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SERVICE PROVIDER PERSPECTIVES ON FAMILY VIOLENCE INTERVENTIONS

PROCEEDINGS OF A WORKSHOP

159106

National Research Council

Institute of Medicine

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ACQUISITIONS

SERVICE PROVIDER PERSPECTIVES ON FAMILY VIOLENCE INTERVENTIONS

PROCEEDINGS OF A WORKSHOP

Committee on the Assessment of Family Violence Interventions

Board on Children and Families

Commission on Behavioral and Social Sciences and Education
National Research Council

Institute of Medicine

NATIONAL ACADEMY PRESS
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Introduction

On February 27, 1995, the Committee on the Assessment of Family Violence Interventions convened a workshop in Washington, D.C., for service providers and researchers who are involved in programs designed to treat, control, and prevent different forms of family violence. The workshop was organized to gather perspectives from practitioners as part of the committee's fact-finding process in conducting a comprehensive study on what is known about the effectiveness of treatment and prevention programs for family violence. It consisted of five panels of speakers, and the agenda was designed to inform the further work of the committee by highlighting the experiences and perspectives of service providers who focus on different aspects of family violence interventions. The five panels were child victim services, spousal victim services, elderly and dependent adult victim services, treatment of offenders, and comprehensive services.

This proceedings of the workshop includes the speakers' presentations and highlights from the discussions that followed each panel of speakers. The presentations reflect the different orientations of service providers who are based in health, social service, and law enforcement settings. Although most of the intervention programs described in this report have not been subject to research evaluations, the committee decided it would be useful to publish the material because it includes both program descriptions and perspectives that describe the evolution of different forms of family violence interventions. The proceedings has been prepared for the benefit of the committee members, workshop participants, project sponsors, and others who are concerned with the direction and quality of services and programs in the area of child maltreatment, spousal violence, treatment of batterers, and elder abuse.

The workshop participants acknowledged the important role that practitioners have played in fostering the development of family violence interventions. In response to recognition of the severity and scope of family violence, legal, health, and social service institutions have established programs for victims, perpetrators, or troubled families. Community-based services, such as battered women's shelter programs, have also been developed by former victims of spousal abuse and grassroots activists. These reforms have not been studied in a systematic manner, however, and information about the implementation and the effectiveness of selected approaches is often difficult to compile. Much of the information regarding the programs that were discussed in the

workshop does not appear in the research literature, and it is often regarded as "fugitive" material.

Evaluating any ongoing social service intervention is methodologically difficult, and this is especially so in the area of family violence, which is characterized by confusion and disagreement about the nature of the problems to be addressed, the outcomes that are desired from intervention programs, and the behaviors that should be studied to assess program effectiveness. This lack of consensus in the field has created barriers for researchers who seek to evaluate selected programs since the basic strategies and processes of the service intervention are often not described in a systematic manner.

The purpose of this workshop was to illustrate the variation in the design of family violence interventions by focusing on a small selection of popular programs as well as novel or promising new approaches to intervention. The intervention programs were suggested from a variety of sources, including government sponsors, committee members, research scientists, advocates of selected approaches, and popular and scientific literature. It is important to recognize that the programs that are presented in this volume are not intended to represent a comprehensive review of all types of interventions, nor do they necessarily represent interventions that are exemplars of best practices in program design, evaluation, or outcomes. Any workshop can cover only a part of the field of family violence; some of the important programs or services that are not included in this proceedings are the child protective service system, foster care or residential programs, mediation efforts, and law enforcement agencies.

The mix of programs included in this report illustrates the challenges presented to program sponsors, public officials, researchers, and others who wish to know more about program effectiveness in the field of family violence interventions. Some programs explicitly articulate their conceptual framework and program strategies. Others do not. Some programs are guided by research and evaluation studies. Others rely essentially on anecdotal reports as indicators of effectiveness. The goals and objectives of the programs also vary in their focus on victims, offenders, or service providers as the primary clients. They also differ in their selection of direct or indirect measures of behavioral change as a means of determining program success. Some program advocates also make uncritical claims of "success" for their own or others' efforts without the support of empirical evidence that can demonstrate relative effectiveness in comparison with alternative programs.

This workshop was part of a larger study by the Committee on the Assessment of Family Violence Interventions, which was established within the National Research Council (NRC) and the Institute of Medicine (IOM) to examine what has been learned from experiences with these programs at the national, state, and local levels. The committee was formed at the request of the U.S. Department of Health and Human Services (Administration for Children and Families, Centers for Disease Control and Prevention, Maternal and Child Health Bureau, National Institute of Mental Health, and Substance Abuse and Mental Health Services Administration), the U.S. Department of Justice (National Institute of Justice), and the Carnegie Corporation of New York in

order to develop an assessment of programs that address different aspects of family violence, including child abuse, domestic or intimate violence, and elder abuse. The Committee on the Assessment of Family Violence Interventions, part of the Board on Children and Families within the NRC and IOM, initiated this study in August 1994.

As part of the study, the committee is also conducting a review of the scientific literature that has evolved in the evaluation of such programs. Earlier NRC studies on violence research, such as *Understanding and Preventing Violence* (Volumes 1-4) (Reiss and Roth, 1993, 1994a,b; Reiss et al., 1994) and *Understanding Child Abuse and Neglect* (National Research Council, 1993) have provided an important review of major research studies in this field. In distinguishing family violence from other forms of assault and violent behavior, for example, the NRC Panel on the Understanding and Control of Violent Behavior observed that because of the continuing relationships among spouses or partners, parents and children, or siblings, violent encounters in family settings can create situations in which victims will be violated repeatedly by the offender. The more powerful offender may threaten the victims with additional violence if the incidents of violence are disclosed to others. Adult victims may avoid disclosure because of fear of stigmatization or denigration, or because of financial, emotional, or physical dependence on the abuser. Child or elderly victims may be too young or vulnerable to disclose their own experiences. The complexity and circuitous nature of family violence, as well as the private settings in which incidents may occur, also decrease the likelihood that such incidents will be observed or reported to others. As a result, interventions in the field of family violence have been difficult to design, implement, and evaluate.

In addition to a literature review, the Committee on the Assessment of Family Violence Interventions is concerned with the perspectives and experiences of individuals who have been directly involved in the development of service and prevention programs. These perspectives are seen as an important complement to the research review because they highlight the strategies, conceptual frameworks, assumptions, and outcome measures that guide the design and implementation of program efforts. Perspectives from the field can reveal areas where research has informed general practice, areas where research is not available to inform practice, and tensions or conflicts that may exist in the field because of competing or contradictory values or conceptual frameworks.

The perspectives of individuals involved in the design or operation of programs can also help enrich research in this area in several ways. They can generate new hypotheses about the nature and origins of family violence, reveal the strengths or limitations of traditional scientific measures, or suggest ways in which general service or policy strategies can be derived from small-scale experiments and demonstration projects. In these proceedings, the committee does not attempt to draw these inferences, but they will be examined in the final report, scheduled for publication in late 1996.

Many workshop participants did not demonstrate a strong orientation toward research and, in some cases, they revealed deeply held ideological or value premises rather than theories that could be tested by empirical studies. The workshop discussion

also suggested that providers often lack the resources to collect and analyze important information on the setting, the goals, the target audiences, and the strategies embedded in the programs they have developed. In publishing these summaries, the committee hopes to stimulate further reflection about the gaps that exist between research and practice in many areas of intervention. Such reflection can provoke an examination of how scientific knowledge may, or may not, guide the development of treatment and prevention programs for family violence. It can also help inform ongoing research efforts by revealing experiences with different types of interventions that appear to challenge prior assumptions or theoretical frameworks and suggest the need to consider new types of interactions in understanding the methods that can discourage or stop family violence.

In presenting the summary of this workshop, the committee does not endorse the views, conclusions, or recommendations proposed by individual workshop speakers. The absence of rigorous evaluation studies that support the interventions discussed in this report emphasizes the need to be cautious in reviewing the claims of the providers. It is important to recognize, however, that a broad range of on-going service interventions are already in place that seek to respond to the urgency of the problem of family violence. The providers who seek to treat or prevent child abuse, domestic violence, and elder abuse cannot wait for definitive evaluations before developing program initiatives. The experiences and insights of the providers, therefore, provide valuable opportunities to gain new insights on topics for which science can help inform the intervention process, as well as opportunities for scientists to learn from the experience of victims and service providers.

The committee will present its findings and recommendations in its final report. Contact information is provided for each workshop participant in the Appendix; more information about any program mentioned in this report should be requested directly from the program representative.

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Child Victim Services

Child victims of family violence include children from infants to adolescents who have experienced physical or sexual abuse or neglect. Child victims can also include children who have witnessed violence directed toward other family members, such as spousal violence. The interventions available for child victims occur in many different institutional settings, such as the courts, hospitals, social services agencies, schools, communities, and the home. They include medical diagnostic and treatment programs, therapeutic counseling programs, child protective services, foster care, residential centers, child witness support programs in judicial settings, and other efforts designed to mitigate the consequences of maltreatment.[1] Other programs, such as family preservation services, are crisis intervention efforts designed to provide intensive support services to families of children who are at risk of external placement in foster care or other form of external care.

A broad range of prevention programs for child abuse has been initiated in the past few decades. These programs include primary, secondary, and tertiary preventive interventions, and they occur in a wide variety of institutional settings as well. Many prevention programs are designed to mitigate risk factors commonly associated with parents who abuse or neglect their children, and the interventions often focus on factors such as harsh forms of corporal punishment, social isolation, substance abuse, and environmental deprivation. Some programs stress the importance of instilling in new parents the ability to understand and respond to an infant or child's developmental needs through family support or home visitation services.

The workshop participants noted that prevention and treatment services present important differences and reveal difficult challenges in dealing with the needs of child victims. Various forms of interventions have been developed in legal, health, and social service settings that focus on particular family, parent, or child needs, but service providers often have limited authority or resources to determine which types or combinations of programs can be provided for selected clients. For example, in the case of home visitation, the family decides which services they want to receive, and the home visitor works with the family in identifying and drawing on resources to focus on the issues they want to address. The home visitor cannot require the family to deal with a substance abuse problem if the family is not ready to address it. However, if the consistent use of alcohol or drugs places a child at risk of abuse, the family can be referred to protective services, which can mandate other forms of service intervention.

The presentations in this section provide a basis for examining the strengths and limitations of programs designed to assist child victims of physical and sexual abuse, as well as programs designed to prevent the occurrence of child maltreatment.

NOTE

[1]For additional information on the research associated with such intervention programs, see National Research Council (1993) *Understanding Child Abuse and Neglect*. Washington, D.C.: National Academy Press.

PROSECUTION OF CHILD ABUSE: THE DENVER EXPERIENCE

Karen S. Steinhauser

Specialization has been a key characteristic of the Denver program. The District Attorney's office has a special prosecution unit staffed by six district attorneys who work only with domestic violence cases and a police unit dedicated to child abuse cases. Victim advocates trained in interviewing children and in investigating child abuse are members of both units. Their sole responsibility is to take care of the children and their families from the time cases are reported until the cases are closed.

The Denver Department of Social Services maintains a 24-hour hotline for receiving all reports of abuse and neglect. Reports of abuse and neglect initiated by Denver Public School employees are referred to the Child Abuse Hotline, as are reports of alleged child sexual abuse received by the Denver Police Department or reports of child sexual abuse received by any personnel in a health care setting or physician's office.

Colorado has enacted laws that make prosecution easier; for example, evidentiary standards have been revised through child hearsay laws to enable prosecutors to use statements children have made to others. Through a constitutional amendment for victims' rights, victims are kept better informed about the status of their case.

The state has also established a Child Fatality Review Committee, comprised of representatives from the Department of Health, the Department of Social Services, the District Attorney's office, police departments, and citizens' organizations. The committee reviews reports of death of all children in the state in order to identify factors or patterns that may contribute to these deaths. The goals of the Child Fatality Review program are (1) to describe trends and patterns of child deaths in Colorado; (2) to identify and investigate the prevalence of risk factors in the population of deceased children; (3) to evaluate service and system responses to children and families who are considered to be at high risk and to offer recommendations for improvements in those services; (4) to characterize high-risk groups in terms that are compatible with the development of public policy; and (5) to improve sources of data by reviewing autopsies, death investigations, and death certificates.

One of the major challenges faced by prosecutors is the lack of resources for treatment or prevention services. Prosecutors may know of children who are indirect victims of violence, especially those who continually witness violence, but the prosecutors cannot intervene unless the children are victims of abuse themselves. Treatment for offenders is not always available, and there is a need for an income-

adjusted fee scale to improve access to services. About 80 percent of the sexual abuse perpetrators are indigent and are unable to pay for treatment services that might be recommended for them. Furthermore, differences exist within the service community over what programs constitute effective treatment.

Definitions of abuse are extremely important in setting the parameters for legal intervention. Colorado statutes include bruising a child as abuse, but the state does not prosecute every time a child is bruised. Similarly, Colorado law also states that appropriate physical discipline is not abuse; however, this can lead to conflicts over what behavior constitutes appropriate physical discipline. Some states, including Colorado, have statutes that hold those individuals who allow a child to be abused to be guilty of abuse themselves, which establishes authority for prosecution of mothers who do not defend their children. Unfortunately, some of these women are themselves victims of abuse by the same perpetrator who is abusing their child and who may intimidate the mother by threatening that she will lose her children and be prosecuted if she reports the spousal abuse.

Child sexual abuse is not only a serious child welfare problem, it is a crime that justifies prosecution by law enforcement and judicial agencies. Yet the prosecution of such crimes often is only a "band-aid" that seeks to deal with complex problems that have not been addressed by family support or treatment programs.

Vigorous prosecution of child sexual abuse cases involving family members sends a message that both perpetrators and children need to hear--violence in the home is a crime. In addition, assigning responsibility for child victimization can sometimes be the only way to stop criminal behavior.

In developing an emphasis on the prosecution of child sexual abuse cases, the Denver District Attorney's office became concerned that experiences with the criminal justice system can sometimes victimize the children that it was trying to help. Lack of coordination and turf battles among agencies and professionals, such as social workers, police officers, therapists, and district attorneys, can harm the children who are caught in the middle.

The city of Denver attempted to remedy this situation in the early 1980s by integrating services for child sex abuse victims into a separate specialized system. An interagency protocol for child-sex-assault victims was developed to establish a set of common goals and to facilitate procedures of participating organizations. Interagency cooperation efforts have been developed at many different points of the child sexual abuse identification, treatment, and prosecution process, including the initial point of contact, child interviews, and professional training programs.

One result of the service integration effort has been in the child interview process. In the past, numerous, disjointed interviews (where children were interviewed on as many as 14 different occasions) were replaced by a common interview process where all agencies are able to question child at the same time. Literature has been developed to explain to children what will happen in court. Child victims also have an opportunity to tour the courtroom in order to see where the trial will occur and where they will sit.

HEALTHY FAMILIES AMERICA

Leslie Mitchel Bond

Healthy Families America (HFA) was established in 1992 by the National Committee for the Prevention of Child Abuse (NCPCA) in partnership with Ronald McDonald Children's Charities and in collaboration with the Hawaii Family Stress Center. The goal of the initiative is to create a nationwide, voluntary, home visitor program for all new parents, particularly those at high risk for child maltreatment and other poor childhood outcomes. Healthy Families America is based on two decades of research and the experiences of the Hawaii Healthy Start program in putting the research into practice.

Through home visits, Healthy Families America attempts to increase parents' knowledge about child development, improve parenting skills, strengthen parent-child relationships, expand use of formal and informal social support, and reduce social isolation. The program goal is to empower families and to build on their strengths. Data show that such visits can lower child abuse reports and decrease accidents, hospital emergency room visits, physical punishment, and increase the spacing between children (Seitz et al., 1985; Lutzker and Rice, 1987; Olds and Henderson, 1990; Breakey and Pratt, 1991). HFA staff estimate that for every $3 spent in prevention, at least $6 is saved in child welfare services, special education, medical care, foster care, and counseling and housing juvenile offenders (Healthy Families America, 1994).

In the creation of HFA, NCPCA has established a process to help states mobilize planning teams or task forces focused on the development of home visitation programs. HFA staff provide these groups with on-site technical assistance and have also developed a variety of supportive materials for use by state planning teams. Almost all of the states have a planning team in place, and half of the states now provide intensive home visitor services to new parents according to the HFA approach.

NCPCA has focused particular attention on the need to institutionalize long-term funding streams for HFA-type efforts. The 1994 Omnibus Budget Reconciliation Bill included a new Family Preservation and Support Services Program that provides federal funds for state child welfare agencies to develop preventive family support services and family preservation services for families in crisis. The 1994 appropriation for this program is $60 million, with estimates of growth to over $900 million by 1998. The legislation requires states to engage in an innovative and broadly inclusive planning process to assess and enhance state and local service capacity. As of May 1995, 12 states have passed legislation that encourages the availability of home visiting services

for families with newborns. In Oregon, for example, $3.3 million was appropriated for a two-year period to create a statewide task force on home visitation and to establish four community-based programs.

To assure quality, all HFA programs adhere to a set of critical elements or best-practice standards as defined by research. The services of Healthy Families America are voluntary. The program uses standardized assessment tools to identify families and communities that are most in need. Culturally comprehensive services that focus on supporting parents and enhancing parent-child interaction and child development are offered to parents before or immediately after their child is born. Services are intense; they are offered at least once a week at first and extend for three to five years. Services also involve linkages to a medical provider to ensure timely immunizations and well child care, as well as financial, food, and housing assistance.

Service providers are selected because of their personal characteristics and the willingness, education, and experience that qualify them to work with at-risk families in culturally diverse communities. Providers have limited caseloads and are trained to understand their role and the principles of home visitation. They receive ongoing supervision.

Beyond adherence to these central elements, the HFA initiative emphasizes the importance of a community-based approach to service delivery. There is no standard curriculum because each community tailors the program to its own needs. Healthy Families America is designed to build on and integrate with other family support services. To that end, HFA programs and state planning teams are collaborating with other family support programs or advocates in their states. Among the many HFA partners are the American Academy of Pediatrics, the Cooperative Extension System, the National Head Start Association, and HIPPY (Home Instruction Program for Preschool Youngsters).

HFA is fostering the importance of self-evaluation in the design of its program, and is in the process of developing a self-assessment strategy to aid sites in ongoing quality management. A research network has also been established to improve the comparability of different programs in general evaluation efforts. The program materials stress that a comprehensive evaluation component needs to be part of any HFA effort in order to learn how best HFA works in a diversity of communities with different economic, sociocultural, and political climates. HFA has developed a set of guidelines to assist in the evaluation of program initiatives which stress that the establishment of a control or comparison group should be of paramount importance in the design of an assessment strategy. The guidelines are as follows:

(1) The evaluation needs to provide for a formal control or comparison group.

(2) The evaluation should include a range of outcome measures.

(3) If possible, multiple methods of data collection should be utilized to obtain information on all critical outcome measures.

(4) The evaluation should not measure outcomes solely in terms of subsequent reports of maltreatment.

(5) The evaluation should include, where possible, standardized measures of outcomes.

(6) Ideally, the evaluation data collection system should be fully integrated into a program's ongoing client information system.

(7) Following an initial assessment of client functioning, subsequent assessment should be conducted on clients in both the treatment and comparison groups every three months for the first year and every six months thereafter until evaluation concludes or the family terminates services.

(8) If possible, post-program interviews or observations should be obtained on at least a sample of program recipients.

(9) Efforts should be made to have at least one post-program contact with all families who drop out of services.

(10) Evaluations should document the process undertaken to establish home visiting services.

The HFA national program office provides detailed evaluation information for its member sites, including description of standardized measures, sample forms that can be used to monitor client progress and service delivery, as well as information regarding the national HFA research network and database.

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CHILD PROTECTIVE SERVICES RESPONSES TO CHILD MALTREATMENT

Joyce Thomas

In the wake of growing concerns about the safety and well-being of children, it is extremely important to improve the quality of and outcomes for children who are known to the child protective services (CPS) system. The incidence, severity, and magnitude of the problems encountered by these children and their families are pervasive and represent one of the most challenging and critical social and public health problems that exist today.

In 1992, the states received nearly 1.9 million reports on child abuse and neglect that involve approximately 2.9 million children. According to data provided by the National Child Abuse and Neglect Data System, only 39 percent of these cases were substantiated, which means about 58 percent were not substantiated (National Child Abuse and Neglect Data System, 1993). In this same year, approximately 1,068 children died as a result of abuse by their parent or caretaker. Of these children, about 49 percent were under 1 year of age, and another 25 percent were between 3 and 5 years old (National Committee for the Prevention of Child Abuse, 1994).

The stresses inherent in child protective services are present because the system was not designed to perform many of the services it currently is asked to provide. The CPS system was originally designed to investigate and identify problems that could be referred to other service programs. However, CPS agencies are now called on to provide treatment services, preventive interventions, and other functions that have been simply patched on to the agencies' basic structure and for which they never have been properly funded. The combination of large caseloads, limited resources, lack of a clear mission, and unsupported administrators has resulted in unreasonably stressful situations which affect the service providers as well as the children and families that this system seeks to help.

But determining the best interests of a child can be a tremendous challenge to child protective service workers, compelling them to address various underlying issues, including social and economic patterns, and religious and cultural issues.

More than half of the children that come to the attention of protective services workers live in poverty and deprivation. The neglect of children from low-income families, regardless of their ethnic background, continues to represent the most serious and constant problem overwhelming child protective services agencies. Of the substantiated cases reported in 1992, 49 percent involved neglect, 23 percent were

physical abuse, and 14 percent were classified as sexual abuse (National Child Abuse and Neglect Data System, 1994).

Many abused and neglected children are eventually placed in the foster care system, including foster family homes, group homes, and emergency shelters. Many others are located in juvenile justice system and mental health facilities. Many children are returned home, with the expectation that community services are available, and that the public CPS or child welfare agencies will provide adequate supervision and monitoring for the protection of these children. Children who are not reunited with their families within a reasonable amount of time often become permanently emotionally damaged by the separation from siblings, schools, and "their" communities. Thousands move from foster placement to foster placement and are denied the opportunities to grow up in a consistent, caring home environment (Williams, 1989; National Commission on Children, 1991).

In most counties across the United States, a single CPS agency located within the local Department of Social Services (or welfare department) has countywide jurisdiction for investigating reports of children at risk for abuse or neglect. With over 3,000 counties in this country, the quality of CPS programs will vary (*Virginia Child Protection Newsletter*, 1993). Many of these agencies experience common problems, however, such as insufficient staff overburdened with excessive caseloads, the pressures associated with investigation, decision making, case management, and serving complex family situations (Williams, 1989). In recent years, public agencies that must respond to reports of child abuse and neglect have faced increasing demands for services, inadequate budgets, criticism about the quality of services, and the tragedies of child fatalities (Krane et al., 1991). Other problems within CPS agencies include workers with no background in human services; inadequately trained staff; resistance from families; undue emphasis on the investigation focus; dealing with "turf" issues with courts, law enforcement, and other public agencies; limited practice capabilities; decreased services for families; fear of liabilities; extensive bureaucratic barriers; confidentiality issues; poor outcome measures; inadequate technology; lack of accountability; and a negative community perception of their role (American Civil Liberties Union, 1990).

Caseworkers often respond to these overwhelming conditions by being openly hostile to their clients and distrustful of the families they serve, rigid in their clinical perceptions, frustrated by the lack of change within the family, angry by the reactions of the public, fatigued by the layers of the bureaucracy and paperwork, and insensitive to the needs of families.

Burn-out and high turnover rates are also common problems. To maintain maximum control and to ensure that resistant parents follow up on directions of the caseworker, "mandated" services are frequently ordered by the court system following a CPS recommendation. Workers are under constant pressure to emphasize "the best interest of the child" and to make sure that the children are in a safe home environment. This has led to an overuse of out-of-home placement of "vulnerable" children. In response to this trend, caseworkers are now advised to rely on a "least restrictive alternative" principle, which emphasizes the desire to allow the child to

remain in the home with the family if the abusive parents can be helped through treatment or program intervention (U.S. Department of Health and Human Services, 1988). Such intervention requires careful monitoring, however.

The CPS agencies also experience universal problems in leadership. Even highly motivated supervisors privately speak of the anxiety they experience because they cannot rely on the caseworkers they supervise. One supervisor, for example, has reported that she made a follow-up visit to a family only to find that their caseworker had not made the visits that had been recorded in the family's case file. An additional problem is the need for greater representation of people of color in the supervisory and senior administrative positions in child welfare and CPS agencies. This issue is being directly addressed by the People of Color Leadership Institute in Washington, D.C., which is supported by the National Center on Child Abuse and Neglect.

People of color, predominantly those in urban communities, are often trapped by poverty, poor housing, unemployment, inadequate parent support, limited educational opportunities, chemical addiction, and health and mental health problems. The collapse of inner-city communities has been accelerated by the success of middle-class blacks, who for the past several decades have left the inner cities and created a vacuum of positive role models for children (Billingsley, 1991).

Public distrust and lack of confidence in the CPS system has resulted in a series of lawsuits filed by the American Civil Liberties Union in the District of Columbia, New York, Connecticut, Kansas, Pennsylvania, Louisiana, New Mexico, Missouri, and Virginia in an attempt to hold the public systems more accountable for the protection of children (American Civil Liberties Union, 1990).

Another sign of shifting public sentiments with regard to the role of CPS to protect children is the emphasis on "permanency planning" and the preservation of the family that formed the core of P.L. 96-272, The Adoption Assistance and Child Welfare Act, adopted in 1980. The intent of this legislation was to provide increased federal funds to support child abuse prevention efforts while also restricting increases in funds for out-of-home placements. Wood et al. (1988) examined the cost for out-of-home placement versus the cost for services in the home. They determined that the cost per child for placement was $3,583, versus $823 for in-home services. The cost of placement for a family of three children was $7,334, as compared to $1,913 for in-home services for the same family. In 1990, the House Select Committee on Children, Youth and Families projected that by 1995, there would be close to 850,000 children in out-of-home placement.

The emphasis on cost containment, family unification, and permanency planning has led to a search for new strategies and new models of service delivery. In an attempt to improve the quality of case manager decisions for abused and neglected children, new tools such as the risk assessment instrument have emerged in CPS systems. These tools are used by CPS caseworkers to distinguish "high-risk" or "imminent harm" cases from "low-risk" cases in order to prioritize services for children and families. These instruments are often poorly suited to cases of child neglect, however, which may not present crisis situations but exercises a cumulative effect if the neglectful environment is chronic.

Many CPS agencies offer family preservation services through contractual or specialized units. The intent of family preservation services is to intervene with the family to reduce the crisis that led to a potential decision to remove the child from the home and to teach the family basic skills that will promote family strengths and parenting skills. In most cases, these programs have adopted the Homebuilders model, which has specific selection criteria.

Concerns have developed, however, that CPS agencies often lack the resources to follow up family preservation services programs with effective family support services. Many professionals believe that family support services are necessary for both new (not yet reported) at-risk or early problem families as well as families who have received family preservation services assistance but require less frequent monitoring. The new emphasis on family-focused, community-based services has emerged as a major priority, but this approach too is not a panacea.

Parents, community agencies, and other organizations must have some opportunity to gain more power and control over their lives. But children cannot be left unprotected within communities that lack resources to support their families. One area that requires new attention is the development of a capacity to determine when additional expertise is needed to go beyond the tradition of neighbors helping neighbors and focus on how *neighborhoods* can be established that support interactive family relationships within a community.

Given the overwhelming nature of the problems confronting the CPS system, cost factors, and the trauma of maltreatment to children and families, new emphasis must be placed on prevention and early intervention strategies. Several promising service delivery models have been developed to help strengthen the family; these models vary in their focus on the parent or other caretakers, the at-risk children, or an entire household. Such models include home visitation programs, self-esteem building efforts, nurturing and support groups, drop-in services, intensive monitoring of behavior, parent education/training, violence prevention, respite services, crisis intervention, school-based programs, career assistance, and combinations of individual programs (Ayoub, 1995). Some research studies have documented that strategies for strengthening families and preventing child abuse and neglect can be effective under certain conditions (Kumpfer, 1993), but the knowledge base in this field is still limited.

Other approaches use a combination of educational strategies such as parent courses, public information campaigns, counseling, classroom education on specific topics, peer education and mentoring, and crisis intervention. Some research on these approaches suggests that programs that are persuasive rather than coercive, or mandated, appear to be more effective (Northrop and Hamrick, 1990).

In considering the merits of community-based approaches, we need to recognize that many communities lack the skilled resources that are necessary to support families at risk for violence or neglect. Public and private agencies need to consider how to prepare communities to assume the responsibility and acquire the resources for family support efforts, especially during periods of extreme duress or chronic difficulty. This is an area that is particularly in need of research attention at this time.

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A CRITIQUE OF CHILD WELFARE AND CHILD PROTECTIVE SERVICE SYSTEM INTERVENTIONS

Roger Friedman

The irony about intervention services is that many systems designed to resolve issues can actually exacerbate the problems they were created to remedy. Despite the work of exceptional caseworkers, the child welfare service system sometimes seems to create as many problems as it resolves, especially when dealing with low-income, minority families. Strengthening and preserving families is the goal of the child welfare system, and the Child Abuse Prevention and Treatment Act (CAPTA) was designed to establish a federal program that would provide support for families that experience child maltreatment. But with the implementation of CAPTA over the last 21 years, the most common services provided by the child protective and child welfare systems have been case investigations and foster care. Foster care was intended to be a respite and a security measure for children when families experienced crisis. In becoming the major form of intervention, however, it has become social policy by default. Involvement with the child welfare system has often led to fragmentation and divisiveness within families. As a result, other programs have been initiated in more recent years to support family unity and cohesiveness.

One such family support group is modeled on the 12-Step movement, which has been adapted from self-help programs first begun by Alcoholics Anonymous. The passage of the 1993 Family Preservation and Family Support Act now strongly encourages child welfare agencies to revamp services to accomplish the goal of building on family strengths in order to keep families together and avoid child placement in foster care or residential centers. The service system is being challenged to integrate formal and informal helping resources and to establish a continuity of service in a variety of programs in order to meet family needs. Severe measures, such as the removal of a child from a home, are required in only a small minority of cases. The large majority of child welfare cases involve working with a family and a community that experience combinations of problems and risk factors, such as poverty, substance abuse, and a culture of violence, that may endanger children but are beyond the control of individual family members.

DISCUSSION HIGHLIGHTS

Conflicts between the goals of protecting children and preserving and supporting families can create significant tensions between caseworkers, administrators, family support advocates, and child welfare officials. The issues of risk, safety, child protection, child welfare, parental rights, and family preservation pervade a broad spectrum of political and social debates associated with enhancing child and family well-being. The monetary costs of protecting children and supporting families have also emerged as a major area of social concern, stimulating a search for new forms of collaboration between public and private agencies to strengthen family services within communities and also reduce expenses of government programs.

Many service providers lack basic information about the nature of the target population and the type of clients and families that are served by child or family service programs. More elaboration of the special needs of children and families who come to the attention of child protective or welfare services would clarify issues that require attention in the implementation of services. Programs would also benefit from richer descriptions and analysis regarding the nature of the services that are provided, the different components of complex service systems, and the problems that arise in seeking to coordinate services among social service, health, and legal institutions.

The participation of key community leaders and institutions in setting standards and expectations regarding family behavior toward children was acknowledged by workshop participants as an important issue that is often overlooked by public and private agencies concerned with child protection and child welfare. Religious leaders, for example, can be important allies in identifying the values that a community wishes to uphold in protecting its children.

The development of national, state, and local systems to investigate reports of child abuse and neglect has created some dangers and potential biases in defining which factors put families at risk of child maltreatment. In some cases (such as the inclusion of unrelated adults in the family household), the child welfare system may judge harshly some family behaviors that are part of the daily lives of many highly functional families of diverse backgrounds. Risk assessment instruments can be valuable tools to reduce arbitrary judgments by caseworkers, but such assessments need to be highly focused and to concentrate on behaviors that are destructive to the child.

Participants stressed the importance of cultural competence in program design in order to address diverse cultural norms and beliefs within the client population because

the lack of cultural sensitivity may adversely affect the success of an intervention program. In this discussion, participants noted that while no direct measures of the attainment of cultural competence currently exist, it involves more than translating materials into another language--materials should be meaningful to and reflect the values of the community. Discussing cultural competence often invokes broad and deeply held views and practices (especially in areas such as corporal punishment). Such discussions demand that all parties value the views and customs of others in seeking to curb practices that may harm children.

Since many communities disagree about what types of behaviors constitute abuse, participants noted that cultural competence affects perceptions and definitions of *violence* as well as *risk*. Outside professionals can support and facilitate the process of defining selected terms, but community representatives play an important role in providing insights into the significance of selected values, beliefs, and attitudes. Thus, everyday decisions, such as whether children need to have regular bedtimes or whether entertaining a houseful of guests at a late hour as a common practice is appropriate, raise basic questions about the standards that should govern a family's behavior. In many cases, practices that constitute abusive punishment or ineffective parenting are associated with young single parents who have limited education and who experience economic deprivation. Community representatives, in collaboration with service providers, can help identify practices that are harmful to children and identify how child discipline or child welfare can be improved for those who are powerless to escape their social condition. However, community representatives can also discourage service interventions when they spuriously attribute harmful practices to "culture" as part of ideological support for those do not have regular access to resources and services that can improve their family functioning.

Spousal Victim Services

In a background paper prepared for the NRC Panel on Understanding the Control of Violent Behavior, Fagan and Browne (1994) observe that research on marital violence has spanned nearly three decades. Although the Pilgrims had adopted laws that prohibited beating female spouses and violence against husbands, and social reform measures were adopted in the latter half of the nineteenth century to stop wife beating and other forms of family violence, it was not until the late 1970s that feminist activists and clinical researchers created a concerted national effort to document and publicize this issue and engage legal, social, and health institutions in developing a broad range of intervention and prevention services.

Schechter (1982) observes that women who were victims of spouse assault presented themselves to feminist grassroots organizations via rape hotlines as well as victim assistance agencies or rape crisis centers. The response of the grassroots organizations identified a wide range of services that were needed to address this problem, including shelters, transportation, counseling, legal assistance, and child care. They also played a key role in discovering the limitations of existing legal remedies to sanction offenders or offer protection to victims. Feminist organizations mobilized through state and national political organizations to eliminate requirements for divorce filing, to obtain an order of protection, and to simplify the prosecution of marital rape. The influence of these grassroots efforts resulted in a campaign that identified spousal violence as a multifaceted public policy issue whose solutions spanned the organizational boundaries of specific social or legal institutions.

The range of programs directed toward adults who experience violence in intimate relationships, regardless of the marital status of the victim and offender, include battered women's shelter and hotline services, restraining and protection orders issued by the courts, and victim advocacy programs.

In this section, the presenters describe different approaches to the complex dilemmas of protecting and empowering victims of spousal violence and address the more fundamental cultural norms that may influence the behavior of the victimizer.

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DOMESTIC VIOLENCE TRAINING PROJECT

Anne H. Flitcraft

In the physical sciences, an important principle has emerged that is called "The Heisenberg Principle," named after the German physicist Werner Heisenberg. This principle states that the more one tries to measure the characteristics of physical nature, especially at the subatomic stage, the greater impact the scientist will have on the phenomenon to be studied. In applying this principle to the social sciences, the same assumptions may hold true. When we as scientists try to observe the basic elements that contribute to the effectiveness or success of a domestic violence intervention program, the intrusion of our measurement instruments, may in fact be altering the nature of that program.

The Domestic Violence Training Project, based in New Haven, Connecticut, uses domestic violence to bring the study of the whole person back to medicine. The project addresses domestic violence using the framework of the public health model, offering programs in primary, secondary, and tertiary prevention.

Primary prevention programs involve basic education. Training programs introduce health care providers to the issue of domestic violence and provide a means for them to discuss domestic violence with the women they examine in contexts such as prenatal programs, nutritional seminars, and diabetes classes.

In the secondary prevention, or early intervention, programs, project staff help hospital emergency personnel to identify victims of domestic violence, provide for the victim's immediate safety, and refer the victim to community resources. The core issues in secondary prevention involve defining what a health care provider's response to domestic violence should be. Project staff believe that emergency room staff should be able to identify victims of domestic violence, comprehensively assess their safety, and, if the clients and their children are not safe, implement a crisis intervention with appropriate multidisciplinary teams. The hope is that the comprehensive safety assessment will become integrated into every physician's basic training program and that this skill will be updated regularly, much like basic cardiopulmonary resuscitation.

Tertiary prevention involves complex case management. The training project's approach stems from the belief that effective responses to the problems that accompany domestic violence are beyond the capability of any single agency. Women who are battered and addicted to alcohol, for example, need both an alcohol treatment program and an intervention against domestic violence. The Domestic Violence Training Project is therefore working to build bridges between health services and treatment for

overlapping problems, such as addictions, high-risk pregnancies, HIV/AIDS, and mental health disorders.

Measurements of effectiveness for these training programs are difficult to achieve. Anecdotal reports suggest that the medical faculty and students are increasingly receptive to the inclusion of domestic violence training components in the educational process of both young and senior physicians and other health personnel. Evaluation studies have not yet been prepared, however, to gauge which forms of education or training are particularly effective in this field.

TRANSFORMING COMMUNITIES

Donna Garske

In 1992, Marin Abused Women's Services of Marin County, California, launched a new program called Transforming Communities (TC): Creating Safety and Justice for Women and Girls. The TC program has now developed four projects in varying stages of development, implementation, and testing.

The assumptions that guide the TC program reflect a gender-based analysis that is distinct from the more prevalent gender-neutral analysis of family or domestic violence. The latter views the family, not society, as the key unit of analysis and believes that any member of the family can be violent or be victimized. The gender-specific approach is derived from the violence against women perspective, which assumes that violence is predominantly initiated by male partners and that all forms of male violence against women, both inside and outside the family, are connected.

TC projects also reflect a belief that the effort to identify reliable risk factors has provided an inadequate basis for effective prevention efforts. Moreover, an approach that concentrates on individual factors will not be able to address underlying social issues or cultural beliefs that may condone or perpetuate male violence against women.

Transforming Communities takes a firm position that men's violence against women stems from a perception of superiority that entitles them to use authority over women, family members, and other perceived subordinates and to exert control over them through any means, including violence. The TC program has conducted survey research that suggests that men typically do not sanction male batterers, but rather excuse a man's abusive behavior by attributing it to circumstances beyond his control. If communities are to change, they will need to actively eliminate such belief systems and practices and replace them with beliefs that benefit everyone and promote the right of women and girls to safety, equality, and justice. Such a community effort will be similar to those for the prevention of substance abuse, HIV/AIDS, and drunk driving.

Transforming Communities works from the assumption that a critical mass is needed to achieve community change within a broader population. The programs are designed to build this movement through specific strategies such as the use of formal and informal sanctions that hold violent men responsible for their abuse, including emotional and verbal violence; building men's awareness of beliefs that support abusive and coercive behavior and holding them accountable for eliminating these beliefs; and helping men who have transformed their beliefs to encourage other men to do so as well.

The TC program is currently undertaking a 5-year campaign to test these assumptions in a project in Novato, California, a city of about 50,000 people. Novato was selected as a test community following a review that examined 10 Marin Country communities according to 33 selected variables, including size of the community, the degree of need for services, and indicators of citizen and community readiness for an intimate violence prevention project. Novato showed the second greatest need in this analysis, based on the number of domestic violence-related calls to law enforcement agencies. Its moderate size makes it typical of other U.S. communities, which will facilitate eventual replication of the project's strategies. Moderate size also enables a strong sense of a unified community, while still allowing for diversity in terms of ethnicity, age, distribution and levels of income, education, and experience.

The goal of the Novato project is to reduce the incidence of domestic violence against women and girls, to test the effectiveness of mobilizing community members to transform sociocultural norms that perpetuate domestic violence, and to test how effectively changing these norms contributes to changing behaviors. The project will be evaluated through a two-level approach that will combine the use of summary measures of outcomes with formative measures of open-systems processes. Survey measures will be used to determine community attitudes toward, understanding of, and willingness to intervene in domestic violence. A control community (San Rafael) has been selected as part of the evaluation for beginning and end measures.

The approach of Transforming Communities is seen as an alternative to the tendency in the United States to approach all problems from an individual, therapeutic approach. By concentrating on social rather than individual change, the program seeks to use the problem of men's violence against women as a catalyst for community and political action that would result in a socially just society for all.

WOMEN'S CENTER AND SHELTER OF GREATER PITTSBURGH

Martha Friday

Founded in the early 1970s, the Women's Center and Shelter of Greater Pittsburgh (WC&S) is almost 25 years old and was one of the first 6 domestic violence programs in the country. A large, urban program rooted in the assumption that battered women are experts on domestic violence and that the program's role is to help them develop and expand their choices, the program has grown beyond shelter services and now sponsors several programs that promote self-sufficiency. Part of the program's basic mission is to work with other agencies and to use the domestic violence experience as a catalyst for the integration of other services.

The WC&S was serving 1,179 women and children annually by 1987, excluding the hotline service, but they were turning away 1,200 others. Realizing that alternatives were needed to meet the practical limitations on shelter availability, the program staff decided to expand in new directions, to develop additional choices for services available to battered women, and to create efforts that go beyond basic shelter toward a self-sufficiency model.

A triage model was developed within the 24-hour hotline service, assigning women in the most immediate danger to shelter. Highest risk includes violence and physical injury, threats with or use of weapons, threats to kill her or suicide threats, break-ins, or statements from the victim like "this time he looks different. He is going to kill me." In 1994, WC&S sheltered 651 women and children for 11,400 nights of shelter.

Women in intermediate danger are assigned to nonresidential counseling. Moderate risk includes emotional, financial, verbal, and some physical abuse, such as blocking, shoving, or stealing keys. This program has grown from 6 women in 1988 to 675 women in 1994. When the shelter is full, women in our hospital-based program can be placed at the hospital for up to 60 nights of short-term shelter or in free motel and hotel rooms through a motel/hotel partnership program. Expenses for services are low: shelter costs $42 per night and counseling costs $33 per hour.

The options and choices developed by WC&S include direct services and efforts to meet housing, income, moving, medical, and legal needs. In 1994 the program served more than 7,000 women and provided telephone counseling to 13,500, but the turn-away rate remains very high (1,800 were turned away from shelter in 1993-1994.) Women can move from one category to another at any time as their circumstances change.

The majority of those served by the WC&S are white (62.3 percent). African-Americans constitute the largest minority group (30.42 percent), with much smaller percentages of Hispanic (5.2 percent), Asian American (1.02 percent), and Native American clients (0.31 percent). The greatest challenge in developing intervention efforts involves the effects of the use of crack cocaine by shelter residents. The program does offer preliminary drug and alcohol counseling on-site, as well as referrals to drug and alcohol treatment centers. The crack addiction, however, often impedes the use of these resources to achieve safe and violence-free homes. WC&S is now planning a new partnership in collaboration with local substance abuse programs to search for new solutions. The programs focused on drug and alcohol treatment have acknowledged that domestic violence affects large numbers of their clients, and they are interested in seeking effective solutions to these difficult issues.

After developing a nonresident counseling program, a separate legal advocacy department was created whose staff works directly with the justice system, serving 4,500 women in 1994 and representing an important alternative to shelter. WC&S established a fund to pay for legal costs that are not covered by Legal Aid, and a *Pro Bono* Mental Health Project has been developed that involves volunteer social workers, psychologists, and psychiatrists for at least one hour a week for a year. The mental health professionals provide long- and short-term counseling to children in six area shelters who have been affected by domestic violence. The goal of the counseling program is to help children cope with domestic violence by assisting them in understanding what is happening to them and to encourage mothers and children to talk together about the impact of domestic violence on their lives. Children thus have access to a private therapist model, which responds to the difficulties with obtaining access to local community health services.

The WC&S program, along with the Pennsylvania Coalition Against Domestic Violence, has developed activities beyond direct services to focus on systems advocacy and broaden the options available for battered women. The Coalition staff have provided leadership in shaping state legislation for Protection From Abuse orders, Protection From Abuse amendments, stalking laws, and other relevant laws. The judicial system has been reformed in Pittsburgh to create specialized courts for domestic violence cases and a domestic violence task force has been created to help coordinate the separate elements of the justice system. In the health area, the Coalition is introducing domestic violence information into standard medical school and police training programs.

WC&S has developed a prevention program for the schools which has curricula for grades 4-12, and a program is in development for younger children in kindergarten through grade 3. The fourth-grade program, Healthy Choices, has been publicized in other publications. As a result, WC&S now fills curriculum requests from other parts of the United States and other countries.

These prevention programs all have an element of crisis intervention in response to disclosures of domestic violence in the home or with the student. The conceptual framework for this program emphasizes that the staff implementing the program should

be part of a community-based domestic violence program, and not a separate training institute serving multiple counties.

The WC&S Community Education Department trains other professionals, including clergy and medical, mental health, and drug and alcohol abuse treatment professionals, so that they can intervene in domestic violence situations. The program also has staff helping to train hospital personnel in a collaborative demonstration program for identifying and assisting battered women. Through this program, 214 battered women were identified in the period July 1994 through January 1995, compared to 36 during the entire previous year. Project staff also participate in the Family Intervention Program at Children's Hospital, which aims to reduce placements to foster care. They also are experimenting with a program involving couples counseling.

The last major program component to be developed was the follow-up program, designed to provide support to former shelter residents and assist with the evaluation of the shelter services. Twenty-seven percent of shelter residents enter the follow-up program.

WC&S has established a basic goal of reducing immediate and long-term domestic violence. The primary outcome expected from the resident (shelter) and nonresident services is that 50-70 percent of the clients will live in violence-free homes for at least one year after intervention. It is expected that a large percentage will live in violence-free homes for a longer period, but the program does not have the capacity to track clients beyond 12 months. Resident and nonresident clients are expected to receive at least 3 of 20 specialized service options available to them, such as medical, housing and legal advocacy services, children's program, translators, referrals, and so forth. Assessments of the level of violence are done in a variety of ways, including the follow-up program with former shelter residents, contacts through the Home Find program or volunteer efforts, and informal "check-ins" with nonresident clients through weekly support groups or a monthly coffee house.

One of the most difficult components of the program to evaluate include the school prevention programs. The pre/post-test scores show increased knowledge of domestic violence dynamics and resources, and school officials continue to request more programs and call for domestic violence crisis interventions. However, WC&S has not been able to conduct a longitudinal study to measure long-term prevention effectiveness. The program is planning a comprehensive prevention/intervention program which will include an evaluation component. This approach involves the selection of a community for a comprehensive service intervention, including K-12 school programs plus intensive training of community police, magistrates, hospital, and other community officials.

At present, the most promising opportunities for intervention services include treatment for drug and alcohol addiction and its effect on achieving violence-free lives; targeting a smaller community for a new model of comprehensive intervention; experimenting with new partners, such as real estate agents in a subsidized "Home Find" service; and replicating successful programs in other communities.

CHICAGO ABUSED WOMEN COALITION

Vickii Coffey

The Chicago Abused Women Coalition (CAWC) is a direct-service organization that opened Chicago's first 24-hour hotline in 1977 and the first domestic violence shelter in 1979. In 1990, the Coalition began to plan how the program could expand these services beyond serving more than 700 women and children annually and to address the needs of thousands of others. CAWC now sponsors an emergency transitional shelter service, a hospital crisis intervention project, and a Domestic Violence Reduction Program. The program is also planning a long-term housing project for women in transition.

In 1992 the Chicago Police Department approached CAWC to discuss the increasing reports of domestic violence in the community. Of the 929 homicides in Chicago that year, 101 were related to domestic violence. In addition, police were receiving over 90,000 calls a year in one district that were coded as domestic violence calls. Some of the families were calling 10 times or more. Other calls often not coded as domestic violence involved vandalism and other property crimes not normally associated with domestic violence. When the police investigated, however, they found that many calls were actually the result of harassments and stalkings.

After studying the demographic data provided by Chicago Police Department, the CAWC found that calls and homicides related to domestic violence were concentrated in seven communities. One of these districts was selected as a demonstration project site for the Domestic Violence Reduction Program, which primarily serves African Americans, the largest ethnic group within the project site community. The program goal is to reduce homicides, injuries, and incidents related to domestic violence by following up emergency 911 calls within 24 to 72 hours within the targeted area. An information system has been created to track families, and a training program has been developed for the Domestic Violence Reduction Unit, composed of crisis teams of police officers and counselor/advocates from CAWC and another service agency who visit homes together in response to 911 calls. The role of these teams is to provide intervention for victims, including direct service, crisis intervention counseling, safe refuge, and referral to shelter services; and some intervention and referral for abusers.

Counselors have learned a great deal from their work responding to 911 calls with the police. After making many such visits, counselors have considered the circumstances under which a strong response may increase the battered woman's risk.

In studying this problem, counselors found that interventions that occur more than 48 to 72 hours following an incident of domestic violence may increase the risk to the woman. Teams arriving after that time may find the couple reconciling; in such circumstances, women may deny that they ever called the hotline, possibly to protect themselves from an immediate resurgence of the violence.

Counselors now hesitate to intervene later than 72 hours after receiving the call. They have had some success in these cases, however, when they have sent letters and brochures to the home.

The Domestic Violence Reduction Program does not yet have a formal evaluation component. The program relies on interim measures of effects, and project staff have noted that the number of calls to the unit have increased, as have the number of orders of protection, reports, and complaints filed, since the demonstration project began. At the same time, families who do not want to accept shelter services have demonstrated a high rate of recidivism and resistance. However, after two or three interventions, many of these families file complaints and orders of protection.

Difficulties have emerged in collaborating with other social services because of different conceptual frameworks and administrative procedures, including cash flow. The experience of collaboration has also produced attention to common concerns, however, such as the need to deal with the safety risks for both victims and service providers in going into homes where there may be violence without being apprised of the situation in advance.

AYUDA, INC.

Suzanne Jackson and Yvonne Martinez Vega

Ayuda is a service program in Washington, D.C., that has worked with immigrants for 25 years. For many years, Ayuda (which means "help" in Spanish) provided legal services to immigrant clients, the majority of whom were men. Staff eventually realized that domestic violence was a key factor that inhibited women from requesting legal assistance services. In 1986, Ayuda established a comprehensive program to serve battered immigrant women, and in 1994 Ayuda's legal clinic, which is staffed by three attorneys, provided services to 390 women in a variety of cases involving restraining orders, child custody decisions, and immigration services. Ayuda's program offers direct legal services and community education, a video for high school students, and educational services for court officials.

Social isolation, which is often associated with abuse, is particularly strong among immigrant women. Many fear that if they come forward, they may be reported to immigration authorities, and many immigrant women are not aware of opportunities to remain legally in the United States. Women who are servants of diplomats have special concerns because their employers often hold their passports. Immigrant women also have cultural and religious issues that need to be addressed in intervention efforts. Many women have had limited education, and many are illiterate in both English and Spanish. About 90 percent of the immigrants in Washington, D.C., are from El Salvador.

When immigrant women come to Ayuda for counseling, they often are eager to turn their lives over to the counselors, who resist this transference. While helping the clients understand their individual situations, the counselors try to empower the women to make their own decisions. This can be difficult, especially for legal advocates who have no formal training in counseling.

The program educates the women about domestic violence. In discussions of how community values support violence and how these values are perpetuated, there is much attention to differences in child-rearing practices for young girls and boys and differences between customs and expectations in Central America and the United States. The clients may realize that they are not helping their children by staying in abusive relationships, because domestic violence damages children at every level of development. Discussions of these cultural issues can initially seem to be a double-edged sword for those women who prefer to be with a Latino man. However, Ayuda's preliminary research has found that Latina women who are married to U.S. citizens are

more likely to be victims of domestic violence than those married to Latino immigrants. Some clients eventually change from victims of domestic violence to community activists working against it.

DISCUSSION HIGHLIGHTS

In the discussion, the participants observed that cultural beliefs that fail to discourage domestic violence often inhibit broader support by major social institutions for reformist efforts. Religious beliefs that prohibit divorce, for example, may encourage male dominance. Some religious leaders may even encourage women not to prosecute violent and abusive husbands.

Similarly, panelists noted that although some police departments have made efforts to support domestic violence victims, individual officers on the street may not be as helpful. Many police officers may not recognize domestic violence incidents as part of an ongoing pattern of behavior. Some officers do not separate couples before interviewing them, or law enforcement officials will ask if a woman wishes to remain with her partner while he is present. In Chicago, the city has developed a special project for dealing with domestic violence perpetrated by police officers because this form of abuse was seen as a factor that inhibited active police responses to other domestic violence cases.

Training programs can sometimes influence such behaviors and offer general remedies to the failures of large institutional systems. For example, the creation of a domestic court and special training programs for the police, magistrates, and prosecutors in some jurisdictions can increase the use of probable-cause arrests in domestic violence cases and can improve the deterrent capability of the law enforcement system. However, most judicial and law enforcement training programs have not been evaluated, and the outcomes associated with such efforts remain uncertain.

What is not known at present is whether, or how often, contact that occurs between the victims of domestic violence and the criminal justice or law enforcement system leads to the effective use of other social services. Some forms of contact, such as a request for a restraining order, represent important opportunities to direct victims to services that do not involve law enforcement personnel (such as shelter programs, child care services, job training, or income support programs). The need for flexible responses at many different levels of separate systems was recognized as an important feature of victim services. Yet it can be difficult to measure the effectiveness of informal referral services, especially when the client does not pursue prosecution or draw upon other law enforcement resources. The importance of capturing key lessons

from the direct experiences of abused women was stressed repeatedly as a major theme in the discussion.

One panelist spoke of the difficulty of introducing expert testimony in court and the need for additional training programs for judicial officers, similar to those that exist in the field of poverty law and legal services seminars. Injury epidemiology databases were also identified as an important resource that, if properly coded, could reflect the extent of domestic violence. At present, however, these databases have no injury code for domestic violence.

Many domestic violence training and service programs rely on categorical funding, comparable to drug and alcohol treatment centers. This arrangement was seen as a major administrative challenge, because it is difficult for such programs to offer comprehensive services that many professionals believe are necessary.

Participants also noted that the special needs of domestic violence victims from different ethnic and social class backgrounds deserve recognition. An approach that might be appropriate for women with independent financial resources may have limited relevance to a woman with no economic or social resources, language difficulties, or limited educational background. Strategies that are effective for urban women may not be useful for rural populations.

Reports of violence in teen dating have prompted some communities to develop early intervention programs for adolescents as a prevention measure for domestic abuse. The use of risk factors to predict the likelihood of abusive relationships is a controversial topic, especially approaches that focus on the "victim" profile and suggest that the victim is to blame in part for the violence that may occur. Service providers are also concerned that some forms of preventive interventions (such as job training efforts) may encourage independent activities by the victim and cause her to act in a way that increases the potential for violence in a relationship. Such efforts may require additional attention to safety planning if the client remains in an abusive relationship but is preparing to leave.

The participants noted that formal scientific evaluations are often not available to determine the effectiveness of intervention programs in the field of domestic violence. Limited measures in this field have created tensions between research and practice, and the urgency of the problem and the need for services often foster a desire to implement promising programs and approaches, even though such efforts may lack empirical evidence of effectiveness. What is particularly needed at this time are more detailed descriptions of intervention goals, the strategies used to achieve specific goals, institutional barriers to case recognition and service implementation, and hypothesized outcomes that could serve as a basis for further research and improvements in service efforts. This research would be particularly useful in the development of training efforts for service providers.

Elderly and Dependent Adult Victim Services

Service and prevention programs in the field of family violence have developed separate approaches for children, spouses, and the elderly. Elder abuse is the most recently "discovered" form of family violence, and its nature and dimensions are not well known. In some cases, elder abuse represents spousal abuse that has simply remained chronic over an extended period of time, and the violence may be discovered only when an injury is apparent. In other situations, elder abuse may be the result of an adult child who has moved back home with a frail parent, possibly as a caregiver, and who exploits the financial or other resources of the parent who may be able to offer only limited resistance.

As noted in a recent report (Reiss and Roth, 1993), elderly victims are disproportionately over age 75. They are more vulnerable to victimization because of illness or impairment and they often reside with the perpetrator of abuse. Women outnumber men as victims, but the research studies have not yet taken into account women's greater risk exposure because of their longer life expectancy. However, illness or impairment of the victim may not be the major risk factor for elder abuse. Research in this field, though not well developed, suggests that there may be different forms of elder abuse, only one of which may be dominated by risk factors suggesting victim frailty or vulnerability.

Intervention programs focused on elder abuse are extremely limited, and only a few innovative efforts have been developed. The workshop speakers emphasized the importance of recognizing the complex dimensions of elder abuse and understanding the need to balance competing principles in this field, such as the safety of senior people as well as their autonomy in making decisions about their personal living circumstances.

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INTERVENING ON BEHALF OF DEPENDENT ELDER ABUSE VICTIMS

Georgia Anetzberger

Much of what is known about interventions on behalf of abused elders comes from anecdotes. There has been little research undertaken to identify various strategies used to prevent and treat elder abuse and even less to assess their efficiency and effectiveness. Theoretical models for formulating interventions have been proposed, but not validated (Phillips, 1986; Pillemer, 1986). Treatment models have been described, but rarely evaluated (Crouse et al., 1981; Quinn and Tomita, 1986; Fulmer and O'Malley, 1987).

The need for research on elder abuse prevention and treatment is widely recognized, and several national research panels have identified areas for exploration (Family Research Laboratory, 1986; Stein, 1991). These areas include evaluation of:

- mandatory reporting,
- state protective service programming,
- identification and screening methods,
- criminal justice strategies, and
- experimental design.

Most panels, however, prioritize the need to evaluate adult protective services, which is widely regarded as the core or pivotal intervention system concerned about elder abuse in the home (Bergman, 1989; U.S. House Select Committee on Aging, 1990).

EVOLUTION OF ADULT PROTECTIVE SERVICES

Authority for adult protective services is usually derived from state law and is centralized in state departments of human services or their equivalent (American Public Welfare Association and National Association of State Units on Aging, 1986). The adult protective model has five components (Burr, 1982):

- report receipt;
- situation investigation;
- case-plan development;

- protective service provision; and
- case monitoring, reassessment, and termination.

This model dominates community response to domestic elder abuse nationwide and reflects the origin of problem recognition and subsequent evolution of intervention strategies.

Public recognition of elder abuse began in the 1950s with concern about the "protective client," which preceded the mid- to late-1970s writings of Robert Butler (1975), the testimony of Suzanne Steinmetz (1978), and the research of Elizabeth Lau and Jordan Kosberg (1979) and others. After World War II, federal agencies, such as the Social Security Administration and Veterans Administration, and social workers, attorneys, and physicians, became alarmed about the large numbers of older people who were handicapped, living outside of institutions, and subject to neglect and exploitation because they could not care for themselves and no one was able or willing to take care of them (Lehmann and Mathiasen, 1963; Hall, 1971).

In the wake of conferences, research, and demonstration projects on the elderly population during the 1960s, a profile of the protective client appeared (Hall 1973; Ferguson, 1978), not unlike the profile for the contemporary stereotypic elder abuse victim (Milt, 1982; Council on Scientific Affairs, 1987). Major characteristics of the protective client include elderly nonmarried females (over age 75) who are mentally incapacitated, physically impaired, have a low income, are unable to self-care, and lack adequate care from others.

A pattern of intervention also emerged. The protective service system, as it was called, emphasized the need for a constellation of preventive, supportive, and surrogate services. It stressed safety over freedom, the importance of interdisciplinary diagnostic study, and the potential transfer of decision-making authority from a client to a guardian, conservator, or other designee (American Public Welfare Association, 1962; O'Neill, 1965; U.S. Senate Special Committee on Aging, 1977; Regan, 1978).

Interest in protective services waned during the early 1970s. Part of this can be attributed to legal and ethical questions raised about the conflict between protective intervention and individual rights (Horstman, 1975; Hobbs, 1976; Regan, 1979). Skepticism over the role of protective services also resulted from the findings of program evaluation projects, such as that undertaken in Cleveland, Ohio, by The Benjamin Rose Institute, which suggested that protective services led to higher rates of institutionalization and death among clientele (Blenkner et al., 1971). Although questions have now been raised about flaws in the original research design and methodology of this project which render the findings questionable (Dunkle et al., 1983), they presented a restraint to program growth in the 1970s.

Although somewhat discredited, protective services did not disappear, primarily due to federal funding through Title XX of the Social Security Act of 1974 and early enactment of state protective laws. As a result, the protective services system was well positioned for the second wave of public recognition about elder abuse, which occurred during the late 1970s, when protective services became the intervention of choice at the

time as advocates sought a system to address elder abuse in its multiple forms. Three characteristics of protective services made it particularly attractive:

(1) It had demonstrated flexibility in expanding its target population. During the 1950s the main emphasis of protective services was on the extremely mentally incompetent adult. This population was enlarged in the 1970s under Title XX to include the marginally incapacitated adult as well. Abused elders easily fit into this broadening framework.

(2) It incorporated the use of legal intervention in problem treatment. No characteristic so distinguishes protective services from other intervention strategies for the aged as the potential use of legal action (Huttman, 1985). That abused elders may require legal assistance made protective services seem like an appropriate vehicle for service linkage.

(3) It was well established nationwide. Therefore, abused elders could be handled within the context of an existing service system, avoiding the difficulties and costs of forming a new one.

The state of Ohio illustrates this phenomenon. Many of the social workers and attorneys who drafted the Ohio Protective Services Law for Adults in 1980 had worked in adult protective services. They believed that public welfare services, available throughout the state, had long experience handling both abused children and adult protective clients and could therefore deal with the needs of abused elders. In the momentum of social action, they gave little thought to the fact that Ohio's public system of adult protective services had never been evaluated. Likewise, they did not question the appropriateness of expanding the definition of protective clientele to include all abused elders without empirical study on the effectiveness of this intervention mode in dealing with physical abuse and other types of maltreatment. Among the states, only Illinois and North Dakota evaluated various programs before instituting a statewide model.

ELDER ABUSE INTERVENTIONS TODAY

Since 1980 a number of studies have been undertaken to advance our understanding of elder abuse and programmatic responses to it (e.g., Anderson and Theiss, 1989; Fredriksen, 1989). Perhaps the most exhaustive of these studies was funded by the Administration on Aging to investigate three model projects along the East Coast. Among its salient findings for response to domestic abuse are the following:

(1) Different types of elder abuse reveal different victim/perpetrator profiles (Wolf et al., 1986). This suggests the need for variation in intervention strategies and services. Yet a number of factors deter this approach, including state law and administrative code, resource scarcity, professional orientation, and personal bias.

(2) Organizational structure does not seem related to client outcome. Three models were explored: service brokerage, coordinating, and mandatory reporting. Of these, only service brokerage had a unique outcome. Because workers using this model had more extensive involvement in client services, they also had a greater tendency to regard situations as unresolved (Wolf and Pillemer, 1984). Although this can be viewed variously, one set of implications suggests the potential for intake limitations, case backlogs, and client dependency.

(3) Necessary but scarce resources for effective intervention include emergency shelter, respite, legal services, and home health care (Wolf et al., 1982). However, even when these resources are available, they often are not designed to meet the needs of abused elders. For instance, battered women's shelters in Cleveland sometimes have second-floor bedrooms and no elevators and lack essential medical and personal care services. Respite volunteers have not been trained to deal with the dynamics of abusive situations in the home, and most legal assistance focuses on advocacy for entitlement rather than intervention on behalf of elder abuse victims. Of the four resources identified, only home health care includes abused elders among its targeted populations, which is reflected in the specialized training for home health aides.

(4) The greatest perceived barrier to effective service provision is lack of receptivity on the part of victims or perpetrators (Wolf et al., 1982). In Ohio, 15 percent of abused elders who are reported to authorities and found in need of protective services refuse services (Ohio Department of Human Services, 1985-1994). One important area for study is the impact of service refusal. Does it actually have negative consequence for the elder in terms of further endangerment or health deterioration? Does service refusal reflect assertion of self-determination with positive consequence for mental health?

Other research has supported these findings. For example, several studies have echoed the complexity of abuse dynamics and need for flexible intervention strategies (Giordano and Giordano, 1983; Anetzberger, 1987; Bristowe and Collins, 1989), and the Pennsylvania Elder Abuse Prevention Project identified similar service gaps (Fiegener et al., 1989).

Another study that illustrates an attempt to examine service delivery to abused elders involved an analysis of data collected through the Illinois Department on Aging (Sengstock et al., 1990). Three important conclusions emanate from this work:

(1) Elder abuse victims are offered the same type of services available to the frail aged.

(2) Victims are more likely to receive extensive services if workers are familiar with their type of abuse.

(3) There is a greater tendency for workers and agencies to become involved in self-neglect than physical abuse situations.

These findings can be interpreted in many different ways. One approach is based on the original concept of the protective client, who resembles the frail aged or self-neglected elder familiar to workers in the study just described. There is a long

history of dealing with this type of individual, and, therefore, there is greater comfort and more services available. Physically abused elders tend to be recent additions to the client caseload. Consequently, many workers are struggling to identify appropriate interventions for them. Also, the social taboo associated with physical abuse against the elderly presents workers with another barrier to overcome in case investigation and service provision.

These findings reveal a bias in service focus on the victim, not the victim-perpetrator dyad, extended family, or even the abusive act itself. As a result, few intervention strategies are directed at the perpetrator. In addition, there has been greater reliance on formal than on informal services in dealing with abused elders. Although several authors have encouraged a family or caregiver orientation in elder abuse prevention and treatment (Edinberg, 1986; Steinmetz, 1990), this orientation is not commonplace. Nevertheless, the effectiveness of one approach over another has not been determined and is an area for future inquiry.

As already noted above, adult protective services has been evolving since the 1970s. Over the years national and local conferences and networks have provided opportunities for information exchange, mutual support, and dissemination of "best practice" techniques and updates on the state of the art in elder abuse research (Bernotavicz, 1982; Inter-Organization Coordination Projects, 1986). In addition, the philosophical orientation of protective services has changed over time from safety over freedom to freedom over safety (Hornby, 1982; Astrein et al., 1984; Anetzberger and Miller, 1995). In Cleveland, the emphasis on freedom is so great among public protective service workers that they are sometimes criticized for not doing enough, since case analyses found only 13 percent of elder abuse situations resulted in protective placement, a restrictive form of intervention (Harel et al., 1989).

Finally, funding for adult protective services has declined during the past decade, largely due to inflation and cuts in Title XX (now called the Social Services Block Grant). Only a handful of states enacted elder abuse reporting or protective service laws with accompanying appropriations, and additional sources of revenue, such as county levies, have been minimal (U.S. House Select Committee on Aging, 1990). Since a funding decline has occurred at the same time that elder abuse reporting has increased and the complexity of abuse situations has become recognized (Tatara, 1990), many workers and agencies have become overextended and frustrated in addressing this problem (McLaughlin, 1988).

THE BENJAMIN ROSE INSTITUTE PROTECTIVE SERVICES

The evolution of adult protective services can be seen in programs at The Benjamin Rose Institute (BRI). BRI is a nonsectarian, voluntary agency that provides health, social, and residential services to older adults and their caregivers. BRI is designated as a protective service provider under Ohio's Protective Services Law for Adults and was one of eight original demonstration sites for adult protective services in the late 1960s.

BRI's model of adult protective services has several characteristics that provide an advantage in handling elder abuse situations when compared with many public agency counterparts. Relying on an endowment and multiple government and private funding sources, BRI is able to offer an interdisciplinary team approach to protective assessment and intervention. Six clinical teams have social workers and nurses as professional staff along with home care aides, case manager assistants, and senior companions as paraprofessional staff. Legal and psychiatric consultants as well as contract therapists and a nutritionist are available to the clinical teams. The result is multiple perspectives for better quality diagnosis and service provision along with shared responsibility for reduced worker isolation and burn-out in handling difficult case situations.

The BRI model of adult protective services allows the agency to remain involved with clients beyond the problem identification and crisis intervention stages, which offers a means of prevention for future reoccurrence of elder abuse. The diversity of services, which range from adult day care to housekeeping to mental health counseling, provides responses for the various needs of protective clients internally, without necessary reliance on other community agencies. The agency's endowment enables them to serve individuals for which there is no reimbursement source.

Three other characteristics of adult protective services at BRI deserve attention. First, an Elder Abuse Consult Team has been established that is available to staff twice monthly, or more often, if requested. Composed of advanced-level administrative and clinical staff with extensive experience in adult protective services, the Team provides outside perspective, guidance, and support for especially complex client situations.

Second, there is a standard orientation for new staff that includes use of a preferred risk assessment tool, clients' rights considerations, and appropriate application of legal interventions. There is also advanced training offered to all staff on an annual basis on new intervention strategies and ethical issues. The orientation and training are essential if staff are to have the knowledge, skills, and confidence to undertake protective services.

Third, BRI participates in several local elder abuse networks, where communication, collaboration, and comradeship can occur across organizations and systems. These networks include Protective Services Designated Agencies Group, Western Reserve Consortium for the Prevention and Treatment of Elder Abuse, and Ohio Coalition for Adult Protective Services.

BRI works through these networks with various agencies to improve the response to elder abuse in Greater Cleveland and throughout the state, particularly in the areas of community education, legislation, and program development.

BRI's current endeavor is a Community Dialogue Series on Ethics and Elder Abuse. This series involves 20-30 professionals across multiple disciplines and systems meeting monthly over a six-month period to discuss such issues as:

- Should elder abuse perpetrators be regarded as people with problems or as criminals?

• Should behavior be labeled elder abuse when the ethnic group involved does not label it as such?

PUBLIC AGENCY PROTECTIVE SERVICES

Public protective service agencies face many challenges that offer a stark contrast to the experience of a voluntary protective service agency such as BRI. Public protective service agencies are routinely placed in the position of being unable to select cases and receive cases that other agencies have rejected (Quinn and Tomita, 1986). The unrealistic expectation that public protective service agencies can and should do anything and everything has diluted their capacity for effective intervention and impedes their ability to maintain reports and investigations, provide adequate services, and offer follow-up to prevent the reoccurrence of elder abuse. Heavy caseloads, insufficient staffing, and inadequate training for staff have led to stigmatization against public protective services in some locales.

In addition, because of limited resources, many public protective service agencies have been unable to hire staff or consultants from other disciplines, which precludes in-house multidisciplinary assessment and intervention and leaves those undertaken by social work alone subject to criticisms of limited perspective (Johnson, 1991).

The criminalization of elder abuse, which began in the mid-1980s, has helped shift elder abuse intervention from social services to the criminal justice system in some states. This shift has left many public protective services workers confused and insecure over their jurisdiction (Harshbarger, 1989), which may hamper their ability to adequately address the problem of elder abuse overall (Formby, 1992).

Finally, elder abuse has increasingly captured the attention of the Older Americans Act Aging Network. Recent reauthorizations of the Act have resulted in greater role and resources for the Aging Network in abuse prevention. At the federal level, this has brought about cooperation between the Administration on Aging, the American Public Welfare Association, and the National Association of State Units on Aging to establish the National Center on Elder Abuse. Unfortunately, cooperation of this magnitude has not always occurred at other levels, leaving some state and local departments of social services and aging pursuing independent courses of action in their attempt to impact elder abuse.

CONCLUDING REMARKS

Our society is only beginning to understand elder abuse as an aspect of family violence and health problems affecting older Americans. Effective interventions can be developed by examining and evaluating different strategies in different communities, but the search will require changing our laws, systems, and approaches as a result.

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CURRENT TRENDS IN ELDER ABUSE RESEARCH

Rosalie S. Wolf

A review of the elder abuse literature more than 15 years after the first report was published discloses an appalling lack of well-designed research, especially when compared with the output for child and spouse abuse over a similar time period. This paucity may be due as much to difficulties in conceptualizing the problem as to lack of funding or investigator interest. While child and spouse abuse attracted the attention of established scholars in psychology, sociology, medicine, and other disciplines early on, elder abuse did not have the same appeal even for gerontologists (Lachs and Pillemer, 1995); in fact, one gerontologist several years ago labeled elder abuse a "dying non-issue" (Callahan, 1986).

Some disinterest might be traced to the complexities of the concept and inconsistencies in the definitions. Elder mistreatment encompasses a range of behaviors from physical abuse to psychological oppression, financial exploitation, neglect, and self-neglect. It can occur in a variety of family and institutional settings and be perpetrated by children, spouses, family members, trusted friends, or caregivers. Although there is consensus about the broad categories (physical, psychological, financial, and neglect), there is less agreement about what the terms represent. Variation both in the classification of types of mistreatment and in the manifestations of each type has compromised the validity and reliability of research efforts. Ethical considerations and confidentiality issues also serve as barriers to undertaking research in this field.

Generally, studies have been primarily exploratory or descriptive. The early studies were valuable in substantiating the existence of the problem. Later efforts helped to characterize the victims, perpetrators, and the abusive situations and to identify risk factors. In the intervening years, only one metropolitan area prevalence study of elder abuse has been carried out, and a national incidence study has just begun. Two studies on elder abuse are currently being funded by the National Institutes of Health; four in total since elder abuse first emerged as a problem. One is examining the perceptions of elder abuse held by middle-aged and older adults residing in seven culturally diverse counties in North Carolina. The other is identifying risk factors for elder mistreatment using state adult protective service agency cases that are also part of a community cohort for whom detailed physical, psychological, and social

status information has been gathered over a 10-year period. Needless to say, only a handful of studies have focused on the assessment of interventions.

ASSESSMENT OF INTERVENTIONS

Given the multiple facets of elder mistreatment, there is a wide array of interventions. Hospitalization and temporary shelter are the more common immediate responses with nursing home placement for more long-term resolutions. In cases that are primarily a result of caregiving stress, helping the caregiver is the treatment of choice. This help includes bringing into the home skilled nursing, homemaker assistance, personal care, meals-on-wheels, chore services, friendly visitors, and respite care; placing the victim in adult day care; and enhancing the ability of the caregiver to cope through counseling, stress management, or skill-building.

When the cases involve physical abuse and an abuser (primarily an adult child) who is dependent financially and/or emotionally on the victim, another avenue of intervention is indicated such as helping the abuser through vocational counseling, job placement, housing assistance, alcohol and drug treatment, mental health services, and financial support and counseling for the victim. Since physical and financial abuse situations are often criminal or civil offenses, interventions may be through the criminal justice system. Legal instruments such as orders of protection, restraining orders, or temporary commitment papers are used, but incarceration of the abuser is rare. Elderly persons are extremely reluctant to press charges against children or spouses, and more often than not, abusers are not willing clients. Court-ordered counseling programs, such as those for wife batterers, do not exist in elder abuse, although several new programs for older battered women and men are organizing support groups for abusers.

EVALUATION STUDIES

In searching the literature for program evaluation studies, seven were located that used experimental or quasi-experimental design or inductive statistics. Five were funded by the Administration on Aging, one by private foundations, and one with state funds. The group of seven includes three studies that measure the effectiveness of delivering protective services and four that address specific programs.

(1) *Elder Abuse and Neglect: Final Report from Three Model Projects* (Wolf et al., 1984; Wolf and Pillemer, 1989).

This report evaluated and compared three programs (in Massachusetts, New York, and Rhode Island) in terms of casework process, interagency coordination, model replicability, and client outcome measured by changes in manifestations of abuse and level of risk. Data were obtained from project staff and community agency personnel interviews, two surveys of community agencies a year apart, baseline and 6-

month assessments of 328 clients, and a comparison of 42 physically abused clients and matched nonabused clients (Wolf et al., 1992; Wolf and Pillemer, 1994).

(2) *An Evaluation of Four Elder Abuse Projects* (Wolf et al., 1992; Wolf and Pillemer, 1994).

This project is a four-phase study of elder abuse programs (Hawaii, California, Wisconsin, and New York) based on the three-model project methodology described above. Again, data were obtained from project staff and community agency personnel interviews, two surveys of community agencies a year apart, baseline and 6-month assessments of 121 clients, and a comparison of 53 abused clients and matched nonabused clients.[1]

(3) *Determining Effective Interventions in a Community-Based Elder Abuse System* (Quinn et al., 1993).

This study analyzed the change in risk level of 537 clients in the Illinois protective services system using a statewide risk assessment protocol[2] based on 23 risk factors and caseworkers' judgments about case closure.

(4) *A Statewide Elder Abuse Prevention Program* (Baumhover et al., 1988; Scogin et al., 1989).

This program, held in community mental health centers in Alabama, sponsored an eight-session caregiver training program for individuals who had abused or were at risk of abusing the person in their care. Three groups were studied: an intervention group (56), a delayed intervention group (16), and a no-intervention group (23). Criteria included changes in level of anger, self-esteem, cost of care, and psychiatric symptoms.

(5) *Evaluation of Guardianship/Conservatorship: An Institutional Diversion National Demonstration Project* (Wilber, 1990).

This evaluation studied a money management program offered as an alternative to guardianship to 60 persons referred by Adult Protective Services and the Office of the Public Guardian in Los Angeles. A randomized experimental/control design was used. Outcome measure was institutionalization.

(6) *Comparison of Paid vs. Volunteer Multidisciplinary Teams in Providing Community-Based Care to Elder Abuse Victims* (Stahl and Hwalek, 1990).

This demonstration program was conducted in two rural and two urban communities in Illinois and included a comparison of having a team or no team on reducing caseworker burn-out.

(7) *An Evaluation of a Program of Volunteer Advocates for Elder Abuse Victims* (Filinson, 1993).

This evaluation was designed to assist victims in the utilization of the criminal justice system. A matched sample (28) drawn retrospectively from the program files

was used to compare with the project clients (42). Criteria for effectiveness included reports to the police, legal actions, relocating the victim or the perpetrator, self-esteem, goal-setting, achievement of goals, and level of case monitoring.

CONCLUSION

Although these studies are an improvement over the first generation of elder abuse research because they are prospective, use control groups, and interview victims directly, the methodology used in all of them would not meet rigorous scientific standards. Most of the samples are too small, data collection processes are subject to biases, and groups are not randomly drawn.

Good research in elder abuse will require the involvement of skilled investigators, increased funding, and active cooperation and partnership of practitioners. Effective intervention strategies will depend on more basic knowledge about the nature of the problem, greater understanding of the causal and contextual factors, and better diagnostic tools. Most services for abused and neglected elders are offered through state-administered, supervised, or contracted programs. At a minimum, states need to update their information systems so that program evaluation will be possible. Several states are in the process, most notably Texas, where a paperless system is being developed in conjunction with its child protective services. Illinois is probably ahead of most states in using research and evaluation to design its delivery system with state funds as well as grant money. More federal dollars should be available for demonstration projects, information systems, and research. Although the National Institute on Aging has designated elder abuse as an area for investigation, a stronger commitment is needed in the form of a specific allocation.

NOTES

[1]Analyses of client data are still in progress.
[2]The Risk Assessment Form used by the Illinois Department on Aging was developed and validated as a client risk assessment by the State of Florida.

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ELDER ABUSE TRAINING FOR HEALTH CARE PROFESSIONALS

Mary Cay Sengstock

As public recognition of elder abuse increases, more professionals have become aware of their responsibility to recognize victims and help them receive assistance. Some professional organizations, such as the Joint Commission on the Accreditation of Healthcare Organizations, now require guidelines for the management of elderly people in hospitals. This fact has motivated some hospitals to train their staff and make the care of the elderly a high priority.

Yet major improvements are still needed. The categorical systems approach to services often makes it difficult to arrange the type of comprehensive or specialized care that elderly victims require. Many cases demand long-term intensive work that is very expensive. Services need to be coordinated, and some important services (such as nutritional care, transportation, or recreational opportunities) are not available. Since many agencies have not yet adopted training programs or policies on this issue, referrals often involve informal arrangements with knowledgeable people rather than contracts with organizations. Furthermore, few opportunities exist for in-depth research or training to help participants evaluate and improve their programs.

Most practicing professionals have no training in elder abuse. In 1990, under a grant from the Administration on Aging, a set of training materials was developed for instruction of health and social service professionals in the identification and management of elder abuse victims and their families. The materials were developed by myself and Dr. James G. O'Brien, Department of Family Practice, Michigan State University School of Medicine (Sengstock and O'Brien, 1990).

Over the past five years, Dr. O'Brien and I have made numerous presentations in Michigan and in other states drawing on these materials. On several occasions we have been joined by attorneys, social workers, and nurses who provide a special expertise in the area of state laws or available social services. In these presentations we refer to the Elder Abuse Screening Test (Hwalek and Sengstock, 1986; Neale et al., 1991) and the *Comprehensive Index of Elder Abuse* (Hwalek and Sengstock, 1986a,b), which I developed with my colleague Melanie Hwalek. These materials detail techniques of identifying abused elders, and the *Comprehensive Index of Elder Abuse* also suggests possible service mechanisms.

The training materials have been incorporated into a training program that is available through the Michigan State University School of Medicine (Sengstock et al., 1990). The initial part of the training program is an introduction to elder abuse, which

includes physical abuse and neglect, psychological abuse and neglect, and financial exploitation. The program focuses on the behaviors and demographic characteristics that distinguish elder abuse from child abuse, physician experience with elder abuse, and the positive and negative features associated with family care of elders.

Most of the training is practical and stresses the early indicators of abuse, so that practitioners can learn to identify elderly victims of abuse before they are seriously injured, become gravely ill, or die. The program includes an introduction to state and local laws regarding abuse, reporting requirements, and related issues such as durable power of attorney and guardianship. Faculty stress detailed features of case management, including attention to family and caregiver dynamics, general approaches, role of other professionals, and suggestions for how to interview victims, abusers, and caregivers.

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THE ROLE OF ADULT PROTECTIVE SERVICES

Henry Blanco

The Elder Rights and Disabled Adults Unit within the Aging and Adult Administration in Arizona includes four statewide programs: Adult Protective Services (APS), Long Term Care Ombudsman, Legal Services Development, and the Benefits Counselor program. In Arizona the typical APS client is a female aged 75 years or older who lives alone on a low income. Ethnicity is fairly representative of the state's general population.

In most states, the APS programmatic framework is developed by state legislation. Since federal laws do not define elder abuse or establish criteria for APS, each state defines its own target populations. All state APS programs do include the elderly either by definition or intent and include abuse, neglect, and exploitation as general criteria for state involvement. Arizona law originally defined adults who were incapacitated as the target population for APS services, but in most cases the client is at risk due to age or physical or mental limitation even though they are not legally incapacitated. As a result, state law was amended to include "vulnerable" adults. Approximately 60 percent of the APS cases in Arizona are listed as "self-neglect," which means that the client is at risk because of his or her own actions or lack of action, rather than the actions of others.

The goal of the APS program is simple, but complex: to prevent or alleviate the abuse, neglect, or exploitation of incapacitated or vulnerable adults. The program recognizes the principle that competent adults have the capacity and the constitutional right to make decisions, including the right to refuse services and intervention, regardless of caseworker opinions of the clients or their lifestyle. This right may be removed through a long and legal process for the assignment of a guardian, if the vulnerable adult is determined to be unable to make decisions that protect his or her own self-interest. State officials need to balance their responsibility to intervene with the individual's right for self-determination, which may involve protecting a client who chooses not to be protected.

Arizona APS program officials give priority to the protection of the client's autonomy and the client's right to remain in control of his or her own destiny. The caseworker has a responsibility to be certain that the client is aware of options, understands these options, and has the capacity to make a decision. If these factors exist and the client refuses to initiate changes, the responsibility is to accept that decision. This process often places the caseworker in the position of protecting the

client from those who wish to force change in the interest of serving the client's needs. As a result, APS may often be seen as "doing nothing" by a community that desires change.

Throughout this process, the assessment of the client's competence and incapacity becomes a critical issue. Arizona courts generally require a physician's statement before considering a petition for guardianship, but the caseworker's role in the assessment process is also critical. In order to minimize the influence of the caseworker's own bias and personal values, APS programs are developing a Risk Assessment form to standardize the assessment process.

The development of this form requires extensive time. The reliability of the original design and methodology were field tested by a series of 60 intake interviews by pairs of APS workers representing both rural and urban areas. The results of the field test suggested that the percentage of agreement among the raters was far from unanimous when major scales of abuse, neglect, and exploitation were calculated. As a result, efforts are continuing to standardize definitions used in the assessment process.

Successful intervention is difficult to define. Since the APS goal is to protect the client's autonomy and right to self-determination, a successful outcome may mean allowing the client to live in a neglectful situation. It may also mean removing an abusive family member from the home. In some cases, however, this family member may be the sole source of transportation or other support, and the public service delivery system is unable to replace those services.

State officials are exploring opportunities at the state and federal level for coordination of intervention services. Title VII of the Older Americans Act, which includes Allotments for Vulnerable Elder Rights Protection Activities, provides funding for activities in this area and requires a systematic and coordinated approach to address these problems. In Arizona we have sought to implement this approach by the development of Elder Rights Process Improvement groups which involve major stakeholders in this area, such as the Attorney General's office, and representatives of the medical, educational, and social service communities.

One important model of interagency collaboration in Arizona is the Medigap Information and Referral Initiative, which was developed to provide health insurance information to senior citizens to ensure that they receive their benefits and to protect them from insurance fraud and abuse. This initiative was developed by the Arizona Department of Economic Security, Aging and Adult Administration, which recognized the need for accurate and readily accessible insurance information. The Department was committed to provide such services through the State Plan on Aging. Funding for the initiative was provided in 1992 by the Health Care Finance Administration and the National Information and Referral Support Center of the National Association of State Units on Aging. The first step was to establish an 800-hotline phone service for eight months. The National Committee to Preserve Social Security and Medicare donated a computer and printer to record Medigap insurance data and to prepare special reports.

The Medigap Information and Referral Program in Arizona plans to develop the following services as part of its effort:

• Counseling to persons needing health insurance information including assistance in filing claims and obtaining benefits; policy comparisons, claim assistance, and rate information; assistance regarding long-term care, home health care, and related efforts; and information regarding alternative health care plans, other health insurance, and potential eligibility for Medicaid benefits.

• Systems of referral to appropriate state and federal agencies for health or insurance-related problems.

• Training programs for staff members, volunteers, and requesting organizations.

The challenges in developing intervention efforts often reflect the difficulty of responding to the client's wishes, especially when the client does not want intervention, or when change may not occur despite our intervention. Training of social service, legal, and medical providers is paramount in this area.

In cases when the client does accept intervention, access to and availability of services become important issues. Interventions can be expensive and extremely limited in some areas. For example, a 75-year-old abused spouse who requires shelter may not find a shelter capable of handling her special needs. In cases where legal testimony is necessary for successful prosecution of offenders, elder abuse victims may not be reliable witnesses to the events because of their age and condition.

Finally, elder abuse needs to be viewed beyond the parameters of child abuse. Many state laws addressing elder abuse were developed by simply incorporating the term "elder" into existing child abuse legislation, and elder abuse programs have suffered from the lack of resources for staff and program development.

DISCUSSION HIGHLIGHTS

Service providers in health, social service, and legal settings who address the problems of elderly populations must consistently strive to balance the goals of sustaining independence and autonomy for elderly clients, reducing the costs of intervention services, and establishing safe and supportive caretaking environments for elderly people. Victims of elder abuse frequently may be physically or financially dependent on their abuser, and those who seek to protect them may not be in a position to assure adequate care if the abuser is removed from the home.

American society lacks a clear definition of caretaker responsibility for elders comparable to parental responsibilities for children. If a caretaker is a financial guardian, this arrangement requires certain contractual obligations. Failure to observe these obligations may provide a basis for legal interventions, but opportunities for involvement by the criminal justice system are very limited in the field of elder abuse. This may be an area that is appropriate for evolution of civil law, but few efforts have been initiated to address the existing problems.

Research on the demographics of elder abuse suggests that an elder is likely to be abused by the person with whom he or she lives (Pillemer and Finklehor, 1988). Since more elders live with their spouses than with their children, more elders are abused by spouses, but the difference in abuse rates between those who live only with their children (44/1,000) and those who live only with their spouse (41/1,000) are not significantly higher. Abused elders are as likely to be male as female, although most of the intervention services appear to focus on elderly women as their primary clients.

Public health nurses identify many elder abuse cases because of their access to private homes. Nurses may seek to intervene when they consider their clients' environments to be dangerous. One opportunity for such intervention is when nurses eliminate their services and thus force their clients to be institutionalized. Local fire departments are also often called in response to elder abuse cases, but they may have little training in intervening in such situations beyond providing emergency care. Police officers are increasingly being reminded to look for abused children when they respond to incidents of domestic violence, but little attention has been given to the need to look for abused elders. Finally, focus group discussions involving several generations and four ethnic groups revealed that elderly people are often more frightened of psychological abuse than physical abuse or financial exploitation, yet

public service agencies have almost no training or resources to deal with this area of abuse.

Topics that deserve further consideration in the evaluation of elder abuse service programs include the topics to be covered in training programs, barriers to change that exist in different target populations, points of recruitment and resistance among service providers, and the identification of components of practice or training that deserve evaluation.

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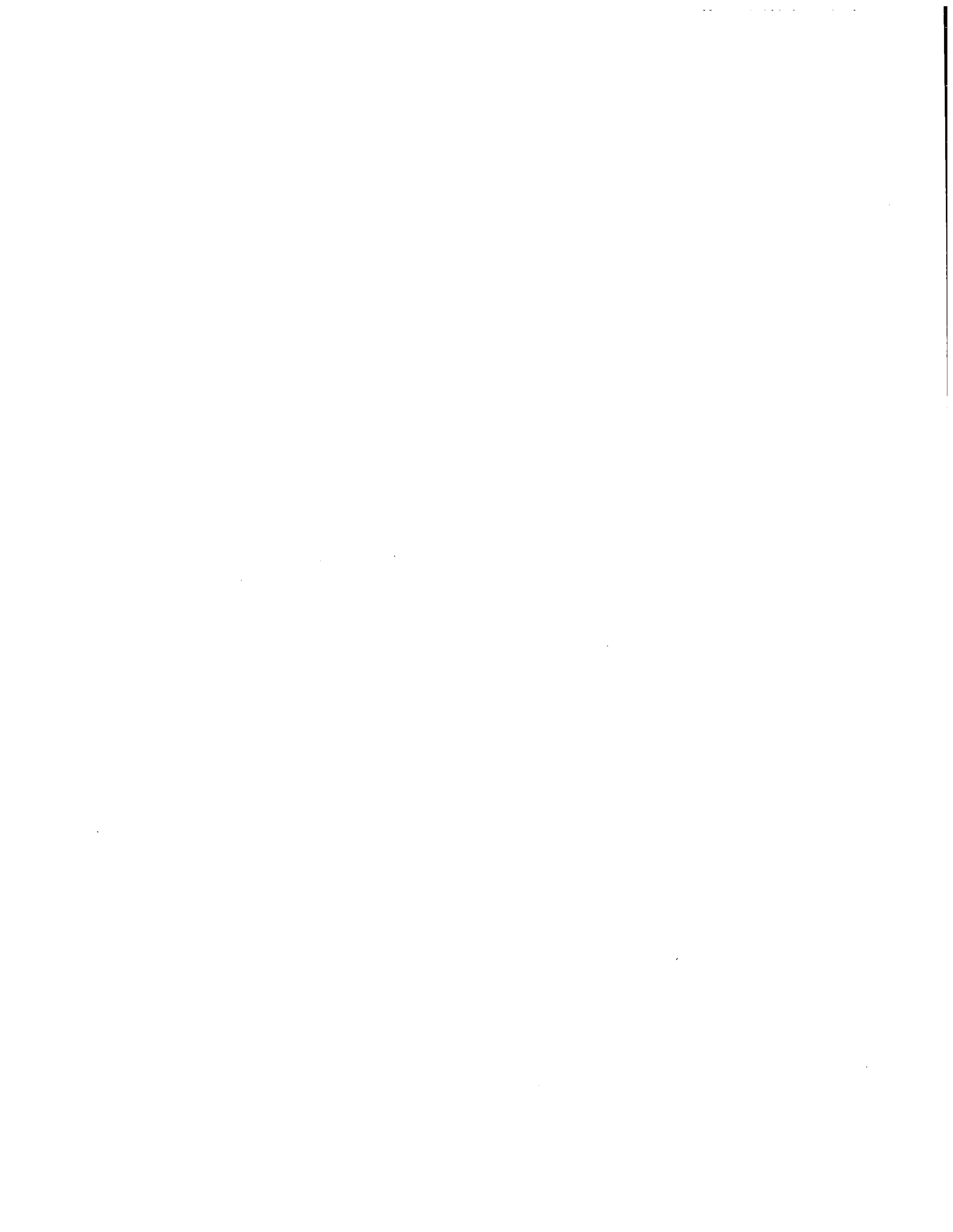

Treatment of Offenders

The treatment, control, and punishment of offenders who engage in child abuse, intimate violence, or elder abuse have been fragmented across many different legal and social service systems in American society. Some forms of assault come within the scope of criminal law where victims may claim protection from law enforcement agencies. In many areas, however, the role of the law in addressing the offenders is very limited or uncertain.

Responding to those who commit acts of violence against children is problematic because current institutional systems rely heavily on self-reports or reports by relatives, neighbors, school officials, or social services or health professionals who may see signs of physical evidence or hear accounts of the assault from the child. Yet law enforcement officials or judges may be reluctant to seek or impose penalties on the offender if physical evidence is not convincing or if a child's testimony is inconsistent.

In addition, some forms of physical abuse may result from corporal punishment or lack of parental awareness of developmental abilities (especially in the area of feeding and toilet training). Effective treatment of such offenses may require therapeutic or educational interventions focused on changing parent or caretaker perceptions or expectations of child behavior. Distinguishing abusive behaviors that result from ignorance or inappropriate perceptions from those that are characterized by a desire to harm a child can be a challenging task for caseworkers and other public officials.

In the field of intimate violence, the law enforcement system has played a more prominent role in dealing with offenders through a variety of instruments, including the use of restraining orders, anti-stalking legislation, increased sanctions, monitoring systems, and mandated treatment programs. However, there is uncertainty within the legal system regarding the extent to which those who commit violence against family members or intimate associates are capable of violence against others in the community. The traditional view of domestic violence cases as "family matters" has impeded the search for public safety measures that could deal effectively with the identification and control of offenders. There is also uncertainty regarding the effectiveness of alternate forms of batterers' treatment programs, which may be voluntary or mandatory as part of a judicial strategy in settling specific offenses.

The evolution of offenders' treatment programs has occurred in a variety of settings, primarily in mental health services and law enforcement settings for batterers and sexual offenders and in social service agencies for physically abusive or neglectful parents. A range of conceptual models, including cognitive, psychoeducational, therapeutic, use of medications, lie detectors, deterrence, and other control/monitoring mechanisms has been used to identify and treat offenders.

In the following presentations, service providers and researchers review a portion of offenders' treatment programs, focusing primarily on cognitive or psychoeducational approaches designed to reduce recidivism among incest offenders and men or parents who are reported for the physical abuse of women and children. In the field of elder abuse, the treatment of offenders has received only minimal attention and has not yet supported the development of specific intervention programs.

ECOBEHAVIORAL MODELS FOR TREATMENT OF CHILD ABUSE PERPETRATORS

John R. Lutzker

After the recognition of child abuse syndrome in the early 1960s, treatment literature in the form of simple case studies and single-case experiments began to appear in the mid-1970s. The focus of these efforts revolved around either the teaching of parents in simple child behavior management techniques (Jeffery, 1976; Crozier and Katz, 1979) or in teaching parents anger control (Polakow and Peabody, 1975) or other stress reduction techniques (Sanford and Tustin, 1974). This work represented a promising beginning for treatment of the parental perpetrators of child abuse, but it was too simplistic when the many mitigating factors that correlate with risk of child abuse are considered. These factors include poverty, child-rearing and problem-solving deficits, lack of knowledge about child development, money management deficits, home safety and cleanliness (health) hazards, inadequate knowledge about maternal/child health and nutrition, inadequate or absent bonding or infant stimulation, poor adult relationships, and delayed basic skills of the child who has been abused.

The ecobehavioral model (Lutzker, 1992) was developed in order to try to address several of these factors by providing in-home multifaceted assessment and services related to many of these factors. These services have included parent-child training, stress reduction, basic skill training of children, money management training, problem-solving skill training, health and safety training programs, pre- and postnatal maternal/child health training, behavioral pediatrics, and the development of bonding through planned activities training and infant stimulation.

Since 1979, Project 12-Ways has offered these ecobehavioral services to families referred for child abuse and neglect in rural southern Illinois. A systematic replication of the Project 12-Ways model (Lutzker, 1984) has been ongoing in southern California since 1988 through Project Ecosystems (Lutzker et al., 1992). This is an in-home service to families whose children are at high risk for child abuse because of their severe behavioral excesses and deficits as a function of developmental disabilities. Also, recently funded by the California Wellness Foundation, Project SafeCare is another systematic replication attempting to provide parent training and health and safety training to families within a 15-week package. This treatment and research project is aimed at examining several issues of replicability of the ecobehavioral model. The average duration that a family is seen by Project 12-Ways is nine months. Thus, one question is whether this 15-week package can be as effective in a more succinct

format. Also, families served by Project 12-Ways, Project Ecosystems, and replications in Florida and Mexico all employ highly trained graduate students as the service providers. Although these developing professionals provided competent services, another question is whether or not these services can also be provided successfully by caseworkers and nurses, and perhaps more indirectly through video formats. Thus, another experimental question being addressed by Project SafeCare is whether or not these other formats can be effective.

There are five methods to evaluate the ecobehavioral model, or any similar model in providing family services. First, "clinical" data should be collected. That is, data are collected whether or not they will be used within experimental designs and whether or not they are necessarily reliable. These include data collected directly by counselors or self-report data collected by the client. For example, a parent might be asked to count the number of criticisms directed at her child during the week. These data, although of little scientific merit, are of great value. First, they can be used to show a parent progress, or lack thereof, in treatment. Another use for these data is for counselor supervision. The counselor can present the data to a supervisor in order to embellish supervision and for the supervisor to have a more complete image of treatment experience with the family. Finally, the data can have a helpful reactive effect. For example, the parent who begins to count and record the frequency of criticisms may actually reduce the frequency as a function of awareness through self-recording.

Case studies represent the next level of evaluation. These are reports that are published in the literature, though lacking the usual scientific criteria for publication. The data often lack reliability or robust research designs, but there are detailed descriptions of dramatic change in highly resistant behavior. For example, Lutzker et al. (1984) described significant household cleanliness and children's hygiene in a family referred for neglect in which the parents displayed developmental delays. The value of these case studies is that they provide researchers and service providers with published accounts of novel treatment techniques that can be replicated and tested for their generality.

A more sophisticated level of evaluation is the use of single-case experiments. These are published studies in which a single individual or family is the subject of the research. If the data are reliable, single-case design allows for confidence that there is internal validity, showing definitively that the treatment is responsible for changes in behavior. For example, Campbell et al. (1983), through a withdrawal research design, showed that stress reduction techniques were responsible for a dramatic reduction in migraine headaches in a mother who was at high risk for child abuse. In addition, a multiple baseline design across responses showed that parent training techniques produced significant change in maternal use of behavior management procedures and instruction-following by the child. Single-case experiments lack external generality; however, like case studies, they allow for possible replication and thus subsequent demonstrations of external generality.

Research using single-case designs with more than one family or group (statistical) research designs represent the next level of evaluation. This kind of

research extends the generality of treatment procedures reported. For example, Barone et al. (1986) used a slide-tape program to reduce household hazards accessible to children whose parents had been referred for abuse or neglect. A multiple baseline design across families clearly showed that the slide-tape program was responsible for the dramatic improvements.

Finally, program evaluation represents the most comprehensive level of evaluation. This can take several forms such as measuring recidivism and comparing it in families treated in one model to another. For example, Lutzker and Rice (1987) showed that there was a lower risk of repeated incidence of abuse among families treated by Project 12-Ways than families in a comparison group who were matched demographically, lived in the same region, but received other services provided by the child protective agency. Other possible program evaluation data can include placement and social validation. Social validation involves questionnaires sent to consumers asking about the quality of the goals, process, and outcome of treatment. O'Brien et al. (1993) explored these issues with consumers who received services from Project Ecosystems. They also asked these questions of agency personnel who referred families to the project. Social validation and other program evaluation allows an examination of the larger questions associated with services aimed at the treatment and prevention of child abuse and neglect. Ideally, all five forms of evaluation outlined here should be included in examining treatment services.

The ecobehavioral model shares some similarities with, but also differences from, other large-scale in-home wrap-around services for families. The primary differences are in the direct observation of behavior and collection of data. For example, in looking at parent-child interactions, independent observers record several operationally defined parent and child responses. Research designs as described above are used to evaluate the effectiveness of each new treatment. In addition, there is a focus on criteria-based performance in teaching staff each ecobehavioral treatment strategy.

Several challenges face all treatment providers in child abuse. Parent compliance to recommended treatment regimens remains one of the biggest of these challenges. Parents who are court-mandated seem to cooperate better than those who are not. Behavioral contracts between the service provider and the family are helpful in assuring compliance. Good humanistic counseling skills of the counselors add to the likelihood of compliance to the otherwise invasive strategies offered within the ecobehavioral model. Some families may comply as a function of negative reinforcement. That is, they do so because they are aware that their compliance will ultimately cause the service provider to go away! Although we would always like to think of ourselves as positive, this reason for compliance may not be problematic as long as change seen in the family is durable. Finally, it must be noted that every treatment provider faces failures, and that often noncompliance cannot be solved.

Although the ecobehavioral model in treating perpetrators of child abuse appears to be effective, several areas deserve future research. More empirical work is needed on the effects of treatment on child victims. Strategies can be explored for teaching children to be aware of cues that might lead to abusive incidents and they can be taught

strategies that could aid in their protection. Empirical approaches need to be improved in teaching parents to have more appropriate child development expectations. Also, there should be explorations into *very intensive* treatment services, such as, perhaps, a 3-week, 24-hour camp-like experience in which families are provided constant feedback on their parenting and problem-solving practices. Finally, evaluation and assessment procedures should continue to be emphasized.

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EVALUATION OF BATTERERS' TREATMENT PROGRAMS

Richard Tolman

Despite the growing use of the criminal justice and social service interventions designed to help change the behavior of perpetrators, the efficacy of such interventions has not yet clearly been established. Although the number of arrests has increased, efforts to assess their effectiveness as a deterrent or as an intervention have shown mixed results. A 1990 research review of group treatment for batterers (Tolman and Bennett, 1990) revealed one consistent finding: in a range of programs, using various methods of interventions, a large proportion of men report that they stop their abusive behavior following involvement in the programs. These outcomes deserve further analysis, however, because of variation in the range of success reported for different treatment programs (from 53 percent to 85 percent) and because "success" is often defined simply as an absence of physical abuse. Various explanatory factors should be considered in this analysis, as well as methodological shortcomings of the studies. For example, lower percentages of success tended to occur in programs with longer-term follow-up and in programs that rely on reports of the women victims rather than self-report measures. More importantly, many treatment programs experience high levels of offender attrition, which dilutes the overall effectiveness of the studies.

The scarcity of experimental studies in the field of batterers' treatment programs is a major shortcoming because it is not clear whether the intervention programs for batterers are responsible for changing men's abusive behavior. Some studies that compare treatment drop-outs with men who have completed treatment demonstrate only modest gains for those who have completed intervention programs.

Additional research is needed that views interventions for batterers in a broader context, including their interactions with the criminal justice system as well as with their partners. For example, the availability of services for battered women is related to an increase in the use of orders of protection as well as in arrest and successful prosecution of batterers. The effects of services for battered women must be considered in evaluations of batterers programs because changes in batterers' behavior may be mistakenly attributed to the interventions for batterers, when, in fact, the changes may be the result of the empowerment of battered women.

In order to improve the evaluations of treatment programs, researchers should look beyond the measurement of the cessation of physical abuse to other indicators of success. Further research is needed to develop measures of sexual and psychological maltreatment, especially since some studies suggest that psychological abuse may

increase as physical abuse decreases. It is possible that if success is described as the absence of threats, intimidation, and other forms of psychological abuse, as well as the absence of physical abuse, then the modest successes in batterers' programs may drop even more.

Measures of separation abuse, such as work and telephone harassment and misuse of child visitation privileges, often are missed in evaluation studies of batterers' treatment programs. Measures are also needed for assessing positive, caring behaviors in egalitarian relationships, not simply measuring the negative skills in relationships. Finally, there is a need for outcome observational measures that can be reported by battered women themselves who may have important perceptions of their partners' behavior or well-being. The well-being of the woman, especially in areas such as safety, stress, self-esteem, and fear, can be an important indicator of effectiveness of a selected treatment program.

One area that has received little attention in the evaluation of batterers' treatment programs is the assessment of relationships between offenders and the children of battered women. If an intervention program is fully effective, improvements may be seen in the aggressive behavior and developmental adjustments of children who often witness scenes of intimate violence. When regarded in this way, treatment programs for batterers could be conceptualized as programs that prevent the use of violence by the children of batterers. Another area that may serve as a good target for early intervention is the pattern of relationships that emerges in high school dating. Some studies suggest that a high incidence of intimate violence occurs in these relationships, but we have little knowledge about what forms of intervention programs are most effective for adolescents who may be experimenting with violence early in their dating relationships.

In conclusion, much effort is needed to improve the variation in the models of treatment that are available for different categories of batterers. Such variation is needed to respond to the needs and impulses of different categories and types of offenders that has emerged from earlier research studies. Studies by Levesque (1995) and others, for example, suggest that batterers at different stages of motivation may respond differently to selected treatment programs. Experimental studies that examine the comparative effects of mandatory versus voluntary programs, the effects of sanctions associated with participation in batterers' treatment programs, and the enhanced use of surveillance and monitoring efforts would help improve the quality of the knowledge base that could guide programmatic efforts in this field.

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TREATMENT OF SEXUAL OFFENDERS

Robert A. Prentky

Research suggests that exclusive intrafamilial sexual offenders have the best treatment prognosis and the lowest recidivism rate of all child molesters. Even incest offenders, however, fall into different categories and vary substantially in amenability for treatment and the risk for offending again. Indeed, incest offenders are differentiable on most of the dimensions that are important for nonincestuous child molesters (e.g., level of social competence, degree of sexual preoccupation with children, and lifestyle impulsivity). By and large, incest offenders are *not* differentiable along the dimensions of amount of contact with children and degree of physical injury.

Treatment programs for sex offenders should include protocols for baseline assessment, progress evaluation, risk assessment, and discharge. On the basis of data obtained from these protocols, informed judgments can be made about differential prognosis, especially in the area of risk assessment.

TREATMENT OR REHABILITATION OF INCEST OFFENDERS

Incest offenders are most successfully treated in group with a cognitive behavioral orientation, often based on a model of relapse prevention. Treatment regimens often include victim empathy training and cognitive restructuring, as well as psychoeducational classes that augment the work in group. Psychoeducational classes provide the cognitive preparation for the affective work that takes place in group. A key to maximizing long-term treatment effectiveness appears to be the affective component of treatment (i.e., awakening genuine feelings of sadness, remorse, guilt, shame, etc.). When these feelings are internalized (e.g., feelings of sadness or shame about one's own victimization, feelings of sadness, or remorse about one's victimization of others) they will provide a powerful defense against re-offending. The potential utility of medication, particularly the SSRI antidepressants (selective serotonin re-uptake inhibitor, such as Prozac), should be considered, as appropriate.

RISK ASSESSMENT

Risk assessment with child molesters occupies a very substantial literature that cannot be reviewed in this brief summary. One of the most enduring themes in this literature concerns victim gender, the notion that same-sex molesters are at the highest risk to re-offend, opposite-sex molesters are at the lowest risk, and bisexual molesters fall somewhere in the middle. As the victim gender theory would predict, incest offenders, who are predominantly opposite sex (father-daughter), are at lowest risk to re-offend.

The victim gender hypothesis has not, however, received uniform support. Our own work (Prentky et al., 1995) on the development of an archival risk assessment scale for child molesters failed to provide any support for the usefulness of victim gender in predicting recidivism. In a 24-year follow-up of 111 treated child molesters, 6 of 10 variables significantly differentiated those who re-offended and from those who did not re-offend. The most powerful predictors of *sexual* recidivism were strength of pedophilic interest (which assesses the extent to which children are a major focus of the offender's thoughts and fantasies), paraphilias, and number of prior sexual offenses. The most powerful predictors of *nonsexual* recidivism were amount of contact with children, juvenile antisocial behavior (e.g., problems in grammar school and junior high school, fighting, vandalism, assaultiveness), adult antisocial behavior (e.g., fighting, assaultiveness, vandalism, illegal drug use), and paraphilias.

Although risk assessment procedures and scales for sex offenders exist that are empirically informed and reasonably accurate, low base rates of re-offending hamper the overall effectiveness of risk assessment. The base-rate problem is particularly serious with exclusive incest offenders who have a very low re-offensive rate. Assuming a sexual recidivism rate of 10 percent with endogamous incest offenders, a prediction device would have to exceed 90 percent accuracy to improve upon a chance prediction of no re-offense. Nevertheless we have a reasonably good idea of what constitutes "risk" for many sex offenders.

CHILD MOLESTER RISK ASSESSMENT SCALE

The child molester risk assessment scale includes the following classification criteria for scale variables:

- Amount of Contact with Children. The amount of contact with children variable is derived from work on the development of a classification system for child molesters (Knight et al., 1989). The amount of contact is a behavioral measure of the time that an offender spends with or near children, and includes sexual *and* nonsexual situations, but excludes parent-related contact. Any involvement in a job and/or social or recreational activities that requires regular contact with children qualifies as nonsexual contact.

• Strength of Pedophilic Interest. The strength of pedophilic interest, or "fixation" variable, assesses the extent to which children are a major focus of the offender's thoughts and fantasies.

• Impulsivity. This variable is a measure of lifestyle impulsivity and includes seven components: (a) unstable employment history, (b) financial irresponsibility, (c) aimlessness or failure to settle down, (d) reckless behavior, (e) inability to maintain an enduring attachment to a sexual partner, (f) repeated instances of aggressive behavior in response to frustration, and (g) subjective experiences of acting on "irresistible impulses."

• Juvenile Antisocial Behavior. The score for juvenile antisocial behavior is derived from six items: (a) problems in grammar school, (b) problems in junior high school, (c) verbal or physical assault on peers at school, (d) vandalism, (e) fighting, and (f) number of nonsexual, victimless offenses.

• Frequency of Prior Sexual Offenses. This variable is the total number of *charges* for serious sexual (i.e., victim-involved) offenses committed as a juvenile and as an adult.

• Paraphilia. This variable is a six-item scale that included exhibitionism, fetishism, transvestism, voyeurism, promiscuity, and compulsive masturbation.

• Substance Abuse History. The score for substance abuse history is derived from three items: (a) frequency of drinking, (b) lifetime alcohol use, and (c) drug use history.

• Social Competence. The score for social competence includes three items: (a) the quality of peer relationships in adulthood, (b) the level of heterosexual attachments in adulthood, and (c) marriage.

• Victim Gender. Victim gender is coded for up to 3 victims per offense and for up to 10 separate offenses. When all known victims are female, the code is "opposite sex." When all known victims are male, the code is "same sex." All other cases are coded as "mixed."

COMMUNITY NOTIFICATION

The issue of community notification of released sex offenders has recently become a major subject of political debate at both the state and federal level. This debate has both statutory and social policy implications and raises at least three major problems. First, we assume that those individuals who are informed about the identity of a recently discharged sex offender will act in a responsible manner. There is little evidence to support that assumption and considerable evidence to support the opposite conclusion, that people will take "matters" into their own hands and the result will be further violence (such as the neighbors who burned down the home of an identified child molester in the state of Washington, or the neighbors who assaulted a man that they mistakenly thought to be a child molester in New Jersey). In general, some degree of vigilantism, resulting in more crime and more injury, should be anticipated as a consequence of community notification.

Second, the purpose of notifying neighbors is for protection (so parents can keep their children away from potentially dangerous people). Although the immediate community may effectively keep their children away from an offender, the offender is not prevented from going to an adjacent community, or getting into his car and driving to an even more distant community. Community notification may accomplish nothing more than forcing the offender to seek his victims elsewhere.

Third, it is possible that some offenders will re-offend because of the stress and pressure imposed by a hostile, rejectionist community that has branded the offender as a pariah. Thus, community notification may unwittingly increase the likelihood that some sex offenders re-offend.

TREATMENT AND PAROLE

Some constructive responses to the problem of potentially dangerous sex offenders include the following:

(1) Risk assessment can be routinely instituted for all sex offenders who, at time of discharge or parole, are deemed to be dangerous by virtue of violence and/or repetitiveness. At the very least, those who are deemed to be at high risk should be mandated for treatment.

(2) Lifetime parole supervision should be considered for highly repetitive sex offenders and those who have committed particularly violent acts. Although this would rarely be necessary for incest offenders, it may be appropriate for many extrafamilial child molesters. Lifetime parole is vastly cheaper than imprisonment, more acceptable than indeterminate sentences on constitutional grounds, and a reasonably good compromise for protecting society. For offenders who are mandated to be in treatment or who need to be on medication (such as Depo Provera), parole supervision substantially increases compliance.

(3) The confidential notification of local police departments and the District Attorney's office is entirely reasonable and can often be an important element of maintenance in the community.

(4) Well-coordinated treatment services provided by *trained* therapists who are experienced working with sex offenders should be available, both in prison as well as after a prisoner returns to the community. Treatment in the community is particularly critical for adjustment and maintenance. Treatment should be considered one aspect of an overall maintenance program that is coordinated by a parole officer.

(5) Intensive parole supervision should be implemented by hiring additional parole officers who will carry small caseloads and who will he highly trained in assessment, evaluation, and community maintenance of sexual offenders. Caseloads should not exceed about 15 offenders to ensure effective supervision. This program of intensive community supervision will be less expensive than keeping sex offenders in prison and more effective than community notification.

Consider, for example, what the cost savings would be in the Commonwealth of Pennsylvania. It costs $25,000 per year to house an inmate in one of the state correctional facilities. A parole officer's average salary is $35,000/yr. If one parole officer had a caseload of only 15 sex offenders, the Commonwealth would save approximately $340,000 by supervising those 15 men in the community rather than keeping them incarcerated ($25,000 x 15 = $375,000 - $35,000).

There are approximately 3,000 sex offenders currently housed in the Commonwealth's penal facilities. If the Commonwealth paroled only 10 percent of the least dangerous offenders (e.g., many of the incest offenders) and hired 20 new parole officers to cover them, the Commonwealth would save about $6.5 million per year (300 x $25,000 = $7,500,000 - (20 x $35,000 = $700,000) = $6,800,000).

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MODEL COURT PROGRAMS FOR DOMESTIC VIOLENCE

Sharon Denaro

Domestic violence involves a complex set of dynamics which court systems are just beginning to address. In the absence of research studies, those who design systems that address domestic violence have, by necessity, depended on the collective wisdom and experience of many experts who work in the field.

Few jurisdictions have integrated systems that combine all the necessary components for development of a systemic approach to reduce domestic violence. However, many jurisdictions have developed one or more programs in specific areas such as:

- Dedicated domestic violence units within the local prosecutor's office, the police department, or both.
- Dynamic treatment modalities for the treatment of the batterer such as the model developed in Duluth, Minnesota.
- Nonprofit corporations established to advocate for victims of domestic violence, which may provide victim advocacy, emergency shelter, legal advocacy, community education, and domestic violence training for court or other agencies.
- Legal clinics sponsored by local law schools, Legal Aid, ethnic organizations, or other special interest groups.
- Specialty courts dedicated to hear domestic violence cases exclusively. Some jurisdictions may feature one or more judges who hear petitions for civil protection orders, while other jurisdictions may focus on domestic violence criminal cases. A few jurisdictions may have courts that hear both criminal and civil domestic violence cases. An ideal approach is the creation of a Domestic Violence Division of the court with jurisdiction to hear all cases where domestic violence is an underlying factor. These cases would not only include protection orders, misdemeanors, and felonies, but also divorce as well as other cases traditionally heard in the family division. This model is currently being considered in Washington, D.C.

Many domestic violence programs were developed because of the determination and zeal of a specific agency or interest group. Many model courts developed because individual judges were dedicated to this approach. Until very recently, commitment for this approach from the highest levels of the court and government has been lacking in most jurisdictions. Well-developed, integrated domestic violence systems require

planning, best accomplished by interagency task forces and re-appropriation of precious public resources. However, without a unified effort at the highest levels of authority, domestic violence initiatives will remain fragmented and research will be hampered.

In 1992 the National Council of Juvenile and Family Court Judges published a survey of selected outstanding model court programs. Few programs are found within completely integrated systems because few such systems exist. The model program initiated in Dade County, Florida, on November 1, 1992, for example (after the completion of the survey), is not included. In addition, the Pennsylvania Coalition Against Domestic Violence in Harrisburg, Pennsylvania, has completed a survey of five jurisdictions that have dedicated civil injunction courts. The Pennsylvania Coalition study (Merryman, 1995) includes Miami, Philadelphia, District of Columbia, Denver, and Indianapolis.

BASIC ASSUMPTIONS

In the development of the Dade County Domestic Violence Plan, a set of the basic assumptions formed the theoretical framework for the court's initiative.

First, when ignored, domestic violence escalates, and many victims return to their abusers. Second, children who witness domestic violence are themselves victims of domestic violence. Third, inaction by the justice system including the police, prosecution, and the court, ensures that the same offender will return to the justice system repeatedly, increasing the possibility of serious injury to the victim. Fourth, the same inaction teaches the victim not to trust the system and teaches the perpetrator that domestic violence is permissible, thus perpetuating the cycle of violence.

System action, early in the cycle of domestic violence, is critical and eventually may stem recidivism. Specialized domestic violence courts, focused on injunctive relief and criminal prosecution of misdemeanors early in the cycle of violence, provide the best opportunity to stop violence before it escalates and also affords the best use of resources. Court-mandated treatment, including jail treatment, will reduce domestic violence. Such treatment should include both a domestic violence and substance abuse component, where appropriate.

Civil protection orders offer victims an additional doorway to the justice system and offer additional protection and support to the victim who may or may not be ready to pursue criminal prosecution. The court system must be "user friendly" to victims of domestic violence so that access to protection orders is assured 24 hours a day, 7 days a week. Both victims and their minor children need treatment and support groups designed to help them recover from the effects of domestic violence. Domestic violence will diminish where there is accountability and strict enforcement of court orders, including:

- court-mandated treatment in both civil and criminal cases;
- monitoring of court orders by the appropriate probation agency;

• further monitoring through a process of judicial review by the judge who entered the order;

• swift prosecution of criminal violations or criminal contempt by trained prosecutors; and

• dependable, consistent police action, including statutory warrantless arrest of offenders, where there is probable cause to believe that a violation of an order of protection has occurred.

Additional assumptions include the belief that coordination of local victim service agencies, advocacy groups, and private treatment providers can provide better service to victims and treatment for offenders.

DADE COUNTY DOMESTIC VIOLENCE PLAN COMPONENTS

The planning group recognized that the development of the initiatives enunciated in the Dade County Domestic Violence Plan would require a standing committee comprised of affected justice system and community representatives. They also determined that evaluation of the "success" of the program would require that all components work together in the development of new services for victims in the future.

In addressing these assumptions, the planners recognized that many of these components already existed in Miami, though they were not necessarily working together or they required enhancement. For example, Dade County had a progressive state law that seemed to mandate interagency cooperation. The court system also had a chief judge who dedicated staff and resources to develop a model program that would include specialized domestic violence courts for both civil and criminal cases. Several judges were willing to help design and then serve in the new court, and a supportive state attorney had established a specialized domestic violence screening and prosecution unit. The system also had a progressive police department willing to make changes; two county-run model programs that included the women's shelter and the domestic violence offender treatment program; and the county manager's office established a unit dedicated to victim advocacy and the coordination of victim services. Finally, the county leadership was willing to fund the project, despite the absence of empirical data that recidivism would be reduced.

The existing components were enhanced by a 24-hour hotline with access to an emergency judge 7 days a week; a domestic violence intake unit run by the court that assists petitioners with emergency petitions for temporary relief and emergency social service referrals; a domestic violence division of the court that hears petitions for civil protection orders, criminal misdemeanors, and provides judicial review of its treatment orders; a dedicated section of the probation department that provides an assessment and monitors compliance of treatment orders; county-funded treatment slots combined with a network of private treatment providers; and free group therapy for children through a division of University of Miami Medical School.

The plan was written by the participants after a thorough examination of other national models. Certain components that were selected as critical to the model were identified, integrated, and coordinated prior to implementation.

Final components of the plan or enhanced components were added following implementation in the criminal misdemeanor and the civil injunction courts. These are described below.

Criminal Misdemeanor Court

Domestic violence criminal cases are filed with one of four judges in the Domestic Violence Division of the court, and these domestic violence judges preside over domestic violence hearings. The court is staffed by public defenders with knowledge of the dynamics of domestic violence. Domestic violence arraignment occurs within 21 days.

The State Attorney's Domestic Crimes Unit consists of specialized prosecutors, paralegal staff, and victim witness counselors. The Domestic Crimes Unit interviews the victim prior to arraignment. Diversion (for first offenders) or a plea is offered to the defendant at arraignment. Both diversion and plea offers mandate treatment (including substance abuse treatment where appropriate) as a condition of diversion or probation. Those defendants who wish to plea not guilty are set for trial.

Defendants deferred or adjudicated guilty are referred to assessment within the domestic violence unit of the probation department and then are assigned to a treatment group. Defendants are assigned according to their geographic location and financial ability to pay for cost of treatment. Indigent and low-income clients are treated by a county-run program or the probation department. Nonindigent clients are referred to private providers on sliding scale.

Compliance is tightly monitored by the probation department and the court. The probation department monitors the progress of the defendant in treatment. Judges review treatment progress on a judicial review calendar, similar to those utilized for drug courts. Probation violations are heard on a separate calendar.

Civil Injunction Court

The Domestic Violence Intake Unit (DVIU) of the court conducts an interview of every individual who wishes to petition for an injunction for protection against domestic violence. This unit, part of the Court Administrator's Office, is assisted by personal from the Clerk's office. The petitioner is assisted with the actual filing for the injunction and emergency social service referrals. Emergency ex-parte injunctions may be obtained through this unit 7 days a week and an emergency hotline number can access an emergency judge 24 hours a day. The hotline number is shared with the local women's shelter. Petitions and ex-parte temporary orders, if they are issued, are served by the sheriff's department at no cost to the petitioner. Permanent injunction

hearings are set within 15 days before a judge in the Domestic Violence Division. Whenever necessary, judges are assisted by staff court coordinators, members of the Florida Bar, who assist litigants with minor children develop both visitation schedules and child support recommendations based on statutory guidelines.

If the court enters a permanent injunction and the respondent is ordered to treatment, the respondent is also ordered to report to the probation department for assessment and monitoring as described in the criminal description above. As in the criminal model, the court provides judicial review. Violations of the court's order may be enforced by either criminal or civil contempt as well as the filing of a new charge. Criminal violations or new charges are prosecuted by the State Attorney's Office.

OUTCOME MEASUREMENTS AND EVALUATION CRITERIA

In September, 1993, one year after the implementation of the Dade County Domestic Violence Plan, John S. Goldkamp from the Crime and Justice Research Institute in Philadelphia, Pennsylvania, received a grant from the National Institute of Justice (NIJ) to study Dade County's domestic violence court process and the outcome of treatment in selected cases.

In addition, the State Justice Institute (SJI) awarded a grant to Dade County's court system to develop a dual-diagnostic treatment model for domestic violence offenders who are also substance abusers. Dr. Goldkamp was again chosen to evaluate this second project within the overall NIJ study. The results of these studies should be ready for publication by Dr. Goldkamp in late 1995.

In addition to this research, the Dade County Grand Jury, Spring Term, 1994 examined domestic homicides, attempted homicides, and stalking cases from the year 1991 (one year prior to the implementation of the domestic violence plan) and 1993 (one year after its adoption) (Final Report of the Dade County Grand Jury, Spring Term A.D. 1994, Circuit Court of the Eleventh Judicial Circuit of Florida In and For Dade County). These data indicate that domestic violence homicides decreased slightly, though overall nondomestic homicides increased. In 1993, 73 percent of the arrestees had a prior criminal arrest for general crimes at the time of arrest as compared to 60 percent of the arrestees in 1991. However, the number of prior arrests for domestic violence offenses among those arrested in 1993 was lower than those arrested in 1991.

With regard to other felonies (not homicides or attempted homicides), overall domestic violence felonies increased from 13 to 16 percent. It is not known whether this reflects an actual increase or increased reporting. In the area of stalking, 73 percent of arrestees had a prior criminal record and 35 percent had been arrested for crimes of domestic violence against their victim.

FINAL OBSERVATIONS

The development of model court programs in coordination and cooperation with other affected justice system agencies, treatment providers, and community advocacy group represents a promising opportunity for intervention services in the field of domestic violence. Coordinated efforts have several positive results:

- the same offenders and victims may stop re-entering the system for repeated violence;
- scarce resources may be utilized in an effective manner without wasteful overlap;
- increasing numbers of defendants may modify their behavior in response to systemwide accountability;
- victims of violence and their children may escape the cycle of violence; and
- the community at large may be educated to the dynamics of domestic violence.

Some of the most challenging difficulties in developing intervention efforts in the field of family violence reside in achieving coordination among the various components. If coordinated systems prove to be an effective means of combating domestic violence, then the initial challenges include the need to identify the necessary system pieces and to convince leaders in the hierarchy of government, the court, and the other identified governmental and community system components to work as a team. Once this is achieved, domestic violence task forces or councils can be empaneled collectively to develop and implement coordinated systems and to develop standard protocols and procedures for each system component. After implementation, interagency boards or committees need to be in place to ensure the effective participation of each component. Funding sources need to be in place so that every community can develop and implement coordinated plans. Local communities would also benefit from the creation of national databases so that innovative programs can be shared with other jurisdictions. The development of standard evaluation criteria would assist each jurisdiction in the assessment of their own programs.

Research on systemic approaches to the problem of domestic violence as well as new and better treatment modalities for offenders, victims, and their children would help to improve the operations of local systems. Many jurisdictions have developed one or more domestic violence court programs, such as specialized police or prosecutor units, dynamic treatment methods, victims advocacy groups, legal clinics, and specialty courts. However, few jurisdictions have integrated systems combining all the components for reducing domestic violence.

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MANALIVE TRAINING PROGRAMS FOR MEN

Hamish Sinclair

Manalive Training Programs for Men has provided innovative batterer re-education programs to communities in the San Francisco Bay Area in California and consultations on male violence intervention programs, nationally and internationally, for over 14 years. The Manalive system of batterer interventions was developed in 1980 for the Marin Abused Women's Services (MAWS) in San Rafael, California, in response to women's experience of violence and their urgent need for it to stop. Since 1985 Manalive has been an independent organization that provides technical assistance and training for individuals and community agencies providing direct services to batterers. Recently we established the Manalive Education and Research Institute to support local programs, research and evaluate intervention methods, provide training services, and educate the public on men's violence.

There are over 20 Manalive community-based programs in the San Francisco Bay Area--several in San Francisco (one Spanish monolingual), including the San Francisco City Sheriff's Department, one at the California State Prison at San Quentin, and programs in Napa, Nevada, and Placer counties. Since 1986, Manalive classes for batterers have been offered 4 nights a week, for 50 weeks each year. Over 1,000 men participate in classes in the Bay Area, and the hotline responded to over 1,800 calls in 1994.

The Manalive programs seek to end men's violence to women by engaging men in changing the beliefs that result in violence to women and in fostering nonauthoritarian relationships of equality and intimacy with women. Manalive programs are based on a six-stage re-education process in a peer setting, utilizing an "each-one-teach-one" methodology under the supervision of a trained facilitator. In the first-, second-, and third-stage classes, each of which meet once a week for 3 hours for 16 weeks, men agree that they are emotionally, verbally, and physically violent to their intimates and agree to stop their violence. They also create a mutually supportive environment in which to change their own beliefs and behaviors and challenge community attitudes that sustain men's violence.

Since a principle of the program is that men must be accountable for their violence, they are required to pay, on a sliding scale, for these classes. Both the classes and the 24-hour hotline are operated by volunteer graduates of the program under the supervision of Manalive staff. As men progress through their own re-education process they assume more responsibility for presenting material, facilitating exercises, and

coordinating logistical support. Men who complete the first year of classes and remain violence-free may participate in an ongoing training program for volunteers. More than 140 men have become volunteers since 1980, and 35 men serve as facilitators, program advocates, and hotline volunteers as of June 1995.

THEORY OF INTERVENTIONS

The system of interventions developed in Manalive programs explicitly relies on a gender analysis of control and coercion. In this model, men's violence is seen as the socially approved enforcement of the cultural belief that men have authority over women and children. Four basic principles inform this model. First, batterers' abusive behavior is an effort to control through a broad continuum of coercive behavior, not limited to physical actions. Second, beliefs and attitudes support abusive behavior. Third, men require education to learn how to change these beliefs and attitudes in order to stop their violence. Fourth, once men are violence-free, they need to learn to express intimacy effectively.

This model generates the following assumptions for program design:

- The intervention focus must be on men because men are the primary perpetrators of domestic violence.
- The intervention focus must be on men's belief system because current social values support and teach male-role domination and the subjugation and subordination of women by men.
- Changing men's loyalty from the male-role belief in their superiority over women to one of equality with women would render violence unnecessary.

The California Alliance Against Domestic Violence has adopted the gender-based intervention theory and has used the Manalive model to establish standards for court-ordered batterer intervention programs mandated in the 1993 California Assembly Bill No. 226. This legislation requires that batterer intervention programs include the examination of "gender roles, socialization, the nature of violence, (and) the dynamics of power and control (Chapter 221, Section 1000.93).

OUTCOMES

The goal of Manalive is attitudinal and behavioral change that will lead to the cessation of violence by men against women. The program seeks to measure its effectiveness by questions such as:

- Has the man's emotional, verbal, and physical violence stopped?
- Does the man take responsibility for his violence and for his efforts to stop it?

- Does the man demonstrate an understanding that attitudes and behaviors to maintain dominance are unacceptable in an intimate relationship?
- Has the man learned that physical, verbal, and emotional abuse represent a male-role belief system that is based on men's domination of women?
- Does the man demonstrate that he has learned intimacy skills to replace his violence?
- Does the man genuinely care for himself and for those who care for him?

Positive responses to these questions are the expected behavioral outcomes of the belief-system change advocated by the program. However, the ultimate success of a program is based on women's reports that the violence has stopped. The practice of monthly partner feedback provides ongoing evaluation of program effectiveness. Not all women participate, either because of fear or unwillingness to continue the relationship. Those who do participate report the cessation of violence as well as marked changes in deep-seated attitudes within the relationships.

Nevertheless, negative outcomes can also be associated with any program. Through partner feedback it is sometimes reported that a man has learned to manipulate or oppress his partner. Attrition rates are also a source of concern. The last analysis indicated that 37 percent of the clients did not finish the entire 32 weeks of the program. This is a significant attrition rate, especially because the men who come to the program represent only a small percentage of the men who actually are violent and who would benefit from the program.

EVALUATIONS

No research team has conducted an evaluation of this program to date. The long-term outcomes of Manalive have not been measured in a systematic way, although one statistical analysis based on the class registration logs and violence-reporting instruments was done in 1988 by Harder and Kibbe, a community-service assessment consulting firm.

Since the program focuses on the development of a community of nonviolent men, there is subsequent contact, and thus there is much anecdotal evidence of its success. Following participation in the program, men talk to each other more openly about their history of violence and their ongoing struggle to stop it. The former participants are the program's best advocates when they declare how fundamentally the program has improved their lives. In fact, a number of men enter the program on the recommendation of men who have participated in the program rather than through the court system. Referrals also come from therapists and counselors who have been through the program and from the extensive 12-step network in the community.

Finally, many men who enter Manalive as batterers become volunteers in the program, sustaining and expanding it, and often becoming advocates to end other men's violence to women in their communities.

OPPORTUNITIES

The increased national interest and attention on the issue of men's violence to women, and the violence of men and boys, has generated promising opportunities for intervention services focused on intimate violence. High-profile events such as the O.J. Simpson trial come at the culmination of an almost 20-year effort by the battered women's shelter movement to place the issue of domestic violence at the center of national attention. This public awareness also provides the opportunity to increase individual attention and community interest in prevention programs focused on men. Manalive has already experienced a significant increase in referrals to the Bay Area programs, as well as requests for information and training services from other programs in the United States and other countries.

The Manalive Education and Research Institute is facilitating the development of neighborhood batterer intervention programs in the San Francisco Bay Area as a model project for the nation. The diverse multicultural population of the Bay Area offers unique challenges in designing culturally sensitive programs, which could provide a rich source of further knowledge about the sources of men's violence and the methods that will end it.

The willingness of program graduates to set up, facilitate, and maintain programs represents an opportunity to bring together a community of men dedicated to ending the current tragedy of men's violence in the home, and, in addition, campaigning to change the contemporary cultural standards that condone male violence.

CHALLENGES

The process of evolving from a direct intervention model to a community prevention model includes a number of distinct challenges. These include:

- Educating men to give priority to the safety of women who choose to leave controlling, coercive relationships, and allocating significant resources to provide services for women who break the batterer's cycle of control.
- Establishing batterer intervention program standards, for example, length of program, aims, content, and quality control methods. These standards would help programs that now exist to operate with greater effectiveness and accountability, and new programs would be based on the experience of the shelter-related intervention community.
- Moving from an intervention strategy that engages men who have been referred to a batterer's program in changing their beliefs and behaviors to a prevention approach that engages all men in preventing male-controlling and coercive behavior.
- Networking with the medical, judicial, probation, and law enforcement agencies to provide technical assistance to improve and integrate effective community responses that hold men accountable for their violent behavior in local cases of domestic violence.

- Building a community of men dedicated to an alternative belief system of cooperation rather than competition and identifying and studying viable models that support this effort in order to reach the "critical mass" required to change sociocultural norms.
- Exploring the role of formerly violent men as advocates to other violent men and as activist/educators in their communities.
- Exploring additional strategies for holding men accountable for their violence, including legal and nonlegal social sanctions.
- Creating an awareness of the essential role that men can play in identifying and preventing men's violence and developing strategies to educate men in regard to the full spectrum of abusive and violent behavior.

The high toll of male violence on the health and well-being of the families and the nation is increasingly a matter of public concern. Approaches need to be developed to reach the men who do the violence and who have it in their power to stop it. One strategy that deserves greater consideration is an examination of the social sources of men's violence and the methods that encourage men to account for and change their violent behavior.

DISCUSSION HIGHLIGHTS

In the workshop discussion that followed these presentations, the participants noted that major attention in treatment services for offenders in the area of child abuse has been given to mothers, rather than fathers, often because service providers have more opportunities for access to mothers in health care and home visitation programs. More thought needs to be given to the role of fathers as caretakers, and opportunities for intervention could be developed in the workplace, health care settings that treat young men, recreational centers, or other settings.

The caretaker or partner's perception of behavior, and attribution of hostile intent or other negative attributes, may be important topics for the development of future intervention programs, both in the field of child abuse and intimate violence. Aspects of coercion and control, rather than just physical violence, deserve attention in developing the frame of reference of treatment programs. The use of power and anxiety in intimate relationships, rather than simple impulse control, are important indicators of behavioral change that have received little attention in offender treatment research. Service providers also need to improve the offenders' skills in dealing with acute confrontations as well as fostering changes in attitudes and beliefs that support abusive behavior.

The impact of batterers' treatment program on child-rearing practices is an additional area that deserves particular attention in future treatment studies. The time-frame for most evaluation studies is 6 to 12 months, which offers little opportunity for observing significant changes in relationships or parent-child dynamics. Domestic violence programs need to focus on children as well as women, which requires coordination and integration of comprehensive programs such as criminal justice and social work.

Panelists agreed that the issue of child abuse as a precursor of later abusive behavior is extremely complex. To understand the impact of abuse on a child in both the near term and later in adolescence, several factors require consideration: the age of onset and duration of the abuse, its invasiveness, and the relationship of the perpetrator to the victim. The notion that the vast majority of sex offenders were themselves abused and are simply doing what was done to them has come into question. While it is true that many sex offenders were abused sexually and otherwise, a large proportion were not.

In the area of domestic violence, one of the emerging challenges of perpetrator services is matching offenders with appropriate interventions. In the absence of demonstrated effectiveness for a particular approach, batterers need to be matched with different forms of treatment, including individual therapy, group counseling, or social change approaches.

The high rates of attrition and noncompliance require consideration in the evaluation of perpetrator interventions, which often seem to require higher standards of success than other interventions. The low success rate for treatment programs may reflect not just the efficacy of treatment but the fact that many batterers drop out or never begin. One participant suggested an analogy to the use of insulin in treating diabetes: the fact that some diabetics refuse insulin does not suggest that insulin treatment does not work; similarly, getting batterers into treatment should be viewed as a separate issue from the effectiveness of the treatment. Yet the issue of motivation and the range of variation among human personalities are crucial in understanding the rates of attrition in voluntary and mandated treatment programs. The factors that influence compliance with treatment are an especially important research topic because the consequence of low compliance is often harm to others.

Research on the reasons and circumstances that clarify why potential clients refuse to participate or drop out in the midst of a treatment programs can provide important insights in this area. The potential for treatment programs to provide surveillance opportunities for future abuse incidents should also be recognized. Additional empirical evidence is needed in assessing different forms of batterers' treatment programs to determine factors that contribute to or weaken their effectiveness.

Finally, it is important to determine the client's degree of participation in a treatment program in assessing the effectiveness of a selected intervention. To be effective, treatment requires a certain level of exposure to key concepts and appropriate feedback on behavioral reports. The efficacy of a program may be weakened if the client is chronically absent, late, or participates in a limited manner. Service providers may require more autonomy or authority in determining whether a client's participation is adequate to justify continuing treatment services in cases where the courts have resorted to this type of intervention as an alternative to punitive sanctions.

Comprehensive Services

The connections and linkages between the causes and consequences of different forms of family violence have prompted some agencies and communities to develop coordinated strategies in treatment and prevention. Comprehensive service efforts can be administrative conveniences designed to integrate fragmented program activities, or they can represent systematic efforts to integrate diverse units into a coherent strategy focused on the treatment and prevention of selected forms of family violence. The desire for integrated, comprehensive, community-based programs that integrate services from health, social service, and legal settings has stimulated a variety of models and approaches that deserve careful analysis. The combination of services, however, creates a major methodological challenge in determining the effectiveness of a comprehensive approach, for it may be difficult to establish adequate measures for comparing the effects of the separate components of programs that involve multiple agency participation.

Three comprehensive programs were presented in the workshop, two of which were based in local criminal justice systems and the third located in a major urban hospital setting. The two criminal justice systems are focused on domestic violence interventions, while the hospital program seeks to use child abuse reports as an early screening device in identifying possible cases of domestic violence. These efforts suggest that there are multiple opportunities for system integration efforts to enhance responses by institutional systems to complex issues of human behavior.

THE DULUTH DOMESTIC ABUSE INTERVENTION PROJECT

Mary E. Asmus

The City of Duluth, Minnesota, has developed a coordinated community response to domestic violence over the past 14 years. The Duluth Domestic Abuse Intervention Project (DAIP) has two primary goals: (1) to bring together various components of the justice and human service systems in the city of Duluth to intervene in domestic violence situations and to protect victims from further violence, and (2) to hold both individual perpetrators and the community itself accountable for the violence that historically has been acceptable in families.

The Duluth project has been built upon three basic assumptions. First, it is the responsibility of the community, not the victim, to stop the battering in domestic violence. The victim is not responsible for bringing on the violence, and the larger community has a responsibility to intervene in domestic violence situations.

Second, victims of domestic violence come from all parts of society, age, race, and class distinctions. Both "nice" and "not nice" women are beaten by their partners. As a result, victim-blaming practices are a form of collusion with the batterer and do not promote the confrontation of the violence itself.

Third, a community cannot effectively intervene against domestic violence without understanding the power dynamics that accompany the violence. Individuals in a violent relationship are not equally powerful, autonomous beings who operate independently of each other. The power differentials between men and women that result from the historic right of men to punish and chastise women are recognized as important elements in the development of a strategy for intervention and prevention.

THEORETICAL FRAMEWORK

These assumptions and goals underlying the efforts of the Duluth DAIP have led to the development of a theoretical framework that guides the activities of the project. Seven activities have been identified as essential elements in the operation of an intervention program:

(1) A theoretical foundation for understanding domestic violence is necessary to understand the problem of domestic violence. Legal and mental health systems cannot be repaired without addressing fundamental errors in thinking about domestic violence

itself. System practitioners in community programs need to substitute a different theoretical foundation for victim-blaming practices, or the result may be a more efficient, but misguided, system of services.

(2) An intervention project should develop policies, procedures, and guidelines for the best practices in each agency. Basic protective measures should be the focus of policy development, and they should address considerations such as the necessity of shifting the burden of responsibility for stopping the violence from the victim to the community; preserving victim autonomy and self-determination; and eliminating broad discrimination while establishing policies that allow agencies to respond effectively to individual cases.

(3) A monitoring function is a necessary part of an intervention strategy. Case monitoring facilitates networking and information sharing among agencies in the community, a process that allows fragmented systems to have greater access to important information about particular cases. Case monitoring should hold both abusers and practitioners accountable to battered women and to community norms and standards.

(4) A coordinated community response facilitates the operation of multiple agencies as a unified system rather than as individual entities. Communication among therapists, probation officers, and prosecutors is one example of a coordinated response.

(5) An intervention program needs to provide basic services for women, including safe housing, financial assistance, legal advocacy, and educational groups. These basic services are fundamental to the development of all other activities, and they determine what policies and procedures are appropriate for women in a particular community. Thus, if a shelter did not exist in a community, then a law enforcement policy of mandatory arrests may not provide protection for women.

(6) Intervention with offenders requires the effective confrontation of abusers in a manner that is protective of victims. The program should acknowledge that most abusers are the products of a community's values and address the broader context of practices that may encourage abusive behavior.

(7) Evaluation is a final essential activity of an intervention project. Evaluation studies need to assess the impact of the intervention on battered women, the impact of battered women on the larger community, and the extent to which the intervention has improved the safety of women within a particular community. Evaluations should also consider whether the system has challenged the historic right of men to batter women and whether deterrents have been created for individual batterers as well as a general deterrent to domestic violence in the community.

OUTCOME MEASURES

Outcome measures in the DAIP are viewed from the perspective of how women experience the system that they turn to for help. The emphasis of the DAIP evaluation effort is on the totality of efforts in the community to address domestic violence rather

than quantitative measurements of specific but sometimes disjointed activities (Novak and Galaway, 1983; Shepard, 1987, 1988, 1990). The project team explores whether violence against women has been reduced in the community, whether individual women have acquired a greater sense of autonomy, and whether deterrents have been created for individual batterers.

DAIP evaluation studies have a continual focus on obtaining input from battered women in the community. Research has also been conducted to determine which abusers are recidivists in Duluth and which abusers are most likely to re-offend. These studies suggest that the men most likely to re-offend exhibit characteristics of alcoholism, severe childhood abuse, and a history of general crime. Through anonymous questionnaires, victims are asked to critique their experience with various practitioners in the system and to evaluate the effect of the overall intervention on their personal safety. The analysis of these questionnaires is analyzed with women who have used the shelter and other services in Duluth.

NEW INITIATIVES

The Duluth project is now developing a new tracking system with a grant from the Centers for Disease Control and Prevention (CDC) that will allow practitioners to have immediate access to updated case information with reports from other service programs. The information will be centralized within the community-based group, the DAIP, and will be accessible to practitioners on a need-to-know basis. The tracking system will be tested to see if it can be replicated or adapted in other cities.

The CDC grant will support additional systemic changes in order to heighten the level of emergency response to particular women who are in situations of increasing danger, because of either increased severity or frequency of violence. This approach will highlight cases at risk for serious assault or homicide if intervention efforts do not occur. The emergency response program will supplement existing efforts to secure broad compliance with basic policies and procedures in the community's legal and mental health systems, including mandatory arrest by police, aggressive prosecution, increased sanctions for offenders, and a movement away from couples counseling toward a group treatment process for men who batter.

DAIP is an institutionalized community advocacy model--a community holding itself accountable for intervention in domestic violence. The program is a nonprofit corporation that receives no funds from the city or county government, although agencies of the criminal justice and mental health systems participate in its activities. The leadership of the Duluth project has come from a community-based group, and this approach provides a creative tension in the system of services. The history and structure of the program has encouraged practitioners to debate and discuss whether enough was being done, how the system might be improved, and whether all aspects of the system have implemented the policies that have been developed. In contrast to a task-force model (comprised of agency representatives with minimal participation of advocates), the Duluth project is characterized by an approach where members of the

community, including battered women, hold the system and community accountable for the protection of battered women. Project staff are concerned that in many communities, in the rush to do something about domestic violence, the voices of the victims may be silenced. Task forces and coordinating councils may not include battered women, and if they do, the women may be add-ons to agency members.

FUTURE CHALLENGES

One of the most challenging difficulties in providing interventions involves the backlash that has arisen in the area of domestic violence. Programs have been criticized because they appear to be biased toward women and victims. The development of mens' rights organizations and the national mood on this issue contribute to this backlash. Research data that suggests that women are as violent as men has contributed to the resistance to program initiatives. As a result, system practitioners and the larger community are often reluctant to view domestic violence in terms of gender and power relationships that exist between men and women.

A second challenge in developing intervention efforts concerns the nature of domestic violence itself. The key goal is to protect battered women and hold abusers accountable for their actions, not simply to develop more efficient systems of service delivery. For this reason, battered women and battered women's advocates need to be involved in developing and evaluating programs and policies in this field. The major challenge for practitioners and communities is to develop practices of substance, not merely of form.

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DOMESTIC VIOLENCE RESPONSE TEAM

Mimi Rose

The Family Violence and Sexual Assault Unit in the District Attorney's Office in Philadelphia is responsible for the prosecution of child abuse, domestic violence between intimate partners and family members, and adult sexual assault. The unit is staffed by 15 prosecutors; 3 victim advocates who provide information, court accompaniment, multiagency coordination social service, housing and mental health referrals for adult and child victims and witnesses; 3 police officers who do follow-up investigation and handle reports of witness intimidation; a domestic violence counselor from a local advocacy agency housed in our unit; undergraduate and law students who volunteer their efforts; and a family therapist and forensic child psychiatrist who consult pro bono when requested. The unit was developed to retain the significant benefits of specialized prosecution. Prior to 1990 the Philadelphia District Attorney's Office had discrete specialized units for child abuse, domestic violence, and adult sexual assault. It became apparent that separate intervention systems to protect children and to protect their caregivers was an unrealistic and sometimes dangerous configuration. The present structure of the unit reflects the reality that child sexual assault is often one incident of a pattern of long-standing abuse within some families.

Three basic principles guide the unit's work. First, criminal justice response to family violence must be proactive as well as reactive. The amount of resources allocated to a prosecution cannot always be determined by the charges filed. Rather than being satisfied by a successful prosecution of a domestic violence homicide, we need to also aggressively intervene in less serious episodes of violence, especially misdemeanor crimes where there are risk factors that should alert us to an increased likelihood of continued violence.

Second, a multidisciplinary approach works best. Collaboration and coordination between prosecutors, victim advocates, social service, and medical and mental health providers is essential. Cross-training, multidisciplinary protocols, and a service referral network must be ongoing efforts. We have come to recognize that the prosecution of family violence may not be the most important intervention. Going to court may be tertiary to other needs better served by other agencies. By recognizing the limitations as well as the possibilities of the criminal justice system, we can seek out alliances and resources to enhance our efforts.

Finally, prosecution of family violence must be user friendly. People who have been hurt by violence must be given information, support, and the opportunity to be

meaningful participants in a case that affects their lives. As prosecutors, our decisions must be informed not only by the needs of our system but by the needs of the victims. The goal of winning a case, so central to our criminal justice response, must be redefined. We win when the quality of life for children and their caregivers is enhanced by involvement in our system. When families are safer, we win.

PROJECT AWAKE

Jennifer Robertson

The AWAKE Project (Advocacy for Women and Kids in Emergencies) assumes that victims of child abuse cannot be protected and aided unless their mothers are too. The program intervenes with mothers of abused children in order to prevent future incidents of child abuse and to improve the welfare of the mothers as well. The framework of the AWAKE Project is based on the belief that child abuse and woman abuse cannot be viewed as separate issues since, in at least one study, the overlap of the two is calculated to be 59.4 percent (Newberger et al., 1989). Conflicts over custody and visitation issues, intertwined with family violence issues, are often long and bitter, since issues of woman abuse can influence custody and visitation decisions.

The AWAKE Project began offering comprehensive services late in 1986 to ensure that Children's Hospital is a safe place for victims of family violence to disclose abuse. The program provides hospital staff from a variety of disciplines with training on family violence in order to assist them in recognizing the subtle signs and symptoms in women and children which may lead to subsequent identification of victims and referrals for AWAKE intervention services. The project offers crisis and long-term intervention services to support, validate, and empower women at risk of domestic violence. The objective is to facilitate changes in service systems to lessen the prevalence of unwarranted separations of mothers and children which in many instances only serve to revictimize both. The goal is to assist women and children in order for them to remain together and safe whenever possible.

AWAKE offers immediate risk assessment and safety planning; one-on-one counseling by phone and in person; a weekly walk-in support group; a six-week educational group; and telephone outreach to every woman referred to the program. The project offers a 10- to 12-week group session for children ages 6-10 who have witnessed or experienced violence each year.

A principal goal of AWAKE is to initiate and maintain interdisciplinary collaborations and community linkages. AWAKE staff members participate in committees within Children's Hospital such as weekly Child Protection team meetings and are also active members of several community and statewide advisory boards. These activities result in resource accessibility which provides optimal service plan development and protection for abused children and also their mothers when necessary.

In addition, AWAKE staff serve as advocates on behalf of all battered women and children with the medical, legal, and criminal justice communities throughout

Massachusetts. Collaboration with shelters and district attorneys is standard practice. Staff members participate in roundtable discussions in several courthouses; provide case consultation to agencies contracted to conduct in-home evaluations when child abuse is reported; and are frequent presenters in medical, legal, and criminal justice training sessions. In 1993 AWAKE initiated and continues to facilitate a Health Care Providers Meeting on Domestic Violence every 6 weeks with participants from over 30 health care facilities in Massachusetts and one each from Rhode Island and Maine.

One particular challenge associated with working with abused women and children in a healthcare environment is the development of specialized security procedures to maximize victim protection. In many cases, acts of violence by abusive partners occur during in-patient hospitalizations of children. AWAKE staff members attend rounds/case conferences and assist unit personnel in developing safety plans that may include visitation schedules; 24-hour security presence on the unit; the barring of the abusive parent; the moving of the medical chart to a secured location; and in many instances the changing of rooms, floors, and the elimination of the name from the reception desk and unit lists. Mothers are consulted in making such security decisions, and no changes or exclusions are implemented without their knowledge and, in most cases, their agreement.

One study of AWAKE cases from 1987 to 1988, which was performed by Kersti Yllo, a professor of sociology at Wheaton College, found that only one case resulted in the removal of a child from the mother by a child protection agency. In the same study, 85 percent of the mothers were no longer being abused after 16 months. Although 60 percent of the children had been physically abused and 24 percent sexually abused, abuse of the children had ceased in 76 percent of the cases.

During 1994, AWAKE served 481 women and 723 children. Preliminary analysis of this client base indicates that after AWAKE intervention, only 12 percent of the women remained with their abusive partners, although more than half still experience varying levels of control and violence, usually associated with visitations and court proceedings. About 87 percent of the women had experienced physical violence; 40 percent disclosed sexual violence; and 100 percent reported repetitive psychological maltreatment. From this clientele, only two mothers lost custody of their children to child protection agencies, but in both instances the child was returned within 90 days.

In determining project effectiveness, AWAKE monitors hospital staff and community provider awareness of service availability and referral protocols; visibility and accessibility to hospital staff, community providers, and abused women; perceptions of awareness, growth, and empowerment in women, which increase their own and their children's safety; and the ability to prevent unnecessary separation of children from their mothers.

Preliminary reports suggest that early identification of abused women in a pediatric medical setting can be effective and provides an atmosphere of safety for the women and their children. If family violence intervention services are offered to mothers in conjunction with medical, mental health, and supportive services for their children, the protective and positive impact can be immense.

In December 1994, AWAKE expanded its services by placing a trilingual/bicultural advocate in a community health center based in a low-income housing development in an area ravaged by poverty, street and family violence, and linguistic isolation. The goals are the same as stated earlier, with an additional goal to lower infant mortality and low-weight births through early identification and intervention with pregnant and also currently parenting women.

AWAKE's future plans include the development of more extensive evaluative research of program services. AWAKE also seeks to stimulate educational centers to develop intake protocols that would promote early identification of child and adult victims of domestic violence in day care, nursery, elementary, and even graduate school levels. Yet fiscal realities may limit opportunities for program growth and the level of service ability.

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DISCUSSION HIGHLIGHTS

The assessment of comprehensive service programs within local and state agencies is challenged by the lack of documentation regarding the basic processes, strategies, assumptions, and conceptual frameworks that are embedded in such efforts. Many comprehensive programs have provided insufficient information regarding their basic program design, characteristics of their client base, data collection efforts, and process components. In the absence of such information, researchers are unable to evaluate the relevant outcomes for such programs or to assess their relative effectiveness compared to categorical efforts within health, social service, or legal settings. What is particularly needed at this time is better documentation regarding the types of interagency coordination problems that are presented by comprehensive service efforts and assessments of the relative effectiveness of information-sharing within comprehensive service programs in various institutional settings.

Although many different service systems can contribute to a comprehensive response to the problems presented by family violence cases, each agency is often too busy with its own responsibilities to develop a coordinating strategy for others. For maximum effectiveness, it is often necessary to identify an independent coordinator whose sole task is to facilitate the necessary connections that are essential to comprehensive services.

Responses to multigenerational issues are especially complex, such as when women who are victims of domestic violence also abuse their children, or when issues of domestic violence require judicial consideration in determining custodial and visitation rights for the offending parent. In some cases, women behave abusively to shield their children from the violence of a man who is abusing both the woman and her children. In some jurisdictions, prosecutors discuss treatment options with social services and, if mitigating circumstances are present, they may support the need for options that facilitate at-home intervention rather than removal of the children.

The size of the community may be a significant factor in shaping the nature of comprehensive interventions. Community sanctions such as those in Duluth, where 1 in every 17 men has been through Domestic Abuse Intervention Project classes, may be more effective in a small city than a large one. Small community size may inhibit effective community responses, however, when victims are unwilling to report abuse because of fear of stigma or shame.

Participants examined the conflicts involved in policies such as mandatory

reporting, mandatory arrest guidelines, prosecution strategies, and sentencing guidelines. Although mandatory policies may encourage victim reportings and system responses, they can be dangerous if they reduce the role of discretionary judgment in responding to the needs and wishes of victims and the professionals who serve them. Mandatory arrest policies may help protect some battered women who would otherwise be reluctant to violate the traditions of privacy and confidentiality that characterize health care, research, and other fields of professional practice. Participants noted that such policies require definitions of probable cause so that reporting officials can recognize signs of warning, rather than relying on individual discretion. If such resources are not available, mandatory reports may do more harm than good.

Another detriment associated with mandatory reporting and arrest policies is the limited availability of services. If sufficient services are not in place to meet the needs of battered women and children, then reporting requirements create a tremendous burden on caseworkers and others. The result can be a response system than tends to emphasize case investigation rather than service delivery.

Participants observed that guidance from victims of family violence was very important, especially in dealing with battered women who are frustrated by the responses from agency representatives. Some systems that have limited resources and that are resistant to change have relied on family violence advocates as a means of holding divided and fragmented systems accountable for the wise use of resources in helping battered women and their children.

Final Observations

The participants in the Workshop on Family Violence Interventions shared a wide range of experience and concerns with the members of the committee. In addition to providing information on selected programs, the speakers offered practice-based perspectives on intervention, outcomes research, and program evaluation efforts in the field of family violence interventions.

In reflecting on the day's presentations, the committee identified a set of key issues that emerged from the presentations and discussions that followed each panel. These issues are highlighted here as a basis for further reflection and attention over the course of the study.

KEY ISSUES

The relationship between responses to child abuse and spouse abuse deserves particular consideration in the design of intervention programs.

Many participants expressed the belief that issues of child protection and domestic violence are intrinsically connected because child abuse and spouse abuse often coexist and may affect both the child's safety and the disposition of child custody cases. Tensions, and even direct conflicts, can arise between advocates for different affected groups who represent differing philosophies (such as child welfare advocates and battered women's advocates). The financial, physical, or emotional dependence of a victim on an abuser also deserves special consideration in establishing effective intervention strategies.

Opportunities for early identification of family violence need to be examined in terms of the organizational settings in which other family services are provided.

The growing involvement of health care providers in assessment and interventions for family violence, for example, raises many questions about opportunities for early identification, referral, and prevention of family violence.

Health providers in public settings have access to fewer resources and generally must handle more difficult cases. They often have limited ability to determine who receives treatment and they often receive only limited feedback on the disposition of cases that may be referred to social services or law enforcement agencies for further attention.

Monitoring and responding to complex cases is a labor-intensive effort.

Health care providers are sometimes brought into the circle of those providing assessment and intervention services on the assumption that such individuals can make risk and safety assessments quickly and inexpensively. However, for complex situations, referral or follow-up services can be very labor intensive, and most service providers do not have compensatory categories for such efforts.

The philosophy or ideology of family violence that underlies an intervention can make a difference in the form and characteristics of the intervention.

One of the major conceptual tensions that is affecting the design of family violence interventions is a discussion over gender-neutral and gender-specific approaches to treatment and prevention programs. Terms such as "spouse abuse" and "domestic violence" are general neutral; many program advocates now prefer terms such as "wife abuse" or "violence against women" to describe the perspectives that should be considered in the design and implementation of services.

Ideology can play a powerful role in shaping the direction and design of an intervention, but it should not restrict the scope of inquiry on program effects. Standards of evidence, guided by research theory and reliable instrumentation, can provide a valuable framework for independently assessing the relative effectiveness of a specific program apart from the claims of success of the program advocates.

Those who work in law enforcement agencies must often consider the threat posed by the offender to other potential victims, even if the current victim is "made safe" and does not wish to press charges. Several workshop participants noted that their philosophical view of family violence as a gender-linked expression of family dynamics had a profound influence on the conceptual framework that formed the basis for their intervention services. This view is held most strongly in the area of batterers' treatment programs for intimate violence.

Poverty and the lack of financial and material resources can affect the natural course of family violence.

Questions in the discussions emerged about intersections between poverty and family violence. The lack of financial and material resources can deeply affect family life, restrict access to services, and inhibit individual abilities or motivation to seek social and professional assistance.

The concept of *community* needs greater clarification in addressing the issue of community involvement and responsibility.

The need to involve communities in recognizing and responding to family violence issues is widely discussed as a major social policy goal. Community programs are increasingly encouraged to develop approaches that are responsive to needs and resources of their members. However, there is extensive variation in the use of the word "community" which could refer to a geographic area, such as a city or neighborhood, or to a group of people who share common values, such as a religion or similar ethnic background.

The rights of an adult to autonomy and self-determination need to be balanced against the community's responsibility to provide safety and to protect potential victims. Similarly, the child's right to safety and protection needs to be considered in the context of preserving family strengths and unity.

The issues of autonomy, safety, self-determination, and "best interests of the child" are value-laden concepts in our society. Service providers in a variety of settings are often frustrated by their efforts to resolve conflicts in responding to the needs of elderly victims who may have varying degrees of competency; in providing services for a woman who chooses to remain with a violent man despite apparent avenues for escape; and in dealing with adolescents who do not wish to remain in abusive home environments.

The determination of cultural competence in service interventions requires further consideration to determine which components are most effective in improving the quality of programs and practitioners.

The workshop participants agreed on the importance of developing culturally competent interventions, but observed that there is an absence of shared definitions, objective standards, or measures of cultural competence. The paucity of research in this area inhibits the evaluation of programs that are designed for special populations as well as the evaluation of programs that may fail to meet the needs of ethnic minorities.

Ecological or sociocultural frameworks that support "social change" approaches to family violence need to be compared with approaches that treat family violence as a reflection of individual pathology or risk factors that require treatment.

The factors that contribute to family violence cut across many sectors, including individual characteristics and experience, the family context, the neighborhood setting, and the culture of society. A major challenge for service providers is to select models that are most effective in addressing different forms of family violence and to find

ways to match interventions to characteristics of the people and communities that request them. In assessing family interventions it is particularly difficult to identify and assess the impact of the interventions as the dynamics of relationships within the family.

The consensus in the field is that there are multiple levels for intervention and multiple opportunities for treatment and prevention, yet program providers who focus on individual risk factors, or who may focus on cultural components of family violence, lack the opportunities to work in a coordinated manner so that their efforts may enhance each other's work.

Interdisciplinary and comprehensive responses require greater attention to the coordination process, the management of costs and cash flow, and evaluation procedures.

Several participants noted that, while interdisciplinary efforts may have the greatest potential for effectiveness, they are complex, requiring the presence of staff members whose sole function is to facilitate successful interdisciplinary interaction. The costs associated with managing coordinated responses across multiple agency settings have not been carefully detailed, and the evaluation procedures that should be applied to efforts that combine different approaches require further examination to develop flexible responses that address key concerns.

Evaluation frameworks and methods require critical examination to determine the best strategies for evaluating family violence interventions.

Service providers in the workshop often expressed reservations about the utility of scientific evaluation methods in capturing the significant effects of a good intervention program. Recognizing that certain types of offenders or victims may respond differently to one form or approach, the research community needs to examine the best methods for identifying which components of an intervention strategy are most likely to succeed with different types of clients, victims, or offenders. Incomplete data sets, high rates of attrition, the absence of baseline data, lack of control groups, and poor behavioral measurement are only a few of the methodological difficulties that discourage the development of rigorous evaluation studies in this field. Furthermore, the urgency of the need for services often prevents the ability to set aside financial resources or personnel that are necessary for evaluation studies.

GAPS IN THE KNOWLEDGE BASE

Few speakers in the workshop offered data on the outcomes or effectiveness of their programs. In some cases, such data were not available, either because the program was in early stages of implementation or because the program did not make systematic efforts to collect such data. Empirical evidence regarding some

interventions is available, however, and the committee will review the scientific literature to determine which evaluation studies have been published in the professional literature, and additional steps will be taken to locate unpublished studies as well.

Many service providers work hard under difficult and challenging conditions to provide treatment or prevention programs whose success may not be obvious. This situation creates a climate in which efforts to measure impact or to assess relative effectiveness are often viewed with suspicion. The lack of resources for both basic services and research in the field of family violence interventions generates competitive and political climates that detract from collaborative efforts to foster the development of data collection and documentation that can provide the basis for analysis of both the strengths and limitations of favored projects.

Child violence against other children, which some researchers have identified as the most frequent form of violence within families, was not addressed at all in the workshop. In addition, the speakers did not address the problems presented by children who witness scenes of family violence in their homes, involving a parent, sibling, or other relative. Intervention programs for these child witnesses are very new and have not yet been carefully examined.

Committee members noted that specific interventions for various types of child abuse--physical, emotional, sexual--received little attention in the discussion, and that the perspective of child welfare agencies--who represent the most common intervenors in child abuse cases--was not directly represented.

While ethnic and cultural issues and their impact on family violence interventions were discussed by workshop participants, the complexity of these issues remains imperfectly understood and seems to require greater attention.

Despite this extensive coverage of spousal abuse interventions, significant gaps exist in the workshop review of intervention services in this area. Nearly all the speakers approached the subject from a similar perspective, that is, from the perspective that spousal abuse can be best understood as gender-related (male violence toward women) rather than as part of a system of interactions within the family, possibly linked to other forms of family violence. The latter perspective may not be associated with many intervention approaches, but it may provide some useful insights in the assessment of policies and programs.

APPENDIX

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