–144.

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School Social Work Services and Maltreated Children

Melissa Jonson-Reid, PhD

School social work exists in some form in the majority of states in this country, and it is one of the largest and oldest specialty areas in the field of social work (Altshuler & Webb, 2009). Several universities offer special training programs to align with state certification requirements established by departments of education. Children who experience maltreatment are disproportionately poor, guaranteeing that most of these vulnerable children will have contact with public schools. The high proportion of maltreated children in specialized school programs such as Special Education (Sullivan & Knutson, 2000) and among populations with behavior problems makes social workers likely to have substantial contact with this population of children (Jonson-Reid et al., 2007). The literature is largely lacking, however, on exactly what services are provided to these children by school social workers or how widespread the potential coverage is. The goal of this article is to lay the groundwork for understanding not only what currently exists but also what *could* exist in practice.

Who Are Included as Maltreated Children?

It is first necessary to define who maltreated children are so that we can quantify just how large this group of children may be. Academics and policy makers disagree about definitions, and clinicians are likely to disagree further. Traditional means of categorizing maltreatment, physical abuse, sexual abuse, neglect, and emotional abuse lay the foundation for the "what" of child maltreatment but do not help us much with "who." Much intervention and prevention work has focused on a subset of children deemed *maltreated* by virtue of a label of "indicated" or "substantiated" by a child protection agency (U.S. Department of Health and Human Services [USDHHS], Administration on Children, Youth, & Families, 2009). Unfortunately, the research suggests that this definition of *maltreatment* excludes the much larger and similarly at-risk group of children who are contacted by child protection but are not substantiated. This is unfortunate, as unsubstantiated children are virtually at the same risk and need for services as substantiated children (Drake, 1996; Hussey et al., 2005; Kohl, Jonson-Reid, & Drake, 2009). Beyond this, there is an unknown, but undoubtedly large, number of "undetected" children (Sedlak et al., 2009).

Within the group of maltreated children, there are variations in the degrees of children's involvement in other service systems. For example, indicators of abuse or neglect that are cause for concern may not meet the legislative standards required to warrant the involvement of child protection services (Kopels, 2006; VanBergeijk, 2006). This may mean that a child is not receiving services from a child protection agency and has total reliance on the school's programs. Other children who are served by child welfare agencies may remain in their homes but may still need collaborative or additional support. Still other children are removed and placed into foster care. They need different types of school social work services that are focused on supporting the child's academic success. However, this help may not necessarily be given with expectations of outreach to the home.

What Is the Burden of Maltreated Children for School Systems?

A study in Omaha using linked records related to child maltreatment, schools, and special education found an overall rate of 14% of children in the school system with official records of maltreatment—and a rate of over 31% among children in special education (Sullivan & Knutson, 2000). This study defined *maltreatment* as occurring in "a child having had at least one substantiated report." This also means that the number of children who were reported to child protective services but not substantiated is not known, but it is certainly higher. Child maltreatment rates also vary by community (Drake & Pandey, 1996), so for some schools, the rate is likely much higher. Also, because the 2003 revision of the Child Abuse Prevention and Treatment Act (CAPTA) required child welfare agencies to refer children in substantiated cases to early childhood programs, the rate may be increasing. Many studies also indicate that children who are maltreated are at higher risk of behavioral and academic problems (Crozier & Barth, 2005; Jonson-Reid, Drake, Kim, Porterfield, & Han, 2004; Leiter & Johnsen, 1997; Shonk & Cicchetti, 2001; Staudt, 2001).

The number of school children with documented maltreatment is large, and the heightened risk for various untoward outcomes for them at school increases the likelihood of referral to some sort of school-based service. One study found that 20% of all school social work cases were referred for suspected or known maltreatment (Jonson-Reid et al., 2007). Because this was a study of school social work case records only, it is not known how many other students on the caseload may have had prior histories of maltreatment that were not a part of the referral. The question remains, What exactly will the nature of the service be, and is it likely to be provided by a school social worker?

Data from the recent school health policies and programs study indicate that fewer than 14% of schools have full-time school social workers (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). School social work roles vary, and while they may include direct services, they may also focus on consultation, coordination, or program development (Constable, 2009). Social workers may operate at the district level in coordination positions, may provide itinerant direct services to multiple schools, or may provide direct services at a single site. In the aforementioned study that found 20% of the school social work caseload was maltreatment-related, the participating districts employed an itinerant model, meaning school social workers had large caseloads and provided primarily crisis intervention and case management (Jonson-Reid et al., 2007).

So how do we think about school social work services and maltreated children? One important question is whether maltreated children should be an automatic target population for school-based services, irrespective of whether the children are demonstrating difficulty in school. In other words, should identification of child maltreatment automatically initiate a set of activities to prevent further harm? If so, the literature on child abuse or trauma-specific treatment might inform such an approach. Reviews of best practices or promising practices can be found online and are nicely summarized in the *Children's Advocacy Center Directors' Guide to Mental Health Services for Abused Children* (Child Welfare Committee, 2008). Many mental health treatment approaches, however, may not have been adapted for use in school settings, and many lack direct application to cases involving neglect without abuse.

Two interventions have been researched, show promising results, and could be executed by school social workers. They include peer-mediated treatment for maltreated preschoolers and Cognitive-Behavioral Intervention for Trauma in Schools (CBITS). Peer-mediated treatment uses the assistance of professionals to stage play situations that facilitate positive peer interaction and support among maltreated preschool-aged children who display socially withdrawn behaviors (Fantuzzo, Manns, Atkins, & Myers, 2005). CBITS was designed for use with school-aged students who have been either directly victimized or indirectly traumatized by witnessing violence. The program includes a short-term group-delivered curriculum and short-term structured individualized sessions, and it can be implemented by school social workers (Stein, Jaycox, & Tu, 2005). Of course, such approaches would likely be difficult in a district where school social workers are limited to providing itinerant case management and crisis intervention.

Another option for targeting the entire population of maltreated children is to consider them part of a broader at-risk population rather than in need of school-based services specific to maltreatment. Such an approach might mean connecting these children with general prevention programs that encourage prosocial behaviors and school success. Examples of programs that could be integrated into schools include Promoting Alternative Thinking Strategies (PATHS) or the Child Development Project (Battistich, Schaps, Watson, & Solomon, 1996; Domitrovich et al., 2010). In such a case, the school social worker might help develop and implement the larger program and refer the appropriate children rather than providing direct services.

Still another focus might be to support the school success of children who are involved with child welfare agencies, either receiving in-home services or in foster care. Several authors have recommended collaborative approaches between school social work and child protection agencies in these cases (Barth, 1985; Ayasse, 1998; Jonson-Reid et al., 2007; Scannapieco, 2006). These approaches range from the collaborative development of programs improving services to maltreated

children, to school social workers providing additional case management, and to formal partnerships providing early intervention services with families (USDHHS, Children's Bureau, 2003; Jonson-Reid & Stahlschmidt, 2009). Although the Children's Bureau (2003) has conducted a review of previously funded projects related to school-based services and child maltreatment, almost all of these projects involved agencies outside the school collaborating with the school to provide services rather than evaluating existing school-based services, such as school social work.

Two exceptions exist regarding known models of school-based support for children involved with child welfare, but the only available data are evaluation based rather than data from controlled research trials. The first exception is Foster Youth Services in California, a statewide set of programs that includes school-based models to support the success of children in foster care (most of whom have maltreatment histories). These programs vary but include some combination of educational record tracking, case management, counseling, and tutoring (Ayasse, 1998). Second is a model that has existed for some time in Missouri and involves the direct referral of preventive services cases (where child care concerns haven not risen to the level required for formal child protection involvement) from child welfare to a school district that has provided additional home visiting and school support for these children (Jonson-Reid & Stahlschmidt, 2009).

School social workers are, and will continue to be, a resource for children experiencing child abuse and neglect. However, practitioners seeking to access or develop services for maltreated children must carefully consider the scope of the population to be served and the fit with available resources in the local schools. If the target of intervention is all children with alleged maltreatment, this population will likely be quite large, so approaches that can be implemented realistically in schools is essential. Further, the type of approach must be considered—individual or group, trauma-specific treatment, large-scale prevention programming, or collaborative school-based support. The match between the desired targets, the proposed intervention, and the availability of school social work services in a given area must be considered. If a school currently utilizes its school social worker for large-scale program development activities, this would not be conducive to providing individual or group treatment. If this model is to be adopted, the school social worker may be a valuable ally and collaborator in the development and implementation of the program, but not necessarily the provider of direct services. Or, if having the services provided directly by school social workers is desired, it is likely additional school social work staff will be needed.

In conclusion, much work still needs to be done to understand the nature of current service provision, training, and the potential impact of school social work services with maltreated children. It is clear that the needs of maltreated children are relevant to the educational and social goals for schools and that maltreated children do regularly attend school. Although this provides a logical rationale for providing school-based services, it is insufficient to simply declare schools as the ideal resource to serve maltreated children. We need to understand the services that are available, identify gaps in needs and training, and test new models that leverage school social work to support the ongoing well-being of maltreated children. We have hope that articles such as this one will encourage this work and result in increased knowledge about the effectiveness and efficacy of such efforts.

References

Altshuler, S., & Webb, J. (2009). School social work: Increasing the legitimacy of the profession. *Children and Schools, 31*(4), 207–218.

Ayasse, A. (1998). Addressing the needs of foster children: The Foster Youth Services Program. In E. Freeman, C. Franklin, R. Fong, G. Schaffer, & E. Timberlake (Eds.), *Multisystem skills and interventions in school social work practice* (pp. 52–61). Washington, DC: NASW Press.

Barth, R. (1985). Collaboration between child welfare and school social work services. *Social Work in Education, 8*(1), 32–47.

Battistich, V., Schaps, E., Watson, M., & Solomon, D. (1996). Preventive effects of the Child Development Project: Early findings from an ongoing multisite demonstration trial. *Journal of Applied Developmental Psychology, 11*(1), 12–35.

Brener, N., Weist, M., Adelman, H., Taylor, L., & Vernon-Smiley, M. (2007). Mental health and social services: Results from the School Health Policies and Programs Study 2006. *Journal of School Health, 77*(8), 486–499.

Child Welfare Committee, National Child Traumatic Stress Network, & National Children's Alliance. (2008). *CAC directors' guide to mental health services for abused children.* Los Angeles, CA, & Durham, NC: National Center for Child Traumatic Stress. Retrieved from: www.nctsnet.org/nctsn_assets/pdfs/CAC_Directors_Guide_Final.pdf

Constable, R. (2009). The role of the school social worker. In C. Massat, R. Constable, S. McDonald, & J. Flynn (Eds.), *School social work: Practice, policy and research* (2nd ed.) (pp. 3–29). Chicago, IL: Lyceum Books.

Crozier, J., & Barth, R. (2005). Cognitive and academic functioning in maltreated children. *Children & Schools, 27*(4), 197–206.

Domitrovich, C., Bradshaw, C., Greenberg, M., Embry, D., Poduska, J., & Ialongo, N. (2010). Integrated models of school-based prevention: Logic and theory. *Psychology in the Schools, 47*(1), 71–88.

Drake, B. (1996). Predictors of preventative services provision among unsubstantiated cases. *Child Maltreatment 1*(2), 68–75.

Drake, B., & Pandey, S. (1996). Understanding the relationship between neighborhood poverty and child maltreatment. *Child Abuse & Neglect, 20*(11), 1003–1018.

Fantuzzo, J., Manz, P., Atkins, M., & Meyers, R. (2005). Peer-mediated treatment of socially withdrawn maltreated preschool children: Cultivating natural community resources. *Journal of Clinical Child and Adolescent Psychology, 34*(2), 320–325.

Hussey, J., Marshal, J., English, D., Knight, E., Lau, A., Dubowitz, H., & Kotch, J. (2005). Defining maltreatment according to substantiation: Distinction without a difference? *Child Abuse & Neglect, 29*(5), 479–472.

Jonson-Reid, M., Drake, B., Kim, J., Porterfield, S., & Han, L. (2004). A prospective analysis of the relationship between reported child maltreatment and special education eligibility among poor children. *Child Maltreatment, 9*(4), 382–394**.**

Jonson-Reid, M., Kim, J., Citerman, B., Columbini, C., Essma, A., Fezzi, N., Green, D., Kontak, D., Mueller, N., & Thomas, B. (2007). Maltreated children in schools: The interface of school social work and child welfare. *Children & Schools, 29*(3), 182–191.

Jonson-Reid, M., & Stahlschmidt, M. (2009, December). *Child abuse prevention evaluation: Final report.* Washington, DC: Washington University, George Warren Brown School of Social Work.

Kohl, P., Jonson-Reid, M., & Drake, B. (2009). Time to leave substantiation behind: Findings from a national probability study. *Child Maltreatment, 14*(1), 17–26.

Kopels, S. (2006). Laws and procedures for reporting child abuse: An overview. In C. Franklin, M. Harris, & P. Allen-Meares (Eds.), *The school services sourcebook: A guide for school-based professionals* (pp. 369–376). New York: Oxford University Press.

Leiter, J., & Johnsen, M. (1997). Child maltreatment and school performance declines: An event history analysis. *American Education Research Journal, 34*(3), 563–589.

Scannapieco, M. (2006). Building effective alliances with child protective services and other child welfare agencies. In C. Franklin, M. Harris, & P. Allen-Meares (Eds.), *The school services sourcebook: A guide for school-based professionals* (pp. 383–388). New York: Oxford University Press.

Sedlak, A., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2009). *Fourth national incidence study of child abuse and neglect (NIS-4): Report to Congress.* Washington, DC: U.S. Department of Health and Human Services, Government Printing Office.

Shonk, S., & Cicchetti, D. (2001). Maltreatment, competency deficits, and risk for academic and behavioral maladjustment. *Developmental Psychology, 37*(1), 3–17.

Staudt, M. (2001). Psychopathology, peer relations, and school functioning of maltreated children: A literature review. *Children & Schools, 23*(2), 85–100.

Stein, B., Jaycox, L., & Tu, W. (2005). *Helping children cope with violence: A school-based program that works.* [Research brief]. Rand Corporation. Retrieved from: www.rand.org/pubs/research_briefs/RB4557-1/

Sullivan, P., & Knuston, J. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect, 24*(10), 1257–1273.

U.S. Department of Health and Human Services (USDHHS), Administration on Children, Youth, and Families. (2009). *Child maltreatment 2007.* Washington, DC: Government Printing Office.

U.S. Department of Health and Human Services (USDHHS), Children's Bureau. (2003). *School-based child maltreatment programs: Synthesis of lessons learned.* Wa**s**hington, DC: Government Printing Office.

VanBergeijk, E. (2006). Identifying child abuse or neglect strategies in a school setting. In C. Franklin, M. Harris, & P. Allen-Meares (Eds.), *The school services sourcebook: A guide for school-based professionals* (pp. 361–368). New York: Oxford University Press.

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School-Based Child Sexual Abuse Prevention Programs: Implications for Practitioners

Ian Barron, DEdPsy, and Keith Topping, PhD, FBPsS

Schools are a primary location for the delivery of child sexual abuse prevention programs. This has both advantages and disadvantages. Further, despite the rapid growth internationally of school-based abuse prevention programs, there continues to be a lack of systematic evaluation, and many of these programs are implemented on trust rather than on evidence of their effectiveness (Finkelhor & Dzuiba-Leatherman, 1995; MacIntyre & Carr, 1999a; Topping & Barron, 2009). Secrecy about abuse (Krivacska, 1990), the difficulty in measuring transfer of skills from programs to real life (Ko & Cosden, 2001), and the complex interaction of factors related to program, presenter, and student have all been barriers to good quality evaluation. In recent years, more evidence has accumulated, but critiques have been rare.

This article summarizes the authors' recent literature review and meta-analysis of the effectiveness of purely school-based child sexual abuse prevention programs (Topping & Barron, 2009) and outlines the primary implications for their effective delivery. We also provide recommendations for teachers and child protection practitioners in planning and delivering sexual abuse prevention programs. First, we present some background information to help frame the context of the issue.

Definitions of child sexual abuse In order for schools to intervene effectively in addressing child sexual abuse, clarity is needed regarding a definition of what constitutes child sexual abuse. This is all the more important given that child abuse is a morally loaded and complex concept (Thorpe, 1994). In a recent review of efficacy studies, Topping and Barron (2009) identified that definitions of child sexual abuse used in program evaluation studies were characterized by omissions and lack of clarity. Only two studies in the review, both of which came from the United States, explicitly defined sexual abuse. Telljohann, Everett, and Price (1997), defined *child sexual abuse* as "non consensual physical contact with a minor for the purpose of sexual gratification." Pohl and Hazzard's (1990) definition was from the *Feeling Yes, Feeling No* prevention program and was reported in child-like language, i.e., "When someone gives you the 'no' feeling by touching or looking at your private parts or having you touch or look at the private parts of their body."

Given the paucity of definitions in efficacy studies, definitions were explored through the broader perspective of child sexual abuse literature. Definitions of child sexual abuse were of three different types (Faller, 1993). They included *criminal* definitions, where the focus was on securing prosecutions; *child protection* definitions, where the focus was on protecting a child's safety; and *clinical* definitions, where the concern was more with the impact of abuse on the child. More recent definitions incorporate peer abuse, child prostitution, Internet grooming and pornography, and pedophile networks, along with traditional categories, such as incest (Chase & Statham, 2005).

For the purpose of the current literature review, *child sexual abuse* is defined as follows:

> Any child below the age of 16 years may be deemed to have been sexually abused when any person(s), by design or neglect, exploits the child, directly or indirectly, in any activity intended to lead to the sexual arousal or other forms of gratification of that person or any other person(s) including organised networks. The definition holds whether or not there has been genital contact and whether or not the child is said to have initiated, or consented to the behaviour. (Scottish Office, 1998)

This definition had been adopted by education, social work, and police agencies in Scotland, and thus it provided a degree of fit between the review reported and practitioner guidelines.

The extent of child sexual abuse Schools need to be aware of the size of the problem. Child sexual abuse occurs across all socioeconomic levels and in all ethnic groups (Dhooper & Schneider, 1995) and can have both short- and long-term consequences. The immediate impact of abuse can lead to a myriad of symptoms, including self-harm, dissociation, substance misuse, posttraumatic stress (intrusion, hyper-vigilance, and avoidance), difficulties in concentration and learning, and lowered self-esteem. In the longer term, difficulties can continue to be pervasive, including depression, interpersonal difficulties, substance abuse, delinquency, and revictimization (Finkelhor, 1986). According to a longitudinal study of 8,292 U.K. families (Roberts, O'Connor, Dunn, & Golding, 2004), child sexual abuse has long-term repercussions, including a negative

impact on adult mental health, parenting relationships, and child adjustment in the succeeding generation.

The extent of child sexual abuse is often reported by either incidence or prevalence statistics. Incidence statistics tend to refer to the number of reported incidents within a given time frame, e.g., the number of cases referred to the child protection system in any given year. Incidence statistics on the whole suggest fairly low levels of occurrence of child sexual abuse, e.g., 2.4 per 1,000 in the U.S. (Faller, 1993), although incidence statistics are increasing internationally. Possible reasons may include increased adult awareness, recognition and willingness to report, or indeed, increased numbers of disclosures from children (Faller, 1993).
In contrast, prevalence studies typically ask adults retrospectively to share whether they were abused in childhood, and as such, these reports are susceptible to memory deficits and distortions. Despite the use of different definitions, populations, and methods, such studies tend to indicate far higher levels of child sexual abuse. In the United States, between 8% and 71% of the female population report some form of sexual victimization, compared with 3% to 37% of the male population (Rind, Tromovitch, & Bauserman, 1998). The age range of greatest risk to both boys and girls is between 7 and 13, but sexual abuse occurs at any age from birth onward (Finkelhor & Baron, 1986).

In comparing incidence with prevalence statistics, we found that many cases go unreported and undetected, and most survivors never tell of their abuse in childhood (Gomes-Schwart, Horowitz, Cardarellii, & Sauziet, 1990). A potential safety outcome for sexual abuse prevention programs could therefore be an increase in children reporting abusive experiences, resulting in a better match between prevalence and incidence statistics (Gough, 1993).

Perpetrators of child sexual abuse Schools need to be aware of where the harm is coming from to target prevention efforts effectively. Prevalence statistics suggest 10%–30% of perpetrators are strangers to their child victims, with the remainder being family members or other persons known to the child. Within this latter group, for girls, one third to half of the perpetrators are family members compared with one tenth to one fifth for boys (Finkelhor, 1984). Sexual abuse by peers is apparently being identified more frequently. Abel and colleagues (1987) reported that 59% of their sample began abusing in adolescence. With more males disclosing abuse, female perpetration is also being identified more often, with incidence figures suggesting that around 10% of substantiated child protection cases involve a female perpetrator (Mendal, 1995). In summary, prevention programs need to address abuse by known adults as well as by strangers, female as well as male perpetration, and abuse by peers.

School as a context for effective delivery Given the pervasiveness of child sexual abuse within society, schools are vehicles for reaching most children. Teachers have a central role in the delivery of the curriculum as well as noticing child behavior that might suggest child sexual abuse. School-based delivery locates the program in a system or ecology that can be sustained over time, so awareness raising in consistent peer and adult groups and consequent follow-up are both more possible. These advantages could be of great importance. However, school-based programs also have the disadvantage that they are likely to be brief and must fit within other curriculum priorities and demands. Programs may be delivered by teachers who are likely to have pedagogical competence but who may have limited content knowledge about child sexual abuse, with possible personal sensitivities and limited confidence. Another major limitation could be the quality of teacher training. Kenny (2004) reported that teachers' self-reported lack of awareness of the signs of child abuse and reporting procedures, and Baginsky and Macpherson (2005) found that providers of initial teacher training often struggled to prepare student teachers to deal with child protection concerns.

If schools are to deliver abuse prevention programs, we need clarity about what is to be achieved. Finkelhor (2009) concisely summarized the main aims of school-based abuse prevention programs as the prevention of significant harm for children, the disclosure of abuse, the reduction in child self-blame, and the increase of sensitivity by the school and community environment. This latter aim involves the education of parents, teachers, and other adults in responding more helpfully to children in need and at risk.

Debates in the absence of evidence Within the context of limited empirical evidence, there has been considerable dispute about the efficacy of school-based sexual abuse prevention programs. Some professionals suggest that these interventions are so sensitive that they should remain in a clinical context, while others have argued for a community-based approach that involves many types of adults in raising awareness. Programs have been criticized for putting too much responsibility on children for keeping themselves safe and for failing to understand the nature of the power adults hold over children (Wyre, 1993). Some opponents suggest that empowering children without parental education places children at risk of further abuse by experiencing physical punishment when they challenge existing parenting norms (Briggs & Hawkins, 1994a, 1994b). There is also debate regarding whether young children can comprehend certain abuse prevention concepts, as well as what concepts should be core for children's safety (Melton, 1992; Krivacka, 1990). Indeed, Cohn (1982) questioned whether children were the appropriate recipients of such programs, citing situations in which children who had a need to trust their adult caretakers for their psychosocial development were placed in the untenable position of being responsible for protecting themselves from their so-called

caretakers. Pelcovitz, Adler, Kaplan, Packman, & Kreiger (1992) suggested that professionals could erroneously conclude that because children had experienced an abuse prevention program, this meant that they were safe from harm.

Evidence from narrative reviews Although previous research reviews have sought to critique efficacy studies, the focus and quality of these reviews have been highly variable. Reviews have grouped all kinds of interventions with diverse populations in all kinds of contexts. Not surprisingly, this identified a range of potentially relevant variables underpinning program effectiveness. These variables included diversity of teaching approaches, impact of different presenters, age range of participants from kindergarten to school-age, developmental appropriateness of the curriculum, and impact of parental involvement. What is important for schools, despite the limited scope of these reviews, is that evidence across studies supported the conclusion that most children could benefit from the concepts learned from abuse prevention programs and the perceived acquisition of self-protection skills (Finkelhor & Strapko, 1992; Gough, 1993; Mayes, Currie, MacLeod, Gillies, & Warden, 1992; Carroll, Miltenberger, & O'Neil, 1992; MacMillan, MacMillan, Offord, Griffith, & MacMillan, 1994; Bevill & Gast, 1998; Miltenberger & Roberts, 1999; MacIntyre & Carr, 2000; Topping & Barron, 2009). The importance of behavioral skills training, modeling, role-playing, and corrective feedback was identified as underpinning skill development. Finkelhor and Strapko (1992) found that programs could lead to knowledge and skill gains for both parents and teachers. None of these reviews, however, was able to conclude that there had been an actual reduction in abuse. School-based sexual abuse prevention programs were, therefore, seen as just one intervention in the range of preventative measures necessary to assure children's safety in society.

Supportive findings from meta-analysis On the whole, meta-analytic reviews, although covering diverse studies, did affirm the main findings of traditional narrative reviews. Davis and Gidycz (2000) for example, reviewed 27 studies and found that children who received prevention programs performed 1.07 SD higher on knowledge and skill measures than control group participants. The highest effect sizes were found for programs that lasted more than four sessions and utilized active behavioral training. The authors argued that longer programs gave children more time to integrate self-protection skills into their cognitive repertoires. Earlier research, however, had indicated that both brief and longer-term programs could be effective, with knowledge gains being maintained (effect size = 0.47) up to a year after program delivery (Heidotting, Keiffer, & Soled, 1995). Program content, participants' age, and socioeconomic status were found to be the significant factors influencing program effectiveness (Rispens, Aleman, & Goudena, 1997).

Despite these findings, there was lack of evidence regarding students' transfer of knowledge and skill gains into real life situations,

with Bolen and Scannapieco (1999) concluding that there was little evidence that programs actually reduced child sexual abuse. As a rebuttal, Finkelhor (2007) reported on over a decade of national U.S.-substantiated child sexual abuse cases up to 2004, indicating a reduction in incidence of child sexual abuse since the implementation of sexual abuse prevention programs. The authors, however, were tentative in making a causal link between prevention programs and the apparent decline in child sexual abuse. Indeed, changes in incidence figures can be more a reflection of changes in policy than actual change in the prevalence of abuse.

In summary, while schools are well situated for teaching children self-protective knowledge and skills and for responding to disclosures of abuse, significant systemic hurdles exist. These include the nature of the school context in which the programs are delivered, levels of parental involvement, clarity of program aims, school and teacher motivation, and teacher skill levels in teaching abuse prevention programs and responding to disclosures. Appropriate training for teachers and schools in the delivery of programs is a key issue (Barron & Topping, in press-a).

Literature Review and Meta-Analysis

Methods

A systematic literature review and meta-analysis were conducted on efficacy studies of school-based child sexual abuse prevention programs over a 12- year period between 1990 and 2002. Computerized bibliographic searches of the Educational Resources Information Centre (ERIC) and the Social Science Citation Index utilized both general and advanced searches. Inclusion criteria included the following: programs designed to prevent child sexual abuse, evaluations with a formal structure and specified outcomes to be assessed, target population representative of the whole school

population, and publications in English. We did not include studies that exclusively focused on preschool children or students with disabilities, or that solely reported parents' and teachers' experiences. There were 22 efficacy studies that met the inclusion criteria. Their methodology was analyzed through four dimensions (target population, prevention program implementation, evaluation methodology, and cost-effectiveness), and outcomes for students were analyzed using nine categories (knowledge, skills, emotion, perception of risk, touch discrimination, reported response to actual threat/abuse, disclosure, negative effects, and maintenance of gains).

Results

Despite the diversity of participants, small sample sizes, differing study designs, variations in measurement tools, and types of intervention, nearly all the studies reviewed found a small but statistically significant knowledge gain. Interestingly, students displayed high levels of prior knowledge of abuse prevention concepts, although the researchers were uncertain about how such knowledge had been obtained. Most of the studies used pencil and paper tests to assess skill acquisition, although the psychometric properties of these tests were largely unknown.

Just over a third of the studies reported emotional gains for participants who participated in a prevention program. These gains tended to be reported as percentages of children's responses or adult observations of a child. The studies used few formal measures, such as an anxiety inventory, self-esteem inventory, or locus of control scale. There were few qualitative studies that sought to explore children's subjective experiences of such programs, and only a small number of studies looked at the participants' perceptions of risk. The results were mixed and, as such, inconclusive. Different methodology and evaluation measures were used in the studies included in the review, which made it difficult to make comparisons among them.

Just over a third of the included studies reported disclosure rates. Many gave overall disclosure rates rather than separate figures for the experimental and control groups, or they reported that disclosures had occurred but gave no figures (Dhooper & Schneider, 1995). For those studies that did indicate the difference, children who experienced prevention programs reported higher disclosure rates. Such disclosures were reportedly characterized by an absence of false allegations (Oldfield, Hays, & Megal, 1996). Hazzard, Kleemeier, & Webb (1990) found that there was little difference in the disclosure rate regardless of whether the program was presented by a teacher or an outside expert consultant. Teacher presenters, however, were required to be well trained**.**

Just over half the studies maintained data collection on the effects of prevention programs over periods that ranged from 6 weeks to the time students transferred to high school (at age 13 years). Some studies showed that knowledge gains were maintained at 2, 3, and 5 months after the program had been completed (Jacobs & Hashima, 1995; Oldfield et al., 1996; Taal & Edelaar, 1997; Warden, Moran, Gillies, Mayes, & MacLeod, 1997; MacIntyre & Carr, 1999a). By contrast, Warden and colleagues (1997) found that unrehearsed knowledge gains tended to be lost between 2 and 3 months postprogram, while in the study conducted by Herbert, Lavoie, Piche, and Poitras (2001), skills decayed at 2 months, yet they were still at higher levels than demonstrated on the pretest.

Over half the studies reported a range of negative experiences for a small number of children who had participated in a program. There was no evidence to suggest that the anxiety experienced by some children was overwhelming. It was unclear whether the reported anxiety was a result of the program, the evaluation measures, or the methodological limitations of the studies. Some authors went on to suggest that a degree of anxiety was helpful, as this may have helped some children to be more alert to the risk of child sexual abuse (Herbert et al., 2001). Casper (1999) explored and addressed the positive outcomes for children from these programs. Older children with lower anxiety and an internal locus of control were positively associated with higher scores following a prevention program. Children who were younger and who felt more anxious, however, were more likely to report that the abuse prevention program enabled them to "learn what to do if touched inappropriately." However, the research into child characteristics has been minimal and narrow in focus.

Discussion

Self-protection knowledge Evidence suggests that the strength of school-based sexual abuse prevention programs lies in their capacity to increase children's knowledge and possibly their skills in relation to avoiding child sexual abuse. Because children come into programs with surprisingly high levels of prior knowledge, gains from these prevention programs are small on average (Tutty, 1994). The amount of prior learning tends to vary with the socioeconomic status of parents (Briggs & Hawkins, 1994a). To fine tune programs for children's learning needs, schools will need first to assess children's prior knowledge. Schools in areas of environmental deprivation may need more comprehensive programs utilizing training for parents (MacIntyre & Carr, 1999a).

How best to adapt programs across the age range will be a challenge for schools. For example, Conte, Rosen, Saperstein, and Shermack (1985) noted that although older children can learn abstract ideas, younger children need concrete concepts with visual cues. Barnett, Manley, and Ciccetti (1993) warned against delivering the curriculum on the erroneous assumption that a child's chronological and developmental age is always consistent. Further, the family's degree of acceptance of the concepts being taught can also affect understanding and retention for some children (Briggs, 1991; Tutty, 1994, 1997, 2000). Two concepts were difficult for children across the age range to grasp; the first is why perpetrators abuse (Pohl & Hazard, 1990), and the second is that trusted

adults, including family members, can be abusers (Tutty, 1992). In considering what content should be taught to children of different ages, schools will need to evaluate whether programs are developmentally and culturally appropriate for students targeted to receive the program, with particular attention paid to concepts that are more difficult to understand.

Self-protection skills While gaining self-protection knowledge is seen as a necessary prerequisite to action, it is not sufficient to keep children safe (Cormack, Johnson, Peters, & Williams, 1998; Briggs & Hawkins, 1994a). Some researchers refer to an attitude/behavior discrepancy, in which children's reports of behavioral intentions to protect themselves do not always fit with their behavior in an actual situation (MacIntyre & Carr, 1999a). However a national study (Finkelhor, Asdigan, & Dzuiba-Leatherman, 1995) indicated that children who had experienced an abuse prevention program were more likely to use the self-protective strategies than children who had not participated in a program. The former group members were also more confident about their strategies. Although there is little research to indicate that self-protective strategies reduce the likelihood of sexual abuse, evidence does exist to suggest that children who have experienced prevention programs do disclose abuse earlier (Gibson & Leitenberg, 2000).

Kolko (1988) broadened the debate over how to teach skills by observing that many of the skills taught in programs are the same as those taught in social education lessons (communication, self esteem, assertiveness, conflict resolution, etc.). A challenge yet to be addressed by research is whether there is a need to teach abuse prevention skills specifically, or whether it will be sufficient to teach children communication skills with advice about how to tell and keep on telling trusted adults about uncomfortable, threatening, and/or abusive experiences. In the absence of evidence supporting the effectiveness of social education lessons, schools are advised to implement evidence-based abuse prevention programs.

Effect sizes It was possible to calculate effect sizes for 11 out of the 22 studies that focused on knowledge and skill gains. Effect sizes were diverse, ranging from 0.14 to 1.40 (small to large effect size). For the 5,812 participants, the mean effect size equalled 0.61, a moderate effect size (Cohen, 1977). In other words, immediately after the completion of the prevention program, children made modest average gains in knowledge and perceived skills.

Researchers identified effective programs by selecting those programs with moderate- to high-effect sizes, i.e., four or more gains in outcome measures (knowledge, skills, emotion, disclosure, and maintenance). These "effective" programs were characterized by a combination of participants seeing how to respond in abusive situations (modeling), talking about and reflecting on what had been seen (discussion) and skills rehearsal (role-playing). Effective programs averaged above five sessions. Because these programs were led by teachers, trained volunteers, mental health professionals, social service staff members, a theater group, and female community workers, it appears that the programs can be delivered effectively by a range of personnel.

Maintenance of gains Follow-up studies suggested another strength of school-based prevention programs; the acquired skills were maintained as long as a year even after a program of only short duration (Briggs & Hawkins, 1994a; Hazzard, Webb, Kleemeier, Angert, & Pohl, 1991). Active involvement of parents and teachers, both during and following the program, can also lead to knowledge and skill gains (MacIntyre & Carr, 1999a; Briggs & Hawkins, 1994b; Hazzard et al., 1991). Casper (1999) reported that participants who received multiple exposures to programs learned significantly more, even when the last exposure had been 3 years earlier, and recommended that children participate in repeated abuse prevention programs. Likewise, booster sessions were found to enhance learning (Tutty, 1997; Briggs & Hawkins, 1994a; Hazzard et al., 1991). Some concepts, however, are more difficult to retain than others, especially "abuse by someone you know" (Plummer, 1984).

Disclosure of significant harm One of the strengths of these programs is their capacity to enable children to share their stories of harm. MacMillan and others (1994) argue that abuse disclosure is the most valid and reliable measure of program success. Most studies to date show that school-based programs lead to small numbers of disclosures, compared with the extent of abuse indicated by prevalence statistics gleaned from the degree to which adults disclose sexual abuse that occurred during their own childhoods.

A recent study suggests that programs may well have the capacity to enable disclosures to levels closer to prevalence statistics. Barron and Topping (in press-b) found that an effective program could lead to a large number and wide diversity of disclosures of significant harm, with such disclosures made confidentially to a survivor help line after the completion of program lessons. Only a small number of previous studies would support the generalization of disclosure beyond program lessons. (MacIntyre & Carr, 1999b; Finkelhor et al., 1995). Barron and Topping concluded that schools need to expect disclosures and be prepared to respond in a variety of ways, including individual support, group work, and where necessary, child protection referrals. A barrier to this was lack of recognition by teachers of disclosures that occurred in the classroom.

A number of studies have sought to clarify factors affecting disclosure, i.e., adult support and belief (Lawson & Chaffin, 1992), the seriousness of the abuse and the relationship to the abuser (Farrell, 1988), and the developmental level of the victim (Hollinger, 1987).

Emotional gains and consequences Children, on the whole, report their experience of abuse prevention programs as positive, and they report emotional gains, such as increased confidence and self-esteem, at the end of programs. For a small number of children, programs seem to generate anxiety (Finkelhor & Dzuiba-Leatherman, 1995; Pohl & Hazzard, 1990; Tutty, 1997). These feelings are mostly mild in nature and of short duration (Binder & McNeil, 1987, Garbarino, 1987; Wurtele, Mars & Miller-Perrin, 1987) and have failed to reach levels of statistical significance (Hazzard et al., 1991; Oldfield et al., 1996). The positive role of anxiety in promoting self-protective behavior has yet to be explored. As a consequence, schools will need to be attentive to children's emotional response to programs, both positive and negative. Some children may need more support to talk about their feelings and deal with their anxiety (Finkelhor & Dzuiba-Leatherman, 1995; Herbert et al., 2001; Pohl & Hazzard, 1990; Herbert et al., 2001). It is important to recognize, however, that some anxiety may be a normal reaction to content and a motivator for change. Further, there is much still to be discovered about the interaction among children's personal characteristics, their reactions (positive or negative) to abuse prevention programs, and the outcomes following programs.

Outcomes for teachers and parents A small number of the reviewed studies also included evidence regarding teachers' outcomes from abuse prevention programs. Early indications suggest that following the delivery of programs, teachers can develop their knowledge, and their attitudes and feelings of comfort may shift in a positive direction (MacIntyre & Carr, 1999a; Pohl & Hazzard, 1990; Madak & Berg, 1992; Sylvester, 1996). Schools need to recognize that teachers may need the opportunity to explore their beliefs and feelings in order to deliver programs effectively. Teachers also need explicit guidance and support to continue the implementation of programs from year to year. Barron and Topping (in press-b) identified the need for schools to train teachers in a prevention mindset, i.e., to maintain disclosure as the primary goal, to expect disclosures, to recognize disclosures as they occur, to receive disclosures in an affirming manner, and move to appropriate action following the disclosure.

Although parental involvement was described as important in the effectiveness of programs, there was little evidence to back up such an assertion. Limited data on outcomes for parents suggest that programs lead to gains in child protection knowledge and safety skills for parents (Finkelhor & Strapko, 1992). Further, programs were found to create a context for communication between children and their parents on a topic that is often difficult to discuss (MacIntyre & Carr, 1999a; Pohl & Hazzard, 1990; Herbert et al., 2001). Prior to program delivery, a small number of parents expressed anxiety about some of the program content, as well as concern for their child's reaction. After children experience a program, their parents are generally positive (Tutty, 1997). Moreover, parents who attend abuse prevention workshops are more likely to be supportive when their child discloses (Briggs & Hawkins, 1994a, 1994b).

Challenges for schools include enabling parents to attend briefing and training sessions, dealing with parents' anticipatory anxiety, working collaboratively with parents by encouraging helpful parental advice and support, and enabling children to share the content and experience of the program with their parents. When such support is provided, there is some evidence to suggest parents can effectively support and teach personal safety (Burgess & Wurtele, 1998**).** However, responding appropriately to children's disclosures of intrafamilial abuse and effectively managing parent/school communication is a major challenge for schools and child protection agencies**.** Schools need to address teachers' lack of knowledge and training about abuse; to help teachers manage their emotional responses, and particularly their fear of disclosure and the potential for litigation following the passing on of information (MacIntyre, 1987, 1990); and to ensure that staff members pass on accurate information to parents (Chen, Dunn, & Han, 2007). School managers influence whether teachers respond by providing clear guidance, support, and encouragement to report abuse (Trudell & Whatley, 1988).

Recent studies Over the past decade, efficacy studies of individual abuse prevention programs have been largely absent from the literature. While a number of authors have sought to review the efficacy literature (Greytak, 2003, Adair, 2006; Zwi, Woolfenden, Wheeler, O'Brien, Tait, & Williams, 2007), outcome evaluation of specific programs has occurred primarily in countries where programs are being delivered for the first time (del Campo & Lopez, 2006). It is interesting that computer-assisted sex abuse prevention programs are being evaluated with some promising results for knowledge, if not attitude gains (Bae & Panuncio, 2009; Yom & Eum, 2005). A recent U.K. study (Barron & Topping, in press-a) highlighted that the way programs are taught may be as significant as what is taught. The authors concluded that teachers and other presenters need to have a thorough knowledge of child abuse and child protection, as well as the capacity to apply child-centered communication within program protocols.

While the review involved an in-depth analysis of the direct effects for children from prevention programs, the broader impact of these programs still needs to be explored in a systematic and thorough manner. Schools need to be attentive to a wider range of benefits, which may include the following: children experiencing a more physically and emotionally safe environment (Weist et al., 2009; Wekerle & Wolfe, 1999**);** awareness raising for parents, teachers, and the larger community; improving the professional response to suspicion and disclosure of abuse (Finkelhor & Daro, 1997); and addressing the consequences of disclosure for children (Finkelhor, 2007). This seems to fit with Wurtele (1999), who argued for programs to be embedded within a public health approach with a focus on environmental and social change.

Conclusions

Despite the methodological limitations of efficacy studies, it appears that schools provide a cost-effective way of delivering abuse prevention programs to the entire child population. Evidence suggests that school-based child sexual abuse prevention programs not only increase children's self-protective knowledge but may also enable a significant proportion of children to disclose a wide range of abuses during abuse prevention lessons. The disclosure of child sexual abuse, however, may be more likely to occur in private to a trusted person or within a confidential context, e.g., survivor helpline. Emotionally, children, on average, report enjoying the programs, benefitting from increases in self-confidence, and feeling less self-blame (Finkelhor, 2009). A small proportion of children experience mild anxiety, but this may actually help to motivate self-protective behaviors. Program effectiveness may relate to how closely teachers follow program guidelines. Despite the above findings, no studies make the connection between program effectiveness and children's actual safety. As such, it is suggested that adult responsiveness is paramount in listening to, believing, and acting to keep safe our children. Prevention programs may be one way of mobilizing such action (Finkelhor, 2009). A range of recommendations for future practice based on the evidence from the current review follows.

Recommendations for Teachers and Practitioners

Effective school-based sex abuse prevention programs need to:

1. Be delivered within a supportive school context
2. Have evaluation of effectiveness built in
3. Incorporate modeling, discussion, and skills rehearsal
4. Be at least four to five lessons long
5. Include booster sessions
6. Have the capacity to be delivered by a range of personnel
7. Involve active parental involvement
8. Assess children's prior knowledge
9. Be developmentally appropriate with concrete concepts and visual aids for younger children
10. Pay particular attention to difficult-to-understand concepts
11. Be observant of children's emotional reactions and provide support as necessary
12. Provide training for teachers that takes into account their attitudes, gives them opportunity to explore their concerns about delivering prevention programs, and enables them to notice and respond appropriately to disclosures.

References

Abel, G. G., Becker, J. V., Mittleman, M., Cunningham-Rathner, J., Rouleau, J. L., & Murphy, W. D. (1987). Self-reported crimes of nonincarcerated paraphiliacs. *Journal of Interpersonal Violence, 2*(1), 3–25.

Adair, J. (2006). The efficacy of sexual violence prevention programs: Implications for schools. *Journal of School Violence*, *5*(2), 87–97.

Bae, J., & Panuncio, R. (2009*).* Development of computer-assisted instruction program for child sexual abuse prevention. *International Journal of Computer Science and Network Security*, *9*(3), 142–147.

Baginsky, M., & Macpherson, P. (2005). Training teachers to safeguard children: Developing a consistent approach. *Child Abuse Review*, *14*(5), 317–330.

Barnett, D., Manley, J. T., & Cicchetti, D. (1993). Defining child maltreatment: The interface between policy and research. In D. Cicchetti & S. L. Toth (Eds.), *Child abuse, child development, and social policy* (pp. 7–73). Norwood, NJ: Ablex.

Barron, I., & Topping, K. (in press-a). Abuse prevention program fidelity: Video analysis of interactions. *Child Abuse Review*.

Barron, I. and Topping, K. (in press-b). School-based abuse prevention: Analysis of disclosures. *Journal of Family Violence*.

Bevill, A. R., & Gast, D. L. (1998). Social safety for young children: A review of the literature on safety skills instruction. *Topics in Early Childhood Special Education*, *18*(4), 222–234.

Binder, R. L., & McNeil, D. E. (1987). Evaluation of a school-based sexual abuse prevention program: cognitive and emotional effects. *Child Abuse & Neglect*, *11*(4), 497–506.

Bolen, R. M., & Scannapieco, M. (1999). Prevalence of child sexual abuse: A corrective meta-analysis. *Social Service Review, 73*(3), 281–313.

Briggs, F. (1991). Child protection programs: Can they protect young children? *Early Development and Care*, *67*(1), 61–72.

Briggs, F., & Hawkins, R. M. (1994a). Follow-up data on the effectiveness of the New Zealand's national school based child protection program. *Child Abuse & Neglect*, *18*(8), 635–643.

Briggs, F., & Hawkins, R. M. (1994b). Follow-up study of children of 5–8 years using child protection programs in Australia and New Zealand. *Early Child Development and Care, 100*(1), 111–117.

Burgess, E., & Wurtele, S. (1998). Enhancing parent-child communication about sexual abuse: a pilot study. *Child Abuse & Neglect*, *22*(11), 1167–1175.

Casper, R. (1999). Characteristics of children who experience positive or negative reactions to a sexual abuse prevention program. *Journal of Child Sexual Abuse*, *7*(4), 97–112.

Carroll, L. A., Miltenberger, R. G., & O'Neil, H.K. (1992). A review and critique of research evaluating child sexual abuse prevention programs. *Education and Treatment of Children, 15*(4), 335–354.

Chase, E., & Statham, J. (2005). Commercial and sexual exploitation of children and young people in the UK: A review. *Child Abuse Review*, *14*(1), 4–25.

Chen, J., Dunne, M., & Han, P. (2007). Prevention of child sexual abuse in China: Knowledge, attitudes, and communication practices of parents of elementary school children. *Child Abuse & Neglect, 31*(7), 747–755.

Cohen, S. (1977). *Statistical power analysis for behavioural sciences.* New York: Academic Press.

Cohn, A. (1982). Stopping abuse before it occurs: Different solutions for different population groups. *Child Abuse & Neglect*, *6*(4), 473–483.

Conte, J., Rosen, C., Saperstein, L., & Shermack, R. (1985). An evaluation of a program to prevent the sexual victimisation of young children. *Child Abuse & Neglect*, *9*, 319–328.

Cormack, P., Johnson, B., Peters, J., & Williams, D. (1998). *Authentic assessment: Implications for teaching and learning*. Canberra: Australian Curriculum Studies Association.

Davis, M. K., & Gidycz, C. A. (2000). Child sexual abuse prevention programs: A meta-analysis. *Journal of Clinical Child Psychology*, *29*(2), 257–265.

del Campo, S., & Lopez, S. (2006). Evaluation of school-based child sexual abuse prevention program. *Psicothema*, *18*(1), 1–8.

Dhooper, S. S., & Schneider, P. L. (1995). Evaluation of a school-based prevention program. *Research on Social Work and Practice*, *5*(1), 36–46.

Faller, K. C. (1993). *Child sexual abuse: Intervention and treatment issues*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Farrell, L. (1988). Factors that affect a victim's self-disclosure in father-daughter incest. *Child Welfare*, *67*(5), 463–469.

Finkelhor, D. (1984). *Sexually victimised children*. New York: Free Press.

Finkelhor, D. (1986). *A sourcebook on child sexual abuse*. Beverly Hills, CA: Sage.

Finkelhor, D. (2007). Prevention of sexual abuse through educational programs directed toward children. *Pediatrics, 120*, 640-645

Finkelhor, D. (2009). The prevention of childhood sexual abuse. *Future of Children, 19*(2), 169–194.

Finkelhor, D., Asdigian, N., & Dzuiba-Leatherman, J. (1995). The effectiveness of victimisation prevention instruction: An evaluation of children's responses to actual threats and assaults. *Child Abuse & Neglect*, *19*(2), 142–153.

Finkelhor, D., & Baron, L. (1986). Risk factors for child sexual abuse. *Journal of Interpersonal Violence*, 1, 43–71.

Finkelhor, D., & Daro, D. (1997). Prevention of child sexual abuse. In M. E. Heifer & R. S. Kemp (Eds.), *The battered child* (5th ed., rev. and exp.)(pp. 615–626). Chicago: University of Chicago Press.

Finkelhor, D., & Dzuiba-Leatherman, J. (1995). Victimisation prevention programs: A national survey of children's exposure and reactions. *Child Abuse & Neglect*, *19*(2), 129–139.

Finkelhor, D., & Strapko, N. (1992). Sexual abuse prevention education: A review of evaluation studies. In D. J. Willis, E. W. Holder, & M. Rosenberg (Eds.), *Prevention of child maltreatment: Developmental and ecological perspectives* (pp. 150–164). New York: Wiley.

Garbarino, J. (1987). Children's response to a sexual abuse prevention program: A study of the *Spiderman Comic*. *Child Abuse & Neglect*, *11*(1), 143–148.

Gibson, L. E., & Leitenberg, H. L. (2000). Child sexual abuse prevention programs: Do they decrease the occurrence of child sexual abuse? *Child Abuse & Neglect*, *24*(9), 1115–1125.

Gomes-Schwart, B., Horowitz, J., Cardarellii, A., & Sauziet, M. (1990). *Child sexual abuse: The initial effects*. Newbury Park, CA: Sage.

Gough, D. (1993). *Child abuse interventions*. London: HMSO.

Greytak, E. (2003). Educating for the prevention of sexual abuse: An investigation of school-based programs for high school students and their applicability to urban schools. *Perspectives on Urban Education*, *2*(1), 1–15.

Hazzard, A., Kleemeier, C., & Webb, C. (1990). Teacher versus expert presentations of sexual abuse prevention programs. *Journal of Interpersonal Violence*, *5*(1), 23–36.

Hazzard, A. P., Webb, C., Kleemeier, C., Angert, L., & Pohl, L. (1991). Child sexual abuse prevention: Evaluation and one-year follow-up. *Child Abuse & Neglect*, *15*(1), 123–138.

Heidotting, T., Keiffer, S., & Soled, S. W. (1995, April). *A quantitative synthesis of child sexual abuse prevention programs.* Paper presented at the annual meeting of the American Educational Research Association, New Orleans, Louisiana.

Herbert, M., Lavoie, F., Piche, C., & Poitras, M. (2001). Proximate effects of a child sexual abuse prevention program in elementary school children. *Child Abuse & Neglect*, *25*(4), 505–522.

Hollinger, J. (1987). *Unspeakable acts*. New York: Contemporary Books.

Jacobs, J. E., & Hashima, P. Y. (1995). Children's perceptions of the risk of sexual abuse. *Child Abuse & Neglect*, *19*(12), 1443–1456.

Kenny, M. (2004). Teachers' attitudes toward and knowledge of child maltreatment. *Child Abuse & Neglect*, *28*(12), 1311–1319.

Ko, S. F., & Cosden, M. A. (2001). Do elementary school-based child abuse prevention programs work? A high school follow-up. *Psychology in Schools*, *38*(1), 57–66.

Kolko, D. J. (1988). Educational programs to promote awareness and prevention of child sexual victimisation: A review and methodological critique. *Clinical Psychological Review, 8*(2), 195–209.

Krivacska, J. J. (1990). *Designing child sexual abuse programs.* Springfield, IL: Charles C. Thomas.

Lawson, L., & Chaffin, M. (1992). False negatives in sexual abuse disclosure interviews: Incidence and the influence of caretakers' beliefs in cases of accidental abuse discovery by diagnosis of STD. *Journal of Interpersonal Violence*, 7(4), 532–542.

MacIntyre, D., & Carr, A. (1999a). Evaluation of the effectiveness of the Stay Safe primary prevention programme for child sexual abuse. *Child Abuse & Neglect*, *23*(12), 1307–1325.

MacIntyre, D., & Carr, A. (1999b). Helping children to the other side of silence: A study of the impact of the Stay Safe Program on Irish children's disclosures of sexual victimisation. *Child Abuse & Neglect*, *23*(12), 1327–1340.

MacIntyre, D., & Carr, A. (2000). Prevention of child sexual abuse: Implications of program evaluation research. *Child Abuse Review*, *9*(3), 183–199.

MacMillan, H. L., MacMillan, J. H., Offord, D. R., Griffith, L., & MacMillan, A. (1994). Primary prevention of child sexual abuse: A critical review. *Journal of Child Psychology and Psychiatry*, *35*(5), 857–876.

McIntyre, T. (1987). Teacher awareness of child abuse and neglect. *Child Abuse & Neglect*, *11*(1) 33–35.

McIntyre, T. (1990). The teacher's role in cases of suspected child abuse. *Education and Urban Society*, *22*(3), 300–306.

Madak, P. R., & Berg, D. H. (1992). The prevention of sexual abuse: An evaluation of 'Thinking About Touching.' *Canadian Journal of Counselling*, *26*(1), 29–40.

Mayes, G., Currie, E., MacLeod, L., Gillies, J., & Warden, D. (1992). *Child Sexual Abuse: A review of literature and educational materials.* Edinburgh: Scottish Academic Press.

Melton, G. B. (1992). The improbability of prevention of child sexual abuse. In D. J. Willis, E. W. Holden, & M. Rosenberg (Eds.), *Prevention of child maltreatment: Developmental and ecological perspectives* (pp. 168–189). New York: Wiley.

Mendal, M. C. (1995). *The male survivor: The impact of sexual abuse.* Thousand Oaks, CA: Sage.

Miltenberger, R. G., & Roberts, J. A. (1999). Emerging issues in the research on child sexual abuse prevention. *Education and Treatment of Children*, *22*(1), 84–102.

Oldfield, D., Hays, B., & Megel, M. E. (1996). Evaluation of the effectiveness of the Project Trust: An elementary school-based victimisation prevention strategy. *Child Abuse & Neglect*, *20*(9), 821–832.

Pelcovitz, D., Adler, N., Kaplan, S., Packman, L., & Kreiger, R. (1992). The failure of a school-based child sexual abuse prevention program. *Journal of American Academy of Child and Adolescent Psychiatry*, *31*(5), 887–892.

Plummer, C. (1984, August). *Preventing sexual abuse: What in-school programs teach children.* Paper presented at the Second National Conference for Family Violence Researchers, Durham, New Hampshire.

Pohl, J. D., & Hazzard, A. (1990). Reactions of children, parents and teachers to child sexual abuse prevention programs. *Education*, *110*(3), 337–344.

Rind, B., Tromovitch, P., & Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin, 124*(1), 22–53.

Rispens, J., Aleman, A., & Goudena, P. P. (1997). Prevention of child sexual abuse victimisation: A meta-analysis of school programs. *Child Abuse & Neglect*, *21*(10), 975–987.

Roberts, R., O`Connor, T., Dunn, J., & Golding, J. (2004). The effects of child sexual abuse in later family life: Mental health, parenting, and adjustment of offspring. *Child Abuse & Neglect*, *28*(5), 525–545.

Scottish Office. (1998). *Protecting children—A shared responsibility: Guidance on inter-agency co-operation.* Edinburgh: Stationary Office.

Sylvester, L. (1996). *Talking about touching: Personal safety curricula (1996 eds.).* [Preschool to grade 3; curriculum evaluation summary]. Seattle: Committee for Children.

Taal, M., & Edelaar, M. (1997). Positive and negative effects of a child sexual abuse prevention program. *Child Abuse & Neglect*, *21*(4), 399–410.

Telljohann, S. K., Everett, S. A., & Price, J. H. (1997). Evaluation of a third grade sexual abuse curriculum. *Journal of School Child Health*, *67*(4), 149–153.

Thorpe, D. (1994). *Evaluating child protection.* New York: Milton Keynes, Open University Press.

Topping, K. J., & Barron, I. G. (2009). School-based child sexual abuse prevention programs: A review of effectiveness. *Review of Educational Research, 79*(1), 431–463.

Trudell, B., & Whately, M. (1988). School sexual abuse prevention: Unintended consequences and dilemmas. *Child Abuse & Neglect, 12*(1), 103–113.

Tutty, L. M. (1992). The ability of elementary school children to learn child sexual abuse prevention concepts. *Child Abuse & Neglect*, *16*(3), 369–384.

Tutty, L. M. (1994). Developmental issues in young children's learning of sexual abuse prevention concepts. *Child Abuse & Neglect*, *18*(2), 179–192.

Tutty, L. M. (1997). Child sexual abuse prevention programs: Evaluating 'Who Do You Tell?' *Child Abuse & Neglect*, *21*(9), 869–881.

Tutty, L. M. (2000). What children learn from sexual abuse prevention programs: Difficult concepts and developmental issues. *Research on Social Work Practice*, *10*(3), 275–300.

Warden, D., Moran, E., Gillies, J., Mayes, G., & MacLeod, L. (1997). An evaluation of a children's safety training program. *Educational Psychology*, *17*(4), 433–448.

Weist, M., Bryant, Y., Dantzler, J., Martin, S., D'Amico, M., Griffith, B., & Gallun, B. (2009). Evaluation of a statewide initiative in the United States to prevent/reduce sexual harassment in schools. *Health Education*, *109*(2), 112–124.

Wekerle, C., & Wolfe, D. A. (1999). Dating violence in mid-adolescence: Theory, significance, and emerging prevention initiatives. *Clinical Psychological Review*, *19*(4), 435–56.

Wurtele, S. (1999). Comprehensiveness and collaboration: Key ingredients of an effective public health approach to preventing child sexual abuse. *Sexual abuse: A journal of research and treatment, 11*(4), 323–325.

Wurtele, S., Mars, S., & Miller-Perrin, C. (1987). Practice makes perfect? The role of participant modelling in sexual abuse prevention programs. *Journal of Consulting and Clinical Psychology*, *55*(4), 599–602.

Wyre, R. (1993). *Perpetrators of child sexual abuse.* [Conference handouts]. Edinburgh: Unpublished.

Yom, Y., & Eun, L. (2005). Effects of a CD-ROM educational program on sexual knowledge and attitude. CIN: *Computers, Informatics, Nursing*, *23*(4), 214–219.

Zwi, K., Woolfenden, S., Wheeler, D. M., O'Brien, T., Tait, P., & Williams, K. J. (2007). School-based education programmes for the prevention of child sexual abuse. *Cochrane Database of Systematic Reviews,* Issue 3 [Art. No.: CD004380]. doi: 10.1002/14651858.CD004380.pub2.

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APSAC Responds to Inclusion of PAS/PAD Information in *Diagnostic and Statistical Manual of Mental Disorders*

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APSAC's response to the [DSM-V/Bernet] proposal that parental alienation syndrome (PAS) or parental alienation disorder (PAD) be included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V), to be published in 2013.

The American Professional Society on the Abuse of Children (APSAC) is "the leading national organization supporting professionals who serve children and families affected by child maltreatment and violence" (APSAC, 2010). The mission of this organization is to foster the best professional response to child maltreatment and violence. Consistent with its mission, APSAC raises concerns about the inclusion of parental alienation syndrome (PAS), parental alienation disorder (PAD), and/or parental alienation in the DSM-V. In partial support of these concerns, we append a letter, signed by the leading researchers on parental alienation—Janet Johnston, PhD, and Joan Kelly, PhD—and cosigned by 17 leading researchers, teachers, and clinicians with extensive experience in the domain of familial dissolution and child response to family break-up. [Editor's note: The referenced letter and the original proposal can be requested from APSAC.]"

The major focus of APSAC's concerns is on the proposed DSM-V criteria for PAD and whether there is research to support these criteria. Although there are a number of articles describing parental alienation as a phenomenon in divorce (Warshak, 2008), the empirical data supporting a disorder are quite weak (e.g., Bruch, 2002; Faller, 1998; Kelly & Johnston, 2001), especially with regard to the criteria proposed by William Bernet, MD (Bernet, 2008, 2009; Bernet, von Boch-Galhau, Baker, & Morrison, 2010). According to Dr. Bernet and his colleagues, the criteria for PAD are as follows:

Proposed Criteria for Parental Alienation Disorder

A. The child—usually the parents are engaged in a hostile divorce—allies himself or herself strongly with one parent and rejects a relationship with the other, alienated parent without legitimate justification. The child resists or refuses visitation or parenting time with the alienated parent.

Comment: The divorce rate is very high in the United States. Almost half of U.S. marriages end in divorce (U.S. Library of Medicine, 2009); approximately four million couples obtain divorces annually (CDC, 2002, 2009). More than half of divorces involve children under the age of 18, although couples with children are slightly less likely to divorce than childless couples (CDC, 2009).

Anger at one or both parents is a normative emotional reaction to divorce by children (Mayo Clinic staff, 2009). This anger and alienation from one or both parents can have a wide range of etiologies and often involves a complex mix of causes (e.g., Corwin, Berliner, Goodman, Goodwin, & White, 1987; Garrity & Baris, 1994; Kelly & Johnston, 2001; Jaffe, Johnston, Crooks, & Bala, 2008; Johnston & Roseby, 1997; Mason, 1999).

A fundamental vulnerability of PAD is that it assumes that the professional evaluating the "alienated child" is omniscient, that is, the professional knows all the sources of the child's rejection of a parent. Most important from the perspective of APSAC, PAD assumes the professional knows with sufficient certainty that the child has NOT been maltreated or otherwise traumatized by the parent he or she is trying to avoid by refusing to visit. Research has consistently demonstrated that a substantial proportion of children fail to disclose maltreatment (e.g., London, Bruck, Ceci, & Schuman, 2005; Lyon, 2007) and/or delay disclosure (e.g., Lamb, Herskowitz, Orbach, & Esplin, 2008; Lyon, 2007; Sas & Cunningham, 1995) and may subsequently recant their earlier disclosures (e.g., Malloy, Lyon, & Quas, 2007). Indeed, PAD relies heavily on subjective judgment of the professional making the diagnosis that the child's rejection is "without legitimate justification."

B. The child manifests the following behaviors:

1. **a persistent rejection or denigration of a parent that reaches the level of a campaign**
2. **weak, frivolous, and absurd rationalizations for the child's persistent criticism of the rejected parent.**

Comment: Consistent with observations regarding Criterion A, Criterion B assumes omniscience of the professional and relies on the professional's subjective interpretation of the child's behaviors and statements. Moreover, the terms used to describe the child's behaviors are not defined. For example, what behavioral manifestations must a child evidence for the child's response to be termed a "campaign"? What behaviors are associated with "weak, frivolous, and absurd rationalizations"? Thus, how will mental health experts determine that the child's behaviors constitute a campaign and that they are weak, frivolous, and absurd?

C. The child manifests two of the following six attitudes and behaviors:

1. **lack of ambivalence**
2. **independent-thinker phenomenon**
3. **reflexive support of one parent against the other**
4. **absence of guilt over exploitation of the rejected parent**
5. **presence of borrowed scenarios**
6. **spread of the animosity to the extended family of the rejected parent.**

Comment: Again, Bernet and colleagues do not define terms, and they propose specific "attitudes and behaviors" that require undue reliance on the professional's subjective judgment. Especially lacking in clarity are the following attitudes and behaviors under Criterion C: (2) independent-thinker phenomenon, and (5) presence of borrowed scenarios. Dr. Gardner included these six indicators in his definition of the parental alienation syndrome 20 years ago (Gardner, 1992, pp. 75–82; see also Gardner, 1998). These attitudes and behaviors appear to be taken directly from Gardner's original work without any critical examination. They are not described in sufficient detail so other mental health professionals can understand exactly what these attitudes and behaviors entail. It is surprising that in the intervening 20 years no better definitions and no research have attempted to measure these characteristics in any systematic way.

D. The duration of the disturbance is at least 2 months.

Comment: The rationale for this duration is not specified. Most childhood disorders in the DSM IV require a duration of 4 weeks or a year. Adult disorders are diagnosable after a duration of 6 months.

E. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

Comment: Children whose parents are involved in a divorce may have clinically significant disturbance for a spectrum of reasons, for example, because their parents' relationship was violent or conflictual before marital dissolution, because their parents are divorcing, because the divorce involves parental conflict, or because the children have been harmed or traumatized. The domains of disturbance, therefore, do not illuminate the etiology.

F. The child's refusal to have visitation with the rejected parent is without legitimate justification. That is, parental alienation disorder is not diagnosed if the rejected parent maltreated the child.

Comment: The first parts of this Criterion, "refusal of visitation" and "without legitimate justification," are redundant with Criterion A and B(2). And yet again, there is a reliance on the omniscience of the mental health expert, that he or she is certain there has been no maltreatment or trauma.

Concluding Comment

Although PAD is described as a relational disorder, the diagnostic criteria are all found in the child. Thus, the child, not the adult, is assumed to have PAD. The absence of reference to any adult behavior has the result of blaming the child, who may have experienced maltreatment the professional is unaware of. At the very least, the child has experienced parental divorce, which research indicates has lasting traumatic impact (e.g., Wallerstein, 1998).

References

American Professional Society on the Abuse of Children (APSAC). (2010). Retrieved Jan. 10, 2010, from *www.apsac.org/*.

Bernet, W. (2008). Parental alienation disorder and DSM-V. *The American Journal of Family Therapy, 36(5),* 349–366.

Bernet, W. (2009). Parental alienation disorder and DSM-V. *Academic Medicine*, *84*(10), 349–366.

Bernet, W., von Boch-Galhau, W., Baker, A., & Morrison, S. (2010). Parental alienation, DMS-V, and ICD-11. *American Journal of Family Therapy*, *38*(2), 76–187.

Bruch, C. (2002). Parental alienation syndrome and alienated children: Getting it wrong in child custody cases. *Child and Family Law Quarterly, 14*(4), 381–400.

Centers for Disease Control and Prevention (CDC). (2002). Cohabitation, marriage, divorce, and remarriage in the United States. *Vital and Health Statistics, Series 23*(22), pp. 1–2.

Centers for Disease Control and Prevention (CDC). (2009, July 29). Births, marriages, divorces, and deaths: Provisional data for 2008. *National Vital Statistics Reports, 57*(19), pp. 1–2.

Corwin, D., Berliner, L., Goodman, G., Goodwin, J., & White, S. (1987). Child sexual abuse and custody disputes: No easy answers. *Journal of Interpersonal Violence, 2*(1), 91–105.

Faller, K. C. (1998). The parental alienation syndrome: What is it and what data support it? *Child Maltreatment, 3*(2), 100–115.

Gardner, R. (1992). *The parental alienation syndrome.* Cresskill, NJ: Creative Therapeutics.

Gardner, R. (1998). *The parental alienation syndrome, second edition.* Cresskill, NJ: Creative Therapeutics.

Garrity, C., & Baris, M. (1994) *Caught in the middle.* San Francisco: Jossey-Bass.

Jaffe, P., Johnston, J., Crooks, C., & Bala, N. (2008). Custody disputes involving allegations of domestic violence: Toward a differentiated approach to parenting plans. *Family Court Review, 46*(3), 500–522.

Johnston, J. (2006). A child-centered approach to high-conflict and domestic-violence families: Differential assessment and interventions. *Journal of Family Studies*, *12*(1), 15–35.

Johnston, J., Lee, S., Olesen, N., & Walters, M. (2005). Allegations and substantiations of abuse in custody-disputing families. *Family Court Review, 43*(2), 283–294.

Johnston, J., & Roseby, V. (1997). *In the name of the child.* New York: Free Press.

Johnston, J., Walters, M., & Olesen, N. (2005a). Is it alienating parenting, role reversal, or child abuse? A study of children's rejection of a parent in child custody disputes. *Journal of Emotional Abuse*, *5*(4), 191–218.

Johnston, J., Walters, M., & Olesen, N. (2005b). The psychological functioning of alienated children in custody disputing families: An exploratory study. *American Journal of Forensic Psychology*, *23*(3), 39–64.

Kelly, J., & Johnston, J. (2001). The alienated child: A reformulation of parental alienation syndrome. *Family Court Review*, *39*(3), 249–266.

London, K., Bruck, M., Ceci, S., & Shuman, D. (2005). Disclosure of child sexual abuse: What does the research tell us about how children tell? *Psychology, Public Policy, and the Law, 11*, 194–226.

Lyon, T. D. (2007). False denials: Overcoming methodological biases in abuse disclosure research. In M. E. Pipe, M. Lamb, Y. Orbach, & A. Cederborg (Eds.), *Disclosing abuse: Delays, denials, retractions, and incomplete accounts (*pp. 41–62). Mahwah, NJ: Earlbaum.

Malloy, L., Lyon, T., & Quas, J. (2007). Filial dependency and recantation of child sexual abuse allegations. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(2), 162–170

Mason, M. A. (1999). *The custody wars.* New York: Basic Books.

Mayo Clinic staff. (2009, May). Children and divorce: Helping kids cope with a breakup. Retrieved January 3, 2010, from: www.mayoclinic.com/health/divorce/HO00055/METHOD=print.

Sas, L., & Cunningham, A. (1995) *Tipping the balance to tell the secret: The public discovery of child sexual abuse.* Available from the London Court Clinic, 254 Pall Mall St., London. N6A 5P6 (519 679 7250).

U.S. Library of Medicine and the National Institutes of Health. (2009). Divorce. *MedlinePlus.* Retrieved January 5, 2010, from: www.nlm.nih.gov/medlineplus/divorce.html.

Wallerstein, J. S., & Lewis, J. M. (1998). The long-term impact of divorce on children: A first report from a 25-year study. *Family & Conciliation Courts Review*, *36*, 368–383.

Warshak, R. (2008). *References relevant to parental alienation syndrome (PAS).* Retrieved July 5, 2010, from: www.warshak.com/alienation/pa-references/pasarticles.html

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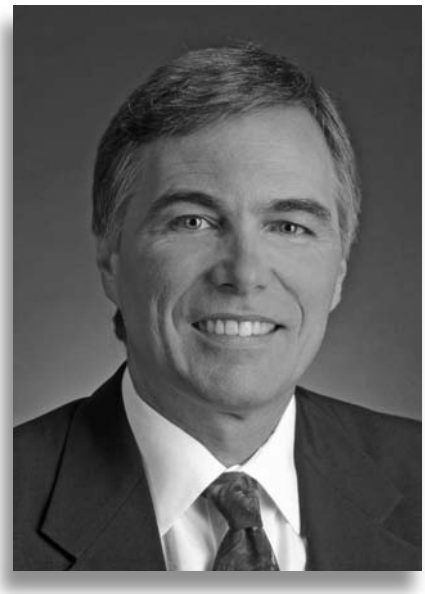
President's Message

Ronald C. Hughes, PhD, MScSA



In this first Message since I assumed the presidency in January 2010, I would like to provide a brief overview of the work the APSAC Board members have been doing to set a vision and a strategic developmental plan for the organization. Our strategic planning process is described in another article in this issue of the *APSAC Advisor,* written by APSAC staff member Michael Bandy. I would also like to communicate my vision of what we hope to gain by this process.

The first phase of the strategic plan, the assessment, was initiated last year by past president, Michael Haney. This assessment identified some problems that are inherent in APSAC's *working board* model. A *working board* is responsible not only for governance of the organization but also for product development.

The problems highlighted in the assessment are typical for a *working board* model. They include the following: (1) Board members routinely have difficulty committing enough time for intensive developmental activities; (2) APSAC lacks structures to efficiently and accurately identify high-priority needs in the practice field; (3) APSAC faces challenges in deciding how to use its Board members' time most effectively; and (4) APSAC lacks a fair and effective system to ensure Board member accountability. In short, to achieve our objectives, the assessment indicated that the Board needed to work harder and smarter and to hold ourselves, and each other, accountable.

Working Harder

I can assure you that APSAC already has a hard-working Board: Our *mixed board* model demands it. The Board must perform the governance responsibilities that are typical of all Boards, but for most Boards in comparable organizations, governance is their only responsibility. APSAC Board members also function as staff when it comes to developmental activities. APSAC does employ a limited number of administrative staff members but does not employ professional staff. Therefore, Board members must administer the development of products that APSAC regularly produces—such as Guidelines, position papers, the review and vetting of training proposals and programs, and overall monitoring and quality control.

This hasn't always been the case. At various times in APSAC's history, the organization has employed professional staff. Due largely to financial constraints, however, the *mixed board* model was adopted, requiring considerable extra time and effort by Board members. Still, the APSAC Board believes that we can and should do more. We have initiated the following to improve our productivity:

1. We are revamping our Board recruitment and orientation processes to clearly delineate the extraordinary commitment expected of new members. We will give a better explanation about our *mixed board* model and the requirements of new members, including professional expertise, a strong desire to serve, and a special commitment of time and effort.
2. To promote product development, we have recommitted to better utilization of ad hoc committees formed from APSAC's talented membership.
3. We have encumbered $40,000 to procure professional help in product design and development. Of this amount, $20,000 was received from a generous anonymous donor.
4. We are considering revamping our committee and subcommittee structures to assure better and faster communication and decision making.

APSAC's Board, with its unique structure and unique responsibilities, requires a unique commitment by its members. We are working to assure that all potential Board members fully understand this.

Working Smarter

No matter how committed and hard working a Board is, there is only so much that can be done, given constraints of time and resources. We must be sure our priorities are legitimate and our work is both effective and efficient. We must do a better job of assessing needs and identifying the most important and timely issues that need to be addressed through our training or product development. We must subsequently allocate our resources to meet the most urgent and significant of those needs.

Doing the strategic plan was the first important step in "working smarter." As a result of the strategic planning process, the Board identified several ways we can do better. They include the following:

1. We are establishing a President's Advisory Council, comprising APSAC members who have held past leadership positions in APSAC's governance. One of the Council's tasks will be to identify timely and critical issues the Board needs to address so they may be proactively addressed.
2. APSAC Board members will be given responsibility to identify and prioritize important areas of concern in their respective professional disciplines.
3. The process for selecting presentations and training workshops for the annual APSAC Colloquium will be modified to increase the number of presentations on evidence-supported practices and interventions.
4. We have implemented several methods to better use the expertise of our talented membership. As I mentioned earlier, we anticipate better and more frequent use of ad hoc committees, supported by a small but significant pot of money we can use to contract with members who work on developing needed products.

The APSAC Board is excited about the promise of the increased capacity these changes will facilitate to meet the professional needs of our members.

Accountability

We already have a structure for "big picture" accountability for APSAC Board operations, and this structure is working well. Board activities are transparent, and information about our financial status, elections, and governance is recorded, available, and routinely shared with APSAC members.

The strategic assessment did indicate that the Board could do better among ourselves in identifying and communicating about our successes and failures in meeting our assigned responsibilities.

Given the multiple and varied tasks of our 14 committees and subcommittees, it is difficult in the best of circumstances to ensure that we're working in an effective and coordinated manner. Tight internal accountability is essential for ongoing planning and management of product development initiatives

We have adopted several strategies to assure better accountability in our developmental initiatives.

1. We have launched a Web-based system for better intra and intercommittee communication. All committees and subcommittees will post and regularly update their work plans, meeting notes, and activities on committee-specific Web pages.
2. We are developing a more effective annual assessment of the Board and its activities.
3. Our revisions to Board member orientation include a new and stronger expectation for all members to hold each other accountable for maximum effort and commitment.

All APSAC Board positions are voluntary. Members contribute time and effort without remuneration, often subsidizing some of the costs of participation out of their own pockets. Still, our expectations for APSAC Board members are even higher. We seek a culture in which Board members see it as a privilege to participate in APSAC's growth and development.

Please feel free to contact me at any time about your thoughts and ideas for APSAC's continuing growth and development, or your willingness to volunteer to work on developmental initiatives and committees. APSAC needs the full support of its members as we move forward to expand our capacity and achieve our strategic goals. We look forward to hearing from you.

APSAC Strategic Plan: Blazing a Path to the Future

Every organization needs to reflect on where it has been, where it is now, and where it is going—and in doing so, creates opportunities to proactively determine its own future. The American Professional Society on the Abuse of Children (APSAC) is no exception.

In the winter of 2009, on the recommendation of the Long-Range Planning Committee, APSAC's Board of Directors unanimously approved hiring Executive Service Corps (ESC) to facilitate a strategic planning process. ESC is a Chicago-based company that works with nonprofits to assist in management, governance, and leadership. The project was overseen by APSAC's Long Range Planning Committee.

Project work began immediately after the decision had been made. The planning process was agreed upon by the APSAC Board and ESC, and a project team was appointed to manage the overall process. ESC spent a good deal of time learning about APSAC. They accomplished this by speaking directly with leadership and staff to analyze and define issues affecting the organization.

The design incorporated many sectors of the APSAC community, including Board and subcommittee members, past APSAC leadership, members-at-large, and staff. Two different survey tools were used. A target audience was defined and phone interviews were conducted. Following the phone interviews, participants were asked to complete an additional, in-depth online survey. The results were then carefully evaluated to identify and categorize critical issues.

In the summer of 2009, the Board held a strategic planning retreat in conjunction with the Annual Colloquium in Atlanta, Georgia. ESC representatives clarified that the keys to successful strategic planning were to develop a vision describing the organization's ideal future state, and identifying and responding to critical issues. Thus, APSAC spent considerable time reviewing its mission, vision, and core values. The Board agreed on a revised vision, based on planning scenarios developed prior to the retreat. The group also articulated and reached consensus on the most strategic issues facing the organization. The planning group then divided into work groups to focus on these critical issues, to identify goals and objectives, and to determine immediate next steps.

Work continued following the retreat, even while members went back to their jobs and lives. Members of the work groups participated in several conference calls to focus the key issues of governance, membership, and programs and services. A draft plan was developed. Then, working with ESC, APSAC further refined the plan, paying particular attention to current and necessary resources to successfully implement it.

At its winter 2010 meeting in San Diego, the Board and staff met again with a representative from ESC to further refine the plan and to establish action steps, timetables, and accountability. The Board approved a final plan, but some additional refinement was needed to clarify some of the plan elements. Since the San Diego meeting, the work groups have been meeting to finalize the plan and to begin implementation.

APSAC's strategic planning process was long and, at times, complex. A key strength of the organization is its multidisciplinary membership. But this asset also can present real challenges when trying to decide what is best for the organization as a whole. The support provided by ESC was critical in helping APSAC overcome obstacles while working to develop a blueprint for its future.

Key Plan Elements

The APSAC Strategic Plan outlines three strategic issues, as well as specific goals for each issue, and then objectives for each goal. It also provides for action steps/primary activities, resources, point persons and collaborators, target due dates, and actual completion dates for each action item. The intent is to use the plan as a tracking tool and to provide accountability to ensure completion of the plan.

Some strategic plan highlights are as follows:

Strategic Issue 1: How can APSAC increase the effectiveness and performance of its Board of Directors?

Goal: APSAC Board of Directors will establish a vision and mission for the organization and will effectively and efficiently plan, implement, and monitor Board and organizational activities to promote achievement of desired outcomes.

- Objective 1 – Complete a strategic plan for ongoing operations.
- Objective 2 – Clarify and publish roles, responsibilities, and expectations of APSAC Board.
- Objective 3 – Develop and implement a plan for ongoing financial support to enhance implementation of Board initiatives, including the strategic plan.
- Objective 4 – Increase the effectiveness and efficiency of APSAC operations.
- Objective 5 – Conduct regular evaluations of Board effectiveness in meeting strategic and operational goals and objectives.
- Objective 6 – Promote effective development of current and new Board members.

Strategic Issue 2: How can APSAC increase its capacity to provide educational and consultative services to a larger, more diverse population of child maltreatment professionals?

Goal: APSAC will increase its member base, including increasing the number and diversity of members, and further member participation in APSAC activities and services.

- Objective 1 – Increase membership base through recruitment of new members and retention of existing ones.
- Objective 2 – Quantify and qualify potential membership.

Strategic Issue 3: How should APSAC modify and enhance its services to members to become and remain eminent in the field of child maltreatment?

Goal: APSAC will provide state-of-the-art programs, services, and products that significantly impact the child maltreatment field.

- Objective 1 – Revise existing and develop new APSAC programs, services, goods, products, and publications to improve quality and relevance to members.
- Objective 2 –Become the premier resource for translating research into practice.

Some of the specific ideas identified in the planning process have already been put into play. For example, APSAC identified the need to provide pertinent, educational information to front-line professionals. The result is the *APSAC Alert*, a new electronic newsletter. The first issue, winter 2010, featured an article titled "Pediatric Burn Abuse Evaluation." The spring 2010 issue focused on "Childhood Maltreatment and Self-Injury."

The APSAC Board is committed to implementing the plan in a manner that benefits APSAC members and, ultimately, makes APSAC as effective as it can be in achieving its mission.

Mission

APSAC is the leading national organization supporting professionals who serve children and families affected by child maltreatment and violence. As a multidisciplinary group of professions, APSAC achieves its mission in a number of ways, most notably through expert training and educational activities, policy leadership and collaboration, and consultation that emphasizes theoretically sound, evidence-based principles.

Vision

APSAC envisions a world where all maltreated or at-risk children and their families have access to the highest level of professional commitment and service.

Journal Highlights

Patti A. Beekman, BS

Early Experiences of Child Maltreatment and Educational Well-being

National reports have indicated that family risks, such as poverty, homelessness, and maltreatment in early childhood, can have adverse effects on children's educational well-being. In this study, the researchers examined how the timing of a child's first experience of maltreatment or homelessness, or both, might influence academic achievement.

The study was conducted in a large county using an entire cohort of second grade students during the 2004–05 academic year. Data were extracted from the Kids Integrated Data System (KIDS). The number of students with complete data ranged from 9,871 to 10,639, depending on the academic outcome measure. The authors found that 12% of the children in the sample had experienced substantiated child maltreatment, and 8% had experienced homelessness.

The study found that child maltreatment had a more pervasive influence on children's academic achievement than did homelessness, and it was also associated with decreased performance on each of the standardized academic achievement measures. The academic area(s) most influenced by maltreatment were different, depending on the age that a child first experienced maltreatment. The authors suggest that developmental science may explain how and why some risk factors have a greater or lesser influence on different areas of development over time.

The authors highlight the importance of collaboration between social service and education professionals as a way to improve educational well-being for children who have experienced early childhood risks. They conclude that study findings support the importance of high-quality early childhood education programs for children who have been maltreated or experienced homelessness.

Perlman, S., & Fantuzzo, J. (2010). Timing and influence of early experiences of child maltreatment and homelessness on children's education well-being. *Children and Youth Services Review, 32*(6), 874–883.

School Change, Academic Progress, and Behavior Problems in Foster Youth

Educational success is an essential component of successful transition into adulthood for all adolescents, and youth in foster care often face challenges that can undermine their educational success. In this study, the authors examined the behavioral and educational outcomes related to changes in school placement for children in foster care. The authors hypothesized that educational achievement would decrease and the number of observed behavior problems would increase as the number of school changes increased.

The authors conducted this study in a group home that operated an on-site public school. The study sample included 159 foster youth who entered the group home between October 2001 and June 2005. The researchers interviewed the youth and reviewed their child protective service files. The youth completed a Youth Self-Report (YSR), which gave researchers information regarding internalizing, externalizing, borderline, and clinical behaviors.

The data indicated the average number of foster care placements to be 7.35, and over 40% of the youth reported more than eight school changes. The authors were unable to confirm the relationship between the number of school changes and academic progress; however, they did find that externalizing behaviors and total behavior problems had a significant relationship with the number of school changes.

The authors suggest that separation and loss experiences may be associated with school changes, and that these may affect a youth's behavior and educational achievement. The authors caution that foster children are not the only population that can be affected by school change. Children of families with high residential mobility may also experience behavior and educational issues.

Sullivan, M. J., Jones, L., & Mathiesen, S. (2010). School change, academic progress, and behavior problems in a sample of foster youth. *Children and Youth Services Review*, *32*(2), 164–170.

School-Based Humane Education as a Strategy to Prevent Violence

The Humane Education Program (HEP) is a violence prevention program for elementary schools that uses animal-related stories, lessons, and activities to foster empathy and responsibility in children's relationships with both people and animals. Curriculum-blended lesson plans met state educational standards by combining academic skills with humane concepts and character education. Because most children have an affinity for animals, humane education classes are more likely to capture their attention.

This article provides an evidence-based rationale for the program, reviews history and methods, and offers recommendations for implementing HEP in elementary schools. Research explains the relationship of empathy and aggression. Empathy is a protective

factor, inversely related to aggression, and empathy for animals is positively associated with empathy for people. Exposure to abuse or violence by young children may disrupt their normal development of empathy and may increase their risk for aggressive behavior toward people during adolescence. HEP emphasizes the connections between exposure to violence, cruelty to animals, and aggressive behavior.

Children's cruelty to animals is another area of study that supports the need for HEP. Cruelty to animals and empathy deficits are associated with bullying and are diagnostic criteria for conduct disorder (CD). Children with serious conduct problems are also at risk for antisocial behavior in adolescence and adulthood. Numerous studies of adults indicate that cruelty to animals is associated with perpetration of child abuse and other violent and nonviolent crimes. In conclusion, given high levels of violence in families and communities, the author advocates collaboration among humane organizations, child welfare, and elementary schools to implement this strategy for violence prevention.

Faver, C. A. (2010). School-based humane education as a strategy to prevent violence: Review and recommendations. *Children and Youth Services Review, 32*(3) 365–370.

Pairing Nurses and Social Workers in Schools

It is difficult for families to access needed services for children who are struggling in school and to utilize these services effectively. This article describes the school-based Child and Family Support Team Initiative (CFST), established in 2005 by the North Carolina General Assembly to help children at risk of school failure or out-of-home placement. The program provides a certified school nurse and a licensed school social worker in 101 schools with high-risk students. State officials coordinate CFST, and the evaluation team at the Center for Child and Family Policy at Duke University assesses the program's effect on academic outcomes. A key component is the involvement of state level and community agencies in family support teams.

Any school faculty or staff member may refer a student for academic factors, social and behavioral issues, and health or services needs, including child welfare. A CFST leader meets with the family to assess needs and develop a single, strengths-based service plan that integrates all service providers, a program goal summarized as ''1 child, 1 family, 1 plan.'' The agency relevant to the student's primary need leads the interagency team, which addresses barriers to services and monitors the child's progress.

A Web-based case management system tracks student data and aggregates trends to inform service needs. During the first two years the program served 13,902 students, half of whom were in elementary schools and the remainder, divided half between middle and high school students. Racial and ethnic composition roughly matched school composition. Student needs were as follows: 73% academic; 65% social services, including child welfare; 49% health/mental health, substance use, or developmental; and 6% legal. Most students had needs in more than one service area.

Now finishing its third school year, the program has met challenges of competing pay scales for nurses, principals who are wary of nurses and social workers leaving school grounds to make home visits, and a need to assimilate roles of CFST and traditional school nurses. The authors conclude by reinforcing how schools, given their primary role in children's lives, are a logical base for interagency teams to address students' needs.

Gifford, E. J., Wells, R., Bai, Y., Troop, T., Miller, S., & Babinski, L. (2010). Pairing nurses and social workers in schools: North Carolina's school-based child and family support teams. *Journal of School Health, 80*(2), 104–108.

Needs and Outcomes for Low-Income Youth in Special Education

While poverty, educational disability, and child maltreatment separately have been associated with negative outcomes, this is the first study to use longitudinal data to examine the needs and outcomes of low-income children in special education by level of child welfare involvement.

Authors used data from a larger longitudinal study of maltreated and low- income students compared with low-income only children born 1982 through 1994 in a Midwest urban school

district. For the current analysis, they narrowed the data to 471 special education students with emotional disturbance (ED). The study compared students' risk for negative outcomes (mental health issues, school problems, and juvenile offenses) with levels of child welfare contact (no report, child maltreatment report but no services, in-home child welfare services, and foster care placement).

Overall, special education students involved with child welfare were most likely to have an ED diagnosis, and they experienced more negative outcomes, such as emergency room treatment for mental health problems, school problems, or delinquency. Prior research has indicated that ED youth in foster care had more negative outcomes than those not in the child welfare system, but the current study suggested that students with in-home child welfare services or reports of maltreatment without services generally had equal or even greater levels of needs than those placed in foster care.

The authors believe their findings underscore the problems and unmet needs of students with ED. They urge schools, child welfare agencies, and the mental health systems to respond with greater coordination and collaboration to provide comprehensive services for these children.

Lee, M., & Jonson-Reid, M. (2009). Needs and outcomes for low-income youth in special education: Variations by emotional disturbance diagnosis and child welfare contact. *Children and Youth Services Review, 31*(7), 722–731.

Kinship Care, Sibling Placement, and School Outcomes

Although literature separately addresses issues of kinship foster care and sibling placement, no prior studies have examined outcomes from both types of placement, including possible interactions when placements involve kinship foster care of sibling groups. This study examines data from youth, caregivers, teachers, and caseworkers to investigate relationships among kinship foster care, sibling placement, and child welfare outcomes, including youth behavior, family and caregiver relationships, and school performance.

The authors used samples from the National Study of Child and Adolescent Well-being (NSCAW) to analyze 2,488 observations of 1,415 different children. Although data were not conclusive regarding interaction between kinship foster care and sibling placement, both placement settings offered advantages, particularly from children's perspective; they reported feeling supported, they felt close to a primary caregiver, and they liked living with the family. School performance findings predicted lower academic performance for white children in kinship placement with siblings. While children in the kinship care of Hispanic, black, and other ethnicities performed as well in school whether siblings were present or not, those in nonkinship placements performed better when placed with siblings. A pattern of conflicting and questionable behavior assessments suggested using multiple reporters of children's behavior and checking any differences in perceptions.

The authors concluded that additional research can investigate if optimal placement would include siblings together in a kinship home. Current practice and policy should continue to promote kinship care, sibling placement, and contact between separated siblings to bolster children already very much at risk in the child welfare system.

Hegar, R. L., & Rosenthal, J. M. (2009). Kinship care and sibling placement: Child behavior, family relationships, and school outcomes. *Children and Youth Services Review, 31*(6), 670–679.

Child Victims of Human Trafficking: Challenges for Child Welfare

This article examines child welfare services to United States and international child victims of commercial sexual exploitation and trafficking. Child victims are most often girls aged 13–14 when taken, and they may be runaways, homeless, delinquent, or in the foster care system. Traffickers may lure children from their parents using lies, coercion, and narcotics, or they kidnap victims from movie theaters, schools, and shopping malls. Children who live close to international borders are at increased risk.

Child victims are survivors of sex slavery and have experienced violence and many abusers. Child welfare agencies may need to repatriate or develop permanent plans for foreign children trafficked across international borders. Paradoxically, victims may be arrested for prostitution after years in captivity and may still not receive help for the emotional trauma and physical abuse they endured.

The authors review current treatment for victims after escape or rescue. Conventional sexual abuse therapy cannot address the complex needs of trafficked children who may have experienced torture, rape, or drug abuse. Victims may exhibit mental and physical trauma, substance abuse, sexually transmitted diseases, pregnancy, and abortion-related complications. In addition, they face stigma and shame about their experiences and may need anonymity in group therapy because traffickers use family death threats to enforce compliance. The authors cite two successful treatment programs: Angela's House in Atlanta and multisystemic therapy (MST).

The authors conclude the article with practice and policy recommendations. They contend that child welfare agencies should collaborate in the community to identify victims, and agencies should use treatment programs with the expertise and cultural knowledge needed to serve victims of child trafficking.

Fong, R., & Berger Cardoso, J. B. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation and Program Planning, 33*(3), 311–316.

Washington Update

Thomas L. Birch, JD, National Child Abuse Coalition

Congress Slow to Move on Budget Appropriations

Congress is moving slowly—actually, not moving very much at all—on developing a budget and drafting appropriations bills to fund the government for the 2011 fiscal year beginning in October. While the President was on time by submitting his budget to Congress on February 1, the House and Senate have not kept up to the schedule. The outlook is not promising.

The Obama budget would freeze total nondefense domestic discretionary spending at the 2010 level. This is what child welfare advocates have been hearing for several months. The President gave the first view of his intentions in his State of the Union address to Congress in February—a call for freezing domestic discretionary spending at current levels for three years. None of this is good news for the future funding prospects of the chronically underfunded federal programs charged with protecting vulnerable children and families.

As a signal that politicians are serious about deficit reduction, a discretionary spending freeze offers an easy path, but it is at the expense of efforts to shore up overburdened services to protect children and prevent child maltreatment, along with a host of other domestic concerns. What's more, the proposed spending freeze bolsters the misapprehension that the deficit is driven by a relatively small account of discretionary funding. In fact, domestic spending, while symbolic in efforts to cut spending and address deficit reduction, accounts for only about 15% of the federal budget. The other 85% consists of defense-related spending, interest on the national debt, and entitlement programs such as Medicaid, Medicare, Social Security, food stamps, and child welfare spending on foster care and adoption placement subsidies.

According to the congressional budget schedule, the House and Senate should have completed action by April 15 with floor votes on a budget resolution for the next fiscal year. The congressional budget resolution is significant in allocating each year the dollar amounts available to the appropriations subcommittees to set funding levels for programs in the various appropriations bills. So far, only the Senate Budget Committee has moved forward, approving a budget resolution on April 22 that includes a $4 billion reduction from President Obama's discretionary spending request, with cuts coming mostly from the State Department and international programs.

In the House, the Budget Committee has not even reached the point of approving a resolution to guide FY11 funding decisions. House Democratic leaders are stuck trying to negotiate an agreement between their fiscally conservative and progressive party members over how much discretionary spending to provide. As might be expected, members of the House are reluctant to vote on broad funding proposals in a budget resolution that could be used against them in the midterm elections coming in November. Reports from the Hill rate the chances as very low for a budget agreement in the House.

As for appropriations, the budget process allows appropriators to draft their bills, even though a budget resolution is incomplete. It is important to recognize that not all types of discretionary domestic spending will be held to the 2010 levels. Instead, only the overall total for spending will be frozen, but Congress will make decisions within the total discretionary spending pool about which programs to eliminate, which to cut, and which to increase. In fact, the President has proposed new funding in the 2011 budget for education and child care.

The Obama administration released its budget for FY11 on February 1, proposing the largest one-year increase in child care funding in over 20 years. The total is $1.6 billion above the FY10 level, for a total of $6.6 billion to serve 235,000 more children than could be served without the additional funds in 2011. Funding for Head Start and Early Head Start, requested at $8.2 billion in the President's FY11 budget, would also get a substantial increase—an additional $989.175 million to sustain services to the approximately 64,000 additional children supported by American Recovery and Reinvestment Act funding in 2010, and to support a full 2% cost-of-living adjustment to offset inflationary costs. According to budget documents, the Office of Head Start plans to promote community efforts to integrate early childhood services.

Among the few programs with an increase in the Obama funding line, the Child Abuse Prevention and Treatment Act (CAPTA) discretionary grant is proposed for $10 million in additional spending to establish a new competitive grant program for states to support the increased use of evidence-based and evidence-informed child maltreatment prevention programs. The new grants will focus on encouraging states to use existing funding streams to support community-based prevention activities rooted in a strong evidence base. Funds also will be used to ensure that child abuse and neglect

prevention is integrated with other state systems for children. Other CAPTA grant funds are frozen at 2010 levels in the Obama budget for 2011: Basic state grants for improvement of state child protective services are at $26,535 million, and community-based child abuse prevention grants are at $41,689 million.

According to the President's proposal, the Family Violence Prevention and Services program would also increase by $10 million, with $4 million allocated to fund 12 new discretionary grants for promising practices to enhance services for children exposed to domestic violence. The grants would support expanding child advocacy staff in shelters and nonresidential domestic violence services, offering training and technical assistance, and providing outreach to child welfare agencies and schools to enhance their response to children exposed to domestic violence. The remaining $6 million would respond to the increased demand for emergency domestic violence shelter services, especially to provide specific services for children in shelters with their nonabusive parent.

With the prospect of a freeze, Congress is charged with setting priorities and deciding where to cut some programs in order to save others. Appropriations Committee chair Rep. David Obey (D-WI) has suggested that instead of additional funding in the coming year, interest groups should expect to see cuts in programs even below the funding levels requested by President Obama. At a hearing before his subcommittee, which funds the Departments of Labor, Health and Human Services, and Education, Obey explained that advocates for the programs funded by his subcommittee would likely see cuts of as much as $3.5 billion to the funding levels requested by President Obama, representing a 2.3% reduction overall.

Prospects for 2012 appear to be no better. The White House Office of Management and Budget has directed all "nonsecurity" federal agencies—essentially the Departments of Defense and Homeland Security, and related agencies—to list what they consider to be wasteful programs and propose budgets for themselves that will cut spending by 5%. The move is intended to enable the Obama administration to achieve the goal of freezing nonsecurity discretionary spending for 3 years at 2010 levels, while making some money available for additional administration priorities.

President Signs Health Care, Home Visiting Into Law

With the enactment of health care reform legislation in March, for the first time federally-mandated funding will be available and dedicated for prevention to support home visitation. Provisions in the Patient Protection and Affordable Care Act, signed into law by President Obama on March 23, authorize $1.5 billion over five years in grants to states—with $100 million in 2010—for Maternal, Infant, and Early Childhood Home Visiting Programs. These are funded through Title V, the maternal and child health block grant, to support a range of voluntary home visitation services to pregnant women, young parents, and their children.

Priority for services would go to low-income families, including pregnant women under age 21 living in communities in need of services. Eligible families would also include those with a history of child abuse or neglect or involved with child welfare services and a history of substance abuse. Eligible children are those with low student achievement and with disabilities or developmental delays.

By late September, states will be required to conduct a statewide needs assessment to identify communities at risk, including those with concentrations of premature and low-birthweight infants and infant mortality, poverty, crime, domestic violence, high rates of high school dropouts, substance abuse, unemployment, or child maltreatment. The needs assessment must also evaluate the quality and extent of existing early childhood home visitation services, including numbers of families already receiving services and gaps in home visitation services.

The law directs states to develop a needs assessment that coordinates the Title V Maternal and Child Health Block Grant needs assessment, the Head Start communitywide strategic planning and needs assessment, and the inventory of unmet needs and current community-based and prevention-focused activities under the Community Based Child Abuse Prevention Program, Title II of the Child Abuse Prevention and Treatment Act (CAPTA).

The new grant program would require that 75% of the funding to a state for home visitation would support models that are well designed, research-based, and rigorously evaluated through randomized control trials or quasi-experimental research designs. The remaining 25% of grant funding could go to support promising and new approaches yet to be evaluated by a similar rigorous process.

The law specifies that the Health Resources and Services Administration (HRSA) and the Administration on Children and Families (ACF), both in HHS, must collaborate in reviewing and analyzing the statewide needs assessments, the awarding of grants, and the program evaluations. In the first step toward implementation of the home visiting program, the two agencies have announced plans to collaborate on the development of evidence-based criteria for identifying home visiting models that have proven positive outcomes for families.

All federal-level policy and program decisions will be made jointly by HRSA and ACF. The announcement includes the expectation that states will ensure collaboration among child-serving programs as they develop their home visiting service systems, modeling the federal-level agency cooperation. The announcement makes it clear that the two federal agencies are committed to creating a home visiting program success as an example of how evidence-based policy and effective collaboration—among federal agencies, between states and the federal government, and across local programs—can yield improved conditions.

In early June, ACF and HRSA issued a funding announcement to support states in addressing the needs assessment required of each grantee state. As states then conduct their needs assessments, HHS will develop program guidance to answer questions about how grants to the states can be used to conduct early childhood home visitation programs that address needs identified by the assessment.

Approximately $90 million will be awarded this summer to fund the new formula-based grant program for eligible states and territories to provide evidence-based home visiting programs for children and families in at-risk communities. The idea is to develop and deliver health, development, early learning, and child abuse and neglect prevention and support services for families who live in at-risk communities. The governor in each state must designate a lead agency to apply for and administer the home visiting program. Additional funding available to Indian tribes will be announced at a later time. Of particular interest will be the defining of the evidence-based criteria (expected to be issued later) for identifying home visiting models that are eligible for participation in the new grant program.

The entitlement funding for the program would increase from $100 million in 2010 to $250 million in 2011, $350 million in 2012, and $400 million in both 2013 and 2014.

Congressional Hearing on Corporal Punishment in Schools

On April 15, the House Committee on Education and Labor, Subcommittee on Healthy Families and Communities, held a hearing on "Corporal Punishment in Schools and Its Effect on Academic Success," the first time since 1992 that Congress has heard testimony on the issue. In opening the hearing, subcommittee chair Rep. Carolyn McCarthy (D-NY) explained that over 220,000 students were paddled in school in the United States in the 2006–2007 school year, according to the most recent data available from the U.S. Department of Education's Office of Civil Rights.

Corporal punishment is permitted in 20 states, McCarthy said, and of the 29 states that prohibit paddling in schools, Ohio just passed its ban on the practice last summer. The OCR statistics indicate that a disproportionate number of those paddled are African American students, who receive physical punishment in schools at twice the national rate, and also school children with disabilities, who are dealt corporal punishment at disproportionately high rates, again twice the rate in some states.

As with reporting information on child abuse and neglect, the youngest children are the most vulnerable, with students in kindergarten through eighth grade more likely to be paddled than high school students. McCarthy stated that she plans to introduce legislation to end paddling in schools, observing that federal statutes already prohibit physical punishment in prisons, jails, and medical facilities.

Witnesses testifying at the hearing included a high school principal and president of the National Association of Secondary School Principals, a high school teacher representing the American Federation of Teachers, a pediatrician, and the mother of a student who was paddled in school even though this parent had indicated on consent forms that she did not want her daughter to be paddled. The witnesses pointed to the negative affects of corporal punishment as an impediment to student learning and an ineffective method for controlling a classroom.

APSAC News

Attendance Soars at 2010 APSAC Colloquium

The 18th Annual APSAC Colloquium was held on June 23–26 in New Orleans, Louisiana. Attendance increased nearly 88% over last year's levels, from just over 400 attendees in 2009 to nearly 750 attendees in 2010. APSAC attributes this increase to a strong program combined with a great location.

Several special programs were provided that promoted increased attendance by law enforcement personnel and by the United States Air Force. Law enforcement officers were able to attend under a grant given to APSAC by the National Center for Missing and Exploited Children.

The 19th APSAC Annual Colloquium will be held in Philadelphia, Pennsylvania, July 13–16, 2011.

Awards Presented at APSAC's 18th Annual Colloquium

During its Annual Colloquium, APSAC celebrated outstanding service and commitment by child maltreatment professionals and APSAC members. Awards were presented during the Friedrich Memorial Lecture, Membership Luncheon, and Awards Ceremony on June 25, 2010. The following list recognizes the recipients and their awards.

Outstanding Service Award

Kathy D. Johnson, MS, Clinical Instructor, Family and Children's Resource Program, University of North Carolina at Chapel Hill

Recognizes a member who has made substantial contributions to APSAC through leadership and service to the society.

Outstanding Professional Award

Emalee G. Flaherty, MD, Director, Child Abuse Pediatrics, Associate Professor of Pediatrics, Feinberg School of Medicine, Northwestern University

Recognizes a member who has made outstanding contributions to the field of child maltreatment and the advancement of APSAC's goals.

Outstanding Research Career Achievement

John Lutzker, PhD, Director, Center for Healthy Development and Visiting Professor of Public Health at Georgia State University

Recognizes an APSAC member who has made repeated, significant and outstanding contributions to research on child maltreatment over his or her career.

Outstanding Service in the Advancement of Cultural Competency in Child Maltreatment Prevention and Intervention

Michael A. de Arrelano, PhD, Associate Professor and Licensed Clinical Psychologist at the National Crime Victims Research and Treatment Center (NCVC), Department of Psychiatry at the Medical University of South Carolina

Recognizes an individual, organization, or agency that has made outstanding contributions to the advancement of cultural competency in child maltreatment prevention and intervention.

Outstanding Front-Line Professional

Richard Kaplan, MD, Medical Director, Center for Safe and Healthy Children, University of Minnesota Children's Hospital Child Abuse Program and Associate Professor of Pediatrics, University of Minnesota School of Medicine.

Recognizes a front-line professional (child protection, law enforcement, mental health or medical professional) who demonstrates extraordinary dedication and skill in direct care efforts on behalf of children and families.

Outstanding Media Coverage

Dennis Ferrier, Reporter, WSMV-TV, Nashville, Tennessee

Recognizes a reporter or team of reporters in newsprint or broadcast journalism whose coverage of child maltreatment issues shows exceptional knowledge, insight, and sensitivity.

***Outstanding Article in the Journal* Child Maltreatment**

A motivational intervention can improve retention in PCIT for low-motivation child welfare clients (2009). *Child Maltreatment, 14*(4), 356–368.

Mark Chaffin, PhD, Professor of Pediatrics in Counseling Psychology, University of Oklahoma College of Medicine

Linda Anne Valle, PhD, Division of Violence Prevention. Centers for Disease Control and Prevention

Beverly White Funderburk, PhD, Assistant Professor of Pediatrics, Child Study Center, University of Oklahoma College of Medicine

Robin H. Gurwitch, PhD, Assistant Professor, Department of Pediatrics, and Director, Early Childhood Intervention Services, Child Study Center, University of Oklahoma

Jane F. Silovsky, PhD, Associate Professor of Pediatrics, Co-Assistant Director, Center on Child Abuse and Neglect, University of Oklahoma College of Medicine

David Bard, PhD, Assistant Professor of Pediatrics, Child Study Center, University of Oklahoma College of Medicine

Carol McCoy, MEd, University of Oklahoma College of Medicine

Michelle R. Kees, PhD, Psychologist, Assistant Professor, Child and Adolescent Psychiatry Outpatient Program, University of Michigan.

Recognizes the authors of a research article judged to be a significant advancement to the field of child maltreatment.

Ronald C. Laney Distinguished Service Award

Jon C. Conte, PhD, Professor, School of Social Work, University of Washington.

Presented on a periodic and exceptional basis by the APSAC Board of Directors to an individual who has exhibited a lifetime of service to others, as exemplified by Ron C. Laney.

William Friedrich Memorial Award

John E. B Myers, JD, Professor and Director, Criminal Justice Concentration, McGeorge School of Law

Presented by the APSAC Board of Directors to an individual who has demonstrated a career that exemplifies the achievements and character of the late William Friedrich.

APSAC Offers Three Advanced Training Institutes in January 2011

The APSAC Advanced Training Institutes are being held in conjunction with the 25th Annual San Diego International Conference on Child and Family Maltreatment, January 23, 2011. APSAC's Advanced Training Institutes offer in-depth training on selected topics. Taught by nationally recognized leaders in the field of child maltreatment, these seminars provide hands-on, skills-based training that is grounded in the latest empirical research. Participants are encouraged to ask questions and give examples from their own experience. The APSAC 2011 Institutes include the following:

Teaching Caregivers to Talk With Children About Feelings: Implications for Treating Child Trauma
Presenters: Monica Fitzgerald, PhD, and Kimberly Shipman, PhD
Sunday, January 23, 2011, 8:00 am–12:00 noon, and 1 pm–4 pm. Lunch on your own. (7 hours)

Advanced Sexual Abuse Evaluation for Medical Providers
Presenters: Lori Frasier, MD, and Suzanne Starling, MD
Sunday, January 23, 2011, 8:00 am–12:00 noon, and 1 pm–4 pm. Lunch on your own. (7 hours)

Advanced Forensic Interviewing
Presenters: Lynda Davies, BA, Michael Haney, PhD, Tom Lyon, JD, PhD, and Julie Kenniston, LSW
Sunday, January 23, 2011, 8:00 am–12:00 noon, and 1 pm–4 pm. Lunch on your own. (7 hours)

Details and registration instructions are available on the APSAC Web site (www.apsac.org) under the Events & Meetings tab, Event List.

Call for Abstracts

APSAC is now accepting abstracts for its 2011 Colloquium, July 13–16 in Philadelphia, Pennsylvania. Details on responding to the Call for Abstracts are available on the APSAC Web site, www.apsac.org.

APSAC Library

The APSAC Advisor Library, powered by OmniPress, includes content dating back to 1990. This online resource provides members with direct access to the vast amount of knowledge that has been published in the association's quarterly newsletter, the APSAC Advisor. Articles are provided in Adobe PDF format and are organized by year, issue, and title. Full search capability is provided.

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.

Conference Calendar

August 24–26, 2010
11th National Conference on Child Sexual Abuse and Exploitation Prevention
National Children's Advocacy Center (NCAC)
New Orleans, LA
256.533.KIDS (5437)
mgrundy@nationalcac.org
www.nationalcac.org

August 8–September 2, 2010
Georgetown University's Leadership Academy
National Technical Assistance Center for Children's Mental Health (NTACCMH)
Santa Fe, NM
202.687.5000
childrensmh@georgetown.edu
www.gucchdtacenter.georgetown.edu/Activities/LeadershipAcademy

September 12–15, 2010
15th International Conference on Violence, Abuse, and Trauma
Institute on Violence, Abuse and Trauma (IVAT)
San Diego, CA
858.527.1860
www.ivatcenters.org

September 12–14, 2010
11th International Conference on Shaken Baby Syndrome/ Abusive Head Trauma
National Center on Shaken Baby Syndrome (NCSBS)
Atlanta, GA
801.627.3399
dvazquez@dontshake.org
www.dontshake.org

September 26–29, 2010
18th ISPCAN International Congress on Child Abuse and Neglect
International Society for the Prevention of Child Abuse and Neglect (ISPCAN)
Honolulu, HI
303.864.5220
congress2010@ispcan.org
www.ispcan.org/congress2010

October 14–16, 2010
6th Biennial Adoption Conference: Open Arms, Open Minds: The Ethics of Adoption in the 21st Century
Adoption Initiative/St. John's University
New York, NY
212.962.4111
adoptioninitiative@gmail.com
www.adoptioninitiative.org

October 20–22, 2010
Alliance for Children and Families National Conference
Milwaukee, WI
414.359.1040
hhanson@alliance1.org
www.alliance1.org

October 20–23, 2010
National Juvenile and Family Law Conference
National Association of Counsel for Children (NACC)
Austin, TX
303.864.5359
advocate@naccchildlaw.org
www.naccchildlaw.org

October 27–29, 2010
Mid-Atlantic Conference on Child Abuse and Neglect
Southern Region Child Advocacy Centers, National Children's Alliance, Maryland Children's Alliance
Ocean City, MD
410.877.5376
lmeyers@mdcha.org
www.mdcha.org

December 13–14, 2010
Child Abuse Conference
ChildSafe. Methodist Behavioral Medicine and CHRISTUS Santa Rosa Children's Hospital
San Antonio, TX
210.675.9000
patriciak@childsafe-sa.org
www.childsafe-sa.org

January 23, 2011
APSAC Advanced Training Institutes
American Professional Society on the Abuse of Children (APSAC)
San Diego, CA
877-402-7722
apsac@apsac.org
www.apsac.org

January 23–28, 2011
25th San Diego International Conference on Child and Family Maltreatment
Chadwick Center for Children and Families
San Diego, CA
858.966.8572
jnelson@rchsd.org
www.chadwickcenter.org

March 28–31, 2011
27th National Symposium on Child Abuse
OJJDP, Child Protection Division, U.S. Department of Justice; Office for Victims of Crime
Huntsville, AL
256.327.3863
mgrundy@nationalcac.org
www.nationalcac.org

July 13-16, 2011
19th APSAC Annual Colloquium
American Professional Society on the Abuse of Children (APSAC)
Philadelphia, PA
877.402.7722
apsac@apsac.org
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