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APPSAC

Enhancing the ability of professionals to respond to children and their families affected by abuse and violence.

Pathway to Hope: A Tribal Community-Based Empowerment Curriculum to Heal Child Sexual Abuse

Diane Payne, BA

Background

While serving as an advocate for adult victims of domestic and sexual violence, and helping Alaska Tribes develop their child abuse response systems in the 1990s, I became aware of the high number of child sexual abuse survivors in rural Alaska villages. In some communities, Native adults courageously exposed the sexual abuse of children although there was still denial and silence from others in the community. As we discussed ways to help those ready to end silence and denial, community education events were planned so that other adults would learn to believe and then support children who reported sexual abuse. Having previously used videos such as *Young Once, Indian Forever* (1996) and *Bitter Earth* (1993) in other Indian Country work, I brought these resources to rural Alaska. (These videos were produced in reservation settings and are no longer available.) However, the videos portrayed cultures and federal or tribal justice systems that were unfamiliar to Alaska Natives. As we worked to open dialog and facilitate awareness about these difficult issues, it was apparent that the voices of other Alaska Natives about the effects of child sexual abuse provided a key to ending silence and denial and finding paths for healing.

In 2004, through training and technical assistance funds, with the support of the Office for Victims of Crime Indian Country grant manager, we started to build Alaska Native-specific resources. We selected an advisory group of Alaska Native people who had been providing victim services and healing and wellness activities in different Tribal communities throughout Alaska to develop a vision for a video to end silence and denial about child sexual abuse in Alaska Native communities and families. The advisory group included elders as well as young adults and represented Alaska Tribes that had a U.S. Department of Justice Children's Justice Act Partnerships for Indian Communities grant to address child sexual abuse. During two days of facilitated discussion, core messages and key elements of the video format were selected. In laying the framework for the *Pathway to Hope* (PTH) video and video guidebook, the advisory group envisioned a time when

Alaska Native people would come together statewide and begin the process of ending silence and supporting child victims. Although the principles of "breaking silence" to heal from various forms of childhood trauma are not unique to Alaska, the mobilization of this concept into actionable, culturally relevant concepts and principles is original. No other program attempting to promote healing from child sexual abuse in Alaska, to date, has originated strictly from the core concepts, values, and beliefs of Alaska indigenous people (Payne, Olson, & Parrish, 2013).

Pathway to Hope Is an Indigenous Approach

The PTH curriculum is adapted to work within the specific culture, community history, and traditional values and practices for the Tribal community where it is delivered. Purposely flexible, the agenda and activities are tailored through multiple planning sessions with key individuals within the Tribe; in fact, they draw from the knowledge and experience of the leaders who are taking steps to end silence about child sexual abuse and promote healing among their people.

The PTH approach is based on belief that healing requires support and information and that sustained effort contributing to healing Native survivors of child sexual abuse takes place when Native people work within their own communities. Furthermore, community ownership and empowerment to address harm and healing must be community-specific to succeed. In delivering this curriculum across five states and two countries (U.S. and Canada), we have found that a high percentage of training participants themselves have a personal history of childhood sexual abuse in addition to being vicariously exposed to trauma material in their helping roles. By providing training to Tribal community facilitators, participants use their cultural strengths and values to create their own collective circle of safety for the healing journey. Within this circle, participants share and acknowledge that topics presented may bring up triggers, past or current negative coping skills, and reminders of personal-family trauma that can make it difficult to stay present. PTH faculty facilitate the collective resilience from vicarious trauma of participants who live and work

in rural Tribal communities where they often wear multiple “professional hats” by validating the connection to one another in sometimes complex ways. While thus being more vulnerable to vicarious trauma even if they are not in a helping role, the participants often experience these complex relationships as a source of great resilience and strength.

How PTH Works

The *Pathway to Hope: Healing Child Sexual Abuse* video, *Tribal Community Facilitator’s Video Guidebook*, and the training agenda and delivery were crafted with an understanding that safety of the participants within their families and communities is paramount if social change can be achieved. The learning environment must promote safety and trust because in close-knit villages, the pain of sexual abuse can be more complex, is felt by many, and has a greater impact because of the way that individuals relate to one another. Therefore, as pointed out in the Foreword of the original version of the *PTH Video Guidebook*, holistic healing for the survivor of sexual abuse often occurs in the larger context of the community (Evensen, 2007). The National Center for Trauma-Informed Care states that the principles of trauma-informed care include understanding trauma and its impact; promoting safety; ensuring cultural competence; supporting consumer control, choice, and autonomy; sharing power and governance; integrating care; and believing that healing happens in relationships and recovery is possible (Payne et al., 2013).

These principles are embedded into the training for PTH. Thus, the Pathway to Hope model promotes evidenced-based and trauma-informed care from a cultural perspective. The PTH program offers research-based facts about childhood sexual abuse from a national, state, and cultural-specific standpoint. It challenges old beliefs and cognitive distortions, and it requires participants to do the bulk of the work. While the trainers present facts and teach techniques, participants are asked to complete the structure and anatomy that will form a geographically specific model of culturally based community healing for each of their own communities. Because the PTH faculty members are not from any of the communities in which they train, they cannot possibly provide the answers to healing for those communities. Instead, they offer tools and information from which participants can create a number of intervention and healing possibilities for individuals, groups, and families in their own communities. Participants are taught about pacing and containment, encouraged to seek outside counseling when needed, and helped to see the painful process of looking inward as a long-term goal that can be successfully tackled only with internal resources and external support.

The PTH model helps to identify both internal resources and ways of creating and improving on external support networks

with the understanding that while cathartic disclosure can be one piece of the healing puzzle, it can also be damaging when done in a way that does not take readiness and support into account. Silencing in the form of historical trauma, continued oppression, and internal oppression reinforce trauma narratives and trauma memories, making them more difficult to process and heal from. This compromises a simple disclosure of trauma in which one experiences cathartic release, which, in isolation, has been found to be re-traumatizing, even for many who aren’t victims of historical trauma (Payne et al., 2013; Manion et al., 1996).

PTH Video and Curriculum

The 40-minute PTH video features two 20-minute segments and represents the voices of more than 40 Native people in Alaska who were interviewed for this production. The content and format are designed to stimulate discussion and promote action steps that will strengthen Tribal community responses to child victimization and support community healing from past child abuse.

The video and guidebook contain visual content that is familiar to Alaska Natives in rural as well as urban areas because the advisors knew that Alaska landscapes, nature sounds, rural images of varied traditional activities, and Native music were needed. Recognizing the importance of language and culture in healing, the video opens with five Native elders each speaking their Alaska Native language (Inupiat, Athabascan, Yupi’k, Tlingit, and Alutiiq) and urging viewers to come together and take action to protect children and help them heal (Pewewardy, 2002). Elder speakers provide insight and guidance for ending denial and silence throughout the video as well.

Through the collective insight and wisdom of the advisory group, core principles were developed to guide the PTH curriculum and training approach. These principles also informed the development of tools and activities found in the video guidebook. The principles are as follows:



Table 1: Truths, Concepts, and Beliefs Explored by Participants Through Facilitated Dialog

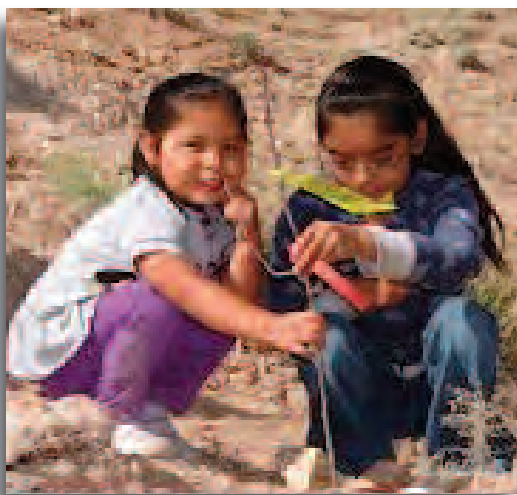
<ol style="list-style-type: none">1. Exploring impact of multigenerational and historical trauma on safety of children now2. Recognizing that there are protections that prevent us from the following:<ul style="list-style-type: none">Believing that children are sexually abusedHolding abusers accountable for their behaviorEnding child sexual abuse3. Examining and understanding how children experience sexual abuse (vulnerability, signs of emotional impact)4. Evaluating community readiness to end denial about child sexual abuse and begin healing by identifying knowledge about child sexual abuse, attitude of Tribal and spiritual leaders, and resources available to address child sexual abuse5. Community-based action strategies toward community ownership to end silence about child sexual abuse and establish support for children:<ul style="list-style-type: none">Coming together to celebrate and honor our childrenTeaching adults and children about personal safetySetting community standards about childrenHealing and support for children when victimized6. Promoting healing and support for children victimized by sexual abuse by providing culturally relevant, supportive services for child and nonoffending caregivers, extended family members, and community members who will help the child heal from acute and chronic pain.
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1. Indigenous people/Tribal communities must take responsibility for the safety and healing of children.
2. Indigenous people/Tribes must have ownership of social problems as well as the development of solutions to those problems.
3. Reclaiming and reviving cultural values, beliefs, and practices to heal children and those victimized as children must begin with understanding historical trauma and in multigenerational dialog.
4. Ongoing mentoring and support for indigenous couriers of community change are essential for Tribal communities to achieve long-term change in attitudes and responses toward children who were victims of sexual abuse.

Applying indigenous learning styles and utilizing experienced-based activities, two PTH faculty members lead participants carefully through examination of issues relating to child sexual abuse dynamics and victimization, healing and wellness for indigenous communities, and community empowerment strategies. During the 3-day interactive training and facilitated dialog, participants are asked to explore their truths, concepts, and beliefs (Table 1).

The depth of exploration into these areas and the stage of action toward community ownership depend primarily on the readiness of the participants individually and collectively and their perception of the readiness of larger community circles to delve into the issues. Each Training of Community Facilitators session ends with an action plan and timeframes that the participants develop through facilitated dialog. To reach this point, participants have evaluated obstacles to ending silence and support for healing, identified strengths and resources that will help address the obstacles, and determined the readiness of certain key groups such as elders, leaders, and parents to support community change.

The PTH advisors felt strongly that only those who had been taught how to measure the readiness of their community, how to present this sensitive and emotional information on child victimization, and how to provide support to survivors who viewed the video should be allowed to use the video. The advisors understood that in any Alaska Native audience, it is likely that as many as two thirds of the group would be survivors of childhood trauma with a high possibility of having painful memories triggered by the material. They felt it essential that the Tribal community facilitators who would use these tools are familiar with and committed



to responding to adult and child survivors in a safe, nurturing, and supportive manner. Thus, participation in the 3-day Tribal Community Facilitator training is the only way to get a copy of the PTH video and the 195-page step-by-step *Tribal Community Facilitator Video Guidebook*.

PTH Demographics and Outcomes

Pathway to Hope Tribal Community Facilitator training has been provided to more than 450 individuals in the states of Alaska, Washington, Montana, Wyoming, and South Dakota as well as for Aboriginal people in the Canadian Province of Manitoba between October 2007 and May 2013. As previously mentioned, each training event is customized to the readiness and goals of the community members who assist with planning the training event. While there are core agenda topics, emphasis and outcomes depend on the participants themselves and vary considerably across these regions.

Participants have always been multigenerational; we urge local planners to include trusted elders and spiritual leaders as well as young people who have interest in community change. Most often the participant groups are predominantly female, but there have always been male participants in each group. The demographics of the trainee groups vary also. At some sessions, training is shared by up to 30 people (a PTH maximum-participant group is 35) representing several Tribes in one geographic area, and in other situations, the participants are all part of one Tribal community. Sometimes 100% of participants are Native, and other times, up to one third of the group is non-Native. The non-Natives most commonly represent law enforcement, local or state child protection workers, behavioral health clinicians, and clergy who have been invited to participate with the Tribal community.

The demographics of the participant group may be indicative of the roles that are committed to changing community attitudes and beliefs about child sexual abuse. For instance, in one session, two Tribes living in close proximity shared the Training of Community Facilitators, and many of the participants working in programs serving children and youth. It was significant that several traditional spiritual leaders attended along with federal law enforcement and prosecution agencies serving these Tribes. This community had recently witnessed a highly publicized multiple child victim case where tensions related to misunderstandings and poor communication. Perhaps the most important accomplishment of that session was the sharing and relationships that developed without focus on a particular case through the course of the 3-day training.

Among participant groups, we have found that community members have remained silent about child sexual abuse because



they are unaware that others also feel the denial and silence should end. For example, when working with a single Tribal community, PTH participants expressed surprise when they realized many others felt the same way they did about addressing child sexual abuse. In another community with several strong child advocates in leadership roles, younger members of the group found safety to express fears, anxiety, suspicions, and frustration about a recent child victim case. In this Tribal community, participants came from programs that didn't often interact with each other so the PTH approach helped them establish a greater, safer bond with each other and develop action steps that were more inclusive of all agencies.

Multi-Tribal PTH training sessions have been held in western Washington, Alaska, and South Dakota. These sessions have been attended primarily by individuals who are already involved with services to children and families, such as child advocacy center staff, child protection investigators, medical personnel, child and adult victim advocates, law enforcement, and political leaders. While many of these professionals are usually at least somewhat knowledgeable about the definition and dynamics of child sexual abuse, we have found that information and guidance on the development of community-based strategies to end silence and denial, increase ownership of the problems, and outreach to change attitudes were welcomed and needed. Furthermore, the training approach facilitates greater willingness to collaborate and support each other in shared, thus sustained, efforts. In one of the multi-Tribal groups, participants became aware that they had common challenges and various strengths; by sharing strategies and initiatives to end silence and denial between their communities, they would maximize their effectiveness and draw strength from each other.

In every unique training session, participants have been guided to acknowledge the historical trauma, identify and analyze their strengths and challenges, and design realistic steps to move their

communities and circles to the next stage of awareness; to create opportunity for improving outcomes for children who have been victimized; to hold offenders accountable; and to prevent further abuse of children. Although each host community and forum has been different, when common threads of community-based dialog and wisdom of Native elders and spiritual leaders are paired with readiness of community service providers, helpers, and leaders, true changes have emerged. In two different regions of Alaska, the PTH session was a direct predecessor to the establishment of a child advocacy center to provide multidisciplinary coordination in investigation and response to child sexual abuse. Some communities have established prevention efforts staffed by volunteers to teach children about personal safety and teach parents about protecting children. Several PTH sites have succeeded in having their Tribal governments legislate a Children's Bill of Rights, one of the activities used during the training. One region of Alaska now has an annual Protecting and Honoring Our Children conference. At all levels, this indigenous model for learning, sharing, helping, and healing brings hope for an end to denial and silence about child sexual abuse for Native people in Alaska and elsewhere.

PTH—Future Efforts

Development and initial delivery of the Pathway to Hope curriculum was funded through a training and technical assistance grant from the U.S. Department of Justice, Office for Victims of Crime to the Tribal Law and Policy Institute. The funds were no longer available after mid-2010, and thus, expenses for all subsequent Training of Tribal Community Facilitators sessions have been covered by the Tribes and organizations that requested the training. A few other sources have also been used: three sessions were funded through the Denver region of the Administration on Children and Families; a few Tribes added the PTH training into their OVC or VAWA grant proposals addressing victim services and support.

Without dedicated funds, this community-based indigenous helping and healing curriculum will continue to be available as requested by Tribes and Tribal organizations that are ready for the community facilitator training. With the hope of securing solid support and sharing this innovative approach, presentations have been made at international forums such as the International Circumpolar Health Conference (2012) and the International Society for the Prevention of Child Abuse and Neglect (2010). Additionally, the PTH approach was shared at national conferences such as the National Indian Child Welfare Association and the San Diego International Conference on Child and Family

Maltreatment shortly after it was unveiled in 2008. As a result of these forums, child victim advocacy programs in Scotland and Zambia have requested the PTH curriculum as well.

The lead faculty, Kimber Olson (formerly Evensen), author of the video guide, and I, coordinator of the PTH video project, continue to seek funding streams that will provide the resources to build PTH work in rural Alaska and elsewhere. As more child advocacy centers are developed in rural Alaska, the need for sustained and knowledgeable community support for children also grows. The advisory group, past participants, and our PTH faculty sincerely believe that this indigenous approach to ending silence and denial is fundamental to community empowerment and healing. The inherent responsibility and right that Tribal Nations have to assure safety for their children and promote healing for those who suffered abuse as children begins with coming together and ending silence and denial.

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Adolescent Mothers Programs to Improve Child Outcomes and Prevent Child Maltreatment

Margaret T. McHugh, MD, MPH

Adolescent pregnancy and teen parenting are topics that garner attention across a wide spectrum of our culture from medical-social-legal professionals to MTV viewers. A simple exercise will clarify the range of material about this subject. First, search Google for “Adolescent Pregnancy” to get about 6,200,000 results, ranging from U.S. Centers for Disease Control and Prevention (CDC) statistics to *Teen* magazine. Second, go online to PubMed to get 2,160 citations dating from 1967. Many of these citations overlap, using information from professional sources. Many sources combine their data with individual case studies of teen parents. Yet the major portion of all this material is retrospective—information gathered after the fact. Data are based on former teen parents, utilizing their age at the birth of their first baby and looking at later outcomes.

A notable exception is the current TV program called *16 and Pregnant* that deals with teens and their infants. Statistics abound in the general media on outcomes such as high school completion rates, levels of poverty, repeat pregnancies, and child protection reports. This presents a dismal picture of the future for teen parents and their children.

Epidemiology

Pregnancy rates have fallen in the past 20 years to an all-time low. The rate for girls ages 15–19 years dropped to 29.4 births per 1,000 births in 2012 from 31.3 per 1,000 in 2011. This is fewer than half the 61.8 per 1,000 births recorded in 1991 (CDC, 2012; Guttmacher, 2010). Although the numbers of pregnancies for girls younger than 15 years are small and, therefore, not deemed statistically significant, they represent an extremely high-risk group of youngsters. According to the CDC’s *Vital Signs* report, they represented 0.4% of all births in 2010 and accounted for 13,520 births in 2008 (CDC, 2013). Studies have shown consistently that 20%–30% of adolescent pregnancies occur in girls who have given birth to at least one child (Manlove, 2011). A recent publication from the CDC reports data about repeat pregnancies in adolescent girls who had their first child before age 15. Statistics covering 2007–2010 present a graphic picture of the failure to address this issue of repeat pregnancies. In 2010, there were 364,859 deliveries to adolescents age 15–19, 66,761

(18.3%) of which were repeat pregnancies. Of that 18.3%, 8,397 (12.6%) were the delivery of a third child, and 1.7% of the 364,859 deliveries were four or more children (CDC, 2013).

The Adolescent Mother

A long list of risk factors and negative outcomes for adolescents and their children has been reported over the years, from medical sources (American Academy of Pediatrics [AAP], 2001) to literature from state and government publications (CDC, 2012). The risk of teen pregnancy increases when the age of first sexual contact is younger than 15, when teens do not use contraceptives, if the partner of the girl is older, and if there are multiple partners (Weiss, 2007). Such factors result in an adolescent who is ill-prepared physically or emotionally for the pregnancy and parenthood. This is reflected in the many problems, both medical and psychosocial, that are experienced by these teens and their children. The prenatal medical issues include poor or no prenatal care and premature deliveries. Those who fall into this category continue other risk-taking behaviors such as alcohol consumption, drug use, and unprotected intercourse, adding to the prenatal burden for the fetus. The concern about low prepregnancy weights in the adolescent parent group may become a minor issue with the rise of overweight and obese adolescents in America. In the clinical setting, there are far more overweight-obese adolescent girls than underweight patients. This population has a greater risk of the onset of diabetes and hypertension during the pregnancy and of preeclampsia at the time of delivery. In the postpartum period, these same adolescents have poor follow-up medical care and no adequate contraception, resulting in the often-repeated statistic that teen mothers are “likely” to have a second child within the 24 months after delivery of their first child.

While seen as a unique phenomenon of the United States, the topic of adolescent parents and their infants can also be found in the Canadian medical literature. In 2004, Leslie and Dibden (2004, p. 561) reviewed “the paediatrician’s role” in the care of teens and their children. A more recent article was published in *Pediatrics* from Canada, comparing teens, young adults, and adult women at the time of delivery (Kingston, Heaman, Fell, &

Chalmers, 2012). In a survey of 6,400 new mothers, the authors found, as other studies have noted over the years, that adolescents had late or no prenatal care. Their data on the social histories of their teen cohort were quite revealing. They showed that 41% of the teens had experienced physical abuse in the past 2 years, twice the rate in young adults and 5 times the rate reported by their adult cohort. One fourth of the those teens reporting abuse had more than three episodes of abuse during those 2 years, more often by family members.

Social Issues for Adolescent Parents

The statistics from The National Campaign to Prevent Teen Pregnancy are quite revealing (2002). One third of parenting adolescents, both males and females, are themselves products of adolescent parent(s). Daughters of teen parents are 22% more likely to become teen mothers themselves than their same-age peers. The majority of adolescent parents are poor. The economic burden for the care of an adolescent mother and her child has steadily mounted over the years (Hoffman, 2006) but is most profound in the subset of teen mothers who have a second child within that 24 month period after the birth of their first child. They are less likely to finish high school, obtain any vocational training, or keep a job (Stewart & Kaye, 2013).

Adolescent parents have a higher rate of maltreatment when they were children. Adolescent mothers are twice as likely to have a reported case of abuse or neglect when compared with mothers who delayed pregnancy until age 20–21 (Hoffman, 2006). In addition, 48% of adolescents in foster care have been pregnant by age 19 compared with 27% of adolescents in the general population (Stewart & Kaye, 2013); and 5% of all teen mothers report that they were homeless at the time of delivery (18–19-year-olds). Pregnant and parenting adolescents report high levels of intimate partner violence, both as victim and as perpetrator (Jacoby, Gorenflo, Black, Wunderlich, & Eyler, 1999; Sue Newman & Campbell, 2011). This, coupled with mental health issues, significantly increases the risk of infant neglect by adolescent mothers (Bartlett, Raskin, Kotate, Nearing & Easterbrooks, 2014). This issue of partner violence was not addressed in AAP reviews until the most recent report in 2012 (Pinzon, Jones, & AAP, 2012).

Research by Manlove and her colleagues (2002) found two factors that can affect the rate of adolescent pregnancies. Adolescents who as children were enrolled in preschool and child care programs that focused on improving education among disadvantaged children had fewer pregnancies and births than a cohort not in such programs. Participation in school, sports, and religious activities was associated with positive reproductive health behaviors, that is, fewer pregnancies.

Infant Medical Issues

The medical problems in the newborn period for the infant of the adolescent mother reflect the poor or nonexistent prenatal care

received by the mother. Infants are often premature, low birth weight infants with the problems associated with these presentations (Chen et al., 2007). If their adolescent parent is not compliant with follow-up medical care, these children don't receive adequate preventive care, as is mirrored in studies showing low immunization rates in this population. They are at greater risk for accidental trauma. One study demonstrated that, compared with older mothers, adolescent mothers perceived less danger in situations and, therefore, may place their infants at greater risk and subsequent injuries (McClure-Martinez & Cohen, 1996).

The child of teen parents is twice as likely to be placed into foster care as a child born to older parents (Stewart & Kaye, 2013). Based on U.S. data, mothers under age 15 through age 18 account for over 61% of first foster care infant placements, accounting for 23.1% in the 18–19-year-old mothers, 24.9% of 16–17-year-old mothers, and 13.5% of age 15 and under teens (Chapin Hall, 2008). These statistics reflect the clinical observation that the youngest of the adolescent parent population usually lives with her infant in her family home or with extended family.

Adolescent Parenting and Child Maltreatment

Dialogue in the literature concerns maternal age and child maltreatment. Babies born to teenagers have increased risk for neglect and abuse based on assumptions that young mothers are uncertain of their roles and can be frustrated by the demands of infant care. Some studies indicate that young maternal age is a risk factor for abuse, including fatalities, while others indicate the presence of reporting biases that may confound the findings (Buchholz & Korn-Bursztyn, 1993; Overpeck, Brenner, Trumble, Trifiletti, & Berendes, 2011). For example, statements suggesting that the children of teen parents suffer higher rates of abuse and neglect than would have occurred if those mothers had delayed childbearing appear in many articles regarding adolescent parenting often without independent data addressing the many confounding variables. In 1992, Connelly and Straus used a nationally representative sample based on the age of the mother at the time of the birth of the abused child. They concluded that the younger the mother, the greater the rate of child abuse, but there was no significant relationship when the mother's age was measured at the maternal age at the time of the abuse. They did conclude that the greater risk was associated with large families and in minority populations, but caretaker age as a risk factor for some forms of maltreatment cannot be demonstrated because research findings are inconsistent (Connelly & Straus, 1992).

Buchholz and Korn-Bursztyn (1993) noted that abuse and neglect are more common in conditions of poverty and isolation, factors that are present in higher numbers of teen parents. Women who were younger at the birth of their child had higher rates of abuse than older mothers. Accidents, infectious diseases, burns, poisoning, and superficial injuries are the most common diagnoses

in the children of teen mothers brought to medical attention (Buchholz & Korn-Bursztyn, 1993). Flanagan, Coll, and Andreozzi (1995) used a small cohort of adolescent mother-infant dyads to conclude that living apart from related adults was the strongest risk factor associated with maltreatment in adolescent parents.

Researchers also found predictive relationships between contextual risk factors for abuse and maternal potential for child maltreatment in first-time adolescent mothers (Dukewick, Borkowski, & Whitman, 1996). Lack of preparation for parenting for the pregnant adolescent was the strongest predictor of child abuse potential. That potential was also related to parental misperception of the child's abilities to understand and comply with parental requests. To prevent abuse, the study concluded, others will need to help the adolescent mother increase "inhibitory mechanisms" for behaving aggressively with children rather than focus on decreasing the level of stress that the mother perceives. The term *more likely* is used in the literature when referring to higher rates of abuse and neglect in teens compared with older mothers.

It is likely that the social, economic, and environmental factors that promote teenage childbearing also create many of the negative outcomes attributed to maternal age alone in older studies, such as during the 1990s (Hoffman & Maynard, 2008). In a recent review of this issue, Lachance, Burrus and Richmond Scott, (2012) concluded that the lack of rigorous evaluations may be attributable to inadequate emphasis on and insufficient funding for the evaluation as well as the challenges confronted by program evaluators working with this adolescent population. More recent reviews of the topic of adolescent childbearing reflect this shift away from a focus on age alone to concepts related to theories and applications of those theories in the care of adolescent parents (Ruedinger & Cox, 2012; Savio Beers & Hollo, 2009). An online presentation by Manlove (2011) provides an overview of adolescent childbearing trends and programs to support adolescent-headed families focusing on those parents age 18 and over.

Models for Secondary Prevention

There are many programs designed, based on limited data, to serve pregnant and parenting teens by incorporating one or more of the elements thought to improve outcomes. An expert panel workgroup targeted a lack of "deep" bench research and studies of best practices that would reach teens, engage them, and retain them in service programs. The panel found that the implementation of the care components of successful programs must be studied and replicated (Corcoran & Pillai, 2007). Secondary prevention programs may be classified as community based, school-community based, and multiagency-medical-facility based. Funding for community-based programs is often founded on statistics of the incidence of adolescent births in a specific geographic area (Clay, Paluzzi, & Max, 2011).

Kahn and Moore (2010) found that home visiting programs that were longer in duration (> 1 year), involved four or more home visits during that time, and focused on early childhood were more effective. Studies have accumulated attesting to the fact that attention to these factors may diminish the repeated pregnancy rate in this population (Meade & Ickovics, 2005; Raneri & Wiemann, 2007; Stevens-Simon, Parsons, & Montgomery, 1986). In 2012, Manlove, Terry-Humen, Mincielli and Moore (2008) summarized 20 programs to determine the elements associated with positive outcomes. For child outcomes, health (preterm births, low birth weight, and immunizations), behaviors, and development were reviewed. The researchers found little impact on low birth weight, with the best results in a program that had a home visiting model with a prenatal component. Parent programs did affect immunization rates with some change in child problem behaviors but not on cognitive development. Parent outcomes included reproductive health, mental health and behaviors, education, employment, and income, but these were less positive. There was minimal impact on substance use during pregnancy, parental mental health, parent education, employment, income, or repeat pregnancies. Improvement in the interaction among parents and children was not common nor was there an impact on the reduction of physical punishment in the programs reviewed. Positive findings appeared in the areas of improvement of parents' realistic expectations of their children and in the home environment, all in programs involving the provision of services during the prenatal period. A common theme was the success of a home visiting model focused on providing parenting education during the prenatal period. The researchers concluded that more information is needed on whether and how preterm births, hospitalization, and parental use of contraception can be improved through parent education.

One such educational effort is Community-Based Adolescent Prevention Programs (CBAPP), in which 26 community-based programs are funded in zip codes with the highest teen birth rates. To sustain this initiative, the Adolescent Pregnancy Prevention and Services Program (APPS) was funded to coordinate existing services and fill the gaps in services to adolescents, regardless of income (Chapin Hall, 2008). Another approach is teen parent programs based in schools, such as the California School Age Families Education (Cal-SAFE) program (2006). This program offered a comprehensive, integrated, community-linked, school-based program. The goals were to improve the educational experiences for pregnant and parenting students, increase the availability of support services for the students, and provide child care and developmental services for their children. During the period 2000–2004, almost 30,000 teens and 20,000 children were enrolled in the program in 460 middle and high schools with noteworthy results for both the teens and their infants. Over 75% of the teens completed their high school education and fewer than 1% had a repeat pregnancy while enrolled in the program. The data concerning the children were equally positive

with only a 7% rate of infants born less than 2,500 grams, and 94% were up to date for age-immunization status.

Healthy Teen Network catalogued all programs serving this population in the United States to create a national directory that would provide support to those individuals working in the adolescent health community (Clay et al., 2011). The survey included 105 programs throughout the U.S. and demonstrates the diversity and the regional variance of these programs, both in numbers of programs available and their accessibility. Over 450 programs were identified, but the majority of the states identified fewer than 20 programs:

- 16 states, as well as the District of Columbia, received Pregnancy Assistance Fund support in 2010.
- 27 states have Nurse–Family Partnership programs.
- 13 states, as well as Puerto Rico and the District of Columbia, maintain statewide directories of programs serving pregnant and parenting teens.

The Network's recommendations were twofold. They recommended that there should be a state-level coordinator either by expanding an existing state position or by creating a new staff position within an existing agency, such as the state health department. An alternative approach would be to support a position within an existing statewide nongovernmental organization or coalition. Such a state-level person or state agency would be responsible for tracking programs, policies, and services for pregnant and parenting teens. This would identify resources as well as gaps in device provision with the ultimate goal of increasing access to those services.

A medical home model with comprehensive and integrated medical care and social services can effectively address the complex needs of adolescent parents and their children (Cox, Buman, Woods, Famakinwa, & Harris, 2012). The program demonstrated improvement in the health care for the children and their adolescent mothers. The immunization rate for the children was 90.2% in the group completing the 2-year program. Repeat pregnancy rates were decreased compared with national averages that used DMPA, an injectable hormonal contraceptive agent, as a major factor in the reduced number of repeat pregnancies. The authors echoed the often-cited problems of doing research on this patient population, including lack of funding and the complex problems posed by this population. In a 1992 statement, modified in 2002, the American Academy of Pediatrics defined a medical home to include eight desirable characteristics: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, developmentally appropriate, and culturally sensitive. These characteristics were applied to address the care of adolescent parents and their children (AAP, 1992, 2002).

There remains the question of which type of program is most helpful to the individual adolescent parent. Determining which

populations have a positive response to different interventions can help identify both risk and protective factors that may differ among populations of adolescent mothers (Jessor, Turbin, & Costa, 1998). Wakschlag and Hans (2000) identified two populations of teen mothers who would require very different types of interventions: teen mothers for whom adolescent childbearing was an adaptive life choice and teen mothers for whom childbearing was related to other problem behaviors. Such determinations need to be applied to programs being implemented with this age group. Within given communities, adolescent parenting is not identified as a problem but rather as normative. In such groups, extended families provide a structure for the young parent and her infant in a protective, nurturing environment. In the second, more troublesome group, that is adolescents with psychosocial issues, there is need for assistance outside the family structure, which is often chaotic and nonsupportive. The challenge is to identify members of these distinct groups and develop appropriate service models for them.

Models for Primary Pregnancy Prevention

Programs have been developed using similar modalities, namely community, school, and medical home models. The Community-Based Adolescent Pregnancy Prevention Program (CBAPP), funded by the New York State Department of Health, is one example (Chapin Hall, 2008). Community agencies in 26 counties with the highest rate of teen pregnancies, based on zip codes, were funded to serve adolescents ages 10–19 with a primary focus on 14–18-year-olds. The services included the following: (1) promotion of abstinence and the delay of sexual activity using appropriate sex education, (2) expansion of educational, recreational, vocational, and economical opportunities for this population, and (3) access to comprehensive family planning and reproductive health care services. Funding for other community agencies that had lowered their pregnancy rates is granted through another program, Adolescent Pregnancy Prevention and Services program (APPS). This funding was intended to continue the efforts of agencies that had been successful in reducing the teen pregnancy rate in their community. Several studies have shown the influence of school-based clinics on both general health and the sexual health of the students (Allison et al., 2012). Programs focusing on adolescent development and located in a medical home have been shown to be successful in reducing teen birth rates (Pinzon et al., 2012). More recently, Sieving et al. demonstrated that health services built on the concepts of youth development could reduce sexual risk taking behaviors in vulnerable youth (Sieving et al., 2013).

Primary prevention-intervention programs and curricula have been developed to address the needs of a population with the highest risk, young people in foster care or other out-of-home care. A unique subset of this population was the subject of an ongoing intervention (Kerr, Leve, & Chamberlain, 2009).

Adolescent girls, described as demonstrating “significant delinquent behaviors” (p. 421), were referred to foster care from the juvenile justice system. The study had a matched set of adolescents, assigned either to multidimensional treatment foster care or to group care. At the end of 2 years, there was a significant reduction in the incidence of pregnancy as well as related high-risk behaviors. The National Campaign to Prevent Teen Pregnancy and Unplanned Pregnancy has a “Special Focus-Foster Care” area on its Web site (www.teenpregnancy.org) as does the Adolescent Sexuality, Pregnancy Prevention and Parenting program (ASPPP) of the Child Welfare League of America (www.cwla.org). Many resources address the concerns of adolescent parents in foster care, providing material for professionals who work with this population. One such resource is the Center for Advanced Studies in Child Welfare at the University of Minnesota (www.cascw.umn.edu).

The Bellevue Hospital Program Model

In the early 1970s, two Bellevue pediatric nurses began an outreach effort to pregnant adolescents being seen in the hospital’s adult Prenatal Clinic. Their activities were based on their clinical observations that the infants of adolescent parents received better medical care when their parents were themselves with their biologic parent or family member rather than when they were alone. Both parent and infant were less likely to get follow-up care when they lived alone, and these mothers were more likely to have another child before the second birthday of their infant. Staff recognized even then the increased risk for maltreatment in this population (Flanagan, Coll, & Andreozzi, 1995). Current national data show that this repeat pregnancy statistic (20%–30%) remains consistent to this day (CDC, 2012).

In 1976, a multidisciplinary team developed a program to address these concerns. The team consisted of those pediatric nurses, separate medical providers for the infant and the adolescent parent, social workers, nutritionists, and child development specialists. The team was able to access psychological and psychiatric assistance from the clinic-based Child and Adolescent Psychiatry Liaison Service for those teenagers needing mental health evaluation and treatment. To address the cultural needs of the Bellevue clinic patient population, 40%–50% of the multidisciplinary team was bilingual in English and Spanish.

The structure of the program was designed to enable the provision of ongoing care to the mother-infant dyad with coordinated care within a single clinic session, during which the child development staff provided an ongoing program centered around parenting issues and child development. These sessions incorporated themes from a curriculum that reviewed developmental stages, the issues and challenges of parenting at each stage, and coping strategies in the informal setting of the clinic playroom. Developmental screening tools such as the Denver and the Bayley were done in the playroom so that the adolescent mothers could have a practical demonstration of these milestones. Other topics

presented in this environment included discussions of birth control methods and other current concerns of the mothers. This model received international attention (Grundström, 1983).

Discussions included in sessions with the teen mothers have grown to include numerous topics involving parenting and raising children (see Table 1). Teens are first asked to reflect on their new roles and changes in roles from child to parent. This includes role conflicts, the role of the new grandmother, and the role of the father. Teens are also asked to reflect on their lifestyle changes and curtailed social activities given their parenting responsibilities. They are provided examples of potential feelings in response to the new baby, frustrations, and reasonable expectations as parents. They are also given assistance to pursue their own educational goals, such as school return, facilities for parenting teens, or the

Table 1. Adolescent Group Topics

<ol style="list-style-type: none"> 1. Reflecting on new role change and new roles within nuclear family <ol style="list-style-type: none"> a) Role conflicts b) Grandmother’s role in advising and assisting c) Father’s role 2. Reflecting on lifestyle change <ol style="list-style-type: none"> a) Parenting responsibilities b) Curtailed social activities 3. Handling feelings in parenting role <ol style="list-style-type: none"> a) Responses to baby (love, anxiety, frustration, anger) b) Expectations 4. Pursuing goals <ol style="list-style-type: none"> a) Continuing education <ol style="list-style-type: none"> 1. Return to school 2. GED b) Work c) Training programs d) Child care arrangements for above 5. Coordinating social needs with child care responsibilities 6. Living arrangements <ol style="list-style-type: none"> a) Privacy b) Family’s response to new member c) Boyfriend’s/husband’s (residence and degree of participation) 7. Frustrations of parenting <ol style="list-style-type: none"> a) Curtailed social activities and freedom b) Role conflict with grandmother c) Baby’s behavior (crying, crankiness, chronic medical needs) 8. Support systems <ol style="list-style-type: none"> a) Respite from parenting role b) Emotional support 9. Child care and babysitting arrangements <ol style="list-style-type: none"> a) Securing reliable help b) Welfare assistance for child care c) Schools for mothers with nursery facilities
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General Education Diploma (GED). Work, training programs, and child care needs and potential financial assistance for these are also addressed. Social work staff assist teens with living arrangements and possible respite from their parenting role.

The Adolescent Mothers Clinic began as a weekly clinic session and then expanded to two sessions as the number of pregnant adolescents recruited to the program increased. This was enhanced by the enthusiastic efforts of the adult prenatal clinic staff as well as Labor and Delivery Room staff, who identified adolescents at the time of delivery who had had little or no prenatal care. Referrals to the program also came from other sources, such as the General Pediatric Clinic, the Emergency Room (a frequent site for the initial contact for a pregnant adolescent), and a multitude of community agencies. In the General Pediatric Clinic, the adolescent mother is often identified during a sick visit for her infant. The mother may have delivered at another facility or has been lost to follow up in our institution. With the closing of the inpatient services after Hurricane Sandy in 2011, all the enrolled pregnant teens delivered at other hospitals but then joined the Adolescent Parenting Program in the reopened clinic building. This protocol was in place until the main hospital reopened in the Spring of 2012.

An identified team of doctors, nurses, social workers, nutritionists, and child development specialists provide care to both mother and child within the framework of a scheduled clinic visit. Care is also offered to the father of the baby if he is an adolescent or young adult in need of medical services. Patients are referred

from within Bellevue—general pediatric clinic, specialty clinics, psychiatric services, and emergency room. They also come from other hospital- and community-based adolescent programs, foster care agencies, child protective services, community physicians, and self/family/friends. Teens are first evaluated in the general adolescent clinic and then referred prenatally to the Bellevue Adolescent Prenatal Clinic. After delivery, the referral is made to the Adolescent Mothers Clinic.

When a pregnant adolescent is identified in these various sites, a team member is notified and speaks to her about enrolling in the program. The criteria for admission to the program remain twofold, based on the age of the mother (less than age 18) and the willingness of the mother to participate in the program. Continuance in the program is also based on age (until the mother is age 18 and her infant at least 6–8 months of age) and ongoing participation in the program. As is true of many similar programs, these criteria are flexible, depending on the needs of both the infant and the mother.

The goals of the program, as explained to the new parents, are medical care for their infant and for themselves, divided but equal in their emphasis and importance. Standards of care for adolescent parents and their infants has been addressed and updated by the American Academy of Pediatrics in 1989, 2001, and again in 2012. For the infant, the goals are (1) the provision of well-child care, including immunizations using AAP guidelines and (2) monitoring of the infant's development, with intensive efforts for those infants with delays. For the adolescent parent, the goals are twofold: (1) stressing the need for an adequate birth control method and (2) education that best suits the adolescent's needs, with a return to school, a GED program, or an English as a second language (ESL) program as possible options.

Program Changes Over Time

The demographic makeup of the Adolescent Parent Program has changed to reflect the general pediatric profile at Bellevue Hospital over the years: 70% Hispanic, 10%–15% African American, 10% white, and 5%–10% other groups. In recent years, the Hispanic population has shifted from Puerto Rican born and Puerto Rican but born in NYC to a greater portion born in Central and South America and in the Dominican Republic.

Over time, the program has expanded to include prenatal care, educational referrals, and medical care for adolescent and young adult fathers. All services are provided in a designated adolescent area of the pediatric clinic. Now, the application of multidisciplinary teamwork begins with the identification and evaluation of a prenatal adolescent. The initial prenatal assessment is done either in one of the Adolescent Clinic sessions (for walk-in patients) or in the Adolescent Gynecology Clinic for those patients referred from other sources. During that visit, the pregnant adolescent meets the staff members who will follow her

through her pregnancy and later with her baby in the Adolescent Parent Program.

It is not unusual for adolescents to seek prenatal care at late stages of their pregnancy, often near term (Hoffman, 2006), so this initial assessment is designed to be comprehensive; medical (including all lab work), nursing, and social work evaluations are completed during this visit. The adolescent is then given an appointment to the Adolescent Prenatal Clinic, where she is seen by the OB staff for ongoing prenatal care as well as by their adolescent team. A prenatal “preparing for the baby” program is provided by the child development staff in the pediatric playroom. Partners of the pregnant adolescent are encouraged to participate in this program. In addition to sessions in the playroom, tours of the hospital’s Labor and Delivery floor are conducted as the time of delivery approaches. All obstetrical services, except for those young people diagnosed with high-risk medical issues, are seen in the adolescent area of the General Pediatric Clinic. The adolescent team works with the high-risk clinic staff to assure ongoing services to that vulnerable population.

A component of the program that was so useful in identifying appropriate educational resources for the adolescent parents was the Babygram program, sponsored by the NYC Board of Education. Babygram was part of Project Return, a community education initiative to address the educational needs of pregnant and parenting teens (New York City Board of Education [OREA], 1993). It was intended to target teens who had dropped out of school or were at risk of dropping out because of pregnancy or parenting. A liaison from the program attended both the prenatal sessions and the Adolescent Parent Program sessions to help the young people identify an appropriate school setting for them. This essential service was curtailed and subsequently eliminated as a result of municipal fiscal cuts. This effort is now done by the social work and child development staff in conjunction with community agencies.

Medical care for adolescent and young adult fathers was added to the services available to our adolescent parent population with the opening of the Adolescent and Young Adult Male Clinic, which meets in the afternoon during one of the Adolescent Parent Program sessions. If the young father is unable to attend that clinic, every effort is made to see the father during the same clinic session as his child and partner. Primary medical care such as immunizations are often given to both young parents in one clinic session. Young fathers are encouraged to participate in the parenting program in the playroom. When present, they are involved in the medical care of the infant and all discussions about future pregnancy planning.

In 1976, the program did not list child maltreatment prevention as a primary goal but rather as the expected outcome of interven-



tions directed specifically to the adolescent mother and her child. The multidisciplinary team acknowledged the barriers confronting pregnant and parenting adolescents, barriers seen daily by the staff of the pediatric clinic. Poverty, lack of education, and adverse childhood experiences were readily identified throughout this population. The team focused on achievable goals within the context of limited resources. The team could assist adolescents in finding appropriate schooling, using community resources to find those placements. The team could help young people damaged by childhood trauma to develop positive parenting skills. The team could provide ongoing, consistent attention to that needy adolescent so that she didn't get lost in a system not designed to provide care to such a population. That attention could be as simple as a reminder call or letter for her appointment for her birth control refill or as complex as a social worker helping a young person in a violent partner relationship (Pinzon et al., 2012).

For the 12-month period from October 1, 2005 to September 30, 2006, 63 teens were enrolled in the parenting program with a total of 120 infants during the same period. There were five repeat pregnancies in the same time period and four elected termination of pregnancy. The remaining pregnancy went to term and the family continues to be seen in the clinic parenting program. Two infants were reported to CPS for medical neglect (one infant with cystic fibrosis, a second infant with limited care postabdominal surgery), and one was reported for abuse (depressed skull fracture). One report was made from a school.

The Program Today

My colleagues and I compared the characteristics and outcomes of the 29 adolescent mothers and their infants in our program at Bellevue Hospital in 2011 with national statistics about teenage pregnancy to determine the effect of the program on measures of medical and psychosocial health of both the mother and child. The adolescent mothers who attended the adolescent mothers group and gave birth to children in 2011 had significantly more clinic visits over the entire year than those who did not attend the group for the entire year ($p=.0006$). No child abuse referrals among group mothers were identified. Within this group, 40% of the adolescent mothers and their families had had prior CPS contact. No significant changes in contraceptive use were found. For the infants at 12 months of age, we recorded significantly more (35.2%) infants with complete immunizations, surpassing NYC immunization rates. We concluded that infants of mothers attending adolescent mothers group had more well-child visits and exceeded NYC immunization rates, and that there were additional health benefits for these infants. Further study is needed to understand how to lengthen pregnancy interval and improve parenting skills for this high-risk group of teens.

The Bellevue Parenting Program is now a component of the clinical rotations of the NYU School of Medicine pediatric training curriculum. Students and house staff rotate through the program, both to provide services as well as see a parenting program in action. Our wish list for the Adolescent Team reflects the ongoing commitment to adolescent parents and their children: make such programs an integral part of pediatric training programs on a national level and restore funding to allow programs such as Babygram to be available to every adolescent parent in conjunction with child care for their children. Along with media attention to the falling teen pregnancy rate, there needs to be continued commitment to restore these successful programs.

Future Research

Based on programs initiated over the years and the results of such projects, the development of a screening tool for primary care providers might help to better identify those adolescents who are at most risk of becoming young parents with problems. It is easy to say that young people who engage in any high-risk behavior—be it alcohol, cigarettes, drugs, truancy, or sexual activity—should be counseled about contraception. A checklist of the psychosocial problems of such teens can provide an overview of their often chaotic home life. Such questions can be posed at routine medical visits but are usually not asked (Hassan et al., 2013). Which of these young people who go on to have a child will not be able to assume the responsibilities of parenthood and endanger their child? Which of these teens will have a family, either nuclear or extended, who will help them and avoid the pitfalls of early parenting? Which of these teens will have access to community agencies that provide those supports when there is no family

input to assure the safety of the infant? The projects reviewed here have involved young people within certain frameworks—clinic-, school-, or community-based, or a combination of such service providers. The daunting task is to identify which program is best suited for the individual teen parent and her infant, and, if the young father of the infant is involved, what program would be most helpful to him. These questions need to be explored to develop a uniform approach to the delivery of services to adolescent families, an approach that can be researched and then implemented for this diverse group of adolescents.

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Effects of Clergy Reporting Laws on Child Maltreatment Report Rates

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Child maltreatment (CM) reporting laws and policies have an important role in the identification, treatment, and prevention of CM in the United States (U.S. Department of Health and Human Services [US DHHS], 2012). Abuse by a member of the clergy “is not only a personal and emotional betrayal, but [also] a spiritual betrayal, with secrecy amplified by the unprecedented and systemic cover-up committed by the Church hierarchy” (Coyne, 2011, p. 15). Recent controversies have resulted in the consideration of changes in mandated U.S. reporting laws that include increasing requirements for clergy and extension to additional professions (Freeh, Sporkin, & Sullivan, 2012; Loviglio, 2012).

Many professionals and policymakers have expected that these changes will result in better identification and response to CM, but the effects of such changes on reporting rates have not yet been systematically evaluated. When the categories of professionals required to report suspected child sexual assault in New South Wales, Australia, for example, were extended to include teachers and other school professionals, there was a significant increase in the number of reports received from teachers but no change in the quality of their reports as measured by the percentage of reports that were verified (Lamond, 1989). When we looked at the association of universal reporting laws with total and confirmed CM reports, there were higher report rates in large counties with universal reporting, but most of the additional confirmed reports were for neglect (Palusci & Vandervort, 2014). It is important to take current specific laws and child and community factors into account if we are to understand the full effects of their implementation on the accurate reporting and identification of CM.

History of Reporting Laws

In the early 1960s, with the support and encouragement of the federal government, U.S. states began enacting laws mandating the reporting of child abuse to government authorities (Vandervort, 2012). Statutes requiring the reporting of suspected cases of child abuse were modeled on earlier laws that required medical professionals to report violence, such as gunshot wounds. Some states mandated all adults to report, while others targeted certain professionals. Early reporting laws contained two limitations: (1) they required the reporting of only serious cases of

physical injury and did not mandate that less severe injuries be reported, and (2) they were typically aimed at medical providers, particularly physicians. In 1974, to assist states in funding their child protection systems and bring more uniformity to the nation’s reporting laws, Congress enacted the Child Abuse Prevention and Treatment Act, which made receipt of federal funding by state child welfare systems contingent on a state’s reporting statute containing certain core elements.

The types of maltreatment that must be reported have since expanded to encompass a range of harms or potential harms to affected children. Child protection laws now require the reporting of physical, sexual, and psychological abuse as well as neglect of varying types—physical, medical, and psychological. Similarly, there has been an expansion of the professions that must report concerns that a child has been abused or neglected, with some states’ reporting statutes now containing a laundry list of professionals who must report suspected cases of maltreatment to child protection agencies. States may exempt certain professionals, such as attorneys and the clergy, from all reporting or decide to exempt them when there are certain circumstances, such as attorney–client or clergy–penitent privilege (National Center for Prosecution of Child Abuse, 2012).

Current Reporting Law Trends for CM

Mandating Clergy to Report

Many state child maltreatment reporting laws address the responsibility of members of the clergy separately from other groups of professionals. Although doctors, social workers, and teachers are typically subject to blanket mandates, clergymen are usually covered by more nuanced legal requirements. First, in states with universal mandatory reporting, if members of the clergy are not explicitly exempted, they are presumably required to report in the same way that all other adult persons in the state are mandated to report. Second, a number of states seem to require clergymen to report suspicions of child maltreatment, but they circumscribe that requirement, sometimes to the extent that the duty to report is, as a practical matter, eliminated.

Maine law, for instance, requires that members of the clergy report suspected child abuse or neglect “except for information received during confidential communications” (Maine Revised

Statutes, 2012). A recent case from Michigan also illustrates this point. The Michigan statute mandates that a member of the clergy report suspected child maltreatment (Michigan Compiled Laws Annotated § 722.623, 2013). However, a separate provision of the state's Child Protection Law provides that legal privileges of communication between a member of the clergy and a parishioner are eliminated except for those communications "made to a member of the clergy in his or her professional character in a confession or similarly confidential communication" (Michigan Compiled Laws Annotated § 722.631, 2013). Applying these statutes, the Michigan Court of Appeals ruled that a minister had no duty to report when a member of the church came to him to seek advice after she had discovered that her husband was sexually abusing their daughter (People v. Prominski, 2013). Thus, even where clergy are mandated to report, that duty is most often much narrower in scope than the duty imposed on other professional groups (Vandervort, 2012).

Child Characteristics

In addition to reporting laws, several child characteristics have been linked to CM and CM reporting. Girls were sexually abused much more often than were boys in NIS-4 (Sedlak et al., 2010), and this gender difference in incidence rates of sexual abuse led to higher rates of total abuse among girls. NIS-4 found also strong and pervasive race differences in the incidence of maltreatment, with the rates of maltreatment for black children significantly higher than those for white and Hispanic children. Latino, Asian/Pacific Islander, and multiracial children were found to have greater risk for being reported, and Native Americans had lower risk for physical abuse reports (Dakil, Cox, Lin, & Flores, 2011). Racial differences in victimization data from the official child welfare system are consistent with known differences for other child outcomes, including evidence that supports the presence of cultural protective factors for Hispanic children, termed the "Hispanic paradox" (Drake et al., 2011). Under the NIS Harm Standard, children with confirmed disabilities had significantly lower rates of physical abuse and moderate harm from maltreatment, but they had significantly higher rates of emotional neglect and serious injury. In another population, physical disability did not increase the risk for any type of victimization once confounding factors and co-occurring disabilities were controlled (Turner et al., 2011).

Family Characteristics

Reporting has also been linked with poor school attendance, disability, family structure, and poverty. In one study, white race, inadequate housing, and receiving public assistance were associated with significantly increased risk of CM recurrence among young children (Palusci, 2011). In the LONGSCAN studies, the mothers of biracial children were poorer, had more alcohol use, and had decreased social support (Fusco & Rautkis, 2012). Children in low socioeconomic-status households had significantly higher rates of maltreatment in all categories and across

both definitional standards in NIS-4. They experienced some type of maltreatment at more than 5 times the rate of other children, were more than 3 times as likely to be abused, and were about 7 times as likely to be neglected (Sedlak et al., 2010).

Children living with their married biological parents universally had the lowest report rates in NIS-4, whereas those living with a single parent who had a cohabiting partner in the household had the highest rate in all maltreatment categories. Compared with children living with married biological parents, those whose single parent had a live-in partner had more than 8 times the rate of maltreatment overall, over 10 times the rate of abuse, and nearly 8 times the rate of neglect. School-aged children who were not enrolled in school were sexually abused more often than enrolled children and more often qualified for inferred harm, an outcome frequently associated with sexual abuse in NIS-4.

Factors at the Community Level

Population size, housing, unemployment, education levels, crime, and religiosity at the community level have also been linked with CM reports. Many of these are measures of social capital, such as the number of religious congregations, personal social support, and support within the neighborhood (Runyan et al., 1998). Studies have documented the association between neglect in early childhood and subsequent externalizing behavior, which may be related in part to families' residence in dangerous neighborhoods (Yonas et al., 2010). In addition to crime, a number of socioeconomic characteristics of neighborhoods have been shown to correlate with child maltreatment rates as measured by official reports to child protective service agencies (Coulton et al., 2007). Higher rates of poverty and higher density of alcohol outlets in urban areas have been associated with higher rates of CM reports in certain communities (Fresithler, Bruce, & Needell, 2007).

In a study of religion and social capital, increasing social capital decreased the odds of neglectful parenting, psychologically harsh parenting, and domestic violence but not harsh physical punishment (Zolotor & Runyan, 2006). Extrinsic religiosity (e.g., church attendance or formal participation in a recognized group) was associated with increased physical abuse potential, with greater social conformity moderating this association (Rodriguez & Henderson, 2010). In a meta-analysis, Mahoney and colleagues (2001) found that while certain religious practices are associated with higher rates of corporal punishment, greater parental religiousness related to more positive parenting and better child adjustment.

Objectives

To better understand these relationships and the effects of mandating clergy to report CM, the objectives of this study were (1) to evaluate the relationship of total and confirmed child maltreatment report rates with state reporting laws requiring clergy to report suspected abuse and neglect, (2) to determine

whether child and community characteristics modify these effects, and (3) to assess whether these relationships, if any, hold with confirmed reports of specific child maltreatment types.

Methods

Dataset Preparation

The National Child Abuse and Neglect Data System (NCANDS) has collected data from U.S. states and territories and offered large annual samples of CM reports since 1990. State CPS agencies voluntarily submit expanded case-level information about child, family, and service characteristics for what is now called the Child File (National Data Archive on Abuse Child Abuse and Neglect, 2002). Although precise definitions vary from state to state, CM type categorizations in NCANDS are based on federal guidelines for evidence of one or more instances of physical abuse, sexual abuse, psychological maltreatment, neglect, or medical neglect (US DHHS, 2002). When state agencies find credible evidence that abuse or neglect has occurred, the report is labeled “substantiated” or “indicated” based on state law and is considered a CPS-confirmed report. Data from more recent years also contain “alternative response victims,” which are also considered confirmed reports, although the investigation process is different (National Data Archive ..., 2002).

As described in another study (Palusci & Vandervort, 2014), NCANDS public use data files were obtained for this study for the year 2000 from the National Data Archive on Child Abuse and Neglect (2002) at Cornell University. The SAS statistical software package, version 9.1 (SAS Institute Inc., Cary, NC), was used for data management and analysis. Duplicative reports occurring on the same day were deleted using a “roll up” procedure provided with the dataset. Variable fields were assessed to determine whether they were missing, categorical, or continuous in nature. Records were sorted by state and county in the dataset and were compared with published information to assess overall dataset integrity.

Study Sample

The child maltreatment report study sample used for this study was derived from the NCANDS dataset from 2000 (National Data Archive..., 2002). This group of NCANDS records has been used successfully in prior research looking at other forms of CM, and this study year was chosen in place of the more recent decennial census in 2010 to enable comparison using more complete data. After aggregation, the overall dataset had reports from 18 U.S. states with county information. Confirmed reports were identified as those that were labeled as “substantiated” or “indicated” or “alternative response victim” in the dataset, and confirmed reports were used for all analyses.

Counties where children lived were identified in the dataset only for those counties where 1,000 or more reports had been made. This resulted in 754,225 total reports with 252,390 confirmed

reports being available for analysis. Confirmed reports could have up to four confirmed CM types from among five types of CM: physical abuse (PA), sexual abuse (SA), neglect (NE), medical neglect (MN), and psychological maltreatment (PM). The U.S. states with county-level data available for our analysis are Arkansas, Delaware, Florida, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Missouri, Nebraska, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Texas, Utah, and Washington.

Review of CM Reporting Laws

One of us (FEV) reviewed applicable state statutes in the 18 study states regarding mandatory reporting requirements. Each state law was examined using state statutory codes as well as session laws to determine whether, in the year 2000, the applicable statutes specifically identified whether religious clergy were specifically required to report suspected abuse or neglect. Table 1 shows the results of our review of these laws with the published state total and confirmed report rates available from NCANDS (US DHHS, 2002).

Table 1. State Reporting Laws and Report Rates, 2000

State	Were clergy mandated to report?	Total report rate per 1,000 children	Confirmed report rate per 1,000 children
AR	No	41.2	8.2
DE	No	43.5	6.2
FL	No	34.4	15.5
KS	No	41.8	8.0
KY	No	44.1	12.2
LA	Sometimes	33.1	5.4
ME	Sometimes	51.7	8.9
MA	No	37.5	13.2
MN	Sometimes	20.8	6.0
MO	Sometimes	73.2	4.7
NE	Yes	26.4	5.1
NC	Yes	46	9.7
OK	Yes	59.6	9.2
PA	Sometimes	30.1	1.7
RI	Yes	49.9	8.9
TX	Yes	25.3	5.1
UT	Sometimes	34.9	8.0
WA	No	44.4	3.1

Source: US DHHS, 2002.

State laws could have an absolute requirement for reporting (“yes”) or certain exclusions could apply (“sometimes”) when clergy reporting was mandated. A number of the reporting laws that designated clergy as mandated reporters also referenced other state code provisions, which imposed limitations on the reporting duty. When this was the case, those other code provisions were reviewed. In these circumstances, the child abuse reporting statute required that a member of the clergy report suspected child maltreatment subject to a separate statute that provided for clergy–penitent communications to be confidential.

Minnesota’s law provides a typical illustration of this phenomenon. Minnesota’s mandatory child abuse reporting law provided that a member of the clergy was mandated to report child maltreatment if the clergyman “received the information while engaged in ministerial duties, provided that a member of the clergy is not required . . . to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c)” (Minnesota Statutes, 2012). In such an instance, we reviewed the referenced statutes. In the case of Minnesota, the statute provided as follows:

(c) A member of the clergy or other minister of any religion shall not, without the consent of the party making the confession, be allowed to disclose a confession made to the member of the clergy or other minister in a professional character, in the course of discipline enjoined by the rules or practice of the religious body to which the member of the clergy or other minister belongs; nor shall a member of the clergy or other minister of any religion be examined as to any communication made to the member of the clergy or other minister by any person seeking religious or spiritual advice, aid, or comfort or advice given thereon in the course of the member of the clergy’s or other minister’s professional character, without the consent of the person.

In such a situation, although the mandated reporting law seems to mandate “universal” or at least some reporting by members of the clergy, given the breadth of the privilege statute, there seems to be nothing that can in fact be reported without the consent of the individual actually confessing to the abuse. As a result, for our analyses, study states were labeled as having a clergy reporting requirement if they at least specifically listed clergy as mandated reporters, with or without an exception in certain circumstances.

Additional County-Level Data Sources

While information is not readily available at the county level about all of the many risk and social capital factors associated with CM reporting, several data sources exist with U.S. county-level data regarding child and community characteristics that link to counties in NCANDS (Table 2). From the U.S. Decennial Census (U.S. Department of Commerce, Census Bureau, 2000a, 2000b), information about the county’s total and child populations less than 18 years of age, child gender, race, ethnicity,

Table 2. CM Variables by Type and Source

Maltreatment Reports	
NCANDS, 2000 (county)	
	Total Reports
	Confirmed Reports (substantiated, indicated, and alternative-response—victim)
	Physical Abuse
	Sexual Abuse
	Neglect
	Medical Neglect
	Psychological Maltreatment
Child Characteristics	
U.S. Census, 2000	
	Population: Total and child, age <18y
	Gender: Children < 18y male (%)
	Race: Children <18y White, Black, Asian, American Indian, Pacific Islander (%)
	Race: Children <18y with two or more races (%)
	Ethnicity: Children <18y Hispanic (%)
	Marriage: Children <18y in married families (%)
	Disability: Children ages 5–15y with no disability (%)
	Isolation: Children with linguistic isolation, %
	Education: Children attending school (%), by age (3–4y, 5–9y, 10–14y, 15–17y)
	Poverty: Children in families at or below 100% federal poverty level
Community Characteristics	
U.S. Census, 2000	
	Education: Adults ages 18–24y without HS completion (%)
	Housing: Occupied housing units (%)
Bureau of Labor Statistics, 2000 (county level)	
	Employment: Unemployment (%)
Association of Religion Data Archives, 2000	
	Religiosity: Number of congregations (per 100,000 children)
FBI Uniform Crime Statistics, 2000 (rate per 100,000 total population)	
	Crime: Index crimes
	Murders
	Rapes
	Aggravated assaults

county unemployment, marriage percentage, education levels, school attendance, housing, poverty, disability, and family linguistic isolation were available. From the Association of Religion Data Archives (2002), data were available from a survey of all religious congregations in each county, including total membership and number of congregations for all religions. The U.S. FBI Uniform Crime Reports (U.S. Department of Justice, 2001) provided information for each county on the total number of index crimes, aggravated assaults, rapes, and murders. Index crimes are the eight crimes the FBI combines to produce its annual crime index: willful homicide, forcible rape, robbery, burglary, aggravated assault, larceny over \$50, motor vehicle theft, and arson.

Data Analysis

As described in another study (Palusci & Vandervort, 2014), statewide child abuse report rates were first compared using NCANDS summary data. To compare variables across counties of varying size, rates were used or calculated as needed for all analyses. Using the NCANDS Child File, the frequency of total and confirmed CPS reports were then calculated by U.S. county, as were confirmed reports by CM subtype. Rates per 1,000 children, 1,000 total population, or 100,000 total population were calculated for each county-level variable as indicated by dividing frequencies by the appropriate population.

Total reports, confirmed reports, and CM types were stratified by state reporting law requirement, and means were compared using T-tests and chi square, as indicated. Variable means were compared for the study counties, states, and the United States as a whole to highlight similarities or differences from the entire population. Cross-sectional ecological design was used for multiple variable comparisons with county as the unit of analysis. County rates were linked with CM reports in a single dataset for the U.S. counties in the 18 study states. Linear regression models with stepwise, backward elimination were used, beginning with an initial model with “clergy reporter requirement” (yes/sometimes vs. no) as the independent variable while controlling for

child and community variables. Alpha was set to 0.05 for all analyses. Results were calculated for full and reduced models.

Human Subjects Protections

Several steps have been taken in the dataset preparation, distribution, and use to protect the privacy of children and families. Names and other identifying information were removed and replaced with unique child and report identifiers prior to distribution. Files were transmitted using secure servers and were stored on secure computers. Because child date of birth had been removed in the data, age was reported only as years. The date of report was rounded to the first half or second half of the month and the county identified only if there were over 1,000 report-child pairs in that county. All geography and other identifiers were masked for fatalities. Unique race-ethnicity records in a county were recoded to “unknown.” Because of these protections, the New York University human subjects committee deemed this research to be exempt from further review.

Results

Relationship of CM Report Rates With State Reporting Laws

Differences occur in the rates of total reports and rates of confirmed reports, depending on the state reporting requirement identified. Among the 18 states with county-level data available, our review of state laws identified 5 states where clergy were considered mandated reporters; an additional 6 states sometimes required clergy to report (Table 1). In states requiring clergy to report all or some of the time, there were lower report rates that were statistically significant for confirmed reports compared with states without this requirement. This difference was statistically significant only for confirmed report rates (Table 3).

County-level data were available in NCANDS for 213 counties, which had a total population of over 69 million people and over 17 million children younger than 18 years of age. These states and counties differed in several ways from the U.S. population as a whole (Table 4). For example, the study counties had significantly fewer Asian children, more children with two or more races, and

Table 3. County Mean Report Rates, by State Law and CM Type

Reporting Law	Counties	Report Rate	Confirmed Rate	PA	SA	NE	PM
<i>All clergy are mandated reporters:</i>							
Yes	91	55.7	15.4*	4.4*	2.1	9.3	1.4*
Sometimes	37	44.5	8.8*	3.6*	1.7	7.3*	1.6
No	83	66.8	25.4	11.6	4.5	17.3	2.2
Rates per 1,000 population							
*Difference from “No”: P<0.05							
CM=child maltreatment; PA= physical abuse; SA=sexual abuse; NE=neglect; PM=psychological maltreatment							

Table 4. Comparison of Variables by Locality, 2000

	U.S.	Selected States	Selected Counties
States, #	50	18	18
Counties, #	3143	1330	213
Total population, #	281,421,906	104,296,664	69,641,321
Child Characteristics			
Child population <18y, #	72,300,000	26,402,677	17,897,170
Male children, %	51.3	51.3	51.3
White children, %	75.1	76.4	73.2
Black children, %	12.3	12.6	15.3
American Indian/Alaskan Native children, %	0.9	1.4	1.6
Asian children, %	3.6	2.0	1.7 AB
Native Hawaiian/Pacific Islander children, %	0.1	0.1	0.1
Children >1 race, %	2.4	2.3	3.3 B
Hispanic children, %	12.5	9.4	12.2 A
Children in married families, %	66.0	67.9	62.1 B
No disability, 5–15y, %	91.9	95.6	93.7 AB
Linguistic isolation, %	4.7	3.9	3.2
In school, 3–4y, %	49.3		48.5
In school, 5–9y, %	97.4		95.6
In school, 10–14y, %	98		98.9
In school, 15–17y, %	94.9	96.8	93.9 A
Children in families at or below 100% federal poverty level, %	9.2	15.4	17.6 B
Community			
No high school completion, 18–24y, %	25.3	18.5	26.9 A
Unemployment rate, %	5.8	5.3	4.0 B
Religious congregations per 100,000 children	3.7	4.2	4.1
Housing units, % occupied	91	89.9	89.3
Index crime rate per 100,000	4124	4219	5,067
Murder rate per 100,000	5.5	4.9	6.1
Rapes per 100,000	32	35.9	38.0 A
Aggravated assaults per 100,000	324	290	402 A

Differs from U.S., P<0.05: A=selected states; B=selected counties

fewer disabled children than did the United States as a whole. There were also more children living in poor families but with less unemployment than the general population. There were several other differences that were not statistically significant.

Effects of Child, Family, and Community Factors

In models controlling for all the child, family, and community factors identified, states with mandated reporting laws requiring clergy to report at least sometimes did not have significantly different total report rates (Table 5). Although there were numerical differences in the strengths of association, significant variables in most of the full models remained so in the corresponding reduced models. In full models for total reports, significant factors included child gender (males), race (American Indian/Native

Alaskan), school attendance (ages 10–14y), family marriage, and poverty. In reduced models, male gender and poverty had increased rates, while black race, Hispanic ethnicity, and school attendance (ages 10–14y) all played a significant role in decreasing rate. The reporting law had no significant effect. For confirmed reports, significantly lower report rates (8 per 1,000 children) were found in both full and reduced models, with significant increases associated with male gender, poverty, and religious congregations in the full model and total child population, male gender, school attendance (ages 10–14y), and crime (index crimes and aggravated assaults) in reduced models.

Effects on Specific CM Types

States' mandated reporting laws have varying association with

Table 5. Multiple Regression: Clergy Reporting on Total and Confirmed Report Rates

Model	Total Report Rate		Confirmed Report Rate	
	Full Model	Reduced Model	Full Model	Reduced
	$r^2=0.3287$	0.2576	0.3865	0.3217
Mandated Reporting				
Clergy (yes/sometimes vs. no)	-3.767	NS	-8.233**	-8.579***
Child Characteristics				
Population, <18y	-0.00005091	-0.00006728*	-0.00001737	0.00002882***
Male children, %	24.52*	26.88**	9.722**	11.32***
White children, %	-1.369	NS	-0.1408	NS
Black children, %	-2.302	-0.6268*	-0.3028	NS
American Indian/Alaskan Native children, %	-3.072*	NS	-0.4550	NS
Asian children, %	-0.5808	NS	0.0954	NS
Native Hawaiian/Pacific Islander children, %	-17.77	NS	-4.644	NS
Children >1 race, %	0.2404	NS	-0.3598	NS
Hispanic children, %	-1.116	-0.7964***	-0.1239	NS
Children in married families, %	71.88*	NS	16.73	NS
No disability, 5-15y, %	2.786	NS	-0.2564	NS
Linguistic isolation, %	-1.744	NS	-0.1434	NS
In school, 3-4y, %	0.6178	NS	0.2435	NS
In school, 5-9y, %	1.162	NS	-0.3354	NS
In school, 10-14y, %	-22.70**	-20.92**	-4.771	-5.899**
In school, 15-17y, %	-1.008	NS	-0.1778	NS
Children at or below poverty level, %	3.464***	2.186***	0.6466*	NS
Community				
No high school completion, 18-24y, %	-0.2886	NS	0.01483	NS
Unemployment rate, %	-0.8663	NS	-1.659	NS
Religious congregations, per 100,000 children	0.1159	NS	0.04656*	NS
Housing units, % occupied	-63.18	NS	-27.65	NS
Index crimes, per 100,000	-0.00598	NS	-0.2325	-0.01915*
Murders, per 100,000	3.581	NS	4.552	NS
Rapes, per 100,000	-5.841	NS	0.1840	NS
Aggravated assaults, per 100,000	0.3696	NS	0.1991	0.2408***

Rates per 1,000, unless otherwise noted.
*P<0.05; **P<0.01; ***P<0.001; NS= P>0.05, not in model

rates of specific child maltreatment confirmed after CPS investigation in bivariate analyses (Table 3). States with at least “sometimes” clergy reporting had decreased confirmation rates for physical abuse compared with states having no requirement. Those always mandating clergy reports had fewer confirmed psychological maltreatment reports, and those with only “sometimes” reporting had significantly fewer cases of confirmed neglect. In models controlling for child, family, and community factors (Table 6), significantly decreased confirmed physical abuse

report rates were noted in both full and reduced models. While there were decreases, none of the other CM rates were significantly associated with clergy mandated reporting requirements in our regression models.

Discussion

It is interesting to note that total CM report rates did not change significantly based on mandated clergy reporting requirements in the 11 states where clergy were required to report at least some of

Table 6. Confirmed Report Rate Models for Clergy Reporting, by Child Maltreatment Type

CM Type	CM Rate Change	
	Full Model	Reduced Model
Physical Abuse	-4.750**	-4.392***
Sexual Abuse	-1.833	NS
Neglect	-2.584	NS
Medical Neglect	-0.4505	NS
Psychological Maltreatment	-0.6576	NS

Rates per 1,000 population
 *P<0.05; **P<0.01; ***P<0.001; NS= P>0.05, not in final model

the time. Child gender, race, ethnicity, middle school attendance, poverty, and crime modified the association between CM rates and mandated reporting, sometimes with a larger effect size. For CM type, there were lower confirmed report rates found for physical abuse. While numerical differences were noted in the strengths of association, significant variables in most of the full models remained so in the corresponding reduced model.

Child, Family, and Community Factors

The contribution of child and community variables noted in our results is in many ways similar to what others have found. Factors such as poverty, race/ethnicity, and gender have been extensively studied and linked to CM reports, confirmed reports, and actual cases across varying communities, although on the community level, the association with poverty is weak (Millett, Lanier, & Drake, 2011). Housing problems and receiving public assistance are related to CM recurrence among young children (Palusci, 2011), while other elements of social capital are associated with physical and sexual abuse rates (Coulton et al., 2007; Freisthler, Bruce, & Needell, 2007). CM rates have been linked to crime rates (Finkelhor & Jones, 2006), and a review of several studies noted important community factors associated with CM reports, such as poverty, unemployment, property values, community resources, child care burdens, crime, social resources, and household crowding, all consistent with our findings (Coulton et al., 2007; Wulczyn, 2009).

Other differences from previous studies are also noted in our results. Unlike NIS-4 (Sedlak et al., 2010), this study finds that counties with a higher proportion of boys have higher CM reporting rates. African American race has been associated with higher reporting rates (Sedlak et al., 2010), while Hispanics have had higher reporting rates but lower confirmation rates for physical abuse, and Native Americans have lower and Pacific Islanders have higher reporting rates than do whites (Dakil et al., 2011). While increased availability of

early child care and early childhood education has been linked with fewer CM reports (Klein, 2011), school attendance was found to be linked to increased reports among 3–4-year-olds and decreased for 10–14-year-olds in our multivariable models. In another study in which mothers who were married, had graduated high school, and had more social supports were found to have fewer CM reports, their children ages 4–8 years attending school, in contrast, were found to be almost 3 times more likely to be reported (Li, Godinet, & Arnsberger, 2011). Child disability, long thought to be associated with increased risk of CM, did not have significant effect in our study. Linguistic isolation, unemployment, and high school graduation also had no effect. Given that social capital factors may act more on the individual level, their effects may not be as important as previously thought on the community level, or they may be additive with other factors in the child or economy (Saluja, Kotch, & Lee, 2003; Zolotor & Runyan, 2006).

Why Fewer Confirmed Reports?

The issues underlying the 10%+ fewer confirmed reports in states with mandated reporting by clergy are more difficult to understand. Although religious beliefs and church attendance have been associated with certain parenting practices and corporal punishment (Mahoney et al., 2001; Rodriguez & Henderson, 2010;



Runyan et al., 1998), only a small difference in confirmed reports was seen in states with mandated clergy reporting or with an increased number of congregations. This suggests that it is both the number of congregations and mandated clergy reporting that are important. Reporting laws that require clergy to “sometimes” or universally report suspected CM are also limited by one or more exclusions (e.g., in the confessional), which may affect these rates. What is clear is that this study does not support the hypothesis that mandating reports by the clergy will necessarily increase total or confirmed CM reports. To explain differences between total report rates and confirmed reports, there are likely other system factors beyond reporting laws that affect case confirmation because it has been suggested that both populations (confirmed and unconfirmed) have similar risk profiles (Hussey et al., 2005).

Giardino, Sacks, and Terry (2012) noted a marked decrease in clergy sexual abuse (CSA) after the year 2000, when the institutional response of the U.S. Catholic Church leaders was on public display with public apologies and commitments to take action to halt the occurrence of such abuse. The authors report the downward clergy CSA trend appears to have begun earlier when compared with the trends in general CSA because cases began their steady decline in the 1980s. They also assert that the predominance of male victims and the relatively higher proportion of adolescents in clergy sexual abuse are clear differences from the age and gender pattern seen in the general CSA problem. At least within the Catholic Church, there appears to be fewer cases now for clergy to

report, but, given that the number of reports from the clergy in states mandating such reports is low overall, it is unclear whether mandating clergy CM reports in additional states will result in increased case identification. It is also possible that fewer CM cases occur (and are therefore reported) in jurisdictions where there are more mandated reporters because there is greater public awareness and less acceptance of CM.

This study confirms that several community and child factors more strongly predict confirmed report rates than do reporting laws. Multiple issues have been debated regarding the U.S. child welfare system overall, ranging from error in identifying actual cases to bias in case investigation and ineffectiveness in service provision (Mathews & Bross, 2008; Melton, 2005). Mandated reporters do not regularly report their suspicions, and case workers may use substantial bias, prompting calls for changes such as increased professional education, increased prosecution for failure to report, and alternative systems using consultation with centers of excellence (Berkowitz, 2008; Cross & Casanueva, 2009; Delaronde, King, Bendel, & Reece, 2000; Flaherty, et al., 2008). Thus, any changes to mandated reporting laws may identify only a small number children and families who would not otherwise be identified.

Limitations

The results of this study cannot address the issue of whether changing clergy reporting laws will actually improve case identification. We also cannot know definitively from this research whether changing state law or policy will result in changes in report or confirmation rates, as this analysis is preliminary and cross-sectional ecological comparisons cannot be used to infer causation. When clergy were surveyed in the 1990s, a sizeable percentage (29%) had no education about child abuse and neglect, and 22% believed that evidence, rather than the suspicion of abuse, was required before a CM report is made (Grossoehme, 1998). This highlights an untapped area for case identification amenable to changes in law, policy, and practice in the United States (John Jay College Research Team, 2011).

While NCANDS is a large dataset covering many U.S. states, several characteristics limit its use in secondary analysis. Year 2000 data were used for completeness, but more accurate analysis of more recent trends may become available using year 2010 census data. County-level data were available only for the 213 counties having 1,000 or more reports in 2000, which may bias the results toward being more predictive for larger states with larger counties. While the 18 study states contained over 69 million people and over 17 million children, these states and counties did not include smaller counties and differed in several ways from the U.S. population as a whole, such as having significantly fewer Asian children, more children of two or more races, and fewer disabled children. There were also more children living in poor families but with less unemployment. No attempts have been made to



make the data representative of the U.S. child population or the population of maltreated children. There are likely several factors working within communities to affect CM reporting rates in addition to those measured in our study, and we may not have been able to capture the “micro-social environments” contributing to CM using county-level data (Vinson & Baldry, 1999).

While exhaustive efforts are underway to assure that data can be combined, the states also use different definitions and policies for what is entered into NCANDS. Some states, for example, expand what can be reported, especially for physical and educational neglect, and wide state-to-state variations are common (Kelly, Barr, & Weatherby, 2006; Mathews & Kenny, 2008). Within states, statutes do not necessarily reflect their actual procedural implementation, and variations across counties in a state can bias the results. Any effects that we found, for example, could be biased by local historical and social factors that reflect on the acceptance of reporting or the child welfare system, separate from state law. It will require additional studies of what happens both within and among states over time to determine the true impact of clergy mandated reporting laws on the identification and reporting of child maltreatment.

Conclusions

State mandated clergy reporting laws affect both total and confirmed CM report rates, sometimes in unexpected ways. When looking at the effects of these laws, it is also important to consider several child, family, and community factors (e.g., social capital) because they may act to modify the results as confounders. Policymakers considering changing mandated reporting laws, such as clergy mandated reporting, need also to consider the effects on reports for different CM types and whether these changes will more accurately identify child maltreatment victims.

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Application of Evidence-Based Therapies to Children in Foster Care: A Survey of Program Developers

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Introduction

It is well established that children in foster care have elevated rates of mental health problems (e.g., dos Reis, Zito, Safer, & Soeken, 2001; Marsenich, 2002; Polihronakis, 2008). According to a literature review by Casey Family Programs, anywhere from 50% to 75% of children entering foster care have behavioral difficulties that rise to the level of requiring mental health services (Fanshel, Finch, & Grundy, 1989). Pilowsky (1995) found rates of psychopathology among children in family foster care that were higher than expected when compared with children from similar backgrounds. More recent data reveal that compared to youth in the general population, youth in foster care are significantly more likely to have at least one lifetime diagnosis of a mental illness (Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). The kinds of emotional and behavioral disorders that have been documented among foster care youth include depression, anxiety, and aggression (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Handwerk, Frimen, Mott, & Stairs, 1998).

In New York City specifically, Lyons (2001) conducted a survey of the health and mental health needs of foster care children to address concerns about the adequacy of mental health interventions for children in this population. Lyons found that nearly one third of a sample drawn from New York City Administration for Children's Services (New York City's child protection services) was classified as having serious emotional disorders compared with 15% in the general population. Lyons also found that 74% of children living in kinship foster care, 73% of children living in regular foster family homes, and 88% of children living in congregate care had diagnosable emotional-behavioral problems. There is no doubt that foster care children in general and in New York City specifically are at high risk for current and long-term mental health problems.

These high rates of mental health problems are understood in the context of the multiple risk factors associated with foster care placement. The vast majority of youth served in the United States foster care system have been removed from their homes due to

abuse or neglect, a significant risk factor for poor outcomes (Barlow, Smailagic, Ferriter, Bennett, & Jones, 2010; Goldman, Lloyd, Murphy, et al., 2007; Perry, 2002, 2006). Not only have children in foster care been abused and neglected but they also have been separated from their primary caregivers, resulting in emotional problems that can interfere with the parent-child attachment bond and placing them at high risk for establishing insecure and dysfunctional relationships (e.g., Bernard, Dozier, Bick, et al., 2012). Other risk factors that contribute to the development of serious emotional and behavioral problems for this population include environmental, social, biological and psychological influences (Kolko & Swenson, 2002).

Despite the overwhelming need, mental health services are not routinely available to children in foster care (Halfon, Mendonca, & Berkowitz, 1995; Halfon, Zepeda, & Inkelas, 2002; Landsverk, Burns, Stambaugh, & Rolls Reutz, 2006). For example, in a national survey only one fourth of children were found to have received what was defined as "adequate" mental health services within a year of entering foster care (Stahmer, Leslie, Hurlburt, et al., 2005). According to a Federal Child and Family Service Review (CFSR), most states failed to meet the psychological and behavioral treatment needs of child abuse and neglect victims (Huber & Grimm, 2004). More recent data are consistent, showing that only a handful of states met the goal of 95% compliance with well-being outcome number 3, defined as children receiving services that met their physical and mental health needs (JBS International, 2011).

Left out of the CFSR is whether the services that were offered were evidence based. This is a notable omission in light of the fact that the field of mental health treatment of emotional and behavioral problems of children (as well as adults) has moved toward evidence-based practice (EBP) (Chambless & Hollon, 1998; Cochrane, 1999). EBP is generally defined as the preferential use of interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems (Cochrane, 1999). EBP

promotes the use of valid evidence for the purpose of helping service delivery organizations select programs and services that will allow them to use their limited resources in the most effective way. Evidence-based practice is distinguished from other types of knowledge such as “evidence-informed” or “evidence-suggested” by Chaffin and Friedrich (2004), who argue that the difficulty with these standards is that the bar is set so low that “inert or harmful practices can qualify, especially given reasonably articulate proponents and a rationale that resonates with current social values” (p. 1099).

According to Barth (2008), the move toward EBP in child welfare practice is now well established, beyond a passing fad or phase, as evidenced by funding sources and government agencies increasingly emphasizing EBP and rewarding agencies for using EBP in their service delivery systems. Several developments, such as a special issue of *Child Welfare* devoted to the topic and the creation of databases cataloguing evidence-based child welfare practices, indicate that the time for evidence-based child welfare programs and policies has come. Nonetheless, research demonstrates that the majority of youth in foster care may not be receiving evidence-based treatments (Cosgrove, Frost, Chown, & Anam, 2013).

Moreover, it remains unknown whether existing evidence-based mental health treatments would in fact be a good fit for children in foster care in light of their specific and sometimes unique needs. Children in foster care typically deal with a set of emotional and behavioral issues some of which are specific to their circumstances that ideally need to be addressed in treatment. However, not all evidence-based treatments—in their current manualized forms—may be able to address these issues.

Based on the combined clinical and research experience of the authors, the following ten issues have been identified as essential for treatment of children in foster care. Most children in foster care have been abused or neglected, or both. Hence, the first essential component of treatment of children in foster care is trauma work to help children process and recover from their traumatic experiences (Issue 1). This should include training in affect regulation (Issue 2), social-interpersonal skills (Issue 3), and promoting secure attachments (Issue 4) as these areas are typically compromised for abused and neglected children (e.g., van der Kolk, Pelcovitz, Roth, et al., 2006). Children in foster care have not only been abused or neglected but they also have been removed from their home and are navigating new and multiple care-giving relationships. The majority of children in the foster care system have a permanency goal of reunification (Goldhaber-Fiebert, Babiarz, Garfield, et al., 2013), and for those whose goal is not reunification, there is still the possibility of ongoing contact with the family of origin. Thus, any mental health treatment a child in foster care receives should include attention to these multiple relationships the child is affected by and involved with (Issue 5). Treatment should, therefore, involve family work on a

number of levels, including improving attachment relationships that have been compromised from abusive or inadequate care-giving (Issue 6), facilitating and helping the family prepare for reunification (Issue 7), reducing family conflict while increasing family bonding and cohesion (Issue 8), and working directly with the biological and foster parents on parenting skills and sensitivity to infant and child developmental needs (Issue 9). A final essential issue relates to the fact that children in the foster care system straddle multiple agencies and social environments (educational, mental health, child welfare, and medical) and that mental health treatment may require coordination and integration across these settings to maximize its effectiveness (Issue 10).

The Current Study

The current study was designed to survey the developers of empirically-supported mental health therapies for children to determine the extent to which they are applicable to the needs of youth in foster care system. We identified three possible categories of treatments: (1) treatments designed and developed specifically for children in foster care, (2) treatments not developed or designed specifically for children in foster care but have been evaluated in a randomized controlled trial (RCT) that included foster care children in the sample, and (3) treatments neither designed nor tested for children in foster care but developed to address at least one of the ten essential foster care treatment issues.

For the Category 1 treatments, we wanted to know (1) how many have been evaluated with children in foster care using a RCT design, (2) how many analyzed the data specifically for children in foster care, (3) how many found positive results for the foster-care specific analyses, (4) how many published and/or presented the results of the foster care-specific analyses, and (5) how many and which of the essential foster care treatment issues could the treatment address without modification.

For the Category 2 treatments—all of which had been evaluated with a RCT that included foster care children in the sample—we wanted to know (1) how many analyzed the RCT data specifically for children in foster care, (2) how many found positive results specifically for the foster care sample, (3) how many published and/or presented the findings of the foster care-specific analyses, and (4) how many and which of the essential foster care treatment issues could the treatment address without modification.

For the Category 3 treatments—none of which had been tested with children in foster care—we wanted to know how many and which of the essential foster care treatment issues could the treatment address without modification.

Identification of Treatments

A comprehensive Internet and academic literature search was conducted to identify therapies for inclusion in our guidebook. We sought manualized (in English) mental health treatments

currently in operation in the United States that could be applicable for children in foster care—that is, the exclusion criteria did not preclude children in foster care.

To identify potential therapies, several evidence-based program registries were reviewed, noting that each uses slightly different procedures and standards for deeming a treatment evidence-based. A second source of identification of therapies came through an extensive literature search using the following search terms: *treatment for foster care, therapy for foster care, evidence-based treatments for maltreatment, and treatment for children who*

have experienced trauma. Through this process, 81 treatments were identified. Table 1 provides an overview of the sources consulted. Where the source is a report, a date is provided.

Study Procedures

An introductory letter was sent via e-mail to the 81 treatment developers or contact persons (obtained from various Web sites) inviting them to review information we had compiled about their treatment and inviting them to complete a brief survey via Qualtrics. We explained that their responses would be compiled in a compendium of treatments (currently available at

<https://www.nyfoundling.org>). Over a four-month period, 75 (92.6%) of the surveys were completed.

Table 1. Program Registries Searched

Source	Search Criteria
Web site: Substance Abuse and Mental Health Services National Registry of Evidence-Based Programs and Practices (NREPP). http://www.nrepp.samhsa.gov	Searchable listing. Keywords used: mental health treatment for children 0–17 years of age.
Report: Kauffman Best Practices Project to Help Children Heal From Child Abuse. (2004). http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTA brochure.pdf .	Non-searchable listing of 3 treatments.
Report: Child Physical and Sexual Abuse: Guidelines for Treatment. http://www.musc.edu/nvcv/resources_prof/OVC_guidelines04-26-04.pdf	Non-searchable listing of 22 treatments.
Web site: California Evidence-Based Clearinghouse for Child Welfare/ http://www.cebc4cw.org/	Searchable database. Nine topics related to mental health treatment were searched: anxiety in children, behavioral management of adolescents, bipolar disorder treatment for children and adolescents, depression treatment for children, discipline behavior treatment for children and adolescents, infant and toddler mental health, sexual behavior problems in children, sexual behavior problems in adolescents, and trauma treatment in children.
Web site: National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices. http://www.nctsnet.org/ncts/nav.do?pid=ctr_top_trmnt_prom	Non-searchable listing of 38 treatments.
Report: Implementing Evidence-Based Practice in Treatment Foster Care: A Resource Guide Prepared by Foster Family-Based Treatment Association. (2008).	Non-searchable listing of 21 treatments.
Report: Regional Research Institute for Human Services.	Non-searchable listing of 7 treatments.

Survey

The 27-item survey was neither confidential nor anonymous and asked the respondents to report on the types of evaluations conducted on the therapy, with special attention to the sampling and effects specific to children in foster care. The survey asked (1) whether the treatment was designed specifically for children in foster care, (2) whether the treatment was deemed effective with children in foster care (the type of research conducted on the treatment, the proportion of foster care children in the various studies, whether the data for children in foster care were analyzed and reported separately), and (3) whether the treatment could—without modification—address the ten essential concerns for children in foster care: promoting secure attachments with caregivers; training in affect regulation; social-interpersonal skills training; parenting skills of caregivers of child clients; working with multiple caregivers; integrating and coordinating with social service agencies and a child’s social environment; conducting trauma work around physical, sexual, and emotional abuse and neglect; engaging in family work to improve attachment relationships; facilitating family reunifica-

tion for children in out-of-home care; and reducing family conflict and promoting family cohesion. The following information was collected from Internet write-ups and confirmed with the program developer or contact person: targeted age of child clients, role of parents in treatment, modality (individual, dyadic, family, or group), core components, and inclusion-exclusion criteria.

Results

Category 1 treatments. Four treatments were reported to have been designed specifically for children in foster care. Information about these treatments is presented in Table 2. As can be seen, of these four treatments, two were tested with children in foster care with a RCT design. Both of these reported to have analyzed the foster care data separately, found positive results, and published and/or presented the findings. These two treatments are attachment and bio-behavioral catch-up and MTFC-P (formerly EIFC). Next we asked how many of these four Category 1 treatments were reported to be able to address the ten essential issues. All but one of the four treatments were rated as being able to address each of the ten issues.

Category 2 treatments. Twenty-two treatments were reported to have been—although not designed specifically for children in foster care—evaluated in a RCT design with foster care children in the sample. These treatments are presented in Table 3. Of these 22 treatments, only one (incredible years) met the criteria of having the foster care data analyzed separately, with positive results, and published and/or presented. Next we asked how many of these 22 treatments were reported to be able to address the ten essential issues. Six of the treatments were rated as addressing all ten issues, ten were rated as addressing nine of the issues, two were rated as addressing eight and seven each, and one treatment each was rated as being able to address six and two issues.

Category 3 treatments. Of the remaining 49 evidence-based mental health treatments for children, we aimed to identify which ones—although neither designed for nor evaluated with children in foster care—would be applicable because of their ability to address the ten issues. Table 4 presents these data. As can be seen, between 38% and 90% of the treatments were rated as being able to address each of the essential issues. A summary score was created that represented the number (out of ten) of the essential issues each treatment was rated as being able to address. The frequency distribution of these variables is presented in Table 5. We found that slightly fewer than one fourth of the treatments were rated as being able to address all ten issues, 13% were rated as being able to address nine issues, and fewer than 10% each were rated as being able to address between two and eight issues.

Discussion

This study was conducted to ascertain whether the current landscape of mental health treatment for children would be appropriate for children in the foster care system. Only four treatments were reported to be specifically designed for foster care youth. Additionally, only two of those four were evaluated using a RCT design that included foster children in the sample, with these data analyzed separately, and with positive results published and/or presented. Furthermore, two treatments developed and tested for the foster care population focus on young children: the ABC program (birth–5 years of age) and MTFC/formerly EIFC, a group-based treatment (3–6-year-olds). No mental health treatment was designed and tested specifically for children in foster care over the age of 6. Moreover, both ABC and MTFC/formerly EIFC require the active participation of parents, which is ideal but not always possible. Thus, of all the evidence-based treatments for providing mental health services to children currently in operation, only four were created with foster children in mind. This represents

Table 2. Category 1 Treatments

Treatment	RCT	% foster care youth	Foster care data analyzed	Foster care data positive	Published foster care data	Essential Issues	Promoting secure attachment	Training affect regulation skills	Social skills training	Parenting skills	Multiple caregivers	Integrating across systems	Trauma work	Family work to improve attachment	Facilitating reunification	Reducing family conflict
ABC	✓	30%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MTFC-P/EIFC	✓	100%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Path-ways		n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Real Life Heroes		n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

n/a = not applicable

Table 3. Category 2 Treatments

Treatment	RCT	% foster care youth	Foster care data analyzed	Foster care data positive	Published foster care data	Essential Issues	Promoting secure attachment	Training in affect regulation skills	Social skills training	Parenting skills	Multiple caregivers	Integrating across systems	Trauma work	Family work to improve attachment	Facilitating reunification	Reducing family conflict
ACTION	✓	65	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Adolescent Coping with Depression Course	✓	10	no	n/a	n/a		✓	✓	✓	✓	✓	✓		✓		
AF-CBT	✓	10	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓			✓
Challenging Horizons	✓	Don't know	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓			✓
Child-Parent Psychotherapy	✓	Don't know	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Collaborative Problem Solving	✓	Don't know	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Combined Parent-Child Psychotherapy	✓	25	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Coping Cat	✓	05	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Coping Power and Anger Coping	✓	10	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Family Behavior Therapy	✓	05	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Incredible Years	✓	100	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrative Developmental Therapy	✓	Don't know	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Multidimensional Treatment Foster Care for Specialized Populations	✓	25	✓	✓	no		✓	✓	✓	✓		✓	✓		✓	✓
Multidimensional Family Therapy	✓	20	no	no	n/a		✓	✓	✓	✓	✓	✓	✓		✓	✓
MST for Child Abuse and Neglect	✓	05	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Parent-Child Interaction Therapy	✓	65	no	n/a	n/a		✓	✓	✓	✓	✓	✓		✓	✓	✓
Problematic Sexualized Behaviors CBT	✓	13	no	n/a	n/a		✓	✓	✓	✓	✓	✓		✓	✓	✓
Prolonged Exposure for Adolescents	✓	??	no	n/a	n/a			✓						✓		
Risk Reduction Through Family Therapy	✓	25	no	n/a	n/a			✓	✓	✓	✓	✓	✓	✓	✓	✓
Seeking Safety	✓	Don't know	no	n/a	n/a		✓	✓	✓	✓		✓	✓			✓
TF-CBT	✓	40	✓	✓	No		✓	✓	✓	✓	✓	✓	✓	✓		✓
TARGET	✓	33	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓		✓

n/a = not applicable

an obvious gap in the service delivery landscape for some of the nation’s most vulnerable children. On a positive note, we found that three of the four Category 1 treatments designed specifically for children in foster care were reported to be able to address all ten essential issues. However, it is important to note that while we consider the ten issues essential for foster care youth, it is unknown at this time whether all ten are essential for effective treatment. This represents an obvious area for future research.

In light of how few treatments have been designed specifically for children in the foster care system, we also aimed to identify treat-

ments that—while not designed specifically for foster care children—have been tested and found to be effective for them. This resulted in the identification of one more program, the incredible years, and two treatments that did find positive results but haven’t published the findings: multidimensional treatment foster care and TF-CBT. (It is unclear why the positive findings haven’t been published.) Of these three treatments (incredible years, multidimensional treatment foster care, and TF-CBT), only incredible years was reported to be able to address all ten essential issues. Again, foster care children—an important consumer of mental health treatments—are for the most part not being purposefully

Table 4. How Many Category 3 Therapies (n=48) Were Reported by Program Developers to Be Able to Address the Ten Essential Issues?

	N	%
Promoting secure attachments with caregivers	37	77.1
Training in affect regulation skills	43	89.6
Social-interpersonal skills training	41	85.4
Parenting skills of caregivers of child clients	35	72.9
Working with multiple caregivers	31	64.6
Integrating and coordinating with social service agencies and child's social environment	25	52.1
Conducting trauma work around physical, sexual, and emotional abuse and neglect	30	62.5
Engaging in family work to improve attachment relationships	32	66.7
Facilitating family reunification for children in out-of-home care	18	37.5
Reducing family conflict and promoting family cohesion	33	68.8
Missing=1		

included in randomized controlled trials testing the efficacy of various treatment protocols. This means that for the majority of evidence-based mental health treatments, it remains unknown whether the therapies would be effective for children in foster care.

Finally, we examined the remaining evidence-based mental health treatments for children and found that of the 49 treatments, 11 reported to be able to address all ten topics/elements: attachment, self-regulation and competency; circle of security, cognitive behavior therapy (anger control training with stress inoculation); functional family therapy; honoring children/mending the circle; intergenerational trauma treatment model; interventions for children with sexual behavior problems—research, theory, treatment; safety, mentoring, advocacy, recovery, and treatment; sanctuary; trauma outcome process assessment (TOPA) model; and trauma-focused integrated play therapy. These treatments were neither designed nor evaluated with children in foster care but report to be able to address the essential issues for treatment of this population. As previously noted, it is unknown whether any or all of these are in fact essential for the effective delivery of mental health treatments for children in foster care, and this should be addressed in future research.

Limitations

All data collected for this project were by self-report. This is particularly relevant for understanding the data regarding the ability of the program to address the ten issues. It seems possible that a treatment could have been rated as being able to address a certain issue but that in reality the treatment really cannot do so without modification to the treatment protocol. It is possible that these ratings represent the ideal or hypothetical rather than the reality, or what the developers of the treatment interventions

Table 5. How Many of the Ten Essential Issues Could Category 3 Treatments (n=46) Address Without Modification, as Reported by Treatment Developers?

	N	%
0	0	0.0
1	0	0.0
2	1	2.2
3	8	17.4
4	1	2.2
5	4	8.7
6	10	21.7
7	3	6.5
8	2	4.3
9	6	13.0
10	11	23.9
Missing=3		

believe not necessarily what they *know* based on empirical findings. For example, many treatments were rated as being able to integrate with other service systems, but we know from experience that this is often quite time consuming and challenging and that in reality this often does not occur as often or as consistently as it should. Likewise, working with multiple caregivers (an essential element that was endorsed by 19 of the 22 Category 2 treatments and 31 of the 49 Category 3 treatments) is in reality quite complicated and cumbersome. We are not aware of any guidelines or practice wisdom available for child welfare agencies who want to implement these treatments for a child welfare population.



Implications and Directions for Future Treatment and Research

The data collected, despite these limitations, highlight several directions for future work in this area. First, it would be important to determine whether the Category 2 treatments are effective specifically for children in foster care. This would involve not just including foster care children in the sample of a RCT but analyzing the data separately to ensure that the positive results are applicable for this subsample. Second, it is important to determine whether the Category 3 treatments are effective for children in foster care by following a similar approach of conducting randomized controlled trials with children in foster care included in the sample to a large enough extent that these data can be analyzed separately.

An additional direction for future research would be to ascertain (of the sample of effective treatments) whether the full range of possible treatment needs are covered. For example, are there treatments to treat various internalizing and externalizing disorders across the various age groups, are there treatments to address attachment-bonding issues in various age groups, and so forth. Significant gaps (e.g., no dyadic treatment for anxiety in school-aged children) could then be the focus of treatment development

options. Yet another direction for the future would be to ascertain whether the ten essential issues are in fact essential and which treatments are able to actually address them. Taken together, these suggested directions reflect an ambitious program of treatment development and program evaluation that would require a long-term commitment of time, energy, and resources. Children living in foster care settings face multiple and complex environmental, social, biological, and psychological risk factors that may require specially designed interventions to meet their unique mental health and environmental needs. Children in foster care deserve nothing less.

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Journal Highlights

Vincent J. Palusci, MD, MS

The Evidence for Prevention

There has been a dramatic increase in the number of articles about child maltreatment prevention. The amount of evidence evaluating interventions has increased, and a growing number of promising programs are available for communities. Many have demonstrated the elements of successful interventions, the populations and risk groups of most benefit, and the translational research to demonstrate that we have met our goals. Many have incorporated our understanding of adverse childhood experiences (ACEs) that have been associated with poor lifelong health and begin to address the mechanisms linking these childhood exposures to adult outcomes (Palusci, 2013). Although treatment after the fact can improve health and prolong life and productivity, the direct and indirect costs of child maltreatment for both children and adults justify early action to prevent child abuse and neglect.

To investigate whether the income-to-needs ratio experienced in early childhood affects brain development at school age, Luby et al. (2013) found novel data to inform the mechanisms by which poverty negatively impacts childhood brain development. In a prospective longitudinal study of emotional development in preschool, children were assessed annually for 3–6 years prior to the time of a magnetic resonance imaging scan and were annually assessed behaviorally for 5–10 years. The researchers found that poverty was associated with smaller white and cortical gray matter and hippocampal and amygdala volumes and that these effects were mediated by caregiving support or hostility and stressful life events. They concluded that exposure to poverty in early childhood materially influences brain development at school age, which further underscores the importance of attention to the well-established deleterious effects of poverty on child development. They also concluded that attempts to enhance early caregiving should be a focused public health target for prevention and early intervention.

Shonkoff (2013, p. 106) summarizes this area of research succinctly: “A brighter future for children whose life prospects are threatened by adversity requires that we build on the seminal contributions of programs like the NFP and leverage advances in 21st-century science to catalyze fresh thinking that changes the narrative for early childhood investment. Improving program quality, enhancing service coordination, and scaling effective interventions are necessary but not sufficient. The marching orders are clear—we must embrace a spirit of constructive dissatisfaction with best practices, continually design and test new ideas, learn

from things that do not work, and settle for nothing less than breakthrough impacts on important outcomes.”

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Medical Services

Medical, mental health, and community-based strategies have been used to prevent child maltreatment. Pediatricians can play an important role in prevention, but health services during the prenatal period and early childhood have generally not been shown to reduce child abuse and neglect universally. The U.S. Preventive Services Task Force recommended in 2004 that there was insufficient evidence to recommend behavioral interventions and counseling to prevent child abuse and neglect, but a later clinical report from the American Academy of Pediatrics (Flaherty et al., 2010) outlined how the pediatrician can help to strengthen families and promote safe, stable, nurturing relationships with the aim of preventing maltreatment and enhancing child development. Selph et al. (2013) updated the recommendations with more recent evidence, concluding that risk assessment and behavioral interventions in pediatric clinics have now been shown to reduce abuse and neglect for young children.

A randomized trial of the Safe Environment for Every Kid (SEEK) model of enhanced pediatric primary care in an inner-city clinic with high-risk families showed lower rates of maltreatment, Child Protective Service (CPS) reports, and harsh punishment plus improved health services after an intervention of pediatric resident education in a primary care medical setting (Dubowitz et al., 2009). To examine the effectiveness of SEEK to help reduce child maltreatment in a relatively low-risk population, Dubowitz et al. (2012) enrolled 18 pediatric practices that were assigned to intervention or control groups, and 1,119 mothers of children ages 0–5 years completed assessments initially and after 6 and 12 months. The SEEK model included training health professionals to address targeted risk factors, offering a parent handouts, and providing a social worker. The researchers found that in the initial and 12-month assessments, SEEK mothers reported less psychological aggression than did controls, and SEEK moth-



ers reported fewer minor physical assaults than did controls. There were few instances of maltreatment documented in the medical records and few CPS reports. They concluded that SEEK offers a promising and practical enhancement of pediatric primary care. Scribano (2013) noted that the SEEK model provides a supportive approach to identifying resources to strengthen families by first identifying social factors that may be harmful to child well-being. In addition, it is likely that the medical home will play an integral role in the anticipated reform of the health care system, having the potential to address key determinants of health disparity in our culture and offering a significant contribution to facilitate a health promotion approach.

Adolescent parenthood is associated with a range of adverse outcomes for young mothers, including mental health problems such as depression, substance abuse, and posttraumatic stress disorder. Hodgkinson et al. (2014) noted that teen mothers are also more likely to be impoverished and reside in communities and families that are socially and economically disadvantaged, adversely affecting maternal mental health, parenting, and behavior outcomes for their children. They reviewed the mental health challenges associated with teen parenthood, barriers that often prevent teen mothers from seeking mental health services and interventions for this vulnerable population that can be integrated into primary care services. They concluded that pediatricians in the primary care setting are in a unique position to address the needs of adolescent parents because teens often turn to them first for assistance with emotional and behavioral concerns.

Gazmararian et al. (2014) launched a program entitled “Text4baby” in 2010 to promote healthy pregnancies and babies by the use of text messaging (hopefully also decreasing maltreatment). A prospective cohort study was conducted with 468 randomly selected pregnant and postpartum women in Atlanta, Georgia, who were queried on cell phone use and instructed on Text4baby enrollment. Among the 209 participants who enrolled, more than 90% reported uninterrupted reception and regular reading of messages, and 88% planned to continue using Text4baby. The authors concluded that this strategy was promising but that additional ways are needed to help women with significant disadvantages enroll and receive the messages.

Tschudy et al. (2013) reviewed potential strategies to integrate medical and community-based prevention strategies, noting that the integration of the family-centered medical home and home visitation would promote overall efficiency and effectiveness and help achieve gains in population health through improving the quality of care, decreasing duplication, reinforcing similar health priorities, decreasing cost, and decreasing health disparities. They suggested that we must integrate the individual and population approaches to health and health care delivery, citing a 2012 Institute of Medicine (IOM) report: *Primary Care and Public Health: Exploring Integration to Improve Population Health*. This report laid out the continuum for integration of primary care and public health stretching from isolation to merging systems. The article provides a brief description of the goals and scope of care of the family-centered medical home and home visiting, outlines the

need for and synergies of integration, applies the IOM's framework and barriers to integration, and uses child developmental surveillance and screening as an example of the potential impact of their integration.

Finkel (2013) has piloted incorporating sexual abuse prevention into pediatric office care, noting that while pediatricians have been leaders in trying to understand what he calls the "disease of sexual victimization," most efforts have been directed at identifying the physical residual by working to establish diagnostic criteria. He proposes a health-based program based on a child's right to personal space and privacy (PSP) rather than prevention. The first step of PSP is to educate parents and children about their right to PSP, and the second is to provide caretakers with age-appropriate language so they can comfortably talk with children throughout childhood. Finkel suggests that children learn what's okay and not okay from their caretakers while parents look to their pediatricians and family doctors for guidance regarding a litany of safety issues. He concludes that now is the time for doctors to take on the issue of PSP and child sexual abuse to demonstrate their leadership regarding this challenging public health issue. McEachern (2012) extends this work to individuals with disabilities, reviewing several studies conducted on sexual abuse of individuals with disabilities and focusing on health-based prevention strategies for this vulnerable population.

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Mental Health-Based Strategies

Using mental health-based treatment models, Langstrom et al. (2013) evaluated the effectiveness of current medical and psychological interventions for individuals at risk of sexually abusing children. They designed a systematic review of interventions designed to prevent reoffending among known abusers and prevention for individuals at risk of sexually abusing children, including randomized controlled trials and prospective observational studies. After reviewing 1,447 abstracts, they retrieved 167 full-text studies and finally included 8 studies meeting criteria with low to moderate risk of bias. They concluded there was weak evidence for interventions aimed at reducing reoffending in identified sexual abusers of children. For adults, evidence from five trials was insufficient regarding both benefits and risks with psychological treatment and pharmacotherapy. For adolescents, limited evidence from one trial suggested that multisystemic therapy prevented re-offense. Lack of adequate research prevented conclusions about effects of other treatments. Evidence was also inadequate regarding effectiveness of treatment for children with sexual behavioral problems in the one trial identified. There was no eligible research on preventive methods for adults and adolescents who had not sexually abused children but were at higher risk of doing so. They concluded that there are major weaknesses in the scientific evidence, particularly regarding adult men, the main category of sexual abusers of children.

Palusci and Ondersma (2012) used the National Child Abuse and Neglect Data System to study tertiary prevention in a cohort of children in 18 states with psychological maltreatment (PM) reports confirmed by child protective services (CPS). They assessed PM recurrence rates after counseling and other services arranged by CPS while controlling for factors associated with service referral and other maltreatment. Propensity score methods were not used. In sum, 11,646 children had a first CPS-confirmed report with PM, and 9.2% of them had a second confirmed PM report within 5 years. Fewer than one fourth of families were referred for services after PM, with service referrals being more likely for families with poverty, drug, or alcohol problems or other violence. Controlling for these factors, they found that counseling referral was associated with a 54% reduction in PM recurrence, but other services were not associated with statistically significant reductions. Few families in which PM was confirmed received any services, and most services provided were not associated with reductions in PM recurrence.

To review the development of a training manual in the United Kingdom specifically looking at the practice elements that are known to prevent the recurrence of abusive and neglectful parenting, Bentovim and Elliott (2014) reviewed 22 randomized controlled interventions to see what could be used to develop a systematic approach for a variety of frontline practitioners in social care, health, and education. Their focus was physical and sexual abuse (with young people as victims and perpetrators), neglect

(including failure to thrive), and emotional abuse (exposure to violence and mental health issues). They found 47 practice elements present across all forms of maltreatment and created a manual entitled *Hope for Children and Families*. It provides a menu of evidence-based, step-by-step modular interventions targeting the profile of abusive and neglectful parenting and associated impairments of children. These practices include a variety of mental health interventions as well as home visiting in modules targeting specific forms of maltreatment organized around the child's developmental needs, parenting capacity, and family and environmental factors. They concluded that there are evidence-based tools to help a wide range of practitioners tackle often complex situations through a combination of basic therapeutic skills. In addition, *Hope for Children and Families* could help with situations in which the threshold for specialist services has not been reached, enabling children and families to earlier access effective interventions.

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Community-Based Strategies

Chahine and Sanders (2013) present a high-level overview of the complex issues, opportunities, and challenges involved in improving child safety and preventing child maltreatment fatalities. A broad, community-based approach is needed, and improving measurement and classification is critical to understanding and preventing child maltreatment fatalities. They stress the need to re-frame child maltreatment interventions from a broad public health perspective. Their article draws on the lessons learned from state-of-the-art safety engineering innovations, research, and other expert recommendations presented in a special issue of the journal.

The Triple P—Positive Parenting Program was designed as a comprehensive, population-level system of parent and family support with five intervention levels of increasing intensity and narrowing population reach. The system combines various targeted interventions to ensure a safe environment, including promoting learning, using assertive discipline, maintaining reasonable expectations, and taking care of oneself as a parent. These principles then translate into 35 specific strategies and parenting skills. Prinz et al. (2009) conducted a large-scale randomized trial of Triple P and noted lesser increases in substantiated child maltreatment, child out-of-home placements, and child maltreatment injuries in the

intervention counties. In follow-up, Shapiro, Prinz, and Sanders (2012) noted the importance of understanding factors that affect worker implementation of evidenced-based parenting and family support interventions. They used structured interviews with 174 service providers from several disciplines who had been trained previously in the delivery of Triple P. These follow-up interviews, conducted an average of about 2 years after in-service training, provided the basis for examining predictors of sustained program use. They found that several provider and organization-level characteristics significantly predicted program use, including provider self-confidence after training, fit of program with ongoing duties, availability of posttraining support, and perceived benefit of intervention for children and families.

Home visiting programs can prevent child abuse and neglect by influencing parenting factors linked to maltreatment. The U.S. Patient Protection and Affordable Care Act established the Maternal, Infant, and Early Childhood Home Visiting Program, which will provide \$1.5 billion to states over 5 years for home visiting program models serving at-risk pregnant women and children from birth to age 5 (Garner, 2013). Advances in neuroscience, epigenetics, and the physiology of stress are revealing the biological mechanisms underlying well-established associations between early childhood adversity and poor adult health. Mediators of physiologic stress become toxic, alter both genome and brain, and lead to a vicious cycle of chronic stress. This “toxic stress” results in a wide array of behavioral attempts to blunt the stress response, a process known as “behavioral allostasis,” through behaviors such as smoking, overeating, promiscuity, and substance abuse. Such behaviors can become maladaptive and result in the unhealthy lifestyles and noncommunicable diseases that are the leading causes of morbidity and mortality. Garner concluded that future efforts to minimize the effects of childhood adversity should focus on expanding the capacity of caregivers and communities to promote the safe, stable, and nurturing relationships that buffer toxic stress as well as the foundational social-emotional, language, and cognitive skills needed to develop healthy, adaptive coping skills.

Olds et al. (2013) noted that the Nurse-Family Partnership delivered by nurses has been found to produce long-term positive effects on maternal and child health in replicated randomized trials, but a persistent question is whether paraprofessional home visitors might produce comparable effects. To examine this, the authors constructed a randomized trial in public and private care settings in Denver, Colorado, with 735 low-income women and their first-born children. Home visits were provided from pregnancy through child age 2 years delivered in one group by paraprofessionals and in the other by nurses. They found that there were no significant paraprofessional effects on emotional-behavioral problems, but paraprofessional-visited children born to mothers with low-psychological resources compared with control group counterparts exhibited fewer errors in visual attention-task switching at



age 9 years. There were no statistically significant paraprofessional effects on other primary outcomes. Nurse-visited children were less likely to be classified as having total emotional-behavioral problems at age 6 years, internalizing problems at age 9 years, and dysfunctional attention at age 9 years. Nurse-visited children born to low-resource mothers compared with control-group counterparts had better receptive language averaged over ages 2, 4, and 6 years and sustained attention averaged over ages 4, 6, and 9 years. There were no significant nurse effects on externalizing problems, intellectual functioning, and academic achievement.

While breastfeeding has been shown to improve several outcomes, young African American mothers continue to breastfeed at low rates and commonly introduce complementary foods earlier than recommended. Edwards et al. (2013) examined the effects of a community doula home-visiting intervention on infant feeding practices among 248 low-income, African American mothers in a randomized trial. Intervention-group mothers received services from paraprofessional doulas who were specialized home visitors trained as childbirth educators and lactation counselors. Doulas provided home visits from pregnancy through 3 months postpartum, and support during childbirth. Control-group mothers received usual prenatal care. They found that doula-group mothers attempted breastfeeding at a higher rate than control-group

mothers and were more likely to breastfeed longer than 6 weeks, although few mothers still breastfed at 4 months. Fewer doula-group mothers introduced complementary foods before 6 weeks of age, while more waited until at least 4 months compared with control-group mothers. They concluded that community doulas may be effective in helping young mothers meet breastfeeding and healthy feeding guidelines and that the intervention's success may lie in the relationship that develops both between doula and mother based on shared cultural background and months of prenatal home visiting as well as the doula's presence at the birth where she supports early breastfeeding experiences.

Dodge et al. (2013) studied the effectiveness in reducing infant emergency medical care for Durham Connects, a program of brief, universal, postnatal nurse home visiting. Using all 4,777 resident births in Durham, North Carolina, over 18 months, they randomly assigned even-birth-date families to intervention and odd-birth-date families to control groups. Intervention families were offered 3–7 contacts between 3 and 12 weeks after birth to assess family needs and connect parents with community resources. After demographic factors were assessed relative to control families, they found that families assigned to intervention had 50% less total emergency medical care use during the first 12 months of life. They concluded that this nurse home visiting program improves population-level infant health care outcomes for the first 12 months of life and can be implemented universally at high fidelity with positive outcomes on infant emergency health care that are similar to those of longer, more intensive home visiting programs.

Matone et al. (2013) compared hospital utilization for early childhood injuries between program recipients and local-area comparison families following statewide implementation of an evidence-based home visitation program. They used propensity score matching on baseline characteristics to create a retrospective cohort of Nurse-Family Partnership (NFP) clients and local area matched comparison women. The main outcome was a count of injury-visit episodes from Medicaid claims for injuries examined in an emergency department or hospital setting during the first 2 years of life for children born to included subjects. The authors found that children of NFP clients were more likely to have higher rates of injury visits in the first 2 years of life than did the children of comparison women, with significantly higher rates of visits among children of NFP clients for superficial injuries. Among more serious injuries, no significant difference in injury visit rates was found between NFP clients and comparison women. Contrary to prior randomized trial data, no reductions in utilization for serious early childhood injuries were demonstrated following statewide implementation of an evidence-based home visitation program. They concluded that significant program variation on outcomes underscores the challenges to successful implementation.

Avellar and Supplee (2013) reviewed the home visiting research literature to assess the evidence of effectiveness for program models that serve families with pregnant women and children from birth to age 5. Home Visiting Evidence of Effectiveness included a systematic search and screening process, a review of the research quality, and an assessment of program effectiveness and reviewers rated studies' capacity to provide unbiased estimates of program impacts. It also determined whether a program met the Department of Health and Human Services' criteria for an evidence-based model. Thus, 32 models were reviewed, of which 12 met the Department of Health and Human Services criteria, and most were shown to have favorable effects on child development. Other common favorable effects included health care usage and reductions in child maltreatment. Less common were favorable effects on birth outcomes. They concluded that home visiting is a promising way to serve families who may be difficult to engage in supportive services, and it has the potential for positive results particularly on health care usage and child development.

Dalziel and Segal (2012) sought to determine the cost-effectiveness of home visiting programs through systematic review using trials reporting child maltreatment outcomes. Lifetime cost offsets associated with maltreatment were derived from a recent Australian study and were estimated as program cost per case of maltreatment prevented and net benefit estimated by incorporating downstream cost savings. They evaluated 33 home visiting programs and derived cost-effectiveness estimates for 25. They found that the incremental cost of home visiting compared with usual care ranged from \$1,800 to \$30,000 per family. Cost-effectiveness estimates ranged from \$22,000 per case of maltreatment prevented to several million. Seven of the 22 programs were of at least adequate quality and were cost saving when including lifetime cost offsets. They concluded that while there is great variation in the cost effectiveness of home visiting programs for the prevention of maltreatment, the most cost-effective programs used professional home visitors in a multidisciplinary team, targeted high-risk populations, and included more than just home visiting.

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Additional articles about prevention are available from the Child Welfare Information gateway, sponsored by the US DHHS AYF at: <http://library.childwelfare.gov/cwig/ws/library/docs/gateway/SimpleSearchForm>

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Washington Update

John Sciamanna

Introduction

The second session of the 113th Congress has been dominated by efforts to move from the gridlock and confrontation that have been the hallmark of Congress over the last several years. The early accomplishments are not historically significant but have allowed some basic functions to take place: finalizing appropriations for the current year, raising the debt ceiling beyond the next election, reauthorizing agriculture programs, and allowing an appropriations process for FY 2015.

Appropriations

In December, Congress approved a budget agreement for fiscal years 2014 and 2015. The agreement allowed Congress to finish the appropriations process for the current fiscal year, FY 2014, and it will allow a regular appropriations process for the next fiscal year. The deal provides \$1.058 trillion for the discretionary budget—the part of the budget that is not automatic (mandatory and/or entitlement) and must be voted on each year. The funding will provide \$520 billion for the Defense Department and \$491 billion for all remaining domestic spending. The agreement replaces the sequestration levels of \$967 billion. The deal also provides a slight increase for FY 2015.

If the deal had not been reached, \$498 billion would have been provided for military spending while \$469 billion would have been allowed for all other domestic discretionary spending. Under the agreement, defense and domestic programs will receive an additional \$23 billion to reach the \$520 billion and \$492 billion totals. Not all sequestration cuts were replaced, and automatic cuts of 5.1% remain for some mandatory funding such as the social services Block grant (SSBG) and the Promoting Safe and Stable Families (PSSF) program.

Shortly after that deal, an omnibus bill, HR 3547 (<http://beta.congress.gov/113/bills/hr3547/BILLS-113hr3547enr.pdf>), was adopted by Congress to provide funding for each of the 12 appropriations bills. The appropriations committee chairs, Senator Barbara Mikulski (D-MD) and Congressman Hal Rogers (R-KY), worked to complete action to make sure all bills had specific funding directed by the appropriators. While there were some relative winners, such as Head Start and pre-kindergarten, even those increases are far from what would have been envisioned a few years ago. Most of the child welfare programs will experience further erosion in funding both through discretionary cuts and mandatory spending cuts with the ongoing sequestration for

SSBG, PSSF, and the home visiting program. These continue to be reduced from their base totals by 5.1% per year for the 2 years of this budget agreement. The Labor–Health and Human Services–Education bill provides \$156 billion. It is a higher total than the \$144 billion allocated in FY 2008, but when that 2008 figure is adjusted by inflation, it is actually \$162 billion in today's dollars; this means that the three departments will get less funding than they received 6 years ago.

Child Maltreatment Data Show Little Change for 2012

In December, the Children's Bureau released the report Child Maltreatment 2012 (http://www.nationalchildabusecoalition.org/uploads/1/4/2/8/14285371/maltreatment_2012.pdf). The numbers are similar to 2011 with 3.4 million referrals or reports to Child Protective Services (CPS). Total referrals included 6.3 million children (some reports including more than one child, for example, siblings). Local CPS screen these referrals according to state standards and definitions; as a result, 2.1 million of the referrals were screened for further evaluation. CPS workers will conduct an investigation again based on each state's definition and standards. In 2012, 678,810 children were "substantiated" as being victims of child abuse and neglect. This figure is an unduplicated count, meaning that each child is counted once even if he or she has come back into the system a second time in the same year. The number was further adjusted to 686,000 children because some state data are missing, and an estimate has been made for all 50 states. The number of substantiated children is close to 2011 numbers, and the rate of child maltreatment is 9.2 per 1000 children.

An estimated 1,640 children died in 2012 due to maltreatment, the highest total since 2009, when the figure was 1,740 children. Many argue that actual child deaths are much higher. This is due to the varying ways a state may collect data. For example, if a child died but there were no siblings or other children in the family and no earlier involvement by CPS, that child death may not be included in this child death number. The rate of child deaths was 2.20 per 100,000 children, a rate that is also the highest since 2009. Consistent with previous years, 70% of child deaths were children under 3 years of age. The rate of child deaths is highest for children under the age of 1; in 2012, the rate was 18.8 per 100,000 children under the age of 1. The victimization rate was higher for boys than girls with 2.54 deaths per 100,000 boys and 1.94 per 100,000 girls.

In regard to the overall maltreatment categories, 78.3% of victims were victims of neglect, 18.3% were victims of physical abuse, and 9.3% were victims of sexual abuse. In terms of sexual abuse by age, 26% of victims were 12–14 years of age, 20.9% were 15–17, and 19.4% were 9–11.

The report indicates that 82% of the perpetrators of maltreatment were between the ages of 18 and 44 years, and 3% were under age 18. Eighty percent of perpetrators were parents, and nearly 89% of these were birth parents. As far as who reports suspected child maltreatment, 57% of reports were by professionals of some category; education officials and law enforcement officials each represented more than 16% of reporters with social service workers (11%) and medical professionals (8%) following. Overall, 19% of reporters were non-professionals and included other relatives (7%), parents (6%), and friends and neighbors (5%). Twenty-two percent of reporters were unclassified, such as anonymous, uncategorized, or unknown.

Of the child victims who received postinvestigation services, 146,000 were placed in foster care for at least some period, and 232,000 received in-home services. While the numbers are based on some estimates and duplicate counts of children, generally 40% of child victims did not receive services. For nonvictims—which could include children where there was a lack of evidence, an alternate or differential response service, siblings of a victim, or unknown status—101,000 were in foster care for some amount of time, and an additional 709,000 received in-home services.

Commission to Eliminate Child Abuse and Neglect Fatalities Begins Process

On February 24, the Commission to Eliminate Child Abuse and Neglect Fatalities, a committee established by the Protect Our Kids Act of 2012, held its first public hearing. The Commission is the result of 2013 approval of the Protect Our Kids Act (HR 6655). The commission has 12 members. The President selected 6 of the members, and the House and Senate leadership each appointed 3 members with the majority parties selecting 2 of the 3 members.

The presidential appointees are as follows: Dr. David Sanders, Casey Family Programs; Theresa Martha Covington, the National Center for the Review and Prevention of Child Deaths; Patricia M. Martin, Presiding Judge of the Child Protection Division, Circuit Court of Cook County, Illinois; Michael R. Petit, Every Child Matters Education Fund; Jennifer Rodriguez, Youth Law Center, and Dr. David Rubin, the Perelman School of Medicine at the University of Pennsylvania.



The 6 congressional members are as follows: Wade Horn, Deloitte Consulting (Senator Mitch McConnell); former Congressman Bud Cramer (Minority Leader Nancy Pelosi); Amy Ayoub, Nevada public speaking and presentation skills coach (Senator Harry Reid); Marilyn Bruguier Zimmerman, National Native Children's Trauma Center (Senator Max Baucus); Susan Dreyfus, Alliance for Children and Families (Speaker John Boehner); and Cassie Bevan, Graduate School of Social Policy and Practice at the University of Pennsylvania (Boehner).

The commission's work includes an examination of the following:

- best practices in preventing child and youth fatalities that are intentionally caused due to negligence, neglect, or a failure to exercise proper care
- the effectiveness of federal, state, and local policies and systems aimed at collecting accurate and uniform data on child fatalities
- the current barriers to preventing fatalities from child abuse and neglect, and how to improve child welfare outcomes
- trends in demographic and other risk factors that are predictive of or correlated with child maltreatment, such as age of the child, child behavior, family structure, parental stress, and poverty
- methods of prioritizing child abuse and neglect prevention families with the highest need
- methods of improving data collection and utilization, such as increasing interoperability among state and local and other data systems.

Adoption Incentive Fund Reauthorization

In December, the Senate Finance Committee passed the Support-

ing At-Risk Children Act of 2013. The legislation bundled together a reauthorization of the adoption incentives fund, new legislative language to address domestic sex trafficking through child welfare, and provisions that deal with child support collection, including provisions to address international treaties.

The Senate adoption incentives fund requirements differ from a House bipartisan bill (HR 3205, <http://www.gop.gov/bill/113/1/hr3205>) in how funds are allocated for the placement of children from foster care into adoptive families. Both bills now provide an award for kinship care placements, although the Senate provides a higher award than the House bill. In addition, the Senate creates a broader definition of kinship care placements. The House bill also creates an additional category of children 14 years and older. Both bills require a greater accountability of state savings than is being realized by states as federal adoption assistance is expanded each year due to the 2008 Fostering Connections to Success Act (PL 110-351). Both bills extend the Family Connections grants that currently fund kinship navigator programs, residential drug treatment, family finding services, and family group decision-making services. Both bills extend the law by 3 years.

In regard to the issue of sex trafficking of children from the child welfare system, the bill creates a number of new requirements on state screening, data reporting, and services to youth, although the new requirements are not accompanied by additional funding. Policies and procedures would have to be in place to screen, identify, and determine services for victims of trafficking for youth up to age of 21 (or at state option, to age 26). It defines *sex trafficking* consistent with federal law that deals with international victims.

The bill also deals with those young people in foster care who end up in what is generally viewed as long-term foster care. They are young people who may be classified as under “another planned permanent living arrangement” or APPLA for short. No youth age 16 or older could be considered APPLA, and similarly to the Hatch bill (S 1518) introduced last year, new requirements would be placed on the courts and states for increased hearings. States would have to give the courts greater accounting of what the agency has done to place young people into adoptive, kinship, or birth families. It would create a definition in law for a “prudent parent” standard. Each child would have to have someone in a foster home or residential facility that could meet these standards. Each child in foster care or a facility would have to have such a person (which could include a foster parent) to make decisions regarding various activities a child in foster care could participate in. This is an attempt to assure that foster children are not denied access to activities and items such as driver’s licenses, attending high school dances, and other activities sometimes restricted due to being in a foster care placement. The bill would also require that children age 14 and older be directly involved in their case planning (currently required of youth 16 and older). The legislation also requires a bill of rights provided to youth 14 or older

who are in foster care, kinship care, or adopted and would specify in law that anyone 14 or older who exits foster care have a birth certificate, Social Security card, driver’s license, and a bank account (unless the child decides not to have a bank account). Failure to do this will require a reduction in a state’s reimbursement under Title IV-E.

The House legislation that deals with the reauthorization of the incentive fund passed the House in late October. Once the Senate decided to bundle the adoption incentive fund with trafficking issues, the House then released a draft just before Christmas. In late February, it released its own proposal on youth in foster care and trafficking-related provisions, titled the Preventing Sex Trafficking and Improving Opportunities for Youth in Foster Care Act and sponsored by the House Ways and Means Subcommittee Chairman, Congressman Dave Reichert (R-WA), and Subcommittee Ranking Member Congressman Lloyd Doggett (D-TX).

Action on all the legislation was delayed in part due to the change in leadership within the Senate Finance Committee; more significantly, the Senate delay beyond last December also cost \$15 million a year in offset (savings) that was going to be used for the Family Connections grants.

Wyden Becomes New Finance Chair as Baucus Departs

In mid-February, the Senate approved retiring Senator Max Baucus (D-MT) for his next job, ambassador to China. The vote was unanimous by a vote of 96 to 0. President Obama made the surprise nomination to the post in November. Senator Ron Wyden (D-OR) becomes the new Chairman of the Senate Finance Committee even though he is actually second in line for the post. The most senior member on the committee, Senator Jay Rockefeller (D-WV), is also retiring at the end of this session. Before becoming the new chair, Senator Wyden had been discreet regarding his priorities for the rest of this year, not wanting to preempt Senator Baucus while he remained chairman. Baucus had been working with the House Chairman of the Ways and Means Committee, Congressman David Camp (R-MI), on a major tax reform effort that is all but dead.

More immediate needs are a package of “tax extenders,” a series of business tax breaks that expire every year or two. Extending the package could cost close to \$50 billion. The Committee also needs to pass either a yearlong or more permanent change to the formula Medicare uses to pay some physicians. The Medicare Sustainable Growth Rate (SRG), sometimes referred to as the “doc fix,” has expired every year since the 1997 budget deal, and Congress usually voids the lower payment formulas at a cost of at least \$20 billion dollars or more each year. Costs can and have been higher depending on the health care inflation rate. Somewhere lost in all of it is the need to extend the Adoption Incentive Fund

and the Family Connections grants. The Family Connections grants require the Congress to find \$15 million a year to pay for the extension (for 3 years).

Teen Births and Pregnancy Rates Plummet From Peak

In December, the National Campaign to Prevent Teen and Unplanned Pregnancy held an anniversary event that also highlighted the significant decrease in teen births and pregnancy rates. Based on the Centers for Disease Control and Prevention (CDC) data, from 1991 to 2010, teen births rates declined by 52% and pregnancy rates declined 42% from 1991 to 2008.

Between 1990 and 2009, pregnancy rates have fallen 51% for non-Hispanic white and non-Hispanic black teens. During this same period, pregnancy rates have fallen 40% for Hispanic teens. To highlight the fact that there is more to accomplish, the organization also released figures that estimate the total public costs of these unplanned pregnancies to the federal, state, and local governments at approximately \$9.4 billion annually. The most significant costs are \$2.1 billion in public sector health care, \$3.1 billion in child welfare, and \$2 billion in related costs of incarceration. Uncalculated are long-term consequences, such as lower numbers of high school graduations and education outcomes, lower lifetime earnings, and other life-changing impacts. Although great costs are still associated with unplanned teen pregnancies, the dramatic decrease means significant savings (\$12 billion) compared with if rates had remained as high.

As evidence that more needs to be done, the United States still exceeds the teen pregnancy rates and births of other industrialized economies, especially when compared with Europe. Teen pregnancy rates are twice as high as those in the highest country in Europe (the United Kingdom) and 10 times as high as in Switzerland. In some populations, such as youth in foster care, much more needs to be done by using a refined strategy that can address the different challenges and complexities encountered by these young people.

Congress Starts Debate on Early Childhood Education

In February, weeks before the release of the President's 2015 budget, the House and Senate held committee hearings on early childhood education. The House committee on Education and the Workforce held a Wednesday morning hearing, which was followed a day later by the Health, Education, Labor and Pensions (HELP) Committee in the Senate.

The House hearing opened with remarks by Committee Chairman Congressman John Kline (R-MN), who focused on what he sees as the number of overlapping child care programs. For his part, ranking member Congressman George Miller (D-CA) re-

futed some of the claims about the number of programs that exist and talked about the importance of expanding early childhood education. He also dissected the testimony of the Government Accountability Office (GAO). The GAO research indicated that 45 different programs deal with early childhood education and child care, suggesting an overlap. During the question-and-answer period, Congressman Miller highlighted the GAO information that 75% of the programs identified as overlapping actually have different missions aside from providing child care, such as the Child and Adult Feeding Care Program, which focuses on nutrition services and does not provide child care.

The Senate HELP Committee held its own hearing with Chairman Tom Harkin (D-IA) and indicated that there would be many hearings with a goal of moving legislation sometime in the spring. Harkin said, "The Committee will devote a great deal of time and attention to the subject of early learning. I strongly encourage the members of this Committee to hold roundtables and have discussions on early learning in their local communities because there is no issue of greater importance than ensuring that our youngest children are provided the support that they need to live healthy, happy, and productive lives" (<http://www.help.senate.gov/newsroom/press/release/?id=f0f2fba9-6be3-4626-b3a4-29cdf77a4303&groups=Chair>).

Ranking member Senator Lamar Alexander (R-TN) sounded a more skeptical tone, arguing that current legislation and the President's proposal include too many mandates. "What we should not do is to fall back into the familiar Washington pattern of noble intentions, a grand promise, lots of federal mandates, and sending the bill to the states with disappointing results." He went on to compare it with Medicaid, which he argued is a budget burden to states. He argued that a better approach would be to provide more funding for the Head Start Centers of Excellence (<http://www.help.senate.gov/newsroom/press/release/?id=7747cc0a-1abb-4b37-98f4-e9c0dc0686b7&groups=Ranking>).

About the Author

John Sciamanna is Executive Director of the National Children's Coalition and was Director of Policy and Government Affairs for the American Humane Association (AHA), overseeing AHA's legislative agenda in Washington, D.C., and working specifically with the Administration, Congress, and other national groups. For close to two decades, he has been working on children's issues, and in the last decade, he has more specifically focused on child welfare issues. Before joining AHA, he worked in the U.S. Senate as a Legislative Assistant, with the American Public Human Services Association (APHSA) as Senior Policy Associate, and most recently as Codirector of Government Affairs for the Child Welfare League of America. Contact:

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APSAC News

Register Today for APSAC's Colloquium This June in New Orleans

APSAC will host its 22nd Annual Colloquium June 11–14 at the Sheraton in New Orleans, Louisiana.

The Colloquium will feature more than 90 institutes and workshops which address all aspects of child maltreatment, including prevention, assessment, intervention, and treatment with victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect. Cultural considerations will also be addressed.

In addition, the Colloquium offers several special events and ample networking opportunities, poster presentations, exhibits, and an awards ceremony.

The educational goal of APSAC's Colloquium is to foster professional excellence in the field of child maltreatment by providing interdisciplinary professional education. Upon completion of this activity, participants should be able to

- Identify physical abuse, sexual abuse, and neglect in children
- Treat abused and neglected children
- Apply model examination techniques for assessment of abused and neglected children
- Describe and utilize the most up-to-date information concerning working with abused and neglected children to improve patient care
- Prepare and report quality testimony in court cases, both as experts and as witnesses

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

To help attendees select their seminars, the Colloquium is divided into convenient tracks: Cultural Diversity, Child Protection/Law Enforcement, Interdisciplinary, Forensic Interviewing, Law, Mental Health, Medicine and Nursing, and Prevention.

The 22nd Annual Colloquium is cosponsored by APSAC with support from the Institute for Continuing Education. Continuing education credit is offered for a variety of disciplines and is awarded on a session-by-session basis with full attendance required at the sessions attended. Representatives from the Institute will be on site to accept applications and assist conference attendees. A separate processing fee is required.

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

2014 Advanced Forensic Interview Clinics Scheduled

APSAC is offering two forensic interview clinics in 2014. These clinics offer 40 hours of intensive training on investigating interviewing of children.

APSAC pioneered the Forensic Interview Training Clinic model to focus on the needs of professionals responsible for conducting forensic and investigative interviews with children in suspected abuse cases. Interviews with children face intense scrutiny and increasingly require specialized training and expertise. These comprehensive clinics provide a unique training experience that offers personal interaction with leading experts in the field of child forensic interviewing. Developed by top experts, APSAC's curriculum teaches a structured narrative interview approach that emphasizes best practices based on research and is guided by best interests of the child.

Attendees will receive a balanced review of several protocols and will develop their own customized narrative interview approach based on the principles taught during the clinics.

The first clinic will be held April 28–May 2, 2014, in Norfolk, Virginia. A second clinic is being offered July 14–18, 2014, in Seattle, Washington. Details and registration are available on the APSAC Web site, www.apsac.org.

Successful Institutes Offered by APSAC in San Diego

APSAC hosted a series of successful Advanced Training Institutes January 27 in San Diego, California. The programs were a part of the Annual San Diego International Conference on Child and Family Maltreatment sponsored by the Chadwick Center. APSAC programs included the following:

Advanced Issues in Child Sexual Abuse, *Debra Esernio-Jenssen, MD, and Barbara Knox, MD*

Exploring Technology in the Forensic Interview and Managing Your Victim Throughout Investigation and Prosecution in the Age of Technology, *Julie Kenniston, MSW, LSW, and Detective Chris Kolcharno*

Take Two: Cognitive Processing: Advanced Clinical Strategies for the CBT Trauma Therapist, *Monica Fitzgerald, PhD, and Jessica Gorrone, MSW*

In addition to offering three educational programs, APSAC exhibited in the conference, and many of its members served as conference faculty. APSAC's Board of Directors held a meeting January 25–26 in conjunction with the conference.

Conference Calendar

April 6–9, 2014
2014 Ray E. Helfer Society Annual Meeting
Ray E. Helfer Society
Annapolis, MD
630.359.4273
dbandy@helfersociety.org
<http://www.helfersociety.org>

April 13–16, 2014
32nd Annual Protecting Our Children National American Indian Conference on Child Abuse and Neglect
National Indian Child Welfare Association (NICWA)
Fort Lauderdale, FL
503.222.4044
lauren@nicwa.org
<http://www.nicwa.org/conference>

April 22–24, 2014
Extended Forensic Interviewing Training
National Children's Advocacy Center
Charlotte, NC
256.533.5437
<http://www.nationalcac.org/ncac-training/efi-training.html>

April 22–25, 2014
15th Annual Child Abuse & Family Violence Summit
“The Power of One in Collaboration With Others”
Clackamas County Sheriff's Office Child Abuse Team
Portland, OR
503.557.5827
jcollinson@co.clackamas.or.us
<http://www.childabusesummit.com>

April 28–May 2, 2014
APSAC Child Forensic Interview Clinic
American Professional Society on the Abuse of Children
Norfolk, VA
877.402.7722
apsac@apsac.org
<http://www.apsac.org>

April 29–May 2, 2014
19th National Conference on Child Abuse and Neglect
Children's Bureau, Administration for Children and Families
New Orleans, LA
703.243.0495
NCCAN@pal-tech.com
<http://www.pal-tech.com/web/NCCAN19>

May 4–6, 2014
International Conference on Shaken Baby Syndrome/Abusive Head Trauma
National Center on Shaken Baby Syndrome
Paris, France
801.447.9360
dvazquez@dontshake.org
<http://www.dontshake.org>

May 21–23, 2014
European Conference on Child Abuse and Neglect
Netherlands Society for the Prevention of Child Abuse and Neglect
Amsterdam, Netherlands
info@euccan.eu
<http://www.euccan.eu>

June 11–14, 2014
22nd APSAC Annual Colloquium
American Professional Society on the Abuse of Children
New Orleans, LA
877.402.7722
apsac@apsac.org
<http://www.apsac.org>

July 14–18, 2014
APSAC Child Forensic Interview Clinic
American Professional Society on the Abuse of Children
Seattle, WA
877.402.7722
apsac@apsac.org
<http://www.apsac.org>

September 7–10, 2014
19th International Conference on Violence, Abuse, and Trauma
“Linking Research, Practice, Advocacy, and Policy”
Institute on Violence, Abuse, and Trauma (IVAT)
San Diego, CA
858.527.1860
ivatconf@alliant.edu
<http://www.ivatcenters.org>

September 15–18, 2014
XXth ISPCAN Conference on Child Abuse and Neglect
International Society for Prevention of Child Abuse and Neglect
Nagoya, Japan
303.864.5220
ispcan@ispcan.org
<http://www.ispcan.org/event/Japan2014>

September 9–11, 2014
Extended Forensic Interviewing Training
National Children's Advocacy Center
Salt Lake City, UT
256.533.5437
<http://www.nationalcac.org/ncac-training/efi-training.html>

April 12–15, 2015
9th Congress
“New Directions in Child Protection and Well-being: Making a Real Difference to Children's Lives”
British Association for the Study and Prevention of Child Abuse and Neglect
University of Edinburgh
Scotland, UK
+44 (0).1904.613605
baspcan@baspcan.org.uk
<http://www.baspcan.org.uk/congress2015.php>

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