Abt Associates Inc.

55 Wheeler Street
Cambridge, Massachusetts
02138-1168

617 492-7100 *telephone*
617 492-5219 *facsimile*

Hampden Square, Suite 500
4800 Montgomery Lane
Bethesda, Maryland
20814-5341

301 913-0500 *telephone*
301 652-3618 *facsimile*

640 North LaSalle Street
Suite 400
Chicago, Illinois
60610-3781

312 867-4000 *telephone*
312 867-4200 *facsimile*

National Institute of Justice

Child Abuse Intervention Strategic Planning Meeting

Background Papers

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Prepared for

Carolyn Peake
Department of Justice
National Institute of Justice
810 7th Street, N.W.
Washington, DC 20531

Prepared by

Kerry Murphy Healey, Ph.D.
Athena Garrett, Ed.M.

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Table of Contents

Background Paper #2: Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect

Background Paper #3: Policies, Practices and Statutes Relating to Child Abuse and Neglect

Executive Summary

The National Institute of Justice (NIJ) Child Abuse Interventions Strategic Planning Meeting Background Papers

Introduction

Child abuse and neglect (CAN) is a growing problem in America. Each year State-level child protective services (CPS) receive higher numbers of reports of CAN--more than 3,000,000 in 1995--and there are now nearly half a million children in out-of-home care, a 72 percent increase over the last decade. While these numbers may reflect better reporting of abuse and neglect and an increased public awareness of the problem, the number of cases is indisputably large and tests the capacity of the current system to provide safety and services to all who need them. The majority of CAN cases substantiated by CPS involve neglect (52 percent), but significant numbers cite physical abuse (25 percent), sexual abuse (13 percent), emotional abuse (5 percent) and medical neglect (3 percent.) CPS is increasingly called on to protect and provide services for children of drug addicted parents, especially drug-exposed newborns. In addition, CPS and the judiciary are beginning to recognize the complex connections between domestic violence and child abuse, including the severe emotional and psychological damage to children who witness violence within the home.

At the same time, research in the field of child abuse and neglect has begun to establish more precise links between children's victimization and later behavioral problems, including school failure, delinquency, violence and adult criminality. Efforts to intervene with victims of CAN to promote future safety and to manage the consequences of abuse are being developed by practitioners, Federal and State agencies, private foundations and researchers. Criminal justice policymakers have a special interest in learning which of these approaches may help CAN victims break the cycle of violence. The three papers in this series provide an overview of key intervention issues, including the types of intervention programs available, the theoretical underpinnings of intervention with victims of CAN, and the policies, bureaucratic structures and laws that constrain or facilitate intervention. (For a discussion of the papers' methodology, see the box "About the Child Abuse and Neglect Background Papers," which follows this section.)

Paper # 1—Managing the Consequences: An Overview of Intervention Strategies for Victims of Child Abuse and Neglect

Intervening to manage the consequences of child abuse and neglect is a daunting task for government due to the size of the population in need of services and the diversity of negative outcomes to be addressed. Research in the field of child abuse and neglect is at an exciting crossroads: researchers are moving from knowing only that CAN increases some victims' vulnerability to delinquency, adult criminality and violent crime, to being able to predict with more certainty which victims of CAN are at the *greatest* risk. The challenge for criminal justice policymakers is to assess current programming to determine where efforts need to be strengthened to maximize the impact of programs targeting those youths who are at the greatest risk for delinquency, adult criminality and violent crime.

Existing Intervention Strategies for Victims of CAN and their Families

Criminal justice and social service efforts to manage the consequences of child abuse and neglect have one or more of the following aims:

- To protect the future welfare of the victim by preventing further abuse (e.g., by providing out-of-home placement or in-home services);
- To address specific psychological, physical, developmental or cognitive damage resulting from the abuse (e.g., by referring child to providers of psychological counseling, therapeutic day care, cognitive-behavioral skills-building programs, or academic assistance) ; or
- To cultivate or reinforce potential protective factors that may help the victim overcome the harmful effects of abuse (e.g., attachment to a non-abusive adult, positive school experience, better academic performance, supportive relationship with non-abusing parent or sibling, or a stabilized living arrangement.)

Decisions concerning the appropriate level of intervention and services to be provided have traditionally rested with the individual case worker. Case worker decisions are often bounded by three, sometimes competing, operating principles: child safety; family preservation; and speed to permanency. Intervention strategies may be emergency measures, intensive short-term programs with narrow goals (such as preventing out-of-home placement) or longer-term lower intensity efforts that involve only limited service referrals. Program referral is often limited by local availability of services or case worker awareness of community resources. Because of the large number of children and families requiring services and the limited amount of case worker, financial and program resources,

services are necessarily rationed. Currently, victims of sexual abuse and severe physical abuse are most frequently referred for criminal justice investigation and program services. Victims of neglect (who are most numerous among victims of CAN) commonly receive few if any services. Children who witness domestic violence and their non-abusing parent are beginning to receive specialized services in some jurisdictions.

A Continuum of Care for High-Risk Victims of CAN

From the standpoint of child welfare and protection, the neediest victims of CAN are those who have suffered demonstrable harm (sexual abuse, severe physical abuse or abandonment) and whose future safety cannot be assured without out-of-home placement. This group of children, however, may not include all those who are at the greatest risk for delinquency. Recent research on the cycle of violence and high-risk victims of CAN has pointed to the following groups as being in need of services to ameliorate the impact of abuse and to deter future delinquency, violence and adult criminality: all CAN victims five years of age or younger; school-aged children with low reading scores; children who have witnessed domestic violence; children with severe behavioral disorders or multiple foster care placements; children with extensive exposure to community violence; children with extensive family histories of substance abuse or a personal history of significant drug use and delinquency; Native American victims of CAN; and sexually aggressive youth. A continuum of care for these high-risk CAN populations is outlined in exhibit 3-3, including suggestions for appropriate types of programming and examples of age-specific programming for these groups now in operation throughout the country and in Canada.

Paper #2 - Theory and Research on the Outcomes of Consequences of Child Abuse and Neglect

There are three areas of theoretical research in the field of child abuse and neglect: theories on the etiology of abuse and neglect; theories on the outcomes of abuse; and theories concerning effective intervention strategies. Some of these theories only seek to explain the origins of abuse and do not lead to a specific intervention strategy. Others provide the basis for both understanding abuse and intervening with victims. Current theory-based interventions rely on one or more of six theories on the origins of abuse:

- **Social learning theory** is the basis for the "cycle of violence" and holds that individuals become abusers because of what they have learned from their social, community and/or familial environment. Social learning theory underlies the belief that children who are abused and neglected will either become abusive in their own family (intergenerational transmission) and/or engage in violent adult criminality in the community. A significant body of research supports the existence of a "cycle of violence" for twenty percent of the CAN population. Interventions based on social learning theory seek to help abusers and victims "unlearn" aggressive and violent behavior through cognitive-behavioral practices of modeling and observation and to learn safe and appropriate means of discipline, self-expression and an accurate understanding of human development.

- **Attachment theory** focuses on the interactions between care givers and their children. According to this theory, abused and neglected children may develop insecure attachments (including anxious/ambivalent, anxious/avoidant or disoriented/disorganized modes of attachment) often resulting in maladaptive behaviors which in turn impair an individual's ability to establish safe and healthy interpersonal relationships. In addition, according to social learning theory, victims of CAN may reproduce the poor attachment patterns they learned from interactions with their own parents with their children. Research suggest that this process may be interrupted by an intense therapeutic or love relationship; thus, interventions based on attachment theory attempt to facilitate the development of secure attachments between mother or father and the child.

- **Ecological theory** attributes the cause of abuse and neglect to individual, familial, community, and cultural systems and postulates that the treatment of abuse and neglect must also address each of those influences. Research suggests, however, that in order to be effective, ecology-based interventions need to assess the degree of influence each system has on the cause and effects of CAN by taking individual variation into account.

- **Family systems theory** concentrates on the interpersonal interactions within the family and examines the ways in which each family member contributes to the abuse and neglect. Critics argue the theory underestimates the influences of power, authority and society on relationships and may misplace the responsibility of abuse and neglect. Interventions based on family systems theory attempt to explicate and eliminate the dysfunctional behaviors within the family unit through individual and family counseling.

- **Self-efficacy theory** suggests that individual expectation of effectiveness influences motivation and behavior and dictates the ability to act toward and achieve a goal. Interventions based on self-efficacy focus on building the belief and the capacity to stop abusive behaviors and to protect oneself from victimization by four methods: performance accomplishment, verbal persuasion, vicarious experience and emotional arousal.

- **Resiliency theory** focuses on the ability of victims to overcome the negative effects of CAN. Interventions based on resiliency theory seek to help victims avoid delinquency and other negative outcomes associated with CAN by developing or enhancing individual, familial and community protective factors, such as self-esteem, academic achievement, parental involvement in child's activities, and a secure supportive relationship with an adult.

Recent Research Finding and Theoretical Trends

Research findings on the outcomes of abuse and neglect vary according to a number of factors: child characteristics (age, emotional and cognitive development, gender, race/ethnicity, and personality); type of trauma (acute or chronic); type of abuse or neglect (physical, sexual, psychological/emotional or witnessing domestic violence); co-occurrence of types of abuse and neglect; and the relationship the child has with others (victimizer, non-offending parent, other family members, other adults and peers.) Factors such as these may mediate or predict a CAN victim's likelihood of becoming delinquent, engaging in violence or other criminality. Research on effective intervention strategies is limited due to methodological weaknesses, however, multi-systemic interventions, cognitive-behavioral treatments, family preservation efforts, therapeutic day care and individual and group therapy have all demonstrated promising outcomes with varying populations. In addition, resiliency research has pointed to the value of a supportive adult in a victim's life. Long-term treatment and follow-up have proven to lead to greater effectiveness, regardless of the intervention strategy.

Examination of Existing Intervention Strategies

Four examples of promising intervention strategies are outlined: The Gilday Center (which offers family preservation and therapeutic day care); Casa Myrna Vazaquez (which uses a multi-systemic combination of therapeutic day care, individual and group therapy and support services); Ina Maka Family Program (a family systems-based family preservation program); and Responsive Advocacy for Learning and Life in Youth (which provides therapy and offers a supportive adult). Each strategy utilizes at least one component of treatment that has demonstrated promising outcomes.

Paper #3: Policies, Practices and Statutes Relating to Child Abuse and Neglect

Responsibility for child protection and welfare is reserved by the Constitution for the States. Each State's system of child protection is a complex web of services and regulations constructed of State statutes, voluntary acceptance of federal funding and oversight, State department of social services policies, court mandates and local regulations and agreements. Each of these factors may constrain or facilitate intervention in child abuse and neglect, for example:

- **Federal legislation**, through restricted funding streams, indirectly influences and constrains State-level CAN programming and CPS procedures while providing an overlay of similar program goals and case management procedures across State systems.
- **State statutes** define child abuse and neglect, identify mandatory reporters and reporting procedures and specify the overall structure of child protective services in the State.
- **Policies and procedures** for intervening in CAN, including how reports are screened, investigated and assessed; cooperation with other agencies, including the criminal justice system; and how services are delivered; may be specified by State, county or local departments of social services.
- **Courts** may also require CPS to provide services or adopt practices in line with legislative mandates. The functioning of the courts may speed or delay decisions concerning permanent placements for victims of CAN.

There is an unusual degree of consensus among child welfare workers, researchers, politicians, criminal justice professionals and the public that current systems for safeguarding abused and neglected children are hobbled by fragmentation of services and policies. Child protective services are often criticized for failing to find a proper balance between parental rights, child safety and family privacy, supplying insufficient safeguards to children in some cases while being too punitive and stigmatizing to families in others. Key problems cited by academics, practitioners, legislators and policymakers include (see exhibit 3-4):

- Inadequate service delivery;
- Poorly organized or inadequate family needs/risk assessment and investigative procedures;
- Insufficient service availability;
- Lack of emphasis on the development of natural or informal "helping networks";
- Failure to link CPS to substance abuse and domestic violence treatment services; and

- Failure to achieve permanency for out-of-home placements in a timely manner.

Current Systems Reforms: Innovative Practices and Proposals

A number of systemic reforms and innovative practices have been undertaken by State legislatures and State or local child welfare agencies to address problems such as inadequate service delivery to lower-risk victims of CAN, the fragmentation of services and policies affecting victims of CAN, the stress caused low-risk children and families by CPS investigation and inadequate family engagement in services. Recent State-level innovations include the creation of multiple response systems, the co-location of services for victims of CAN, the use of family group decision-making to aid child placement decisions, and integrating domestic violence and child protective services. Proposals for systemic reforms, two of which have been implemented on a limited basis, include the Children's Research Center's model for highly structured case assessment and management, a model for building community partnerships for child protection from the John F. Kennedy School of Government's Executive Session on Child Protection, and the American Bar Association's recommendations for implementing judicial permanency planning reform.

About The Child Abuse and Neglect Background Papers

In preparation for the Child Abuse Interventions Strategic Planning Meeting, scheduled October 20-21, 1997, in Washington, D.C., the National Institute of Justice commissioned three background papers:

- **Paper #1,** "Managing the Consequences: An Overview of Intervention Strategies for Victims of Child Abuse and Neglect;
- **Paper #2,** "Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect," and
- **Paper #3,** "Policies, Practices and Statutes Relating to Child Protection and Welfare."

Together, these papers are intended to provide an overview of current research, practices, innovations, and key issues in the field of child abuse and neglect (CAN) and to provide a starting point for conference discussions.

Sources of information

Information in these papers has been drawn from a number of sources, including:

- **Interviews**—Unstructured telephone and in-person interviews were conducted with more than 35 leading researchers, policymakers and practitioners in the field of child abuse and neglect (see Appendix A for a listing of names and affiliations of interviewees);
- **Conferences**—The authors obtained information concerning current research at two conferences, the American Professional Society on the Abuse of Children (APSAC) 5th National Colloquium (Miami, June 1997) and the National Institute of Justice Research and Evaluation Conference (Washington, D.C., July 1997) and participated in the Advanced and Basic Training on Child Advocacy Centers (Miami, June 1997);
- **Literature review**—A literature review was conducted utilizing relevant electronic data bases as well as materials collected by the National Research Council. Program materials provided by practitioners, statistics and other information provided by national organizations concerned with CAN (see Appendix B for a list of national organizations contacted for the papers) and media reports were also reviewed; and
- **On-site observations**—The authors observed family group conferences in Oregon and foster care reviews in Massachusetts.

Some of the research findings cited in this paper are still preliminary, and several studies are not yet published. Any policy recommendations, conclusions, or risk typologies derived from research findings are the authors' unless otherwise noted (e.g., Hall's typologies for sexually aggressive youths) and may *not* reflect the opinions of the researchers interviewed.

Scope and Organization of the Papers

Paper #1: "Managing the Consequences: An Overview of Intervention Strategies for Victims of Child Abuse and Neglect

Paper #1 reviews current intervention strategies, key issues and funding sources related to CAN populations generally, then shifts its focus to highlight a continuum of age-appropriate interventions targeting only those victims of child abuse and neglect who have been identified by recent research to be at the *greatest risk* of delinquency or arrest as adults (see Exhibit 1-3). The paper focuses on interventions appropriate for children in substantiated cases of abuse or neglect; it does not consider primary prevention programming, but does discuss secondary prevention programming, where appropriate. The paper is divided in two parts:

Part I reviews and discusses existing intervention strategies with victims of CAN and their caretakers, including the goals of intervention, the allocation of prosecutorial and programmatic resources among victims, identification of services, funding sources for interventions and the current role of the criminal justice system in service provision.

Part II highlights eight high-risk groups of abused and neglected children drawn from the research literature on the relationships between child abuse, delinquency, adult criminality, and violence and various personal and demographic characteristics (e.g., age, gender, race, ethnicity, substance abuse history, family of origin, or socio-economic factors.) Age-appropriate intervention strategies are suggested for children who fall into one or more of the following high-risk categories:

- less than 5 years old;
- low reading scores;
- exposure to domestic violence;
- severe behavioral disorders or multiple foster care placements;
- extensive exposure to community violence, especially if diagnosed with post-traumatic stress disorder (PTSD);
- extensive family history of drug or alcohol abuse and/or child who reports intensive drug involvement combined with serious criminality (not necessarily arrests);
- Native American victims;
- classification as sexually aggressive youth (SAY) or an abuse profile likely to result in later sexual aggression.

Research also has begun to isolate "protective" factors that, for some victims, appear to buffer the impact of abuse and deter anti-social behaviors. A second selection criteria for programs highlighted in this paper was an emphasis on cultivating pro-social protective factors in high-risk victims of child abuse and neglect. Other factors considered in program selection include preferences for:

- early intervention strategies including parent education;
- school-based interventions for victims over five years old;
- culturally sensitive and appropriate programming; and
- interventions that can be offered in ways and in settings that are accessible and non-stigmatizing (e.g., neighborhood-based programs open to the public without a referral or programs that have both abused and non-abused participants).

While the programs highlighted in this paper were recommended by researchers or practitioners as "promising," no independent evaluation of the merits of the programs has been undertaken by the author and most have not been independently evaluated.

Paper #2: "Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect"

Paper #2 provides an overview of the theoretical bases for the interventions discussed in paper #1, an examination of research identifying differential outcomes of abuse and neglect according to multiple factors and a detailed discussion of research findings concerning risk and protective factors influencing delinquency and adult criminality for victims of child abuse and neglect. The paper is divided into three parts:

Part I reviews theories concerning the etiology and sequalae of child abuse and neglect. Six theories are described:

- social learning theory;
- attachment theory;
- ecological theory;
- family systems theory;
- self-efficacy theory; and
- resiliency theory.

Each theory is discussed in the context of abuse and neglect, compared to other theories and critiqued. Examples of representative theory-based intervention programs are provided.

Part II reviews recent research findings and theoretical trends in the field of child abuse and neglect and discusses the common and differential outcomes of abuse and neglect gathered from current literature. In particular, types of abuse and neglect, gender, race, and developmental stage are discussed in the context of their impact on victim outcomes. In addition, research on abuse and neglect as a predictor for delinquency, violence and adult criminality is discussed. Effective intervention strategies for victims of abuse and neglect are reviewed. Protective factors which may mediate the negative consequences of abuse and neglect are suggested.

Part III provides a detailed examination of four intervention strategies clarifying for each the theoretical framework, objectives, and methods. Where possible, information concerning program assessment tools and evaluations are provided.

Paper #3: "Policies, Practices and Statutes Relating to Child Protection and Welfare"

Paper #3 focuses on the broad legal and institutional context of intervention in child abuse and neglect to clarify which laws, policies and practices in the field constrain or facilitate intervention strategies. The first half of the paper reviews the most typical responses to reports of child abuse and neglect by

child protective services (CPS), child welfare officials and criminal justice agencies--including law enforcement, prosecutors and the courts. These systems are then considered in the context of Federal legislation designed to influence State and local child protection policies and procedures, State legislation defining CAN and mandatory reporting laws.

The second half of the paper focuses on innovative practices and proposals for systemic reforms generated from the field, the research community and State-level legislation. Innovative practices highlighted include:

- the creation of multiple response systems;
- the co-location of personnel serving abused and neglected children;
- Children's Advocacy Centers (CACs);
- a multi-agency Child Protection Team; and
- integrating domestic violence and child protection services.

These initiatives were chosen to illustrate legislative trends or cutting-edge reforms in action. Three proposals for systemic reform are also reviewed: the Children's Research Center's model for structured case management; a proposal for building community partnerships for child protection from the John F. Kennedy School of Government's Executive Session on Child Protection; and the American Bar Association's study of model judicial implementation of permanency planning reform. These proposals were selected not only for their merit, but also to illustrate in part the broad range of targets systemic reforms may have--CPS, the community (defined broadly to include the full range of public agencies, civic and religious organizations and private program providers), and the courts.

Background Paper #1:

Managing the Consequences: An Overview of Intervention Strategies for Victims of Child Abuse and Neglect

Kerry Murphy Healey, Ph.D.
Abt Associates Inc.

October 3, 1997

Introduction

Intervening to manage the consequences of child abuse and neglect (CAN) is a daunting task for government due to the size of the population in need of services and the diversity of negative outcomes to be addressed.[1] Although the psychological, physical, and emotional toll of child abuse and neglect is heavy for *all* victims, the majority of victims do *not* go on to commit violent crimes.[2] Victimization does, however, increase the likelihood of delinquency and later criminality sufficiently to make CAN victims of special concern to criminal justice policy makers. According to one retrospective study, CAN victims were 59 percent more likely to be arrested as juveniles and 27 percent more likely to be arrested as adults; CAN victims were 29 percent more likely to have committed violent crime than those who had not been maltreated.[3] In view of these findings, criminal justice policy makers are increasing their efforts to learn how to help CAN victims break the cycle of violence.

Research in the fields of child abuse and neglect, delinquency and violent criminality is at an exciting crossroads: researchers are moving from knowing only that CAN increases some victims' vulnerability to delinquency, adult criminality and violent crime, to being able to predict with more certainty which victims of CAN are at the greatest risk. The challenge for criminal justice policy makers is to assess current programming and policies relating to abused and neglected children to determine where State and Federal efforts need to be strengthened in order to maximize the impact of programs targeting those abused and neglected youths who are at the *greatest risk* for delinquency, adult criminality and violent crime.

Child abuse and neglect (CAN) is a growing problem in America: in 1995, States received an estimated 3,110,000 reports of abuse and neglect and nearly half a million children were living in out-of-home care—a 72 percent increase over the last decade.[4] Of the slightly more than one million substantiated or indicated cases of CAN, the majority involve neglect (52 %). The remainder is divided between physical abuse (25%), sexual abuse (13%), emotional abuse (5%), medical neglect (3%) and other forms of CAN, such as abandonment, threats, or congenital drug addiction (14%).[5] (See Exhibit 1-1.) In 1995, nearly 40 percent of CAN victims were five years old or younger (see Exhibit 1-2) and those under five years old accounted for 85 percent of abuse and neglect fatalities.[6]

Part I: Existing Intervention Strategies for Victims of CAN and Their Families

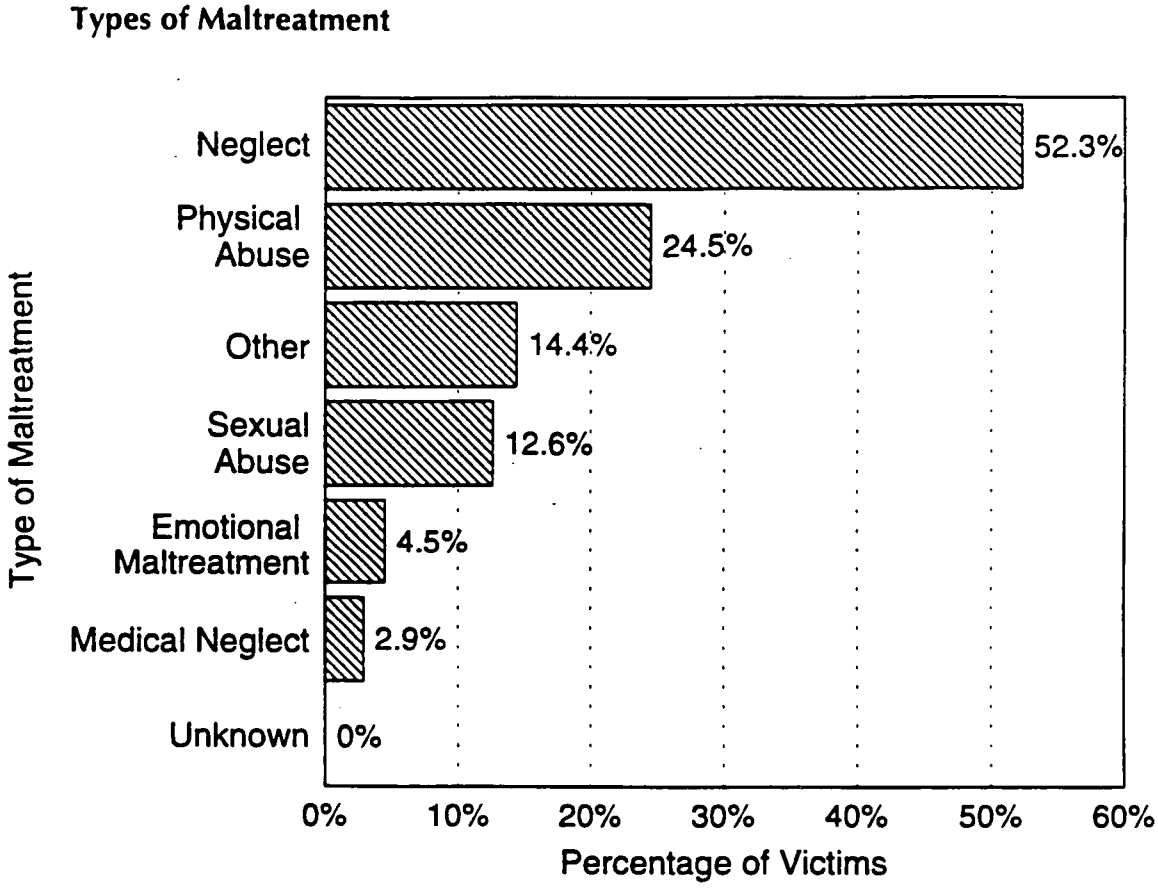
Social service efforts to manage the consequences of child abuse and neglect have one or more of the following aims:

- ***To protect the future welfare of the victim by preventing further abuse*** through the provision of emergency services, out-of-home placement or intensive in-home services;
- ***To address specific psychological, physical, developmental or cognitive damage resulting from the abuse*** by referring the child to providers of psychological counseling, therapeutic day care, cognitive-behavioral skills-building programs, or academic assistance ; or
- ***To cultivate or reinforce potential protective factors that may help the victim overcome the harmful effects of abuse,*** such as promoting attachment to a non-abusive adult, positive school experiences, better academic performance, a supportive relationship with non-abusing parent or sibling, or a stabilized living arrangement.[7]

The first goal of intervention—protecting the safety of the child and preventing further abuse—is approached differently depending on the severity of abuse, the issues to be resolved by the family, and the resources available to the family and to child protection and welfare workers. Child protection workers may achieve child safety by:

- emergency removal of the child from the home;

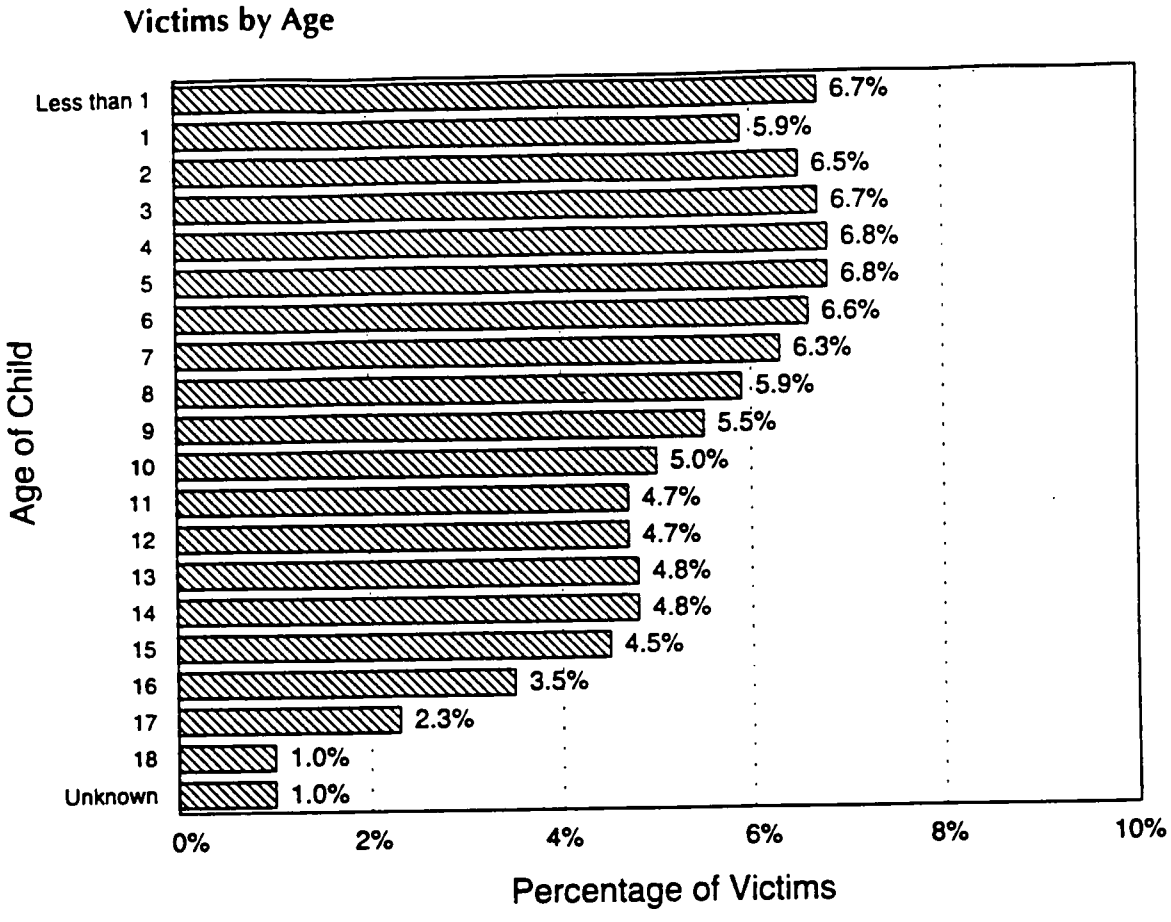
Exhibit 1-1



N = 1,000,502 victims in 49 States.
Note: Percentages total more than 100 percent because some States report more than one type of maltreatment per victim.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Child Maltreatment 1995: Reports From the States to the National Child Abuse and Neglect Data System* (Washington, DC: U.S. Government Printing Office, 1997).

Exhibit 1-2



N = 833,115 victims in 45 States.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Child Maltreatment 1995: Reports From the States to the National Child Abuse and Neglect Data System* (Washington, DC: U.S. Government Printing Office, 1997).

- short or long-term out-of-home placement;
- short-term intensive in-home assessment and service provision to the family and the child; or
- facilitating access to community-based services for the child and family on a longer term, less intensive basis.

Decisions concerning the appropriate level of intervention and specific program referrals for victims and their caretakers have traditionally rested with the individual case worker or, in the most severe cases, the courts. As discussed below and in Paper #3, risk assessment and service planning are currently the target of a number of innovations intended to decrease the systems' dependence on individual judgment. Examples of recent systemic innovations that influence program referral include the development of standardized risk and needs assessment tools and collaborative case decision making including criminal justice personnel or the extended family.

Current Intervention Strategies: Objectives and Controversies

While emphases differ slightly from jurisdiction to jurisdiction, the majority of child protection and welfare interventions are bounded by three, sometimes conflicting, operating principles:

- **Child Safety**—Child safety is the first objective of intervention;
- **Family Preservation**—Preference is given to those intervention strategies that maximize family preservation or reunification and minimize out-of-home placement (a value reinforced by federal funding restrictions, see below);[8] and
- **Speed to Permanency**—In the event of out-of-home placement, reunification or other permanent placement should be achieved as quickly as possible (e.g., Massachusetts law requires a permanency plan within eighteen months, although this is not always achieved).

These principles, if inflexibly pursued, can result in tension between competing goals. For example, the priority given to family reunification may delay substantially the quest for permanent placement of children residing in out-of-home care: for families with serious long-term problems, such as substance abuse or mental illness, even up to eighteen months is often not sufficient to resolve these difficult problems. Correlatively, child safety may be compromised if reunification is pursued too aggressively in order to meet an arbitrary permanency goal.

A number of researchers and practitioners interviewed for this paper stressed the need for greater emphasis on the welfare of the child over family reunification, and expressed serious concern that the goal of family reunification was being pursued indiscriminately, resulting in wasted resources, delayed permanency for children in out-of-home care, as well as emotional damage to the child, who may be encouraged by agency policies to have overly optimistic hopes concerning his or her family's ability to change.

Several experts interviewed suggested instead a policy of rigorous family assessment to determine a family's strengths, deficits and capacity for positive change, combined with a swift termination of the parental rights of those who are not good candidates for intervention. Widom's recent preliminary research finding that "not living with both parents" (i.e., living with one parent or in surrogate care) was not associated with higher delinquency for victims of child abuse and neglect[9] suggests that permanent placement with the non-abusive parent, long-term foster care, adoption, guardianship or kinship care may be as appropriate and beneficial a goal for a number of abused and neglected children as family preservation. Widom's work also points to the potential strength of surrogate care as a protective factor: less than 10 percent of abused and neglected children in out-of-home placement who reported a strong relationship with a foster parent became delinquent.[10]

In balancing the potential emotional and psychological damage resulting from out-of-home placement, research points to the need to consider the developmental age of the child (e.g., children less than 6 months old are thought to be least bonded to their primary care giver, and children older than five may be better able to understand why separation is occurring), and the degree to which the child can be maintained in familiar surroundings.[11] For example, children in kinship care, those able to remain in the same school, the same neighborhood, or with their siblings, are thought to be less adversely affected by out-of-home placement.

At the same time, evaluations of family preservation programming, such as Homebuilders, have generally had methodological problems and thus failed to conclusively answer the question whether such efforts—if properly implemented—are effective in preventing out-of-home placement.[12] A recent, methodologically rigorous evaluation of Illinois' family preservation experiment, Families First, showed no significant program impact on rates of out-of-home placement. Schuerman points to a number of factors that may have impeded the effectiveness of the model—most persuasively the lack of program resources available for referrals, especially substance abuse services—but concludes that a "robust" model should be able to withstand somewhat flawed and varied implementation.[13]

Schuerman and others note that while the family preservation services' impact on out-of-home placement is unclear, the families served were generally in extreme need or crisis and no doubt benefitted from the additional services in ways not measured by the evaluation.

Both researchers and practitioners favor *preventative* interventions that stress family support services, such as home visitation, parenting skills building and prenatal counseling. To this end, some of those interviewed argued that family preservation resources would be best spent on broad-based programming to prevent child abuse and neglect in healthy but vulnerable families (e.g., teen mothers or young families living in poverty or in violent communities), rather than on the smaller number of abusive, multi-problem families who are less likely to respond to services. The shift toward prevention and away from traditional reactive child welfare models is exemplified by the number of programs seeking to replicate Hawaii's Healthy Start program . For example, in 1998, a new Massachusetts program, Healthy Families, will make home visits available to all the estimated 5000 teenage mothers who give birth in the State annually at a cost of $5 million (or $1000 per family.)

Balancing Priorities: A Case Study in Wisconsin

Child welfare policy makers in Wisconsin have developed and implemented a service provision model that attempts to balance family preservation with a pragmatic assessment of the family's strengths and ability to change. The model recognizes that the best interest of an abused child may be served by either out-of-home placement or family preservation efforts depending on the severity of the abuse, the potential of the parents to change, and the developmental stage of the child. Under this model, family preservation may mean the removal and/or prosecution of the abusive parent or individual from the household, and the strengthening of the remaining family unit.

According to Mary Dibble, in Wisconsin's Bureau of Program and Policy, initial family assessment is not just incident-based: a longitudinal assessment, encompassing the family's history of involvement with services and other factors are examined before a service level is assigned by the social worker. Safety planning is central to the assessment process, and safety planning is revisited if a child is to be reunified with her family. Early in the process, attempts are made by the social worker to engage the family and cultivate informal support networks, such as extended family, friends and neighbors. By helping to build informal support networks (and not merely providing program-based service referrals), social workers expect a more permanent benefit to the family. At the heart of the Wisconsin approach is the idea that the relationship between the worker and the family must be based on respect and the case worker's understanding of what the *family* thinks it needs. According to Dibble, "The family must feel cared about, clearly directed, not disrespected. The relationship must be a partnership."

Many of the case workers are creative in meeting clients' needs. One county agency got the community involved; schools donated shower facilities to homeless families, businesses donated mattresses. Through a pilot program funded by the State, workers are able to provide intensive in-home assistance to neglectful families, involving practical support, skills building, and problem solving using resources such as anger management interventions, day care, and counseling to help parents set and follow a consistent schedule of care for their children.

In a program soon to be piloted in Wisconsin (and currently in use in West Virginia) a formal assessment of family strengths, deficits and capacity will be made by the social worker and then discussed with a supervisor to develop an individualized service plan. The assessment looks at the following factors that have been associated with successful family preservation outcomes:

1. Ability to use a support network;
2. Ability to develop trusting relationships;
3. Ability to develop a positive "family vision" (how they would like their family to be);
4. Family maintenance (the degree to which they are motivated to keep their children); and
5. Capacity (cognitive limitations).

The social worker assesses family strengths and weaknesses, then targets the intervention to the deficits. Strengths— such as knowing when to seek help, having an informal support system or the ability to verbalize needs and concerns—are not merely listed, but built upon to assist the family in reaching its goals. If no capacity is found (for example, due to cognitive limitations), the service plan focuses on safety services for the child.

Social workers assess the extent to which the model results in the development of a safe home environment, the creation of an informal family support system, the use of formal supports, and improved parent functioning (e.g., coping and self-control, self-esteem, verbal expression and response, socialization, expectations and sensitivity to children, and problem solving.)

Timing and Length of Intervention

Interventions may be emergency measures, intensive short-term programs with narrow goals (such as preventing out-of-home placement or creating a safer and more stable home environment) or longer-term, lower intensity efforts that involve only limited service referrals.

Emergency services

Emergency services to victims of CAN may include the use of Child Advocacy Centers (CAC) to provide a safe and comforting environment in which victims may meet with law enforcement, prosecutors, medical professionals, counselors and social service providers. Emergency intervention may also be hospital-based, such as Boston's Advocacy for Women and Children in Emergencies (AWAKE), which identifies and screens for domestic violence and child abuse in the emergency room, providing both emergency and on-going services to help the mother take control of her life and protect her children against their mutual abuser (see program summaries, Paper #2). First foster care placements, which are frequently temporary, are also considered emergency intervention. Emergency responses to CAN may involve several agencies, including the criminal justice system.

Intensive short-term interventions

Short-term intervention, typified by intensive family preservation efforts, may be 90 days or less. Typically these efforts are intended to prevent out-of-home placement for children at imminent risk. In practice, intensive services are often targeted to high-risk families in crisis, since imminent risk of placement is difficult to identify. During the intervention, the family has the attention of a social worker with a much reduced caseload—between two to 15 families—who provides crisis intervention, counseling and, following a family needs assessment, coordinates comprehensive services, that may include material assistance. Criticisms of this form of intervention have been that families in crisis frequently need longer periods of intensive services, and that mechanisms for providing adequate aftercare for these families often do not exist. Once transferred to the case loads of regular social workers, previously intensively served families may find it difficult to maintain progress. Another problem encountered by intensive family preservation efforts is limited availability of services—a problem that cuts across all forms of intervention.

Long-term, low intensity intervention

A majority of substantiated cases referred to child welfare services are likely to receive limited service referrals. In one jurisdiction, longer-term interventions were regarded as an opportunity to observe and assess the family over a longer period (two months) in order to formulate a better service plan. One practitioner emphasized, however, that where children remain in the home during long-term assessment, safety planning is critical.[14] Much of traditional child welfare work follows this model.

In a system emphasizing *differentiated response* (usually a two track system separating those cases needing investigation from those that require only services, see Paper #3), the initial investigation and

assessment will consider not only the current incident, but also the family's history and characteristics before choosing a level of intervention. Unfortunately, an overburdened system may choose long-term, low intensity intervention by default.

Intervention "Booster Shots"

Certain types of abuse may result in the need for periodic intervention. For example, victims of child sex abuse (CSA) may experience recurrent psychological problems as they pass through each developmental stage toward—and into—adulthood. Parents or caretakers of CSA victims should be trained to recognize key developmental milestones and to re-initiate services as needed.[15] Similarly, victims of pre-natal drug exposure may experience cognitive, developmental and social problems at various developmental stages. Caretakers of drug-exposed infants need information on child development so that they can seek screening and assistance for any suspected delays.

On-going services also are needed by reunited families as well as adoptive families whose children may—at some later date—develop behavioral, cognitive, psychological or social problems as a result of earlier abuse. It is thought that on-going services to adoptive and reunited families would help to prevent multiple placements, a risk factor for delinquency (see below).

Who Receives Services?

With the large number of CAN victims and caretakers to be served, case worker time, criminal justice referrals, and program resources are necessarily rationed. Victims of sexual abuse (who account for 13% of all abuse and neglect cases) and severe physical abuse (25%) are most frequently referred for criminal justice action and program services.[16] In general, neglect cases—especially chronic low-level neglect—receive few or no services. However, experts emphasize that sexual abuse, physical violence, neglect, and emotional and psychological abuse often co-occur (approximately one-third of all cases have multiple abuse allegations), so that some victims of emotional and psychological abuse and neglect are actually being served. Indeed, some commentators argue that *all* child abuse involves emotional abuse.

One explanation for the official attention accorded sex abuse and physical abuse cases is simply that these cases often focus on a poignant, single episode (or culminating episode) of abuse and are more easily grasped by busy social workers or the courts. Another possible explanation is one of public pressure on government: the public is understandably horrified by media reports of child sex crime and

physical brutality against children. Child protection and welfare workers as well as criminal justice professionals cannot appear to be insensitive to these victims. Neglect or emotional and psychological abuse are likely to be chronic conditions, far more easily hidden from social workers and often too vague for prosecutors (see Paper #3 for a discussion of the laws defining CAN.) Nor do these cases, except in the most extreme instances, attract the attention of the media and the public.

Some researchers and practitioners question the criminal justice and social welfare emphasis on imminent risk versus cumulative harm. Studies suggest that victims of chronic neglect, as well as children who witness domestic violence may be as vulnerable to psychological, cognitive and social harms as victims of physical violence or sexual abuse. In particular, one researcher and policy maker expressed concern that elevated levels of aggression among neglected youth who had received few services may result in later delinquency (see below).

A new category of services: CAN and domestic violence

A growing number of services are becoming available to victims of domestic violence and their abused children. Increasingly, children who have witnessed domestic violence—whether or not they have been physically abused themselves—are recognized as having special needs. Courts and social workers are beginning to institute procedures and programming to identify and serve victims of CAN who live in violent homes, as well as children who may otherwise not be known to a child welfare agency who live in homes where domestic violence has come to the attention of the courts or hospital emergency rooms. Part II of this paper discusses the co-occurrence of domestic violence and child abuse and gives examples of existing community-based and hospital-based interventions.

Service identification, availability and barriers to utilization

Individual treatment interventions (especially psychodynamic and cognitive behavioral counseling) and family-based interventions (e.g., intensive family preservation) are the most widely-available and frequently utilized interventions for victims of CAN and their families. A recurring concern in the literature on intervention and in interviews with practitioners was limited service availability. For example, services for sexually aggressive youth (estimated to be 10% of foster care population) are frequently unavailable. A policy maker in Washington State reported that there is only one provider of services to sexually aggressive youths in the State.

Some program providers and State-level policy makers voiced concerns that where a range of programs *are* available, social workers may not be sufficiently familiar with program content or

philosophy to make appropriate referrals. A researcher who works closely with child protection services in one State gave the following example of poor communication between researchers, policy makers, practitioners and program providers:

> *Research on the State's severe cases of physical abuse and CAN fatalities revealed that a key factor in many cases was unrealistic parental expectations caused by ignorance of child development. State-level policy makers directed social workers to refer parents of severely abused children to receive parenting classes. Social workers referred parents to the available classes. No improvement was seen in the rates of severe physical abuse or CAN-related child deaths. Inquiries by the researcher revealed that the parenting classes to which these high-risk parents had been referred were skills-based and failed to discuss unrealistic parental expectations or child development.*

For another instance, a researcher who had designed an intervention for parents of victims of child sex abuse (CSA), and offered it free-of-charge at a local Child Advocacy Center (where CSA cases are brought for investigation and crisis intervention), reported that his program opened with only two participants. Barriers to service utilization may have included the failure of social workers to refer to the program, the possibility that on-going intervention information provided to families in crisis was lost, that parents may not wish to return to a setting that reminds them of the abuse and, finally, that family members may not be receptive to counseling so near in time to the abuse.

The Current Role of the Criminal Justice System

Currently, criminal justice agencies become involved with only the most severe cases of child abuse and neglect: those in which prosecution of the abuser is appropriate and/or where the custody of the child is overseen by the courts. In practice, most prosecutions focus on acute episodes of child abuse, such as sexual assaults or severe physical abuse. Chronic, but less severe, cases of physical abuse and neglect are more frequently addressed (if at all) by child welfare workers than by criminal justice personnel.

Few programmatic interventions for the victims of child abuse and neglect are directly provided by the criminal justice system (CJS). However, as discussed in Paper #3, interagency cooperation and victim-sensitive procedures—such as properly trained investigators, the use of Child Advocacy Centers for emergency intervention and interviewing and victim advocates at trial—may significantly reduce the stress of CJS involvement for child abuse victims and thus help to limit the consequences of abuse and neglect for those children who have been most severely victimized.[17]

Criminal justice agencies do, however, network with outside agencies and interventions via multi-agency or community initiatives. A number of school-based and community-based interventions with wide public and private support list criminal justice agencies among their participating groups (see the description of the Child Development-Community Policing program, below). At the Federal level, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) currently funds several initiatives to provide technical assistance, services and structural support for victims of CAN. For example, OJJDP sponsors:

- the National Council of Juvenile and Family Court Judges (NCJFCJ) project to provide training and technical assistance to judges, social service personnel, citizen volunteers and others to prevent unnecessary foster care placement, and promote reunification and permanency.[18]

- the Jimmy Rice Law Enforcement Training Center at the National Center for Missing and Exploited Children, which provides training and technical assistance to federal, State, and local law enforcement personnel to enhance their response to nonparental abduction.

- Parents Anonymous, Inc. (PA) allowing it to expand its services to include forty (40) new parent groups that serve high risk, inner city and Native American populations. In addition, PA will develop program materials to meet the needs of people of color, create a fathers' initiative, provide technical assistance to TA groups operating in correctional settings and engage in public education.

In addition, OJJDP administers the Office of Justice Programs' (OJP) multi-agency Safe Kids-Safe Streets initiative which supports community-based approaches to reducing abuse and neglect. Programs and projects funded at five sites under Safe Kids-Safe Streets include a Children's Advocacy Center (see Paper #3), the development of a multidisciplinary service delivery system for use in Indian country, a computer tracking system and database to monitor child abuse cases in Indian country, a multi-agency neighborhood-based system to prevent and respond to abuse and neglect, a multi-agency countywide CAN task force and a prevention program emphasizing home-based assessment and services. A number of other OJJDP-funded delinquency prevention initiatives may be appropriate interventions for victims of CAN who are at high risk for delinquency, although CAN victims are not their stated focus (see Part II, below.)

Current trends in child welfare are likely to further limit the direct involvement of the criminal justice system in child abuse and neglect cases. Social service agencies are moving toward a system of differentiated response to reports of child abuse and neglect with the aim of targeting services and social worker resources more efficiently. A key component of differentiated response is determining which families require court intervention and supervision (this group is assumed to be small), which

families can safely be referred to community-based programs under the supervision of a social worker, and which families need only voluntary services.[19]

An innovative approach developed in Travis County, Texas, houses police, a sheriff, a prosecutor and child welfare workers together in one office and uses a collaborative model of case assessment and management. This approach, which is described more fully in Paper #3, increases CJS involvement while more effectively targeting prosecution and services. This model offers a number of advantages for both the CJS and child welfare workers. The most important advantage of the model is increased information sharing between agencies that allows all agencies to view the case in a family, school and community context. The resident prosecutor handles both the criminal and civil litigation related to the cases. This unified, cooperative approach to case management is especially important in the context of recent research documenting relationships between child abuse and neglect, domestic violence, substance abuse and violent crime—problems that, in the past, have been addressed individually by separate criminal justice or social welfare agencies.

Who Funds Interventions for Victims of Child Abuse and Neglect?

States and counties are responsible for providing the majority of funding for child welfare services. In 1990, 57% of service costs were borne by the States; the percentage is thought to be higher today, especially in States with large urban populations.

There are more than 100 Federally-funded human services programs to support families in the areas of public health, social services, mental health, juvenile justice, substance abuse, education, public assistance, housing, and job training. Funds for child abuse and neglect policy coordination are channeled through the Child Abuse Prevention and Treatment Act (CAPTA), while child welfare services are funded under Titles IV-B, IV-E, and XX of the Social Security Act.[20]

States receive funds for emergency services under Title IV-A, and a number of federal grants for services to at-risk children and families, including: Title XIX (Medicaid); Child Abuse and Neglect Basic Grants and "Baby Doe" Grants; Child Abuse and Neglect Discretionary Grants; Child Care and Development Block Grants; Children's Justice Grants; and Alcohol, Drug Abuse and Mental Health Grants.

Private funding to localities in the form of foundation grants is important because it offers program flexibility and encourages innovation. Foundations that have a history of funding child welfare programs include: Carnegie Corporation of New York, Casey Family Foundation, Edna McConnell Clark Foundation, Ford Foundation, Kellogg Foundation, Northwest Area Foundation, Pew Charitable Trusts, and Robert Wood Johnson Foundation.

Part II: A Continuum of Care for High-Risk Victims of CAN

The daunting numbers of victims of child abuse and neglect—as well as the high cost of intervention— make it critical that resources are directed to those victims who have the greatest needs. As discussed above, from the standpoint of child welfare and protection, the neediest children are those who have suffered demonstrable harm (sex abuse, severe physical abuse or abandonment) and whose future safety cannot be assured without intensive intervention or out-of-home placement. *This group of children, however, may not be at greatest risk for delinquency.* For example, victims of sex abuse—whose cases are most likely to be adjudicated and have more access to sophisticated case management approaches such as those used by Child Advocacy Centers—are less likely than either victims of neglect or physical abuse (or non-maltreated children) to become delinquent.[21] By contrast, witnessing domestic violence—an event less likely to attract the attention of the criminal justice system or, in most jurisdictions, child welfare services—may have a profound impact on that victim's future criminality.[22] Similarly, victims of neglect rarely receive services, yet neglect and exposure to community violence (both factors likely to co-occur with poverty) could be expected to raise delinquency rates for African-American males.[23] Thus, the population of abused and neglected children most likely to face involvement in the criminal justice system may be a different group than is currently served by the child welfare community. The following is an attempt to draft a research-based typology to serve criminal justice policy makers in their efforts to identify and intervene with those victims of CAN who are the greatest risk of delinquency.

Which Victims of CAN are at High Risk for Offense?

Widom's 1992 research on the cycle of violence found that 15.8 percent of children who were physically abused (only) and 12.5 percent of children who were neglected (only) had arrests for violent crimes as contrasted with 7.9 percent of a comparison group who had not been maltreated.[24] (Widom's study did not find victims of child sexual abuse generally to be at increased risk for violent criminality,[25] but later studies have identified a subset of CSA victims that are likely to become sexually aggressive youths.[26]) Widom's early work raised questions about how to identify and intervene with those victims of CAN who were most vulnerable to delinquency, adult criminality and violent criminal behaviors. More recent research by Widom and others has begun to offer a clearer picture of this subset of all CAN victims than previously had been available. (See Paper #2) For the purposes of this paper, eight (8) CAN populations have been identified from the research as being at

increased risk for delinquency or as being particularly vulnerable to developing further risk factors for delinquency:

All victims of CAN five (5) years old or younger

Researchers are united in recommending early intervention for victims of CAN to preempt developmental delays and cognitive impairment that can result in poor school performance, a risk factor for later delinquency.[27] In addition, programming provided for the youngest victims of CAN and their caretakers may promote child safety, reducing death rates among this most endangered group. Early intervention may also contribute to the development of secure attachment to the primary care giver, a protective factor thought to mitigate the impact of CAN. Special home, hospital and community-based outreach to victims five years old or younger (40 percent of all CAN victims) is needed. (See Exhibit 1-2).

School-aged children with low reading scores

Higher than average intelligence and strong reading scores have been cited by some researchers as protective factors promoting resiliency and pro-social behaviors in victims of CAN.[28] One explanation for the connection between higher reading scores and lower delinquency rates may be that good readers are more likely to develop a greater commitment to school, attachment to teachers, aspirations to attend college and to associate with peers who hold conventional values—all protective factors that have been found to increase resiliency and reduce delinquency.[29] One researcher has suggested that while intervening to increase cognitive ability in school-aged children was problematic, boosting reading scores in victims of CAN was not only possible but might offer an excellent opportunity to cultivate multiple protective factors in a school-based setting.[30]

Children who have witnessed domestic violence[31]

The correlation between partner abuse and child abuse is strong: the likelihood of child abuse is 129 percent higher when partner abuse is present.[32] An estimated 30 percent of all substantiated cases of child abuse also involve spouse abuse, and approximately 50 percent of men who batter their partners also abuse children in their spouse's care.[33] Research suggests that for children in violent homes, witnessing their mother's abuse can be as potent an influence on psychological health and future violent behaviors as experiencing physical abuse personally.[34] Moreover, research shows that approximately 90 percent of children in homes where there is spouse abuse see or hear the abuse.[35] Psychologists emphasize the scope of

damage resulting from this exposure: it may include PTSD, trauma, shock, guilt, intense fears, nightmares, bed wetting, anger, physical aggression, anxiety, withdrawal, somatic complaints and developmental, motor, speech and cognitive delays. Men who witnessed severe domestic violence as children are found to be 1000 percent more likely than those raised in a non-violent setting to batter their spouse.[36] Intervention for this group of victims—both those who have been physically or sexually abused in the context of a violent household and those who have witnessed violence against their mother—is critical to breaking the cycle of violence leading to child and spouse abuse in adult victims of CAN.

Children with severe behavioral disorders or multiple foster care placements

Widom's research has suggested that children who have had multiple foster care placements are at increased risk for delinquency.[37] Children with multiple foster care placements frequently are reported to have severe behavioral disorders. Some commentators hypothesize that as children experience the serial loss of caretakers (perhaps due to their problem behaviors), their ability to form a secure attachment is damaged, thus compounding the difficulty of building a stable relationship with the next foster family. Intervening with young children who appear to be developing severe behavioral disorders and counseling their caretakers concerning effective parenting and coping strategies may succeed in preventing multiple placements for these children. In addition, respite care may be needed to assist parents or foster parents seeking to provide stability for these children. For children who have already experienced multiple placements, counseling concerning attachment issues and behavior modification programming may help them to break the pattern of self-destructive behaviors likely to lead to further loss and to delinquency.

Children with extensive exposure to community violence—
(especially those with a diagnosis of PTSD)[38]

Witnessing community violence is a daily trauma to many children in impoverished urban neighborhoods. A New Orleans study of 5th graders' exposure to violence found that 91 percent had witnessed violence and more than half had been victims of community violence.[39] A study of New Haven, Connecticut, 6th, 7th, 8th and 10th graders found that 30 percent reported seeing one crime or more *daily*.[40] Recent research by Saunders and Kilpatrick found that 65 percent of male African-American victims of CAN reported personally witnessing serious violence. For African-American male victims—especially for those diagnosed with post-traumatic stress disorder (PTSD)—witnessing community violence significantly increased

the likelihood of delinquency.[41] Interventions to lessen the impact of exposure to community violence are needed as well as community-based initiatives to improve neighborhood safety.

Children with extensive family histories of substance abuse[42] or a personal history of significant drug use and delinquency (self-reported, not based on arrests)[43]

Saunders and Kilpatrick found that for female White and African-American adolescents, delinquency was strongly correlated with a family history of alcohol abuse or significant personal substance abuse. Johnson's research on drug-involved youths found that less than two percent of youths reported both significant drug use (defined for this study as cocaine or heroin use in the past year) and self-reported two or more index offenses (robbery, felony assault, or felony thefts); however, this two percent of youths had such a high delinquency rate that they were thought to be responsible for between 40 and 60% of all felony crimes reported, plus a disproportionate number of drug sales. If Johnson's findings are replicable, identifying, and intervening with, this population could have a significant impact on delinquency rates.

Native American victims of CAN

Recent research by Saunders and Kilpatrick highlighted the exceptionally high rate of delinquency among Native American adolescents: 32 percent of Native American males reported delinquency in the past year, and 40 percent reported committing a delinquent act at some point in their lives.[44] Victimization rates for Native American males were also higher in a number of categories than those for Whites, Hispanics, and African-Americans. For example, 36 percent of Native American adolescent males had been physically assaulted (as compared to 30 percent of African American males or 19 percent of White males); 13 percent had been sexually assaulted (as opposed to 7 percent of African-American males and 2 percent of White males); 19 percent had been physically abused (as compared with 16 percent of African American males and 7 percent of White males); and 66 percent had witnessed community violence (as compared with 65 percent of African-American males and 39 percent of White males.) Female Native American adolescents had rates of victimization similar to those for African American females, but a much higher rate of personal substance abuse (23 percent for Native American females compared to 12 percent for African American females.) Native American adolescents also reported the highest proportions of families with significant histories of drug or alcohol abuse. Taken together, these multiple victimizations and familial risk factors suggest that Native American children and adolescents are at extremely high risk for delinquency and require special intervention strategies suited to their culture.

Sexually aggressive youth (SAY)

Adult sex offenders often report that they began sexually abusing others as juveniles.[45] In Vermont, sexually aggressive youths were reported to be responsible for 45 percent of all child sexual abuse cases.[46] In Washington State, researchers estimate that 10 percent of the children served by child welfare workers fit the statutory definition of sexually agressive youths.[47] The relationship between CAN and the development of sexually agressive behaviors has been explored in detail by Hall and Mathews, who found that only sexually abused children whose abuse included specific characteristics (e.g., physical abuse and sadism, among others) were at risk for becoming sexually aggressive.[48] Other research has pointed to severe physical abuse as a precursor of sexually aggressive behaviors. (See Paper #2) Both CSA victims fitting Hall's typology of SAY and youths in child protective services who have already begun to display sexually aggressive behaviors need services to protect other children from abuse and to deter them from juvenile and adult sex offense.

Children and families in some of these categories are easily identified; however, victims with more complex or subtle risk factors—such as a diagnosis of PTSD, family or personal history of substance abuse or CSA characteristics likely to lead to problem sexual behaviors—would require a more skilled and thorough assessment to insure proper program placement (see the box "Assessment to Identify High-Risk Victims of CAN.")

Exhibit 1-3 enumerates types of interventions that are designed to respond to the needs of these special CAN populations as well as provides examples of age-appropriate programming for victims and their caretakers. The program list is not intended to be definitive, only to illustate representative programming approaches. Brief program descriptions are provided below (see also Paper #2 for further information on selected programs).

Assessing CAN Victims' Risk for Delinquency

Following a finding of child abuse or neglect, victims and their caretakers need careful assessment to determine whether the child is at heightened risk for delinquency or further damage that could impair the child's resiliency. Risk factors to target in the assessment of CAN victims include (see Paper #2 for a full discussion of the relevant research):

- age (less than 5 years old);
- poor reading skills;
- less than average I.Q.;
- family history of domestic violence, especially for female victims;
- severe behavioral disorders (in young children);
- multiple foster care placements;
- family history of drug or alcohol abuse, especially for white female victims;
- victim with extensive drug use (frequent cocaine or herion use) combined with self-reported serious criminality (i.e., two or more index offenses);
- extensive exposure to community violence, especially for African-American victims;
- PTSD combined with exposure to community violence, especially for African-American male victims;
- Native Americans, especially male victims;
- highly disorganized or criminally-involved family;
- primary personal relationship with peers; and
- for CSA victims, abuse and caretaker characteristics likely to result in sexually agressive behaviors in victims (e.g., degree of sexual arousal during abuse, severe physical abuse and sadism, and violent, criminally-involved families of origin.)[49]

As indicated above and detailed in Paper #2, the most recent research indicates that risk factors for delinquency among victims of CAN vary *significantly* by gender, race and ethnicity.[50] Assessors will need to give additional weight to those factors known to be especially strong predictors of delinquency for specific groups (e.g., PTSD combined with exposure to community violence for African-American males or a family history of substance abuse or domestic violence for females.) A risk factor for delinquency among the general population that does *not* appear to be an additional risk to CAN victims is not living with both parents (removing an abusive parent may be of benefit to these children.)[51] Similarly, children in foster care should not automatically be considered high-risk: one study found that for foster children who have a close relationship with their foster parents the likelihood of future violence is very low (less than 10 percent.)[52]

The following interventions are examples of existing programming targeting the needs of high risk victims of CAN. Paper #2 provides descriptions for other programs listed in Exhibit 1-3: The Compassion Workshop, Silver Spring, Maryland (child abuse and spouse abuse); Homebuilders, a national program (family preservation); The Family Center--Parenting Journey, Cambridge, Massachusetts (parenting therapy); Advocacy for Women and their Abused Kids in Emergencies (AWAKE), Boston, Massachusetts (child and spouse abuse); Responsive Advocacy for Learning and Life in Youth (RALLY), Boston, Massachusetts (school-based multi systemic intervention) and Casa Myrna, Boston, Massachusetts (child abuse and spouse abuse).

I. Programs Serving Children Under Five Years Old

Copeland Early Childhood Center (CECC), Duluth, Minnesota

The Copeland early Childhood Centers offers comprehensive programming for approximately 100 children from birth to five years of age and their parents daily. Based in a Housing and Redevelopment Building, The Copeland Center's programming includes Early Childhood Family Education, Head Start, and Mother and Child programs. The CECC serves families referred by CPS, the courts, law enforcement, doctors, and social workers as well as self-referred clients. The *Early Childhood Family Education* program provides stimulating programs for children from birth to five years old directed by licensed early childhood education teachers while parents meet with a licensed parent facilitator who organizes presentations and discussions to improve parents' skills. *Head Start* is offered at the same site for four and five year olds. Families of children enrolled in Head Start are eligible for a range of support services and are encouraged to volunteer in the classroom to gain work experience. The Mother and Child program provides assistance to mothers and children who need to improve English language and literacy skills. Mothers receive Adult Basic Education and English as a Second Language as well as information about American culture and parenting support. Children receive services through the Early Childhood Family Education program that emphasize language development.

Exhibit 1-3

CAN Populations at Heightened Risk for Delinquency and Related Intervention Strategies

CAN Populations At Heightened Risk for Delinquency	Research Identifying Risk	Type of Intervention Indicated	Programmatic Examples of Age-Appropriate Interventions				
			Birth-K (0-5 yrs.)	Grades 1-5 (6-11 yrs.)	Grades 6-8 (12-14 yrs.)	Grades 9-12 (15-18 yrs.)	Parents, Guardians, or Foster Families
1. All abused children younger than 5 years	Widom[a] Thornberry[b]	• Home visitation • Therapeutic daycare • Parent education	• Gilday Center • Homebuilders • Copeland Center				• Gilday Center • Homebuilders • MELD (formerly Minnesota Early Learning Center) • Copeland Center
2. Children with low reading scores	Widom Saunders[c]	• Reading readiness • School-based tutoring		• Seattle Social Development Project (SSDP)	• Responsive Advocacy for Learning and Life in Youth (RALLY)	• RALLY	
3. Children who have witnessed domestic violence	Widom Saunders Peled,[d] et al. Thornberry	• Family, group or individual counseling • Batterer intervention • Parenting education	• Advocacy for Women and Their Abused Kids in Emergencies (AWAKE) • Parents and Children Together (PACT) • Casa Mirna	• AWAKE • PACT • Casa Mirna	• AWAKE • PACT • Casa Mirna	• The Parenting Journey • AWAKE • PACT • Casa Mirna	• The Parenting Journey • Compassion Workshop • AWAKE • PACT • Casa Mirna
4. Children with severe behavioral disorders or multiple foster care placements	Widom	• Parenting education • Behavior modification • Assistance to foster/adoptive families • Permanency planning	• Gilday Center	• Ellen Stem Pair Therapy Program (ESPTP)	• ESPTP • RALLY	• ESPTP • RALLY	• Gilday Center • MELD
5. Children with extensive exposure to community violence (espec. those diagnosed with PTSD)	Saunders	• School-based Alternatives-To-Violence programming • Academic assistance • Counseling • Community-based violence prevention	• Child Development/ Community Policing (CD-CP)	• CD-CP • ESPTP	• CD-CP • ESPTP • RALLY	• Boston Juvenile Court Clinic (BJCC) • ESPTP • RALLY	• BJCC

6. Children with extensive family histories of drug or alcohol abuse or self-reported intensive drug use and delinquencies	Saunders Johnson, et al.[e]	• Counseling/support for children of substance abusers • Drug/alcohol education • Anger management/dispute resolution training • Parenting classes for teens	• Gilday Center • Casa Mirna	• SSDP • ESPTP • Casa Mirna	• RALLY • ESPTP • Casa Mirna	• BJCC • ESPTP • Casa Mirna	• Gilday Center • Casa Mirna
7. Native American children	Saunders	• Family group conferencing • Drug/alcohol education • Anger management/dispute resolution • Parenting education for parents and teens	• Ina Maka	• Ina Maka	• Ina Maka	• Ina Maka	• Ina Maka
8. Sexually aggressive youth	Widom English[f] Freeman-Longo[g] Hall et al.[h]	• Family and individual counseling	• SHIFT (Sexual Health in Family Treatment)	• SHIFT	• SHIFT	• SHIFT	• SHIFT

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[c] Thornberry, T.P., "Violent Families and Youth Violence," *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Fact Sheet #21*, (Washington, D.C.: OJJDP), December 1994.

[d] Peled, E., P.G. Jaffe, and S.L. Edleson, eds. *Ending the Cycle of Violence: Community Responses to Children of Battered Women*, (Thousand Oaks, CA: Sage Publications, Inc., 1995): 28-32.

[e] Johnson, B., E.D. Wish, J. Schmeidler and D. Huizinga, "Concentration of Delinquent Offending: Serious Drug Involvement and High Delinquency Rates," in *Drugs and Crime*, ed. R. Dembo, (Lanham, Maryland: University Press of America, 1993): 1-26.

[f] Interview with Diana English, Office Chief, Office of Childrens Administration Research, Department of Social and Health Services, Washington State, June 1997.

[g] Freeman-Longo, R.E., "Challenging Our Thoughts," presented at the National Summit: Promoting Public Safety Through the Effective Management of Sex Offenders in the Community, Sponsored by the U.S. Department of Justice, Washington, D.C., November 24-26, 1996.

[h] Hall, D.K. and F. Mathews, "Problematic Sexual Behavior in Sexually Abused Children: A Preliminary Typology" unpublished paper, York University and Central Toronto Youth Services, 1997; Hall, D.K. and F. Mathews, "Factors Associated with Sexual Behavior Problems in Young Sexually Abused Children," (paper currently being reviewed for publication), 1997.

MELD, a national program based in Minneapolis, Minnesota

MELD, founded in Minneapolis in 1975, provides an array of parenting education and support programs at 100 sites in fifteen States and Canada. MELD receives referrals from social service agencies, hospitals, The United Way, word-of-mouth and the local juvenile justice system offers parenting education and support groups for new parents; parents of children under three years old who are chronically ill or disabled; adolescent mothers aged 13-20 years; young single mothers of children 3 to 5 years old; Spanish language parents; Hmong parents; young fathers; and parents who are deaf or hard of hearing. One young father's group is held in the Hennepin County, Minnesota, Homeschool Detention Center, a correctional facility for 14 to 17 year olds. MELD curriculum addresses health, child development, child guidance, family management and personal growth. A 1995 evaluation by the National Committee for the Prevention of Child Abuse (NCPCA) of eight child abuse prevention programs in Philadelphia showed that the MELD program in conjunction with home visitation "showed the best results in impacting factors that predict child abuse and neglect, especially among high risk adolescent mothers."[53] In addition, other evaluations have indicated that program participants had more appropriate expectations concerning their child's abilities, were more empathetic in interaction with their children and believed less strongly in corporal punishment. Adolescent mothers who were program participants postponed second pregnancies, made better use of community resources, and over half of college-age participants were enrolled in post-secondary education.

Gilday Center, Roxbury, Massachusetts

Located in the Mission Hill Housing Development, the Gilday Center provides services to infant and toddlers and their families. A privately funded non-profit, the Gilday Center also receives funding and referrals from the Massachusetts Department of Social Services to provide special services to infants 6 weeks old to 2.9 years who are the subjects of substantiated cases of abuse and neglect. The goals of treatment for children at the Gilday Center are to identify and redress the developmental effects of abuse and neglect through individual, pair, and group play and to provide intensive, consistent and on-going support to help the child develop age-appropriate personal and social expectations and responses. Parents have the opportunity to learn new skills, receive support, and build informal community-based support networks. For example, parents participate in group sessions that encourage the discussion of parenting issues, provide information on developmentally appropriate behaviors, and offer practical information concerning housing or other resources. Parents also spend time observing teachers modelling appropriate communications techniques and responsiveness with the children.

II. Programming to Address the Impact of Domestic Violence on Children

Parents and Children Together (PACT), New Haven Connecticut

Sponsored by the Coordinating Council for Children in Crisis (CCCC), PACT offers psychoeducational group services to mothers and their children ages 6 to 12 who are victims of or witnesses to domestic violence. (See Appendix A for Group curriculums.) PACT's Children's group attempts to address the trauma of witnessing domestic violence by encouraging children to share their feelings, learn safety strategies, practice non-violent conflict resolution, and build self-esteem. Mothers' groups focus on helping abused women to understand the impact of domestic violence on children and encourage safety planning for family members. With funding from the Connecticut Department of Children and Families, the CCCC offers a number of free home-based services intended to prevent child abuse and neglect including parent education, advocacy, individual and group counseling for abused women, and therapy and support services to victims of child sexual abuse.[54]

III. Court-based Intervention

Boston Juvenile Court Clinic (BJCC), Boston, Massachusetts

BJCC, founded in 1967, is the oldest court-based intervention for victims of CAN and their families in America. BJCC is the child mental health branch of the Boston Juvenile Court. Following a finding of abuse or neglect, the Court refers children to BJCC for mental health and family assessments. BJCC offers three intervention programs for parents and children: a 10 week *parenting group* focusing on the development of active parenting skills for parents who have lost custody of their children or who are at serious risk for losing them; *Alternatives to Violence*, a 6 to 8 week anger management program for juveniles who have been identified as truants or as committing other minor offenses and are thought to be at risk for more serious criminality; and a ten week *alcohol and substance abuse education program* for incorrigible or other at-risk court-involved children.

Seattle Social Development Project (SSDP)

The Seattle Social Development Project is a six-year, elementary school-based program focusing on preventing delinquency in low-income children. SSDP seeks to reduce known risk factors for delinquency (such as academic failure, drug abuse and early behavioral problems) and to cultivate protective factors through promoting high level of social bonding to pro-social individuals (teachers, peers and parents) and institutions (the family and school). The program targets classroom methods likely to promote academic success and participation, social skills training to teach problem solving skills and to prevent early anti-social behavior, cope with peer rejection and contact with anti-social peers. Parenting training is offered to encourage parents' positive reinforcement of program goals, moderate disciplinary practices and to help parents assist children with developing reading and math skills. In addition, parents of fifth and sixth graders are taught skills to help their children resist substance abuse. Evaluations suggest that for boys the intervention succeeded in increasing academic and social skill and reducing delinquency: at sixth grade, 47 percent of male program participants had initiated delinquency compared to 67 percent of the boys in a control group.[55]

Ellen Stern Pair Therapy Program (ESPTP), Boston, Massachusetts

ESPTP is a therapeutic approach to developing interpersonal skills in children who display aggressive or extremely passive behaviors or who suffer social isolation. The immediate aim of the therapy, which involves matching the child to a same sex child of similar age for the duration of counseling, is to facilitate children in resolving conflicts and integrating multiple perspectives in order to help them make healthier behavioral choices. The long-term goal of the therapy is to help the child develop meaningful peer relationships that can increase the child's resistance to risk-taking behavior, such as interpersonal violence or drug abuse.

V. Law Enforcement-based Intervention

Child Development-Community Policing (CD-CP), New Haven, Connecticut

CD-CP is a collaboration between New Haven Police and child development specialists at the Yale Child Study Center to intervene appropriately and sensitively with children who have witnessed violent crime. The project includes cross training in which police learn more about children's psychological and developmental response to witnessing violence from development experts, and mental health professional ride with police in squad cars, and spend time in police stations and on the street. Specially trained officers and clinicians are on-call 24 hours a day to respond to the needs of children who are in crisis as the result of witnessing violent crime. The program has been replicated in Framingham, Massachusetts and recognized as a model program by and received support from OJJDP.[56]

VI. Intervention for Sexually Aggressive Youths

Sexual Health in Family Treatment (SHIFT), British Columbia, Canada

Therapists at SHIFT work with children (12 years or younger) with sexual behavior problems who have experienced abuse or violence in their families. The intensive program provides individual, family and group therapy to the child and his or her caretakers. Using a strengths-based, family systems approach, therapists target the structure and organization of the family and its communication patterns, affective tones and nurturing behaviors, control and decision making, conflict resolution, and boundary issues. The goal of the therapy is to eliminate sexually aggressive or inappropriate behaviors in the child and to enhance family functioning and child social skills.

VII. Comprehensive Programming for Native Americans

Ina Maka (United Indians of All Tribes Foundation), Seattle, Washington

Ina Maka offers comprehensive family systems interventions that emphasize family preservation and incorporate traditional Native American practices and beliefs. Ina Maka programming includes family counseling; alcohol and drug crisis intervention services; home-based crisis intervention services; Foster care recruitment, placement, and advocacy; counseling for survivors of sexual abuse, batterers'

intervention; domestic violence interventions for women and children; and victim advocacy. Families who have a substantiated case of CAN or who are assessed by the Department of Health Services to be at risk for CAN may be referred to Ina Maka for counseling. In addition, Ina Maka offers a 10-12 week Life Skills Group for adolescents addressing issues of assertiveness, belief systems, negotiating skills, types of CAN, economic abuse, and dating relationships. Ina Maka uses individual, family and group counseling as well as education and skills building to address the multiple problems and victimizations presented by their clients.

Existing OJJDP Programming Appropriate for High Risk CAN Populations

OJJDP currently funds or plans to fund a number of risk and protective factor-focused delinquency prevention initiatives that may be appropriate for intervening with high-risk CAN populations. For example:

- **Youth Substance Abuse Prevention Program** (President's Crime Prevention Council)—To assist grass-roots, community-based, youth-led organizations that focus on youth drug and alcohol abuse prevention activities;
- **Youth-Centered Conflict Resolution** (Illinois Institute for Dispute Resolution—A collaborative effort to develop broad-based national conflict resolution strategy and to provide information and technical assistance concerning conflict resolution to individuals, organizations and communities;
- **Teens, Crime and Community: Teens in Action in the 90s (TCC)** (National Crime Prevention Council and the National Institute for Citizen Education in the Law)—TCC and Boys and Girls Clubs of America partner to engage in a variety of activities intended to improve their schools and communities.
- **Communities in Schools (CIS)** (Federal Interagency Partnership)—The program serves high-risk youths and their families by providing school-based social, employment, mental health, drug prevention, and entrepreneurship resources.
- **Risk Reduction Via Promotion of Youth Development** (OJJDP with the National Institute of Mental Health)—An elementary school-based experimental program to promote "coping-competence," reduce behavioral problems, deter substance abuse, and prevent school failure. Intervention strategies target both home and school environments and include a classroom program, a school-wide conflict management program, peer social skills training, and home-based family support.
- **Henry Ford Health System (HFHS) Center**—A program to reduce community violence and gang participation featuring community patrols, tutoring, drama, peer education, and substance abuse prevention.

Conclusion

Intervening with victims of CAN to prevent delinquency is still an experimental pursuit. Although research is providing stronger evidence of the correlation between certain variables (e.g., types of victimization, demographic characteristics, family histories or cultural milieu) and delinquency, adult criminality and violent crime, much is still unknown. Perhaps the most pressing need is for high-quality experimental program evaluations testing whether current interventions can indeed inhibit the development of anti-social behaviors in victims of CAN. Answering the question, "What works for victims of CAN?" will undoubtedly be a slow and difficult process, but the potential reward of future reductions in domestic violence, child abuse and neglect, sex crimes, substance abuse and violent criminality makes it an urgent enterprise.

Endnotes

1. See Paper #2 in this series, "Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect (CAN)," for a detailed discussion of the sequelae of child abuse and neglect.

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19. Interview with Debra Whitcomb, Educational Development Center, Newton, Massachusetts, June 1997.

20. The information in section is primarily drawn from, American Humane Association, "Twenty Years After CAPTA: A Portrait of the Child Protective Services System," unpublished report, Englewood, Colorado, May 27, 1994.

21. Widom, "The Cycle of Violence." Future research may wish to explore the connection between the degree and quality of attention given a case by the criminal justice system and subsequent victim delinquency across different types of abuse.

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35. Ibid.: 5.

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48. Hall and Mathews, "Factors Associated with Sexual Behavior Problems"; and Hall and Mathews, "Problematic Sexual Behavior".

49. Hall and Mathews, "Problematic Sexual Behavior."

50. Saunders and Kilpatrick, "Victimization."

51. Widom, preliminary presentation of findings, Annual Conference on Criminal Justice Research and Evaluation, July 21, 1997.

52. Ibid.

53. Program information, "MELD: Programs to Strengthen Families," Minneapolis, Minnesota, March, 1997.

Appendix A

Clifford Beers Guidance Clinic

and

Coordinating Council for Children in Crisis

present:

P.A.C.T.

Coordinating Council For Children In Crisis, Inc.
131 Dwight Street
New Haven, CT 06511
(203)624-2600

CHILD WITNESSES OF DOMESTIC VIOLENCE
PARENTING GROUP

Week 1: **Effects on Children of Witnessing Violence.** Awareness of the effects of violence on children provides parents with a context for understanding their children's behavior. Consciousness-raising in this area can also have a positive impact on parents' approach to discipline.

Week 2: **Effects of Early Life Experiences on Parenting.** An awareness of the ways in which early experiences influence us as adult parents allows parents to make conscious choices about aspects of their family of origin they wish to include or exclude in their current families. Parents do not need to be victims of their past by repeating the mistakes of their parents.

Week 3. **Parents' Rights/Children's Rights.** Some men and women are still rigidly confined to traditional gender roles and beliefs. Such attitudes tend to contribute to and reinforce family violence. Parents are encouraged to meet their needs within other significant life roles, and learn how to avoid abusing their power as adults toward their children.

Week 4. **Discipline vs. Punishment.** Research suggests that battered women are at increased risk for abusing their children. They are frequently isolated, lack outside support, and are the primary caretaker of the children. It is crucial for these mothers to know the difference between discipline and punishment and to learn non-violent approaches to discipline.

Week 5: **Self-Esteem in Children.** Children of battered women were found to have less self-esteem than children from non-violent homes (Hughes, 1988). Parents of child witnesses of violence need to make a conscious effort to support and strengthen their children's self-esteem.

Week 6: **Communication.** Children from violent homes often experience confusion as a result of mixes messages, double standards, misrepresentations of behavior and lack of permission to ask clarifying questions. Parents can be helped to establish open and direct communication with their children by identifying their own style of verbal and nonverbal communication.

Week 7: **Children's Relationships With Peers and Siblings.** Survivors of abuse often report their children's hostile, negative and destructive patterns of interaction with peers and siblings. They fear their children will grow up to repeat the cycle of violence, taking on perpetrator and victim behavior. Parents are encouraged to discuss with their children appropriate and inappropriate expressions of feelings, while validating the existence of different feelings for different children.

Week 8: **Changing Families.** A high rate of separation and divorce exists among families where woman battering occurs. Separation and divorce, along with remarriage or repartnering can be extremely stressful to children. Understanding the manner in which children manifest, defend, or resolve feelings related to changes in the family is the first step toward healthy family restructuring.

The Goals of the Children's Group

•Breaking the Secret

This complex group goal helps children define violence (abuse is not okay, it's not my fault), become educated regarding their feelings (it's okay to feel and to express feelings), and share personal experiences (I'm not the only one). Universalizing the experience through telling or drawing stories, promotes expression of feelings and promotes healing.

•Learning to Protect Oneself

The life realities of the children who participate in this project indicates a need for self-protection training. Safety planning may include telephone role plays, sexual abuse education (good touch - bad touch), group leaders role-modeling assertive conflict resolution strategies.

•Having Positive Social Interaction Experiences

A positive experience can be described as one in which children feel safe, and encounter fun and enjoyment. The children's feelings of trust and safety in the group are a precondition for "breaking the secret". Fun activities provide the children with an immediate gratification that balances the heavier violence related aspects of the group.

•Learning Positive Conflict Resolution

Through the use of role plays, the child will be aided in identifying upset feelings and different (appropriate) ways of expressing such feelings. As children are accustomed to seeing anger expressed by striking out, the goal is to help children discover alternative methods of expressing anger.

•Strengthening Self-esteem

Children witnesses of violence are often dis-empowered. They also often feel different from other children and sometimes they are themselves abused. It is expected that participation in the group will empower the children and strengthen their self-esteem. Several group activities and general supportive and validating interaction with group leaders throughout the group contribute to the achievement of this goal. These include positive reinforcement of children, such as complimenting children for what they said and did and reassuring them that their thoughts and feelings were valid. Another way of empowering the children is by enabling them to make as many choices as possible in the course of the group sessions.

Further, achievement of each of the other four goals contributes to children's positive self-perception. The process of breaking the secret tends to reduce children's shame, guilt, and isolation associated with the violence. Through learning to protect themselves children are empowered and strengthen their confidence in their own skills. A positive experience in group means for the children a positive experience of themselves, of their capacities to be respected and cared for and to be part of a positive enjoyable interaction.

PARENTS AND CHILDREN TOGETHER

Children's Group

SESSION #1 (Introductions and group rules) (Pre-Tests)
WHAT IS ABUSE?
"Abuse is not ok"
Basic definitions of violence and abuse
Become comfortable with "breaking the secret"
Feeling of the day is "happy" **(Snack)**
Make posters
Close with personal affirmations

SESSION #2 (Review rules)
ANGER
"It's ok to be angry but it's not ok to abuse others"
Learn to differentiate between appropriate and inappropriate expressions of anger
Feel safe to express uncomfortable feelings
Feeling of the day is "angry"
Role Plays **(Snack)**
Discuss co-existence of contradictory feelings of love and anger,conflicts and loyalty
Close with personal affirmations

SESSION #3
WHEN PARENTS FIGHT
"It' not my fault"
No one deserves abuse
Learn that people are responsible for their behavior
Feeling of the day is "confused"
Read story, *Something is Wrong in My House*
Discuss personal experiences **(Snack)**
Drawings,Clay,Collage
Close with personal affirmations

SESSION#4
IT'S NOT ALWAYS HAPPY AT MY HOUSE
"I'm not the only one whose parents fight"
Feeling of the day is, "Brave"
Decrease isolation
Confront range of feelings such as: anger, pain, frustration, confusion, guilt, sadness
Video: *A Family Affair*
Discuss reactions to movie **(Snack)**
Relaxation Exercise
Close with personal affirmations

SESSION #5
Sharing personal experiences with violence
Feeling of the day is "hurt"
Relate experiences to feelings
Feel less ashamed
Group murals depicting most violent events/ Three Wishes
(Snack)
Free-Time Activity
Close with personal affirmations

SESSION #6
Parents And Children Together
Group members display their creations
Share safety plans
Bring a dish made by moms and children
What have we all learned? **(Post-Tests)**

Background Paper #2:

Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect

Athena Garrett, Ed.M.
Abt Associates Inc.

October 3, 1997

Introduction

In recent years, the reports of child abuse and neglect (CAN) have risen at a rapid rate.[1] In response, there has been a proliferation of theoretical and programmatic innovations from a number of fields, including sociology, psychology, medicine and criminal justice. This paper reviews the growing body of research on the etiology of CAN, the consequences for victims, and theories concerning effective treatments and interventions. In particular, recent research concerning the demographic characteristics associated with increased criminality in victims of CAN is reviewed, and the most promising intervention and treatment strategies are summarized.

The theoretical assumptions informing child abuse and neglect interventions are shifting. Originally, child abuse and neglect was believed to be a consequence of individual psychopathology. Currently, researchers and practitioners are beginning to recognize that it is also a familial and social problem that requires more comprehensive and creative interventions. Increased attention is being given to the ability of individuals and families to successfully remedy the negative impact of victimization. Theories and interventions are moving from an individualistic, deficit-oriented model toward a more ecological, strengths-based model, which is focused on individual and familial resilience.

Part I: Theories Guiding Research and Intervention

A number of theories guide research and intervention strategies for child abuse and neglect. This section discusses social learning, attachment, ecological, family systems, self-efficacy and resiliency theories. Typically, intervention programs incorporate at least two of these six theories. (See Part III for program summaries illustrating each theory.)

Social Learning Theory

According to social learning theory, behavior is learned through two methods: we either learn by being rewarded for our actions (instrumental learning), or we observe and imitate the behavior of those around us (modeling).[2] Researchers postulate that abused children learn to be abusive through modeling and instrumental learning and may continue their abusive behavior into adulthood. This pattern of learned aggression is commonly referred to as the "cycle of violence,"[3]or the intergenerational transmission of violence.

Critique of Theory

Some researchers question the direct and inevitable pattern outlined by social learning theorists. They question the broad-based application of the cycle of violence theory, pointing to findings that only 20-30 percent of CAN victims become involved in abusive and criminal behavior.[4] Azar states that the focus of social learning theory is too narrow and does not include multiple factors that influence family functioning.[5]

Additionally, when parenting education and other social learning-based treatments are more discussion-based than action-oriented, they tend to be ineffective, especially with lower socioeconomic groups.[6] Action-oriented interventions with parents and children, on the other hand include 'hands-on' learning and modeling. For example, a mother may observe a practitioner in a daycare setting interacting with her child. The practitioner models nurturing, pro-social and age-appropriate responses to the child's behaviors, followed by the parent's own interaction with the child. The practitioner may then observe and participate by providing both verbal and physical cues to the parent, which indicate and encourage appropriate behaviors.

Programs Based on this Model

Initially, interventions based on social learning theory focused exclusively on the perpetrator. More recent interventions also focus on the family, with some inclusion of community members when relevant and possible. Social learning theory is the foundation for such practical cognitive-behavioral interventions as education groups with parents and adolescents and emotion and behavior management with adolescents and children. Interventions based on social learning theory commonly have the purpose of stopping current and preventing future CAN, teaching both the parent and child appropriate and acceptable familial interaction, and teaching pro-social and learning skills.

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132. National Research Council, *Understanding Child Abuse and Neglect*, 254.

133. Ibid.

134. Chaffin, M., B. Bonner, K. B. Worley and L. Lawson, "Treating Abused Adolescents," in *The APSAC Handbook on Child Maltreatment*, ed. J. Briere, L. Berliner, J. A. Bulkley, C. Jenny and T. Reid, Thousand Oaks, CA: Sage, 1996: 133.

135. Ibid., 129.

136. Van der Kolk, B. A., D. Pelcovitz, S. Roth, F. Mandel, A. McFarlane and J. L. Herman, "Dissociation, Somatization, and Affect Dysregulation: The Complexity of Adaption to Trauma," *American Journal of Psychiatry,* Festschrift Supplement, 7 (1996): 83-93.

137. National Research Council, *Understanding Child Abuse and Neglect.*

138. Ibid.

139. Ibid.

140. Ibid.

141. Hart, "Psychological Maltreatment," 83-84.

142. Interview with Cathy Ayoub, Harvard University, Cambridge, 1997.

143. Chaffin, "Treating Abused Adolescents," 130.

Because social learning theory attributes behavior to lessons learned from the environment, it is closely related to ecological theory. However, programs that are heavily influenced by social learning theory, focus treatment more narrowly on the family. Programs founded on ecological theory involve a wider range of external services and systems to address multiple factors that impact the family environment.

Program Examples

Parents and Children Together (PACT) in New Haven, Conneticut, provides services that are strongly influenced by social learning theory. Groups for parents focus on child development and clear parent-child communication. Additionally, they help the entire family to learn safety strategies, share feelings and practice non-violent conflict resolution.

Attachment Theory

Attachment theorists believe humans develop a repertoire of behaviors that promote interaction between themselves and their care givers.[7] Children learn these behaviors as a result of how their caregivers nurture them. According to attachment theory, the type of bond that develops between child and care giver effects the child's later relationships.[8] Attachment theory describes four bonding types: secure, anxious/ambivalent, anxious/avoidant, and disoriented/disorganized. The securely attached child freely explores surroundings and is easily comforted. Children with anxious/ambivalent attachments move easily between the caregiver and a stranger when looking for comfort but will simultaneously resist the comfort given. Children who experience anxious/avoidant attachments manifest distrust of the care giver, poor exploration, resistance to separation from the caregiver, and an inability to be comforted. Disoriented/disorganized attachment patterns are characterized by erratic and confused behavior as the child is unable to discern which behaviors gain favorable attention from the caregiver.[9]

Secure attachment patterns are thought to develop from a consistent and nurturing caregiver, whereas the other, insecure attachments, are the result of inconsistent, emotionally neglectful and/or abusive caregiving. Attachment theory suggests that children who are neglected or abused may be more distrustful, have limited self-esteem, and seek out more maladaptive relationships later in life than those who have not been neglected or abused. Several researchers have cited that as many as 80 percent of abused infants and children exhibit insecure attachment patterns.[10]

Some suggest that abuse and neglect not only impact attachment patterns in children, but these patterns carry over into adulthood through an "internal working model"[11] of relationships; in other words, the type of caregiving children receive is the type we come to expect and recreate in adulthood. Research suggests that "internal working models" can either be adaptive and buffer stress or maladaptive and lead to impaired interpersonal relationships and self-esteem.[12] This perspective is salient when addressing CAN. Perpetrators of CAN may behave according to their own "internal-working model" created by their bond to their parent. For example, children raised by neglectful parents may develop insecure attachments that could be recreated in their attachments to their own children when they become parents. Consequently, a neglected child may be predisposed to becoming a neglectful parent. This is similar to social learning theory. Both attachment theory and social learning theory support the "cycle of violence" definition of abuse and neglect.

Critique of Theory

As with social learning theory, attachment theory as the single predictor of child abuse and its intergenerational transmission is not always considered a sufficient explanation. Azar describes it as a "perpetrator model" limited in explaining the occurrence of child abuse and neglect.[13] Other critics claim that the emphasis on the parent-child bond to explain and design programs for child maltreatment is too narrowly focused and they highlight the importance of the contextual influences of community and culture.[14]

Some attachment theorists hold that attachment styles form early in infancy and cannot be altered unless a dramatic transformation occurs from an intensive therapeutic or love relationship. Recently, some theorists have modified this perspective and claimed that relationships throughout life affect expectations of and behavior within relationships. Rutter's evidence that psychiatric disorders can develop as a result of events in middle childhood, despite adaptive development through infancy and early childhood, suggests that early adjustment patterns are not set and can be transformed throughout life.[15]

Programs Based on this Model

Programs concerned with attachment issues tend to adopt one of two strategies. The first strategy is to replace the existing insecure bond between the child and the caregiver with a new, more secure bond through out-of-home placement. Program developers may believe that if children remain with abusive, neglectful, or non-nurturing caregivers, they will develop maladaptive relationship styles. Therefore, they should be placed in more consistently nurturing environments. In contrast, the second strategy

focuses on preserving the family while working to repair the caregiver-child bond. The belief underlying this strategy is that the separation from the original caregiver could result in irreparable damage and even less secure relationships in the future.

A compelling study of attachment suggests a link between attachment styles, types of abuse, and adult functioning outcomes. Researchers at the Michigan State University Department of Psychology found that childhood neglect influences symptomology and dysfunctional attachment styles more than physical abuse does.[16] Additionally, neglected children had lower intellectual and social competence and impaired language development.[17] Their research suggests that neglect and abuse should be viewed distinctly, and perhaps programs should be developed with this differentiation in mind. Programs designed for neglected children may require a consistent, nurturing adult who fosters secure attachments, while incorporating a language and social skills development component. However, children who have been physically abused may not need interventions as heavily focused on developing secure attachment styles.

Program Examples

Compassion Workshop is an example of a program designed according to attachment theory which incorporates social learning theory in its treatment modalities. It is an intervention for child, partner and elder abuse and treats both perpetrators and victims. Participation may be voluntary (self-referred) or involuntary (court-ordered). The program addresses physical and emotional abuse by attempting to resolve attachment problems through a cognitive restructuring technique called HEALS: Healing, Explain to yourself, Apply self-compassion, Love yourself, and Solve. The program providers hope to help participants understand their own attachment histories and create balanced and secure attachments in their relationships. By looking at their own, and assumed dysfunctional, childhood attachment patterns, they are encouraged to alter their existing attachment patterns with their mates and children. In addition, the program is designed to help participants build self-esteem, develop self-compassion and compassion for others, and eliminate violent expression of emotions. In an evaluation study, 87 percent of Compassion Workshop participants were violence-free at the end of one year, compared to 41 percent of a comparison group comprised of participants from other batterer programs.[18]

The Gilday Center is a therapeutic daycare/family preservation intervention that combines attachment and social learning theory. The Center is contracted by the Massachusetts Department of Social Services to serve families that have a substantiated case of CAN but sufficient strength to be restored.

The daycare providers work with child victims to facilitate age-appropriate emotional, cognitive, social and physical development by establishing safe and nurturing relationships between themselves and the child (attachment). Providers also create an individual educational plan for each child to further address the manifestations of trauma from CAN. For the parents, practitioners use the cognitive-behavioral practices of observation and modeling through active parent instruction at the daycare. The interventions with parents and their children are designed to help parents establish consistent and appropriate responses to their children's needs while facilitating the mother-child bond.

Ecological Theory

Early theories of child maltreatment assumed that abuse and neglect stemmed from a parent's personality disorder.[19] Later critiques demonstrated that less than ten percent of abusive parents were emotionally maladjusted.[20] Current research and interventions grounded in ecological theory hold that abuse and neglect result from multiple factors. These factors are divided into four systems: individual (ontogenic), family (mesosystem), community (exosystem), and culture (macrosystem).[21] Included in these systems are the following influences: peers, school, workplace, economic factors, childrearing history, child characteristics, parent characteristics, marital relationship, social support and socio-cultural milieu.[22]

When considering why child abuse and neglect occur, ecological theorists include influences on the family such as surrounding community violence and isolation from the community.[23] For example, families impacted by extreme community violence may subsequently isolate themselves for protection, but consequently disconnect themselves from resources and the influence of appropriate community standards of childraising. Therefore, employment, economic, and relational stressors that may contribute to abusive and neglecting behaviors are not addressed through community support. In addition, due to a normative taboo against child maltreatment, the occurance of maltreatment can lead to further isolation as family members develop a code of silence.

Ecological theory is similar to the transactional and transitional models of child abuse and neglect. All three depart from earlier theories of individual pathology to include contextual influences. "Transactional" is occasionally used interchangeably with "ecological". Though the transactional model's antecedents focused more on two-way interactions between parent and child,[24] it later included the more complex influences of multiple systems.[25] The transitional model is similarly defined with an additional clarification of how system interactions can escalate.[26]

Critique of Theory

Widom argues that ecological theory is too rigid and does not allow sufficiently for individual variation.[27] For individuals and families involved in CAN, the degree of influence by each level (individual, familial, community and socio-cultural) may differ dramatically. A child who has been sexually abused may be committed to school, involved with peers and dissociated from family, whereas, in another family a sexually abused child may be disconnected from the community and isolated from peers. Additionally, the child's developmental stage may alter the extent to which a system impacts him or her. An ecological system that is based on an adult perspective may not be developmentally appropriate for children.

Programs Based on this Model

For child abuse and neglect cases, the ecological perspective focuses on influences beyond the parent-child dyad and coordinates interventions that address all systems. If, as the theory states, child maltreatment is the result of multiple factors from various systems, then in order to be effective, programs need to address each factor and system. Interventions grounded in this theory include home visitation, parent groups, and facilitation of social and economic supports.

Program Examples

Homebuilders is an example of an intervention founded on ecological theory. This intensive home-based crisis intervention and education program is designed to preserve high-risk families and reduce out-of-home placements (See "Managing the Consequences"). Program providers (CPS) serve two families at a time, are on call in the evening and on weekends, and work with the family to develop communication skills, child management, child/family safety and stability, and to resolve crises.[28] Successful outcomes have been reported for preventing out-of-home placements and client satisfaction; however, assessments have been criticized for lack of true random assignment and other methodological weaknesses. Neglected children have less positive outcomes in this program, and the best outcomes have resulted when services are concrete, such as securing financial support for the family.[29]

The National Head Start/Public School Early Childhood Transition Demonstration Project is another example of an intervention based on ecological theory. The Transition Project provides comprehensive and ongoing services to support low income children and families for four years (compared to the traditional Head Start program which lasts for one year.)[30] Researchers, policymakers, and practitioners recognized the need to address not only the multiple systems impacting

students' academic achievement, but also to deter the "fade-out effect," a loss of the gains achieved through a one-year early intervention in the following elementary years.[31] In addition to facilitating a young child's cognitive, emotional, developmental and physical growth, the program focuses on creating links among parents, families, school, community, and the social services by which a family may be strengthened. The effectiveness of such coordinated and long-term intervention is supported by a convincing body of research.[32]

Family Systems Theory

Family systems theory is similar to ecological theory in that both focus on the entire family unit when assessing the needs and service approach for responding to child abuse and neglect. Family systems theory, however, focuses primarily on the family and is derived from a group/family therapy model that identifies problems as the consequence of dysfunctional reflexive relationships among family members.[33]

Traditionally, family systems theorists defined child abuse and neglect according to the contributing roles of each family member. For example, in cases of incest where the father is the perpetrator, the possibility that the mother's reluctant intervention may appear to be tacit approval would be explored as a contributing factor in the repeated occurrence of the abuse.[34]

Critique of Theory

Critics are concerned with the theory's failure to recognize the influence of power and society on human behavior.[35] Some critics worry that the discussion of the victim's and bystander's roles in the abuse may be overemphasized and relieve the perpetrator of responsibility.[36] In addition, because the perpetrator is usually an adult in a position of authority, his or her power position is a dominant characteristic that mitigates the victim's behavior choices.[37]

Programs Based on this Model

Prevention and intervention strategies designed according to family systems theory focus on relationships within the family. For example, a family systems observer would provide feedback to the family about their interactions. Proponents believe that by transforming the interactions in the family the abusive behaviors can be diminished and eventually eliminated and the victim's safety restored.[38] Individual and family counseling are the most common treatment methods derived from this model.

Program Examples

The Family Center is located in Somerville, Massachusetts, and its goal is to strengthen and preserve the family. The curriculum currently being used and developed is the "The Parenting Journey" which incorporates family systems theory, attachment theory, and social learning theory. The program focuses on the entire family to address issues and provide insights into family dynamics through a family support program. The providers also attempt to help parents resolve destructive parenting patterns based on their own childhood experiences. Families may be referred by CPS or self-referred. Participants receive family therapy with a focus on group dynamics to develop self-awareness, respect, and parenting skills. The Parenting Journey is a new curriculum that has not been evaluated.[39]

Ina Maka Family Program in Seattle, Washington, is another example of an intervention based on family systems theory. It is a comprehensive family preservation program designed to prevent the "break-up of at-risk Indian and non-Indian families," which utilizes both traditional Native American healing practices and modern psychotherapeutic modalities.[40] Clients are referred by Washington State Social Service Agencies for Families and Children (DSHS), CPS, Local and County Court and Probation Officers, numerous tribes and Indian Reservations throughout Puget Sound, and self-referral. Ina Maka provides services to perpetrators and victims. This program helps clients develop positive self-esteem, anger management skills, healthy family communication and parenting skills through short-term and long-term treatment and aftercare services. Additionally, the program has intake/emergency services, domestic violence intervention programs, sexual abuse programs, alcohol and drug abuse treatment, minority diversion services (to preserve and reunite high-risk minority families), and foster care services (for example, home studies, recruitment, case managment and supervision, support services, Indian Child Welfare Legal Services/Reunification, and adoption enrollment). Ina Maka uses the Personal Objective Inventory (POI), a treatment outcome measure, which "provides an objective measure of an individual's level of health in certain areas. "[41] It is a new instrument and the findings have not yet been determined.

Self-Efficacy Theory

Many programmatic models based on ecological theory also incorporate self-efficacy theory. Self-efficacy theory focuses on how personal characteristics of the child and, especially, the parent influence family functioning.[42] Self-efficacy theory addresses how a parent's expectations of effectiveness impact their motivation and behavior.[43] An individual's expectations dictate if they will start and continue actions to achieve a goal.

Self-efficacy theory may be a useful tool for bridging the gap between knowledge and behavior. A gap between knowledge and behavior is apparent when parents know they should not hit their children, but are unable to seek out methods to achieve this goal. Self-efficacy theory states that this knowledge/behavior gap is due to the parents' belief that they cannot behave in a manner that would stop them from abusing their children. The parents may not try to find support groups or they may not continue therapy once started.

Four methods for influencing efficacy expectations have been specified.[44] Performance accomplishment is the method that motivates people to act and persist because they have previously experienced the effectiveness of their behaviors. It is reportedly the most effective method of motivation. The three remaining methods, are verbal persuasion, vicarious experience, and emotional arousal.[45]

Critique of Theory

Self-efficacy theory, according to Olds, is limited because it does not incorporate a developmental perspective.[46] Additionally, it addresses an individual's emotions only through the impact of actions. The effects of personal histories are not adequately addressed by this theory.

Programs Based on This Model

Prevention and intervention programs incorporate self-efficacy theory to motivate families. Programs using this theory may specify small achievable tasks and goals to give the participants a sense of performance accomplishment, which will contribute to their belief that they can effectively carry out more complex and long-term actions and goals.

Program Examples

The intervention program Advocacy for Women and their Abused Kids in Emergencies (AWAKE), located in Boston, Massachusetts, is based on self-efficacy theory, attachment theory, and social learning theory . It was the first program in the country to provide services to both battered women and their abused children in a pediatric setting.[47] The intervention is designed to: make the hospital a safe place to reveal violence in the family and protect every victim; stop abuse by taking a stand against it; provide the abused woman with support and empower her to protect herself and her children from violence and coercion by restoring the victim with a sense of control over her life (with dignity and power); and to keep children and women safe and together, whenever possible.[48] The program screens parent-child emergency room visits for domestic violence and child abuse and provides

Part III: Examination of Existing Intervention Strategies

From the many interventions researched, three have been profiled in this section. These interventions have been selected to depict how intervention programs use theory to design practice and because of their promise as effective intervention strategies for CAN. Most of the interventions selected were created explicitly to stop CAN and/or domestic violence as well as to restore the victims and/or family. (See Exhibit 1-3 in Paper #1.) Others, such as school-based interventions, are designed to improve academic achievement in at risk populations generally, but also address issues of CAN.

The Gilday Center: Roxbury, Massachusetts - founded in 1972

Director: Janice Higgins, LICSW

Assistant Director: Mary Watson Avery, M.S.

I. **Description:** Family Preservation/Therapeutic Daycare Program

A. A nonprofit agency and center funded by private donors, United Way, Associated Day Care Services, and contracted by Massachusetts Department of Social Services.

B. Designed to prevent out-of-home placement by providing parents and children with emotional safety and support, pursue the best interest of each family, and educate parents about child development and their own personal development.

C. Provides services to infants and toddlers 6 weeks to 2.9+ years old who have substantiated experiences of abuse and neglect (51As) [+ six weeks]. Current enrollment 14 children: 6 african american; 3 multi-racial; 4 hispanic; 1 caucasian.

D. Provides a limited number of slots to the community (not protection cases) in which it is based (Mission Hill Housing Development).

II. **Theoretical Framework:**

A. Program is guided by development theories of early childhood, focusing on social, emotional, physical, and cognitive skills.

B. Attachment and Social Learning Theory guide the structure of the interventions with parents and children to help them establishsecure attachments through the cognitive-behavioral practices of observation and modeling, and active parent instruction.

C. Resiliency theory informs child interventions which are based on each child's response to the trauma s/he has experienced.

III. **Objective:** To provide the victims of abuse and neglect with appropriate and specialized treatment that will enable them to develop a healthy identity and healthy relationships with their families, peers, and other adults, while simultaneously supporting the parents in parenting skills, social skills, and community connection.

A. **Children:** Identify and alleviate the developmental effects of abuse and neglect through individual, pair, and group play, and provide intensive, consistent, ongoing support to help the child develop age-appropriate personal and social expectations and responses.

B. **Parents:** Provide parents with opportunities to learn new skills, establish parental support, and facilitate community connections through which to meet their social, economic, and personal needs.

C. **Community:** Provide community-based daycare services to families in Mission Hill Housing Development and maintain positive community relations.

D. **DSS:** Provide family preservation services to parents with infants and toddlers who have had a substantiated case of CAN, but have the necessary strength to either maintain the family unit or re-unite.

IV. **Method:** Families identified and referred by the CPS worker to receive family reunification/therapeutic day care services.

A. **Parents:** attend site with caseworker to meet director and complete the initial intake.

1. Initial intake to determine the needs of the child, parent and family.

a. Determine if Gilday is an appropriate placement.
b. Establish parents' commitment.
c. Ensure attendance of both child and parent.
d. Arrange transportation.

2. Parent Participation/Training (9:00 a.m. – 12:30 p.m., one day a week/weekly)

1 hour a. **Group Session*** with all other parents of children at the center, led by the director.

ecological (support) (1) an arena to discuss present, current, and future parenting issues and events (what's happening with kids).

cognitive-behavioral (2) developmental aspect e.g., toilet training when child is ready, how, and language development.

(3) Resource issues — housing, information sharing.

* Group Sessions span the range from practical/everyday to emotional/personal problems and are both organic and nonorganic in nature.

1 hour b. **Classroom Session:** Parents spend the hour in the classroom watching/observing children and workers (modeling) and are provided with clear illustrations of communication styles, patterns, and responses to childrens' behaviors.

continued advocacy. By being advocates for the women, they hope to promote self-advocating behaviors in the mothers and their children. AWAKE receives referrals from other hospitals, social workers, lawyers, shelters, therapists, victim/witness advocates, criminal justice workers, and clients themselves.[49] From a preliminary analysis of 46 cases, abuse of the mother ended in 85 percent, according to self-report, and in 76 percent of the cases, abuse of the child had stopped according to the mother. Additionally, women and children served were found to have a low rate of foster care placement.[50]

Resiliency Theory

Historically, child abuse and neglect research and interventions were grounded in the belief that inevitably the victim is damaged by the trauma. Mediating influences that may alter the impact of maltreatment typically were not considered. However, recent research has demonstrated that factors such as severity of abuse, frequency of abuse, age of the victim, and relationship to the perpetrator can predict later adjustment. Additionally, certain positive elements of support have been shown to affect the long-term impact of child maltreatment. Factors such as social support,[51] parental warmth[52] and the victim's healthy relationship with a supportive adult[53] influence healthy development and avoidance of delinquent behavior.

Because childhood abuse and neglect do not always result in maladaptive behavior in adulthood,[54] new research is focusing on discovering the mediating factors that contribute to healthy adult psychological development.[55] A primary goal of the research is to discover the protective factors that can be included in an intervention.

Resiliency theory does not explain why abuse and neglect occur, rather, it explains why children are not inevitably damaged by CAN. It may also explain how the "cycle of violence" can be interrupted. This theory focuses on the victims of childhood maltreatment and on methods to mitigate the impact of the maltreatment.

Critique of Theory

Most resiliency theorists would agree that resiliency theory cannot be the soul underpinning of child abuse and neglect interventions.[56] Though programs can reduce the effects of maltreatment, which may in turn reduce the likelihood of later maladjustment and delinquency, protective factors may not

be able to directly reduce the occurrence of abuse and neglect. Thus, programs still need to be in place that are designed to stop current abuse.

Programs Based on this Model

Resiliency theorists design programs that create or increase the influence of protective factors in a child's life. A variety of studies have defined the factors that protect the child from stress, with the most prominent factor being social support.[57] Children who had significant social support and/or sought social support (a coping strategy) showed healthier adult adjustment.[58] These protective factors[59] buffer the child from the negative effects of maltreatment. Research suggests designing interventions that create healthy and consistent social relationships with both adults and peers.[60] However, Widom's research indicates that a close relationship with a responsible adult may prevent deliquency, whereas having a close relationship with a peer may increase risk.[61] In her research she noted that among CAN victims who listed an adult, particularly a foster parent, as the person with whom they had the closest relationship less than ten percent were involved in future violence. For those who listed siblings as their closest relationship, however, forty percent had been arrested for violence.

Program Examples

Responsive Advocacy for Learning and Life in Youth (RALLY) is a school-based, developmental intervention "focused on children's capacity to overcome problems."[62] This individualized program connects students with an in-school mentor who supports the child's competencies while helping with school work and emotional and behavioral issues.

1 hour

c. **Social Session:** Freeform with snacks — Opportunity for parents to interact with each other and the center staff.

d. **Individual Session:** Center Director may provide one-on-one counseling with a parent if the parent has need and is not receiving such services elsewhere.

B. Children: May enter the daycare after being referred by DSS or through the voucher system* for low-income families. Ideally 12 (daycare) slots are for DSS cases and 4 slots are for voucher facilities.

1. **Developmental milestones:** individual education plans for every child based on both the assessment and observation.

2. **Interventions (clinical):** Pair Play Project

   a. Case-by-case interventions based on child, abuse history/experiences, exposure to substances, relationship with parents, and level of resiliency.

   b. Center practice regarding attachment and resiliency.

      (1) provide a sense of security and belonging as all children have picture of self/home at table; maintain constancy (e.g., sleep in same place every day).

      (2) observe children in play and facilitate play.

      (3) provide mixed age groups.

      (4) help children transition to new placement/preschool.

* Voucher slots are filled by Mission Hill community members who are not currently involved with DSS, but have qualified for voucher — typically a strong family situation.

C. Providers

1. **DSS Child Protection Worker:**

   a. Makes referral, accompanies parent to first meeting.
   b. Conducts a standard/uniform evaluation every 6 months.
   c. Holds multiple meetings between evaluations to check progress of child/parent/family.

2. **Daycare Workers:** All are qualified by the Office for Children (OFC) in Early Childhood Education (teacher/lead teacher), with at least a Bachelors, some Masters and are bilingual.

   a. One-on-one supervision with director bi-weekly; mental health support by consultation.

   b. Weekly team meeting (2 teams, each classroom is a team).

      (1) specific issues in classroom: behaviors, hygiene.

(2) physical assault: what to do — using safe restraint.
(3) slow developing language skills: how to facilitate early intervention.

c. Provide extensive, ongoing documentation of CNP issues.

(1) able to identify family issues that need to be addressed.
(2) identify at-risk behaviors and inform parent (facilitated by ongoing parent interaction).

3. **Director/Assistant Director:** Make reports to CPS worker —

a. In cases where there is current abuse, a 51A is filed, and if it is a voucher placement, it may be transitioned to a DSS slot

b. Assistant Director: 3 years in position; 3 successful transfers from voucher to DSS slot

V. **Assessment:** Required by the Office For Children every 3 months for infants and every 6 months for toddlers. Agency has developed an instrument on developmental milestones and provides DSS with an **anecdotal evaluation** every 6 months.

A. Gilday Assessment covers:

1. Attachment
2. Regular domains of development
3. Gross/fine motor skills
4. Image of self
5. Emotional and social development
6. Relationships to peers and environment
7. Verbal communication

B. Trauma manifestation assessment covers:

1. Depression
2. Lack of response
3. State management — always falling asleep, always awake
4. Crossover group: in utero exposure to drugs
5. Hypervigilance: over-examination of the environment
6. Inhibition/partial inhibition of play

VI. **Outcomes:** Child and parent progress noted and documented on a regular basis, 3 or 6 month intervals, and supported statement in the interim.

A. Individual, familial and interpersonal skills improvement.

B. Maintain family cohesiveness, enhanced parent-child bond.

C. Provides an early start to a long process of recovery and development to child, parent, and family.

D. DSS responsible for follow-up and evaluations — Gilday has not developed any longitudinal follow-up and does not have any specific statistical outcome data on specific subjects.*

* Gilday does have anecdotal outcomes and individual case studies completed by graduate student interns. DSS does not have follow-up and evaluation reports.

Casa Myrna Vazaquez: Boston, Massachusetts, founded in 1976

Director of Education and Training: Debra Robbin

Coordinator of Children's Services: Chris Bucco

Director of Support Services: Patricia Cullen

I. **Description:** Domestic Violence Shelter for Women and Children

A. A nonprofit agency with multi-level public and private funding from: United Way; Massachusetts Department of Social Services; Hart McKinney; HUD; Mass Bar Foundation; Crime Victim's Assistance; and an Emergency Shelter Grant.

B. Designed to stop domestic violence and child abuse in the community and in families, to protect individuals, and provide survivors with the necessary support to prevent future violence and victimization.[2]

C. Provides emergency, short-term, and long-term shelter, treatment, and advocacy for victims of domestic violence and their children. Serves 35-40 women and 60-65 children in its residential programs.

D. Provides support services to community members (non-residential) through a crisis hotline, mental health services, and education and training outreach to corporations, community, and victims.

II. **Theoretical Framework:**

A. Attachment theory informs the structure of the program which recognizes the importance of the mother-child bond and facilitates the development of positive and healthy relationships and functioning by providing shelter and support to both .

B. Social Learning theory guides the work of advocates who collaborate with mothers to secure services for both themselves and their children.

2 Do not provide services for women who are the primary perpetrators of child abuse.

C. Ecological theory is the foundation for the multidisciplinary and multisystemic outreach and services provided by the program.

III. **Objectives:** to protect women and children from domestic violence and prevent future violence in families and throughout the community.

A. Children: Provide child witnesses and victims of abuse with a safe and nurturing environment; identify and address the negative effects through early intervention; and support the mother-child relationship.

B. Parents: Protect victims of domestic violence from abuse; identify and address physical/mental health, legal, economic, and support needs; and support the mothers' ability to care for children in a safe and nurturing way.

C. Community: Provide residential and corporate community with information about domestic violence, access to services, and training and education to stop it.

III. **Methods:** clients referred from the hotline, emergency rooms, DSS, private physicians/psychologists, police officers, and clinics; self-referrals with sources from community/corporate education and training sessions, word-of-mouth; clients come from other shelters, cities, states, and countries.

A. Residential and Community Programs and Services

1. Short-term residential: clients may stay for a maximum of 90 days.

   a. Emergency Shelter (2): shelter and services to 15 women & 26 children.

   b. Safe Home Program (1): home and services to 6 women & 12 children.

      (1) space rented for mother/children in private homes.
      (2) women and children receive services at the shelter.

2. Long-term residential: clients may stay for a maximum of 18 months (funded by the Department of Transitional Assistance).

   a. Women and Children's Transitional Program: 10 women & 14 children.

   b. Adolescent Transitional Program: 8 teens and 12 children.

3. Support Services for short-term and long-term clients and community.

   a. Outreach and Hotline: available to all.
   b. Mental Health: clients only.
   c. Children's Services: clients only.
   d. Legal Services: clients only.
   e. Education and Training: available to all.

Type of CAN as a Predictor for Sex-Related Crimes

Abused and neglected children generally are at increased risk of being arrested for sex crimes. The risk is especially pronounced among neglected children.[116] Sexual abuse victims, especially females, appear more likely to be arrested for prostitution[1] than children who have been physically abused.[117]

In one study, approximately 10.5 percent of the female victims of sexual abuse had engaged in prostitution compared to 9 percent of neglect victims.[118] Sexual abuse was neither associated with increased risk for sex crimes in general,[119] nor were male victims found to be at increased risk for committing sodomy or rape.[120]

The occurrence of sexual behavior problems in victims of sexual abuse

Widom's research "did not find victims of child sexual abuse generally to be at increased risk for violent criminality, but later studies have identified a subset of child sexual abuse victims that are likely to become sexually aggressive youths."[121] In a new study by Hall, four variables were found to affect whether a child who has been sexually abused develops sexual behavior problems: whether the child experienced sexual arousal, the occurrence of sadism, the co-occurrence of physical and emotional abuse and who the victim blamed. Of these, the strongest predictor of both self-focused and interpersonal sexual behavior problems was arousal. Interpersonal sexual behavior problems, such as becoming a sexually aggressive youth, were predicted by: arousal, sadism, physical abuse and emotional abuse. Hall's study found that the closeness of the relationship to the perpetrator and duration or frequency of abuse were not significant predictors of sexual behavior problems.[122]

According to Hall, the victim's amenability to treatment was determined by several factors. If the victim experienced only partial arousal and had strong family structure and support, then the outcomes were favorable. If the victim's family engaged in sexualized interactions and family violence, but had low criminality, then the outcomes were mediocre. If the victim experienced severe sadism, had a violent family surrounded by a criminal cultural milieu and had serious PTSD, then the outcomes were poor and monitoring was recommended.[123]

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1 Debra Whitcomb reported that although 75% of street prostitutes had been abused, 57% lived at home when they were first sexually exploited. Although there has been some suggestion that victims of abuse runaway from home and subsequently become involved in survival prostitution, causality is unclear. Exploitation is not necessarily associated with homelessness. Source: Preliminary research findings presented at the Meeting the Challenges of Criminal Justice Research and Evaluation, sponsored by the National Institute of Justice, U.S. Department of Justice, July 21, 1997, Washington D.C.

Witnessing Violence as a Predictor of Delinquency and Adult Criminality

Some research indicates a relationship between witnessing violence and delinquent and violent behavior. Preliminary studies have found that witnessing violence increases the likelihood of later youth violence,[124] and that 74 percent of youth who witness violence engage in delinquent behavior compared to 49 percent who do not witness violence, according to self-report.[125] In a retrospective study of incarcerated males, Kruttschnitt found witnessing violence to be significantly associated with subsequent violent crime, but only among non-whites.[126] In his study of victimization as a risk factor for delinquency, Saunders defined witnessing violence as "lifetime experience of actually seeing someone shot with a gun, cut with a knife, sexually assaulted, mugged or robbed, or threatened with a weapon." Saunders found witnessing violence (community and family) to be a significant predictor for whites, but an even greater predictor for blacks, particularly those who had also developed PTSD. Saunders also found witnessing family violence to be a significant predictor of delinquency for females.[127]

Physical Abuse and Neglect as Predictors of Delinquency and Criminality

Many researchers have found victims of physical abuse to be at greater risk for delinquency and more likely to be arrested for violent crime than other CAN victims.[128] Saunders found a differential outcome for blacks and whites, with physical assault and abuse being a significant predictor of delinquency for whites, but not for blacks.[129] Physical abuse has also been identified as a risk factor for drinking, drug use, arrests for rape and other sex offenses, and adult criminality.[130] Childhood neglect has also been associated with high rates of violent criminal offending.[131]

In summary, victimization may lead to delinquency and violent adult criminality, but it is difficult to predict who will become delinquent. The findings reported above give some guidance on how different types of CAN may lead to different types of delinquency and criminality but are by no means conclusive. Race and gender appear to lead to differential outcomes for some types of CAN and not for others. Further research is needed to determine how race, gender, and class influence the consequences of victimization.

Research on Effective Intervention Strategies

Many intervention programs are considered promising. However, there is little empirical research to support their effectiveness. Intervention programs either focus on a specific type of abuse or intervene

Sexual Abuse

Infancy: insecure attachments.

Pre-school: PTSD, inappropriate sexual behavior, anxiety, increased internalizing and externalizing problems, nightmares.[86]

School-aged: neurotic, aggressive and hyperactive.[87]

Adolescence: onset of puberty advanced by one year,[88] bulemia,[89] suicidal or self-destructive behaviors, depression,[90] withdrawl, aggression, running away, substance abuse, and anxiety.[91]

Neglect

Infancy: non-organic failure to thrive syndrome,[92] anxiously attached(anxious/avoidant).[93]

Preschool: serious behavior problems,[94] inattentive and uninvolved in learning.[95]

School-aged: withdrawn, inattentive.

Adolescence: poor peer relationships.

Differential Outcomes of Abuse and Neglect by Gender and Race

Similar to research on the developmental impact of CAN, the impact of gender, race, and socio-economic status are understudied and ill understood. The few studies that exist tend to disagree on the nature of the relationships between these variables and outcomes. A summary of relevant research follows.

Gender

Female victims of sexual abuse exhibit greater internalized aggression.[96] In studies conducted exclusively with females, victims of sexual abuse were found to have lower self-esteem[97] and greater cognitive impairment[98] than non-abused girls. They were also found to have poor relationships with their mothers.[99] Female victims of sexual abuse are also at greater risk of engaging in prostitution, while male victims of sexual abuse are not.[100] However, both male and female victims of neglect are at greater risk of engaging in prostitution, although the risk remains higher for females.[101]

One study found that boys who are physically abused show a higher degree of hypervigilance, a symptom of PTSD.[102] Saunder's preliminary research found that African-American males who had witnessed violence and had PTSD were at significantly higher risk for delinquency than all other populations. Widom found that female victims of abuse and neglect had higher rates of arrest for violence, but male victims did not.[103]

For children who have witnessed family violence, Yawney identifies differential outcomes in terms of gender. Yawney reports that boys tend to exhibit aggression, tantrums, fighting, bullying, lying, cheating and destructiveness, whereas girls are passive, compliant, overly dependent, stubborn, and suffer increased somatic complaints. Behaviors that boys and girls had in common in response to witnessing family violence were excessive teasing, worrying, low frustration levels, and withdrawn behavior.[104]

Race

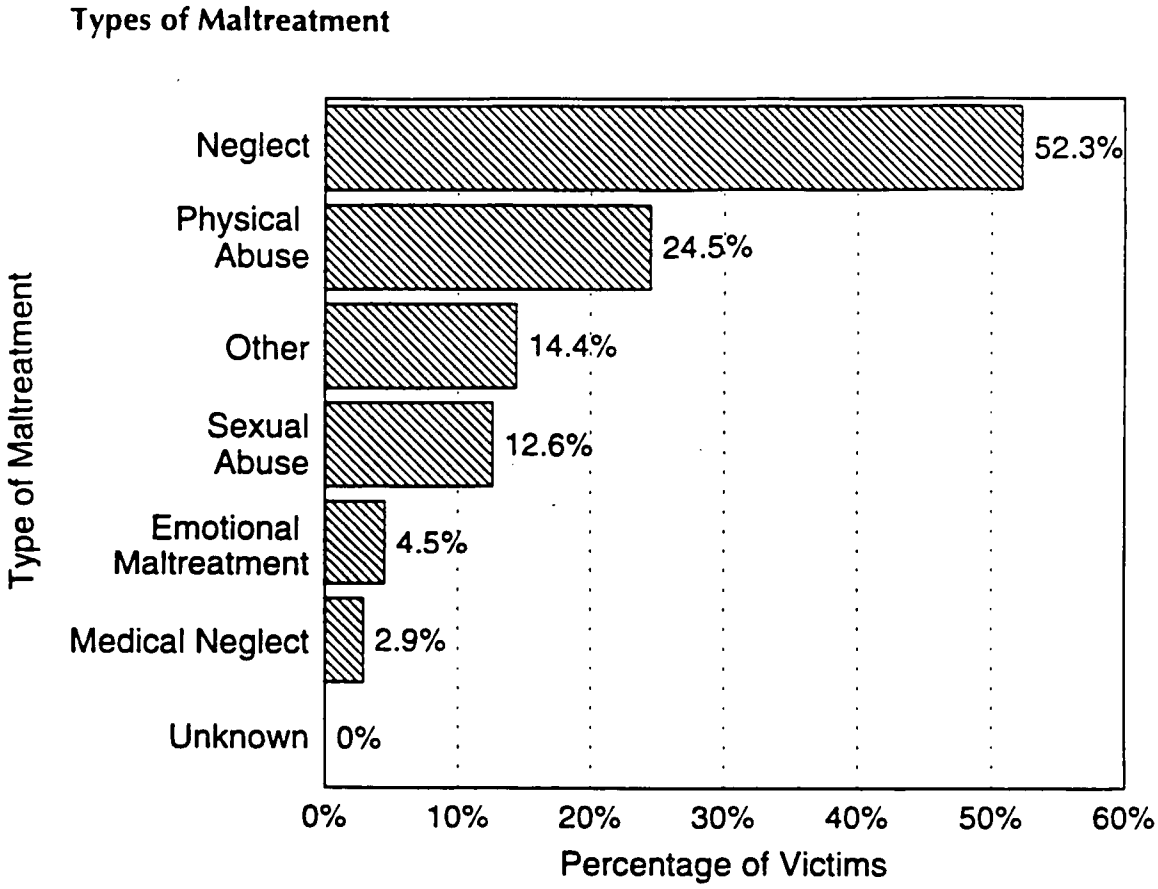
Kruttschnitt and colleagues found a significant association between exposure to parental violence and subsequent violent crime in male victims, but only among non-Whites.[105] In a recent presentation to the National Institute of Justice (NIJ), Widom stated, "there seems to be a differential impact of childhood victimization on the criminal consequences for African-American children as compared to White children."[106]

Research on Delinquency and Adult Criminality

The outcomes of CAN extend beyond childhood into adolescence and adulthood. Research suggests that victimization may lead to delinquency and/or adult criminality. A recent study by Maxfield and Widom found that CAN increases the risk for juvenile arrests by 59 percent, adult arrest by 27 percent, and arrest for violent crime by 29 percent.[107] In her recent presentation to NIJ, however, Widom emphasized that not all abused children become delinquent, criminal and violent, despite their increased risk. According to her research, 21 percent of CAN victims are arrested for violence.[108]

Studies do not agree which type of CAN is the most significant predictor of violent crime. Some researchers suggest that children who have been physically abused are the most likely to have arrests for violent crime(21%),[109] followed by victims of neglect (20%).[110] Other researchers claim that children who witness domestic violence have the strongest risk for subsequent violence.[111] Yet other researchers argue that experiencing multiple forms of abuse is the key correlate to delinquency [112] and to violent crime.[113] One study found that multiple forms of victimization doubles the risk of self-reported violence.[114] Finally, neglect victims are identified by some researchers to be the most likely to engage in violent criminal behavior, citing emotional neglect specifically to be the "most potent predictor of violent crime."[115] Given these conflicting reports, it is unclear which type of CAN is most likely to lead to delinquency or adult criminality.

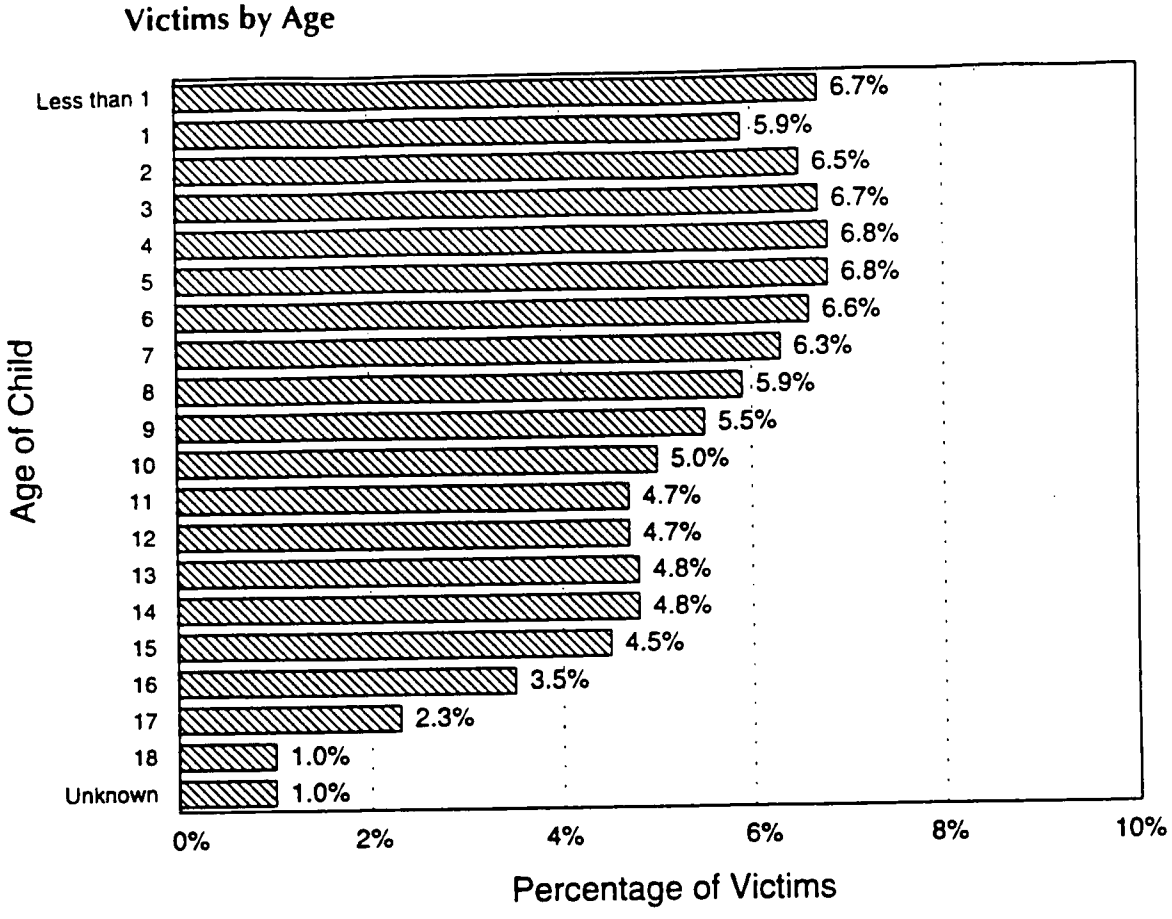
Exhibit 1-1



N = 1,000,502 victims in 49 States.
Note: Percentages total more than 100 percent because some States report more than one type of maltreatment per victim.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Child Maltreatment 1995: Reports From the States to the National Child Abuse and Neglect Data System* (Washington, DC: U.S. Government Printing Office, 1997).

Exhibit 1-2



N = 833,115 victims in 45 States.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Child Maltreatment 1995: Reports From the States to the National Child Abuse and Neglect Data System* (Washington, DC: U.S. Government Printing Office, 1997).

- short or long-term out-of-home placement;
- short-term intensive in-home assessment and service provision to the family and the child; or
- facilitating access to community-based services for the child and family on a longer term, less intensive basis.

Decisions concerning the appropriate level of intervention and specific program referrals for victims and their caretakers have traditionally rested with the individual case worker or, in the most severe cases, the courts. As discussed below and in Paper #3, risk assessment and service planning are currently the target of a number of innovations intended to decrease the systems' dependence on individual judgment. Examples of recent systemic innovations that influence program referral include the development of standardized risk and needs assessment tools and collaborative case decision making including criminal justice personnel or the extended family.

Current Intervention Strategies: Objectives and Controversies

While emphases differ slightly from jurisdiction to jurisdiction, the majority of child protection and welfare interventions are bounded by three, sometimes conflicting, operating principles:

- **Child Safety**—Child safety is the first objective of intervention;
- **Family Preservation**—Preference is given to those intervention strategies that maximize family preservation or reunification and minimize out-of-home placement (a value reinforced by federal funding restrictions, see below);[8] and
- **Speed to Permanency**—In the event of out-of-home placement, reunification or other permanent placement should be achieved as quickly as possible (e.g., Massachusetts law requires a permanency plan within eighteen months, although this is not always achieved).

These principles, if inflexibly pursued, can result in tension between competing goals. For example, the priority given to family reunification may delay substantially the quest for permanent placement of children residing in out-of-home care: for families with serious long-term problems, such as substance abuse or mental illness, even up to eighteen months is often not sufficient to resolve these difficult problems. Correlatively, child safety may be compromised if reunification is pursued too aggressively in order to meet an arbitrary permanency goal.

A number of researchers and practitioners interviewed for this paper stressed the need for greater emphasis on the welfare of the child over family reunification, and expressed serious concern that the goal of family reunification was being pursued indiscriminately, resulting in wasted resources, delayed permanency for children in out-of-home care, as well as emotional damage to the child, who may be encouraged by agency policies to have overly optimistic hopes concerning his or her family's ability to change.

Several experts interviewed suggested instead a policy of rigorous family assessment to determine a family's strengths, deficits and capacity for positive change, combined with a swift termination of the parental rights of those who are not good candidates for intervention. Widom's recent preliminary research finding that "not living with both parents" (i.e., living with one parent or in surrogate care) was not associated with higher delinquency for victims of child abuse and neglect[9] suggests that permanent placement with the non-abusive parent, long-term foster care, adoption, guardianship or kinship care may be as appropriate and beneficial a goal for a number of abused and neglected children as family preservation. Widom's work also points to the potential strength of surrogate care as a protective factor: less than 10 percent of abused and neglected children in out-of-home placement who reported a strong relationship with a foster parent became delinquent.[10]

In balancing the potential emotional and psychological damage resulting from out-of-home placement, research points to the need to consider the developmental age of the child (e.g., children less than 6 months old are thought to be least bonded to their primary care giver, and children older than five may be better able to understand why separation is occurring), and the degree to which the child can be maintained in familiar surroundings.[11] For example, children in kinship care, those able to remain in the same school, the same neighborhood, or with their siblings, are thought to be less adversely affected by out-of-home placement.

At the same time, evaluations of family preservation programming, such as Homebuilders, have generally had methodological problems and thus failed to conclusively answer the question whether such efforts—if properly implemented—are effective in preventing out-of-home placement.[12] A recent, methodologically rigorous evaluation of Illinois' family preservation experiment, Families First, showed no significant program impact on rates of out-of-home placement. Schuerman points to a number of factors that may have impeded the effectiveness of the model—most persuasively the lack of program resources available for referrals, especially substance abuse services—but concludes that a "robust" model should be able to withstand somewhat flawed and varied implementation.[13]

Schuerman and others note that while the family preservation services' impact on out-of-home placement is unclear, the families served were generally in extreme need or crisis and no doubt benefitted from the additional services in ways not measured by the evaluation.

Both researchers and practitioners favor *preventative* interventions that stress family support services, such as home visitation, parenting skills building and prenatal counseling. To this end, some of those interviewed argued that family preservation resources would be best spent on broad-based programming to prevent child abuse and neglect in healthy but vulnerable families (e.g., teen mothers or young families living in poverty or in violent communities), rather than on the smaller number of abusive, multi-problem families who are less likely to respond to services. The shift toward prevention and away from traditional reactive child welfare models is exemplified by the number of programs seeking to replicate Hawaii's Healthy Start program . For example, in 1998, a new Massachusetts program, Healthy Families, will make home visits available to all the estimated 5000 teenage mothers who give birth in the State annually at a cost of $5 million (or $1000 per family.)

Balancing Priorities: A Case Study in Wisconsin

Child welfare policy makers in Wisconsin have developed and implemented a service provision model that attempts to balance family preservation with a pragmatic assessment of the family's strengths and ability to change. The model recognizes that the best interest of an abused child may be served by either out-of-home placement or family preservation efforts depending on the severity of the abuse, the potential of the parents to change, and the developmental stage of the child. Under this model, family preservation may mean the removal and/or prosecution of the abusive parent or individual from the household, and the strengthening of the remaining family unit.

According to Mary Dibble, in Wisconsin's Bureau of Program and Policy, initial family assessment is not just incident-based: a longitudinal assessment, encompassing the family's history of involvement with services and other factors are examined before a service level is assigned by the social worker. Safety planning is central to the assessment process, and safety planning is revisited if a child is to be reunified with her family. Early in the process, attempts are made by the social worker to engage the family and cultivate informal support networks, such as extended family, friends and neighbors. By helping to build informal support networks (and not merely providing program-based service referrals), social workers expect a more permanent benefit to the family. At the heart of the Wisconsin approach is the idea that the relationship between the worker and the family must be based on respect and the case worker's understanding of what the *family* thinks it needs. According to Dibble, "The family must feel cared about, clearly directed, not disrespected. The relationship must be a partnership."

Many of the case workers are creative in meeting clients' needs. One county agency got the community involved: schools donated shower facilities to homeless families, businesses donated mattresses. Through a pilot program funded by the State, workers are able to provide intensive in-home assistance to neglectful families, involving practical support, skills building, and problem solving using resources such as anger management interventions, day care, and counseling to help parents set and follow a consistent schedule of care for their children.

In a program soon to be piloted in Wisconsin (and currently in use in West Virginia) a formal assessment of family strengths, deficits and capacity will be made by the social worker and then discussed with a supervisor to develop an individualized service plan. The assessment looks at the following factors that have been associated with successful family preservation outcomes:

1. Ability to use a support network;
2. Ability to develop trusting relationships;
3. Ability to develop a positive "family vision" (how they would like their family to be);
4. Family maintenance (the degree to which they are motivated to keep their children); and
5. Capacity (cognitive limitations).

The social worker assesses family strengths and weaknesses, then targets the intervention to the deficits. Strengths— such as knowing when to seek help, having an informal support system or the ability to verbalize needs and concerns—are not merely listed, but built upon to assist the family in reaching its goals. If no capacity is found (for example, due to cognitive limitations), the service plan focuses on safety services for the child.

Social workers assess the extent to which the model results in the development of a safe home environment, the creation of an informal family support system, the use of formal supports, and improved parent functioning (e.g., coping and self-control, self-esteem, verbal expression and response, socialization, expectations and sensitivity to children, and problem solving.)

Timing and Length of Intervention

Interventions may be emergency measures, intensive short-term programs with narrow goals (such as preventing out-of-home placement or creating a safer and more stable home environment) or longer-term, lower intensity efforts that involve only limited service referrals.

Emergency services

Emergency services to victims of CAN may include the use of Child Advocacy Centers (CAC) to provide a safe and comforting environment in which victims may meet with law enforcement, prosecutors, medical professionals, counselors and social service providers. Emergency intervention may also be hospital-based, such as Boston's Advocacy for Women and Children in Emergencies (AWAKE), which identifies and screens for domestic violence and child abuse in the emergency room, providing both emergency and on-going services to help the mother take control of her life and protect her children against their mutual abuser (see program summaries, Paper #2). First foster care placements, which are frequently temporary, are also considered emergency intervention. Emergency responses to CAN may involve several agencies, including the criminal justice system.

Intensive short-term interventions

Short-term intervention, typified by intensive family preservation efforts, may be 90 days or less. Typically these efforts are intended to prevent out-of-home placement for children at imminent risk. In practice, intensive services are often targeted to high-risk families in crisis, since imminent risk of placement is difficult to identify. During the intervention, the family has the attention of a social worker with a much reduced caseload—between two to 15 families—who provides crisis intervention, counseling and, following a family needs assessment, coordinates comprehensive services, that may include material assistance. Criticisms of this form of intervention have been that families in crisis frequently need longer periods of intensive services, and that mechanisms for providing adequate aftercare for these families often do not exist. Once transferred to the case loads of regular social workers, previously intensively served families may find it difficult to maintain progress. Another problem encountered by intensive family preservation efforts is limited availability of services—a problem that cuts across all forms of intervention.

Long-term, low intensity intervention

A majority of substantiated cases referred to child welfare services are likely to receive limited service referrals. In one jurisdiction, longer-term interventions were regarded as an opportunity to observe and assess the family over a longer period (two months) in order to formulate a better service plan. One practitioner emphasized, however, that where children remain in the home during long-term assessment, safety planning is critical.[14] Much of traditional child welfare work follows this model.

In a system emphasizing *differentiated response* (usually a two track system separating those cases needing investigation from those that require only services, see Paper #3), the initial investigation and

assessment will consider not only the current incident, but also the family's history and characteristics before choosing a level of intervention. Unfortunately, an overburdened system may choose long-term, low intensity intervention by default.

Intervention "Booster Shots"

Certain types of abuse may result in the need for periodic intervention. For example, victims of child sex abuse (CSA) may experience recurrent psychological problems as they pass through each developmental stage toward—and into—adulthood. Parents or caretakers of CSA victims should be trained to recognize key developmental milestones and to re-initiate services as needed.[15] Similarly, victims of pre-natal drug exposure may experience cognitive, developmental and social problems at various developmental stages. Caretakers of drug-exposed infants need information on child development so that they can seek screening and assistance for any suspected delays.

On-going services also are needed by reunited families as well as adoptive families whose children may—at some later date—develop behavioral, cognitive, psychological or social problems as a result of earlier abuse. It is thought that on-going services to adoptive and reunited families would help to prevent multiple placements, a risk factor for delinquency (see below).

Who Receives Services?

With the large number of CAN victims and caretakers to be served, case worker time, criminal justice referrals, and program resources are necessarily rationed. Victims of sexual abuse (who account for 13% of all abuse and neglect cases) and severe physical abuse (25%) are most frequently referred for criminal justice action and program services.[16] In general, neglect cases—especially chronic low-level neglect—receive few or no services. However, experts emphasize that sexual abuse, physical violence, neglect, and emotional and psychological abuse often co-occur (approximately one-third of all cases have multiple abuse allegations), so that some victims of emotional and psychological abuse and neglect are actually being served. Indeed, some commentators argue that *all* child abuse involves emotional abuse.

One explanation for the official attention accorded sex abuse and physical abuse cases is simply that these cases often focus on a poignant, single episode (or culminating episode) of abuse and are more easily grasped by busy social workers or the courts. Another possible explanation is one of public pressure on government: the public is understandably horrified by media reports of child sex crime and

physical brutality against children. Child protection and welfare workers as well as criminal justice professionals cannot appear to be insensitive to these victims. Neglect or emotional and psychological abuse are likely to be chronic conditions, far more easily hidden from social workers and often too vague for prosecutors (see Paper #3 for a discussion of the laws defining CAN.) Nor do these cases, except in the most extreme instances, attract the attention of the media and the public.

Some researchers and practitioners question the criminal justice and social welfare emphasis on imminent risk versus cumulative harm. Studies suggest that victims of chronic neglect, as well as children who witness domestic violence may be as vulnerable to psychological, cognitive and social harms as victims of physical violence or sexual abuse. In particular, one researcher and policy maker expressed concern that elevated levels of aggression among neglected youth who had received few services may result in later delinquency (see below).

A new category of services: CAN and domestic violence

A growing number of services are becoming available to victims of domestic violence and their abused children. Increasingly, children who have witnessed domestic violence—whether or not they have been physically abused themselves—are recognized as having special needs. Courts and social workers are beginning to institute procedures and programming to identify and serve victims of CAN who live in violent homes, as well as children who may otherwise not be known to a child welfare agency who live in homes where domestic violence has come to the attention of the courts or hospital emergency rooms. Part II of this paper discusses the co-occurrence of domestic violence and child abuse and gives examples of existing community-based and hospital-based interventions.

Service identification, availability and barriers to utilization

Individual treatment interventions (especially psychodynamic and cognitive behavioral counseling) and family-based interventions (e.g., intensive family preservation) are the most widely-available and frequently utilized interventions for victims of CAN and their families. A recurring concern in the literature on intervention and in interviews with practitioners was limited service availability. For example, services for sexually aggressive youth (estimated to be 10% of foster care population) are frequently unavailable. A policy maker in Washington State reported that there is only one provider of services to sexually aggressive youths in the State.

Some program providers and State-level policy makers voiced concerns that where a range of programs *are* available, social workers may not be sufficiently familiar with program content or

philosophy to make appropriate referrals. A researcher who works closely with child protection services in one State gave the following example of poor communication between researchers, policy makers, practitioners and program providers:

> *Research on the State's severe cases of physical abuse and CAN fatalities revealed that a key factor in many cases was unrealistic parental expectations caused by ignorance of child development. State-level policy makers directed social workers to refer parents of severely abused children to receive parenting classes. Social workers referred parents to the available classes. No improvement was seen in the rates of severe physical abuse or CAN-related child deaths. Inquiries by the researcher revealed that the parenting classes to which these high-risk parents had been referred were skills-based and failed to discuss unrealistic parental expectations or child development.*

For another instance, a researcher who had designed an intervention for parents of victims of child sex abuse (CSA), and offered it free-of-charge at a local Child Advocacy Center (where CSA cases are brought for investigation and crisis intervention), reported that his program opened with only two participants. Barriers to service utilization may have included the failure of social workers to refer to the program, the possibility that on-going intervention information provided to families in crisis was lost, that parents may not wish to return to a setting that reminds them of the abuse and, finally, that family members may not be receptive to counseling so near in time to the abuse.

The Current Role of the Criminal Justice System

Currently, criminal justice agencies become involved with only the most severe cases of child abuse and neglect: those in which prosecution of the abuser is appropriate and/or where the custody of the child is overseen by the courts. In practice, most prosecutions focus on acute episodes of child abuse, such as sexual assaults or severe physical abuse. Chronic, but less severe, cases of physical abuse and neglect are more frequently addressed (if at all) by child welfare workers than by criminal justice personnel.

Few programmatic interventions for the victims of child abuse and neglect are directly provided by the criminal justice system (CJS). However, as discussed in Paper #3, interagency cooperation and victim-sensitive procedures—such as properly trained investigators, the use of Child Advocacy Centers for emergency intervention and interviewing and victim advocates at trial—may significantly reduce the stress of CJS involvement for child abuse victims and thus help to limit the consequences of abuse and neglect for those children who have been most severely victimized.[17]

Criminal justice agencies do, however, network with outside agencies and interventions via multi-agency or community initiatives. A number of school-based and community-based interventions with wide public and private support list criminal justice agencies among their participating groups (see the description of the Child Development-Community Policing program, below). At the Federal level, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) currently funds several initiatives to provide technical assistance, services and structural support for victims of CAN. For example, OJJDP sponsors:

- the National Council of Juvenile and Family Court Judges (NCJFCJ) project to provide training and technical assistance to judges, social service personnel, citizen volunteers and others to prevent unnecessary foster care placement, and promote reunification and permanency.[18]

- the Jimmy Rice Law Enforcement Training Center at the National Center for Missing and Exploited Children, which provides training and technical assistance to federal, State, and local law enforcement personnel to enhance their response to nonparental abduction.

- Parents Anonymous, Inc. (PA) allowing it to expand its services to include forty (40) new parent groups that serve high risk, inner city and Native American populations. In addition, PA will develop program materials to meet the needs of people of color, create a fathers' initiative, provide technical assistance to TA groups operating in correctional settings and engage in public education.

In addition, OJJDP administers the Office of Justice Programs' (OJP) multi-agency Safe Kids-Safe Streets initiative which supports community-based approaches to reducing abuse and neglect. Programs and projects funded at five sites under Safe Kids-Safe Streets include a Children's Advocacy Center (see Paper #3), the development of a multidisciplinary service delivery system for use in Indian country, a computer tracking system and database to monitor child abuse cases in Indian country, a multi-agency neighborhood-based system to prevent and respond to abuse and neglect, a multi-agency countywide CAN task force and a prevention program emphasizing home-based assessment and services. A number of other OJJDP-funded delinquency prevention initiatives may be appropriate interventions for victims of CAN who are at high risk for delinquency, although CAN victims are not their stated focus (see Part II, below.)

Current trends in child welfare are likely to further limit the direct involvement of the criminal justice system in child abuse and neglect cases. Social service agencies are moving toward a system of differentiated response to reports of child abuse and neglect with the aim of targeting services and social worker resources more efficiently. A key component of differentiated response is determining which families require court intervention and supervision (this group is assumed to be small), which

families can safely be referred to community-based programs under the supervision of a social worker, and which families need only voluntary services.[19]

An innovative approach developed in Travis County, Texas, houses police, a sheriff, a prosecutor and child welfare workers together in one office and uses a collaborative model of case assessment and management. This approach, which is described more fully in Paper #3, increases CJS involvement while more effectively targeting prosecution and services. This model offers a number of advantages for both the CJS and child welfare workers. The most important advantage of the model is increased information sharing between agencies that allows all agencies to view the case in a family, school and community context. The resident prosecutor handles both the criminal and civil litigation related to the cases. This unified, cooperative approach to case management is especially important in the context of recent research documenting relationships between child abuse and neglect, domestic violence, substance abuse and violent crime—problems that, in the past, have been addressed individually by separate criminal justice or social welfare agencies.

Who Funds Interventions for Victims of Child Abuse and Neglect?

States and counties are responsible for providing the majority of funding for child welfare services. In 1990, 57% of service costs were borne by the States; the percentage is thought to be higher today, especially in States with large urban populations.

There are more than 100 Federally-funded human services programs to support families in the areas of public health, social services, mental health, juvenile justice, substance abuse, education, public assistance, housing, and job training. Funds for child abuse and neglect policy coordination are channeled through the Child Abuse Prevention and Treatment Act (CAPTA), while child welfare services are funded under Titles IV-B, IV-E, and XX of the Social Security Act.[20]

States receive funds for emergency services under Title IV-A, and a number of federal grants for services to at-risk children and families, including: Title XIX (Medicaid); Child Abuse and Neglect Basic Grants and "Baby Doe" Grants; Child Abuse and Neglect Discretionary Grants; Child Care and Development Block Grants; Children's Justice Grants; and Alcohol, Drug Abuse and Mental Health Grants.

Private funding to localities in the form of foundation grants is important because it offers program flexibility and encourages innovation. Foundations that have a history of funding child welfare programs include: Carnegie Corporation of New York, Casey Family Foundation, Edna McConnell Clark Foundation, Ford Foundation, Kellogg Foundation, Northwest Area Foundation, Pew Charitable Trusts, and Robert Wood Johnson Foundation.

Part II: A Continuum of Care for High-Risk Victims of CAN

The daunting numbers of victims of child abuse and neglect—as well as the high cost of intervention— make it critical that resources are directed to those victims who have the greatest needs. As discussed above, from the standpoint of child welfare and protection, the neediest children are those who have suffered demonstrable harm (sex abuse, severe physical abuse or abandonment) and whose future safety cannot be assured without intensive intervention or out-of-home placement. *This group of children, however, may not be at greatest risk for delinquency.* For example, victims of sex abuse—whose cases are most likely to be adjudicated and have more access to sophisticated case management approaches such as those used by Child Advocacy Centers—are less likely than either victims of neglect or physical abuse (or non-maltreated children) to become delinquent.[21] By contrast, witnessing domestic violence—an event less likely to attract the attention of the criminal justice system or, in most jurisdictions, child welfare services—may have a profound impact on that victim's future criminality.[22] Similarly, victims of neglect rarely receive services, yet neglect and exposure to community violence (both factors likely to co-occur with poverty) could be expected to raise delinquency rates for African-American males.[23] Thus, the population of abused and neglected children most likely to face involvement in the criminal justice system may be a different group than is currently served by the child welfare community. The following is an attempt to draft a research-based typology to serve criminal justice policy makers in their efforts to identify and intervene with those victims of CAN who are the greatest risk of delinquency.

Which Victims of CAN are at High Risk for Offense?

Widom's 1992 research on the cycle of violence found that 15.8 percent of children who were physically abused (only) and 12.5 percent of children who were neglected (only) had arrests for violent crimes as contrasted with 7.9 percent of a comparison group who had not been maltreated.[24] (Widom's study did not find victims of child sexual abuse generally to be at increased risk for violent criminality,[25] but later studies have identified a subset of CSA victims that are likely to become sexually aggressive youths.[26]) Widom's early work raised questions about how to identify and intervene with those victims of CAN who were most vulnerable to delinquency, adult criminality and violent criminal behaviors. More recent research by Widom and others has begun to offer a clearer picture of this subset of all CAN victims than previously had been available. (See Paper #2) For the purposes of this paper, eight (8) CAN populations have been identified from the research as being at

increased risk for delinquency or as being particularly vulnerable to developing further risk factors for delinquency:

All victims of CAN five (5) years old or younger

Researchers are united in recommending early intervention for victims of CAN to preempt developmental delays and cognitive impairment that can result in poor school performance, a risk factor for later delinquency.[27] In addition, programming provided for the youngest victims of CAN and their caretakers may promote child safety, reducing death rates among this most endangered group. Early intervention may also contribute to the development of secure attachment to the primary care giver, a protective factor thought to mitigate the impact of CAN. Special home, hospital and community-based outreach to victims five years old or younger (40 percent of all CAN victims) is needed. (See Exhibit 1-2).

School-aged children with low reading scores

Higher than average intelligence and strong reading scores have been cited by some researchers as protective factors promoting resiliency and pro-social behaviors in victims of CAN.[28] One explanation for the connection between higher reading scores and lower delinquency rates may be that good readers are more likely to develop a greater commitment to school, attachment to teachers, aspirations to attend college and to associate with peers who hold conventional values—all protective factors that have been found to increase resiliency and reduce delinquency.[29] One researcher has suggested that while intervening to increase cognitive ability in school-aged children was problematic, boosting reading scores in victims of CAN was not only possible but might offer an excellent opportunity to cultivate multiple protective factors in a school-based setting.[30]

Children who have witnessed domestic violence[31]

The correlation between partner abuse and child abuse is strong: the likelihood of child abuse is 129 percent higher when partner abuse is present.[32] An estimated 30 percent of all substantiated cases of child abuse also involve spouse abuse, and approximately 50 percent of men who batter their partners also abuse children in their spouse's care.[33] Research suggests that for children in violent homes, witnessing their mother's abuse can be as potent an influence on psychological health and future violent behaviors as experiencing physical abuse personally.[34] Moreover, research shows that approximately 90 percent of children in homes where there is spouse abuse see or hear the abuse.[35] Psychologists emphasize the scope of

damage resulting from this exposure: it may include PTSD, trauma, shock, guilt, intense fears, nightmares, bed wetting, anger, physical aggression, anxiety, withdrawal, somatic complaints and developmental, motor, speech and cognitive delays. Men who witnessed severe domestic violence as children are found to be 1000 percent more likely than those raised in a non-violent setting to batter their spouse.[36] Intervention for this group of victims—both those who have been physically or sexually abused in the context of a violent household and those who have witnessed violence against their mother—is critical to breaking the cycle of violence leading to child and spouse abuse in adult victims of CAN.

Children with severe behavioral disorders or multiple foster care placements

Widom's research has suggested that children who have had multiple foster care placements are at increased risk for delinquency.[37] Children with multiple foster care placements frequently are reported to have severe behavioral disorders. Some commentators hypothesize that as children experience the serial loss of caretakers (perhaps due to their problem behaviors), their ability to form a secure attachment is damaged, thus compounding the difficulty of building a stable relationship with the next foster family. Intervening with young children who appear to be developing severe behavioral disorders and counseling their caretakers concerning effective parenting and coping strategies may succeed in preventing multiple placements for these children. In addition, respite care may be needed to assist parents or foster parents seeking to provide stability for these children. For children who have already experienced multiple placements, counseling concerning attachment issues and behavior modification programming may help them to break the pattern of self-destructive behaviors likely to lead to further loss and to delinquency.

Children with extensive exposure to community violence—
(especially those with a diagnosis of PTSD)[38]

Witnessing community violence is a daily trauma to many children in impoverished urban neighborhoods. A New Orleans study of 5th graders' exposure to violence found that 91 percent had witnessed violence and more than half had been victims of community violence.[39] A study of New Haven, Connecticut, 6th, 7th, 8th and 10th graders found that 30 percent reported seeing one crime or more *daily*.[40] Recent research by Saunders and Kilpatrick found that 65 percent of male African-American victims of CAN reported personally witnessing serious violence. For African-American male victims—especially for those diagnosed with post-traumatic stress disorder (PTSD)—witnessing community violence significantly increased

the likelihood of delinquency.[41] Interventions to lessen the impact of exposure to community violence are needed as well as community-based initiatives to improve neighborhood safety.

Children with extensive family histories of substance abuse[42] or a personal history of significant drug use and delinquency (self-reported, not based on arrests)[43]

Saunders and Kilpatrick found that for female White and African-American adolescents, delinquency was strongly correlated with a family history of alcohol abuse or significant personal substance abuse. Johnson's research on drug-involved youths found that less than two percent of youths reported both significant drug use (defined for this study as cocaine or heroin use in the past year) and self-reported two or more index offenses (robbery, felony assault, or felony thefts); however, this two percent of youths had such a high delinquency rate that they were thought to be responsible for between 40 and 60% of all felony crimes reported, plus a disproportionate number of drug sales. If Johnson's findings are replicable, identifying, and intervening with, this population could have a significant impact on delinquency rates.

Native American victims of CAN

Recent research by Saunders and Kilpatrick highlighted the exceptionally high rate of delinquency among Native American adolescents: 32 percent of Native American males reported delinquency in the past year, and 40 percent reported committing a delinquent act at some point in their lives.[44] Victimization rates for Native American males were also higher in a number of categories than those for Whites, Hispanics, and African-Americans. For example, 36 percent of Native American adolescent males had been physically assaulted (as compared to 30 percent of African American males or 19 percent of White males); 13 percent had been sexually assaulted (as opposed to 7 percent of African-American males and 2 percent of White males); 19 percent had been physically abused (as compared with 16 percent of African American males and 7 percent of White males); and 66 percent had witnessed community violence (as compared with 65 percent of African-American males and 39 percent of White males.) Female Native American adolescents had rates of victimization similar to those for African American females, but a much higher rate of personal substance abuse (23 percent for Native American females compared to 12 percent for African American females.) Native American adolescents also reported the highest proportions of families with significant histories of drug or alcohol abuse. Taken together, these multiple victimizations and familial risk factors suggest that Native American children and adolescents are at extremely high risk for delinquency and require special intervention strategies suited to their culture.

Sexually aggressive youth (SAY)

Adult sex offenders often report that they began sexually abusing others as juveniles.[45] In Vermont, sexually aggressive youths were reported to be responsible for 45 percent of all child sexual abuse cases.[46] In Washington State, researchers estimate that 10 percent of the children served by child welfare workers fit the statutory definition of sexually agressive youths.[47] The relationship between CAN and the development of sexually agressive behaviors has been explored in detail by Hall and Mathews, who found that only sexually abused children whose abuse included specific characteristics (e.g., physical abuse and sadism, among others) were at risk for becoming sexually aggressive.[48] Other research has pointed to severe physical abuse as a precursor of sexually aggressive behaviors. (See Paper #2) Both CSA victims fitting Hall's typology of SAY and youths in child protective services who have already begun to display sexually aggressive behaviors need services to protect other children from abuse and to deter them from juvenile and adult sex offense.

Children and families in some of these categories are easily identified; however, victims with more complex or subtle risk factors—such as a diagnosis of PTSD, family or personal history of substance abuse or CSA characteristics likely to lead to problem sexual behaviors—would require a more skilled and thorough assessment to insure proper program placement (see the box "Assessment to Identify High-Risk Victims of CAN.")

Exhibit 1-3 enumerates types of interventions that are designed to respond to the needs of these special CAN populations as well as provides examples of age-appropriate programming for victims and their caretakers. The program list is not intended to be definitive, only to illustate representative programming approaches. Brief program descriptions are provided below (see also Paper #2 for further information on selected programs).

Assessing CAN Victims' Risk for Delinquency

Following a finding of child abuse or neglect, victims and their caretakers need careful assessment to determine whether the child is at heightened risk for delinquency or further damage that could impair the child's resiliency. Risk factors to target in the assessment of CAN victims include (see Paper #2 for a full discussion of the relevant research):

- age (less than 5 years old);
- poor reading skills;
- less than average I.Q.;
- family history of domestic violence, especially for female victims;
- severe behavioral disorders (in young children);
- multiple foster care placements;
- family history of drug or alcohol abuse, especially for white female victims;
- victim with extensive drug use (frequent cocaine or herion use) combined with self-reported serious criminality (i.e., two or more index offenses);
- extensive exposure to community violence, especially for African-American victims;
- PTSD combined with exposure to community violence, especially for African-American male victims;
- Native Americans, especially male victims;
- highly disorganized or criminally-involved family;
- primary personal relationship with peers; and
- for CSA victims, abuse and caretaker characteristics likely to result in sexually agressive behaviors in victims (e.g., degree of sexual arousal during abuse, severe physical abuse and sadism, and violent, criminally-involved families of origin.)[49]

As indicated above and detailed in Paper #2, the most recent research indicates that risk factors for delinquency among victims of CAN vary *significantly* by gender, race and ethnicity.[50] Assessors will need to give additional weight to those factors known to be especially strong predictors of delinquency for specific groups (e.g., PTSD combined with exposure to community violence for African-American males or a family history of substance abuse or domestic violence for females.) A risk factor for delinquency among the general population that does *not* appear to be an additional risk to CAN victims is not living with both parents (removing an abusive parent may be of benefit to these children.)[51] Similarly, children in foster care should not automatically be considered high-risk: one study found that for foster children who have a close relationship with their foster parents the likelihood of future violence is very low (less than 10 percent.)[52]

The following interventions are examples of existing programming targeting the needs of high risk victims of CAN. Paper #2 provides descriptions for other programs listed in Exhibit 1-3: The Compassion Workshop, Silver Spring, Maryland (child abuse and spouse abuse); Homebuilders, a national program (family preservation); The Family Center--Parenting Journey, Cambridge, Massachusetts (parenting therapy); Advocacy for Women and their Abused Kids in Emergencies (AWAKE), Boston, Massachusetts (child and spouse abuse); Responsive Advocacy for Learning and Life in Youth (RALLY), Boston, Massachusetts (school-based multi systemic intervention) and Casa Myrna, Boston, Massachusetts (child abuse and spouse abuse).

I. Programs Serving Children Under Five Years Old

Copeland Early Childhood Center (CECC), Duluth, Minnesota

The Copeland early Childhood Centers offers comprehensive programming for approximately 100 children from birth to five years of age and their parents daily. Based in a Housing and Redevelopment Building, The Copeland Center's programming includes Early Childhood Family Education, Head Start, and Mother and Child programs. The CECC serves families referred by CPS, the courts, law enforcement, doctors, and social workers as well as self-referred clients. The *Early Childhood Family Education* program provides stimulating programs for children from birth to five years old directed by licensed early childhood education teachers while parents meet with a licensed parent facilitator who organizes presentations and discussions to improve parents' skills. *Head Start* is offered at the same site for four and five year olds. Families of children enrolled in Head Start are eligible for a range of support services and are encouraged to volunteer in the classroom to gain work experience. The Mother and Child program provides assistance to mothers and children who need to improve English language and literacy skills. Mothers receive Adult Basic Education and English as a Second Language as well as information about American culture and parenting support. Children receive services through the Early Childhood Family Education program that emphasize language development.

Exhibit 1-3

CAN Populations at Heightened Risk for Delinquency and Related Intervention Strategies

CAN Populations At Heightened Risk for Delinquency	Research Identifying Risk	Type of Intervention Indicated	Programmatic Examples of Age-Appropriate Interventions				
			Birth-K (0-5 yrs.)	Grades 1-5 (6-11 yrs.)	Grades 6-8 (12-14 yrs.)	Grades 9-12 (15-18 yrs.)	Parents, Guardians, or Foster Families
1. All abused children younger than 5 years	Widom[a] Thornberry[b]	• Home visitation • Therapeutic daycare • Parent education	• Gilday Center • Homebuilders • Copeland Center				• Gilday Center • Homebuilders • MELD (formerly Minnesota Early Learning Center) • Copeland Center
2. Children with low reading scores	Widom Saunders[c]	• Reading readiness • School-based tutoring		• Seattle Social Development Project (SSDP)	• Responsive Advocacy for Learning and Life in Youth (RALLY)	• RALLY	
3. Children who have witnessed domestic violence	Widom Saunders Peled,[d] et al. Thornberry	• Family, group or individual counseling • Batterer intervention • Parenting education	• Advocacy for Women and Their Abused Kids in Emergencies (AWAKE) • Parents and Children Together (PACT) • Casa Mirna	• AWAKE • PACT • Casa Mirna	• AWAKE • PACT • Casa Mirna	• The Parenting Journey • AWAKE • PACT • Casa Mirna	• The Parenting Journey • Compassion Workshop • AWAKE • PACT • Casa Mirna
4. Children with severe behavioral disorders or multiple foster care placements	Widom	• Parenting education • Behavior modification • Assistance to foster/adoptive families • Permanency planning	• Gilday Center	• Ellen Stem Pair Therapy Program (ESPTP)	• ESPTP • RALLY	• ESPTP • RALLY	• Gilday Center • MELD
5. Children with extensive exposure to community violence (espec. those diagnosed with PTSD)	Saunders	• School-based Alternatives-To-Violence programming • Academic assistance • Counseling • Community-based violence prevention	• Child Development/ Community Policing (CD-CP)	• CD-CP • ESPTP	• CD-CP • ESPTP • RALLY	• Boston Juvenile Court Clinic (BJCC) • ESPTP • RALLY	• BJCC

6. Children with extensive family histories of drug or alcohol abuse or self-reported intensive drug use and delinquencies	Saunders Johnson, et al.[e]	• Counseling/support for children of substance abusers • Drug/alcohol education • Anger management/dispute resolution training • Parenting classes for teens	• Gilday Center • Casa Mirna	• SSDP • ESPTP • Casa Mirna	• RALLY • ESPTP • Casa Mirna	• BJCC • ESPTP • Casa Mirna	• Gilday Center • Casa Mirna
7. Native American children	Saunders	• Family group conferencing • Drug/alcohol education • Anger management/dispute resolution • Parenting education for parents and teens	• Ina Maka	• Ina Maka	• Ina Maka	• Ina Maka	• Ina Maka
8. Sexually aggressive youth	Widom English[f] Freeman-Longo[g] Hall et al.[h]	• Family and individual counseling	• SHIFT (Sexual Health in Family Treatment)	• SHIFT	• SHIFT	• SHIFT	• SHIFT

[a] Widom, C.S.,"Childhood Sexual Abuse and Its Criminal Consequences," *Society* (May/June, 1996): 50; Widom, C.S., "The Cycle of Violence," *Research in Brief*, (Washington, D.C.: U.S. Department of Justice, National Institute of Justice, October 1992): 3; Widom, C.S., presentation of preliminary research findings, National Institute of Justice Annual Conference on Criminal Justice Research and Evaluation, July 21, 1997.

[b] Saunders, B. and D. Kilpatrick, "Victimization as a Risk Factor for Delinquency Among Gender and Racial/Ethnic Subgroups: Results from the National Survey of Adolescents," research findings presented at the National Institute of Justice Annual Conference on Criminal Justice Research and Evaluation, Washington, D.C., July 21, 1997.

[c] Thornberry, T.P., "Violent Families and Youth Violence," *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Fact Sheet #21*, (Washington, D.C.: OJJDP), December 1994.

[d] Peled, E., P.G. Jaffe, and S.L. Edleson, eds. *Ending the Cycle of Violence: Community Responses to Children of Battered Women*, (Thousand Oaks, CA: Sage Publications, Inc., 1995): 28-32.

[e] Johnson, B., E.D. Wish, J. Schmeidler and D. Huizinga, "Concentration of Delinquent Offending: Serious Drug Involvement and High Delinquency Rates," in *Drugs and Crime*, ed. R. Dembo, (Lanham, Maryland: University Press of America, 1993): 1-26.

[f] Interview with Diana English, Office Chief, Office of Childrens Administration Research, Department of Social and Health Services, Washington State, June 1997.

[g] Freeman-Longo, R.E., "Challenging Our Thoughts," presented at the National Summit: Promoting Public Safety Through the Effective Management of Sex Offenders in the Community, Sponsored by the U.S. Department of Justice, Washington, D.C., November 24-26, 1996.

[h] Hall, D.K. and F. Mathews, "Problematic Sexual Behavior in Sexually Abused Children: A Preliminary Typology" unpublished paper, York University and Central Toronto Youth Services, 1997; Hall, D.K. and F. Mathews, "Factors Associated with Sexual Behavior Problems in Young Sexually Abused Children," (paper currently being reviewed for publication), 1997.

MELD, a national program based in Minneapolis, Minnesota

MELD, founded in Minneapolis in 1975, provides an array of parenting education and support programs at 100 sites in fifteen States and Canada. MELD receives referrals from social service agencies, hospitals, The United Way, word-of-mouth and the local juvenile justice system offers parenting education and support groups for new parents; parents of children under three years old who are chronically ill or disabled; adolescent mothers aged 13-20 years; young single mothers of children 3 to 5 years old; Spanish language parents; Hmong parents; young fathers; and parents who are deaf or hard of hearing. One young father's group is held in the Hennepin County, Minnesota, Homeschool Detention Center, a correctional facility for 14 to 17 year olds. MELD curriculum addresses health, child development, child guidance, family management and personal growth. A 1995 evaluation by the National Committee for the Prevention of Child Abuse (NCPCA) of eight child abuse prevention programs in Philadelphia showed that the MELD program in conjunction with home visitation "showed the best results in impacting factors that predict child abuse and neglect, especially among high risk adolescent mothers."[53] In addition, other evaluations have indicated that program participants had more appropriate expectations concerning their child's abilities, were more empathetic in interaction with their children and believed less strongly in corporal punishment. Adolescent mothers who were program participants postponed second pregnancies, made better use of community resources, and over half of college-age participants were enrolled in post-secondary education.

Gilday Center, Roxbury, Massachusetts

Located in the Mission Hill Housing Development, the Gilday Center provides services to infant and toddlers and their families. A privately funded non-profit, the Gilday Center also receives funding and referrals from the Massachusetts Department of Social Services to provide special services to infants 6 weeks old to 2.9 years who are the subjects of substantiated cases of abuse and neglect. The goals of treatment for children at the Gilday Center are to identify and redress the developmental effects of abuse and neglect through individual, pair, and group play and to provide intensive, consistent and on-going support to help the child develop age-appropriate personal and social expectations and responses. Parents have the opportunity to learn new skills, receive support, and build informal community-based support networks. For example, parents participate in group sessions that encourage the discussion of parenting issues, provide information on developmentally appropriate behaviors, and offer practical information concerning housing or other resources. Parents also spend time observing teachers modelling appropriate communications techniques and responsiveness with the children.

II. Programming to Address the Impact of Domestic Violence on Children

Parents and Children Together (PACT), New Haven Connecticut

Sponsored by the Coordinating Council for Children in Crisis (CCCC), PACT offers psychoeducational group services to mothers and their children ages 6 to 12 who are victims of or witnesses to domestic violence. (See Appendix A for Group curriculums.) PACT's Children's group attempts to address the trauma of witnessing domestic violence by encouraging children to share their feelings, learn safety strategies, practice non-violent conflict resolution, and build self-esteem. Mothers' groups focus on helping abused women to understand the impact of domestic violence on children and encourage safety planning for family members. With funding from the Connecticut Department of Children and Families, the CCCC offers a number of free home-based services intended to prevent child abuse and neglect including parent education, advocacy, individual and group counseling for abused women, and therapy and support services to victims of child sexual abuse.[54]

III. Court-based Intervention

Boston Juvenile Court Clinic (BJCC), Boston, Massachusetts

BJCC, founded in 1967, is the oldest court-based intervention for victims of CAN and their families in America. BJCC is the child mental health branch of the Boston Juvenile Court. Following a finding of abuse or neglect, the Court refers children to BJCC for mental health and family assessments. BJCC offers three intervention programs for parents and children: a 10 week *parenting group* focusing on the development of active parenting skills for parents who have lost custody of their children or who are at serious risk for losing them; *Alternatives to Violence*, a 6 to 8 week anger management program for juveniles who have been identified as truants or as committing other minor offenses and are thought to be at risk for more serious criminality; and a ten week *alcohol and substance abuse education program* for incorrigible or other at-risk court-involved children.

IV. School-based Programming

Seattle Social Development Project (SSDP)

The Seattle Social Development Project is a six-year, elementary school-based program focusing on preventing delinquency in low-income children. SSDP seeks to reduce known risk factors for delinquency (such as academic failure, drug abuse and early behavioral problems) and to cultivate protective factors through promoting high level of social bonding to pro-social individuals (teachers, peers and parents) and institutions (the family and school). The program targets classroom methods likely to promote academic success and participation, social skills training to teach problem solving skills and to prevent early anti-social behavior, cope with peer rejection and contact with anti-social peers. Parenting training is offered to encourage parents' positive reinforcement of program goals, moderate disciplinary practices and to help parents assist children with developing reading and math skills. In addition, parents of fifth and sixth graders are taught skills to help their children resist substance abuse. Evaluations suggest that for boys the intervention succeeded in increasing academic and social skill and reducing delinquency: at sixth grade, 47 percent of male program participants had initiated delinquency compared to 67 percent of the boys in a control group.[55]

Ellen Stern Pair Therapy Program (ESPTP), Boston, Massachusetts

ESPTP is a therapeutic approach to developing interpersonal skills in children who display aggressive or extremely passive behaviors or who suffer social isolation. The immediate aim of the therapy, which involves matching the child to a same sex child of similar age for the duration of counseling, is to facilitate children in resolving conflicts and integrating multiple perspectives in order to help them make healthier behavioral choices. The long-term goal of the therapy is to help the child develop meaningful peer relationships that can increase the child's resistance to risk-taking behavior, such as interpersonal violence or drug abuse.

V. Law Enforcement-based Intervention

Child Development-Community Policing (CD-CP), New Haven, Connecticut

CD-CP is a collaboration between New Haven Police and child development specialists at the Yale Child Study Center to intervene appropriately and sensitively with children who have witnessed violent crime. The project includes cross training in which police learn more about children's psychological and developmental response to witnessing violence from development experts, and mental health professional ride with police in squad cars, and spend time in police stations and on the street. Specially trained officers and clinicians are on-call 24 hours a day to respond to the needs of children who are in crisis as the result of witnessing violent crime. The program has been replicated in Framingham, Massachusetts and recognized as a model program by and received support from OJJDP.[56]

VI. Intervention for Sexually Aggressive Youths

Sexual Health in Family Treatment (SHIFT), British Columbia, Canada

Therapists at SHIFT work with children (12 years or younger) with sexual behavior problems who have experienced abuse or violence in their families. The intensive program provides individual, family and group therapy to the child and his or her caretakers. Using a strengths-based, family systems approach, therapists target the structure and organization of the family and its communication patterns, affective tones and nurturing behaviors, control and decision making, conflict resolution, and boundary issues. The goal of the therapy is to eliminate sexually aggressive or inappropriate behaviors in the child and to enhance family functioning and child social skills.

VII. Comprehensive Programming for Native Americans

Ina Maka (United Indians of All Tribes Foundation), Seattle, Washington

Ina Maka offers comprehensive family systems interventions that emphasize family preservation and incorporate traditional Native American practices and beliefs. Ina Maka programming includes family counseling; alcohol and drug crisis intervention services; home-based crisis intervention services; Foster care recruitment, placement, and advocacy; counseling for survivors of sexual abuse, batterers'

intervention; domestic violence interventions for women and children; and victim advocacy. Families who have a substantiated case of CAN or who are assessed by the Department of Health Services to be at risk for CAN may be referred to Ina Maka for counseling. In addition, Ina Maka offers a 10-12 week Life Skills Group for adolescents addressing issues of assertiveness, belief systems, negotiating skills, types of CAN, economic abuse, and dating relationships. Ina Maka uses individual, family and group counseling as well as education and skills building to address the multiple problems and victimizations presented by their clients.

Existing OJJDP Programming Appropriate for High Risk CAN Populations

OJJDP currently funds or plans to fund a number of risk and protective factor-focused delinquency prevention initiatives that may be appropriate for intervening with high-risk CAN populations. For example:

- **Youth Substance Abuse Prevention Program** (President's Crime Prevention Council)—To assist grass-roots, community-based, youth-led organizations that focus on youth drug and alcohol abuse prevention activities;
- **Youth-Centered Conflict Resolution** (Illinois Institute for Dispute Resolution—A collaborative effort to develop broad-based national conflict resolution strategy and to provide information and technical assistance concerning conflict resolution to individuals, organizations and communities;
- **Teens, Crime and Community: Teens in Action in the 90s (TCC)** (National Crime Prevention Council and the National Institute for Citizen Education in the Law)—TCC and Boys and Girls Clubs of America partner to engage in a variety of activities intended to improve their schools and communities.
- **Communities in Schools (CIS)** (Federal Interagency Partnership)—The program serves high-risk youths and their families by providing school-based social, employment, mental health, drug prevention, and entrepreneurship resources.
- **Risk Reduction Via Promotion of Youth Development** (OJJDP with the National Institute of Mental Health)—An elementary school-based experimental program to promote "coping-competence," reduce behavioral problems, deter substance abuse, and prevent school failure. Intervention strategies target both home and school environments and include a classroom program, a school-wide conflict management program, peer social skills training, and home-based family support.
- **Henry Ford Health System (HFHS) Center**—A program to reduce community violence and gang participation featuring community patrols, tutoring, drama, peer education, and substance abuse prevention.

Conclusion

Intervening with victims of CAN to prevent delinquency is still an experimental pursuit. Although research is providing stronger evidence of the correlation between certain variables (e.g., types of victimization, demographic characteristics, family histories or cultural milieu) and delinquency, adult criminality and violent crime, much is still unknown. Perhaps the most pressing need is for high-quality experimental program evaluations testing whether current interventions can indeed inhibit the development of anti-social behaviors in victims of CAN. Answering the question, "What works for victims of CAN?" will undoubtedly be a slow and difficult process, but the potential reward of future reductions in domestic violence, child abuse and neglect, sex crimes, substance abuse and violent criminality makes it an urgent enterprise.

Endnotes

1. See Paper #2 in this series, "Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect (CAN)," for a detailed discussion of the sequelae of child abuse and neglect.

2. Cathy Spatz Widom, in her presentation of preliminary research findings at the National Institute of Justice Criminal Justice Research and Evaluation Conference, Washington, D.C., July 21, 1997, estimated that 80% of abused and neglected children do not commit violent crimes.

3. Maxfield, M.G. and C.S. Widom, "The Cycle of Violence: Revisited Six Years Later," *Archives of Pediatric and Adolescent Medicine*, 150:390-395, cited in Office of Children's Administration Research, "Childhood Victimization and Delinquency, Adult Criminality and Violent Criminal Behavior: A Replication and Extension," unpublished program proposal, Olympia, Washington, n.d.

4. Child Welfare League of America, "Children '97: Embracing the Future" (statistical summary), unpublished typescript, p.1.

5. U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Child Maltreatment 1995: Reports from the States to the National Child Abuse and Neglect Data System*, Washington, D.C.: Government Printing Office, 1997:2-7.

6. Child Welfare League of America, "Children '97: Embracing the Future." In 1985, 1,215 children died of abuse and neglect.

7. Smith, C.A., A.J. Lizotte, T.P. Thornberry and M.D. Krohn, "Resilience to Delinquency," *The Prevention Researcher*, 4 (2) (Spring, 1997):5

8. See the "reasonable efforts" provision of the Social Security Act, as amended, 42 U.S.C.§ 671(a)(15).

9. Widom, "presentation of preliminary research."

10. Ibid.

11. Information provided by the National Research Council.

12. Kaye, E. and J. Bell, "Evaluability Assessment of Family Preservation Programs" (Final Report), unpublished report submitted to U.S. Department of Health and Human Services, May 18, 1993.

13. Schuerman, J.R., T.L. Rzepnicki, J.H. Littell, *Putting Families First: An Experiment in Family Preservation*, New York: Aldine de Gruyter, 1994: 229-240.

14. Interview with Mary Dibble, Bureau of Program and Policy, Madison, Wisconsin, June 1997.

15. Interview with Diana English, Office of Children's Administration Research, Olympia, Washington, June 1997.

16. Information provided by the National Center on Child Abuse and Neglect Data System.

17. Runyan, D., M. Everson, G. Edelsohn, W. Hunter and M.L. Coulter, "Impact of Legal Intervention on Sexually Abused Children," *Journal of Pediatrics*, 113 (1988): 647-653.

18. Bureau of Justice Assistance (BJA), Bureau of Justice Statistics (BJS), Office of Juvenile Justice Delinquency and Prevention (OJJDP), National Institute of Justice (NIJ) and Office for Victims of Crime (OVC), *Office of Justice Programs Fiscal Year 1997 Program Plans*, Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, 1997: 85-86.

19. Interview with Debra Whitcomb, Educational Development Center, Newton, Massachusetts, June 1997.

20. The information in section is primarily drawn from, American Humane Association, "Twenty Years After CAPTA: A Portrait of the Child Protective Services System," unpublished report, Englewood, Colorado, May 27, 1994.

21. Widom, "The Cycle of Violence." Future research may wish to explore the connection between the degree and quality of attention given a case by the criminal justice system and subsequent victim delinquency across different types of abuse.

22. Thornberry, T.P., "Violent Families and Youth Violence," *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Fact Sheet #21*, (Washington, D.C.: OJJDP), December 1994; Saunders, B. and D. Kilpatrick, "Victimization as a Risk Factor for Delinquency Among Gender and Racial/Ethnic Subgroups: Results from the National Survey of Adolescents," research findings presented at the National Institute of Justice Annual Conference on Criminal Justice Research and Evaluation, Washington, D.C., July 21, 1997.

23. Kruttschnitt, C. And M. Dornfeld, "Childhood Victimization, Race and Violent Crime," *Criminal Justice and Behavior,* 18 (December 1991): 448-463. Kruttschnitt cites lack of parental supervision as a predictor of delinquency in African American males.

24. Widom, C.S., "The Cycle of Violence," *Research in Brief*, (Washington, D.C.: U.S. Department of Justice, National Institute of Justice, October 1992): 3.

25. Ibid.

26. Hall, D.K. and F. Mathews, "Problematic Sexual Behavior in Sexually Abused Children: A Preliminary Typology" unpublished paper, York University and Central Toronto Youth Services, 1997; Hall, D.K. and F. Mathews, "Factors Associated with Sexual Behavior Problems in Young Sexually Abused Children," (paper currently being reviewed for publication), 1997.

27. Widom, C.S., "Child Victims: In Search of Opportunities to Break the Cycle of Violence," unpublished paper, presented to the National Institute of Justice Perspectives on Crime and Justice meeting, Washington, D.C., April 8, 1997.

28. Widom, C.S., presentation of preliminary research findings, National Institute of Justice Criminal Justice Research and Evaluation Conference, July 21, 1997; see also Mulvey, E.P., M.W. Arthur and N.D. Reppucci, "The Prevention of Juvenile Delinquency: A Review of the Research," The Prevention Researcher, 4(20) (Spring 1997):2-3.

29. Smith, C.A., A.J. Lizotte, T.P. Thornberry and M.D. Krohn, "Resilience to Delinquency":5.

30. Widom, presentation of preliminary research findings, Criminal Justice Research and Evaluation Conference, July 21, 1997.

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32. National Center on Women and Family Law, Inc., "The Effects of Woman Abuse on Children: Psychological and Legal Authority," 2nd ed., unpublished typescript, 1994: 4-14.

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41. Saunders and Kilpatrick, "Victimization as a Risk Factor for Delinquency Among Gender and Racial/Ethnic Subgroups: Results from the National Survey of Adolescents."

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43. Johnson, B., E.D. Wish, J. Schmeidler and D. Huizinga, "Concentration of Delinquent Offending: Serious Drug Involvement and High Delinquency Rates," in *Drugs and Crime*, ed. R. Dembo, Lanham, Maryland: University Press of America, 1993: 1-26.

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Appendix A

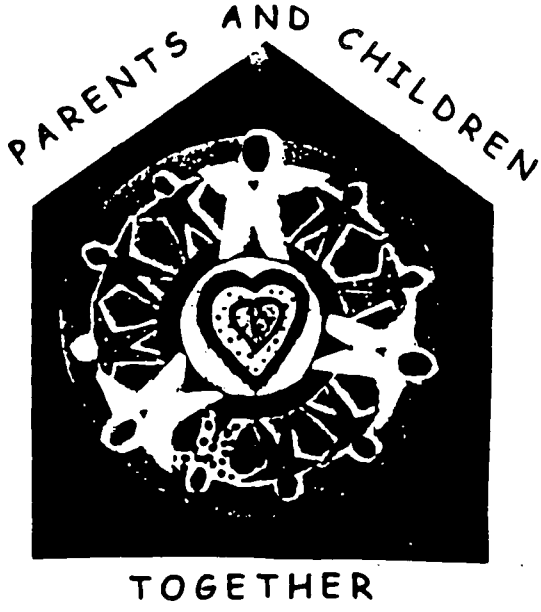
Clifford Beers Guidance Clinic

and

Coordinating Council for Children in Crisis

present:

P.A.C.T.



Coordinating Council For Children In Crisis, Inc.
131 Dwight Street
New Haven, CT 06511
(203)624-2600

CHILD WITNESSES OF DOMESTIC VIOLENCE
PARENTING GROUP

Week 1: **Effects on Children of Witnessing Violence.** Awareness of the effects of violence on children provides parents with a context for understanding their children's behavior. Consciousness-raising in this area can also have a positive impact on parents' approach to discipline.

Week 2: **Effects of Early Life Experiences on Parenting.** An awareness of the ways in which early experiences influence us as adult parents allows parents to make conscious choices about aspects of their family of origin they wish to include or exclude in their current families. Parents do not need to be victims of their past by repeating the mistakes of their parents.

Week 3. **Parents' Rights/Children's Rights.** Some men and women are still rigidly confined to traditional gender roles and beliefs. Such attitudes tend to contribute to and reinforce family violence. Parents are encouraged to meet their needs within other significant life roles, and learn how to avoid abusing their power as adults toward their children.

Week 4. **Discipline vs. Punishment.** Research suggests that battered women are at increased risk for abusing their children. They are frequently isolated, lack outside support, and are the primary caretaker of the children. It is crucial for these mothers to know the difference between discipline and punishment and to learn non-violent approaches to discipline.

Week 5: **Self-Esteem in Children.** Children of battered women were found to have less self-esteem than children from non-violent homes (Hughes, 1988). Parents of child witnesses of violence need to make a conscious effort to support and strengthen their children's self-esteem.

Week 6: **Communication.** Children from violent homes often experience confusion as a result of mixes messages, double standards, misrepresentations of behavior and lack of permission to ask clarifying questions. Parents can be helped to establish open and direct communication with their children by identifying their own style of verbal and nonverbal communication.

Week 7: **Children's Relationships With Peers and Siblings.** Survivors of abuse often report their children's hostile, negative and destructive patterns of interaction with peers and siblings. They fear their children will grow up to repeat the cycle of violence, taking on perpetrator and victim behavior. Parents are encouraged to discuss with their children appropriate and inappropriate expressions of feelings, while validating the existence of different feelings for different children.

Week 8: **Changing Families.** A high rate of separation and divorce exists among families where woman battering occurs. Separation and divorce, along with remarriage or repartnering can be extremely stressful to children. Understanding the manner in which children manifest, defend, or resolve feelings related to changes in the family is the first step toward healthy family restructuring.

The Goals of the Children's Group

•Breaking the Secret

This complex group goal helps children define violence (abuse is not okay, it's not my fault), become educated regarding their feelings (it's okay to feel and to express feelings), and share personal experiences (I'm not the only one). Universalizing the experience through telling or drawing stories, promotes expression of feelings and promotes healing.

•Learning to Protect Oneself

The life realities of the children who participate in this project indicates a need for self-protection training. Safety planning may include telephone role plays, sexual abuse education (good touch - bad touch), group leaders role-modeling assertive conflict resolution strategies.

•Having Positive Social Interaction Experiences

A positive experience can be described as one in which children feel safe, and encounter fun and enjoyment. The children's feelings of trust and safety in the group are a precondition for "breaking the secret". Fun activities provide the children with an immediate gratification that balances the heavier violence related aspects of the group.

•Learning Positive Conflict Resolution

Through the use of role plays, the child will be aided in identifying upset feelings and different (appropriate) ways of expressing such feelings. As children are accustomed to seeing anger expressed by striking out, the goal is to help children discover alternative methods of expressing anger.

•Strengthening Self-esteem

Children witnesses of violence are often dis-empowered. They also often feel different from other children and sometimes they are themselves abused. It is expected that participation in the group will empower the children and strengthen their self-esteem. Several group activities and general supportive and validating interaction with group leaders throughout the group contribute to the achievement of this goal. These include positive reinforcement of children, such as complimenting children for what they said and did and reassuring them that their thoughts and feelings were valid. Another way of empowering the children is by enabling them to make as many choices as possible in the course of the group sessions.

Further, achievement of each of the other four goals contributes to children's positive self-perception. The process of breaking the secret tends to reduce children's shame, guilt, and isolation associated with the violence. Through learning to protect themselves children are empowered and strengthen their confidence in their own skills. A positive experience in group means for the children a positive experience of themselves, of their capacities to be respected and cared for and to be part of a positive enjoyable interaction.

PARENTS AND CHILDREN TOGETHER

Children's Group

SESSION #1 **(Introductions and group rules) (Pre-Tests)**
WHAT IS ABUSE?
"Abuse is not ok"
Basic definitions of violence and abuse
Become comfortable with "breaking the secret"
Feeling of the day is "happy" **(Snack)**
Make posters
Close with personal affirmations

SESSION #2 (Review rules)
ANGER
"It's ok to be angry but it's not ok to abuse others"
Learn to differentiate between appropriate and inappropriate expressions of anger
Feel safe to express uncomfortable feelings
Feeling of the day is "angry"
Role Plays **(Snack)**
Discuss co-existence of contradictory feelings of love and anger,conflicts and loyalty
Close with personal affirmations

SESSION #3
WHEN PARENTS FIGHT
"It' not my fault"
No one deserves abuse
Learn that people are responsible for their behavior
Feeling of the day is "confused"
Read story, *Something is Wrong in My House*
Discuss personal experiences **(Snack)**
Drawings,Clay,Collage
Close with personal affirmations

SESSION#4
IT'S NOT ALWAYS HAPPY AT MY HOUSE
"I'm not the only one whose parents fight"
Feeling of the day is, "Brave"
Decrease isolation
Confront range of feelings such as: anger, pain, frustration, confusion, guilt, sadness
Video: *A Family Affair*
Discuss reactions to movie **(Snack)**
Relaxation Exercise
Close with personal affirmations

SESSION #5
Sharing personal experiences with violence
Feeling of the day is "hurt"
Relate experiences to feelings
Feel less ashamed
Group murals depicting most violent events/ Three Wishes
(Snack)
Free-Time Activity
Close with personal affirmations

SESSION #6
Parents And Children Together
Group members display their creations
Share safety plans
Bring a dish made by moms and children
What have we all learned? **(Post-Tests)**

Background Paper #2:

Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect

Athena Garrett, Ed.M.
Abt Associates Inc.

October 3, 1997

Introduction

In recent years, the reports of child abuse and neglect (CAN) have risen at a rapid rate.[1] In response, there has been a proliferation of theoretical and programmatic innovations from a number of fields, including sociology, psychology, medicine and criminal justice. This paper reviews the growing body of research on the etiology of CAN, the consequences for victims, and theories concerning effective treatments and interventions. In particular, recent research concerning the demographic characteristics associated with increased criminality in victims of CAN is reviewed, and the most promising intervention and treatment strategies are summarized.

The theoretical assumptions informing child abuse and neglect interventions are shifting. Originally, child abuse and neglect was believed to be a consequence of individual psychopathology. Currently, researchers and practitioners are beginning to recognize that it is also a familial and social problem that requires more comprehensive and creative interventions. Increased attention is being given to the ability of individuals and families to successfully remedy the negative impact of victimization. Theories and interventions are moving from an individualistic, deficit-oriented model toward a more ecological, strengths-based model, which is focused on individual and familial resilience.

Part I: Theories Guiding Research and Intervention

A number of theories guide research and intervention strategies for child abuse and neglect. This section discusses social learning, attachment, ecological, family systems, self-efficacy and resiliency theories. Typically, intervention programs incorporate at least two of these six theories. (See Part III for program summaries illustrating each theory.)

Social Learning Theory

According to social learning theory, behavior is learned through two methods: we either learn by being rewarded for our actions (instrumental learning), or we observe and imitate the behavior of those around us (modeling).[2] Researchers postulate that abused children learn to be abusive through modeling and instrumental learning and may continue their abusive behavior into adulthood. This pattern of learned aggression is commonly referred to as the "cycle of violence,"[3]or the intergenerational transmission of violence.

Critique of Theory

Some researchers question the direct and inevitable pattern outlined by social learning theorists. They question the broad-based application of the cycle of violence theory, pointing to findings that only 20-30 percent of CAN victims become involved in abusive and criminal behavior.[4] Azar states that the focus of social learning theory is too narrow and does not include multiple factors that influence family functioning.[5]

Additionally, when parenting education and other social learning-based treatments are more discussion-based than action-oriented, they tend to be ineffective, especially with lower socioeconomic groups.[6] Action-oriented interventions with parents and children, on the other hand include 'hands-on' learning and modeling. For example, a mother may observe a practitioner in a daycare setting interacting with her child. The practitioner models nurturing, pro-social and age-appropriate responses to the child's behaviors, followed by the parent's own interaction with the child. The practitioner may then observe and participate by providing both verbal and physical cues to the parent, which indicate and encourage appropriate behaviors.

Programs Based on this Model

Initially, interventions based on social learning theory focused exclusively on the perpetrator. More recent interventions also focus on the family, with some inclusion of community members when relevant and possible. Social learning theory is the foundation for such practical cognitive-behavioral interventions as education groups with parents and adolescents and emotion and behavior management with adolescents and children. Interventions based on social learning theory commonly have the purpose of stopping current and preventing future CAN, teaching both the parent and child appropriate and acceptable familial interaction, and teaching pro-social and learning skills.

128. Kolko, "Child Physical Abuse;" Widom, "Childhood Sexual Abuse and Its Criminal Consequences."

129. Saunders, "Victimization as a Risk Factor for Delinquency Among Gender and Racial/Ethnic Subgroups: Results From a National Survey of Adolescents."

130. Kolko, "Child Physical Abuse;" Widom, "Childhood Sexual Abuse and Its Criminal Consequences."

131. Kruttschnitt, C., J. D. McLeod and M. Dornfeld, "The Economic Environment of Child Abuse," *Social Problems*, 41 (1994): 299-315.

132. National Research Council, *Understanding Child Abuse and Neglect*, 254.

133. Ibid.

134. Chaffin, M., B. Bonner, K. B. Worley and L. Lawson, "Treating Abused Adolescents," in *The APSAC Handbook on Child Maltreatment*, ed. J. Briere, L. Berliner, J. A. Bulkley, C. Jenny and T. Reid, Thousand Oaks, CA: Sage, 1996: 133.

135. Ibid., 129.

136. Van der Kolk, B. A., D. Pelcovitz, S. Roth, F. Mandel, A. McFarlane and J. L. Herman, "Dissociation, Somatization, and Affect Dysregulation: The Complexity of Adaption to Trauma," *American Journal of Psychiatry,* Festschrift Supplement, 7 (1996): 83-93.

137. National Research Council, *Understanding Child Abuse and Neglect.*

138. Ibid.

139. Ibid.

140. Ibid.

141. Hart, "Psychological Maltreatment," 83-84.

142. Interview with Cathy Ayoub, Harvard University, Cambridge, 1997.

143. Chaffin, "Treating Abused Adolescents," 130.

Because social learning theory attributes behavior to lessons learned from the environment, it is closely related to ecological theory. However, programs that are heavily influenced by social learning theory, focus treatment more narrowly on the family. Programs founded on ecological theory involve a wider range of external services and systems to address multiple factors that impact the family environment.

Program Examples

Parents and Children Together (PACT) in New Haven, Conneticut, provides services that are strongly influenced by social learning theory. Groups for parents focus on child development and clear parent-child communication. Additionally, they help the entire family to learn safety strategies, share feelings and practice non-violent conflict resolution.

Attachment Theory

Attachment theorists believe humans develop a repertoire of behaviors that promote interaction between themselves and their care givers.[7] Children learn these behaviors as a result of how their caregivers nurture them. According to attachment theory, the type of bond that develops between child and care giver effects the child's later relationships.[8] Attachment theory describes four bonding types: secure, anxious/ambivalent, anxious/avoidant, and disoriented/disorganized. The securely attached child freely explores surroundings and is easily comforted. Children with anxious/ambivalent attachments move easily between the caregiver and a stranger when looking for comfort but will simultaneously resist the comfort given. Children who experience anxious/avoidant attachments manifest distrust of the care giver, poor exploration, resistance to separation from the caregiver, and an inability to be comforted. Disoriented/disorganized attachment patterns are characterized by erratic and confused behavior as the child is unable to discern which behaviors gain favorable attention from the caregiver.[9]

Secure attachment patterns are thought to develop from a consistent and nurturing caregiver, whereas the other, insecure attachments, are the result of inconsistent, emotionally neglectful and/or abusive caregiving. Attachment theory suggests that children who are neglected or abused may be more distrustful, have limited self-esteem, and seek out more maladaptive relationships later in life than those who have not been neglected or abused. Several researchers have cited that as many as 80 percent of abused infants and children exhibit insecure attachment patterns.[10]

Some suggest that abuse and neglect not only impact attachment patterns in children, but these patterns carry over into adulthood through an "internal working model"[11] of relationships; in other words, the type of caregiving children receive is the type we come to expect and recreate in adulthood. Research suggests that "internal working models" can either be adaptive and buffer stress or maladaptive and lead to impaired interpersonal relationships and self-esteem.[12] This perspective is salient when addressing CAN. Perpetrators of CAN may behave according to their own "internal working model" created by their bond to their parent. For example, children raised by neglectful parents may develop insecure attachments that could be recreated in their attachments to their own children when they become parents. Consequently, a neglected child may be predisposed to becoming a neglectful parent. This is similar to social learning theory. Both attachment theory and social learning theory support the "cycle of violence" definition of abuse and neglect.

Critique of Theory

As with social learning theory, attachment theory as the single predictor of child abuse and its intergenerational transmission is not always considered a sufficient explanation. Azar describes it as a "perpetrator model" limited in explaining the occurrence of child abuse and neglect.[13] Other critics claim that the emphasis on the parent-child bond to explain and design programs for child maltreatment is too narrowly focused and they highlight the importance of the contextual influences of community and culture.[14]

Some attachment theorists hold that attachment styles form early in infancy and cannot be altered unless a dramatic transformation occurs from an intensive therapeutic or love relationship. Recently, some theorists have modified this perspective and claimed that relationships throughout life affect expectations of and behavior within relationships. Rutter's evidence that psychiatric disorders can develop as a result of events in middle childhood, despite adaptive development through infancy and early childhood, suggests that early adjustment patterns are not set and can be transformed throughout life.[15]

Programs Based on this Model

Programs concerned with attachment issues tend to adopt one of two strategies. The first strategy is to replace the existing insecure bond between the child and the caregiver with a new, more secure bond through out-of-home placement. Program developers may believe that if children remain with abusive, neglectful, or non-nurturing caregivers, they will develop maladaptive relationship styles. Therefore, they should be placed in more consistently nurturing environments. In contrast, the second strategy

focuses on preserving the family while working to repair the caregiver-child bond. The belief underlying this strategy is that the separation from the original caregiver could result in irreparable damage and even less secure relationships in the future.

A compelling study of attachment suggests a link between attachment styles, types of abuse, and adult functioning outcomes. Researchers at the Michigan State University Department of Psychology found that childhood neglect influences symptomology and dysfunctional attachment styles more than physical abuse does.[16] Additionally, neglected children had lower intellectual and social competence and impaired language development.[17] Their research suggests that neglect and abuse should be viewed distinctly, and perhaps programs should be developed with this differentiation in mind. Programs designed for neglected children may require a consistent, nurturing adult who fosters secure attachments, while incorporating a language and social skills development component. However, children who have been physically abused may not need interventions as heavily focused on developing secure attachment styles.

Program Examples

Compassion Workshop is an example of a program designed according to attachment theory which incorporates social learning theory in its treatment modalities. It is an intervention for child, partner and elder abuse and treats both perpetrators and victims. Participation may be voluntary (self-referred) or involuntary (court-ordered). The program addresses physical and emotional abuse by attempting to resolve attachment problems through a cognitive restructuring technique called HEALS: Healing, Explain to yourself, Apply self-compassion, Love yourself, and Solve. The program providers hope to help participants understand their own attachment histories and create balanced and secure attachments in their relationships. By looking at their own, and assumed dysfunctional, childhood attachment patterns, they are encouraged to alter their existing attachment patterns with their mates and children. In addition, the program is designed to help participants build self-esteem, develop self-compassion and compassion for others, and eliminate violent expression of emotions. In an evaluation study, 87 percent of Compassion Workshop participants were violence-free at the end of one year, compared to 41 percent of a comparison group comprised of participants from other batterer programs.[18]

The Gilday Center is a therapeutic daycare/family preservation intervention that combines attachment and social learning theory. The Center is contracted by the Massachusetts Department of Social Services to serve families that have a substantiated case of CAN but sufficient strength to be restored.

The daycare providers work with child victims to facilitate age-appropriate emotional, cognitive, social and physical development by establishing safe and nurturing relationships between themselves and the child (attachment). Providers also create an individual educational plan for each child to further address the manifestations of trauma from CAN. For the parents, practitioners use the cognitive-behavioral practices of observation and modeling through active parent instruction at the daycare. The interventions with parents and their children are designed to help parents establish consistent and appropriate responses to their children's needs while facilitating the mother-child bond.

Ecological Theory

Early theories of child maltreatment assumed that abuse and neglect stemmed from a parent's personality disorder.[19] Later critiques demonstrated that less than ten percent of abusive parents were emotionally maladjusted.[20] Current research and interventions grounded in ecological theory hold that abuse and neglect result from multiple factors. These factors are divided into four systems: individual (ontogenic), family (mesosystem), community (exosystem), and culture (macrosystem).[21] Included in these systems are the following influences: peers, school, workplace, economic factors, childrearing history, child characteristics, parent characteristics, marital relationship, social support and socio-cultural milieu.[22]

When considering why child abuse and neglect occur, ecological theorists include influences on the family such as surrounding community violence and isolation from the community.[23] For example, families impacted by extreme community violence may subsequently isolate themselves for protection, but consequently disconnect themselves from resources and the influence of appropriate community standards of childraising. Therefore, employment, economic, and relational stressors that may contribute to abusive and neglecting behaviors are not addressed through community support. In addition, due to a normative taboo against child maltreatment, the occurance of maltreatment can lead to further isolation as family members develop a code of silence.

Ecological theory is similar to the transactional and transitional models of child abuse and neglect. All three depart from earlier theories of individual pathology to include contextual influences. "Transactional" is occasionally used interchangeably with "ecological". Though the transactional model's antecedents focused more on two-way interactions between parent and child,[24] it later included the more complex influences of multiple systems.[25] The transitional model is similarly defined with an additional clarification of how system interactions can escalate.[26]

Critique of Theory

Widom argues that ecological theory is too rigid and does not allow sufficiently for individual variation.[27] For individuals and families involved in CAN, the degree of influence by each level (individual, familial, community and socio-cultural) may differ dramatically. A child who has been sexually abused may be committed to school, involved with peers and dissociated from family, whereas, in another family a sexually abused child may be disconnected from the community and isolated from peers. Additionally, the child's developmental stage may alter the extent to which a system impacts him or her. An ecological system that is based on an adult perspective may not be developmentally appropriate for children.

Programs Based on this Model

For child abuse and neglect cases, the ecological perspective focuses on influences beyond the parent-child dyad and coordinates interventions that address all systems. If, as the theory states, child maltreatment is the result of multiple factors from various systems, then in order to be effective, programs need to address each factor and system. Interventions grounded in this theory include home visitation, parent groups, and facilitation of social and economic supports.

Program Examples

Homebuilders is an example of an intervention founded on ecological theory. This intensive home-based crisis intervention and education program is designed to preserve high-risk families and reduce out-of-home placements (See "Managing the Consequences"). Program providers (CPS) serve two families at a time, are on call in the evening and on weekends, and work with the family to develop communication skills, child management, child/family safety and stability, and to resolve crises.[28] Successful outcomes have been reported for preventing out-of-home placements and client satisfaction; however, assessments have been criticized for lack of true random assignment and other methodological weaknesses. Neglected children have less positive outcomes in this program, and the best outcomes have resulted when services are concrete, such as securing financial support for the family.[29]

The National Head Start/Public School Early Childhood Transition Demonstration Project is another example of an intervention based on ecological theory. The Transition Project provides comprehensive and ongoing services to support low income children and families for four years (compared to the traditional Head Start program which lasts for one year.)[30] Researchers, policymakers, and practitioners recognized the need to address not only the multiple systems impacting

students' academic achievement, but also to deter the "fade-out effect," a loss of the gains achieved through a one-year early intervention in the following elementary years.[31] In addition to facilitating a young child's cognitive, emotional, developmental and physical growth, the program focuses on creating links among parents, families, school, community, and the social services by which a family may be strengthened. The effectiveness of such coordinated and long-term intervention is supported by a convincing body of research.[32]

Family Systems Theory

Family systems theory is similar to ecological theory in that both focus on the entire family unit when assessing the needs and service approach for responding to child abuse and neglect. Family systems theory, however, focuses primarily on the family and is derived from a group/family therapy model that identifies problems as the consequence of dysfunctional reflexive relationships among family members.[33]

Traditionally, family systems theorists defined child abuse and neglect according to the contributing roles of each family member. For example, in cases of incest where the father is the perpetrator, the possibility that the mother's reluctant intervention may appear to be tacit approval would be explored as a contributing factor in the repeated occurrence of the abuse.[34]

Critique of Theory

Critics are concerned with the theory's failure to recognize the influence of power and society on human behavior.[35] Some critics worry that the discussion of the victim's and bystander's roles in the abuse may be overemphasized and relieve the perpetrator of responsibility.[36] In addition, because the perpetrator is usually an adult in a position of authority, his or her power position is a dominant characteristic that mitigates the victim's behavior choices.[37]

Programs Based on this Model

Prevention and intervention strategies designed according to family systems theory focus on relationships within the family. For example, a family systems observer would provide feedback to the family about their interactions. Proponents believe that by transforming the interactions in the family the abusive behaviors can be diminished and eventually eliminated and the victim's safety restored.[38] Individual and family counseling are the most common treatment methods derived from this model.

Program Examples

The Family Center is located in Somerville, Massachusetts, and its goal is to strengthen and preserve the family. The curriculum currently being used and developed is the "The Parenting Journey" which incorporates family systems theory, attachment theory, and social learning theory. The program focuses on the entire family to address issues and provide insights into family dynamics through a family support program. The providers also attempt to help parents resolve destructive parenting patterns based on their own childhood experiences. Families may be referred by CPS or self-referred. Participants receive family therapy with a focus on group dynamics to develop self-awareness, respect, and parenting skills. The Parenting Journey is a new curriculum that has not been evaluated.[39]

Ina Maka Family Program in Seattle, Washington, is another example of an intervention based on family systems theory. It is a comprehensive family preservation program designed to prevent the "break-up of at-risk Indian and non-Indian families," which utilizes both traditional Native American healing practices and modern psychotherapeutic modalities.[40] Clients are referred by Washington State Social Service Agencies for Families and Children (DSHS), CPS, Local and County Court and Probation Officers, numerous tribes and Indian Reservations throughout Puget Sound, and self-referral. Ina Maka provides services to perpetrators and victims. This program helps clients develop positive self-esteem, anger management skills, healthy family communication and parenting skills through short-term and long-term treatment and aftercare services. Additionally, the program has intake/emergency services, domestic violence intervention programs, sexual abuse programs, alcohol and drug abuse treatment, minority diversion services (to preserve and reunite high-risk minority families), and foster care services (for example, home studies, recruitment, case managment and supervision, support services, Indian Child Welfare Legal Services/Reunification, and adoption enrollment). Ina Maka uses the Personal Objective Inventory (POI), a treatment outcome measure, which "provides an objective measure of an individual's level of health in certain areas. "[41] It is a new instrument and the findings have not yet been determined.

Self-Efficacy Theory

Many programmatic models based on ecological theory also incorporate self-efficacy theory. Self-efficacy theory focuses on how personal characteristics of the child and, especially, the parent influence family functioning.[42] Self-efficacy theory addresses how a parent's expectations of effectiveness impact their motivation and behavior.[43] An individual's expectations dictate if they will start and continue actions to achieve a goal.

Self-efficacy theory may be a useful tool for bridging the gap between knowledge and behavior. A gap between knowledge and behavior is apparent when parents know they should not hit their children, but are unable to seek out methods to achieve this goal. Self-efficacy theory states that this knowledge/behavior gap is due to the parents' belief that they cannot behave in a manner that would stop them from abusing their children. The parents may not try to find support groups or they may not continue therapy once started.

Four methods for influencing efficacy expectations have been specified.[44] Performance accomplishment is the method that motivates people to act and persist because they have previously experienced the effectiveness of their behaviors. It is reportedly the most effective method of motivation. The three remaining methods, are verbal persuasion, vicarious experience, and emotional arousal.[45]

Critique of Theory

Self-efficacy theory, according to Olds, is limited because it does not incorporate a developmental perspective.[46] Additionally, it addresses an individual's emotions only through the impact of actions. The effects of personal histories are not adequately addressed by this theory.

Programs Based on This Model

Prevention and intervention programs incorporate self-efficacy theory to motivate families. Programs using this theory may specify small achievable tasks and goals to give the participants a sense of performance accomplishment, which will contribute to their belief that they can effectively carry out more complex and long-term actions and goals.

Program Examples

The intervention program Advocacy for Women and their Abused Kids in Emergencies (AWAKE), located in Boston, Massachusetts, is based on self-efficacy theory, attachment theory, and social learning theory . It was the first program in the country to provide services to both battered women and their abused children in a pediatric setting.[47] The intervention is designed to: make the hospital a safe place to reveal violence in the family and protect every victim; stop abuse by taking a stand against it; provide the abused woman with support and empower her to protect herself and her children from violence and coercion by restoring the victim with a sense of control over her life (with dignity and power); and to keep children and women safe and together, whenever possible.[48] The program screens parent-child emergency room visits for domestic violence and child abuse and provides

continued advocacy. By being advocates for the women, they hope to promote self-advocating behaviors in the mothers and their children. AWAKE receives referrals from other hospitals, social workers, lawyers, shelters, therapists, victim/witness advocates, criminal justice workers, and clients themselves.[49] From a preliminary analysis of 46 cases, abuse of the mother ended in 85 percent, according to self-report, and in 76 percent of the cases, abuse of the child had stopped according to the mother. Additionally, women and children served were found to have a low rate of foster care placement.[50]

Resiliency Theory

Historically, child abuse and neglect research and interventions were grounded in the belief that inevitably the victim is damaged by the trauma. Mediating influences that may alter the impact of maltreatment typically were not considered. However, recent research has demonstrated that factors such as severity of abuse, frequency of abuse, age of the victim, and relationship to the perpetrator can predict later adjustment. Additionally, certain positive elements of support have been shown to affect the long-term impact of child maltreatment. Factors such as social support,[51] parental warmth[52] and the victim's healthy relationship with a supportive adult[53] influence healthy development and avoidance of delinquent behavior.

Because childhood abuse and neglect do not always result in maladaptive behavior in adulthood,[54] new research is focusing on discovering the mediating factors that contribute to healthy adult psychological development.[55] A primary goal of the research is to discover the protective factors that can be included in an intervention.

Resiliency theory does not explain why abuse and neglect occur, rather, it explains why children are not inevitably damaged by CAN. It may also explain how the "cycle of violence" can be interrupted. This theory focuses on the victims of childhood maltreatment and on methods to mitigate the impact of the maltreatment.

Critique of Theory

Most resiliency theorists would agree that resiliency theory cannot be the soul underpinning of child abuse and neglect interventions.[56] Though programs can reduce the effects of maltreatment, which may in turn reduce the likelihood of later maladjustment and delinquency, protective factors may not

be able to directly reduce the occurrence of abuse and neglect. Thus, programs still need to be in place that are designed to stop current abuse.

Programs Based on this Model

Resiliency theorists design programs that create or increase the influence of protective factors in a child's life. A variety of studies have defined the factors that protect the child from stress, with the most prominent factor being social support.[57] Children who had significant social support and/or sought social support (a coping strategy) showed healthier adult adjustment.[58] These protective factors[59] buffer the child from the negative effects of maltreatment. Research suggests designing interventions that create healthy and consistent social relationships with both adults and peers.[60] However, Widom's research indicates that a close relationship with a responsible adult may prevent deliquency, whereas having a close relationship with a peer may increase risk.[61] In her research she noted that among CAN victims who listed an adult, particularly a foster parent, as the person with whom they had the closest relationship less than ten percent were involved in future violence. For those who listed siblings as their closest relationship, however, forty percent had been arrested for violence.

Program Examples

Responsive Advocacy for Learning and Life in Youth (RALLY) is a school-based, developmental intervention "focused on children's capacity to overcome problems."[62] This individualized program connects students with an in-school mentor who supports the child's competencies while helping with school work and emotional and behavioral issues.

Part III: Examination of Existing Intervention Strategies

From the many interventions researched, three have been profiled in this section. These interventions have been selected to depict how intervention programs use theory to design practice and because of their promise as effective intervention strategies for CAN. Most of the interventions selected were created explicitly to stop CAN and/or domestic violence as well as to restore the victims and/or family. (See Exhibit 1-3 in Paper #1.) Others, such as school-based interventions, are designed to improve academic achievement in at risk populations generally, but also address issues of CAN.

The Gilday Center: Roxbury, Massachusetts - founded in 1972

Director: Janice Higgins, LICSW

Assistant Director: Mary Watson Avery, M.S.

I. **Description:** Family Preservation/Therapeutic Daycare Program

A. A nonprofit agency and center funded by private donors, United Way, Associated Day Care Services, and contracted by Massachusetts Department of Social Services.

B. Designed to prevent out-of-home placement by providing parents and children with emotional safety and support, pursue the best interest of each family, and educate parents about child development and their own personal development.

C. Provides services to infants and toddlers 6 weeks to 2.9+ years old who have substantiated experiences of abuse and neglect (51As) [+ six weeks]. Current enrollment 14 children: 6 african american; 3 multi-racial; 4 hispanic; 1 caucasian.

D. Provides a limited number of slots to the community (not protection cases) in which it is based (Mission Hill Housing Development).

II. **Theoretical Framework:**

A. Program is guided by development theories of early childhood, focusing on social, emotional, physical, and cognitive skills.

B. Attachment and Social Learning Theory guide the structure of the interventions with parents and children to help them establishsecure attachments through the cognitive-behavioral practices of observation and modeling, and active parent instruction.

C. Resiliency theory informs child interventions which are based on each child's response to the trauma s/he has experienced.

III. **Objective:** To provide the victims of abuse and neglect with appropriate and specialized treatment that will enable them to develop a healthy identity and healthy relationships with their families, peers, and other adults, while simultaneously supporting the parents in parenting skills, social skills, and community connection.

A. **Children:** Identify and alleviate the developmental effects of abuse and neglect through individual, pair, and group play, and provide intensive, consistent, ongoing support to help the child develop age-appropriate personal and social expectations and responses.

B. **Parents:** Provide parents with opportunities to learn new skills, establish parental support, and facilitate community connections through which to meet their social, economic, and personal needs.

C. **Community:** Provide community-based daycare services to families in Mission Hill Housing Development and maintain positive community relations.

D. **DSS:** Provide family preservation services to parents with infants and toddlers who have had a substantiated case of CAN, but have the necessary strength to either maintain the family unit or re-unite.

IV. **Method:** Families identified and referred by the CPS worker to receive family reunification/therapeutic day care services.

A. **Parents:** attend site with caseworker to meet director and complete the initial intake.

1. Initial intake to determine the needs of the child, parent and family.

   a. Determine if Gilday is an appropriate placement.
   b. Establish parents' commitment.
   c. Ensure attendance of both child and parent.
   d. Arrange transportation.

2. Parent Participation/Training (9:00 a.m. – 12:30 p.m., one day a week/weekly)

1 hour

a. **Group Session*** with all other parents of children at the center, led by the director.

ecological (support)

(1) an arena to discuss present, current, and future parenting issues and events (what's happening with kids).

cognitive-behavioral

(2) developmental aspect e.g., toilet training when child is ready, how, and language development.

(3) Resource issues — housing, information sharing.

* Group Sessions span the range from practical/everyday to emotional/personal problems and are both organic and nonorganic in nature.

1 hour

b. **Classroom Session:** Parents spend the hour in the classroom watching/observing children and workers (modeling) and are provided with clear illustrations of communication styles, patterns, and responses to childrens' behaviors.

1 hour

c. **Social Session:** Freeform with snacks — Opportunity for parents to interact with each other and the center staff.

d. **Individual Session:** Center Director may provide one-on-one counseling with a parent if the parent has need and is not receiving such services elsewhere.

B. Children: May enter the daycare after being referred by DSS or through the voucher system* for low-income families. Ideally 12 (daycare) slots are for DSS cases and 4 slots are for voucher facilities.

1. **Developmental milestones:** individual education plans for every child based on both the assessment and observation.

2. **Interventions (clinical):** Pair Play Project

   a. Case-by-case interventions based on child, abuse history/experiences, exposure to substances, relationship with parents, and level of resiliency.

   b. Center practice regarding attachment and resiliency.

      (1) provide a sense of security and belonging as all children have picture of self/home at table; maintain constancy (e.g., sleep in same place every day).

      (2) observe children in play and facilitate play.

      (3) provide mixed age groups.

      (4) help children transition to new placement/preschool.

* Voucher slots are filled by Mission Hill community members who are not currently involved with DSS, but have qualified for voucher — typically a strong family situation.

C. Providers

1. **DSS Child Protection Worker:**

   a. Makes referral, accompanies parent to first meeting.
   b. Conducts a standard/uniform evaluation every 6 months.
   c. Holds multiple meetings between evaluations to check progress of child/parent/family.

2. **Daycare Workers:** All are qualified by the Office for Children (OFC) in Early Childhood Education (teacher/lead teacher), with at least a Bachelors, some Masters and are bilingual.

   a. One-on-one supervision with director bi-weekly; mental health support by consultation.

   b. Weekly team meeting (2 teams, each classroom is a team).

      (1) specific issues in classroom: behaviors, hygiene.

(2) physical assault: what to do — using safe restraint.
(3) slow developing language skills: how to facilitate early intervention.

c. Provide extensive, ongoing documentation of CNP issues.

(1) able to identify family issues that need to be addressed.
(2) identify at-risk behaviors and inform parent (facilitated by ongoing parent interaction).

3. **Director/Assistant Director:** Make reports to CPS worker —

a. In cases where there is current abuse, a 51A is filed, and if it is a voucher placement, it may be transitioned to a DSS slot

b. Assistant Director: 3 years in position; 3 successful transfers from voucher to DSS slot

V. **Assessment:** Required by the Office For Children every 3 months for infants and every 6 months for toddlers. Agency has developed an instrument on developmental milestones and provides DSS with an **anecdotal evaluation** every 6 months.

A. Gilday Assessment covers:

1. Attachment
2. Regular domains of development
3. Gross/fine motor skills
4. Image of self
5. Emotional and social development
6. Relationships to peers and environment
7. Verbal communication

B. Trauma manifestation assessment covers:

1. Depression
2. Lack of response
3. State management — always falling asleep, always awake
4. Crossover group: in utero exposure to drugs
5. Hypervigilance: over-examination of the environment
6. Inhibition/partial inhibition of play

VI. **Outcomes:** Child and parent progress noted and documented on a regular basis, 3 or 6 month intervals, and supported statement in the interim.

A. Individual, familial and interpersonal skills improvement.

B. Maintain family cohesiveness, enhanced parent-child bond.

C. Provides an early start to a long process of recovery and development to child, parent, and family.

D. DSS responsible for follow-up and evaluations — Gilday has not developed any longitudinal follow-up and does not have any specific statistical outcome data on specific subjects.*

* Gilday does have anecdotal outcomes and individual case studies completed by graduate student interns. DSS does not have follow-up and evaluation reports.

Casa Myrna Vazaquez: Boston, Massachusetts, founded in 1976

Director of Education and Training: Debra Robbin

Coordinator of Children's Services: Chris Bucco

Director of Support Services: Patricia Cullen

I. **Description:** Domestic Violence Shelter for Women and Children

A. A nonprofit agency with multi-level public and private funding from: United Way; Massachusetts Department of Social Services; Hart McKinney; HUD; Mass Bar Foundation; Crime Victim's Assistance; and an Emergency Shelter Grant.

B. Designed to stop domestic violence and child abuse in the community and in families, to protect individuals, and provide survivors with the necessary support to prevent future violence and victimization.[2]

C. Provides emergency, short-term, and long-term shelter, treatment, and advocacy for victims of domestic violence and their children. Serves 35-40 women and 60-65 children in its residential programs.

D. Provides support services to community members (non-residential) through a crisis hotline, mental health services, and education and training outreach to corporations, community, and victims.

II. **Theoretical Framework:**

A. Attachment theory informs the structure of the program which recognizes the importance of the mother-child bond and facilitates the development of positive and healthy relationships and functioning by providing shelter and support to both .

B. Social Learning theory guides the work of advocates who collaborate with mothers to secure services for both themselves and their children.

2 Do not provide services for women who are the primary perpetrators of child abuse.

C. Ecological theory is the foundation for the multidisciplinary and multisystemic outreach and services provided by the program.

III. **Objectives:** to protect women and children from domestic violence and prevent future violence in families and throughout the community.

A. Children: Provide child witnesses and victims of abuse with a safe and nurturing environment; identify and address the negative effects through early intervention; and support the mother-child relationship.

B. Parents: Protect victims of domestic violence from abuse; identify and address physical/mental health, legal, economic, and support needs; and support the mothers' ability to care for children in a safe and nurturing way.

C. Community: Provide residential and corporate community with information about domestic violence, access to services, and training and education to stop it.

III. **Methods:** clients referred from the hotline, emergency rooms, DSS, private physicians/psychologists, police officers, and clinics; self-referrals with sources from community/corporate education and training sessions, word-of-mouth; clients come from other shelters, cities, states, and countries.

A. Residential and Community Programs and Services

1. Short-term residential: clients may stay for a maximum of 90 days.

   a. Emergency Shelter (2): shelter and services to 15 women & 26 children.

   b. Safe Home Program (1): home and services to 6 women & 12 children.

      (1) space rented for mother/children in private homes.
      (2) women and children receive services at the shelter.

2. Long-term residential: clients may stay for a maximum of 18 months (funded by the Department of Transitional Assistance).

   a. Women and Children's Transitional Program: 10 women & 14 children.

   b. Adolescent Transitional Program: 8 teens and 12 children.

3. Support Services for short-term and long-term clients and community.

   a. Outreach and Hotline: available to all.
   b. Mental Health: clients only.
   c. Children's Services: clients only.
   d. Legal Services: clients only.
   e. Education and Training: available to all.

Type of CAN as a Predictor for Sex-Related Crimes

Abused and neglected children generally are at increased risk of being arrested for sex crimes. The risk is especially pronounced among neglected children.[116] Sexual abuse victims, especially females, appear more likely to be arrested for prostitution[1] than children who have been physically abused.[117]

In one study, approximately 10.5 percent of the female victims of sexual abuse had engaged in prostitution compared to 9 percent of neglect victims.[118] Sexual abuse was neither associated with increased risk for sex crimes in general,[119] nor were male victims found to be at increased risk for committing sodomy or rape.[120]

The occurrence of sexual behavior problems in victims of sexual abuse

Widom's research "did not find victims of child sexual abuse generally to be at increased risk for violent criminality, but later studies have identified a subset of child sexual abuse victims that are likely to become sexually aggressive youths."[121] In a new study by Hall, four variables were found to affect whether a child who has been sexually abused develops sexual behavior problems: whether the child experienced sexual arousal, the occurrence of sadism, the co-occurrence of physical and emotional abuse and who the victim blamed. Of these, the strongest predictor of both self-focused and interpersonal sexual behavior problems was arousal. Interpersonal sexual behavior problems, such as becoming a sexually aggressive youth, were predicted by: arousal, sadism, physical abuse and emotional abuse. Hall's study found that the closeness of the relationship to the perpetrator and duration or frequency of abuse were not significant predictors of sexual behavior problems.[122]

According to Hall, the victim's amenability to treatment was determined by several factors. If the victim experienced only partial arousal and had strong family structure and support, then the outcomes were favorable. If the victim's family engaged in sexualized interactions and family violence, but had low criminality, then the outcomes were mediocre. If the victim experienced severe sadism, had a violent family surrounded by a criminal cultural milieu and had serious PTSD, then the outcomes were poor and monitoring was recommended.[123]

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1 Debra Whitcomb reported that although 75% of street prostitutes had been abused, 57% lived at home when they were first sexually exploited. Although there has been some suggestion that victims of abuse runaway from home and subsequently become involved in survival prostitution, causality is unclear. Exploitation is not necessarily associated with homelessness. Source: Preliminary research findings presented at the Meeting the Challenges of Criminal Justice Research and Evaluation, sponsored by the National Institute of Justice, U.S. Department of Justice, July 21, 1997, Washington D.C.

Witnessing Violence as a Predictor of Delinquency and Adult Criminality

Some research indicates a relationship between witnessing violence and delinquent and violent behavior. Preliminary studies have found that witnessing violence increases the likelihood of later youth violence,[124] and that 74 percent of youth who witness violence engage in delinquent behavior compared to 49 percent who do not witness violence, according to self-report.[125] In a retrospective study of incarcerated males, Kruttschnitt found witnessing violence to be significantly associated with subsequent violent crime, but only among non-whites.[126] In his study of victimization as a risk factor for delinquency, Saunders defined witnessing violence as "lifetime experience of actually seeing someone shot with a gun, cut with a knife, sexually assaulted, mugged or robbed, or threatened with a weapon." Saunders found witnessing violence (community and family) to be a significant predictor for whites, but an even greater predictor for blacks, particularly those who had also developed PTSD. Saunders also found witnessing family violence to be a significant predictor of delinquency for females.[127]

Physical Abuse and Neglect as Predictors of Delinquency and Criminality

Many researchers have found victims of physical abuse to be at greater risk for delinquency and more likely to be arrested for violent crime than other CAN victims.[128] Saunders found a differential outcome for blacks and whites, with physical assault and abuse being a significant predictor of delinquency for whites, but not for blacks.[129] Physical abuse has also been identified as a risk factor for drinking, drug use, arrests for rape and other sex offenses, and adult criminality.[130] Childhood neglect has also been associated with high rates of violent criminal offending.[131]

In summary, victimization may lead to delinquency and violent adult criminality, but it is difficult to predict who will become delinquent. The findings reported above give some guidance on how different types of CAN may lead to different types of delinquency and criminality but are by no means conclusive. Race and gender appear to lead to differential outcomes for some types of CAN and not for others. Further research is needed to determine how race, gender, and class influence the consequences of victimization.

Research on Effective Intervention Strategies

Many intervention programs are considered promising. However, there is little empirical research to support their effectiveness. Intervention programs either focus on a specific type of abuse or intervene

Sexual Abuse

Infancy: insecure attachments.

Pre-school: PTSD, inappropriate sexual behavior, anxiety, increased internalizing and externalizing problems, nightmares.[86]

School-aged: neurotic, aggressive and hyperactive.[87]

Adolescence: onset of puberty advanced by one year,[88] bulemia,[89] suicidal or self-destructive behaviors, depression,[90] withdrawl, aggression, running away, substance abuse, and anxiety.[91]

Neglect

Infancy: non-organic failure to thrive syndrome,[92] anxiously attached(anxious/avoidant).[93]

Preschool: serious behavior problems,[94] inattentive and uninvolved in learning.[95]

School-aged: withdrawn, inattentive.

Adolescence: poor peer relationships.

Differential Outcomes of Abuse and Neglect by Gender and Race

Similar to research on the developmental impact of CAN, the impact of gender, race, and socio-economic status are understudied and ill understood. The few studies that exist tend to disagree on the nature of the relationships between these variables and outcomes. A summary of relevant research follows.

Gender

Female victims of sexual abuse exhibit greater internalized aggression.[96] In studies conducted exclusively with females, victims of sexual abuse were found to have lower self-esteem[97] and greater cognitive impairment[98] than non-abused girls. They were also found to have poor relationships with their mothers.[99] Female victims of sexual abuse are also at greater risk of engaging in prostitution, while male victims of sexual abuse are not.[100] However, both male and female victims of neglect are at greater risk of engaging in prostitution, although the risk remains higher for females.[101]

One study found that boys who are physically abused show a higher degree of hypervigilance, a symptom of PTSD.[102] Saunder's preliminary research found that African-American males who had witnessed violence and had PTSD were at significantly higher risk for delinquency than all other populations. Widom found that female victims of abuse and neglect had higher rates of arrest for violence, but male victims did not.[103]

For children who have witnessed family violence, Yawney identifies differential outcomes in terms of gender. Yawney reports that boys tend to exhibit aggression, tantrums, fighting, bullying, lying, cheating and destructiveness, whereas girls are passive, compliant, overly dependent, stubborn, and suffer increased somatic complaints. Behaviors that boys and girls had in common in response to witnessing family violence were excessive teasing, worrying, low frustration levels, and withdrawn behavior.[104]

Race

Kruttschnitt and colleagues found a significant association between exposure to parental violence and subsequent violent crime in male victims, but only among non-Whites.[105] In a recent presentation to the National Institute of Justice (NIJ), Widom stated, "there seems to be a differential impact of childhood victimization on the criminal consequences for African-American children as compared to White children."[106]

Research on Delinquency and Adult Criminality

The outcomes of CAN extend beyond childhood into adolescence and adulthood. Research suggests that victimization may lead to delinquency and/or adult criminality. A recent study by Maxfield and Widom found that CAN increases the risk for juvenile arrests by 59 percent, adult arrest by 27 percent, and arrest for violent crime by 29 percent.[107] In her recent presentation to NIJ, however, Widom emphasized that not all abused children become delinquent, criminal and violent, despite their increased risk. According to her research, 21 percent of CAN victims are arrested for violence.[108]

Studies do not agree which type of CAN is the most significant predictor of violent crime. Some researchers suggest that children who have been physically abused are the most likely to have arrests for violent crime(21%),[109] followed by victims of neglect (20%).[110] Other researchers claim that children who witness domestic violence have the strongest risk for subsequent violence.[111] Yet other researchers argue that experiencing multiple forms of abuse is the key correlate to delinquency [112] and to violent crime.[113] One study found that multiple forms of victimization doubles the risk of self-reported violence.[114] Finally, neglect victims are identified by some researchers to be the most likely to engage in violent criminal behavior, citing emotional neglect specifically to be the "most potent predictor of violent crime."[115] Given these conflicting reports, it is unclear which type of CAN is most likely to lead to delinquency or adult criminality.

Differential Outcomes of Abuse and Neglect

Research identifying differential outcomes according to type of abuse is limited. Many researchers specialize in one area of abuse, such as physical abuse or sexual abuse. Therefore, research comparing different types of abuse is rare. Existing research, according to experts in the field, is new and currently has insufficient data to support differentiated interventions based on type of abuse only. Generalizing findings from this research is viewed cautiously due to methodological limitations.

The following is a limited summary of the research on how the consequences of child victimization differ according to type of abuse. Different types of abuse were compared to determine which were the strongest predictors of symptomology. Research findings have been grouped according to symptom categories: psychological/PTSD; academic performance/cognitive; and behavioral-interpersonal/affect-emotional.

Psychological/PTSD

In comparative studies involving psychological outcomes, victims of sexual abuse and neglect demonstrated the most severe symptoms. According to one study, victims of child sexual abuse are more likely than other victims of child maltreatment to be diagnosed with PTSD.[72] Additionally, depression may be more prevalent in children who are sexually abused than in children who are physically abused.[73] Victims of neglect also fared worse than physically abused children. Between neglect and physical abuse, neglect was a stronger predictor of more severe psychological problems, such as anxiety, depression, somatization, paranoia, and hostility. Researchers also reported that neglected children are more likely to exhibit anxious attachment styles and, later, more difficulties in relationships.[74]

Academic Performance/Cognitive

In a study by Perez and Widom, comparing cognitive and academic impact across types of abuse, victims of neglect showed the most deficits. Adults who had been neglected as children had significantly lower IQ and reading levels than non-abused controls. Those who had been physically abused had lower IQ scores than non-abused controls. However, adults sexually abused as children did not differ from the non-abused controls. Parallel results were found in a study of school aged children (K-12), which suggests that the academic and cognitive impact of CAN differs according to type of abuse.[75]

Behavioral /Interpersonal and Affect/Emotional

According to the literature reviewed, children who have been physically abused tend to be more aggressive than children who have been neglected.[76] Neglected children are found to be more withdrawn and inattentive than physically abused children.[77]

Differential Outcomes of Abuse and Neglect by Development

Developmental research on the outcomes of CAN is currently in its infancy. Some symptoms carry over from one developmental stage to the next, others do not. Whether these developmental differences are a consequence of the abuse and neglect or a manifestation of personal development has not been established. The following is a brief review of some of the age-specific findings concerning the outcomes of CAN according to type of abuse.

Consequences of CAN by Developmental Stage

Children Who Witness Violence (family violence & community violence)

Infancy: poor health, poor sleep habits, and excessive screaming.[78]

Pre-school: terror, shaking, stuttering, decreased cognitive skills, and regression.[79]

School-aged: developmental delays, sleep disturbances, enuresis, speech and hearing difficulties, eating disturbances, psychosomatic complaints, shaking and nail-biting.[80] They also startle easily and show low cognition, diminished memory, suppression of affect, and hypervigilance.[81]

Adolescence: poor school performance and dropping out as well as precocious sexual behavior, drug use, antisocial behavior and feelings of guilt and shame.[82]

Psychological Abuse

Infancy: attachment disorders and failure to thrive.

Pre-school: aggression, attacking peers in distress, poor appetite, and enuresis.

School-aged: disruptive classroom behavior and aggression.

Adolescent: antisocial behavior and problems with peers.[83]

Physical Abuse

Infancy: failure to thrive, cognitive impairment.

Pre-school: repeated motor play, less parallel and group play.[84]

School-aged: less likely to initiate positive peer interactions, less well-liked by peers.[85]

Adolescence: antisocial behavior.

Part II: Recent Research Findings, Trends, and Recommendations in the Field of CAN

The following section is divided according to common outcomes of CAN, differentiated outcomes by type of CAN, stage of development, gender and race, and new research on delinquency. It concludes with a discussion of research on effective intervention strategies. Delinquency has been separated because of the focus of the NIJ Child Abuse and Neglect Interventions Strategic Planning Meeting.

A General Survey of Consequences for CAN Victims

- **Medical/Physical**
  bruises, skin markings, cuts,
  burns, serious physical injuries (brain damage, death),
  severe health complications, body disregulation
- **Psychiatric/Post Traumatic Stress Disorder**
  anxiety, nightmares, generalized fear response,
  depression, psychopathology, neurosis,
  character disorders, trauma-specific fears
- **Attachment/Self-Esteem**
  poor attachment, separation problems,
  lack of empathy, low self-esteem,
  affective problems, temperament problems
- **Cognitive/Developmental**
  low verbal, cognitive and motor abilities,
  regression, lower performance on cognitive tasks,
  language deficits, developmental delays
- **Academic Performance**
  concentration problems, declining grades,
  poor school achievement,
  truancy, dropping out
- **Behavioral/Interpersonal**
  less social competence, acting out,
  self-destructive behavior, physical aggression,
  antisocial behavior, withdrawal, avoidance

Sources: Cichetti, D. and V. Carlson, *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect*, New York: Cambridge University Press, 1989; Peled, I., P. G. Jaffe and J. L. Edelson, *Ending the Cycle of Violence: Community Responses to Children of Battered Women*, Thousand Oaks, CA: Sage, 1995; Herman, K, "Effects Of Violence on Adult Functioning/Child Development," unpublished fact sheet, presented at the Fifth National Colloquium of American Profession Society on the Abuse of Children, June, 1997.

Common Outcomes of Abuse and Neglect

The research literature indicates that victims of all types of abuse and neglect commonly have one or more of the following problems:

- aggression;[63]
- depression;[64]
- limited self-esteem;[65]
- low social functioning;[66]
- low cognitive skills; and/or[67]
- attachment problems.[68]

These symptoms are not found in all victims, and victims with symptoms suffer them with varying severity. The child's developmental stage, race and gender, and other factors may influence symptom manifestation (See the box "The consequences of CAN vary according to multiple factors").

Two other symptoms should be mentioned when discussing the effects of CAN because of their prevalence in the literature: post-traumatic stress disorder (PTSD) and inappropriate sexual behavior. PTSD is associated with each type of abuse with the exception of neglect and psychological abuse.[69] Inappropriate sexual behavior is recognized as a potential consequence of sexual abuse or physical abuse.[70] It has also been noted that adolescents who witness family violence may engage in precocious sexual behavior.[71]

The Consequences of CAN Vary According to Multiple Factors:

- **Child Characteristics:** age, emotional and cognitive development, gender, race/ethnicity, personality strengths (resiliency);
- **Type of Trauma:** Type I: acute (a single event) or Type II: chronic (repeated);
- **Type of Abuse or Neglect:** physical, sexual, psychological/emotional abuse or witnessing domestic violence;
- **Co-occurrence of Types of Abuse and Neglect; and**
- **Relationships the child has with:** victimizer, non-offending parent, other family members, other adults, and peers.

with at-risk populations in general (with victims of abuse and neglect being a subset of that category). The relative effectiveness of abuse-specific versus non-specific interventions is unknown.

Existing outcome research on whether interventions are effective has significant methodological limitations such as small sample sizes, lack of control or comparison groups, or no follow-up concerning further victimization.[132] Additionally, "common assessment strategies have not been used across different interventions, making it difficult to know what works for whom."[133]

Despite these limitations, several intervention strategies (for example, multi-systemic, cognitive-behavioral, family preservation, therapeutic day care, therapy and a supportive adult) have demonstrated promising outcomes for treatment effectiveness. "One well-researched approach, multi-systemic therapy, has had excellent results for adolescents with delinquent behavior."[134] Short-term cognitive-behavioral modeling[135] has been an effective treatment for PTSD.[136] Family preservation, although not consistently effective, may work more often with physically abused children than with neglected children.[137] Additionally, some evidence suggests that therapeutic day care positively impacts the developmental progress of physically abused children[138] in the areas of fine and gross motor skills, cognitive development, social and emotional functioning, and language development.[139] Therapy and relationships with supportive adults have also been shown to break the "cycle of violence." Egeland found that women who had been severely physically abused as children and received at least a year of therapy during childhood or had a supportive relationship with an adult during childhood did not currently abuse their own children.[140]

The type of strategy is not the only factor that contributes to effective interventions. Length of intervention has also been studied. Some results suggest that more than 10 meetings, whether insight-oriented, group or family-centered, lead to greater treatment effectiveness for at-risk families.[141] This finding is supported by other researchers who call for long-term treatment and follow-up.[142]

Many current intervention strategies are based on resiliency theory. This theory outlines the mediating factors that can protect a child from the negative outcomes of CAN. A review of the leading research in this area provides a list of individual, family and community protective factors.

Protective Factors that Mediate the Outcomes of Child Abuse and Neglect

Individual Characteristics

- autonomous, independent
- high self-esteem
- easy temperament
- intelligence (high IQ)
- high reading scores
- expectations/aspirations for college
- commitment to school
- attachment to teachers
- low disorganization
- responsible
- internal locus of control
- positive social orientation

Family Factors

- parental warmth
- parental supervision
- parental attachment
- one good parent relationship
- parent's positive evaluation of peers
- parental involvement in child's activities

Community Factors

- secure, supportive relationship with adult
- peers' conventional values

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Intervention strategies based on resiliency theory focus on the natural strengths of the child and seek to enhance the individual, familial, and/or community protective factors. For example RALLY, focuses primarily on developing protective factors in individual students, such as high reading scores, commitment to school, and positive social orientation by providing one-on-one and group tutoring, counseling, and social activities.

B. Intervention Methods:

1. **Children:** children of all ages are accepted at the shelter and complete age-appropriate screenings and assessments for early intervention and referrals.

   a. Direct childcare provided on the premises: art therapy and play therapy in addition to early childhood development focused on cognitive, emotional, physical and social skills.

   b. Children's advocates work with child and parent to secure necessary education, medical, and social support for the child.

   c. Children may also receive individual or group counseling, either onsite, or community, school or hospital-based, if necessary.

2. **Parents:** complete mental health intake to identify personal and parenting needs.

   a. Advocates work with mothers to secure housing, economic, legal and protection assistance.

   b. Counseling may be individual or group; parents may participate in art therapy.

   c. Referrals for mental health needs and substance abuse treatment.

3. **Providers:**

   a. Children's Advocates: background in early childhood education and development; experience with childhood trauma.

      1. Provide direct childcare.

      2. Direct art therapy, play therapy and referrals for early intervention.

      3. Provide mothers with Individual Parenting Support to help mothers:

         a. Understand how children have been effected by domestic violence and/or child abuse.

         b. Address the need of their children while in the shelter.

   b. Women's Advocates: experience in and understanding of domestic violence and abuse issues.

      1. Complete assessments Mental Health Intake.

      2. Identify other necessary assessments (substance abuse).

      3. Collaborate with mothers to secure education, medical, legal, mental health, and social services for herself and child.

V. **Assessments:**

A. **Children:** complete appropriate assessments according to age - infancy (0-2), preschool (2-5), school aged (6-12), adolescents (13+).

1. **Children's Services Intake**: developed in collaboration with the Child Witness to Violence Project at Boston Medical Center; meet with mother and child to complete a developmental history and determine the history of abuse; and design a treatment plan.

2. **Denver Screening for Infants and Toddlers**.

3. **Earling Screening Inventory** (Miesels, Henderson, Martson, & Olson, 1983).

B. **Mothers:** complete **Mental Health Intake:** an open-ended questionnare complete by self report.

a. History of childhood and adulthood abuse.
b. History of alcohol and drug abuse.
c. Family of Origin and Nuclear Family Genogram.
d. Identify signs of PTSD and trauma, assess and develop a treatment plan.

VI. **Outcomes:** A four-year follow-up study to determine the correlation between substance abuse and trauma (incurred by domestic violence and child abuse), was conducted by the Center for Substance Abuse Prevention ("Project Basta," grant # SP0509) in 1995, and directed by Michelle Drum, however the report and findings could not be obtained.

Responsive Advocacy for Learning and Life in Youth (RALLY) Project: Brighton, Massachusetts - piloted in 1995

Director: Gil Noam, Ph.D.

Site Coordinator: Kim Pucci, Ed.M.

Program Coordinator: Kendra Winner, Ed.M.

I. **Description:** A School-based Academic and Psychosocial Intervention Program

A. A collaboration between the Boston Public Schools, Massachusetts General Hospital, McLean Hospital, Harvard Medical School, and Harvard Graduate School of Education, funded in part by the Boston Public School Department's "Vanguard Project" and private grants.

B. Designed to facilitate the inclusion of students with emotional, behavioral and learning problems in the regular education classroom through mentoring relationships to promote resiliency in learning and life.

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C. Provides services to 20-40 middle school students with a focus on sixth and seventh grade prevention and intervention and a limited follow-up component for eighth grade students who participated in the program previously.

D. At least twenty-five percent of students receiving services through the program have been involved with the court through the Department of Social Services and/or the Department of Youth Services for abuse and neglect or through a Child in Need of Services Petition (CHINS).

II. Theoretical Framework:

A. Program is founded on resiliency theory and is a "developmental intervention focused on the capacities of children to overcome problems," utilizing multiple methods to enhance the unique strengths of each child.

B. The ecological approach is also a fundamental part of the program which attempts to connect the student and his/her parents to the necessary supports in school (peers and teachers) the community, and with other providers in the student's life.

C. Cognitive-behavioral theories and theories of moral development guide the everyday activities of the prevention practitioners in class and counseling.

III. Objective: To provide students at risk with support to prevent academic failure, anti-social and delinquent behavior, and to promote self-efficacy, interpersonal, and academic success.

A. Students: Help students develop a commitment to school, improve academic achievement, develop positive social relationships, and bridge the fragmented spheres of family, school, and community.

B. Parents: Facilitate school-home communication and provide parents and families with support.

C. Community: Establish partnerships with the community in supporting at-risk students and families and incorporate community-based services as an intervention option.

IV. Method: An entire "cluster" of students in the same grade complete initial assessments to identify students at risk, with those identified being matched with a prevention practitioner. Students may be self-referrred or referred by teachers, prevention practitioners, and student support services.

A. Students: Complete further detailed assessments, and the prevention practitioner designs an intervention program with the student, based on assessment results and contextual understanding of the student's strengths and coping skills.

1. Classroom: assist students identified and other students in the classroom with academic work.

2. Counseling: work with student outside of classroom (refer for further evaluation with psychiatrist if needed).

a. One-on-one

b. Pairs

c. Groups: designed in collaboration with the student support services or independently on a yearly basis as needed.

(1) boys' group

(2) girls' group

(3) violence prevention group (1995/1996)

(4) Vietnamese girls' group (1996/1997)

3. After School Program: for academic tutoring and social skills development - currently coordinating a partnership with the Boy's and Girl's Club.

4. Community-based referral: for health/mental health services.

B. Prevention Practitioners: Masters of Education students work in the classroom, school, and community with middle school students.

1. Establish mentoring relationship of trust and structured support through academic tutoring, individual and/or group counseling, and social activities.

2. Communicate and collaborate with teachers regarding student strengths, appropriate teaching methods, and progress.

3. Establish a working relationship with parents and families to link school and home.

4. Weekly training session with director, site coordinator, program coordinator, and three post-doctoral psychiatrists completing fellowships in child psychiatry.

5. Weekly supervision with director and/or site coordinator to focus on individual cases and action plans.

C. Director, Program Coordinator, Site Coodinator, and Psychiatrists: Provide ongoing support to students and staff.

1. Complete periodic classroom observation of students in the program.

2. Evaluation and referrals for students with severe behavioral, emotional, and learning problems.

3. Develop and oversee quantitative, qualitative, and longitudinal data collection and research.

V. **Assessments:** To measure student progress in terms of academic performance, social skills development, psychological and emotional development and maturity.

A. An entire cluster (96) of students in grade six or seven complete:

1. Youth Self Report For Ages 11-18 (Achenbach 1-91 edition).

2. BECK's Inventory For Depression.

B. Student's identified as at-risk (32) complete:

1. **Harvard RALLY Project Student Information Questionnaire** - provides detailed family, nationality, medical, school (including special needs and standardized test scores), disciplinary history, and *court involvement* information.

2. **Student Profile** - highlights the student's interests, school/personal goals, home/family/interests, school and community services.

3. **Teacher's Report Form** (Achenbach 1/91 edition) - provides detailed academic performance, perspective on academic and social development, IQ, readiness and/or aptitude testing, motivation, self-control.

4. **Harvard-Taft Classroom Behavior Scale** - completed by director or psychiatrists through direct observation of the student to provide a third perspective and completed periodically throughout the year to note progress.

C. **Parent Contact Form** - completed by the prevention practitioner each time contact/conversation with parent occurs, noting the purpose, information gathered, impressions, and plan for action.

VI. **Outcomes:** Follow-up data for 6 eighth grade students who participated in the project in seventh grade is being collected and analyzed.

A. Project Status - project is in the third phase:

1. Phase one: implementation in the seventh grade cluster (1995/1996);

2. Phase two: creation/introduction of new assessment tools (student questionnaire) with seventh grade and follow-up with first group (1996/1997);

3. Phase three: implementation in the sixth grade (1997/1998) and follow-up with eighth grade students.

B. Quantitative - creating a database for follow-up through grades, disciplinary action/involvement, and attendance.

C. Qualitative - academic and personal development.

1. Improved peer/peer and adult/peer relationships and interactions.

2. Increased school and community connections.

3. Improved self-reflection and esteem and more balanced internalizing/externalizing behaviors.

Conclusion

Both researchers and practitioners rely on multiple theories of CAN or combinations of theories in their work. Social learning and attachment theory underlie most theoretical explanations of and treatments for CAN. However, current approaches are increasingly incorporating ecological and resiliency theories. Knowledge has increased about victims' differential responses to CAN based on type of abuse, individual and family characteristics, and racial and cultural differences. Researchers are also beginning to gather substantially more data on how victimization may lead to delinquency and criminality.

Currently the most significant gaps in research are how victimization impacts development and which interventions are effective. Researchers have established a reasonable understanding of how symptoms manifest themselves differently according to development and the ages at which victimization may be most detrimental but are uncertain how victimization impacts further development. It is also unclear whether or not the consequences of abuse in adulthood can be averted during childhood or adolescence.[143] This lack of knowledge makes it difficult to determine if the changes victims experience over time are consequences simply of time, intervention or both. Specifically, researchers need to determine how the passage of time impacts CAN victims' development and whether interventions in childhood and adolescence can promote and sustain healthy development into adulthood. Future research is needed to determine the efficacy of early and later intervention and which interventions are best suited to specific groups of victims.

Background Paper #3:

Policies, Practices and Statutes Relating to Child Abuse and Neglect

Kerry Murphy Healey, Ph.D.
Abt Associates Inc.

October 3, 1997

Introduction

Interventions to manage the consequences of child abuse and neglect (CAN) operate in the institutional context of State and Federal laws, the bureaucratic structures and procedures adopted by each State's child child welfare agencies; local policies; and each State's criminal justice system. Each of these may constrain or facilitate intervention in child abuse and neglect. This paper considers the role of each of these influences on child abuse and neglect policies and services, reviews current innovations in the field and concludes with an overview of proposed reforms to the child protection services system.

Responsibility for child protection and welfare is reserved by the Constitution for the States. Each State's system of child protection is a complex web of services and regulations constructed of State statutes, voluntary acceptance of federal funding and oversight, State department of social services policies, court mandates and local regulations and agreements.

- **Federal legislation**, through restricted funding streams, indirectly influences and constrains State-level CAN programming and child protective services (CPS) procedures while providing an overlay of similar program goals and case management procedures across State systems.
- **State statutes** define child abuse and neglect, identify mandatory reporters and reporting procedures and specify the overall structure of CPS in the State.
- **Policies and procedures** for intervening in CAN, including how reports are screened, investigated and assessed; cooperation with other agencies, including the criminal justice

system; and how services are delivered may be specified by State, county or local departments of social services (see exhibits 3-1A, 3-1B and 3-1C.)

- **Courts** may also require CPS to provide services or adopt practices in line with legislative mandates.[1] The functioning of the courts may speed or delay decisions concerning permanent placements for victims of CAN.

There is an unusual degree of consensus among child welfare workers, researchers, politicians, criminal justice professionals and the public that current systems for safeguarding abused and neglected children are hobbled by fragmentation of services and policies. Child protective services (CPS) are often criticized for failing to find a proper balance between parental rights, child safety and family privacy--supplying insufficient safeguards to children, in some cases, while being too punitive and stigmatizing to families in others. Academics and child welfare practitioners working together on these issues have advanced a number of cogent criticisms of the current child protection structure. Key problems cited include:

- *Inadequate service delivery.* Many victims of CAN, especially those suffering neglect, receive very limited services or no services at all. In 1996, the National Committe to Prevent Child Abuse (NCPCA) estimated that 30 percent of substantiated CAN cases (or approximately 290,700 children) receive *no* services, with individual State's estimates of cases receiving no services ranging from 0 percent to 85 percent. [2]

- *Poorly organized or inadequate family needs/risk assessment and investigation.*

- *Insufficient service availability.*

- *Lack of emphasis on the development of natural or informal "helping networks"* such as friends, relatives, clergy, neighbors, community groups.

- *Failure to link CPS to substance abuse and domestic violence treatment services,* despite the identification of substance abuse as the primary presenting problem in CPS case loads.[3]

- *Failure to achieve permanency for out-of-home placements in a timely manner* and thereby limit the risks posed by multiple placements and disrupted attachment for the child.[4]

This paper attempts to place these issues within their legal and institutional context so that policymakers can better understand how systems might be changed to support effective interventions with victims of CAN.

Child Protective Services, Child Welfare and the Criminal Justice System: Case Processing from Report to Intervention[5]

In 1995, more than three million reports of child abuse and neglect were received by State-level child protective services agencies.[6] Since the introduction of mandatory reporting laws in the 1960s, the burgeoning number of child maltreatment reports has stretched the CPS system to its limits--increasing from just 4 reports per 1000 children in 1975 to 47 reports per 1000 children in 1994.[7] The actual number of CAN cases is thought to be even larger: other CAN victims who may not be reflected in the number of reports received by State CPS agencies include children of military personnel or Native American children, who are protected under other systems.[8] This section attempts to describe how a typical State CPS system responds to and processes reports of abuse and neglect. While there are many differences between States--as well as between counties or localities within each State--many share core practices.

Screening Reports of Abuse and Neglect

Reports of child abuse and neglect frequently involve families in crisis. Which agency (if any) responds greatly depends on the nature of the crisis or reported incident, the degree of danger to the child, and the availability of services. Child abuse may be reported first to the police, who may investigate and/or refer the case to child protective services. Alternatively, CAN reports may be received directly by CPS, who then screen reports to decide whether law enforcement investigation is appropriate (most often, in cases of sexual abuse or severe physical abuse or neglect.) Crimes against children by strangers are investigated by law enforcement but may not meet the criteria for intervention by CPS (see below). Commonly, no attempt is made to assess the overall service needs of the family at the time of a report. Instead, screening criteria are used to limit investigations to reports involving emergencies to which the system must respond to ensure the safety of the child. In most States, CPS screens according to the following three criteria:

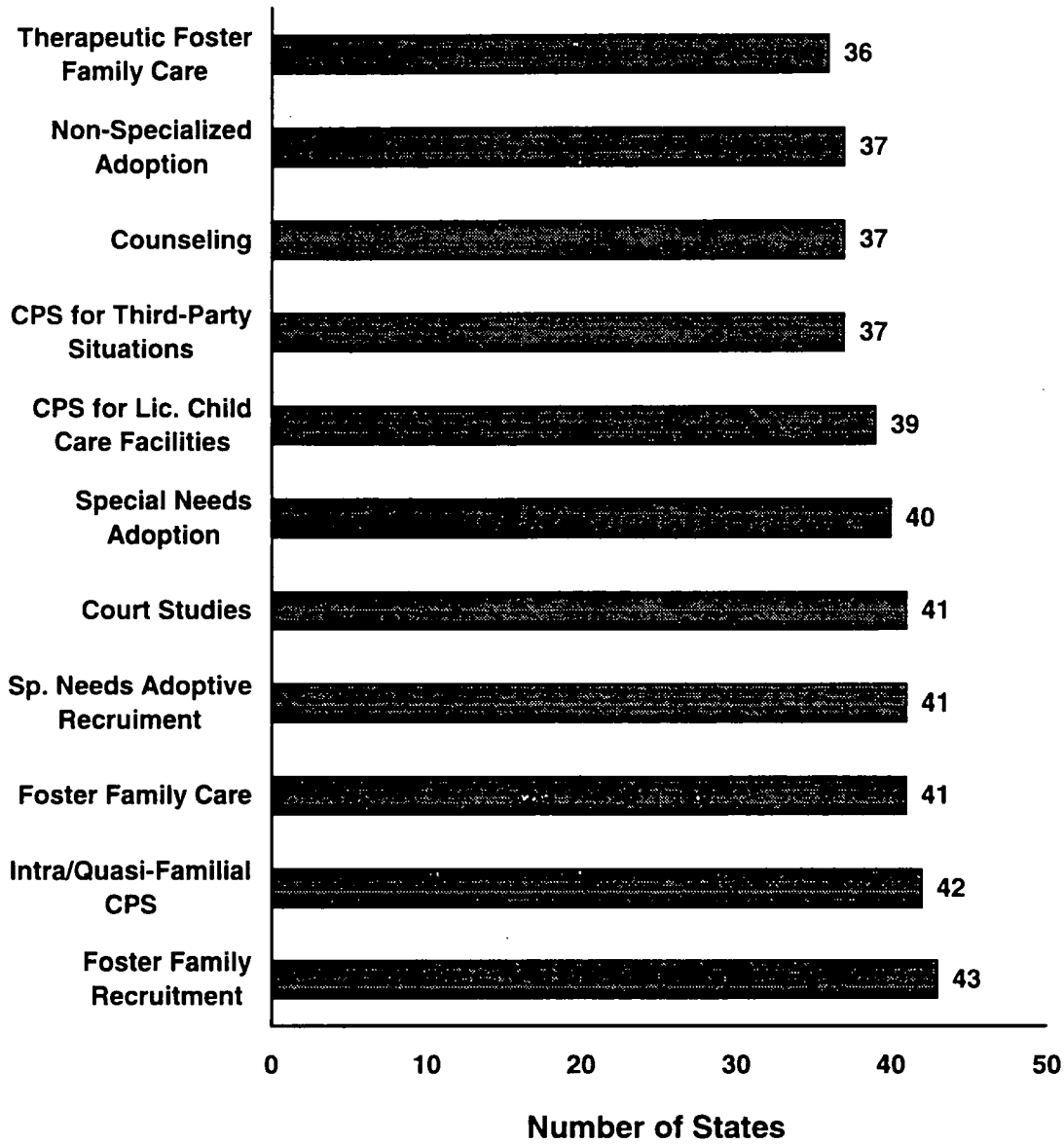
1. Reports must concern children under 18 years old;

2. The reported abuser must be responsible for the health and welfare of the child (e.g., a parent, caretaker or guardian); and

3. The report must allege abuse or neglect constituting evidence of harm to the child or a risk or threat of harm to the child.[9]

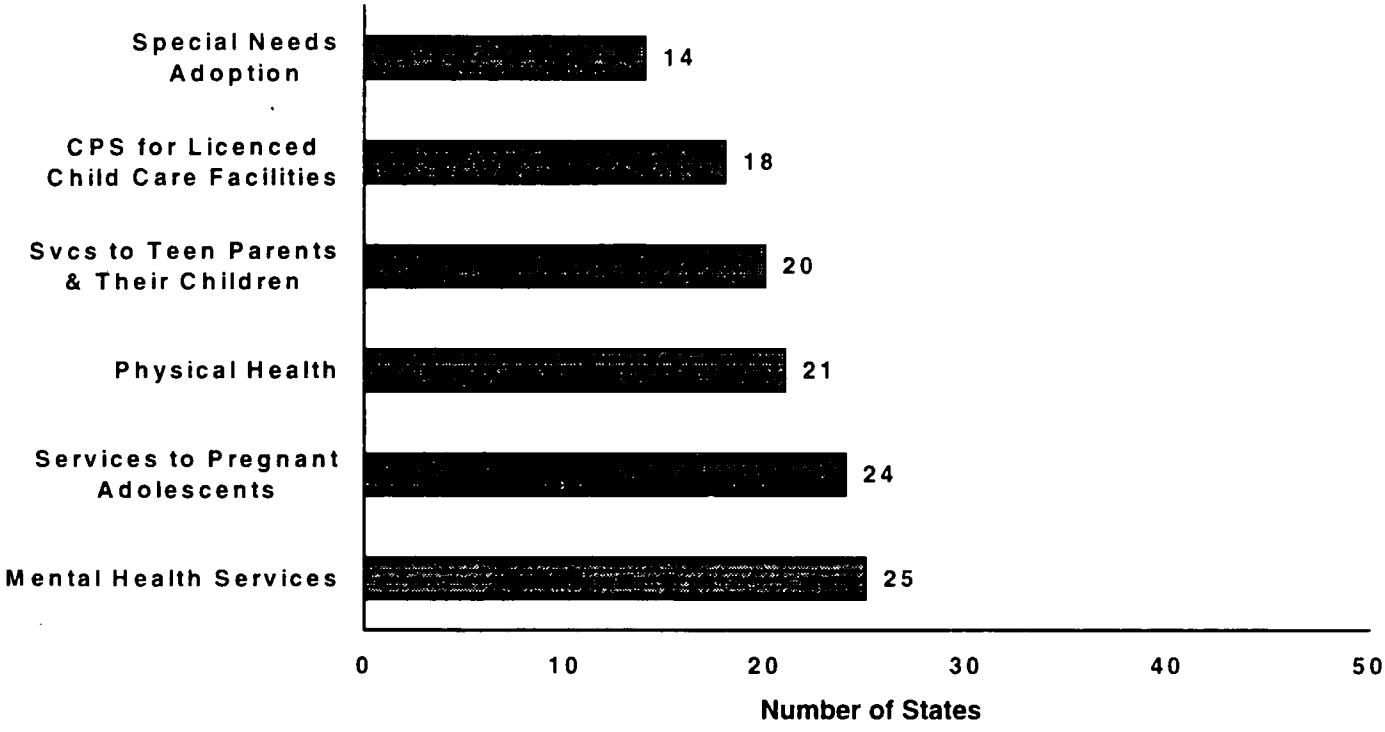
Exhibit 3-1A

Services Delivered by Public Child Welfare Agencies

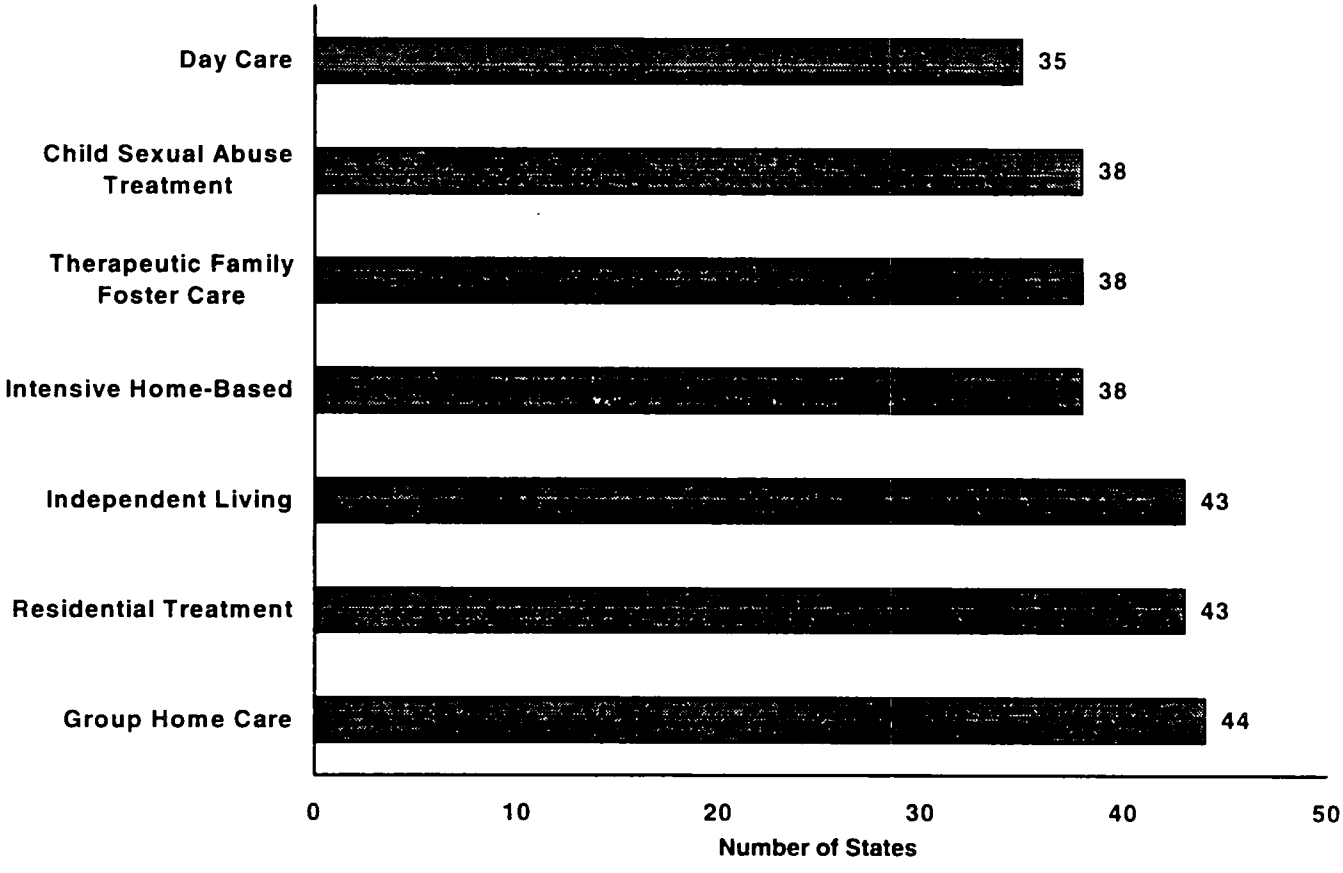


Source: American Public Welfare Association, *Factbook*, 1990.

Exhibit 3-1B
Services Delivered by Other Divisions Within the Public Child Welfare Agency



Exhibt 3-1C
Services Delivered by Contract Providers



Source: American Public Welfare Association, *Factbook*, 1990.

Additional criteria used in some States include: information concerning the location of the child and abuser (seven States); factual allegations that meet statutory or policy definitions of CAN (twelve States and the District of Columbia); and an array of factors including the timing and severity of the abuse, the age of the child, the relationship of the perpetrator to the child and the willingness of the parents to protect the child (six States.) Families not yet in crisis, but in need of preventative services (for example, those who are recently homeless or parents struggling with drug addiction) are unlikely to qualify for CPS assistance and must seek services through other social welfare agencies. (See the discussion of differentiated response, below.)

Investigation

Approximately 50 percent—or 1.5 million—of reported CAN cases meet the screening criteria and are investigated by CPS; the other half are closed due to lack of evidence of abuse or insufficient evidence to compel services.[10] Investigation may involve visiting the family, seeing the child, and interviewing the reporter. In emergency cases, investigation may be undertaken immediately, while a typical investigation begins in one to two days following the report and is completed in less than ten days. In serious cases, the child may be taken into protective custody during the investigation. Waldfogel notes that the investigation process, whether it is conducted by CPS alone or in conjunction with law enforcement, is

> . . . quite intimidating from the perspective of the family. The investigator, after all, is informing the family about allegations, reading a statement of their rights, and/or warning them of a court action to remove the children from their home. Although the investigator may also be trying to assess the family's situation and need for services, the primary focus of the investigation is making a determination as to the safety of the child victim and the likely identity of the adult perpetrator.[11]

According to the American Humane Association, while standards vary for substantiated cases (also termed indicated, confirmed or valid in some States), the general standard used is either:

1) that available facts or circumstances would cause a reasonable person to believe that abuse or neglect had occurred; or

2) there is either "some credible evidence" (18 States), "credible evidence" (11 States and Puerto Rico) or "a preponderance of evidence" (11 States and the District of Columbia) to indicate that abuse or neglect occurred.[12]

Individual States have *extremely* varied rates of substantiation—from 8 percent to 80 percent.[13] This variation spurs debate concerning appropriate levels of State intervention in families, lack of resources

for proper investigation and intervention, and the assessment skills of some social workers. No one explanation for the great variation in rates of substantiation has gained general acceptance.

Approximately 20 percent of investigated cases involve severe CAN requiring criminal prosecution and/or civil proceedings to remove the child from the home. In the remaining open cases (80 percent), the child is judged to be safe at home with the provision of services; typically a family needs assessment is conducted and a service plan is developed consisting of periodic calls or visits from a case worker and, possibly, the provision of some support services or referrals.[14] These services and referrals may be provided directly by CPS workers, by related child or family welfare agencies or by private community-based contractors (see exhibits 3-1A to 3-1C.) Within the 80 percent judged to be safe at home, a small portion of especially high risk families may be singled out to receive intensive family preservation services.

Intensive Family Preservation

As of 1991, 31 States had piloted family preservation programs, and Federal and State legislative interest in family preservation programming remains high (see below.)[15] In jurisdictions that have intensive family preservation programs, case screening includes the identification of families of children who are at *imminent risk* for out-of-home placement. High-risk families are provided with a social worker with a limited case load (as few as two families) for four-to-six weeks of intensive intervention. (Systems differ, one jurisdiction offered a modified version of intensive family preservation that allowed for larger case loads and a longer service period of three months.) The services are home-based, family centered, community-centered, crisis oriented and intended to enhance family functioning and empower families to solve their own problems.[16] Homebuilders, one of the most common family preservation models, expects social workers to provide an extensive and diverse group of services including parent effectiveness training, emotion management, interpersonal skills building, assertiveness training, clinical assistance and referrals, advocacy and a range of practical and material assistance such as, money management, job assistance, academic training, and assistance in building informal support networks. At the end of the intervention, successful cases are transferred back to CPS workers with regular case loads for follow-up.

Children in Out-of-Home Placement

In the most severe cases, CPS requests temporary custody of the child in the family, probate, juvenile or district court. The child may be placed in foster care or in kinship care (if the relative's home is

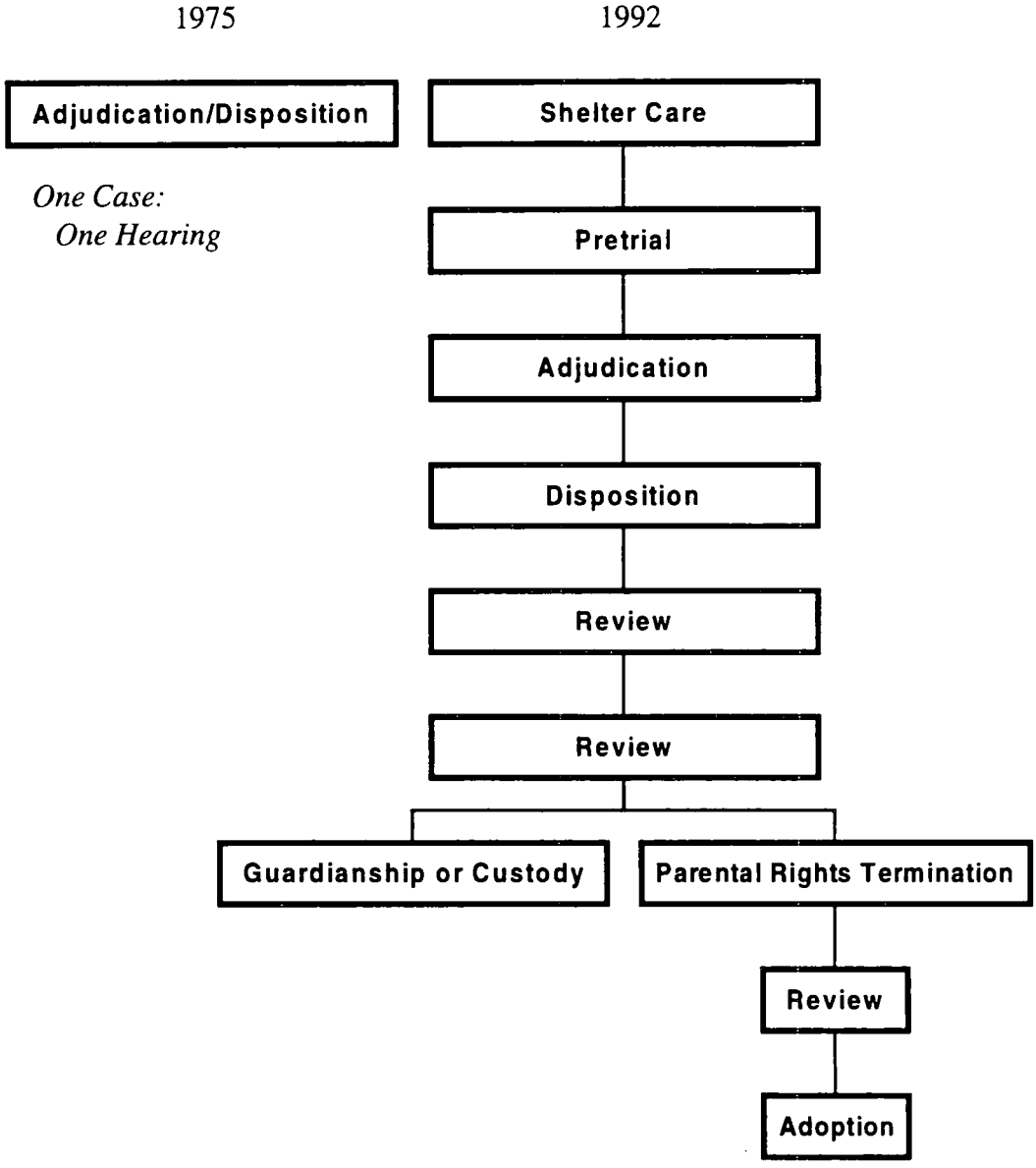
inspected and approved).[17] The case worker conducts a family assessment and creates a service plan for the family that may include services and goals for both the child and the perpetrator as well as any non-abusing caretaker. A typical service plan for abusive and neglectful parents hoping to regain custody of a child in out-of-home placement might include (as appropriate) compulsory services such as substance abuse treatment and periodic urine screens, attendance at AA meetings, mental health counseling, battered women's counseling and batterer intervention, parenting classes, and/or stipulations that the parent obtain adequate housing, maintain household hygiene, abstain from drug use and criminality, take required medications and demonstrate interest in the child through regular visitation.[18] Typical service plans for older victims in out-of-home care may include psychological counseling, substance abuse treatment or independent living skills training (for teens) and may stipulate behaviors, such as attending school, obeying foster parents' house rules and cooperating with visitation. The duties of foster parents and CPS workers may also be laid out in service plans. Case workers may be expected to contact the child, the parents, schools and key service providers monthly and to monitor the child's medical care. Compliance with these plans is periodically reviewed (usually every 6 months) to monitor progress toward goals and to reassess the appropriateness of the goals. For children in out-of-home care, CPS may seek as a goal family reunification, long-term substitute care, guardianship or adoption.

Both Federal and State-level policies attempt to limit the average duration of out-of-home placement; however, a 1995 Massachusetts study found that among a group of 206 severely maltreated children who had been removed from their parents, 21 percent were still awaiting permanent placement seven and a half years later.[19] Delays are frequently blamed on the courts, which are typically required to hold numerous hearings before terminating parental rights (see exhibit 3-2) or on parents who refuse to voluntarily relinquish parental rights over children with whom they cannot (e.g., due to untreated drug addiction or long-term incarceration) or do not wish to be reunited.

Civil and Criminal Proceedings

Civil cases concerning protective custody for abused and neglected children usually involve an attorney for the social service agency (usually a city or county attorney), an attorney for the parents (two, if the parents' interests conflict), and an attorney and/or guardian *ad litem* (GAL) for the child. Child advocates are either lawyers (GALs) or trained volunteers from a Court Appointed Special Advocate (CASA) program (see the box, "The Court Appointed Special Advocate Program.") In criminal cases, children are not represented by a lawyer because they are usually witnesses, not parties

Exhibit 3-2
Typical Sequence of Hearings:
For Child in Foster Care Who Cannot be Returned Home



Source: Hardin, Mark, H. Ted Rubin, and Debra Ratterman Balser, A Second Court that Works: Judicial Implementation of Permanency Planning Reforms." Washington, D.C.: ABA, 1995.

to the case. A social worker or victim advocate may be assigned, however, to explain the proceedings to the child and offer support. This person may assist with the preparation of a victim statement, if requested by the court.

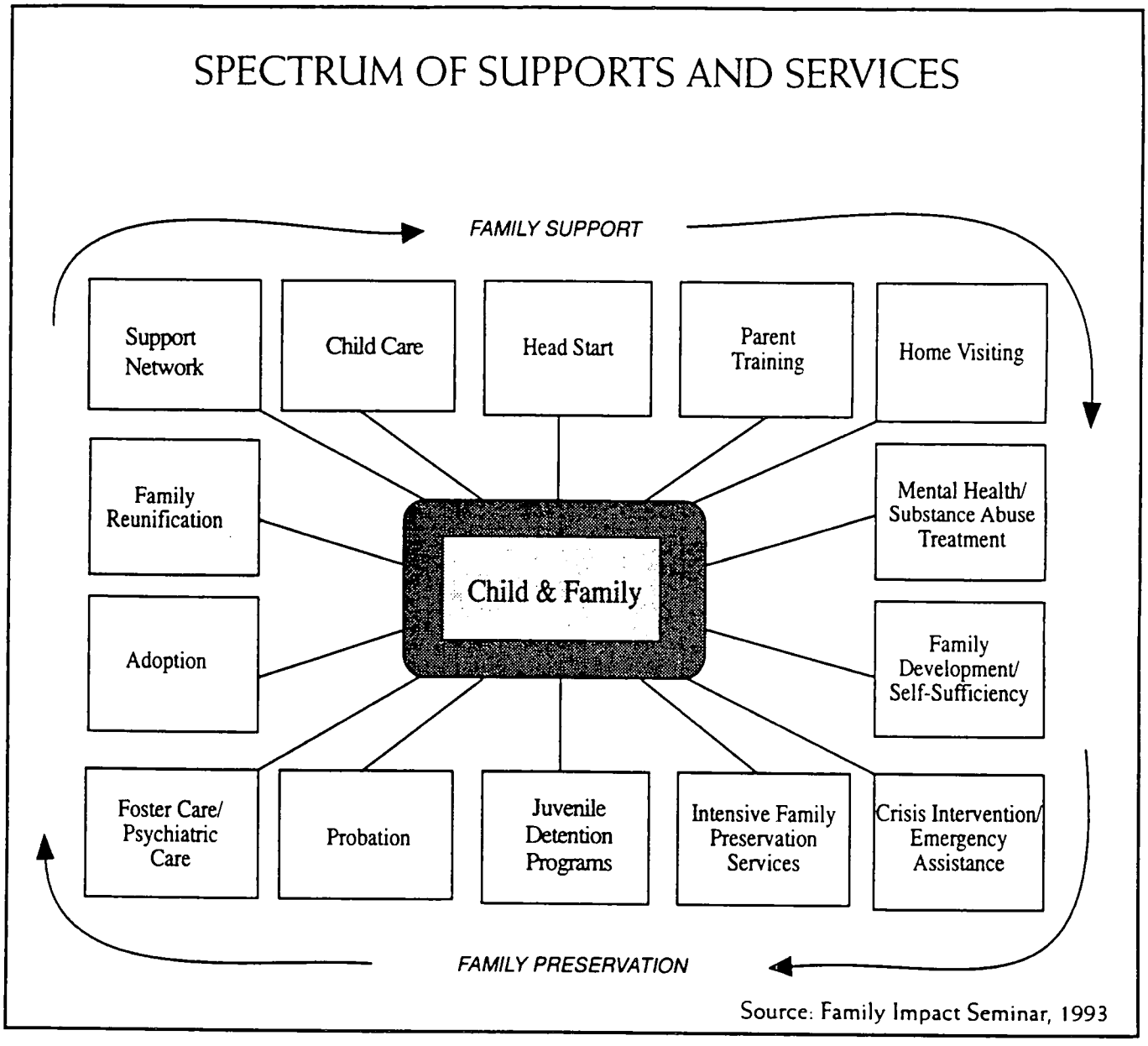
The Court Appointed Special Advocate (CASA) Program

The CASA program, founded in 1977 to assist abused and neglected children appearing in juvenile court, has more than 40,000 volunteers, is available in all 50 States and is known under many names—including Pro-kids, Child Advocates, Foster Child Advocate Services and Voices for Children.[20] GALs and CASA volunteers assist young children who may be unable or unqualified to determine their own best interest and older children who may need their opinions effectively voiced before the court. A child's attorney's recommendations may be different from that of the child advocate, whose job it is to seek the best interest of the child over the child's own wishes, if necessary. Child advocates are important to the system because they are thought to be more likely to have investigated the case thoroughly and to have met with the child due to the small number of cases they typically handle.

Issues Raised by Current Practices

The current model of CPS—as its name implies—is heavily weighted toward child protection as opposed to the promotion of child and family welfare or preventative intervention with high-risk families. Many of the children who are the subject of unsubstantiated reports of CAN, as well as those in substantiated cases receiving only minimal services, may be at substantial risk for future abuse or other negative outcomes, such as poor school performance or delinquency. Because the current model of CPS is incident-based, chronic low-grade abuse and neglect are least likely to qualify for services. Research on the long-term effects of chronic neglect and more subtle forms of abuse such as witnessing domestic violence or emotional and psychological abuse, suggests that the crisis-orientation of the current system overlooks the substantial harms resulting from these other abusive behaviors (see Paper #2.) As discussed below, five States' experiments with differentiated response—a screening system that creates two tracks of CAN cases, those in need of combined law enforcement and CPS response and those in need of intensive family services—are an effort to bring services to a broader range of CAN victims and their families in a more supportive, less adversarial context.

Exhibit 3-3


SPECTRUM OF SUPPORTS AND SERVICES
FAMILY SUPPORT
Support Network
Child Care
Head Start
Parent Training
Home Visiting
Family Reunification
Mental Health/ Substance Abuse Treatment
Child & Family
Adoption
Family Development/ Self-Sufficiency
Foster Care/ Psychiatric Care
Probation
Juvenile Detention Programs
Intensive Family Preservation Services
Crisis Intervention/ Emergency Assistance
FAMILY PRESERVATION
Source: Family Impact Seminar, 1993

but also medical neglect, psychological maltreatment, and deprivation of those things (physical and moral) necessary for healthy child development.

Statutory definitions of abuse and neglect are diverse, but many contain similar definitions of the following three crimes:

- **Physical Abuse** —the non-accidental infliction of physical harm to a child (a child is usually defined as someone under 18 years, but some jurisdictions stipulate a lower age, 15 or 16 years old.) The regulation of the use of corporal punishment by parents or other caretakers remains controversial. The majority of States (29 States) explicitly permit the "reasonable use of force" by parents or other official caretakers to discipline a child. Other States define excessive corporal punishment in separate statutes (7 States) or as part of the statutory definition of child physical abuse (11 States).

- **Neglect**—failure (by omission or intentionally) to provide a child with the basic necessities of life, such as food, shelter, clothing, medical care, and in some jurisdictions, education.

- **Sexual Abuse**—All States distinguish between sexual offenses against children (those under the age of 18) and those against adults. In general, States define three categories of sexual offenses against children:

    1. Sexual penetration (vaginal, anal, oral intercourse);
    2. Sexual contact; and
    3. Incest

    Incest laws vary widely by State, but penalties generally take into account the age of the victim, the closeness of the blood relation, and the presence of force. Penalties for other forms of sexual abuse differ based on the relationship between the offender and the victim (e.g., custodial, teacher, or stranger); the age of the victim and offender; and the circumstances of the assault (e.g., force, threats, weapons, or bodily harm.)

Most cases of child abuse and neglect are not criminally prosecuted. Penalties imposed for even severe physical abuse are generally low, not more than five yearsincarceration. However, penalties for sexual abuse generally range from one year to life imprisonment. As a matter of public policy, it is debated whether the criminalization of child physical abuse and neglect achieves an improved environment for the child. Some observers note the negative impact of fines, imprisoned parents, or out-of-home care on child welfare. On the other hand, most commentators accept that criminalization has symbolic importance. Many of the structural innovations discussed in this paper aim to balance the criminal justice and social welfare response so that children are best served.

Other Forms of Abuse Prohibited by Statute

The traditional legal phrase "endangering welfare" is much broader than most modern definitions of child abuse and neglect, encompassing physical abuse, neglect, abandonment, criminal non-support, psychological maltreatment, passive abuse (such as the "non-offending" parent who fails to intervene in or report abuse or neglect), or contributing to the delinquency or truancy of a minor. Statutes using this language currently are being replaced with ones using more precise definitions that define these offenses separately.

Psychological Maltreatment

Psychological abuse or maltreatment is beginning to be addressed in the criminal codes of some jurisdictions. Psychological maltreatment is an implicit component of all forms of child abuse, and this is defined in terms of the outcomes of abuse for the child: "any abuse, physical or verbal, that results in behavioral, developmental, or psychological problems in the child."[27] Five types of psychological maltreatment are identified in some statutes:

- Spurning (verbal degradation/ rejection);
- Terrorizing (verbal or situational threats);
- Isolating (confinement);
- Exploiting and corrupting (encouraging antisocial behavior); and
- Denying emotional responsiveness.[28]

As of 1991, 21 States include severe psychological maltreatment in their child abuse statutes.

Abandonment

Abandonment is given different definitions in the civil and criminal law. Under civil law it is a ground for the termination of parental rights. Its most common definition in civil law is "parental conduct indicating a conscious disregard of the obligations of parenthood."[29] The common definition under criminal law is far more literal: The parent or legal custodian must desert the child "intending permanently to abandon the child."[30]

Failure to protect from abuse and neglect

As of 1991, twenty-four States had statutes penalizing persons responsible for children for failing to intervene and prevent child abuse, even when that person is also being victimized. Most statutes, however, allow as a defense to the crime of failure to protect a child from abuse and neglect the fear of "serious or substantial" bodily injury.

Homicide by abuse

In the past, deaths of abused children were difficult to prosecute as first degree murder because it was hard to show evidence of intent to kill—indeed often the defendant did not intend to kill the child, only to abuse severely. Seventeen States now have separate penalties for homicide by abuse that do not have the same evidentiary requirements as other murders, thus allowing these deaths to be punished at the same level as first degree murder.

Medical neglect

Twenty-six States exempt parents from medical neglect charges if they claim a religious right to alternative spiritual treatments. Courts weigh the potential danger to the child and the State's interest in protecting the welfare of the child against the parents' parental and religious rights. However, if death results from non-treatment, the U.S. Supreme Court has taken positions on religious freedom that would permit prosection.

Mandatory Reporting Requirements

In most States, mandatory reporting laws were passed in the early 1960s in response to publicity concerning Kempe's identification of the "battered child syndrome."[31] Perhaps due the rapid time frame in which these laws were enacted, there is a great deal of consensus among State statutes regulating mandatory reporters of child abuse and neglect. Fourteen States with the most sweeping statutes (Idaho, Florida, Kentucky, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, Oklahoma, Rhode Island, Tennessee, Texas, Utah, Wyoming) use the formula "any persons" or " any other persons" following an almost standard list of mandatory reporters:

- Medical care providers (including dentists, podiatrists, medical examiners, and Christian Science Practitioners);
- School and day care staff;

in the near future.[36] Other States, such as New Hampshire, South Carolina and South Dakota have instituted similar changes without legislation. Most models emphasize thorough family assessment leading to a two or three-tiered system intended to segregate cases requiring investigation and court-involvement (as well as services) from those families needing only services. The goal of differentiated response is to make child welfare and service provision central to CPS and to reduce unnecessary and stigmatizing investigations that may alienate families in need of services.

Florida—Florida has instituted sweeping changes to reduce State-level CPS regulations, devolve more policy-making power to counties, and to establish a dual-track response system that separates the investigative function—now handled by law enforcement—from the family-centered services that now typify CPS in Florida. Both investigative track and assessment track families receive the same services, however, the courts oversee the investigative track cases to insure child safety. At the heart of the new system is the elimination of the traditional dual function of CPS (investigator/service provider), to allow social workers to focus on developing more supportive and less adversarial relationships with children and families receiving services. To establish the separate and supportive role of CPS, first contact with investigative track families is made by both a police officer, who investigates the allegations, and a Family Services Response System case worker who is there as a service provider. (See Appendix A.1)

Missouri—Missouri has funded five pilot projects testing a dual track case management system that separates investigation of child abuse and neglect reports from family assessment and service provision. The idea behind the Missouri dual track system is to insure that resources are available promptly to both types of cases, not only the most serious cases. Like Florida's system, the Missouri pilot programs will use law enforcement officers to investigate serious cases of child abuse and neglect, while CPS workers simultaneously offer services to families without assigning blame. Participating Departments of social services will be asked to restructure costs to fund community-based service provision. Evaluations of the pilot programs will be provided to the State legislature with a view to expanding the system State-wide. (See Appendix A.2)

Virginia—In 1996, the Virginia legislature directed the Department of Social Services to establish a three-year program in three to five areas of the State piloting a multiple response system to reports of child abuse and neglect. Like Florida and Missouri, the Virginia

legislation envisions a dual-track system where more serious cases are investigated in coordination with law enforcement and less serious cases receive family assessment and access to community-based services. (See Appendix A.3)

Co-location of Personnel Serving Abused and Neglected Children

Abused and neglected children and their families are often involved with a number of public agencies and private service providers, including police, prosecutors, civil lawyers, victim advocates, social workers and an array of private service providers. The following initiatives attempt to bring these disparate groups together to facilitate case management, service delivery, crisis intervention and case investigation and to make service utilization easier, less intimidating and less stigmatizing for victims and their families.

Neighborhood-based services

Three States have enacted legislation mandating or facilitating the creation of neighborhood-based multiple service delivery teams or service sites, and similar legislation is being considered in other States. Hawaii will establish a pilot project in two locations, "Neighborhood Places," where public (including CPS) and private child welfare services can be delivered. Kentucky has its own version of a "Neighborhood Place" pilot program, where CPS and other services are offered in a school-based setting. The PATCH project in Iowa is a locally-initiated project to deploy neighborhood-based CPS service delivery teams to assist families and children.

Children's Advocacy Centers (CAC)

Children's Advocacy Centers provide a safe, child-friendly environment for crisis intervention, criminal investigation, medical treatment and service provision for victims of severe child abuse and their non-offending family members. Typically CACs bring together under one roof representatives from the many agencies that are involved with severe cases child abuse: CPS workers, law enforcement officers, prosecutors, medical services personnel, mental health professionals and victim advocates. By providing crisis intervention, investigation and services at one child-oriented location, the child victims served by these centers (who are most frequently victims of sexual abuse) are able to tell their stories to joint investigation teams, thus avoiding the stress and revictimization associated with repeated questioning in various institutional settings. Victims also benefit from the increased case coordination and enhanced judgement of Multidisciplinary Case Review Teams.

The first Child Advocacy Center was founded in Alabama in 1985. Today the National Network of Children's Advocacy Centers has 124 full member programs, 12 State chapters and 73 associated member agencies. A further 200 programs are in development across the country. CACs are located in a variety of settings—in the community, in prosecutor's offices and hospitals—and receive funding from many sources, including the U.S. Department of Justice's Office for Juvenile Justice and Delinquency Prevention (OJJDP) and the Office for Victims of Crime (OVC). A number of CACs limit their services to victims of child sexual abuse, others will accept a limited number severely physically maltreated children as well. These priorities reflect a desire to target services to those populations most likely to be involved in criminal investigations and prosecutions. As States and counties reform their CPS systems to formalize the role of law inforcement in investigative track CAN cases, the CAC model merits consideration for broad replication because it provides a mechanism for the appropriate involvement of law enforcement and prosecutors with victims of CAN.

Travis County, Texas, Child Protection Team

The Travis County, Texas, Child Protection Team is a collaboration between the district attorney's office, the county sheriff's office (with their victim services division), the Austin Police Department (with their victim services division), the Travis County Children's Advocacy Center and the Texas Department of Protective and Regulatory Services. The Child Protection Team executive committee recognizes that each of these agencies contributes to child protection and welfare and that collaboration among agencies will reduce child revictimization by investigative agencies, optimize information sharing and result in more efficient and appropriate case management (see Appendix B for interagency agreements.) The Child Protection Team staff—which is housed together and hopes to move its office closer to the county's CAC—includes one senior prosecutor, a police officer, a sheriff and social workers from child protective services. According to Assistant District Attorney LaRu Woody, Director of the Family Justice Division, team members work together to investigate physical and sexual abuse allegations. Advantages to the system include shared information, cross-disciplinary expertise, the ability to interview the victim only once and increased coordination between lawyers handling civil and criminal cases concerning the same child or family. Woody observed that team members shared general knowledge as well as case information; for example, experienced law enforcement officers were able to assist newer social workers who were unfamiliar with CAN investigations.

Family Decision-Making Models

The New Zealand Family Group Conference model, based in part on traditional Maori practices, emphasizes the involvement of extended family networks in stopping family violence and making decisions about the welfare of children. In Canada, Newfoundland and Labrador are currently piloting family group decision-making models based on feminist analyses and Canadian aboriginal practices that emphasize "reintegrative shaming," communal responsibilty and allowing all family voices to be heard.[37] Similar family-centered decision-making models—such as the Oregon Family Unity Model (see Appendix C)—have been adopted in Oregon to assist with child protection and welfare decision-making. In addition, family group decsion-making models are being considered in other States, such as Kansas, Michigan, and Illinois.

In Oregon, family group decision making is the first route of intervention for both substantiated and unsubstantiated cases of CAN.[38] Participation in family group decision making may be voluntary or involuntary and may take one of two forms:

- ***Family group conferences*** are one-time meetings in which the family is allowed during one part of the conference to meet alone to create their own solutions and plans before rejoining the professional social workers, who then help them formulate a plan to be presented to the courts; or

- ***Family unity meetings*** are planning and problem-solving sessions facilitated by the social worker or, preferably, an impartial person (so that the social worker can participate). They follow a prescribed agenda moving from an introduction of all the people present in relation to the child, to a statement of purpose, a statement of concerns (family and agency), family strengths assessment, an enumeration of options, the development of a written list of formal and informal family supports, and concludes with a decision and a timeline for implementation.

In Oregon, family group decision making is cost neutral, and reported to work well with the most difficult cases. According to John Powers, Supervisor and Branch Manager of the Tillamook Services to Children and Families, "If you can enter into a non-adversarial relationship with the family, you have a better chance of getting a positive result."

Integrating Domestic Violence and Child Protection Services

In 1996, eight States passed legislation to address the complex issues involved in intervening with families where both the mother and the children are battered. Most of these laws required State agencies to screen for domestic violence in CAN investigations and to provide services to enhance the safety of the mother as well as the child; others mandate training on these issues for CPS workers.[39]

- Mental health and social workers;
- Law enforcement or criminal justice professionals (including lawyers, judges, guardians *ad litem*, corrections personnel); and, in most States,
- Photographic processors.[32]

The circumstances under which reporters are obligated to contact child welfare officials vary, but all include reason to believe a child has been abused or neglected. A few statutes clarify for film processors and physicians what sorts of events need to be reported. Most commonly, the death of a child must be reported, and any venereal disease or pregnancy in young children must be reported.

Privileged communications

Statutes generally contain a clause on privileged communications. In this regard, there is great variation between statutes. In 12 States, the clergy, when receiving confession or counseling a member of their religion, are specifically exempted from mandatory reporting requirements. In six other States, clergy are specifically compelled to report suspected child abuse, regardless of the source of information or context in which the information was disclosed. There is also disagreement concerning attorney-client privilege: the majority of State's are either silent on the point or specifically affirm clients' rights to privileged communication with their lawyers, but four States suspend attorney-client privilege in the case of suspected child abuse.

Innovative provisions

A few more modern and innovative statutes name as mandatory reporters battered women's counselors, substance abuse counselors or victim advocates. While these persons would be included under the "any other person" clause of a number of statutes, naming them is consistent with current research that points to the co-occurrence of child abuse with partner abuse and child abuse and neglect with substance abuse.

Special Reporting Procedures

A number of States have special reporting procedures relating to drug-exposed infants and child fatalities.

Drug Exposed Infants. Seven States (California, Illinois, Iowa, Minnesota, Missouri, Oklahoma, and Utah) have special reporting procedures for suspected drug-exposed infants and foetuses. Most of these statutes focus on the evaluation and referral of newborns who appear to have been drug-exposed. However, a few States (notably Illinois and Minnesota) focus on the identification of drug abusing pregnant women, and their referral to substance abuse treatment and other services. The Minnesota Statute provides for the "emergency admission" of pregnant women who refuse "recommended voluntary services" or fail recommended treatment. No statute criminalizes maternal drug abuse for pregnant women; however, a finding of infant drug exposure is considered by some statutes to be grounds for a finding of neglect.[33]

Suspicious Deaths. Twenty States have statutes regulating reports of suspicious child fatalities. The majority of these statutes address procedures for mandatory reporters in general or medical examiners in particular to follow in the case of a suspicious death of a child. Forty-eight States have either local or State-wide Child Death Review Teams.[34] Fatality reviews generally focus on process and attempt to determine why the child's contacts with CPS or other agencies (if any) failed to result in appropriate safeguards.

Current Systems Reforms: Innovative Practices

A number of systemic reforms and innovative practices have been undertaken by State legislatures and State or local child welfare agencies to address problems such as inadequate service delivery to low-risk victims of CAN, the fragmentation of services and policies affecting victims of CAN, the stress caused low-risk children and families by CPS investigation and inadequate family engagement in services. Over the last five years, State-level legislation has been the catalyst for a number of systemic reforms including the creation of multiple response systems, the co-location of services for victims of CAN, family group decision-making and the provision of integrated services for families where both the child and the mother are battered. [35] The following section provides examples of some promising innovative practices from both legislation and the field.

The Creation of Multiple Response Systems

A number of States—including Florida, Iowa, Missouri, North Dakota, and Virginia—have undertaken reforms or pilot projects aimed at differentiating meaningfully between types of child abuse reports and to clarify the role of CPS. More States are expected to introduce similar legislation

Another frequently debated issue is the "explosion" of children entering and languishing in foster care. The foster care crisis may be a red herring: the number of children in foster care per 1000 children increased only 55 percent between 1980 and 1994, while reports of CAN increased 161 percent during the same period.[21] In addition, the re-classification of extended family members who had previously received Aid to Families with Dependent Children (AFDC) support for caring for abused and neglected children as funded kinship foster care providers may have created an artificial "surge" in foster care utilization.[22] Finally, as Schuerman points out, caution is needed in interpreting national compilations of substitute care statistics due to incomplete data from some States and data that are not comparable between States.[23] More research is needed to determine the average length of stay in substitute care, recidivism and the proportion children in kinship care before conclusions should be drawn about whether foster care is being misused.

Federal Legislation and Child Welfare

The Federal government's impact on child welfare policy must be indirect because the U.S. Constitution reserves domestic relations and family law for the States. Because participation in Federal programs is voluntary, the program requirements imposed by Federal legislation on funding recipients do not violate the Constitution. The influence of Federal legislation is, nonetheless, quite powerful. For example, federal funding under the Adoption Assistance and Child Welfare Act of 1980 ties foster care funding to the requirement that "reasonable efforts" be made to preserve families before children are removed from their homes. The "reasonable efforts" provisions of the 1980 Act provided a springboard for the piloting of intensive family preservation initiatives across the country and focused CPS resources on family reunification and permanency planning. In addition, the 1980 Act required a case plan for each foster child and reviews to insure that it is being followed. As discussed above, these practices and priorites provide a common thread connecting otherwise disparate State and local CPS systems. Federal legislation not directly addressing child abuse and neglect can also affect State CPS systems. For example, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) that replaced Aid to Families with Dependent Children (AFDC) and related programs with block grants to States known as Temporary Assistance to Needy Families (TANF), raised concerns among some observers that families losing AFDC, food stamp, or Social Security Income (for children with disabilities) are likely to become consumers in the already over-extended child welfare and protection system.[24] Other key Federal child welfare legislation includes:[25]

- **Social Security Act of 1935**—the first Federal statute funding child welfare services. It included: Title IV-A (ADC, later known as AFDC), that addressed the needs of children in families without parental support; and Title IV-B (Child Welfare Services) that provides funding to States for foster care.

- **Child Abuse Prevention and Treatment Act (CAPTA)**—CAPTA was passed in 1974 and has been frequently revised and updated. CAPTA established the National Center for Child Abuse and Neglect (now within the Department of Helath and Human Services) and provided incentives to States to develop systems to identify, report and respond to CAN. CAPTA also funded the development of services for victims of CAN and their families.

- **Indian Child Welfare Act of 1978**—The 1978 Act emphasized the preservation of Native American families and the empowerment of Native American tribes and families to influence decisions concerning their children.

- **Family Preservation and Support Act of 1993**—The 1993 Act provides grants to State CPS agencies to provide family support and preservation services and requires the submission of State plans for reforms in the delivery of child and family services.

Early Federal legislation has been criticized for funding foster care while failing to support home-based family preservation or support services. With the Act of 1993, the emphasis has shifted toward supporting the development of a full spectrum of supports and services for victims of CAN and their families (see exhibit 3-3, "Spectrum of Supports and Services".) [26]

State Statutes Defining Child Abuse and Neglect

The criminalization of child abuse and neglect has its roots in the social reforms of the late 19th century and early 20th century. The neglected or exploited children of the poor were an early target of social and legal reforms intended to remove children from poorhouses or inadequate housing and place them in institutions or substitute care. With the advent in the 1930s of government assistance to mothers and children, the need for this sort of intervention diminished. Historically, the use of physical force to "educate" or discipline a child has been accepted by the law as a private prerogative of a parent, the limiting of which was thought to undermine the family. In the 1960s, however, new theories about physical abuse were popularized by the medical community, and laws to detect and prevent physical abuse multiplied. Child sexual abuse (CSA) laws evolved separately from laws addressing child physical abuse and neglect and have reflected the social values of the eras in which they were enacted. Over the course of the last century, the focus of legislation regulating sexual contact with minors has moved from the protection of young girls' virginity, to preventing teenage pregnancy, to protecting the physical security of children. By the 1980s, most State laws were expanded to include not only penalties for sexual abuse and severe physical maltreatment or neglect,

The Massachusetts' Department of Social Services (DSS) has undertaken a number of initiatives to better protect and serve abused and neglected children in homes where the mother is also a victim of domestic violence.[40] First, eleven domestic violence specialists are based in local DSS offices to consult on cases, cultivate community services for battered women and children and, in some instances, provide direct services. Second, a pilot program featuring interagency teams comprised of representatives of DSS, law enforcement, battered women's programs, batterer interventions, the courts, hospitals and visitation centers, meet regularly to formulate holistic service plans for cases involving multiple victims. Third, DSS has developed training and protocols for DSS workers to help them identify and intervene safely and effectively in cases involving domestic violence as well as child abuse. Finally, clinical supports for victims of domestic violence and their abused children were offfered, including evaluation services, batterer programs, visitation centers and psycho-educational groups for DSS-involved battered women.

Of the 22,000 cases reviewed by social workers and their supervisors in 1994, 10,500 (48 percent) were identified as involving domestic violence. The interagency pilot program evaluation suggests that services may reduce out-of-home placement for children with battered mothers (between 11.6 and 12.8 for cases in the pilot program compared to 15.2 percent Statewide.) The cost of the Domestic Violence Program is approximately 1.1 million annually, of which 40 percent is State-funded and 60 percent is Federally funded through the Family Violence Prevention and Services Act (FVPSA). An additional 9.7 million is provided by DSS for shelter services.

Proposals for System-wide Reforms

Advocates for system-wide reforms have proposed a number of modifications to the current system and offered models ranging from guidelines for structured assessment and management of CAN cases, to the reorientation of child protective services toward a community-based model and judicial models to expedite permanency planning.

Using Structured Assessment and Case Management

The National Council on Crime and Delinquency has established the Children's Research Center (CRC) to promote research and evaluation concerning child welfare systems and to assist agencies to develop highly structured case management, risk assessment and needs assessment systems.[41] The CRC works with State and local agencies to develop customized actuarial tools to predict risk of future

abusive or neglectful behaviors and to specify appropriate corresponding case management service levels. As of 1993, CRC models had been developed for Alaska, Michigan, Oklahoma, Rhode Island and Wisconsin. CRC case management models are based on two principles:

- Case management decisions can be significantly improved through the consistent use of highly structured assessment procedures; and
- The priority given to cases by staff must correspond directly to the assessment process.

CRC research has shown that separate assessment instruments are needed to predict the risk of physical abuse and the risk of neglect (see Appendix D for sample CRC risk assessment instruments.) CRC research has also found the between 15 and 25 percent of cases that would be classified "high risk" using CRC measures are currently not receiving services, while cases that would be considered low risk on the CRC scales may be carried for months or years. In response to critics who argue that individual case differences require case decisions based on the case worker's own judgement, CRC noted that actuarial tools do not make the decision for the worker, but guide the decision more acuately than personal judgment alone. According to the CRC, "Research has generally demonstrated that simple actuarial tools can predict human behavior more accurately that even a well-trained clinical staff person."[42]

Building Community Partnerships

The Executive Session on Child Protection at Harvard University's John F. Kennedy School of Government, brought together leading researchers, child welfare administrators, judges, activists and policymakers to propose a more effective response to child abuse and neglect. At the core of their work is the notion that instead of responsibility for child safety resting with one agency (CPS), a broadbased community coalition of parents, public and private agencies, organizations and individuals should share this responsibility, creating a "community partnership for child protection."[43] (See Exhibits 3-4 and 3-5.) Participants stress that the idea of a community partnership is not Utopian; diverse communities such as Cedar Rapids, Illinois, Louisville, Kentucky, Jacksonville, Florida, and Los Angeles are currently developing such partnerships. Community partnerships rely on community-based services and engaging a broad range of community members, such as parents, neighbors, schools, religious organizations, law enforcement and community programs to monitor child safety. Executive Session participants named seven stages of development for the transition to community partnerships:

Exhibit 3-4

CHARACTERISTICS OF THE CURRENT AND PROPOSED APPROACHES TO CHILD PROTECTION

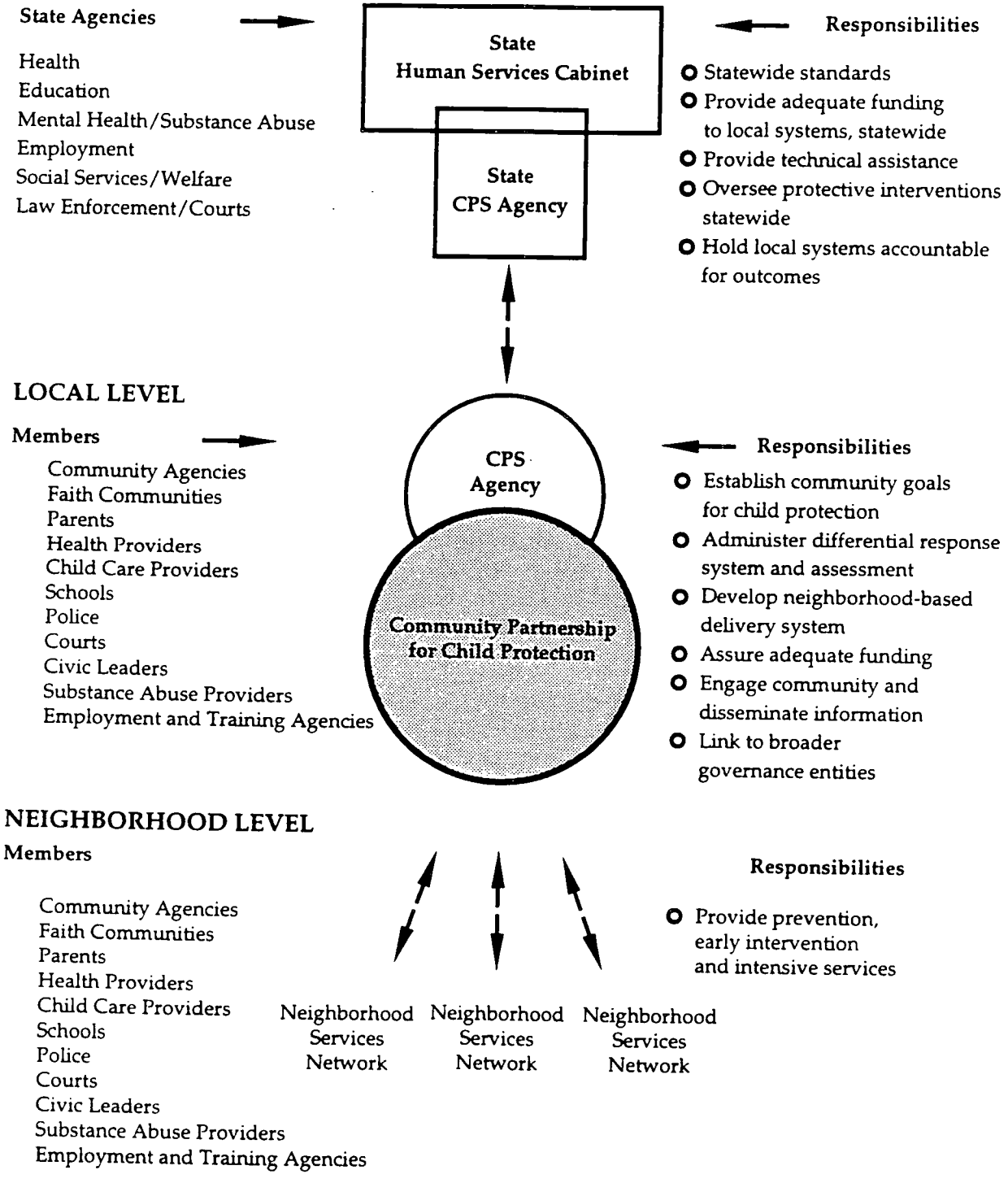
	Current Approach	Community Partnership Approach
CHILD PROTECTION 1. Case entry/case finding	• Mandated reports mix cases that are appropriate and inappropriate for CPS agency attention (roughly 50% of cases coming to CPS now are unsubstantiated) • Little or no preventive assistance is offered, so reporting is often the only option	• Mandated reports to the CPS agency are more appropriate because community alternatives exist to which many families can be referred • Targeted interventions for families likely to become CPS referrals are available before families are referred or reported
2. Assessment/investigation	• "One-size-fits-all" investigation of a specific incident • Investigations do not include comprehensive family assessment • Law enforcement haphazardly involved, with little likelihood of eventual prosecution of even serious offenders	• CPS agencies can respond in several ways, based on needs and the severity of reported abuse/neglect • All cases receive comprehensive family assessment, after initial screening • Law enforcement systematically involved in all investigations of serious physical and sexual abuse; more frequent prosecution for serious offenders
3. Service provision	• Few services available, even when the investigation is complete; capacity to customize services to a family's individualized needs is limited • Control of services is highly centralized • Natural helping networks (friends, neighbors, etc.) have little role with CPS, and are often hostile to it	• The community partnership ensures families have access to a customized array of services, supports, and opportunities; health care providers, child care resources, schools, and other community institutions are sentinels to detect risk • Substance abuse, domestic violence, and other key services are expanded and better coordinated • The community partnership involves community supports and natural helping networks extensively, including family, extended family, neighbors, and other helpers

	Current Approach	Community Partnership Approach
3. Service provision (Cont.)	• Links to substance abuse, domestic violence, and other key services are rarely made	• The community partnership promotes and implements neighborhood-based service delivery
4. Substitute parental care	• Placements too often are made without the option first for in-home services • Children often linger in substitute care while family's appropriateness for providing on-going parenting is determined	• Triggered only after intensive in-home services have been tried or considered • Emphasis is on timely, fair, and safety-oriented decisions about reunification or movement toward adoption or other permanent placement; criterion is child safety
RESPONSIBILITY AND ACCOUNTABILITY	• The public CPS agency is the only agency responsible and accountable for child protection	• The community partnership is responsible for engaging parents and many community agencies in child protection, developing a community-wide plan for child safety, and performing many service delivery responsibilities formerly done solely by the public CPS agency; the CPS agency retains legal responsibility for protective interventions for specific children • The community partnership reports on child protection outcomes to the community, and links with other community governance entities to ensure overall accountability
HEALTHY DEVELOPMENT OF ALL CHILDREN	• Few communities have explicit community goals and strategies to promote children's and families' well-being • Many communities have too few services; services are inequitably distributed across communities • Jobs/employment strategies are fragmented, sporadic, and rarely linked to child welfare and CPS • Categorical financing interferes with service provision	• Communities adopt clear goals to improve outcomes for children and families • Communities have a comprehensive array of community supports, particularly early family supports • Employment and economic development strategies are a top priority in neighborhoods • Financing is more flexibly available to meet individualized needs, and is tied to achieving outcomes

Source : Frank Farrow with the Executive Session on Child Protection, "Child Protection: Building Community Partnerships," John F. Kennedy School of Government, Harvard University.

Exhibit 3-5

COMMUNITY PARTNERS: EVENTUAL ROLES AND RESPONSIBILITIES



Source : Frank Farrow with the Executive Session on Child Protection, "Child Protection: Building Community Partnerships," John F. Kennedy School of Government, Harvard University

- Agreeing on a direction for change;
- Starting the partnerships;
- Creating differential responses to the varied needs of families for child protection;
- Developing comprehensive neighborhood-based supports and services;
- Transforming public child protection agency services (focusing on comprehensive assessments, understanding the dynamics of substance abuse and domestic violence and other risks to children, and work with multi-disciplinary and multi-agency teams);
- Shifting intake and follow-on services for lower-risk cases to a community-based system; and
- Instituting community governance and accountability for protecting children.

Model Courts: Permanency Planning Reforms

The American Bar Association has conducted two studies of courts that are implementing reforms designed to help abused and neglected children find permanent, safe placements. Key problems with juvenile court functioning cited in the studies include:

- the number of issues to be decided in each case (see exhibit 3-2);
- the number of people involved in each hearing (lawyers, social workers, guardians ad litem, law enforcement);
- lack of information concerning the structure or function of the child welfare system;
- lack of information concerning the services available to families in the community;
- delays in case processing;
- delays in permanency for foster children; and
- wasted social worker hours in court.

The Kent County Juvenile Court in Grand Rapids, Michigan, was selected by the ABA as a model for advanced judicial permanency planning reforms.[44] The Kent County court was of interest for several reasons, including its expeditious handling of cases, a high frequency of terminated parental rights for parents whose children were placed in custody, and a high number of adoptions for children whose parent's rights had been terminated. The Kent County court addressed many of the inefficiencies

found in typical juvenile court functioning through efficient, professional staffing and well-organized court procedures that target the functions required of juvenile courts in child protection cases by State and Federal law.

In particular, experienced or well-trained staff was key to the court's superior functioning. Long-term judges, who receive approximately 180 new child protection cases per year, handle each case assigned to them from the primary hearing through the termination of parental rights and adoption. In addition, once a judge has been involved with child protection hearings concerning one child in a family, all other cases concerning siblings are assigned to the same judge. Another important staffing policy involves the use of "hearing coordinators" who present legal and social service files to the court and who are responsible for recording case hearing information, scheduling next hearing dates, and coordinating materials and parties for future hearings. Researchers also noted a unified sense of purpose between court staff, prosecutors and child welfare workers. Court procedures were designed to minimize waiting and scheduling uncertainty for social workers, parents and lawyers.

A second principle which characterized the court was an emphasis on strict adherence to demanding hearing schedules and prompt and thorough attention to cases. The hearing schedules imposed by the court were generally more swift than those required by State and Federal laws, and no case was ever allowed to go off-calendar--at each hearing the next hearing date was set. Finally, researchers concluded that the intensive hearings held early in a case created both financial advantages and benefits to the child: the average stay in foster care was reduced to approximately one year and the court costs associated with each case were reasonable (approximately $2,000.)

Conclusion

The legal, institutional and practical constraints on interventions for victims of child abuse and neglect are many. However, the widely shared consensus that reforms are needed is generating a wealth of innovative practices and pilot projects that may point the way for the development of better systems in the near future. Of particular interest are reforms that emphasize the use of interdisciplary teams to guide case management--such as the Massachusetts domestic violence initiative and the Travis County, Texas, interagency Child Protection Team. Another encouraging trend is the co-location of services and efforts to provide neighborhood-based services to victims of CAN and their families. Finally, the shift in Federal funding priorities toward the provision, through State grants, of support for a

continuum of family preservation and family support services presents the opportunity to expand and improve interventions for victims of CAN.

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7. Waldfogel, "Toward a New Paradigm for Child Protective Services": 2.

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10. Waldfogel, "Toward a New Paradigm for Child Protective Services": 6. The American Humane Association points out that as high as this number is, a 1986 study by the U.S. Department of Health and Human Services suggested that cases investigated by CPS agencies annually may represent only 35 percent of those children actually endangered by abuse and neglect. American Humane Association, "Twenty Years After CAPTA": 19.

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Differential Outcomes of Abuse and Neglect

Research identifying differential outcomes according to type of abuse is limited. Many researchers specialize in one area of abuse, such as physical abuse or sexual abuse. Therefore, research comparing different types of abuse is rare. Existing research, according to experts in the field, is new and currently has insufficient data to support differentiated interventions based on type of abuse only. Generalizing findings from this research is viewed cautiously due to methodological limitations.

The following is a limited summary of the research on how the consequences of child victimization differ according to type of abuse. Different types of abuse were compared to determine which were the strongest predictors of symptomology. Research findings have been grouped according to symptom categories: psychological/PTSD; academic performance/cognitive; and behavioral-interpersonal/affect-emotional.

Psychological/PTSD

In comparative studies involving psychological outcomes, victims of sexual abuse and neglect demonstrated the most severe symptoms. According to one study, victims of child sexual abuse are more likely than other victims of child maltreatment to be diagnosed with PTSD.[72] Additionally, depression may be more prevalent in children who are sexually abused than in children who are physically abused.[73] Victims of neglect also fared worse than physically abused children. Between neglect and physical abuse, neglect was a stronger predictor of more severe psychological problems, such as anxiety, depression, somatization, paranoia, and hostility. Researchers also reported that neglected children are more likely to exhibit anxious attachment styles and, later, more difficulties in relationships.[74]

Academic Performance/Cognitive

In a study by Perez and Widom, comparing cognitive and academic impact across types of abuse, victims of neglect showed the most deficits. Adults who had been neglected as children had significantly lower IQ and reading levels than non-abused controls. Those who had been physically abused had lower IQ scores than non-abused controls. However, adults sexually abused as children did not differ from the non-abused controls. Parallel results were found in a study of school aged children (K-12), which suggests that the academic and cognitive impact of CAN differs according to type of abuse.[75]

Behavioral /Interpersonal and Affect/Emotional

According to the literature reviewed, children who have been physically abused tend to be more aggressive than children who have been neglected.[76] Neglected children are found to be more withdrawn and inattentive than physically abused children.[77]

Differential Outcomes of Abuse and Neglect by Development

Developmental research on the outcomes of CAN is currently in its infancy. Some symptoms carry over from one developmental stage to the next, others do not. Whether these developmental differences are a consequence of the abuse and neglect or a manifestation of personal development has not been established. The following is a brief review of some of the age-specific findings concerning the outcomes of CAN according to type of abuse.

Consequences of CAN by Developmental Stage

Children Who Witness Violence (family violence & community violence)

Infancy: poor health, poor sleep habits, and excessive screaming.[78]

Pre-school: terror, shaking, stuttering, decreased cognitive skills, and regression.[79]

School-aged: developmental delays, sleep disturbances, enuresis, speech and hearing difficulties, eating disturbances, psychosomatic complaints, shaking and nail-biting.[80] They also startle easily and show low cognition, diminished memory, suppression of affect, and hypervigilance.[81]

Adolescence: poor school performance and dropping out as well as precocious sexual behavior, drug use, antisocial behavior and feelings of guilt and shame.[82]

Psychological Abuse

Infancy: attachment disorders and failure to thrive.

Pre-school: aggression, attacking peers in distress, poor appetite, and enuresis.

School-aged: disruptive classroom behavior and aggression.

Adolescent: antisocial behavior and problems with peers.[83]

Physical Abuse

Infancy: failure to thrive, cognitive impairment.

Pre-school: repeated motor play, less parallel and group play.[84]

School-aged: less likely to initiate positive peer interactions, less well-liked by peers.[85]

Adolescence: antisocial behavior.

Part II: Recent Research Findings, Trends, and Recommendations in the Field of CAN

The following section is divided according to common outcomes of CAN, differentiated outcomes by type of CAN, stage of development, gender and race, and new research on delinquency. It concludes with a discussion of research on effective intervention strategies. Delinquency has been separated because of the focus of the NIJ Child Abuse and Neglect Interventions Strategic Planning Meeting.

A General Survey of Consequences for CAN Victims

- **Medical/Physical**
  bruises, skin markings, cuts,
  burns, serious physical injuries (brain damage, death),
  severe health complications, body disregulation
- **Psychiatric/Post Traumatic Stress Disorder**
  anxiety, nightmares, generalized fear response,
  depression, psychopathology, neurosis,
  character disorders, trauma-specific fears
- **Attachment/Self-Esteem**
  poor attachment, separation problems,
  lack of empathy, low self-esteem,
  affective problems, temperament problems
- **Cognitive/Developmental**
  low verbal, cognitive and motor abilities,
  regression, lower performance on cognitive tasks,
  language deficits, developmental delays
- **Academic Performance**
  concentration problems, declining grades,
  poor school achievement,
  truancy, dropping out
- **Behavioral/Interpersonal**
  less social competence, acting out,
  self-destructive behavior, physical aggression,
  antisocial behavior, withdrawal, avoidance

Sources: Cichetti, D. and V. Carlson, *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect*, New York: Cambridge University Press, 1989; Peled, I., P. G. Jaffe and J. L. Edelson, *Ending the Cycle of Violence: Community Responses to Children of Battered Women*, Thousand Oaks, CA: Sage, 1995; Herman, K, "Effects Of Violence on Adult Functioning/Child Development," unpublished fact sheet, presented at the Fifth National Colloquium of American Profession Society on the Abuse of Children, June, 1997.

Common Outcomes of Abuse and Neglect

The research literature indicates that victims of all types of abuse and neglect commonly have one or more of the following problems:

- aggression;[63]
- depression;[64]
- limited self-esteem;[65]
- low social functioning;[66]
- low cognitive skills; and/or[67]
- attachment problems.[68]

These symptoms are not found in all victims, and victims with symptoms suffer them with varying severity. The child's developmental stage, race and gender, and other factors may influence symptom manifestation (See the box "The consequences of CAN vary according to multiple factors").

Two other symptoms should be mentioned when discussing the effects of CAN because of their prevalence in the literature: post-traumatic stress disorder (PTSD) and inappropriate sexual behavior. PTSD is associated with each type of abuse with the exception of neglect and psychological abuse.[69] Inappropriate sexual behavior is recognized as a potential consequence of sexual abuse or physical abuse.[70] It has also been noted that adolescents who witness family violence may engage in precocious sexual behavior.[71]

The Consequences of CAN Vary According to Multiple Factors:

- **Child Characteristics:** age, emotional and cognitive development, gender, race/ethnicity, personality strengths (resiliency);
- **Type of Trauma:** Type I: acute (a single event) or Type II: chronic (repeated);
- **Type of Abuse or Neglect:** physical, sexual, psychological/emotional abuse or witnessing domestic violence;
- **Co-occurrence of Types of Abuse and Neglect;** and
- **Relationships the child has with:** victimizer, non-offending parent, other family members, other adults, and peers.

with at-risk populations in general (with victims of abuse and neglect being a subset of that category). The relative effectiveness of abuse-specific versus non-specific interventions is unknown.

Existing outcome research on whether interventions are effective has significant methodological limitations such as small sample sizes, lack of control or comparison groups, or no follow-up concerning further victimization.[132] Additionally, "common assessment strategies have not been used across different interventions, making it difficult to know what works for whom."[133]

Despite these limitations, several intervention strategies (for example, multi-systemic, cognitive-behavioral, family preservation, therapeutic day care, therapy and a supportive adult) have demonstrated promising outcomes for treatment effectiveness. "One well-researched approach, multi-systemic therapy, has had excellent results for adolescents with delinquent behavior."[134] Short-term cognitive-behavioral modeling[135] has been an effective treatment for PTSD.[136] Family preservation, although not consistently effective, may work more often with physically abused children than with neglected children.[137] Additionally, some evidence suggests that therapeutic day care positively impacts the developmental progress of physically abused children[138] in the areas of fine and gross motor skills, cognitive development, social and emotional functioning, and language development.[139] Therapy and relationships with supportive adults have also been shown to break the "cycle of violence." Egeland found that women who had been severely physically abused as children and received at least a year of therapy during childhood or had a supportive relationship with an adult during childhood did not currently abuse their own children.[140]

The type of strategy is not the only factor that contributes to effective interventions. Length of intervention has also been studied. Some results suggest that more than 10 meetings, whether insight-oriented, group or family-centered, lead to greater treatment effectiveness for at-risk families.[141] This finding is supported by other researchers who call for long-term treatment and follow-up.[142]

Many current intervention strategies are based on resiliency theory. This theory outlines the mediating factors that can protect a child from the negative outcomes of CAN. A review of the leading research in this area provides a list of individual, family and community protective factors.

Protective Factors that Mediate the Outcomes of Child Abuse and Neglect

Individual Characteristics

- autonomous, independent
- high self-esteem
- easy temperament
- intelligence (high IQ)
- high reading scores
- expectations/aspirations for college
- commitment to school
- attachment to teachers
- low disorganization
- responsible
- internal locus of control
- positive social orientation

Family Factors

- parental warmth
- parental supervision
- parental attachment
- one good parent relationship
- parent's positive evaluation of peers
- parental involvement in child's activities

Community Factors

- secure, supportive relationship with adult
- peers' conventional values

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Intervention strategies based on resiliency theory focus on the natural strengths of the child and seek to enhance the individual, familial, and/or community protective factors. For example RALLY, focuses primarily on developing protective factors in individual students, such as high reading scores, commitment to school, and positive social orientation by providing one-on-one and group tutoring, counseling, and social activities.

B. Intervention Methods:

1. **Children:** children of all ages are accepted at the shelter and complete age-appropriate screenings and assessments for early intervention and referrals.

    a. Direct childcare provided on the premises: art therapy and play therapy in addition to early childhood development focused on cognitive, emotional, physical and social skills.

    b. Children's advocates work with child and parent to secure necessary education, medical, and social support for the child.

    c. Children may also receive individual or group counseling, either onsite, or community, school or hospital-based, if necessary.

2. **Parents:** complete mental health intake to identify personal and parenting needs.

    a. Advocates work with mothers to secure housing, economic, legal and protection assistance.

    b. Counseling may be individual or group; parents may participate in art therapy.

    c. Referrals for mental health needs and substance abuse treatment.

3. **Providers:**

    a. **Children's Advocates:** background in early childhood education and development; experience with childhood trauma.

        1. Provide direct childcare.

        2. Direct art therapy, play therapy and referrals for early intervention.

        3. Provide mothers with Individual Parenting Support to help mothers:

            a. Understand how children have been effected by domestic violence and/or child abuse.

            b. Address the need of their children while in the shelter.

    b. **Women's Advocates:** experience in and understanding of domestic violence and abuse issues.

        1. Complete assessments Mental Health Intake.

        2. Identify other necessary assessments (substance abuse).

        3. Collaborate with mothers to secure education, medical, legal, mental health, and social services for herself and child.

V. Assessments:

A. **Children:** complete appropriate assessments according to age - infancy (0-2), preschool (2-5), school aged (6-12), adolescents (13+).

1. **Children's Services Intake**: developed in collaboration with the Child Witness to Violence Project at Boston Medical Center; meet with mother and child to complete a developmental history and determine the history of abuse; and design a treatment plan.

2. **Denver Screening for Infants and Toddlers**.

3. **Earling Screening Inventory** (Miesels, Henderson, Martson, & Olson, 1983).

B. **Mothers:** complete **Mental Health Intake:** an open-ended questionnare complete by self report.

a. History of childhood and adulthood abuse.
b. History of alcohol and drug abuse.
c. Family of Origin and Nuclear Family Genogram.
d. Identify signs of PTSD and trauma, assess and develop a treatment plan.

VI. **Outcomes:** A four-year follow-up study to determine the correlation between substance abuse and trauma (incurred by domestic violence and child abuse), was conducted by the Center for Substance Abuse Prevention ("Project Basta," grant # SP0509) in 1995, and directed by Michelle Drum, however the report and findings could not be obtained.

Responsive Advocacy for Learning and Life in Youth (RALLY) Project: Brighton, Massachusetts - piloted in 1995

Director: Gil Noam, Ph.D.

Site Coordinator: Kim Pucci, Ed.M.

Program Coordinator: Kendra Winner, Ed.M.

I. **Description:** A School-based Academic and Psychosocial Intervention Program

A. A collaboration between the Boston Public Schools, Massachusetts General Hospital, McLean Hospital, Harvard Medical School, and Harvard Graduate School of Education, funded in part by the Boston Public School Department's "Vanguard Project" and private grants.

B. Designed to facilitate the inclusion of students with emotional, behavioral and learning problems in the regular education classroom through mentoring relationships to promote resiliency in learning and life.

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C. Provides services to 20-40 middle school students with a focus on sixth and seventh grade prevention and intervention and a limited follow-up component for eighth grade students who participated in the program previously.

D. At least twenty-five percent of students receiving services through the program have been involved with the court through the Department of Social Services and/or the Department of Youth Services for abuse and neglect or through a Child in Need of Services Petition (CHINS).

II. Theoretical Framework:

A. Program is founded on resiliency theory and is a "developmental intervention focused on the capacities of children to overcome problems," utilizing multiple methods to enhance the unique strengths of each child.

B. The ecological approach is also a fundamental part of the program which attempts to connect the student and his/her parents to the necessary supports in school (peers and teachers) the community, and with other providers in the student's life.

C. Cognitive-behavioral theories and theories of moral development guide the everyday activities of the prevention practitioners in class and counseling.

III. Objective: To provide students at risk with support to prevent academic failure, anti-social and delinquent behavior, and to promote self-efficacy, interpersonal, and academic success.

A. Students: Help students develop a commitment to school, improve academic achievement, develop positive social relationships, and bridge the fragmented spheres of family, school, and community.

B. Parents: Facilitate school-home communication and provide parents and families with support.

C. Community: Establish partnerships with the community in supporting at-risk students and families and incorporate community-based services as an intervention option.

IV. Method: An entire "cluster" of students in the same grade complete initial assessments to identify students at risk, with those identified being matched with a prevention practitioner. Students may be self-referrred or referred by teachers, prevention practitioners, and student support services.

A. Students: Complete further detailed assessments, and the prevention practitioner designs an intervention program with the student, based on assessment results and contextual understanding of the student's strengths and coping skills.

1. Classroom: assist students identified and other students in the classroom with academic work.

2. Counseling: work with student outside of classroom (refer for further evaluation with psychiatrist if needed).

a. One-on-one

b. Pairs

c. Groups: designed in collaboration with the student support services or independently on a yearly basis as needed.

(1) boys' group

(2) girls' group

(3) violence prevention group (1995/1996)

(4) Vietnamese girls' group (1996/1997)

3. After School Program: for academic tutoring and social skills development - currently coordinating a partnership with the Boy's and Girl's Club.

4. Community-based referral: for health/mental health services.

B. Prevention Practitioners: Masters of Education students work in the classroom, school, and community with middle school students.

1. Establish mentoring relationship of trust and structured support through academic tutoring, individual and/or group counseling, and social activities.

2. Communicate and collaborate with teachers regarding student strengths, appropriate teaching methods, and progress.

3. Establish a working relationship with parents and families to link school and home.

4. Weekly training session with director, site coordinator, program coordinator, and three post-doctoral psychiatrists completing fellowships in child psychiatry.

5. Weekly supervision with director and/or site coordinator to focus on individual cases and action plans.

C. Director, Program Coordinator, Site Coodinator, and Psychiatrists: Provide ongoing support to students and staff.

1. Complete periodic classroom observation of students in the program.

2. Evaluation and referrals for students with severe behavioral, emotional, and learning problems.

3. Develop and oversee quantitative, qualitative, and longitudinal data collection and research.

V. **Assessments:** To measure student progress in terms of academic performance, social skills development, psychological and emotional development and maturity.

A. An entire cluster (96) of students in grade six or seven complete:

1. Youth Self Report For Ages 11-18 (Achenbach 1-91 edition).

2. BECK's Inventory For Depression.

B. Student's identified as at-risk (32) complete:

1. **Harvard RALLY Project Student Information Questionnaire** - provides detailed family, nationality, medical, school (including special needs and standardized test scores), disciplinary history, and *court involvement* information.

2. **Student Profile** - highlights the student's interests, school/personal goals, home/family/interests, school and community services.

3. **Teacher's Report Form** (Achenbach 1/91 edition) - provides detailed academic performance, perspective on academic and social development, IQ, readiness and/or aptitude testing, motivation, self-control.

4. **Harvard-Taft Classroom Behavior Scale** - completed by director or psychiatrists through direct observation of the student to provide a third perspective and completed periodically throughout the year to note progress.

C. **Parent Contact Form** - completed by the prevention practitioner each time contact/conversation with parent occurs, noting the purpose, information gathered, impressions, and plan for action.

VI. **Outcomes:** Follow-up data for 6 eighth grade students who participated in the project in seventh grade is being collected and analyzed.

A. Project Status - project is in the third phase:

1. Phase one: implementation in the seventh grade cluster (1995/1996);

2. Phase two: creation/introduction of new assessment tools (student questionnaire) with seventh grade and follow-up with first group (1996/1997);

3. Phase three: implementation in the sixth grade (1997/1998) and follow-up with eighth grade students.

B. Quantitative - creating a database for follow-up through grades, disciplinary action/involvement, and attendance.

C. Qualitative - academic and personal development.

1. Improved peer/peer and adult/peer relationships and interactions.

2. Increased school and community connections.

3. Improved self-reflection and esteem and more balanced internalizing/externalizing behaviors.

Conclusion

Both researchers and practitioners rely on multiple theories of CAN or combinations of theories in their work. Social learning and attachment theory underlie most theoretical explanations of and treatments for CAN. However, current approaches are increasingly incorporating ecological and resiliency theories. Knowledge has increased about victims' differential responses to CAN based on type of abuse, individual and family characteristics, and racial and cultural differences. Researchers are also beginning to gather substantially more data on how victimization may lead to delinquency and criminality.

Currently the most significant gaps in research are how victimization impacts development and which interventions are effective. Researchers have established a reasonable understanding of how symptoms manifest themselves differently according to development and the ages at which victimization may be most detrimental but are uncertain how victimization impacts further development. It is also unclear whether or not the consequences of abuse in adulthood can be averted during childhood or adolescence.[143] This lack of knowledge makes it difficult to determine if the changes victims experience over time are consequences simply of time, intervention or both. Specifically, researchers need to determine how the passage of time impacts CAN victims' development and whether interventions in childhood and adolescence can promote and sustain healthy development into adulthood. Future research is needed to determine the efficacy of early and later intervention and which interventions are best suited to specific groups of victims.

Background Paper #3:

Policies, Practices and Statutes Relating to Child Abuse and Neglect

Kerry Murphy Healey, Ph.D.
Abt Associates Inc.

October 3, 1997

Introduction

Interventions to manage the consequences of child abuse and neglect (CAN) operate in the institutional context of State and Federal laws, the bureaucratic structures and procedures adopted by each State's child child welfare agencies; local policies; and each State's criminal justice system. Each of these may constrain or facilitate intervention in child abuse and neglect. This paper considers the role of each of these influences on child abuse and neglect policies and services, reviews current innovations in the field and concludes with an overview of proposed reforms to the child protection services system.

Responsibility for child protection and welfare is reserved by the Constitution for the States. Each State's system of child protection is a complex web of services and regulations constructed of State statutes, voluntary acceptance of federal funding and oversight, State department of social services policies, court mandates and local regulations and agreements.

- **Federal legislation**, through restricted funding streams, indirectly influences and constrains State-level CAN programming and child protective services (CPS) procedures while providing an overlay of similar program goals and case management procedures across State systems.
- **State statutes** define child abuse and neglect, identify mandatory reporters and reporting procedures and specify the overall structure of CPS in the State.
- **Policies and procedures** for intervening in CAN, including how reports are screened, investigated and assessed; cooperation with other agencies, including the criminal justice

system; and how services are delivered may be specified by State, county or local departments of social services (see exhibits 3-1A, 3-1B and 3-1C.)

- **Courts** may also require CPS to provide services or adopt practices in line with legislative mandates.[1] The functioning of the courts may speed or delay decisions concerning permanent placements for victims of CAN.

There is an unusual degree of consensus among child welfare workers, researchers, politicians, criminal justice professionals and the public that current systems for safeguarding abused and neglected children are hobbled by fragmentation of services and policies. Child protective services (CPS) are often criticized for failing to find a proper balance between parental rights, child safety and family privacy--supplying insufficient safeguards to children, in some cases, while being too punitive and stigmatizing to families in others. Academics and child welfare practitioners working together on these issues have advanced a number of cogent criticisms of the current child protection structure. Key problems cited include:

- *Inadequate service delivery.* Many victims of CAN, especially those suffering neglect, receive very limited services or no services at all. In 1996, the National Committe to Prevent Child Abuse (NCPCA) estimated that 30 percent of substantiated CAN cases (or approximately 290,700 children) receive *no* services, with individual State's estimates of cases receiving no services ranging from 0 percent to 85 percent. [2]

- *Poorly organized or inadequate family needs/risk assessment and investigation.*

- *Insufficient service availability.*

- *Lack of emphasis on the development of natural or informal "helping networks"* such as friends, relatives, clergy, neighbors, community groups.

- *Failure to link CPS to substance abuse and domestic violence treatment services,* despite the identification of substance abuse as the primary presenting problem in CPS case loads.[3]

- *Failure to achieve permanency for out-of-home placements in a timely manner* and thereby limit the risks posed by multiple placements and disrupted attachment for the child.[4]

This paper attempts to place these issues within their legal and institutional context so that policymakers can better understand how systems might be changed to support effective interventions with victims of CAN.

Child Protective Services, Child Welfare and the Criminal Justice System: Case Processing from Report to Intervention[5]

In 1995, more than three million reports of child abuse and neglect were received by State-level child protective services agencies.[6] Since the introduction of mandatory reporting laws in the 1960s, the burgeoning number of child maltreatment reports has stretched the CPS system to its limits--increasing from just 4 reports per 1000 children in 1975 to 47 reports per 1000 children in 1994.[7] The actual number of CAN cases is thought to be even larger: other CAN victims who may not be reflected in the number of reports received by State CPS agencies include children of military personnel or Native American children, who are protected under other systems.[8] This section attempts to describe how a typical State CPS system responds to and processes reports of abuse and neglect. While there are many differences between States--as well as between counties or localities within each State--many share core practices.

Screening Reports of Abuse and Neglect

Reports of child abuse and neglect frequently involve families in crisis. Which agency (if any) responds greatly depends on the nature of the crisis or reported incident, the degree of danger to the child, and the availability of services. Child abuse may be reported first to the police, who may investigate and/or refer the case to child protective services. Alternatively, CAN reports may be received directly by CPS, who then screen reports to decide whether law enforcement investigation is appropriate (most often, in cases of sexual abuse or severe physical abuse or neglect.) Crimes against children by strangers are investigated by law enforcement but may not meet the criteria for intervention by CPS (see below). Commonly, no attempt is made to assess the overall service needs of the family at the time of a report. Instead, screening criteria are used to limit investigations to reports involving emergencies to which the system must respond to ensure the safety of the child. In most States, CPS screens according to the following three criteria:

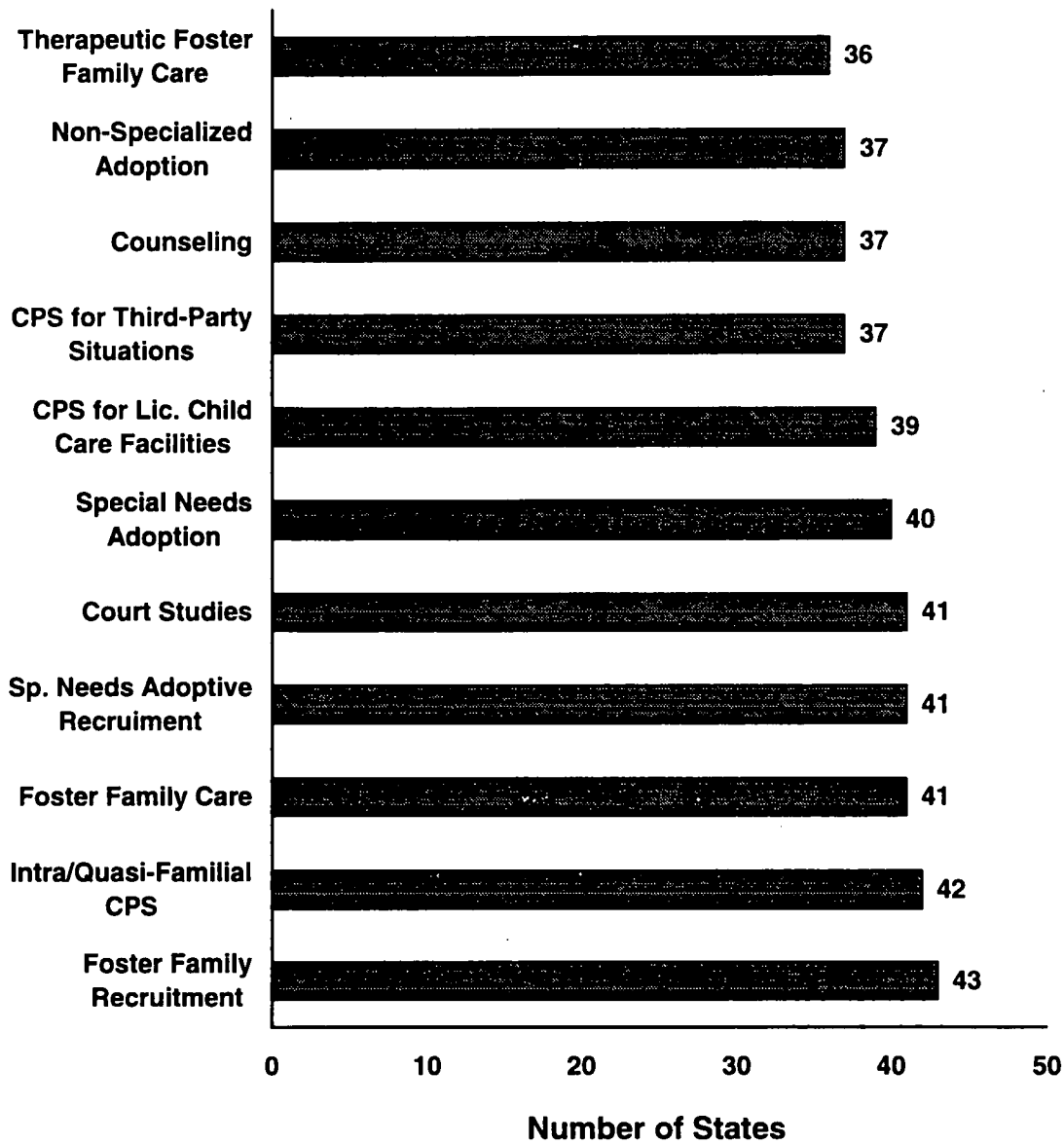
1. Reports must concern children under 18 years old;

2. The reported abuser must be responsible for the health and welfare of the child (e.g., a parent, caretaker or guardian); and

3. The report must allege abuse or neglect constituting evidence of harm to the child or a risk or threat of harm to the child.[9]

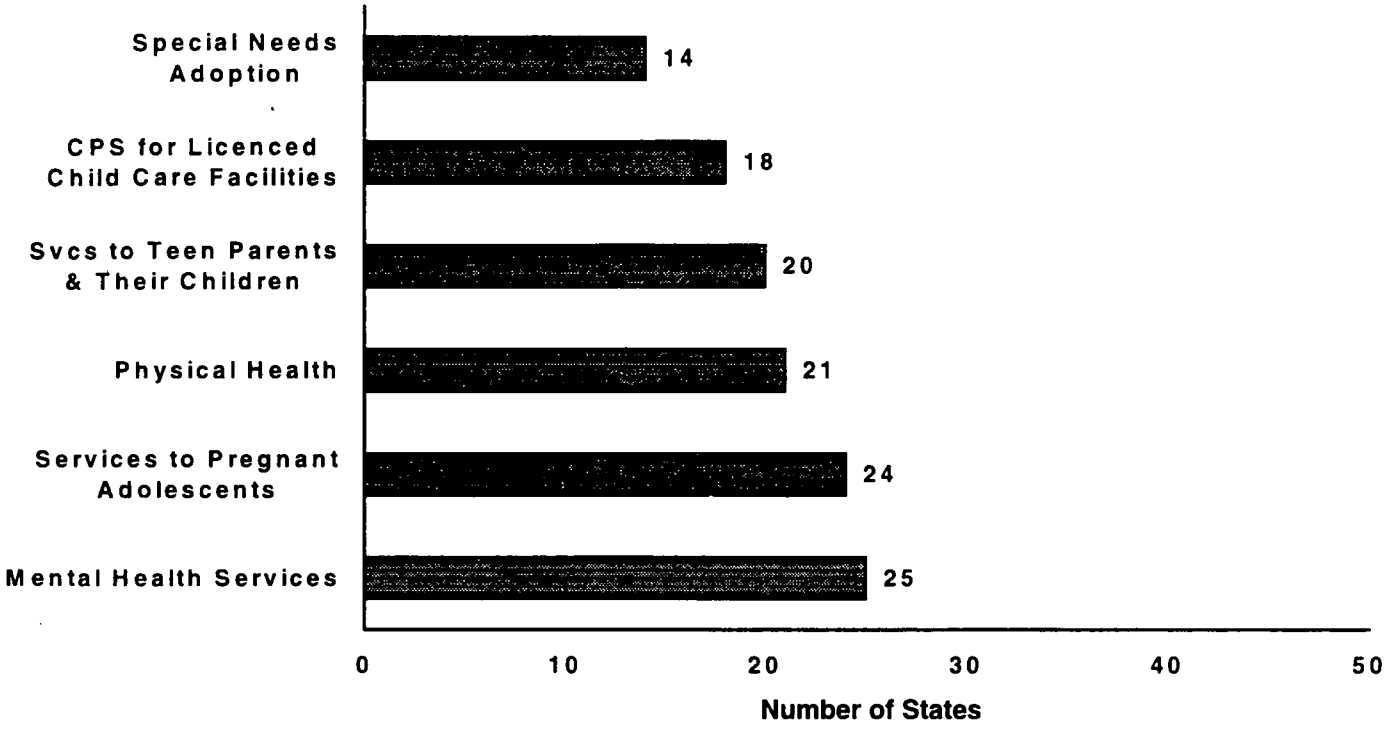
Exhibit 3-1A

Services Delivered by Public Child Welfare Agencies

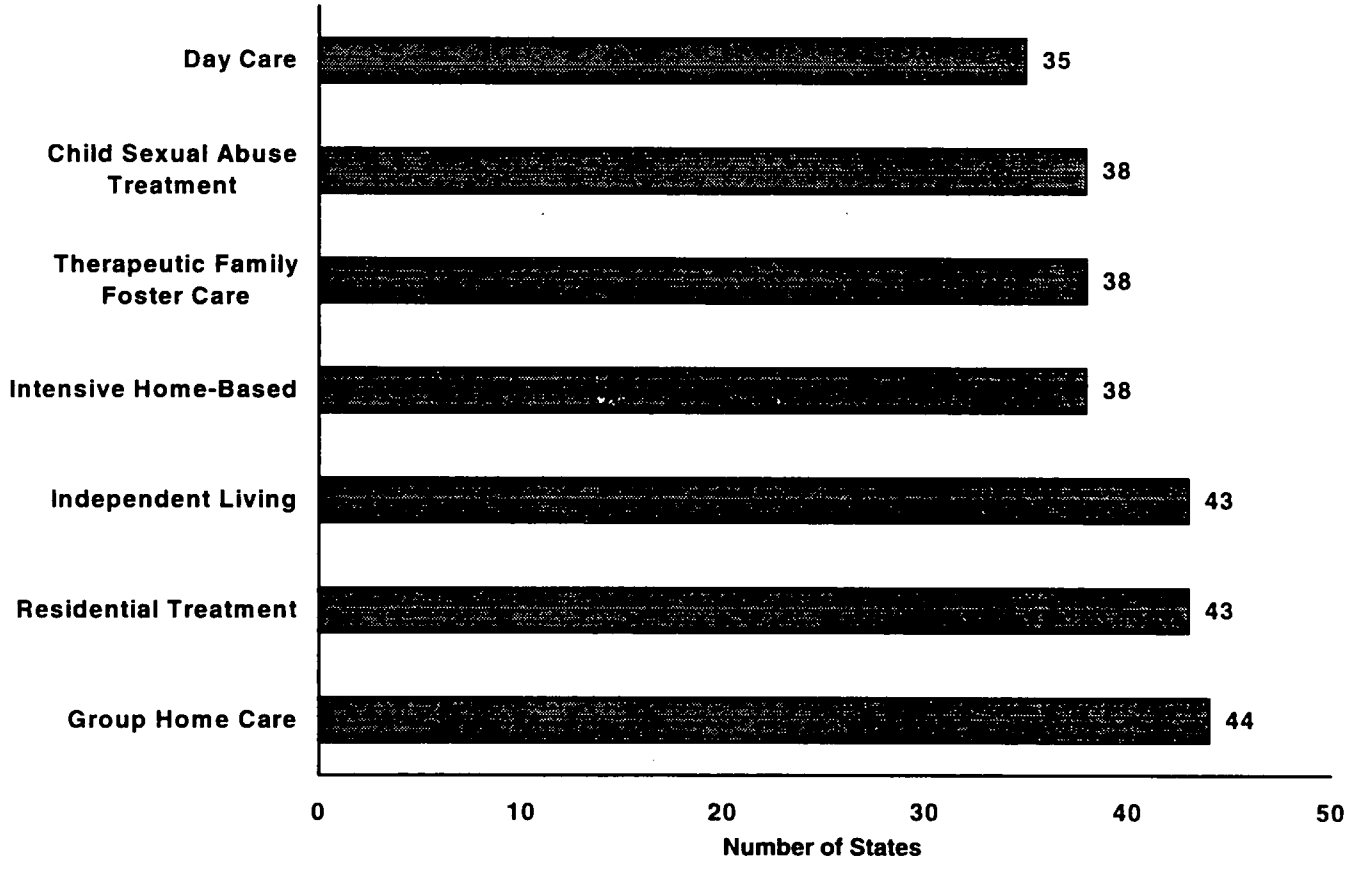


Source: American Public Welfare Association, *Factbook*, 1990.

Exhibit 3-1B
Services Delivered by Other Divisions Within the Public Child Welfare Agency



Exhibt 3-1C
Services Delivered by Contract Providers



Source: American Public Welfare Association, *Factbook*, 1990.

Additional criteria used in some States include: information concerning the location of the child and abuser (seven States); factual allegations that meet statutory or policy definitions of CAN (twelve States and the District of Columbia); and an array of factors including the timing and severity of the abuse, the age of the child, the relationship of the perpetrator to the child and the willingness of the parents to protect the child (six States.) Families not yet in crisis, but in need of preventative services (for example, those who are recently homeless or parents struggling with drug addiction) are unlikely to qualify for CPS assistance and must seek services through other social welfare agencies. (See the discussion of differentiated response, below.)

Investigation

Approximately 50 percent—or 1.5 million—of reported CAN cases meet the screening criteria and are investigated by CPS; the other half are closed due to lack of evidence of abuse or insufficient evidence to compel services.[10] Investigation may involve visiting the family, seeing the child, and interviewing the reporter. In emergency cases, investigation may be undertaken immediately, while a typical investigation begins in one to two days following the report and is completed in less than ten days. In serious cases, the child may be taken into protective custody during the investigation. Waldfogel notes that the investigation process, whether it is conducted by CPS alone or in conjunction with law enforcement, is

> . . . quite intimidating from the perspective of the family. The investigator, after all, is informing the family about allegations, reading a statement of their rights, and/or warning them of a court action to remove the children from their home. Although the investigator may also be trying to assess the family's situation and need for services, the primary focus of the investigation is making a determination as to the safety of the child victim and the likely identity of the adult perpetrator.[11]

According to the American Humane Association, while standards vary for substantiated cases (also termed indicated, confirmed or valid in some States), the general standard used is either:

1) that available facts or circumstances would cause a reasonable person to believe that abuse or neglect had occurred; or

2) there is either "some credible evidence" (18 States), "credible evidence" (11 States and Puerto Rico) or "a preponderance of evidence" (11 States and the District of Columbia) to indicate that abuse or neglect occurred.[12]

Individual States have *extremely* varied rates of substantiation—from 8 percent to 80 percent.[13] This variation spurs debate concerning appropriate levels of State intervention in families, lack of resources

for proper investigation and intervention, and the assessment skills of some social workers. No one explanation for the great variation in rates of substantiation has gained general acceptance.

Approximately 20 percent of investigated cases involve severe CAN requiring criminal prosecution and/or civil proceedings to remove the child from the home. In the remaining open cases (80 percent), the child is judged to be safe at home with the provision of services; typically a family needs assessment is conducted and a service plan is developed consisting of periodic calls or visits from a case worker and, possibly, the provision of some support services or referrals.[14] These services and referrals may be provided directly by CPS workers, by related child or family welfare agencies or by private community-based contractors (see exhibits 3-1A to 3-1C.) Within the 80 percent judged to be safe at home, a small portion of especially high risk families may be singled out to receive intensive family preservation services.

Intensive Family Preservation

As of 1991, 31 States had piloted family preservation programs, and Federal and State legislative interest in family preservation programming remains high (see below.)[15] In jurisdictions that have intensive family preservation programs, case screening includes the identification of families of children who are at *imminent risk* for out-of-home placement. High-risk families are provided with a social worker with a limited case load (as few as two families) for four-to-six weeks of intensive intervention. (Systems differ, one jurisdiction offered a modified version of intensive family preservation that allowed for larger case loads and a longer service period of three months.) The services are home-based, family centered, community-centered, crisis oriented and intended to enhance family functioning and empower families to solve their own problems.[16] Homebuilders, one of the most common family preservation models, expects social workers to provide an extensive and diverse group of services including parent effectiveness training, emotion management, interpersonal skills building, assertiveness training, clinical assistance and referrals, advocacy and a range of practical and material assistance such as, money management, job assistance, academic training, and assistance in building informal support networks. At the end of the intervention, successful cases are transferred back to CPS workers with regular case loads for follow-up.

Children in Out-of-Home Placement

In the most severe cases, CPS requests temporary custody of the child in the family, probate, juvenile or district court. The child may be placed in foster care or in kinship care (if the relative's home is

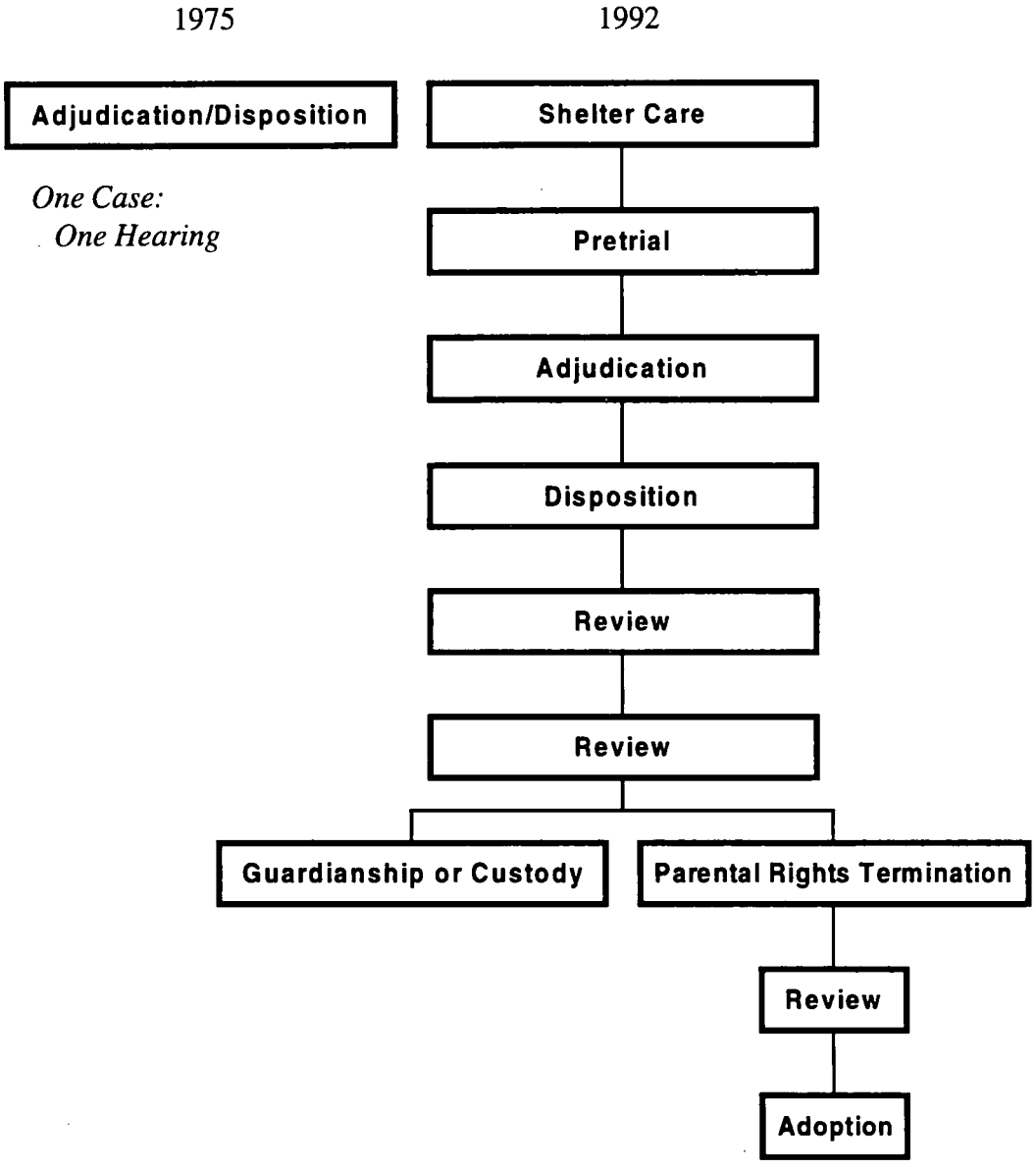
inspected and approved).[17] The case worker conducts a family assessment and creates a service plan for the family that may include services and goals for both the child and the perpetrator as well as any non-abusing caretaker. A typical service plan for abusive and neglectful parents hoping to regain custody of a child in out-of-home placement might include (as appropriate) compulsory services such as substance abuse treatment and periodic urine screens, attendance at AA meetings, mental health counseling, battered women's counseling and batterer intervention, parenting classes, and/or stipulations that the parent obtain adequate housing, maintain household hygiene, abstain from drug use and criminality, take required medications and demonstrate interest in the child through regular visitation.[18] Typical service plans for older victims in out-of-home care may include psychological counseling, substance abuse treatment or independent living skills training (for teens) and may stipulate behaviors, such as attending school, obeying foster parents' house rules and cooperating with visitation. The duties of foster parents and CPS workers may also be laid out in service plans. Case workers may be expected to contact the child, the parents, schools and key service providers monthly and to monitor the child's medical care. Compliance with these plans is periodically reviewed (usually every 6 months) to monitor progress toward goals and to reassess the appropriateness of the goals. For children in out-of-home care, CPS may seek as a goal family reunification, long-term substitute care, guardianship or adoption.

Both Federal and State-level policies attempt to limit the average duration of out-of-home placement; however, a 1995 Massachusetts study found that among a group of 206 severely maltreated children who had been removed from their parents, 21 percent were still awaiting permanent placement seven and a half years later.[19] Delays are frequently blamed on the courts, which are typically required to hold numerous hearings before terminating parental rights (see exhibit 3-2) or on parents who refuse to voluntarily relinquish parental rights over children with whom they cannot (e.g., due to untreated drug addiction or long-term incarceration) or do not wish to be reunited.

Civil and Criminal Proceedings

Civil cases concerning protective custody for abused and neglected children usually involve an attorney for the social service agency (usually a city or county attorney), an attorney for the parents (two, if the parents' interests conflict), and an attorney and/or guardian *ad litem* (GAL) for the child. Child advocates are either lawyers (GALs) or trained volunteers from a Court Appointed Special Advocate (CASA) program (see the box, "The Court Appointed Special Advocate Program.") In criminal cases, children are not represented by a lawyer because they are usually witnesses, not parties

Exhibit 3-2
Typical Sequence of Hearings:
For Child in Foster Care Who Cannot be Returned Home



Source: Hardin, Mark, H. Ted Rubin, and Debra Ratterman Balser, A Second Court that Works: Judicial Implementation of Permanency Planning Reforms." Washington, D.C.: ABA, 1995.

to the case. A social worker or victim advocate may be assigned, however, to explain the proceedings to the child and offer support. This person may assist with the preparation of a victim statement, if requested by the court.

The Court Appointed Special Advocate (CASA) Program

The CASA program, founded in 1977 to assist abused and neglected children appearing in juvenile court, has more than 40,000 volunteers, is available in all 50 States and is known under many names—including Pro-kids, Child Advocates, Foster Child Advocate Services and Voices for Children.[20] GALs and CASA volunteers assist young children who may be unable or unqualified to determine their own best interest and older children who may need their opinions effectively voiced before the court. A child's attorney's recommendations may be different from that of the child advocate, whose job it is to seek the best interest of the child over the child's own wishes, if necessary. Child advocates are important to the system because they are thought to be more likely to have investigated the case thoroughly and to have met with the child due to the small number of cases they typically handle.

Issues Raised by Current Practices

The current model of CPS—as its name implies—is heavily weighted toward child protection as opposed to the promotion of child and family welfare or preventative intervention with high-risk families. Many of the children who are the subject of unsubstantiated reports of CAN, as well as those in substantiated cases receiving only minimal services, may be at substantial risk for future abuse or other negative outcomes, such as poor school performance or delinquency. Because the current model of CPS is incident-based, chronic low-grade abuse and neglect are least likely to qualify for services. Research on the long-term effects of chronic neglect and more subtle forms of abuse such as witnessing domestic violence or emotional and psychological abuse, suggests that the crisis-orientation of the current system overlooks the substantial harms resulting from these other abusive behaviors (see Paper #2.) As discussed below, five States' experiments with differentiated response—a screening system that creates two tracks of CAN cases, those in need of combined law enforcement and CPS response and those in need of intensive family services—are an effort to bring services to a broader range of CAN victims and their families in a more supportive, less adversarial context.

Another frequently debated issue is the "explosion" of children entering and languishing in foster care. The foster care crisis may be a red herring: the number of children in foster care per 1000 children increased only 55 percent between 1980 and 1994, while reports of CAN increased 161 percent during the same period.[21] In addition, the re-classification of extended family members who had previously received Aid to Families with Dependent Children (AFDC) support for caring for abused and neglected children as funded kinship foster care providers may have created an artificial "surge" in foster care utilization.[22] Finally, as Schuerman points out, caution is needed in interpreting national compilations of substitute care statistics due to incomplete data from some States and data that are not comparable between States.[23] More research is needed to determine the average length of stay in substitute care, recidivism and the proportion children in kinship care before conclusions should be drawn about whether foster care is being misused.

Federal Legislation and Child Welfare

The Federal government's impact on child welfare policy must be indirect because the U.S. Constitution reserves domestic relations and family law for the States. Because participation in Federal programs is voluntary, the program requirements imposed by Federal legislation on funding recipients do not violate the Constitution. The influence of Federal legislation is, nonetheless, quite powerful. For example, federal funding under the Adoption Assistance and Child Welfare Act of 1980 ties foster care funding to the requirement that "reasonable efforts" be made to preserve families before children are removed from their homes. The "reasonable efforts" provisions of the 1980 Act provided a springboard for the piloting of intensive family preservation initiatives across the country and focused CPS resources on family reunification and permanency planning. In addition, the 1980 Act required a case plan for each foster child and reviews to insure that it is being followed. As discussed above, these practices and priorites provide a common thread connecting otherwise disparate State and local CPS systems. Federal legislation not directly addressing child abuse and neglect can also affect State CPS systems. For example, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) that replaced Aid to Families with Dependent Children (AFDC) and related programs with block grants to States known as Temporary Assistance to Needy Families (TANF), raised concerns among some observers that families losing AFDC, food stamp, or Social Security Income (for children with disabilities) are likely to become consumers in the already over-extended child welfare and protection system.[24] Other key Federal child welfare legislation includes:[25]

- **Social Security Act of 1935**—the first Federal statute funding child welfare services. It included: Title IV-A (ADC, later known as AFDC), that addressed the needs of children in families without parental support; and Title IV-B (Child Welfare Services) that provides funding to States for foster care.

- **Child Abuse Prevention and Treatment Act (CAPTA)**—CAPTA was passed in 1974 and has been frequently revised and updated. CAPTA established the National Center for Child Abuse and Neglect (now within the Department of Helath and Human Services) and provided incentives to States to develop systems to identify, report and respond to CAN. CAPTA also funded the development of services for victims of CAN and their families.

- **Indian Child Welfare Act of 1978**—The 1978 Act emphasized the preservation of Native American families and the empowerment of Native American tribes and families to influence decisions concerning their children.

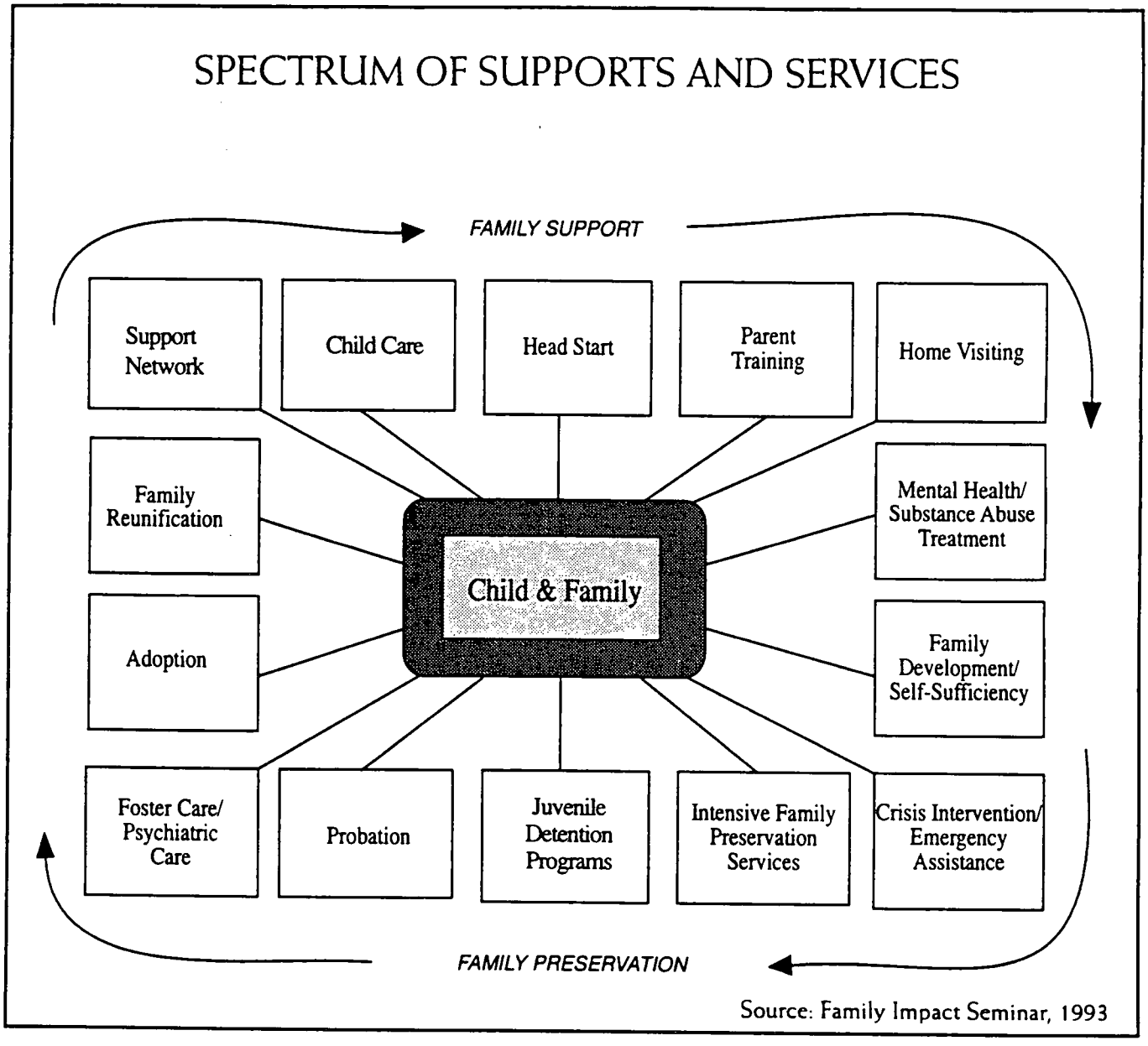
- **Family Preservation and Support Act of 1993**—The 1993 Act provides grants to State CPS agencies to provide family support and preservation services and requires the submission of State plans for reforms in the delivery of child and family services.

Early Federal legislation has been criticized for funding foster care while failing to support home-based family preservation or support services. With the Act of 1993, the emphasis has shifted toward supporting the development of a full spectrum of supports and services for victims of CAN and their families (see exhibit 3-3, "Spectrum of Supports and Services".) [26]

State Statutes Defining Child Abuse and Neglect

The criminalization of child abuse and neglect has its roots in the social reforms of the late 19th century and early 20th century. The neglected or exploited children of the poor were an early target of social and legal reforms intended to remove children from poorhouses or inadequate housing and place them in institutions or substitute care. With the advent in the 1930s of government assistance to mothers and children, the need for this sort of intervention diminished. Historically, the use of physical force to "educate" or discipline a child has been accepted by the law as a private prerogative of a parent, the limiting of which was thought to undermine the family. In the 1960s, however, new theories about physical abuse were popularized by the medical community, and laws to detect and prevent physical abuse multiplied. Child sexual abuse (CSA) laws evolved separately from laws addressing child physical abuse and neglect and have reflected the social values of the eras in which they were enacted. Over the course of the last century, the focus of legislation regulating sexual contact with minors has moved from the protection of young girls' virginity, to preventing teenage pregnancy, to protecting the physical security of children. By the 1980s, most State laws were expanded to include not only penalties for sexual abuse and severe physical maltreatment or neglect,

Exhibit 3-3


SPECTRUM OF SUPPORTS AND SERVICES
FAMILY SUPPORT
Support Network
Child Care
Head Start
Parent Training
Home Visiting
Family Reunification
Mental Health/ Substance Abuse Treatment
Child & Family
Adoption
Family Development/ Self-Sufficiency
Foster Care/ Psychiatric Care
Probation
Juvenile Detention Programs
Intensive Family Preservation Services
Crisis Intervention/ Emergency Assistance
FAMILY PRESERVATION
Source: Family Impact Seminar, 1993

but also medical neglect, psychological maltreatment, and deprivation of those things (physical and moral) necessary for healthy child development.

Statutory definitions of abuse and neglect are diverse, but many contain similar definitions of the following three crimes:

- **Physical Abuse** —the non-accidental infliction of physical harm to a child (a child is usually defined as someone under 18 years, but some jurisdictions stipulate a lower age, 15 or 16 years old.) The regulation of the use of corporal punishment by parents or other caretakers remains controversial. The majority of States (29 States) explicitly permit the "reasonable use of force" by parents or other official caretakers to discipline a child. Other States define excessive corporal punishment in separate statutes (7 States) or as part of the statutory definition of child physical abuse (11 States).

- **Neglect**—failure (by omission or intentionally) to provide a child with the basic necessities of life, such as food, shelter, clothing, medical care, and in some jurisdictions, education.

- **Sexual Abuse**—All States distinguish between sexual offenses against children (those under the age of 18) and those against adults. In general, States define three categories of sexual offenses against children:

    1. Sexual penetration (vaginal, anal, oral intercourse);
    2. Sexual contact; and
    3. Incest

    Incest laws vary widely by State, but penalties generally take into account the age of the victim, the closeness of the blood relation, and the presence of force. Penalties for other forms of sexual abuse differ based on the relationship between the offender and the victim (e.g., custodial, teacher, or stranger); the age of the victim and offender; and the circumstances of the assault (e.g., force, threats, weapons, or bodily harm.)

Most cases of child abuse and neglect are not criminally prosecuted. Penalties imposed for even severe physical abuse are generally low, not more than five yearsincarceration. However, penalties for sexual abuse generally range from one year to life imprisonment. As a matter of public policy, it is debated whether the criminalization of child physical abuse and neglect achieves an improved environment for the child. Some observers note the negative impact of fines, imprisoned parents, or out-of-home care on child welfare. On the other hand, most commentators accept that criminalization has symbolic importance. Many of the structural innovations discussed in this paper aim to balance the criminal justice and social welfare response so that children are best served.

Other Forms of Abuse Prohibited by Statute

The traditional legal phrase "endangering welfare" is much broader than most modern definitions of child abuse and neglect, encompassing physical abuse, neglect, abandonment, criminal non-support, psychological maltreatment, passive abuse (such as the "non-offending" parent who fails to intervene in or report abuse or neglect), or contributing to the delinquency or truancy of a minor. Statutes using this language currently are being replaced with ones using more precise definitions that define these offenses separately.

Psychological Maltreatment

Psychological abuse or maltreatment is beginning to be addressed in the criminal codes of some jurisdictions. Psychological maltreatment is an implicit component of all forms of child abuse, and this is defined in terms of the outcomes of abuse for the child: "any abuse, physical or verbal, that results in behavioral, developmental, or psychological problems in the child."[27] Five types of psychological maltreatment are identified in some statutes:

- Spurning (verbal degradation/ rejection);
- Terrorizing (verbal or situational threats);
- Isolating (confinement);
- Exploiting and corrupting (encouraging antisocial behavior); and
- Denying emotional responsiveness.[28]

As of 1991, 21 States include severe psychological maltreatment in their child abuse statutes.

Abandonment

Abandonment is given different definitions in the civil and criminal law. Under civil law it is a ground for the termination of parental rights. Its most common definition in civil law is "parental conduct indicating a conscious disregard of the obligations of parenthood."[29] The common definition under criminal law is far more literal: The parent or legal custodian must desert the child "intending permanently to abandon the child."[30]

Failure to protect from abuse and neglect

As of 1991, twenty-four States had statutes penalizing persons responsible for children for failing to intervene and prevent child abuse, even when that person is also being victimized. Most statutes, however, allow as a defense to the crime of failure to protect a child from abuse and neglect the fear of "serious or substantial" bodily injury.

Homicide by abuse

In the past, deaths of abused children were difficult to prosecute as first degree murder because it was hard to show evidence of intent to kill—indeed often the defendant did not intend to kill the child, only to abuse severely. Seventeen States now have separate penalties for homicide by abuse that do not have the same evidentiary requirements as other murders, thus allowing these deaths to be punished at the same level as first degree murder.

Medical neglect

Twenty-six States exempt parents from medical neglect charges if they claim a religious right to alternative spiritual treatments. Courts weigh the potential danger to the child and the State's interest in protecting the welfare of the child against the parents' parental and religious rights. However, if death results from non-treatment, the U.S. Supreme Court has taken positions on religious freedom that would permit prosection.

Mandatory Reporting Requirements

In most States, mandatory reporting laws were passed in the early 1960s in response to publicity concerning Kempe's identification of the "battered child syndrome."[31] Perhaps due the rapid time frame in which these laws were enacted, there is a great deal of consensus among State statutes regulating mandatory reporters of child abuse and neglect. Fourteen States with the most sweeping statutes (Idaho, Florida, Kentucky, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, Oklahoma, Rhode Island, Tennessee, Texas, Utah, Wyoming) use the formula "any persons" or " any other persons" following an almost standard list of mandatory reporters:

- Medical care providers (including dentists, podiatrists, medical examiners, and Christian Science Practitioners);
- School and day care staff;

- Mental health and social workers;
- Law enforcement or criminal justice professionals (including lawyers, judges, guardians *ad litem*, corrections personnel); and, in most States,
- Photographic processors.[32]

The circumstances under which reporters are obligated to contact child welfare officials vary, but all include reason to believe a child has been abused or neglected. A few statutes clarify for film processors and physicians what sorts of events need to be reported. Most commonly, the death of a child must be reported, and any venereal disease or pregnancy in young children must be reported.

Privileged communications

Statutes generally contain a clause on privileged communications. In this regard, there is great variation between statutes. In 12 States, the clergy, when receiving confession or counseling a member of their religion, are specifically exempted from mandatory reporting requirements. In six other States, clergy are specifically compelled to report suspected child abuse, regardless of the source of information or context in which the information was disclosed. There is also disagreement concerning attorney-client privilege: the majority of State's are either silent on the point or specifically affirm clients' rights to privileged communication with their lawyers, but four States suspend attorney-client privilege in the case of suspected child abuse.

Innovative provisions

A few more modern and innovative statutes name as mandatory reporters battered women's counselors, substance abuse counselors or victim advocates. While these persons would be included under the "any other person" clause of a number of statutes, naming them is consistent with current research that points to the co-occurrence of child abuse with partner abuse and child abuse and neglect with substance abuse.

Special Reporting Procedures

A number of States have special reporting procedures relating to drug-exposed infants and child fatalities.

Drug Exposed Infants. Seven States (California, Illinois, Iowa, Minnesota, Missouri, Oklahoma, and Utah) have special reporting procedures for suspected drug-exposed infants and foetuses. Most of these statutes focus on the evaluation and referral of newborns who appear to have been drug-exposed. However, a few States (notably Illinois and Minnesota) focus on the identification of drug abusing pregnant women, and their referral to substance abuse treatment and other services. The Minnesota Statute provides for the "emergency admission" of pregnant women who refuse "recommended voluntary services" or fail recommended treatment. No statute criminalizes maternal drug abuse for pregnant women; however, a finding of infant drug exposure is considered by some statutes to be grounds for a finding of neglect.[33]

Suspicious Deaths. Twenty States have statutes regulating reports of suspicious child fatalities. The majority of these statutes address procedures for mandatory reporters in general or medical examiners in particular to follow in the case of a suspicious death of a child. Forty-eight States have either local or State-wide Child Death Review Teams.[34] Fatality reviews generally focus on process and attempt to determine why the child's contacts with CPS or other agencies (if any) failed to result in appropriate safeguards.

Current Systems Reforms: Innovative Practices

A number of systemic reforms and innovative practices have been undertaken by State legislatures and State or local child welfare agencies to address problems such as inadequate service delivery to low-risk victims of CAN, the fragmentation of services and policies affecting victims of CAN, the stress caused low-risk children and families by CPS investigation and inadequate family engagement in services. Over the last five years, State-level legislation has been the catalyst for a number of systemic reforms including the creation of multiple response systems, the co-location of services for victims of CAN, family group decision-making and the provision of integrated services for families where both the child and the mother are battered. [35] The following section provides examples of some promising innovative practices from both legislation and the field.

The Creation of Multiple Response Systems

A number of States—including Florida, Iowa, Missouri, North Dakota, and Virginia—have undertaken reforms or pilot projects aimed at differentiating meaningfully between types of child abuse reports and to clarify the role of CPS. More States are expected to introduce similar legislation

in the near future.[36] Other States, such as New Hampshire, South Carolina and South Dakota have instituted similar changes without legislation. Most models emphasize thorough family assessment leading to a two or three-tiered system intended to segregate cases requiring investigation and court-involvement (as well as services) from those families needing only services. The goal of differentiated response is to make child welfare and service provision central to CPS and to reduce unnecessary and stigmatizing investigations that may alienate families in need of services.

Florida—Florida has instituted sweeping changes to reduce State-level CPS regulations, devolve more policy-making power to counties, and to establish a dual-track response system that separates the investigative function—now handled by law enforcement—from the family-centered services that now typify CPS in Florida. Both investigative track and assessment track families receive the same services, however, the courts oversee the investigative track cases to insure child safety. At the heart of the new system is the elimination of the traditional dual function of CPS (investigator/service provider), to allow social workers to focus on developing more supportive and less adversarial relationships with children and families receiving services. To establish the separate and supportive role of CPS, first contact with investigative track families is made by both a police officer, who investigates the allegations, and a Family Services Response System case worker who is there as a service provider. (See Appendix A.1)

Missouri—Missouri has funded five pilot projects testing a dual track case management system that separates investigation of child abuse and neglect reports from family assessment and service provision. The idea behind the Missouri dual track system is to insure that resources are available promptly to both types of cases, not only the most serious cases. Like Florida's system, the Missouri pilot programs will use law enforcement officers to investigate serious cases of child abuse and neglect, while CPS workers simultaneously offer services to families without assigning blame. Participating Departments of social services will be asked to restructure costs to fund community-based service provision. Evaluations of the pilot programs will be provided to the State legislature with a view to expanding the system State-wide. (See Appendix A.2)

Virginia—In 1996, the Virginia legislature directed the Department of Social Services to establish a three-year program in three to five areas of the State piloting a multiple response system to reports of child abuse and neglect. Like Florida and Missouri, the Virginia

legislation envisions a dual-track system where more serious cases are investigated in coordination with law enforcement and less serious cases receive family assessment and access to community-based services. (See Appendix A.3)

Co-location of Personnel Serving Abused and Neglected Children

Abused and neglected children and their families are often involved with a number of public agencies and private service providers, including police, prosecutors, civil lawyers, victim advocates, social workers and an array of private service providers. The following initiatives attempt to bring these disparate groups together to facilitate case management, service delivery, crisis intervention and case investigation and to make service utilization easier, less intimidating and less stigmatizing for victims and their families.

Neighborhood-based services

Three States have enacted legislation mandating or facilitating the creation of neighborhood-based multiple service delivery teams or service sites, and similar legislation is being considered in other States. Hawaii will establish a pilot project in two locations, "Neighborhood Places," where public (including CPS) and private child welfare services can be delivered. Kentucky has its own version of a "Neighborhood Place" pilot program, where CPS and other services are offered in a school-based setting. The PATCH project in Iowa is a locally-initiated project to deploy neighborhood-based CPS service delivery teams to assist families and children.

Children's Advocacy Centers (CAC)

Children's Advocacy Centers provide a safe, child-friendly environment for crisis intervention, criminal investigation, medical treatment and service provision for victims of severe child abuse and their non-offending family members. Typically CACs bring together under one roof representatives from the many agencies that are involved with severe cases child abuse: CPS workers, law enforcement officers, prosecutors, medical services personnel, mental health professionals and victim advocates. By providing crisis intervention, investigation and services at one child-oriented location, the child victims served by these centers (who are most frequently victims of sexual abuse) are able to tell their stories to joint investigation teams, thus avoiding the stress and revictimization associated with repeated questioning in various institutional settings. Victims also benefit from the increased case coordination and enhanced judgement of Multidisciplinary Case Review Teams.

The first Child Advocacy Center was founded in Alabama in 1985. Today the National Network of Children's Advocacy Centers has 124 full member programs, 12 State chapters and 73 associated member agencies. A further 200 programs are in development across the country. CACs are located in a variety of settings—in the community, in prosecutor's offices and hospitals—and receive funding from many sources, including the U.S. Department of Justice's Office for Juvenile Justice and Delinquency Prevention (OJJDP) and the Office for Victims of Crime (OVC). A number of CACs limit their services to victims of child sexual abuse, others will accept a limited number severely physically maltreated children as well. These priorities reflect a desire to target services to those populations most likely to be involved in criminal investigations and prosecutions. As States and counties reform their CPS systems to formalize the role of law inforcement in investigative track CAN cases, the CAC model merits consideration for broad replication because it provides a mechanism for the appropriate involvement of law enforcement and prosecutors with victims of CAN.

Travis County, Texas, Child Protection Team

The Travis County, Texas, Child Protection Team is a collaboration between the district attorney's office, the county sheriff's office (with their victim services division), the Austin Police Department (with their victim services division), the Travis County Children's Advocacy Center and the Texas Department of Protective and Regulatory Services. The Child Protection Team executive committee recognizes that each of these agencies contributes to child protection and welfare and that collaboration among agencies will reduce child revictimization by investigative agencies, optimize information sharing and result in more efficient and appropriate case management (see Appendix B for interagency agreements.) The Child Protection Team staff—which is housed together and hopes to move its office closer to the county's CAC—includes one senior prosecutor, a police officer, a sheriff and social workers from child protective services. According to Assistant District Attorney LaRu Woody, Director of the Family Justice Division, team members work together to investigate physical and sexual abuse allegations. Advantages to the system include shared information, cross-disciplinary expertise, the ability to interview the victim only once and increased coordination between lawyers handling civil and criminal cases concerning the same child or family. Woody observed that team members shared general knowledge as well as case information; for example, experienced law enforcement officers were able to assist newer social workers who were unfamiliar with CAN investigations.

Family Decision-Making Models

The New Zealand Family Group Conference model, based in part on traditional Maori practices, emphasizes the involvement of extended family networks in stopping family violence and making decisions about the welfare of children. In Canada, Newfoundland and Labrador are currently piloting family group decision-making models based on feminist analyses and Canadian aboriginal practices that emphasize "reintegrative shaming," communal responsibilty and allowing all family voices to be heard.[37] Similar family-centered decision-making models—such as the Oregon Family Unity Model (see Appendix C)—have been adopted in Oregon to assist with child protection and welfare decision-making. In addition, family group decsion-making models are being considered in other States, such as Kansas, Michigan, and Illinois.

In Oregon, family group decision making is the first route of intervention for both substantiated and unsubstantiated cases of CAN.[38] Participation in family group decision making may be voluntary or involuntary and may take one of two forms:

- ***Family group conferences*** are one-time meetings in which the family is allowed during one part of the conference to meet alone to create their own solutions and plans before rejoining the professional social workers, who then help them formulate a plan to be presented to the courts; or

- ***Family unity meetings*** are planning and problem-solving sessions facilitated by the social worker or, preferably, an impartial person (so that the social worker can participate). They follow a prescribed agenda moving from an introduction of all the people present in relation to the child, to a statement of purpose, a statement of concerns (family and agency), family strengths assessment, an enumeration of options, the development of a written list of formal and informal family supports, and concludes with a decision and a timeline for implementation.

In Oregon, family group decision making is cost neutral, and reported to work well with the most difficult cases. According to John Powers, Supervisor and Branch Manager of the Tillamook Services to Children and Families, "If you can enter into a non-adversarial relationship with the family, you have a better chance of getting a positive result."

Integrating Domestic Violence and Child Protection Services

In 1996, eight States passed legislation to address the complex issues involved in intervening with families where both the mother and the children are battered. Most of these laws required State agencies to screen for domestic violence in CAN investigations and to provide services to enhance the safety of the mother as well as the child; others mandate training on these issues for CPS workers.[39]

The Massachusetts' Department of Social Services (DSS) has undertaken a number of initiatives to better protect and serve abused and neglected children in homes where the mother is also a victim of domestic violence.[40] First, eleven domestic violence specialists are based in local DSS offices to consult on cases, cultivate community services for battered women and children and, in some instances, provide direct services. Second, a pilot program featuring interagency teams comprised of representatives of DSS, law enforcement, battered women's programs, batterer interventions, the courts, hospitals and visitation centers, meet regularly to formulate holistic service plans for cases involving multiple victims. Third, DSS has developed training and protocols for DSS workers to help them identify and intervene safely and effectively in cases involving domestic violence as well as child abuse. Finally, clinical supports for victims of domestic violence and their abused children were offfered, including evaluation services, batterer programs, visitation centers and psycho-educational groups for DSS-involved battered women.

Of the 22,000 cases reviewed by social workers and their supervisors in 1994, 10,500 (48 percent) were identified as involving domestic violence. The interagency pilot program evaluation suggests that services may reduce out-of-home placement for children with battered mothers (between 11.6 and 12.8 for cases in the pilot program compared to 15.2 percent Statewide.) The cost of the Domestic Violence Program is approximately 1.1 million annually, of which 40 percent is State-funded and 60 percent is Federally funded through the Family Violence Prevention and Services Act (FVPSA). An additional 9.7 million is provided by DSS for shelter services.

Proposals for System-wide Reforms

Advocates for system-wide reforms have proposed a number of modifications to the current system and offered models ranging from guidelines for structured assessment and management of CAN cases, to the reorientation of child protective services toward a community-based model and judicial models to expedite permanency planning.

Using Structured Assessment and Case Management

The National Council on Crime and Delinquency has established the Children's Research Center (CRC) to promote research and evaluation concerning child welfare systems and to assist agencies to develop highly structured case management, risk assessment and needs assessment systems.[41] The CRC works with State and local agencies to develop customized actuarial tools to predict risk of future

abusive or neglectful behaviors and to specify appropriate corresponding case management service levels. As of 1993, CRC models had been developed for Alaska, Michigan, Oklahoma, Rhode Island and Wisconsin. CRC case management models are based on two principles:

- Case management decisions can be significantly improved through the consistent use of highly structured assessment procedures; and
- The priority given to cases by staff must correspond directly to the assessment process.

CRC research has shown that separate assessment instruments are needed to predict the risk of physical abuse and the risk of neglect (see Appendix D for sample CRC risk assessment instruments.) CRC research has also found the between 15 and 25 percent of cases that would be classified "high risk" using CRC measures are currently not receiving services, while cases that would be considered low risk on the CRC scales may be carried for months or years. In response to critics who argue that individual case differences require case decisions based on the case worker's own judgement, CRC noted that actuarial tools do not make the decision for the worker, but guide the decision more acuately than personal judgment alone. According to the CRC, "Research has generally demonstrated that simple actuarial tools can predict human behavior more accurately that even a well-trained clinical staff person."[42]

Building Community Partnerships

The Executive Session on Child Protection at Harvard University's John F. Kennedy School of Government, brought together leading researchers, child welfare administrators, judges, activists and policymakers to propose a more effective response to child abuse and neglect. At the core of their work is the notion that instead of responsibility for child safety resting with one agency (CPS), a broadbased community coalition of parents, public and private agencies, organizations and individuals should share this responsibility, creating a "community partnership for child protection."[43] (See Exhibits 3-4 and 3-5.) Participants stress that the idea of a community partnership is not Utopian; diverse communities such as Cedar Rapids, Illinois, Louisville, Kentucky, Jacksonville, Florida, and Los Angeles are currently developing such partnerships. Community partnerships rely on community-based services and engaging a broad range of community members, such as parents, neighbors, schools, religious organizations, law enforcement and community programs to monitor child safety. Executive Session participants named seven stages of development for the transition to community partnerships:

Exhibit 3-4

CHARACTERISTICS OF THE CURRENT AND PROPOSED APPROACHES TO CHILD PROTECTION

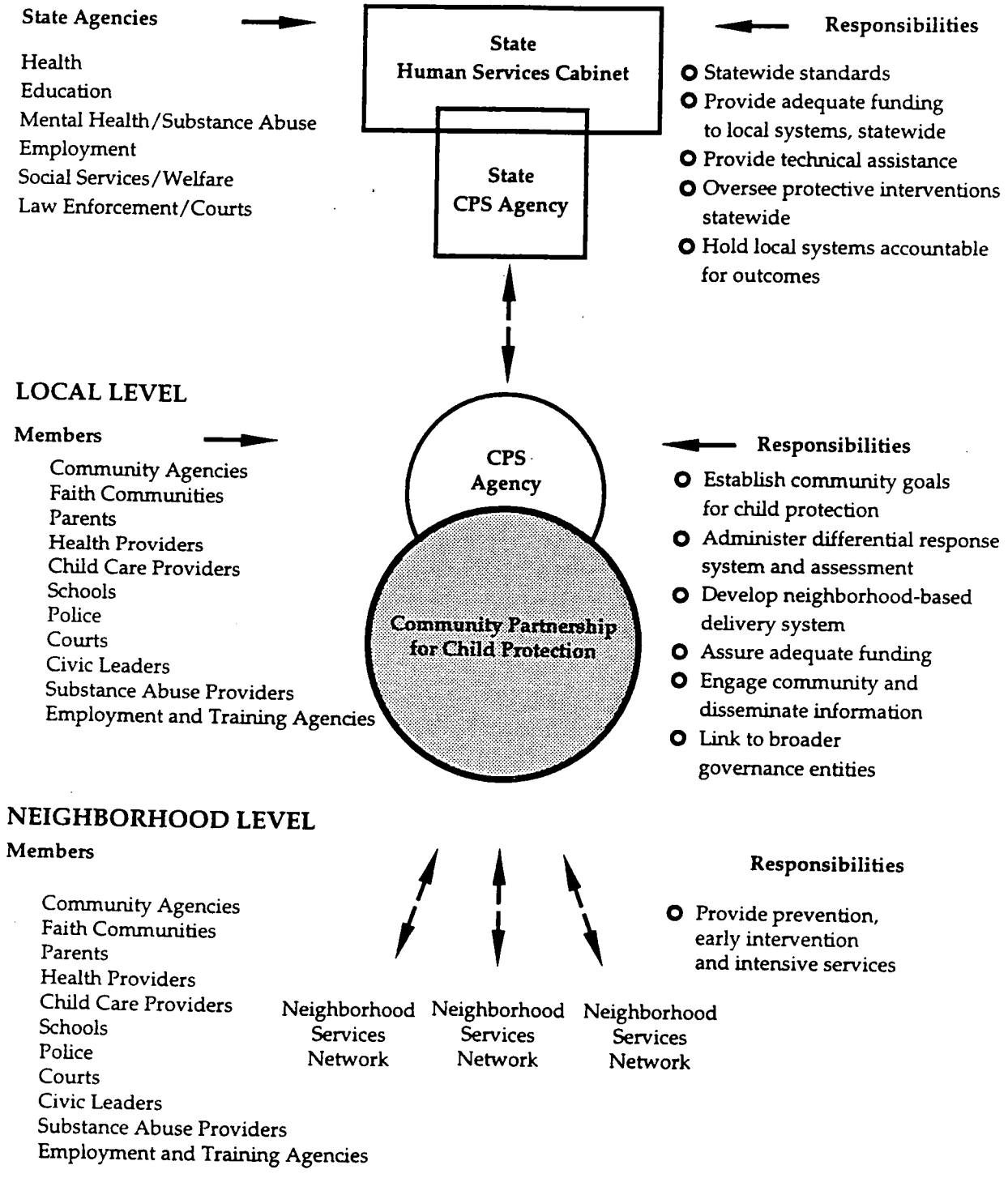
	Current Approach	Community Partnership Approach
CHILD PROTECTION 1. Case entry/case finding	• Mandated reports mix cases that are appropriate and inappropriate for CPS agency attention (roughly 50% of cases coming to CPS now are unsubstantiated) • Little or no preventive assistance is offered, so reporting is often the only option	• Mandated reports to the CPS agency are more appropriate because community alternatives exist to which many families can be referred • Targeted interventions for families likely to become CPS referrals are available before families are referred or reported
2. Assessment/investigation	• "One-size-fits-all" investigation of a specific incident • Investigations do not include comprehensive family assessment • Law enforcement haphazardly involved, with little likelihood of eventual prosecution of even serious offenders	• CPS agencies can respond in several ways, based on needs and the severity of reported abuse/neglect • All cases receive comprehensive family assessment, after initial screening • Law enforcement systematically involved in all investigations of serious physical and sexual abuse; more frequent prosecution for serious offenders
3. Service provision	• Few services available, even when the investigation is complete; capacity to customize services to a family's individualized needs is limited • Control of services is highly centralized • Natural helping networks (friends, neighbors, etc.) have little role with CPS, and are often hostile to it	• The community partnership ensures families have access to a customized array of services, supports, and opportunities; health care providers, child care resources, schools, and other community institutions are sentinels to detect risk • Substance abuse, domestic violence, and other key services are expanded and better coordinated • The community partnership involves community supports and natural helping networks extensively, including family, extended family, neighbors, and other helpers

	Current Approach	Community Partnership Approach
3. Service provision (Cont.)	• Links to substance abuse, domestic violence, and other key services are rarely made	• The community partnership promotes and implements neighborhood-based service delivery
4. Substitute parental care	• Placements too often are made without the option first for in-home services • Children often linger in substitute care while family's appropriateness for providing on-going parenting is determined	• Triggered only after intensive in-home services have been tried or considered • Emphasis is on timely, fair, and safety-oriented decisions about reunification or movement toward adoption or other permanent placement; criterion is child safety
RESPONSIBILITY AND ACCOUNTABILITY	• The public CPS agency is the only agency responsible and accountable for child protection	• The community partnership is responsible for engaging parents and many community agencies in child protection, developing a community-wide plan for child safety, and performing many service delivery responsibilities formerly done solely by the public CPS agency; the CPS agency retains legal responsibility for protective interventions for specific children • The community partnership reports on child protection outcomes to the community, and links with other community governance entities to ensure overall accountability
HEALTHY DEVELOPMENT OF ALL CHILDREN	• Few communities have explicit community goals and strategies to promote children's and families' well-being • Many communities have too few services; services are inequitably distributed across communities • Jobs/employment strategies are fragmented, sporadic, and rarely linked to child welfare and CPS • Categorical financing interferes with service provision	• Communities adopt clear goals to improve outcomes for children and families • Communities have a comprehensive array of community supports, particularly early family supports • Employment and economic development strategies are a top priority in neighborhoods • Financing is more flexibly available to meet individualized needs, and is tied to achieving outcomes

Source : Frank Farrow with the Executive Session on Child Protection, "Child Protection: Building Community Partnerships," John F. Kennedy School of Government, Harvard University.

Exhibit 3-5

COMMUNITY PARTNERS: EVENTUAL ROLES AND RESPONSIBILITIES



Source : Frank Farrow with the Executive Session on Child Protection, "Child Protection: Building Community Partnerships," John F. Kennedy School of Government, Harvard University

- Agreeing on a direction for change;
- Starting the partnerships;
- Creating differential responses to the varied needs of families for child protection;
- Developing comprehensive neighborhood-based supports and services;
- Transforming public child protection agency services (focusing on comprehensive assessments, understanding the dynamics of substance abuse and domestic violence and other risks to children, and work with multi-disciplinary and multi-agency teams);
- Shifting intake and follow-on services for lower-risk cases to a community-based system; and
- Instituting community governance and accountability for protecting children.

Model Courts: Permanency Planning Reforms

The American Bar Association has conducted two studies of courts that are implementing reforms designed to help abused and neglected children find permanent, safe placements. Key problems with juvenile court functioning cited in the studies include:

- the number of issues to be decided in each case (see exhibit 3-2);
- the number of people involved in each hearing (lawyers, social workers, guardians ad litem, law enforcement);
- lack of information concerning the structure or function of the child welfare system;
- lack of information concerning the services available to families in the community;
- delays in case processing;
- delays in permanency for foster children; and
- wasted social worker hours in court.

The Kent County Juvenile Court in Grand Rapids, Michigan, was selected by the ABA as a model for advanced judicial permanency planning reforms.[44] The Kent County court was of interest for several reasons, including its expeditious handling of cases, a high frequency of terminated parental rights for parents whose children were placed in custody, and a high number of adoptions for children whose parent's rights had been terminated. The Kent County court addressed many of the inefficiencies

found in typical juvenile court functioning through efficient, professional staffing and well-organized court procedures that target the functions required of juvenile courts in child protection cases by State and Federal law.

In particular, experienced or well-trained staff was key to the court's superior functioning. Long-term judges, who receive approximately 180 new child protection cases per year, handle each case assigned to them from the primary hearing through the termination of parental rights and adoption. In addition, once a judge has been involved with child protection hearings concerning one child in a family, all other cases concerning siblings are assigned to the same judge. Another important staffing policy involves the use of "hearing coordinators" who present legal and social service files to the court and who are responsible for recording case hearing information, scheduling next hearing dates, and coordinating materials and parties for future hearings. Researchers also noted a unified sense of purpose between court staff, prosecutors and child welfare workers. Court procedures were designed to minimize waiting and scheduling uncertainty for social workers, parents and lawyers.

A second principle which characterized the court was an emphasis on strict adherence to demanding hearing schedules and prompt and thorough attention to cases. The hearing schedules imposed by the court were generally more swift than those required by State and Federal laws, and no case was ever allowed to go off-calendar--at each hearing the next hearing date was set. Finally, researchers concluded that the intensive hearings held early in a case created both financial advantages and benefits to the child: the average stay in foster care was reduced to approximately one year and the court costs associated with each case were reasonable (approximately $2,000.)

Conclusion

The legal, institutional and practical constraints on interventions for victims of child abuse and neglect are many. However, the widely shared consensus that reforms are needed is generating a wealth of innovative practices and pilot projects that may point the way for the development of better systems in the near future. Of particular interest are reforms that emphasize the use of interdisciplary teams to guide case management--such as the Massachusetts domestic violence initiative and the Travis County, Texas, interagency Child Protection Team. Another encouraging trend is the co-location of services and efforts to provide neighborhood-based services to victims of CAN and their families. Finally, the shift in Federal funding priorities toward the provision, through State grants, of support for a

continuum of family preservation and family support services presents the opportunity to expand and improve interventions for victims of CAN.

Endnotes

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2. Wang, C.-T. and D. Daro, "Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1996 Annual Fifty State Survey," National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse, working paper #808, April 1997: 11.

3. Ibid: 10.

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5. This section relies on descriptions provided in: Waldfogel, J., "Toward a New Paradigm for Child Protective Services," unpublished paper, Kennedy School of Government, Harvard University, April 1996; American Humane Association, "Twenty Years After CAPTA"; Sagatun, I., *Child Abuse and the Legal System*, Chicago: Nelson-Hall, 1995: 35-63; as well as interviews with practitioners Wisconsin, West Virginia, Massachusetts and Oregon.

6. Child Welfare League of America, "Children '97: Embracing the Future" (statistical summary), unpublished typescript, p.1.

7. Waldfogel, "Toward a New Paradigm for Child Protective Services": 2.

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9. American Humane Association, "Twenty Years After CAPTA":16.

10. Waldfogel, "Toward a New Paradigm for Child Protective Services": 6. The American Humane Association points out that as high as this number is, a 1986 study by the U.S. Department of Health and Human Services suggested that cases investigated by CPS agencies annually may represent only 35 percent of those children actually endangered by abuse and neglect. American Humane Association, "Twenty Years After CAPTA": 19.

11. Waldfogel, "Toward a New Paradigm for Child Protective Services": 6.

12. American Humane Association, "Twenty Years After CAPTA": 21.

13. Ibid: 23.

14. Waldfogel, "Toward a New Paradigm for Child Protective Services": 5-7.

15. Smith, S.L., "Family Preservation Services: State Legislative Initiatives," National Conference of State Legislatures, unpublished report, June 1991.

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17. Davis, N. and J. Chiancone, "The Kinship Care Option: Applying Research to Practice," *Child Law Practice*, 15 (6), n.d.: 90-95.

18. Observation of foster care review panels, Massachusetts Department of Social Services, 1996-1997.

19. Jellinek, M.S., M. Little, K. Benedict, J.M. Murphy and M. Pagano, "Placement Outcomes of 206 Severely Maltreated Children in the Boston Juvenile Court System," *Child Abuse and Neglect*, 19(9) (1995): 1051-1064.

20. Sagatun, *Child Abuse and the Legal System*: 49-63.

21. In 1980, there were 302,000 or 4.5 per 1000 children in foster care; in 1994, there were 468,000 or 7 per 1000 children in foster care. In 1980, there were 1,154,000 reports of CAN (or 18 per 1000 children); in 1994, there were 3,140,000 reports of CAN (or 7 per 1000 reports). Waldfogel, "Toward a New Paradigm for Child Protective Services": 2 and 8.

22. Waldfogel, "Toward a New Paradigm of Child Protective Services":9.

23. Schuerman, Rzepnicki and Littell, *Putting Families First: An Experiment in Family Preservation*: 9-11.

24. Knitzer, J. And S. Bernard, "The New Welfare Law and Vulnerable Families: Implications for Child Welfare/Child Protection Systems," *Children and Welfare Reform Series*, Issue Brief 3, National Center for Children in Poverty, 1997.

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26. Cohen, E. And T. Ooms, "From 'Good Enough' to 'Best Possible': An Assessment Tool for the Child and Family Services Plan," Washington, D.C.: Family Impact Seminar, n.d.

27. This section draws on U.S. Department of Health and Human Services, "Reporting Laws: Definitions of Child abuse and Neglect," *Child Abuse and Neglect State Statutes Series* (Number 1), National Clearinghouse on Child Abuse and Neglect, December 31, 1995; U.S. Department of Health and Human Services, "Crimes: Physical Abuse," *Child Abuse and Neglect State Statutes Series* (Number 33), National Clearinghouse on Child Abuse and Neglect, December 31, 1995; U.S. Department of Health and Human Services, "Crimes: Criminal Neglect and Abandonment," *Child Abuse and Neglect State Statutes Series* (Number 31), National Clearinghouse on Child Abuse and Neglect, December 31, 1995; and Trost, T. and J. Bulkley, "Child Maltreatment: A Summary and Analysis of Criminal Statutes," American Bar Association, Center on Children and the Law, unpublished report, 1993.

28. Trost and Bulkley, "Child Maltreatment."

29. Ibid.

30. Del. Code Ann. Tit. 11§1101 (1989), cited in Trost and Bulkley, "Child Maltreatment."

31. In 1963, Henry Kempe published a landmark article in the *Journal of the American Medical Association* identifying the "battered child syndrome." Waldfogel, "Towards a New Paradigm of Child Protective Services": 11.

32. U.S. Department of Health and Human Services, "Reporting Laws: Mandatory Reporters," Child Abuse and Neglect State Statutes Series (Number 2), National Clearinghouse on Child Abuse and Neglect, December 31, 1995.

33. U.S. Department of Health and Human Services, "Reporting Laws: Reporting Drug-Exposed Infants," *Child Abuse and Neglect State Statutes Series* (Number 8), National Clearinghouse on Child Abuse and Neglect, December 31, 1995; U.S. Department of Health and Human Services, "Reporting Laws: Reporting Suspicious Deaths," *Child Abuse and Neglect State Statutes Series* (Number 7), National Clearinghouse on Child Abuse and Neglect, December 31, 1995; and U.S. Department of Health and Human Services, "Reporting Laws: Mandatory Autopsies and Child Death Review Teams," *Child Abuse and Neglect State Statutes Series* (Number 13), National Clearinghouse on Child Abuse and Neglect, December 31, 1995.

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35. Information for this section was drawn from the following sources: National Conference of State Legislatures, Childrens and Families Program, "Legislative Trends in Child Protective Services Reform": 1; National Council of Juvenile and Family Court Judges, *Family Violence Legislative Update*, n.p., 2 (1996); Schecter, S. "Model Initiatives Linking Domestic Violence and Child Welfare," unpublished paper prepared for the conference *Domestic Violence and Child Welfare: Integrating Policy and Practice for Families*, Iowa School of Social Work, June 8-10, 1994; and the National Conference of State Legislature's *State Legislative Summary Series*, "Children Youth and Family Issues," for 1992, 1994 and 1996.

36. Ibid. See also, National Conference of State Legislatures, "Background Information Packet: Reconsidering Child Protection," Annual Meeting, July 30, 1996.

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38. Telephone interviews with Oregon social workers and site visit with Ted Keys, developer of the Oregon Family Unity Meeting Model, July 1997; observation of a Family Unity Meeting, July 19, 1997.

39. National Council of Juvenile and Family Court Judges, *Family Violence Legislative Update*: 9.

40. "Massachusetts DSS Protects Children by Protecting Mothers," *Synergy* (a publication of the National Council of Juvenile and Family Court Judges), 2(1) (Summer 1996):6-8; "Domestic Violence Protocol for CPS" (Protocol #PR-95-002), issued 2/13/95, Department of Social Services, Massachusetts.

41. Children's Research Center, "A New Approach to Child Protection: The CRC Model," Madison, Wisconsin: National Council on Crime and Delinquency, November 1993.

42. Ibid.: 8.

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44. Information in this section is from the report Hardin, M., H.T. Rubin and D.R. Baker, *A Second Court that Works: Judicial Implementation of Permanency Planning Reforms*, Washington, D.C.: American Bar Association, 1995 and Hardin, M., *Judicial Implementation of Permanency Planning Reform: One Court that Works*, Chicago: ABA Center on Children and the Law, 1992.

Appendix A

Examples of State-Level Legislation Mandating the Creation of Dual-Track CPS Systems

Appendix A.1

Florida—Summary of Model Child Protection Legislation

Clarifies and strengthens law enforcement role

- Clarifies that law enforcement has the lead in conducting criminal investigations of child abuse and neglect.

- Creates two pilot projects where local sheriffs will work with HRS to restructure the way both agencies respond to reports of child abuse and neglect when a criminal investigation occurs simultaneously with a child protection assessment.

- Establishes an 11 member Task Force on Family Safety that is charged with examining the improved coordination among child welfare system, domestic violence programs and law enforcement (report due December 1, 1996).

Informational documents available upon request:

Detailed analyses of each bill passed
Child Protection Strategic Plan, December 1992
Child Protection Strategic Plan Status Report, 1993
Family Services Response System, March 1995

For further information, please contact:

Linda F. Radigan
Assistant Secretary
Children and Family Services
2811 Industrial Plaza Drive
Tallahassee, Florida 32301
Telephone: (904) 488-8762
FAX: (904) 487-0688

Appendix A.2

Missouri—Solicitation for Proposals for Demonstration Sites (5)

MODEL CHILD PROTECTION LEGISLATION
STATE OF FLORIDA
REPORT TO NATIONAL COUNCIL OF STATE LEGISLATURES
OCTOBER 21, 1995

1992 LEGISLATURE REQUIRED DEPARTMENT TO PREPARE A CHILD PROTECTION STRATEGIC PLAN
(Chapter 92-58, Laws of Florida)

- Called for decrease in focus on technical aspects of child protection and an improved responsiveness to the needs of children and their families.
- Required broad community planning process to gather input and build consensus.
- Establishment of a Child Protection Strategic Plan that articulates values, goals, reform recommendations, statutory and policy changes.
- Creation of Health and Human Services Boards (HHSBs) in each district to provide budget and policy oversight for all department programs.

1993 LEGISLATURE AMENDED CHAPTER 415, FLORIDA STATUTES, TO ADD PART III, FAMILY SERVICE RESPONSE SYSTEM
(Chapter 93-25, Laws of Florida)

Ground breaking legislation allowing communities and the department to develop "differential community systems" for child protection.

- Known as the Family Services Response System (FSRS - Part III, Chapter 415, F.S.), this alternative method is intended to offer a non-adversarial and highly individualized responses to child abuse and neglect.

States that policies and procedures that provide for child protection intervention through the department's family services response system should be based on the

- The intervention should insure the safety of children.

- The intervention should engage families in constructive, supportive, and nonadversarial relationships.

- The intervention should intrude as little as possible into the life of the family, be focused on clearly defined objectives, and take the most parsimonious path to remedy a family's problems.

- The intervention should be based upon outcome evaluation results that demonstrate success in supporting families and protecting children.

FSRS plans may be developed voluntarily to cover part or whole district, but must contain the following provisions:

- All reports of child abuse or neglect will continue to be received and screened at the Florida Abuse Hotline and transmitted to districts.

- The district will "triage" or initially screen the reports in order to establish what reports will be handled as FSRS.

- The district retains the responsibility for notifying the state attorney and law enforcement agency immediately upon receipt of certain mandated types of reports such as child death due to abuse or neglect, sexual abuse or aggravated child abuse.

- Reports handled under FSRS do not require classification (labeling of perpetrators) for purposes of future background screening.

1994 AMENDMENTS TO CHAPTERS 39, 44, 49, 119, 409, 415, FLORIDA STATUTES (CHAPTER 94-164, LAWS OF FLORIDA)

Strengthens case planning procedures.

- Requires that the services delineated in the case plan be designed to improve the conditions in the parents' home and aid in maintaining the child in the child's own home, or facilitate the return of the child to the child's own home or facilitate the permanent placement of the child.

- Requires that the service intervention be the least intrusive possible into the life of a family, focused on clearly defined objectives, take the most efficient

path to a quick reunification or permanent placement and, to the extent possible, be grounded in outcome evaluation results that demonstrate success in the reunification or permanent placement process.

Improves procedural protections for children and parents.

- Provides procedures that will allow for a more effective and properly balanced termination of parental rights process when reunification efforts have failed.

- Provides procedures for the development of a case plan when the parents are unwilling or unable to participate. Provides that the unwillingness or inability of a parent to participate in the development of a case plan shall not prohibit the filing of a petition for dependency or for termination of parental rights.

- Adds to the definition of abandonment a provision stating that the incarceration of any person responsible for the care of a child does not prohibit a finding of abandonment.

- Provides additional requirements to ensure that persons entitled to notice are properly served with a summons to a hearing.

  Requires that when an affidavit of diligent search has been filed, the petitioner must continue to search for and attempt to serve the person for whom the affidavit has been filed until excused from further search by the court.

Improves media access in high profile cases.

- It allows HRS to petition the court for an order for the immediate public release of records of the department which pertain to the investigation of abuse, neglect, abandonment, or exploitation of the child or vulnerable adult who suffered serious bodily injury.

Discourages false reporting

- It allows HRS to aggressively respond to false reports of child abuse or neglect by allowing HRS to impose a fine, not to exceed $1000.00 for each violation, on a person who knowingly and willfully makes a false report.

1995 AMENDMENTS TO CHAPTERS 39,232, 402, 415, FLORIDA STATUTES (Chapter 95-228, Laws of Florida)

Eliminates a highly adversarial "labeling process" and employment consequence; improves overall bckgrounds screening efforts.

- In 1985 background screening legislation passed requiring background checks for persons employed in certain programs for children and people with disabilities. HRS was responsible for searching for child and adult abuse or neglect reports and for forwarding fingerprint cards to the Florida Department of Law Enforcement for a search of state criminal history records.

- As of October 1995, HRS will no longer be required to classify all reports of child abuse and neglect for the purpose of employment screening. The classifications of all reports currently in the central abuse tracking system are declared invalid. By July 1997, The Florida Department of Law Enforcement will assume responsibility for criminal background checks for purposes of employment screening.

- HRS will still maintain records in order to detect patterns of abuse and the bill allows HRS to maintain all records for a longer period of time – for seven years after the date of the last entry in the service record or until the child is 18 years old.

- Hiring agencies will receive and review entire criminal record from FDLE.

- Hiring agencies must share employment history information and may not be held liable unless records were maliciously falsified.

Long-term care

- Allows the court to terminate the supervision of temporary and long-term relative and non-relative custody cases when the placement is stable and needs no supervision.

- Under certain conditions, long-term foster care may become a permanency option for a child, much like adoption.

DFS

SB 595

A Child Protection System

Community Partnership and Collaborative Effort

Missouri Department of Social Services

I. INTRODUCTION

During the 1993-94 legislative session, the General Assembly passed, and Governor Carnahan signed into law Senate Bill 595, which revised the Child Abuse and Neglect statutes. The most significant revision is the establishment of a demonstration initiative to assess the impact of utilizing two different methods of intervening when there is a report of child abuse or neglect. SB 595 requires the division to investigate some reports of abuse and neglect, but allows a family assessment on cases that do not require law enforcement involvement or removal of a child. This initiative establishes five demonstration sites which are to run for three years. These three-year demonstration sites will test the philosophy of the two-track service delivery system and assess its effectiveness in improving the response of the division and the community to reports of child abuse and neglect.

The Division of Family Services (DFS) is soliciting proposals for these demonstration sites from DFS county offices in collaboration with other local community stakeholders, such as juvenile courts, public schools, law enforcement, treatment agencies, etc. The division encourages proposals that implement this approach in neighborhoods, counties, or a collaboration of several counties.

II. PRINCIPLES OF SENATE BILL 595 CHILD PROTECTION SYSTEM

The underlying principle of the Child Protection System, as embodied in Senate Bill 595, is that the families coming to the attention of the Division of Family Services have different intervention needs and require flexible responses from the division and the community in order to protect children and meet the needs of the family. This proposed system establishes a demonstration initiative to assess the impact of utilizing two different methods (or a "two-track" approach) of intervening when there is a report of child abuse or neglect. SB 595 requires the division to investigate some reports of abuse and neglect, but allows a family assessment in cases that would not be considered, if true, a criminal violation. This section identifies the philosophical basis of this legislation.

- Parents have the primary responsibility for, and are the primary resource for their children.
- All child welfare intervention by state and community agencies has as its first goal, the welfare and safety of the child.
- The Child Protection System must be designed to be child-centered, family-focused, community-based, and culturally sensitive.
- The Division of Family Services will collaborate with the community to identify, support, and treat families in a family-supportive, non-threatening manner, in both Investigative and Family Assessment situations.
- A Family Assessment approach, stressing the strengths of the family, identifying and treating the family's needs, and assuring the safety of the child, is the appropriate approach for cases not requiring law enforcement involvement or the removal of the child.
- Neighborhoods and communities are the primary source of opportunities and supports for families, and have a primary responsibility in assuring the safety and vitality of their members.
- Only a comparatively small percentage of current Child Abuse and Neglect reports are criminal in nature or will result in the removal of the child or alleged perpetrator.
- Division of Family Services staff who co-investigate serious Child Abuse and Neglect reports with law enforcement, must be competent in law enforcement procedures, fact finding, evidence gathering, etc., as well as effective social intervention and assessment.

- Service needs identified with all families should be addressed as quickly and effectively as possible by the Division of Family Services, the community, and the family making decisions.
- Services and supports for families are designed to build on the strengths and resources of families and communities.
- The Child Protection System will not unnecessarily label families or individuals as either perpetrators of abuse and/or neglect or victims of abuse and/or neglect.

In summary, the "two-track" service delivery approach is designed to focus the investigation efforts of DFS and law enforcement on cases that would be a crime, or would likely result in the removal of the alleged perpetrator or the child. The remaining families will be served through the Family Assessment and Service Delivery approach in order to address any service needs. (Note: Families who are investigated will need services similar or identical to those provided to families who receive the Family Assessment approach. See page 13.)

III. KEY COMPONENTS OF SENATE BILL 595 CHILD PROTECTION SYSTEM

Once the demonstration sites are selected, the procedure for handling reports of child abuse and neglect will be changed for those sites. This section describes the key components of the demonstration project. This section is not intended to provide definitive procedures that will be followed, but to provide the reader with a general understanding of the components and some decisions that have been finalized.

A. Transfer of Cases from the Child Abuse and Neglect Hotline

Reports of child abuse and neglect received by Hotline staff will be forwarded to the demonstration sites. The definitions of abuse and neglect have not changed. Therefore, except for the expansion of the definition of "those responsible for the care, custody, and control of the child" that was previously identified for DFS staff, the families that DFS serves under the "two-track" system are essentially the same that DFS currently serves.

B. Referral Screening Process

Demonstration sites will be responsible for screening reports received from the Hotline and classifying those reports as either Investigation or Family Assessment reports. The classification criteria and policy to assure uniformity in classification is under development and will be provided to the demonstration sites in a manual and in staff training. Sites will need to identify how they would implement this screening process.

For the purpose of this discussion, the following guidelines will be used to determine whether a report from the Hotline will be classified as an Investigation or a Family Assessment:

1. Parameters of Investigation Cases

Investigation cases are those where the acts of the alleged perpetrator, if confirmed, are criminal violations and/or where the action/inaction of the alleged perpetrator may not be criminal, but which if continued would lead to the removal of the child or the alleged perpetrator from the home.

Investigation cases will include:

- Reports of serious physical, medical or emotional abuse and serious neglect cases where a referral for criminal investigation is warranted;

- All reports of sexual abuse;
- All other reports that do not fall into the above categories but which, if confirmed, would be a violation of the criminal co . tatutes listed in Senate Bill 595;
- Cases, including chronic neglect, where specific acts of the alleged perpetrator have a high probability of leading to the court-ordered removal of the child or alleged perpetrator from the home; and
- All cases referred to the Out-Of-Home Investigation (OHI) Unit.

2. *Parameters of Family Assessment Cases*

Family Assessment reports are cases of mild, moderate, or first-time abuse or neglect, or reports where the only concern is a threat of serious abuse or neglect if there is no intervention. These cases will include reports where law enforcement action or child removal does not appear necessary to e: the safety of the child.

Family assessment track reports will include:

- Mild, moderate, or first-time reports of physical abuse or neglect (including medical neglect);
- Mild or moderate reports of emotional maltreatment; and
- Educational neglect reports.

Each demonstration site will establish procedures for the classification of reports as investigation or Family Assessment. If the report is classified as an inve tion, DFS will immediately notify the appropriate local law enforcement agency to assist in the investigation. If the case is classified as a Family Assessment, the report will be assigned to a DFS Children's Services Worker who will contact the family and conduct a thorough Family Assessment to determine any risk to the child's safety and to identify service needs of the family.

C. *Initiation of Intervention*

In both investigation and Family Assessment cases, staff w initiate the investigation or assessment within 24 hours of the ref otline, (or 72 hours in educational neglect cases) and will complete n/family assessment within 30 days.

D. *Transfer of Cases Between Tracks*

In a small percentage of cases it will be determined that it is more appropriate for an Investigation case to be handled through the Family Assessment approach and vice versa. One of the primary goals of the demonstration project is to perfect the initial screening function to assure that this transfer is kept to an acceptable minimum. However, SB 595 acknowledges that some cases must transfer due to information obtained during the Investigation/Family Assessment. The statute requires cases to be transferred, as appropriate.

The demonstration sites will need to develop a process to assure appropriate transfer of cases when a transfer is necessary. A component of this transfer process should be discussion with the screening staff prior to or at the time of transfer. When such transfers are made, they are to be done in the least disruptive way possible for the family and should minimize service delivery interruption.

The statute also requires the commencement of an Investigation if during or after the family assessment, the family refuses voluntary services and it is determined that such services are necessary to reduce the high risk of future abuse or neglect.

E. Community Collaboration

The Child Protection System will promote the safety of children and the integrity and preservation of the family. All community resources and the division are to collaborate in providing support, assistance and services to children and families. This collaboration is to result in the identification of comprehensive local services and assure access to those services for children and families where there is a risk of abuse or neglect. This collaboration will involve local law enforcement in conducting investigations, community agencies in facilitating a family assessment approach with families not requiring an Investigation, and a variety of local resources in providing treatment services.

F. Independent Evaluation

The statute requires that an independent (non-DFS) evaluation be conducted according to accepted objective research principles to determine the effectiveness of this approach in intervention. The results of this independent evaluation will be used to assess the "success or failure" of the two-track approach to Child Protection Services.

G. Legislative Approval of Statewide Implementation

The Division of Family Services is required to submit to the General Assembly, by January 1, 1998, documentation sufficient to determine if the two-track system should be implemented statewide.

IV. PROPOSAL REQUIREMENTS

Division of Family Services staff, in conjunction with interested community collaborations, are to submit a written description of how they will propose to meet the expectations of the demonstration sites. There will also be a verbal presentation of the proposal before a committee.

In order for the most appropriate and representative sites to be selected, each of the following items must be addressed in your proposal:

A. Philosophical Approach

The proposal is to include a broad description of the philosophical beliefs of the DFS office(s), juvenile court, law enforcement and other public/private agencies involved in the collaboration and how these beliefs are compatible with the goals of SB 595. The description should also include how these beliefs were agreed upon locally and why variations from the principles detailed in this material are appropriate to the operation of your site.

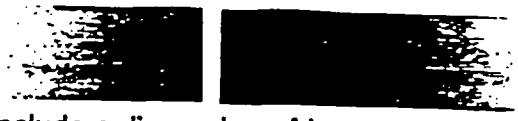
B. Site Description

It is important that the collaboration include, in the proposal, a description of the geographic (metro or rural, neighborhood or several counties), population, economic, ethnic and cultural diversity of the demonstration site. Statistical information should be included which describes the site, such as number of child abuse/neglect reports handled over the last three years, open Family-centered Services cases, Probable Cause rate, number of children removed from their home, Preventive Services cases, caseload sizes, etc. This information will assist in assuring that sites selected are representative of the state and usable for purposes of demonstrating impact when compared with similar areas.

In order to gather statistical information a variety of sources are available. These sources include the CA/N Annual Report, Monthly Administrative Analysis Report, Division of Research and Evaluation (314-751-3060), Census information, etc.

C. Implementing the Case Screening Mechanism

The proposal must provide an identification of staff ed locally to classify (screen) reports received from the Hotline igation or Family Assessment. (The actual classification criteria ndardized and provided to the sites prior to implementation. nay choose to use a committee, supervisor or some other method y the reports.



The proposal must include a discussion of how the classification process will assure that Investigations/Family Assessments will be initiated within 24 hours, including weekends and holidays.

It is expected that some of the reports will switch between Investigation and Family Assessment tracks. However, the classification process must have as one of its goals to minimize the necessity of this reassignment. The proposal must discuss how the cases will be transferred between tracks.

D. Staff Assignment

The demonstration sites will need to determine how they will assign staff to conduct Investigations or Family Assessments. As stated earlier, a minority of the reports will be Investigation while the majority will be Family Assessment. The site will need to decide how staff will be assigned. The proposal should indicate if staff will be assigned as generalists (conduct Investigations and do Family Assessments/FCS) or specialists. Other options, suggested by demonstration sites, will be considered.

The proposal should indicate the number of staff in the site and the number that will be dedicated to the project. It should also include a discussion of how staff will be assigned, especially if multiple counties are included in the site. For example, there may be a plan to use regional investigation teams. The proposal should discuss why a particular plan was adopted.

Your staff assignment plan must be able to:

1. Initiate all Investigations/Family Assessments within 24 hours of receipt of the report from the Hotline (or 72 hours in cases of educational neglect);

2. Conclude Investigations/Family Assessments within 30 days;

3. Effectively transfer cases between tracks, when necessary, without delay in service delivery;

4. Assess family strengths, needs, and risk to the child in all cases on an on-going basis;

5. Make contact in order to initiate third-party treatment services immediately (within 48 hours of the time that the service need is identified); and

6. Describe how the staff assignment plan will assure continuity in service delivery for families and children.

E. *Community Involvement and Support*

It is vital that key stakeholders in the community are supportive of and involved in the demonstration site. Stakeholders may include law enforcement, prosecutors, juvenile courts, schools, treatment agencies, medical and public health agencies, GALs and CASA, Legal Aid, etc. The proposal must address the collaboration and agreements that have or will be forged among these stakeholders. In particular, the proposal should include:

1. Copies of written agreements between the stakeholders or letters of support for the demonstration site. If it is not possible to get letters of support or agreements from some key stakeholders, the proposal should detail how these agreements will be developed in the future;

2. How on-going coordination and collaboration will be maintained and enhanced to meet the needs of the families and children;

3. A description of current and future programs and services which will lead to a comprehensive service delivery system;

4. Current initiatives within the community or initiatives being pursued (including volunteer activities) which might positively or negatively affect the ability of the community to successfully implement this demonstration project;

5. How current or future services will be coordinated with this project to provide a full range of services; and

6. A description of any community stakeholders or agencies that may be interested in working with the division to address the needs of families that do not come to the attention of the division through a child abuse or neglect report. (For example Preventive Services Referrals).

F. *Training Needs*

The proposal must include a detailed description of the training needs that are anticipated by division staff and other collaborating agencies in order to successfully implement and maintain the demonstration project. For example, there may be a need for training in cultural sensitivity, family assessment and Family-centered services, case screening, investigative skills, community mobilization, etc. The proposal should address the ability of the community to provide this training and the need for outside assistance. Initial training on the philosophy and the policy and procedures will be provided prior to the start of the project. Ongoing training will be designed and provided as identified.

G. *Public Education and Awareness*

Describe steps that will be taken to advise and inform the community of the demonstration site and the impact that is expected. How will site staff explain the difference between the new "two-track" process and the current system of division intervention? Once the sites have been selected, technical assistance will be provided.

H. *Evaluation Criteria*

The division will be contracting for an independent evaluation of the demonstration project. The evaluation will address the program outcomes and results that the site believes are important to be measured to determine the success or failure of the "two-track" system. Additional criteria to be evaluated for all sites will be developed in addition to site-specific criteria. The proposal should address the outcomes or results expected from the successful implementation of the legislation in the site, and how the site will cooperate and work with the independent evaluation.

Appendix A.3

Virginia—Statute Establishing a Multiple Response System

CHAPTER 856

An Act to amend the Code of Virginia by adding in Chapter 12.1 of Title 63.1 a section numbered 63.1-248.18, establishing a child protective services multiple response system.

[H 36]

Approved April 9, 1996

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 12.1 of Title 63.1 a section numbered 63.1-248.18 as follows:

§ 63.1-248.18. Establishment of pilot multiple response system.

A. By March 1, 1997, the Department shall establish a multiple response child protective services system in at least three but no more than five areas of the state selected by the Department. Areas may be composed of any combination of one or more counties or cities or both counties and cities. The multiple response system is designed to protect children at risk by effective use of available community resources. When appropriate, families will be offered services through the local department or through community agencies to promote safe, positive relationships within families by emphasizing prevention and assistance; or when otherwise appropriate, local departments will investigate, in conjunction with law-enforcement agencies pursuant to memoranda of understanding, allegations of child abuse or neglect for appropriate intervention or follow up action. The Department shall develop criteria for the selection of pilot areas which shall include an assessment of the effectiveness of the area's plan for community involvement in child protective services and a determination of whether local departments in the area have effective agreements with law-enforcement agencies and the attorney for the Commonwealth ensuring interagency cooperation.

By November 1, 1996, the Department shall submit to the House Committee on Health, Welfare and Institutions and the Senate Committee on Rehabilitation and Social Services a report outlining the plan for the multiple response system, including copies of any requests for proposals and the criteria developed for selection of pilot areas.

The pilot programs shall be subject to the provisions of this chapter, State Board regulations and Department policies except to the extent that such regulations and policies are inconsistent with the provisions of this section.

The State Board shall promulgate regulations to implement the provisions of this section to be effective within 280 days of July 1, 1996.

B. Upon receipt of a report of child abuse or neglect, the local department, after making an initial assessment shall determine whether the appropriate level of intervention is (i) investigation, (ii) family assessment and services or (iii) referral by the local department for services even though the report does not meet the definition of abuse or neglect. The Department shall develop an assessment instrument which shall be used to determine the appropriate level of intervention. A report may be reclassified at any time during the local department's involvement with the case.

C. The local department may investigate any report of child abuse or neglect but the following reports of child abuse or neglect shall be investigated regardless of the outcome of the assessment: (i) sexual abuse, (ii) child fatality, (iii) abuse or neglect resulting in serious injury as defined in § 18.2-371.1, (iv) child has been taken into the custody of the local department of social services or (v) cases involving a caretaker at a state licensed child day center, religiously exempt child day center, regulated family day home, private or public school, or hospital or any institution.

D. Cases determined to be appropriate for investigation shall be investigated in accordance with the provisions of this chapter. Investigations shall be completed within forty-five days of receipt of the report. However, upon written justification by the local department, such investigation may be extended

up to a total of sixty days. Upon completion of the investigation, the department shall consult with the child's family about services to address the family's needs.

In cases determined to be appropriate for family assessment, the local department shall immediately contact the subject of the report and the family of the child alleged to have been abused or neglected and give each a written explanation of the family assessment procedure, verbally explain the procedure, and assess the service needs of the family. The purpose of the family assessment is to ensure the safety of the child identified in the report and, if appropriate, to provide services that deter future child abuse and neglect. The family assessment and identification of service needs shall be based on information gathered from the family and other sources. The family assessment shall be completed within forty-five days of receipt of the report. However, upon written justification by the local department, the family assessment may be extended up to a total of sixty days.

The family assessment shall be in writing and shall be completed in accordance with State Board regulation. Upon completion of the family assessment, the department shall consult with the family about services to address the family's needs.

E. Families have the option of declining the services offered as a result of the family assessment. If the family declines the services, the case shall be closed unless the local department determines that sufficient cause exists to redetermine the case as one that needs to be investigated. In no instance shall a case be redetermined as an investigation solely because the family declines services. The local department shall commence an immediate investigation if, at any time during the family assessment and services approach, it determines that an investigation is required. Such an investigation shall be completed within forty-five days of the date that it is determined that an investigation is required.

F. Reports that are not investigated shall not be determined founded or unfounded and shall not be entered into the central registry. Reports that are investigated shall be determined founded or unfounded, and founded reports shall be entered into the central registry in accordance with the provisions of this chapter. The subject of the report shall have access to his own record in the central registry.

G. All child abuse and neglect reports and the department's subsequent involvement with the case shall be recorded. The record, which shall be separate from the central registry, shall be accessible only to the Department and to local departments for child protective services. The subject of the report is the person who is alleged to have committed abuse or neglect. The subject of the report shall have access to his own record. Records of reports not investigated shall be purged three years after the date of the report if there are no subsequent reports regarding the same child or the person who is the subject of the report in that three years. The department shall retain such records for an additional period of up to two years if requested in writing by the person who is the subject of such complaint or report.

H. The Department shall develop a training program for all staff persons involved in child protective services in the pilot programs, and all such staff shall receive this training.

I. The Department shall evaluate and report on the impact and effectiveness of the multiple response system in meeting the purposes of the system. The evaluation shall include, but is not limited to, the following information: turnover rate of child protective services workers, changes in the number of investigations, the number of families receiving services, the number of families rejecting services, the effectiveness of the initial assessment in determining the appropriate level of intervention, the impact on out-of-home placements, the cost effectiveness of the system, the availability of needed services, community cooperation, successes and problems encountered, the overall operation of the multiple response system and recommendations for improvement. The Department shall submit a preliminary report to the House Committee on Health, Welfare and Institutions and the Senate Committee on Rehabilitation and Social Services by December 15, 1997, and subsequent annual reports by December 15, 1998, and by December 15, 1999.

2. That this act shall become effective only if state funds are provided to carry out the provisions of this section by the 1996 General Assembly.

Appendix B

Travis County, Texas, Child Protection Team Organizational Documents

B.1 Executive Committee Agreement

B.2 Interagency Agreement

Appendix B.1

Executive Committee Agreement

TRAVIS COUNTY CHILD PROTECTION TEAM

EXECUTIVE COMMITTEE AGREEMENT

THE CHILD PROTECTION TEAM WILL HAVE AN EXECUTIVE COMMITTEE MADE UP OF DESIGNATED REPRESENTATIVES FROM THE MEMBER ENTITIES. THE PURPOSE OF THIS COMMITTEE WILL BE TO PROVIDE THE TEAM WITH A MULTI-DISCIPLINARY GOVERNING BODY TO ADDRESS TEAM ISSUES. THE COMMITTEE'S PRIMARY FUNCTION WILL BE TO MAKE JOINT DECISIONS ABOUT PROTOCOLS AND PROCEDURES AND MATTERS OF POLICY AFFECTING TEAM OPERATIONS.

THE FOLLOWING MEMBER ENTITIES WILL BE REPRESENTED ON THE EXECUTIVE COMMITTEE: TRAVIS COUNTY DISTRICT ATTORNEY'S OFFICE, AUSTIN POLICE DEPARTMENT, TRAVIS COUNTY SHERIFF'S OFFICE, TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER, AND THE TEXAS DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES.

EACH MEMBER ENTITY WILL HAVE DESIGNATED REPRESENTATIVES ON THE COMMITTEE WHO MAY ATTEND AND PARTICIPATE IN THE CPT EXECUTIVE COMMITTEE MEETINGS. EACH ENTITY WILL DESIGNATE ONE PRIMARY VOTING DELEGATE, FOR A TOTAL OF FIVE VOTING DELEGATES, WHO WILL REPRESENT THE MEMBER ENTITY AND HAVE THE AUTHORITY TO ACT ON BEHALF OF THE ENTITY IN A BINDING FASHION. THE DELEGATE WILL HAVE ONE VOTE PER PERSON WHEN MAKING DECISIONS DETERMINING POLICY AND PROCEDURE. EACH MEMBER ENTITY WILL ALSO DESIGNATE AN ALTERNATE VOTING DELEGATE TO VOTE IN THE ABSENCE OF THE PRIMARY VOTING DELEGATE.

BEFORE ANY ACTION CAN BE TAKEN BY A VOTE, THERE MUST BE AT LEAST

ONE REPRESENTATIVE, VOTING OR NON-VOTING, FROM EACH ENTITY PRESENT AT THE MEETING. ADVANCED NOTICE OF AN AGENDA ITEM REQUIRING A VOTE IS REQUIRED AND MAY BE GIVEN IN WRITING OR VERBALLY. A MAJORITY VOTE WILL DETERMINE THE ISSUE/DECISION.

THE UNDERSIGNED SUPPORT AND AGREE TO THE ABOVE EXECUTIVE COMMITTEE AGREEMENT:

ELIZABETH WATSON
CHIEF OF POLICE
AUSTIN POLICE DEPT

7-13-95
DATE

RONALD EARLE
TRAVIS COUNTY DISTRICT ATTORNEY

7-5-95
DATE

TRAVIS COUNTY SHERIFF'S OFFICE

7-7-95
DATE

KAREN EELLS
REGIONAL DIRECTOR
TEXAS DEPT. OF PROTECTIVE AND
REGULATORY SERVICES

7/11/95
DATE

TOM FORBES
CHAIRMAN OF THE BOARD
TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER

7-17-95
DATE

CPT EXECUTIVE COMMITTEE DELEGATES

** DENOTES THE PRIMARY VOTING DELEGATE FOR THE ENTITY
 * DENOTES THE ALTERNATE VOTING DELEGATE FOR THE ENTITY

DISTRICT ATTORNEY:

** DIRECTOR OF FAMILY JUSTICE DIVISION
 * CHIEF PROSECUTOR, CHILD PROTECTION TEAM
   CAC PROSECUTOR, CHILD PROTECTION TEAM

AUSTIN POLICE DEPARTMENT:

APD INVESTIGATIONS:

** DEPUTY POLICE CHIEF, COMMUNITY RESPONSE BUREAU
 * DEPUTY POLICE CHIEF, CRIMINAL INVESTIGATIONS BUREAU
   LIEUTENANT, CHILD ABUSE SECTION
   SR./SGT., CHILD ABUSE SECTION
   SR./SGT., CHILD ABUSE SECTION

APD VICTIM SERVICES:

   DIRECTOR, VICTIM SERVICES
   SUPERVISOR, VICTIM SERVICES

TRAVIS COUNTY SHERIFF'S OFFICE:

** CAPTAIN (CUTLER)
 * _____
   _____

TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER:

** EXECUTIVE DIRECTOR
   PROGRAM COORDINATOR
   CLINICAL DIRECTOR

TEXAS DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES:

** LEAD PROGRAM DIRECTOR
 * PROGRAM DIRECTOR, INVESTIGATIONS
   INVESTIGATIONS SUPERVISOR

Appendix B.2

Interagency Agreement

TRAVIS COUNTY CHILD PROTECTION TEAM
INTERAGENCY AGREEMENT

Child abuse is a significant social issue facing our community. In 1994, over 1300 confirmed cases of abuse and neglect were investigated in Travis County.

The system for dealing with child abuse in Travis County consists of a network of agencies with distinct individual mandates under the law but whose collective goal is the protection of children. The community, too, has a distinct, primary interest in the protection of children. The community and the agencies which deal with child abuse are strongly committed to a collaborative approach to the problem, to avoid the "revictimization" of children by the system itself and to better meet their respective mandates.

This revictimization occurs when the child victim is forced to tell his or her story over and over again to representatives in each agency involved in child abuse investigations. Such interviews often take place in strange and forbidding environments. Revictimization is further aggravated when the agency representatives do not communicate with one another. The child is often left with the feeling that, since the victimization by the system is worse than that which brought them into the system, they made a mistake in telling about the abuse in the first place; or worse still, the child tells of the abuse only to be returned to an abusive situation.

To improve the system's response to children, the community and the agencies which deal with abused and neglected children established the Child Protection Team in 1991. With the formation of this Team, member agencies and the community made their commitment to collaboration a reality and began to work together on a daily basis. Because of this collaboration, children are now better served by a system that was put in place to protect them.

MISSION STATEMENT

The mission of the Travis County Child Protection Team is to more effectively protect the children of this community by consolidating the community, investigative, legal and social services provided by the Travis County District Attorney's Office, Travis County Sheriff's Office, Austin Police Department, their respective Victim Services Divisions, the Travis County Children's Advocacy Center and the Texas Department of Protective and Regulatory Services into one collaborative effort.

In support of this Mission, the Travis County Child Protection Team has as its goals the following:

1) Better protect and nurture children by reducing the trauma to children caused by multiple investigative interviews;
2) Improve collaboration to ensure coordinated investigations and provide more coordinated services to families; and
3) Enhance the quality of investigations to improve the protection of children and the prosecution of perpetrators.

MEMBERSHIP

The Travis County Child Protection Team is made up of the following entities, with their respective legal mandates, roles, and responsibilities (description of agency roles is limited to responsibilities performed within the Child Protection Team):

AUSTIN POLICE DEPARTMENT

One of the mandates of the Austin Police Department is to investigate all criminal cases of physical abuse and neglect of children 14 years of age or younger, and sexual abuse of children younger than 17 years of age, occurring in the city of Austin, Texas. Responsibilities include the gathering and preservation of evidence to ensure a prosecutable criminal case. This includes interviewing and taking statements of witnesses and suspects, evidence collection, scene preservation and the preparation and execution of search and arrest warrants. The Department also provides necessary immediate crisis intervention in the form of crisis counseling and follow-up to children and families involved in the criminal justice system. The Department's counselors also conduct forensic interviews of child victims or witnesses. A "forensic interview" means an interview conducted for the purpose of gathering accurate information relevant to a civil or criminal investigation of child abuse or neglect for evidentiary purposes. The forensic interview will follow guidelines established to meet evidentiary requirements.

Other crisis intervention services provided by the Department include information and referral for services, community training and assistance with victim's compensation.

TRAVIS COUNTY SHERIFF'S OFFICE

One of the mandates of the Travis County Sheriff's Office is to investigate all criminal cases of physical abuse and neglect of children 14 years of age or younger, and sexual abuse of children younger than 17 years of age, occurring in Travis County, Texas. Responsibilities include the gathering and preservation of evidence to ensure a prosecutable criminal case. This includes interviewing and taking statements of witnesses and suspects, evidence collection, scene preservation and the preparation and execution of search and arrest warrants.

TRAVIS COUNTY DISTRICT ATTORNEY'S OFFICE

The statutory mandate of the District Attorney is to see that justice is done. The District Attorney's Office prosecutes all felony criminal cases of physical abuse, sexual abuse and neglect of a child. The office also represents the Department of Protective and Regulatory Services in civil cases involving child abuse and neglect. Responsibilities include providing prompt and comprehensive legal advice to other members of the team regarding criminal and civil investigations of child abuse and neglect on a 24 hour basis; assisting with the preparation of civil legal documents necessary to protect children; assisting law

enforcement with all aspects of criminal investigations, including assistance with grand jury subpoenas, search warrants and charging decisions; facilitating the coordination of investigations and services for families involved in the child welfare and criminal justice systems; and reviewing all criminal child abuse cases for presentation to the grand jury, closure, or return for further investigation.

TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER

The Children's Advocacy Center represents the investment of the community in the future of its children. The mission of the Center is to provide the place where members of the community can show their commitment to our children through community involvement or participation in the intervention, coordination and delivery of services to children. As a non profit, facility-based community organization governed by an independent Board of Directors, the Center provides the voice of the community in its efforts to protect children. The facility serves as a neutral, child-friendly environment for interviewing children about abuse or neglect. Through collaboration with other Team members, the Center seeks to prevent the re-victimization of the child by the system by minimizing the trauma surrounding the interview and reducing the number of times a child must be interviewed. Advocacy Center counselors conduct forensic interviews of child victims or witnesses. The Center provides counseling and support services, information and referral for services to families,

volunteer services, community education and advocacy for children. Responsibilities also include facilitating joint investigations and interviews among member agencies, coordinating multi-disciplinary case staffings, assisting with multi-disciplinary training, and providing case review, case follow-up and casetracking. The Center also provides a Court School program to assist parents and children who are involved in the court system.

TEXAS DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES

One of the mandates of the Department of Protective and Regulatory Services is to investigate allegations of child abuse and neglect by parents, relatives or caretakers to assess and address any issues related to the child's protection, including issues of present or future risk of abuse or neglect. Once risk is identified, services are provided to reduce the risks and to alleviate the effects of abuse and neglect. Services range from moderate in-home contact to removal of the child from the home. Responsibilities include coordinating with outside resources, family members, and the courts to address any changing factors affecting the child's ongoing safety.

CHILD PROTECTION TEAM EXECUTIVE COMMITTEE

The Travis County Child Protection Team will have an Executive Committee made up of designated representatives from each agency and the Children's Advocacy Center. This Committee will

establish its own authority to act by virtue of a rule-making agreement. (see attached) The purpose of this Committee will be to provide the Team with a multi-disciplinary governing body to address Team issues. The Committee will, at a minimum, address the following issues:

1) The Committee will establish regular meetings to provide a consistent means of communication and a forum for discussing Team issues. The Committee will also select a chairperson for the Executive Committee to serve as convenor and chair of the Executive Committee's meetings;

2) The Committee will develop, approve and adopt written policies and procedures for the Team's collaborative operations;

3) The Committee will develop, approve and adopt specific goals and objectives to strengthen the mission of the CPT;

4) The Committee will develop, approve and adopt written performance measures to measure CPT achievements;

5) The Committee will prepare and maintain Executive Committee reports reflecting the collaborative effort. The reports will be distributed to management of member agencies on a regular basis.

Each entity named in this agreement is a full member of the Child Protection Team.

The members agree that interviews of children twelve years of age and younger will be conducted at the Children's Advocacy Center. Interviews of children older than twelve at the Center are encouraged. The choice of interviewer for all children will be

in the discretion of the investigator handling the case. The members recognize that the best interest of the child is served when investigations and services are coordinated and when agencies collaborate in a way that is mutually supportive. Each member accepts and supports the value of the role and contribution of every other member and agrees to support the collaborative effort. This includes the commitment of resources to the Team and the sharing of information to the extent allowed by law. The members also commit to an ongoing evaluation of the collaborative effort.

THE UNDERSIGNED AGREE TO THE TERMS OF THIS INTERAGENCY COOPERATIVE AGREEMENT:

RONALD EARLE
TRAVIS COUNTY DISTRICT ATTORNEY — DATE: 7-5-95

BRUCE TODD
MAYOR OF THE CITY OF AUSTIN — DATE: 7-14-95

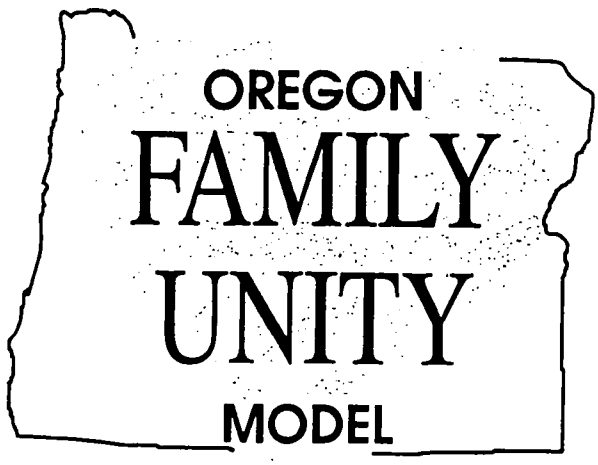
TERRY KEEL
TRAVIS COUNTY SHERIFF — DATE: 7-7-95

KAREN EELLS
DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES — DATE: 7/12/95

TOM FORBES
CHAIRMAN OF THE BOARD
TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER — DATE: 7-17-95

Appendix C

Oregon Family Unity Model Pamphlet



An option to consider for strengthening families.

To strengthen families and increase safety, security and stability for children.

Design

- **Values and Beliefs** – foundation of model.
- **Option I** – keeping family together.
- **Option II** – reuniting family.
- **Family Unity Meeting** – a process to resolve concerns.
- **Touch Points** – the visual creation of the family support systems.

Values & Beliefs

The foundation of the model.

- **Families have strengths and can change.** They deserve respect. Families have wisdom and solutions. Families and communities are our best resource.
- **Strengths are what ultimately resolve concerns.** It is important to set up opportunities for families to show their strengths.
- **Strengths are discovered** through listening, noticing and paying attention to people.
- **Strengths are enhanced when they are acknowledged and encouraged.**
- **People gain a sense of hope when they are listened to.** People are more inclined to listen to others if they are listened to.
- **Options are preferable to advice. Advice is basically disrespectful.** Options provide choices. Choices empower. Advice disempowers.
- **Empowering people is preferable to controlling them.**
- **A consultant is more helpful to people than a boss.** It is important to remember we work with and for the family – the family does not work for us.

Options

Option I
Keeping family together

1. **Caseworker** identifies family.
2. Caseworker invites family to a **"Family Unity" meeting to determine if there is some way we can help this family stay together.**

Option II
Reuniting family

1. Caseworker identifies family they feel may be able to reunite.
2. Caseworker informs family he/she has nominated them for a family unity meeting to consider child's return to them.

3. **The family and the caseworker choose the participants** for the meeting. The family may bring whomever they choose, such as neighbor, relative, friend, employer, pastor, etc. Worker may choose people to serve as consultants, i.e., family therapists, parent trainer, school teacher, etc.
4. The family is given a copy of the **"Family Unity Meeting"** outline prior to the meeting.
5. The caseworker invites someone to chair the meeting and sets or designates someone to schedule time, place, reservation of room, invitations, and refreshments.

Meeting

A process to resolve concerns.

1. **Introduction** of all persons present. (Usually best if people can introduce themselves as this gives them a chance to make personal connection.)
2. **Purpose of meeting defined.** Example: "We are here to see if there are ways we can help this family stay together."
3. **Concerns** (of agency and family). What are we worried about? State all concerns clearly, honestly, respectfully.
4. **Assess family strengths.**
5. **Options family has thought about** to resolve issues of concern. "What is your (family's) best thinking on how things could be better here?" What ideas do they have to deal with this?
6. **Any additional ideas or options** for the family to consider from participants? Professionals may ✓ choose to leave the room and permit the family to deliberate alone, or co-create options with parents.
7. **Develop touch points work sheet.** Agreement of who is willing to help family. A visual look of who agrees to do what, and when they will do it. Give each participant a copy of the touch points work sheet. Family and case manager keep master copy.
8. **Make decision.** (Set date for implementation of plan.)
9. **Meeting adjourned. Everyone leaves together.**

Appendix D

Sample Children's Research Center Assessment Tools

D.1 Alaska Child Protection Abuse Scale

D.2 Michigan Family Assessment of Needs

D.3 Michigan Family Risk Assessment for Neglect

Appendix D.1

ALASKA CHILD PROTECTION ABUSE SCALE

		Score
1.	Number of Prior Reports of Abuse	
	None 0	
	One 1	
	Two 2	
	Three or More 4	____
2.	Number of Prior Placements Outside of Family Residence	
	None 0	
	One or More 1	____
3.	Number of Abuse/Neglect Types Noted in Current Referral	
	One 0	
	Two or Three 2	
	Four or More 3	____
4.	Number of Adults in Home (18 Years of Age or Older)	
	Two or Fewer 0	
	Three or More 2	____
5.	Number of Children in Home	
	Two or Fewer 0	
	Three or More 2	____
6.	Either Caretaker Abused as Child	
	No 0	
	Yes 2	____
7.	Caretaker History of Drug/Alcohol Abuse	
	None 0	
	One Caretaker 1	
	Both Caretakers 3	____
8.	One or Both Caretakers Previously Convicted of a Felony Offense	
	No 0	
	Yes 1	____
9.	Caretaker(s) Primarily Involved in Negative Social Relationships	
	No 0	
	Yes 2	____
10.	Caretaker(s) History of Depression	
	None 0	
	Significant, long term episodes by either caretaker 1	
	Episode(s) include suicide attempt by either caretaker 3	____
11.	Cooperation with Agency Demonstrated by Perpetrator/Caretaker(s)	
	Not Applicable 0	
	Cooperative 0	
	Uncooperative 1	
	Hostile/Threatening 3	____
12.	View of Abuse by Non Perpetrator/Caretaker(s)	
	Not Applicable 0	
	More Serious than Agency . . . . . -2	
	Consistent with Agency View 0	
	Less Serious than Agency 2	____
	TOTAL RISK SCORE	____

Appendix D.2

Michigan Family Assessment of Needs

S1. Emotional Stability
- a. Appropriate Response 0
- b. Both Parents or Single Parent, Some Problems 3
- c. Chronic Depression, Severely Low Esteem, Emotional Problems . . . . . 5 ____

S2. Parenting Skills
- a. Appropriate Skills 0
- b. Improvement Needed 3
- c. Destructive/Abusive Parenting . . . . . 5 ____

S3. Substance Abuse
- a. No Evidence of Problem 0
- b. One Caretaker with Some Substance Problem 2
- c. One Caretaker with Serious Problem or Both Caretakers with Some Substance Problem 3
- d. Problems resulting in Chronic Dysfunction . . . . . 5 ____

S4. Domestic Relations
- a. Supportive Relationship/Single Caretaker 0
- b. Marital Discord, Lack of Cooperation 2
- c. Serious Marital Discord/Domestic Violence . . . . . 4 ____

S5. Social Support System
- a. Adequate Support System 0
- b. Limited Support System 2
- c. No Support or Destructive Relationships . . . . . 4 ____

S6. Interpersonal Skills
- a. Appropriate Skills 0
- b. Limited or Ineffective Skills 2
- c. Hostile/Destructive . . . . . 4 ____

S7. Literacy
- a. Adequate Literacy Skills 0
- b. Marginally Literate 2
- c. Illiterate . . . . . 3 ____

S8. Intellectual Capacity
- a. Average or Above Functional Intelligence 0
- b. Some impairment, Difficulty in Decision Making Skills 2
- c. Severe Limitation . . . . . 3 ____

S9. Employment
- a. Employed or No Need 0
- b. Unemployed but Looking 1
- c. Unemployed, not Interested . . . . . 2 ____

S10. Physical Health Issues
- a. No Problem 0
- b. Health Problem or Handicap that Affects Family 1
- c. Serious Health Problems or Handicap that Affects Ability to Provide for or Protect Child . . . . . 2 ____

S11. Resource Availability/Management
- a. Sufficient Income to Meet Needs 0
- b. On Assistance/Intermittent Income 2
- c. Financial Crisis . . . . . 3 ____

S12. Housing
- a. Adequate Housing 0
- b. Some Housing Problems, but Correctable 1
- c. No Housing, Eviction Notice . . . . . 2 ____

S13. Child Characteristics
- a. Age Appropriate, No Problems 0
- b. Minor Physical, Emotional, Intelligence Problems 1
- c. Significant Problems that put Strain on Family 2
- d. Severe Problems Resulting in Dysfunction . . . . . 3 ____

Appendix D.3

Michigan Family Risk Assessment for Neglect

			Score
N1.	Current Complaint is for Neglect		
	a. No	0	
	b. Yes	2	____
N2.	Number of Prior Assigned Complaints		
	a. None	0	
	b. One or More	2	____
N3.	Number of Children in the Home		
	a. Three or Fewer	0	
	b. Four or More	2	____
N4.	Number of Adults in Home at Time of Complaint		
	a. Two or More	0	
	b. One/None	3	____
N5.	Characteristics of Female Caretaker (check and add for score)		
	a. Not Applicable	0	
	b. ___ Lacks parenting skills	1	
	c. ___ Lacks self-esteem	1	
	d. ___ Apathetic or Hopeless	2	____
N6.	Caretaker(s) Socially Isolated or Withdrawn or Involved in Harmful Relationships		
	a. Neither Caretaker	0	
	b. One Caretaker	2	
	c. Both Caretakers	3	____
N7.	Female Caretaker Has a History of Alcohol or Drug Abuse		
	a. No	0	
	b. Yes	3	____
N8.	Amount of Current Household Income		
	a. Over $2,000 Per Month	0	
	b. $600 to $2,000 Per Month	1	
	c. Under $600	2	____
N9.	Perpetrator's Motivation to Change		
	a. Motivated and Realistic	0	
	b. Unmotivated	1	
	c. Motivated but Unrealistic	2	____
		TOTAL SCORE	____

Appendix A

Selected Individuals Interviewed for the Child Abuse and Neglect Background Papers

Selected Individuals Interviewed for the Child Abuse and Neglect Background Papers

Interviews with and materials provided by the following experts, researchers, policymakers and practitioners contributed significantly to the Child Abuse and Neglect Background Papers. Some individuals were interviewed in person, others by telephone; a number were contacted more than once. All interviews were conducted between June 1 and September 12, 1997.

Marylee Allen
Director
Child Welfare and Mental Health
Children's Defense Fund
Washington, D.C.

Catherine Ayoub, R.N., Ed.D.
Children and the Law
Harvard Graduate School of Education
Cambridge, Massachusetts

Dan Brewer, M.A., C.M.H.C.
Ina Maka Family Program
Seattle, Washington

Chris Bucco
Coordinator of Children's Services
Casa Myrna Vazquez
Boston, Massachusetts

Gale Burford, M.S.W., Ph.D.
Memorial University of Newfoundland
School of Social Work
St. Johns, Newfoundland
Canada

Rosemary Chalk
Board on Children,Youth and Families
National Research Council
Washington, D.C.

Nancy Chandler
Executive Director
National Network of Child Advocacy Centers
Washington, D.C.

Linda Crane, M.S.W.
Social Worker/Family Therapist
Polk Branch
State Office for Services to Children and Families
Dallas, Oregon

Mary Dibble,
Bureau for Children, Youth and Families
Department of Health and Social Services
Madison, Wisconsin

Patricia Cullen
Director of Supportive Services
Casa Myrna Vazquez
Boston, Massachusetts

Howard Davidson
American Bar Association
Washington, D.C.

Diana English, Ph.D.
Office Chief
Office of Children's Administration Research
Department of Social and Health Services
Olympia, Washington

Marti Erickson
Director
Institute on Child Development
Minneapolis, Minnesota

David Finkelhor, Ph.D.
Family Research Laboratory
University of New Hampshire
Durham, New Hampshire

John M. Hagadorn, Ph.D.
University of Illinois-Chicago
Chicago, Illinois

Darlene Kordich Hall, Ph.D.
York University
North York, Ontario
Canada

Paul Hodlin, L.I.C.S.W.
Assistant Director
Boston Juvenile Court Clinic
Boston, Massachusetts

Sue Horbach, M.A.
Director
Early Childhood Family Education
Duluth, Minnesota

Ted Keys
Program Coordinator
Family-Based Services
Services to Children and Families
Salem, Oregon

Sherrie Lookner
Director
Childcare for Department of Social Services
Massachusetts DSS
Boston, Massachusetts

Gil Noam, Ph.D.
Director
Responsive Advocacy in for Learning and Life in Youth (RALLY)
Harvard Graduate School of Education
Cambridge, Massachusetts

Anne Peretz, L.I.C.S.W.
Founder and President
The Family Center
Somerville, Massachusetts

Kim Pucci, Ed.M.
Site Coordinator
Responsive Advocacy for Learning and Life in Youth (RALLY)
Harvard Graduate School of Education
Cambridge, Massachusetts

Jennifer Roberston
Director
Advocacy for Women and Kids in Emergencies (AWAKE)
Children's Hospital
Boston, Massachusetts

David S. Robinson, Ed.D.
Simmons College School of Social Work
Boston, Massachusetts

Myra Rosenbaum
Family Policy Analyst
AWAKE
Children's Hospital
Boston, Massachusetts

Benjamin Saunders, Ph.D.
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
Charleston, South Carolina

Bill Showell
Trainer
Family Group Decision Making
Portland State University
Portland, Oregon

Emily Soloway
Director of Tribal Social Services
Confederate Salish Kootenai Tribes
Pulson, Montana

Rosalie Walls
Executive Director
ACT II Child and Family Services
Coquitlam, British Columbia
Canada

Mary Avery Watson, M.S.
Assistant Director
Gilday Center
Roxbury, Massachusetts

Jeffery N. Wherry, Ph.D.
University of Missouri
St. Louis, Missouri

Cathy Spatz Widom, Ph.D.
School of Criminal Justice
State University of New York at Albany
Albany, New York

Debra Witcomb, Ph.D.
Educational Development Center
Newton, Massachusetts

Nina Williams-Mbengue
National Conference on State Legislatures
Denver, Colorado

Laru Woody
Assistant District Attorney
Director, Family Justice Division
Austin, Texas

Appendix B

National Organizations Concerned with Child Abuse and Neglect Contacted for the Background Papers

National Organizations Concerned with Child Abuse and Neglect

The following national organizations were contacted and provided information which was helpful in the preparation of the Child Abuse and Neglect Background Papers.

American Bar Association Center on Children and the Law

American Professional Society on the Abuse of Children

Child Welfare League

Children's Defense Fund

Family Violence Prevention Fund

National Academy of Sciences

National Center for Children in Poverty

National Center for Missing and Exploited Children

National Clearinghouse on Child Abuse and Neglect

National Conference of State Legislatures

National Council of Juvenile and Family Court Judges Family Violence Project

National Network of Child Advocacy Centers

National Organization for Women Legal Defense and Education Fund

Abt Associates Inc.

55 Wheeler Street
Cambridge, Massachusetts
02138-1168

617 492-7100 *telephone*
617 492-5219 *facsimile*

Hampden Square, Suite 500
4800 Montgomery Lane
Bethesda, Maryland
20814-5341

301 913-0500 *telephone*
301 652-3618 *facsimile*

640 North LaSalle Street
Suite 400
Chicago, Illinois
60610-3781

312 867-4000 *telephone*
312 867-4200 *facsimile*

National Institute of Justice

Child Abuse Intervention Strategic Planning Meeting

Background Papers

October 3, 1997

Prepared for

Carolyn Peake
Department of Justice
National Institute of Justice
810 7th Street, N.W.
Washington, DC 20531

Prepared by

Kerry Murphy Healey, Ph.D.
Athena Garrett, Ed.M.

169290

Table of Contents

Background Paper #2: Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect

Background Paper #3: Policies, Practices and Statutes Relating to Child Abuse and Neglect

Executive Summary

The National Institute of Justice (NIJ) Child Abuse Interventions Strategic Planning Meeting Background Papers

Introduction

Child abuse and neglect (CAN) is a growing problem in America. Each year State-level child protective services (CPS) receive higher numbers of reports of CAN--more than 3,000,000 in 1995--and there are now nearly half a million children in out-of-home care, a 72 percent increase over the last decade. While these numbers may reflect better reporting of abuse and neglect and an increased public awareness of the problem, the number of cases is indisputably large and tests the capacity of the current system to provide safety and services to all who need them. The majority of CAN cases substantiated by CPS involve neglect (52 percent), but significant numbers cite physical abuse (25 percent), sexual abuse (13 percent), emotional abuse (5 percent) and medical neglect (3 percent.) CPS is increasingly called on to protect and provide services for children of drug addicted parents, especially drug-exposed newborns. In addition, CPS and the judiciary are beginning to recognize the complex connections between domestic violence and child abuse, including the severe emotional and psychological damage to children who witness violence within the home.

At the same time, research in the field of child abuse and neglect has begun to establish more precise links between children's victimization and later behavioral problems, including school failure, delinquency, violence and adult criminality. Efforts to intervene with victims of CAN to promote future safety and to manage the consequences of abuse are being developed by practitioners, Federal and State agencies, private foundations and researchers. Criminal justice policymakers have a special interest in learning which of these approaches may help CAN victims break the cycle of violence. The three papers in this series provide an overview of key intervention issues, including the types of intervention programs available, the theoretical underpinnings of intervention with victims of CAN, and the policies, bureaucratic structures and laws that constrain or facilitate intervention. (For a discussion of the papers' methodology, see the box "About the Child Abuse and Neglect Background Papers," which follows this section.)

services are necessarily rationed. Currently, victims of sexual abuse and severe physical abuse are most frequently referred for criminal justice investigation and program services. Victims of neglect (who are most numerous among victims of CAN) commonly receive few if any services. Children who witness domestic violence and their non-abusing parent are beginning to receive specialized services in some jurisdictions.

A Continuum of Care for High-Risk Victims of CAN

From the standpoint of child welfare and protection, the neediest victims of CAN are those who have suffered demonstrable harm (sexual abuse, severe physical abuse or abandonment) and whose future safety cannot be assured without out-of-home placement. This group of children, however, may not include all those who are at the greatest risk for delinquency. Recent research on the cycle of violence and high-risk victims of CAN has pointed to the following groups as being in need of services to ameliorate the impact of abuse and to deter future delinquency, violence and adult criminality: all CAN victims five years of age or younger; school-aged children with low reading scores; children who have witnessed domestic violence; children with severe behavioral disorders or multiple foster care placements; children with extensive exposure to community violence; children with extensive family histories of substance abuse or a personal history of significant drug use and delinquency; Native American victims of CAN; and sexually aggressive youth. A continuum of care for these high-risk CAN populations is outlined in exhibit 3-3, including suggestions for appropriate types of programming and examples of age-specific programming for these groups now in operation throughout the country and in Canada.

- **Self-efficacy theory** suggests that individual expectation of effectiveness influences motivation and behavior and dictates the ability to act toward and achieve a goal. Interventions based on self-efficacy focus on building the belief and the capacity to stop abusive behaviors and to protect oneself from victimization by four methods: performance accomplishment, verbal persuasion, vicarious experience and emotional arousal.

- **Resiliency theory** focuses on the ability of victims to overcome the negative effects of CAN. Interventions based on resiliency theory seek to help victims avoid delinquency and other negative outcomes associated with CAN by developing or enhancing individual, familial and community protective factors, such as self-esteem, academic achievement, parental involvement in child's activities, and a secure supportive relationship with an adult.

Recent Research Finding and Theoretical Trends

Research findings on the outcomes of abuse and neglect vary according to a number of factors: child characteristics (age, emotional and cognitive development, gender, race/ethnicity, and personality); type of trauma (acute or chronic); type of abuse or neglect (physical, sexual, psychological/emotional or witnessing domestic violence); co-occurrence of types of abuse and neglect; and the relationship the child has with others (victimizer, non-offending parent, other family members, other adults and peers.) Factors such as these may mediate or predict a CAN victim's likelihood of becoming delinquent, engaging in violence or other criminality. Research on effective intervention strategies is limited due to methodological weaknesses, however, multi-systemic interventions, cognitive-behavioral treatments, family preservation efforts, therapeutic day care and individual and group therapy have all demonstrated promising outcomes with varying populations. In addition, resiliency research has pointed to the value of a supportive adult in a victim's life. Long-term treatment and follow-up have proven to lead to greater effectiveness, regardless of the intervention strategy.

Examination of Existing Intervention Strategies

Four examples of promising intervention strategies are outlined: The Gilday Center (which offers family preservation and therapeutic day care); Casa Myrna Vazaquez (which uses a multi-systemic combination of therapeutic day care, individual and group therapy and support services); Ina Maka Family Program (a family systems-based family preservation program); and Responsive Advocacy for Learning and Life in Youth (which provides therapy and offers a supportive adult). Each strategy utilizes at least one component of treatment that has demonstrated promising outcomes.

- Failure to achieve permanency for out-of-home placements in a timely manner.

Current Systems Reforms: Innovative Practices and Proposals

A number of systemic reforms and innovative practices have been undertaken by State legislatures and State or local child welfare agencies to address problems such as inadequate service delivery to lower-risk victims of CAN, the fragmentation of services and policies affecting victims of CAN, the stress caused low-risk children and families by CPS investigation and inadequate family engagement in services. Recent State-level innovations include the creation of multiple response systems, the co-location of services for victims of CAN, the use of family group decision-making to aid child placement decisions, and integrating domestic violence and child protective services. Proposals for systemic reforms, two of which have been implemented on a limited basis, include the Children's Research Center's model for highly structured case assessment and management, a model for building community partnerships for child protection from the John F. Kennedy School of Government's Executive Session on Child Protection, and the American Bar Association's recommendations for implementing judicial permanency planning reform.

Scope and Organization of the Papers

Paper #1: "Managing the Consequences: An Overview of Intervention Strategies for Victims of Child Abuse and Neglect

Paper #1 reviews current intervention strategies, key issues and funding sources related to CAN populations generally, then shifts its focus to highlight a continuum of age-appropriate interventions targeting only those victims of child abuse and neglect who have been identified by recent research to be at the *greatest risk* of delinquency or arrest as adults (see Exhibit 1-3). The paper focuses on interventions appropriate for children in substantiated cases of abuse or neglect; it does not consider primary prevention programming, but does discuss secondary prevention programming, where appropriate. The paper is divided in two parts:

Part I reviews and discusses existing intervention strategies with victims of CAN and their caretakers, including the goals of intervention, the allocation of prosecutorial and programmatic resources among victims, identification of services, funding sources for interventions and the current role of the criminal justice system in service provision.

Part II highlights eight high-risk groups of abused and neglected children drawn from the research literature on the relationships between child abuse, delinquency, adult criminality, and violence and various personal and demographic characteristics (e.g., age, gender, race, ethnicity, substance abuse history, family of origin, or socio-economic factors.) Age-appropriate intervention strategies are suggested for children who fall into one or more of the following high-risk categories:

- less than 5 years old;
- low reading scores;
- exposure to domestic violence;
- severe behavioral disorders or multiple foster care placements;
- extensive exposure to community violence, especially if diagnosed with post-traumatic stress disorder (PTSD);
- extensive family history of drug or alcohol abuse and/or child who reports intensive drug involvement combined with serious criminality (not necessarily arrests);
- Native American victims;
- classification as sexually aggressive youth (SAY) or an abuse profile likely to result in later sexual aggression.

Research also has begun to isolate "protective" factors that, for some victims, appear to buffer the impact of abuse and deter anti-social behaviors. A second selection criteria for programs highlighted in this paper was an emphasis on cultivating pro-social protective factors in high-risk victims of child abuse and neglect. Other factors considered in program selection include preferences for:

- early intervention strategies including parent education;
- school-based interventions for victims over five years old;
- culturally sensitive and appropriate programming; and
- interventions that can be offered in ways and in settings that are accessible and non-stigmatizing (e.g., neighborhood-based programs open to the public without a referral or programs that have both abused and non-abused participants).

child protective services (CPS), child welfare officials and criminal justice agencies--including law enforcement, prosecutors and the courts. These systems are then considered in the context of Federal legislation designed to influence State and local child protection policies and procedures, State legislation defining CAN and mandatory reporting laws.

The second half of the paper focuses on innovative practices and proposals for systemic reforms generated from the field, the research community and State-level legislation. Innovative practices highlighted include:

- the creation of multiple response systems;
- the co-location of personnel serving abused and neglected children;
- Children's Advocacy Centers (CACs);
- a multi-agency Child Protection Team; and
- integrating domestic violence and child protection services.

These initiatives were chosen to illustrate legislative trends or cutting-edge reforms in action. Three proposals for systemic reform are also reviewed: the Children's Research Center's model for structured case management; a proposal for building community partnerships for child protection from the John F. Kennedy School of Government's Executive Session on Child Protection; and the American Bar Association's study of model judicial implementation of permanency planning reform. These proposals were selected not only for their merit, but also to illustrate in part the broad range of targets systemic reforms may have--CPS, the community (defined broadly to include the full range of public agencies, civic and religious organizations and private program providers), and the courts.

Background Paper #1:

Managing the Consequences: An Overview of Intervention Strategies for Victims of Child Abuse and Neglect

Kerry Murphy Healey, Ph.D.
Abt Associates Inc.

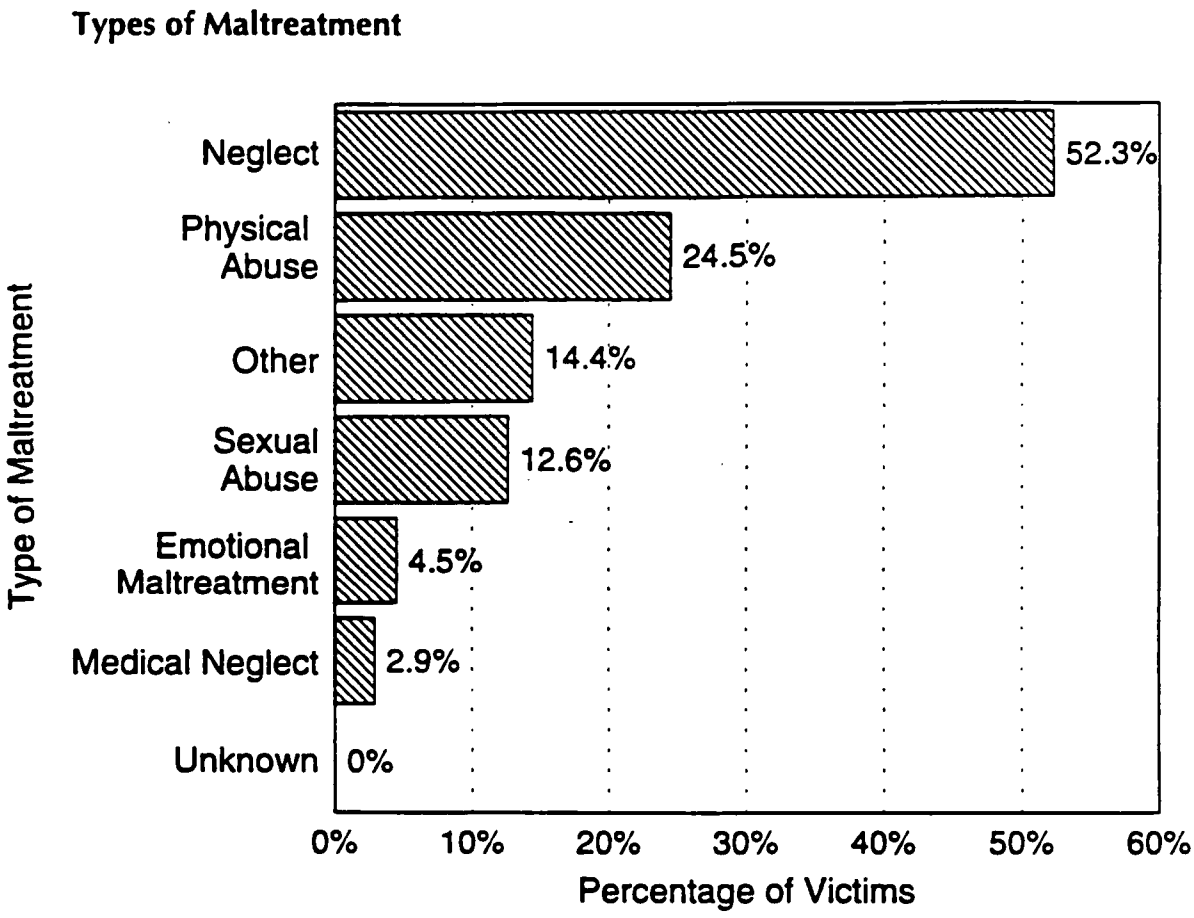
October 3, 1997

Introduction

Intervening to manage the consequences of child abuse and neglect (CAN) is a daunting task for government due to the size of the population in need of services and the diversity of negative outcomes to be addressed.[1] Although the psychological, physical, and emotional toll of child abuse and neglect is heavy for *all* victims, the majority of victims do *not* go on to commit violent crimes.[2] Victimization does, however, increase the likelihood of delinquency and later criminality sufficiently to make CAN victims of special concern to criminal justice policy makers. According to one retrospective study, CAN victims were 59 percent more likely to be arrested as juveniles and 27 percent more likely to be arrested as adults; CAN victims were 29 percent more likely to have committed violent crime than those who had not been maltreated.[3] In view of these findings, criminal justice policy makers are increasing their efforts to learn how to help CAN victims break the cycle of violence.

Research in the fields of child abuse and neglect, delinquency and violent criminality is at an exciting crossroads: researchers are moving from knowing only that CAN increases some victims' vulnerability to delinquency, adult criminality and violent crime, to being able to predict with more certainty which victims of CAN are at the greatest risk. The challenge for criminal justice policy makers is to assess current programming and policies relating to abused and neglected children to determine where State and Federal efforts need to be strengthened in order to maximize the impact of programs targeting those abused and neglected youths who are at the *greatest risk* for delinquency, adult criminality and violent crime.

Exhibit 1-1



N = 1,000,502 victims in 49 States.
Note: Percentages total more than 100 percent because some States report more than one type of maltreatment per victim.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Child Maltreatment 1995: Reports From the States to the National Child Abuse and Neglect Data System* (Washington, DC: U.S. Government Printing Office, 1997).

- short or long-term out-of-home placement;
- short-term intensive in-home assessment and service provision to the family and the child; or
- facilitating access to community-based services for the child and family on a longer term, less intensive basis.

Decisions concerning the appropriate level of intervention and specific program referrals for victims and their caretakers have traditionally rested with the individual case worker or, in the most severe cases, the courts. As discussed below and in Paper #3, risk assessment and service planning are currently the target of a number of innovations intended to decrease the systems' dependence on individual judgment. Examples of recent systemic innovations that influence program referral include the development of standardized risk and needs assessment tools and collaborative case decision making including criminal justice personnel or the extended family.

Current Intervention Strategies: Objectives and Controversies

While emphases differ slightly from jurisdiction to jurisdiction, the majority of child protection and welfare interventions are bounded by three, sometimes conflicting, operating principles:

- **Child Safety**—Child safety is the first objective of intervention;
- **Family Preservation**—Preference is given to those intervention strategies that maximize family preservation or reunification and minimize out-of-home placement (a value reinforced by federal funding restrictions, see below);[8] and
- **Speed to Permanency**—In the event of out-of-home placement, reunification or other permanent placement should be achieved as quickly as possible (e.g., Massachusetts law requires a permanency plan within eighteen months, although this is not always achieved).

These principles, if inflexibly pursued, can result in tension between competing goals. For example, the priority given to family reunification may delay substantially the quest for permanent placement of children residing in out-of-home care: for families with serious long-term problems, such as substance abuse or mental illness, even up to eighteen months is often not sufficient to resolve these difficult problems. Correlatively, child safety may be compromised if reunification is pursued too aggressively in order to meet an arbitrary permanency goal.

Schuerman and others note that while the family preservation services' impact on out-of-home placement is unclear, the families served were generally in extreme need or crisis and no doubt benefitted from the additional services in ways not measured by the evaluation.

Both researchers and practitioners favor *preventative* interventions that stress family support services, such as home visitation, parenting skills building and prenatal counseling. To this end, some of those interviewed argued that family preservation resources would be best spent on broad-based programming to prevent child abuse and neglect in healthy but vulnerable families (e.g., teen mothers or young families living in poverty or in violent communities), rather than on the smaller number of abusive, multi-problem families who are less likely to respond to services. The shift toward prevention and away from traditional reactive child welfare models is exemplified by the number of programs seeking to replicate Hawaii's Healthy Start program . For example, in 1998, a new Massachusetts program, Healthy Families, will make home visits available to all the estimated 5000 teenage mothers who give birth in the State annually at a cost of $5 million (or $1000 per family.)

In a program soon to be piloted in Wisconsin (and currently in use in West Virginia) a formal assessment of family strengths, deficits and capacity will be made by the social worker and then discussed with a supervisor to develop an individualized service plan. The assessment looks at the following factors that have been associated with successful family preservation outcomes:

1. Ability to use a support network;
2. Ability to develop trusting relationships;
3. Ability to develop a positive "family vision" (how they would like their family to be);
4. Family maintenance (the degree to which they are motivated to keep their children); and
5. Capacity (cognitive limitations).

The social worker assesses family strengths and weaknesses, then targets the intervention to the deficits. Strengths— such as knowing when to seek help, having an informal support system or the ability to verbalize needs and concerns—are not merely listed, but built upon to assist the family in reaching its goals. If no capacity is found (for example, due to cognitive limitations), the service plan focuses on safety services for the child.

Social workers assess the extent to which the model results in the development of a safe home environment, the creation of an informal family support system, the use of formal supports, and improved parent functioning (e.g., coping and self-control, self-esteem, verbal expression and response, socialization, expectations and sensitivity to children, and problem solving.)

Timing and Length of Intervention

Interventions may be emergency measures, intensive short-term programs with narrow goals (such as preventing out-of-home placement or creating a safer and more stable home environment) or longer-term, lower intensity efforts that involve only limited service referrals.

assessment will consider not only the current incident, but also the family's history and characteristics before choosing a level of intervention. Unfortunately, an overburdened system may choose long-term, low intensity intervention by default.

Intervention "Booster Shots"

Certain types of abuse may result in the need for periodic intervention. For example, victims of child sex abuse (CSA) may experience recurrent psychological problems as they pass through each developmental stage toward—and into—adulthood. Parents or caretakers of CSA victims should be trained to recognize key developmental milestones and to re-initiate services as needed.[15] Similarly, victims of pre-natal drug exposure may experience cognitive, developmental and social problems at various developmental stages. Caretakers of drug-exposed infants need information on child development so that they can seek screening and assistance for any suspected delays.

On-going services also are needed by reunited families as well as adoptive families whose children may—at some later date—develop behavioral, cognitive, psychological or social problems as a result of earlier abuse. It is thought that on-going services to adoptive and reunited families would help to prevent multiple placements, a risk factor for delinquency (see below).

Who Receives Services?

With the large number of CAN victims and caretakers to be served, case worker time, criminal justice referrals, and program resources are necessarily rationed. Victims of sexual abuse (who account for 13% of all abuse and neglect cases) and severe physical abuse (25%) are most frequently referred for criminal justice action and program services.[16] In general, neglect cases—especially chronic low-level neglect—receive few or no services. However, experts emphasize that sexual abuse, physical violence, neglect, and emotional and psychological abuse often co-occur (approximately one-third of all cases have multiple abuse allegations), so that some victims of emotional and psychological abuse and neglect are actually being served. Indeed, some commentators argue that *all* child abuse involves emotional abuse.

One explanation for the official attention accorded sex abuse and physical abuse cases is simply that these cases often focus on a poignant, single episode (or culminating episode) of abuse and are more easily grasped by busy social workers or the courts. Another possible explanation is one of public pressure on government: the public is understandably horrified by media reports of child sex crime and

philosophy to make appropriate referrals. A researcher who works closely with child protection services in one State gave the following example of poor communication between researchers, policy makers, practitioners and program providers:

> *Research on the State's severe cases of physical abuse and CAN fatalities revealed that a key factor in many cases was unrealistic parental expectations caused by ignorance of child development. State-level policy makers directed social workers to refer parents of severely abused children to receive parenting classes. Social workers referred parents to the available classes. No improvement was seen in the rates of severe physical abuse or CAN-related child deaths. Inquiries by the researcher revealed that the parenting classes to which these high-risk parents had been referred were skills-based and failed to discuss unrealistic parental expectations or child development.*

For another instance, a researcher who had designed an intervention for parents of victims of child sex abuse (CSA), and offered it free-of-charge at a local Child Advocacy Center (where CSA cases are brought for investigation and crisis intervention), reported that his program opened with only two participants. Barriers to service utilization may have included the failure of social workers to refer to the program, the possibility that on-going intervention information provided to families in crisis was lost, that parents may not wish to return to a setting that reminds them of the abuse and, finally, that family members may not be receptive to counseling so near in time to the abuse.

The Current Role of the Criminal Justice System

Currently, criminal justice agencies become involved with only the most severe cases of child abuse and neglect: those in which prosecution of the abuser is appropriate and/or where the custody of the child is overseen by the courts. In practice, most prosecutions focus on acute episodes of child abuse, such as sexual assaults or severe physical abuse. Chronic, but less severe, cases of physical abuse and neglect are more frequently addressed (if at all) by child welfare workers than by criminal justice personnel.

Few programmatic interventions for the victims of child abuse and neglect are directly provided by the criminal justice system (CJS). However, as discussed in Paper #3, interagency cooperation and victim-sensitive procedures—such as properly trained investigators, the use of Child Advocacy Centers for emergency intervention and interviewing and victim advocates at trial—may significantly reduce the stress of CJS involvement for child abuse victims and thus help to limit the consequences of abuse and neglect for those children who have been most severely victimized.[17]

families can safely be referred to community-based programs under the supervision of a social worker, and which families need only voluntary services.[19]

An innovative approach developed in Travis County, Texas, houses police, a sheriff, a prosecutor and child welfare workers together in one office and uses a collaborative model of case assessment and management. This approach, which is described more fully in Paper #3, increases CJS involvement while more effectively targeting prosecution and services. This model offers a number of advantages for both the CJS and child welfare workers. The most important advantage of the model is increased information sharing between agencies that allows all agencies to view the case in a family, school and community context. The resident prosecutor handles both the criminal and civil litigation related to the cases. This unified, cooperative approach to case management is especially important in the context of recent research documenting relationships between child abuse and neglect, domestic violence, substance abuse and violent crime—problems that, in the past, have been addressed individually by separate criminal justice or social welfare agencies.

Part II: A Continuum of Care for High-Risk Victims of CAN

The daunting numbers of victims of child abuse and neglect—as well as the high cost of intervention— make it critical that resources are directed to those victims who have the greatest needs. As discussed above, from the standpoint of child welfare and protection, the neediest children are those who have suffered demonstrable harm (sex abuse, severe physical abuse or abandonment) and whose future safety cannot be assured without intensive intervention or out-of-home placement. *This group of children, however, may not be at greatest risk for delinquency.* For example, victims of sex abuse—whose cases are most likely to be adjudicated and have more access to sophisticated case management approaches such as those used by Child Advocacy Centers—are less likely than either victims of neglect or physical abuse (or non-maltreated children) to become delinquent.[21] By contrast, witnessing domestic violence—an event less likely to attract the attention of the criminal justice system or, in most jurisdictions, child welfare services—may have a profound impact on that victim's future criminality.[22] Similarly, victims of neglect rarely receive services, yet neglect and exposure to community violence (both factors likely to co-occur with poverty) could be expected to raise delinquency rates for African-American males.[23] Thus, the population of abused and neglected children most likely to face involvement in the criminal justice system may be a different group than is currently served by the child welfare community. The following is an attempt to draft a research-based typology to serve criminal justice policy makers in their efforts to identify and intervene with those victims of CAN who are the greatest risk of delinquency.

Which Victims of CAN are at High Risk for Offense?

Widom's 1992 research on the cycle of violence found that 15.8 percent of children who were physically abused (only) and 12.5 percent of children who were neglected (only) had arrests for violent crimes as contrasted with 7.9 percent of a comparison group who had not been maltreated.[24] (Widom's study did not find victims of child sexual abuse generally to be at increased risk for violent criminality,[25] but later studies have identified a subset of CSA victims that are likely to become sexually aggressive youths.[26]) Widom's early work raised questions about how to identify and intervene with those victims of CAN who were most vulnerable to delinquency, adult criminality and violent criminal behaviors. More recent research by Widom and others has begun to offer a clearer picture of this subset of all CAN victims than previously had been available. (See Paper #2) For the purposes of this paper, eight (8) CAN populations have been identified from the research as being at

damage resulting from this exposure: it may include PTSD, trauma, shock, guilt, intense fears, nightmares, bed wetting, anger, physical aggression, anxiety, withdrawal, somatic complaints and developmental, motor, speech and cognitive delays. Men who witnessed severe domestic violence as children are found to be 1000 percent more likely than those raised in a non-violent setting to batter their spouse.[36] Intervention for this group of victims—both those who have been physically or sexually abused in the context of a violent household and those who have witnessed violence against their mother—is critical to breaking the cycle of violence leading to child and spouse abuse in adult victims of CAN.

Children with severe behavioral disorders or multiple foster care placements

Widom's research has suggested that children who have had multiple foster care placements are at increased risk for delinquency.[37] Children with multiple foster care placements frequently are reported to have severe behavioral disorders. Some commentators hypothesize that as children experience the serial loss of caretakers (perhaps due to their problem behaviors), their ability to form a secure attachment is damaged, thus compounding the difficulty of building a stable relationship with the next foster family. Intervening with young children who appear to be developing severe behavioral disorders and counseling their caretakers concerning effective parenting and coping strategies may succeed in preventing multiple placements for these children. In addition, respite care may be needed to assist parents or foster parents seeking to provide stability for these children. For children who have already experienced multiple placements, counseling concerning attachment issues and behavior modification programming may help them to break the pattern of self-destructive behaviors likely to lead to further loss and to delinquency.

Children with extensive exposure to community violence—
(especially those with a diagnosis of PTSD)[38]

Witnessing community violence is a daily trauma to many children in impoverished urban neighborhoods. A New Orleans study of 5th graders' exposure to violence found that 91 percent had witnessed violence and more than half had been victims of community violence.[39] A study of New Haven, Connecticut, 6th, 7th, 8th and 10th graders found that 30 percent reported seeing one crime or more *daily*.[40] Recent research by Saunders and Kilpatrick found that 65 percent of male African-American victims of CAN reported personally witnessing serious violence. For African-American male victims—especially for those diagnosed with post-traumatic stress disorder (PTSD)—witnessing community violence significantly increased

Sexually aggressive youth (SAY)

Adult sex offenders often report that they began sexually abusing others as juveniles.[45] In Vermont, sexually aggressive youths were reported to be responsible for 45 percent of all child sexual abuse cases.[46] In Washington State, researchers estimate that 10 percent of the children served by child welfare workers fit the statutory definition of sexually agressive youths.[47] The relationship between CAN and the development of sexually agressive behaviors has been explored in detail by Hall and Mathews, who found that only sexually abused children whose abuse included specific characteristics (e.g., physical abuse and sadism, among others) were at risk for becoming sexually aggressive.[48] Other research has pointed to severe physical abuse as a precursor of sexually aggressive behaviors. (See Paper #2) Both CSA victims fitting Hall's typology of SAY and youths in child protective services who have already begun to display sexually aggressive behaviors need services to protect other children from abuse and to deter them from juvenile and adult sex offense.

Children and families in some of these categories are easily identified; however, victims with more complex or subtle risk factors—such as a diagnosis of PTSD, family or personal history of substance abuse or CSA characteristics likely to lead to problem sexual behaviors—would require a more skilled and thorough assessment to insure proper program placement (see the box "Assessment to Identify High-Risk Victims of CAN.")

Exhibit 1-3 enumerates types of interventions that are designed to respond to the needs of these special CAN populations as well as provides examples of age-appropriate programming for victims and their caretakers. The program list is not intended to be definitive, only to illustate representative programming approaches. Brief program descriptions are provided below (see also Paper #2 for further information on selected programs).

The following interventions are examples of existing programming targeting the needs of high risk victims of CAN. Paper #2 provides descriptions for other programs listed in Exhibit 1-3: The Compassion Workshop, Silver Spring, Maryland (child abuse and spouse abuse); Homebuilders, a national program (family preservation); The Family Center--Parenting Journey, Cambridge, Massachusetts (parenting therapy); Advocacy for Women and their Abused Kids in Emergencies (AWAKE), Boston, Massachusetts (child and spouse abuse); Responsive Advocacy for Learning and Life in Youth (RALLY), Boston, Massachusetts (school-based multi systemic intervention) and Casa Myrna, Boston, Massachusetts (child abuse and spouse abuse).

I. Programs Serving Children Under Five Years Old

Copeland Early Childhood Center (CECC), Duluth, Minnesota

The Copeland early Childhood Centers offers comprehensive programming for approximately 100 children from birth to five years of age and their parents daily. Based in a Housing and Redevelopment Building, The Copeland Center's programming includes Early Childhood Family Education, Head Start, and Mother and Child programs. The CECC serves families referred by CPS, the courts, law enforcement, doctors, and social workers as well as self-referred clients. The *Early Childhood Family Education* program provides stimulating programs for children from birth to five years old directed by licensed early childhood education teachers while parents meet with a licensed parent facilitator who organizes presentations and discussions to improve parents' skills. *Head Start* is offered at the same site for four and five year olds. Families of children enrolled in Head Start are eligible for a range of support services and are encouraged to volunteer in the classroom to gain work experience. The Mother and Child program provides assistance to mothers and children who need to improve English language and literacy skills. Mothers receive Adult Basic Education and English as a Second Language as well as information about American culture and parenting support. Children receive services through the Early Childhood Family Education program that emphasize language development.

6. Children with extensive family histories of drug or alcohol abuse or self-reported intensive drug use and delinquencies	Saunders Johnson, et al.[e]	• Counseling/support for children of substance abusers • Drug/alcohol education • Anger management/dispute resolution training • Parenting classes for teens	• Gilday Center • Casa Mirna	• SSDP • ESPTP • Casa Mirna	• RALLY • ESPTP • Casa Mirna	• BJCC • ESPTP • Casa Mirna	• Gilday Center • Casa Mirna
7. Native American children	Saunders	• Family group conferencing • Drug/alcohol education • Anger management/dispute resolution • Parenting education for parents and teens	• Ina Maka	• Ina Maka	• Ina Maka	• Ina Maka	• Ina Maka
8. Sexually aggressive youth	Widom English[f] Freeman-Longo[g] Hall et al.[h]	• Family and individual counseling	• SHIFT (Sexual Health in Family Treatment)	• SHIFT	• SHIFT	• SHIFT	• SHIFT

[a] Widom, C.S.,"Childhood Sexual Abuse and Its Criminal Consequences," *Society* (May/June, 1996): 50; Widom, C.S., "The Cycle of Violence," *Research in Brief*, (Washington, D.C.: U.S. Department of Justice, National Institute of Justice, October 1992): 3; Widom, C.S., presentation of preliminary research findings, National Institute of Justice Annual Conference on Criminal Justice Research and Evaluation, July 21, 1997.

[b] Saunders, B. and D. Kilpatrick, "Victimization as a Risk Factor for Delinquency Among Gender and Racial/Ethnic Subgroups: Results from the National Survey of Adolescents," research findings presented at the National Institute of Justice Annual Conference on Criminal Justice Research and Evaluation, Washington, D.C., July 21, 1997.

[c] Thornberry, T.P., "Violent Families and Youth Violence," *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Fact Sheet #21*, (Washington, D.C.: OJJDP), December 1994.

[d] Peled, E., P.G. Jaffe, and S.L. Edleson, eds. *Ending the Cycle of Violence: Community Responses to Children of Battered Women*, (Thousand Oaks, CA: Sage Publications, Inc., 1995): 28-32.

[e] Johnson, B., E.D. Wish, J. Schmeidler and D. Huizinga, "Concentration of Delinquent Offending: Serious Drug Involvement and High Delinquency Rates," in *Drugs and Crime*, ed. R. Dembo, (Lanham, Maryland: University Press of America, 1993): 1-26.

[f] Interview with Diana English, Office Chief, Office of Childrens Administration Research, Department of Social and Health Services, Washington State, June 1997.

[g] Freeman-Longo, R.E., "Challenging Our Thoughts," presented at the National Summit: Promoting Public Safety Through the Effective Management of Sex Offenders in the Community, Sponsored by the U.S. Department of Justice, Washington, D.C., November 24-26, 1996.

[h] Hall, D.K. and F. Mathews, "Problematic Sexual Behavior in Sexually Abused Children: A Preliminary Typology" unpublished paper, York University and Central Toronto Youth Services, 1997; Hall, D.K. and F. Mathews, "Factors Associated with Sexual Behavior Problems in Young Sexually Abused Children," (paper currently being reviewed for publication), 1997.

II. Programming to Address the Impact of Domestic Violence on Children

Parents and Children Together (PACT), New Haven Connecticut

Sponsored by the Coordinating Council for Children in Crisis (CCCC), PACT offers psychoeducational group services to mothers and their children ages 6 to 12 who are victims of or witnesses to domestic violence. (See Appendix A for Group curriculums.) PACT's Children's group attempts to address the trauma of witnessing domestic violence by encouraging children to share their feelings, learn safety strategies, practice non-violent conflict resolution, and build self-esteem. Mothers' groups focus on helping abused women to understand the impact of domestic violence on children and encourage safety planning for family members. With funding from the Connecticut Department of Children and Families, the CCCC offers a number of free home-based services intended to prevent child abuse and neglect including parent education, advocacy, individual and group counseling for abused women, and therapy and support services to victims of child sexual abuse.[54]

III. Court-based Intervention

Boston Juvenile Court Clinic (BJCC), Boston, Massachusetts

BJCC, founded in 1967, is the oldest court-based intervention for victims of CAN and their families in America. BJCC is the child mental health branch of the Boston Juvenile Court. Following a finding of abuse or neglect, the Court refers children to BJCC for mental health and family assessments. BJCC offers three intervention programs for parents and children: a 10 week *parenting group* focusing on the development of active parenting skills for parents who have lost custody of their children or who are at serious risk for losing them; *Alternatives to Violence*, a 6 to 8 week anger management program for juveniles who have been identified as truants or as committing other minor offenses and are thought to be at risk for more serious criminality; and a ten week *alcohol and substance abuse education program* for incorrigible or other at-risk court-involved children.

V. Law Enforcement-based Intervention

Child Development-Community Policing (CD-CP), New Haven, Connecticut

CD-CP is a collaboration between New Haven Police and child development specialists at the Yale Child Study Center to intervene appropriately and sensitively with children who have witnessed violent crime. The project includes cross training in which police learn more about children's psychological and developmental response to witnessing violence from development experts, and mental health professional ride with police in squad cars, and spend time in police stations and on the street. Specially trained officers and clinicians are on-call 24 hours a day to respond to the needs of children who are in crisis as the result of witnessing violent crime. The program has been replicated in Framingham, Massachusetts and recognized as a model program by and received support from OJJDP.[56]

VI. Intervention for Sexually Aggressive Youths

Sexual Health in Family Treatment (SHIFT), British Columbia, Canada

Therapists at SHIFT work with children (12 years or younger) with sexual behavior problems who have experienced abuse or violence in their families. The intensive program provides individual, family and group therapy to the child and his or her caretakers. Using a strengths-based, family systems approach, therapists target the structure and organization of the family and its communication patterns, affective tones and nurturing behaviors, control and decision making, conflict resolution, and boundary issues. The goal of the therapy is to eliminate sexually aggressive or inappropriate behaviors in the child and to enhance family functioning and child social skills.

VII. Comprehensive Programming for Native Americans

Ina Maka (United Indians of All Tribes Foundation), Seattle, Washington

Ina Maka offers comprehensive family systems interventions that emphasize family preservation and incorporate traditional Native American practices and beliefs. Ina Maka programming includes family counseling; alcohol and drug crisis intervention services; home-based crisis intervention services; Foster care recruitment, placement, and advocacy; counseling for survivors of sexual abuse, batterers'

Conclusion

Intervening with victims of CAN to prevent delinquency is still an experimental pursuit. Although research is providing stronger evidence of the correlation between certain variables (e.g., types of victimization, demographic characteristics, family histories or cultural milieu) and delinquency, adult criminality and violent crime, much is still unknown. Perhaps the most pressing need is for high-quality experimental program evaluations testing whether current interventions can indeed inhibit the development of anti-social behaviors in victims of CAN. Answering the question, "What works for victims of CAN?" will undoubtedly be a slow and difficult process, but the potential reward of future reductions in domestic violence, child abuse and neglect, sex crimes, substance abuse and violent criminality makes it an urgent enterprise.

15. Interview with Diana English, Office of Children's Administration Research, Olympia, Washington, June 1997.

16. Information provided by the National Center on Child Abuse and Neglect Data System.

17. Runyan, D., M. Everson, G. Edelsohn, W. Hunter and M.L. Coulter, "Impact of Legal Intervention on Sexually Abused Children," *Journal of Pediatrics*, 113 (1988): 647-653.

18. Bureau of Justice Assistance (BJA), Bureau of Justice Statistics (BJS), Office of Juvenile Justice Delinquency and Prevention (OJJDP), National Institute of Justice (NIJ) and Office for Victims of Crime (OVC), *Office of Justice Programs Fiscal Year 1997 Program Plans*, Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, 1997: 85-86.

19. Interview with Debra Whitcomb, Educational Development Center, Newton, Massachusetts, June 1997.

20. The information in section is primarily drawn from, American Humane Association, "Twenty Years After CAPTA: A Portrait of the Child Protective Services System," unpublished report, Englewood, Colorado, May 27, 1994.

21. Widom, "The Cycle of Violence." Future research may wish to explore the connection between the degree and quality of attention given a case by the criminal justice system and subsequent victim delinquency across different types of abuse.

22. Thornberry, T.P., "Violent Families and Youth Violence," *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Fact Sheet #21*, (Washington, D.C.: OJJDP), December 1994; Saunders, B. and D. Kilpatrick, "Victimization as a Risk Factor for Delinquency Among Gender and Racial/Ethnic Subgroups: Results from the National Survey of Adolescents," research findings presented at the National Institute of Justice Annual Conference on Criminal Justice Research and Evaluation, Washington, D.C., July 21, 1997.

23. Kruttschnitt, C. And M. Dornfeld, "Childhood Victimization, Race and Violent Crime," *Criminal Justice and Behavior,* 18 (December 1991): 448-463. Kruttschnitt cites lack of parental supervision as a predictor of delinquency in African American males.

24. Widom, C.S., "The Cycle of Violence," *Research in Brief*, (Washington, D.C.: U.S. Department of Justice, National Institute of Justice, October 1992): 3.

25. Ibid.

26. Hall, D.K. and F. Mathews, "Problematic Sexual Behavior in Sexually Abused Children: A Preliminary Typology" unpublished paper, York University and Central Toronto Youth Services, 1997; Hall, D.K. and F. Mathews, "Factors Associated with Sexual Behavior Problems in Young Sexually Abused Children," (paper currently being reviewed for publication), 1997.

27. Widom, C.S., "Child Victims: In Search of Opportunities to Break the Cycle of Violence," unpublished paper, presented to the National Institute of Justice Perspectives on Crime and Justice meeting, Washington, D.C., April 8, 1997.

43. Johnson, B., E.D. Wish, J. Schmeidler and D. Huizinga, "Concentration of Delinquent Offending: Serious Drug Involvement and High Delinquency Rates," in *Drugs and Crime*, ed. R. Dembo, Lanham, Maryland: University Press of America, 1993: 1-26.

44. Saunders and Kilpatrick, "Victimization."

45. Office of Children's Administration Research, "Female and Male Children with Sexually Aggressive Behaviors: A Comparison of Sexually Aggressive Children on Open/Active DCFC Caseloads," Washington State Department of Social and Health Services, September 1995:2.

46. Freeman-Longo, R.E., "Challenging Our Thoughts," typescript summary of comments at the National Summit: Promoting Public Safety Through the Effective Management of Sex Offenders in the Community, sponsored by the U.S. Department of Justice, Washington, D.C., Novenmber 24-26, 1996.

47. Interview with Diana English, Office Chief, Office of Childrens Administration Research, Department of Social and Helath Services, Washington State, June 1997.

48. Hall and Mathews, "Factors Associated with Sexual Behavior Problems"; and Hall and Mathews, "Problematic Sexual Behavior".

49. Hall and Mathews, "Problematic Sexual Behavior."

50. Saunders and Kilpatrick, "Victimization."

51. Widom, preliminary presentation of findings, Annual Conference on Criminal Justice Research and Evaluation, July 21, 1997.

52. Ibid.

53. Program information, "MELD: Programs to Strengthen Families," Minneapolis, Minnesota, March, 1997.

Appendix A

Clifford Beers Guidance Clinic

and

Coordinating Council for Children in Crisis

present:

P.A.C.T.

Coordinating Council For Children In Crisis, Inc.
131 Dwight Street
New Haven, CT 06511
(203)624-2600

The Goals of the Children's Group

•Breaking the Secret

This complex group goal helps children define violence (abuse is not okay, it's not my fault), become educated regarding their feelings (it's okay to feel and to express feelings), and share personal experiences (I'm not the only one). Universalizing the experience through telling or drawing stories, promotes expression of feelings and promotes healing.

•Learning to Protect Oneself

The life realities of the children who participate in this project indicates a need for self-protection training. Safety planning may include telephone role plays, sexual abuse education (good touch - bad touch), group leaders role-modeling assertive conflict resolution strategies.

•Having Positive Social Interaction Experiences

A positive experience can be described as one in which children feel safe, and encounter fun and enjoyment. The children's feelings of trust and safety in the group are a precondition for "breaking the secret". Fun activities provide the children with an immediate gratification that balances the heavier violence related aspects of the group.

•Learning Positive Conflict Resolution

Through the use of role plays, the child will be aided in identifying upset feelings and different (appropriate) ways of expressing such feelings. As children are accustomed to seeing anger expressed by striking out, the goal is to help children discover alternative methods of expressing anger.

•Strengthening Self-esteem

Children witnesses of violence are often dis-empowered. They also often feel different from other children and sometimes they are themselves abused. It is expected that participation in the group will empower the children and strengthen their self-esteem. Several group activities and general supportive and validating interaction with group leaders throughout the group contribute to the achievement of this goal. These include positive reinforcement of children, such as complimenting children for what they said and did and reassuring them that their thoughts and feelings were valid. Another way of empowering the children is by enabling them to make as many choices as possible in the course of the group sessions.

Further, achievement of each of the other four goals contributes to children's positive self-perception. The process of breaking the secret tends to reduce children's shame, guilt, and isolation associated with the violence. Through learning to protect themselves children are empowered and strengthen their confidence in their own skills. A positive experience in group means for the children a positive experience of themselves, of their capacities to be respected and cared for and to be part of a positive enjoyable interaction.

SESSION #5
Sharing personal experiences with violence
Feeling of the day is "hurt"
Relate experiences to feelings
Feel less ashamed
Group murals depicting most violent events/ Three Wishes
(Snack)
Free-Time Activity
Close with personal affirmations

SESSION #6
Parents And Children Together
Group members display their creations
Share safety plans
Bring a dish made by moms and children
What have we all learned? **(Post-Tests)**

Background Paper #2:

Theory and Research on the Outcomes and Consequences of Child Abuse and Neglect

Athena Garrett, Ed.M.
Abt Associates Inc.

October 3, 1997

Introduction

In recent years, the reports of child abuse and neglect (CAN) have risen at a rapid rate.[1] In response, there has been a proliferation of theoretical and programmatic innovations from a number of fields, including sociology, psychology, medicine and criminal justice. This paper reviews the growing body of research on the etiology of CAN, the consequences for victims, and theories concerning effective treatments and interventions. In particular, recent research concerning the demographic characteristics associated with increased criminality in victims of CAN is reviewed, and the most promising intervention and treatment strategies are summarized.

The theoretical assumptions informing child abuse and neglect interventions are shifting. Originally, child abuse and neglect was believed to be a consequence of individual psychopathology. Currently, researchers and practitioners are beginning to recognize that it is also a familial and social problem that requires more comprehensive and creative interventions. Increased attention is being given to the ability of individuals and families to successfully remedy the negative impact of victimization. Theories and interventions are moving from an individualistic, deficit-oriented model toward a more ecological, strengths-based model, which is focused on individual and familial resilience.

Part I: Theories Guiding Research and Intervention

A number of theories guide research and intervention strategies for child abuse and neglect. This section discusses social learning, attachment, ecological, family systems, self-efficacy and resiliency theories. Typically, intervention programs incorporate at least two of these six theories. (See Part III for program summaries illustrating each theory.)

Because social learning theory attributes behavior to lessons learned from the environment, it is closely related to ecological theory. However, programs that are heavily influenced by social learning theory, focus treatment more narrowly on the family. Programs founded on ecological theory involve a wider range of external services and systems to address multiple factors that impact the family environment.

Program Examples

Parents and Children Together (PACT) in New Haven, Conneticut, provides services that are strongly influenced by social learning theory. Groups for parents focus on child development and clear parent-child communication. Additionally, they help the entire family to learn safety strategies, share feelings and practice non-violent conflict resolution.

Attachment Theory

Attachment theorists believe humans develop a repertoire of behaviors that promote interaction between themselves and their care givers.[7] Children learn these behaviors as a result of how their caregivers nurture them. According to attachment theory, the type of bond that develops between child and care giver effects the child's later relationships.[8] Attachment theory describes four bonding types: secure, anxious/ambivalent, anxious/avoidant, and disoriented/disorganized. The securely attached child freely explores surroundings and is easily comforted. Children with anxious/ambivalent attachments move easily between the caregiver and a stranger when looking for comfort but will simultaneously resist the comfort given. Children who experience anxious/avoidant attachments manifest distrust of the care giver, poor exploration, resistance to separation from the caregiver, and an inability to be comforted. Disoriented/disorganized attachment patterns are characterized by erratic and confused behavior as the child is unable to discern which behaviors gain favorable attention from the caregiver.[9]

Secure attachment patterns are thought to develop from a consistent and nurturing caregiver, whereas the other, insecure attachments, are the result of inconsistent, emotionally neglectful and/or abusive caregiving. Attachment theory suggests that children who are neglected or abused may be more distrustful, have limited self-esteem, and seek out more maladaptive relationships later in life than those who have not been neglected or abused. Several researchers have cited that as many as 80 percent of abused infants and children exhibit insecure attachment patterns.[10]

focuses on preserving the family while working to repair the caregiver-child bond. The belief underlying this strategy is that the separation from the original caregiver could result in irreparable damage and even less secure relationships in the future.

A compelling study of attachment suggests a link between attachment styles, types of abuse, and adult functioning outcomes. Researchers at the Michigan State University Department of Psychology found that childhood neglect influences symptomology and dysfunctional attachment styles more than physical abuse does.[16] Additionally, neglected children had lower intellectual and social competence and impaired language development.[17] Their research suggests that neglect and abuse should be viewed distinctly, and perhaps programs should be developed with this differentiation in mind. Programs designed for neglected children may require a consistent, nurturing adult who fosters secure attachments, while incorporating a language and social skills development component. However, children who have been physically abused may not need interventions as heavily focused on developing secure attachment styles.

Program Examples

Compassion Workshop is an example of a program designed according to attachment theory which incorporates social learning theory in its treatment modalities. It is an intervention for child, partner and elder abuse and treats both perpetrators and victims. Participation may be voluntary (self-referred) or involuntary (court-ordered). The program addresses physical and emotional abuse by attempting to resolve attachment problems through a cognitive restructuring technique called HEALS: Healing, Explain to yourself, Apply self-compassion, Love yourself, and Solve. The program providers hope to help participants understand their own attachment histories and create balanced and secure attachments in their relationships. By looking at their own, and assumed dysfunctional, childhood attachment patterns, they are encouraged to alter their existing attachment patterns with their mates and children. In addition, the program is designed to help participants build self-esteem, develop self-compassion and compassion for others, and eliminate violent expression of emotions. In an evaluation study, 87 percent of Compassion Workshop participants were violence-free at the end of one year, compared to 41 percent of a comparison group comprised of participants from other batterer programs.[18]

The Gilday Center is a therapeutic daycare/family preservation intervention that combines attachment and social learning theory. The Center is contracted by the Massachusetts Department of Social Services to serve families that have a substantiated case of CAN but sufficient strength to be restored.

Critique of Theory

Widom argues that ecological theory is too rigid and does not allow sufficiently for individual variation.[27] For individuals and families involved in CAN, the degree of influence by each level (individual, familial, community and socio-cultural) may differ dramatically. A child who has been sexually abused may be committed to school, involved with peers and dissociated from family, whereas, in another family a sexually abused child may be disconnected from the community and isolated from peers. Additionally, the child's developmental stage may alter the extent to which a system impacts him or her. An ecological system that is based on an adult perspective may not be developmentally appropriate for children.

Programs Based on this Model

For child abuse and neglect cases, the ecological perspective focuses on influences beyond the parent-child dyad and coordinates interventions that address all systems. If, as the theory states, child maltreatment is the result of multiple factors from various systems, then in order to be effective, programs need to address each factor and system. Interventions grounded in this theory include home visitation, parent groups, and facilitation of social and economic supports.

Program Examples

Homebuilders is an example of an intervention founded on ecological theory. This intensive home-based crisis intervention and education program is designed to preserve high-risk families and reduce out-of-home placements (See "Managing the Consequences"). Program providers (CPS) serve two families at a time, are on call in the evening and on weekends, and work with the family to develop communication skills, child management, child/family safety and stability, and to resolve crises.[28] Successful outcomes have been reported for preventing out-of-home placements and client satisfaction; however, assessments have been criticized for lack of true random assignment and other methodological weaknesses. Neglected children have less positive outcomes in this program, and the best outcomes have resulted when services are concrete, such as securing financial support for the family.[29]

The National Head Start/Public School Early Childhood Transition Demonstration Project is another example of an intervention based on ecological theory. The Transition Project provides comprehensive and ongoing services to support low income children and families for four years (compared to the traditional Head Start program which lasts for one year.)[30] Researchers, policymakers, and practitioners recognized the need to address not only the multiple systems impacting

Program Examples

The Family Center is located in Somerville, Massachusetts, and its goal is to strengthen and preserve the family. The curriculum currently being used and developed is the "The Parenting Journey" which incorporates family systems theory, attachment theory, and social learning theory. The program focuses on the entire family to address issues and provide insights into family dynamics through a family support program. The providers also attempt to help parents resolve destructive parenting patterns based on their own childhood experiences. Families may be referred by CPS or self-referred. Participants receive family therapy with a focus on group dynamics to develop self-awareness, respect, and parenting skills. The Parenting Journey is a new curriculum that has not been evaluated.[39]

Ina Maka Family Program in Seattle, Washington, is another example of an intervention based on family systems theory. It is a comprehensive family preservation program designed to prevent the "break-up of at-risk Indian and non-Indian families," which utilizes both traditional Native American healing practices and modern psychotherapeutic modalities.[40] Clients are referred by Washington State Social Service Agencies for Families and Children (DSHS), CPS, Local and County Court and Probation Officers, numerous tribes and Indian Reservations throughout Puget Sound, and self-referral. Ina Maka provides services to perpetrators and victims. This program helps clients develop positive self-esteem, anger management skills, healthy family communication and parenting skills through short-term and long-term treatment and aftercare services. Additionally, the program has intake/emergency services, domestic violence intervention programs, sexual abuse programs, alcohol and drug abuse treatment, minority diversion services (to preserve and reunite high-risk minority families), and foster care services (for example, home studies, recruitment, case managment and supervision, support services, Indian Child Welfare Legal Services/Reunification, and adoption enrollment). Ina Maka uses the Personal Objective Inventory (POI), a treatment outcome measure, which "provides an objective measure of an individual's level of health in certain areas. "[41] It is a new instrument and the findings have not yet been determined.

Self-Efficacy Theory

Many programmatic models based on ecological theory also incorporate self-efficacy theory. Self-efficacy theory focuses on how personal characteristics of the child and, especially, the parent influence family functioning.[42] Self-efficacy theory addresses how a parent's expectations of effectiveness impact their motivation and behavior.[43] An individual's expectations dictate if they will start and continue actions to achieve a goal.

continued advocacy. By being advocates for the women, they hope to promote self-advocating behaviors in the mothers and their children. AWAKE receives referrals from other hospitals, social workers, lawyers, shelters, therapists, victim/witness advocates, criminal justice workers, and clients themselves.[49] From a preliminary analysis of 46 cases, abuse of the mother ended in 85 percent, according to self-report, and in 76 percent of the cases, abuse of the child had stopped according to the mother. Additionally, women and children served were found to have a low rate of foster care placement.[50]

Resiliency Theory

Historically, child abuse and neglect research and interventions were grounded in the belief that inevitably the victim is damaged by the trauma. Mediating influences that may alter the impact of maltreatment typically were not considered. However, recent research has demonstrated that factors such as severity of abuse, frequency of abuse, age of the victim, and relationship to the perpetrator can predict later adjustment. Additionally, certain positive elements of support have been shown to affect the long-term impact of child maltreatment. Factors such as social support,[51] parental warmth[52] and the victim's healthy relationship with a supportive adult[53] influence healthy development and avoidance of delinquent behavior.

Because childhood abuse and neglect do not always result in maladaptive behavior in adulthood,[54] new research is focusing on discovering the mediating factors that contribute to healthy adult psychological development.[55] A primary goal of the research is to discover the protective factors that can be included in an intervention.

Resiliency theory does not explain why abuse and neglect occur, rather, it explains why children are not inevitably damaged by CAN. It may also explain how the "cycle of violence" can be interrupted. This theory focuses on the victims of childhood maltreatment and on methods to mitigate the impact of the maltreatment.

Critique of Theory

Most resiliency theorists would agree that resiliency theory cannot be the soul underpinning of child abuse and neglect interventions.[56] Though programs can reduce the effects of maltreatment, which may in turn reduce the likelihood of later maladjustment and delinquency, protective factors may not

Part II: Recent Research Findings, Trends, and Recommendations in the Field of CAN

The following section is divided according to common outcomes of CAN, differentiated outcomes by type of CAN, stage of development, gender and race, and new research on delinquency. It concludes with a discussion of research on effective intervention strategies. Delinquency has been separated because of the focus of the NIJ Child Abuse and Neglect Interventions Strategic Planning Meeting.

A General Survey of Consequences for CAN Victims

- **Medical/Physical**
  bruises, skin markings, cuts,
  burns, serious physical injuries (brain damage, death),
  severe health complications, body disregulation
- **Psychiatric/Post Traumatic Stress Disorder**
  anxiety, nightmares, generalized fear response,
  depression, psychopathology, neurosis,
  character disorders, trauma-specific fears
- **Attachment/Self-Esteem**
  poor attachment, separation problems,
  lack of empathy, low self-esteem,
  affective problems, temperament problems
- **Cognitive/Developmental**
  low verbal, cognitive and motor abilities,
  regression, lower performance on cognitive tasks,
  language deficits, developmental delays
- **Academic Performance**
  concentration problems, declining grades,
  poor school achievement,
  truancy, dropping out
- **Behavioral/Interpersonal**
  less social competence, acting out,
  self-destructive behavior, physical aggression,
  antisocial behavior, withdrawal, avoidance

Sources: Cichetti, D. and V. Carlson, *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect*, New York: Cambridge University Press, 1989; Peled, I., P. G. Jaffe and J. L. Edelson, *Ending the Cycle of Violence: Community Responses to Children of Battered Women*, Thousand Oaks, CA: Sage, 1995; Herman, K., "Effects Of Violence on Adult Functioning/Child Development," unpublished fact sheet, presented at the Fifth National Colloquium of American Profession Society on the Abuse of Children, June, 1997.

Differential Outcomes of Abuse and Neglect

Research identifying differential outcomes according to type of abuse is limited. Many researchers specialize in one area of abuse, such as physical abuse or sexual abuse. Therefore, research comparing different types of abuse is rare. Existing research, according to experts in the field, is new and currently has insufficient data to support differentiated interventions based on type of abuse only. Generalizing findings from this research is viewed cautiously due to methodological limitations.

The following is a limited summary of the research on how the consequences of child victimization differ according to type of abuse. Different types of abuse were compared to determine which were the strongest predictors of symptomology. Research findings have been grouped according to symptom categories: psychological/PTSD; academic performance/cognitive; and behavioral-interpersonal/affect-emotional.

Psychological/PTSD

In comparative studies involving psychological outcomes, victims of sexual abuse and neglect demonstrated the most severe symptoms. According to one study, victims of child sexual abuse are more likely than other victims of child maltreatment to be diagnosed with PTSD.[72] Additionally, depression may be more prevalent in children who are sexually abused than in children who are physically abused.[73] Victims of neglect also fared worse than physically abused children. Between neglect and physical abuse, neglect was a stronger predictor of more severe psychological problems, such as anxiety, depression, somatization, paranoia, and hostility. Researchers also reported that neglected children are more likely to exhibit anxious attachment styles and, later, more difficulties in relationships.[74]

Academic Performance/Cognitive

In a study by Perez and Widom, comparing cognitive and academic impact across types of abuse, victims of neglect showed the most deficits. Adults who had been neglected as children had significantly lower IQ and reading levels than non-abused controls. Those who had been physically abused had lower IQ scores than non-abused controls. However, adults sexually abused as children did not differ from the non-abused controls. Parallel results were found in a study of school aged children (K-12), which suggests that the academic and cognitive impact of CAN differs according to type of abuse.[75]

Sexual Abuse

Infancy: insecure attachments.

Pre-school: PTSD, inappropriate sexual behavior, anxiety, increased internalizing and externalizing problems, nightmares.[86]

School-aged: neurotic, aggressive and hyperactive.[87]

Adolescence: onset of puberty advanced by one year,[88] bulemia,[89] suicidal or self-destructive behaviors, depression,[90] withdrawl, aggression, running away, substance abuse, and anxiety.[91]

Neglect

Infancy: non-organic failure to thrive syndrome,[92] anxiously attached(anxious/avoidant).[93]

Preschool: serious behavior problems,[94] inattentive and uninvolved in learning.[95]

School-aged: withdrawn, inattentive.

Adolescence: poor peer relationships.

Differential Outcomes of Abuse and Neglect by Gender and Race

Similar to research on the developmental impact of CAN, the impact of gender, race, and socio-economic status are understudied and ill understood. The few studies that exist tend to disagree on the nature of the relationships between these variables and outcomes. A summary of relevant research follows.

Gender

Female victims of sexual abuse exhibit greater internalized aggression.[96] In studies conducted exclusively with females, victims of sexual abuse were found to have lower self-esteem[97] and greater cognitive impairment[98] than non-abused girls. They were also found to have poor relationships with their mothers.[99] Female victims of sexual abuse are also at greater risk of engaging in prostitution, while male victims of sexual abuse are not.[100] However, both male and female victims of neglect are at greater risk of engaging in prostitution, although the risk remains higher for females.[101]

One study found that boys who are physically abused show a higher degree of hypervigilance, a symptom of PTSD.[102] Saunder's preliminary research found that African-American males who had witnessed violence and had PTSD were at significantly higher risk for delinquency than all other populations. Widom found that female victims of abuse and neglect had higher rates of arrest for violence, but male victims did not.[103]

Type of CAN as a Predictor for Sex-Related Crimes

Abused and neglected children generally are at increased risk of being arrested for sex crimes. The risk is especially pronounced among neglected children.[116] Sexual abuse victims, especially females, appear more likely to be arrested for prostitution[1] than children who have been physically abused.[117]

In one study, approximately 10.5 percent of the female victims of sexual abuse had engaged in prostitution compared to 9 percent of neglect victims.[118] Sexual abuse was neither associated with increased risk for sex crimes in general,[119] nor were male victims found to be at increased risk for committing sodomy or rape.[120]

The occurrence of sexual behavior problems in victims of sexual abuse

Widom's research "did not find victims of child sexual abuse generally to be at increased risk for violent criminality, but later studies have identified a subset of child sexual abuse victims that are likely to become sexually aggressive youths."[121] In a new study by Hall, four variables were found to affect whether a child who has been sexually abused develops sexual behavior problems: whether the child experienced sexual arousal, the occurrence of sadism, the co-occurrence of physical and emotional abuse and who the victim blamed. Of these, the strongest predictor of both self-focused and interpersonal sexual behavior problems was arousal. Interpersonal sexual behavior problems, such as becoming a sexually aggressive youth, were predicted by: arousal, sadism, physical abuse and emotional abuse. Hall's study found that the closeness of the relationship to the perpetrator and duration or frequency of abuse were not significant predictors of sexual behavior problems.[122]

According to Hall, the victim's amenability to treatment was determined by several factors. If the victim experienced only partial arousal and had strong family structure and support, then the outcomes were favorable. If the victim's family engaged in sexualized interactions and family violence, but had low criminality, then the outcomes were mediocre. If the victim experienced severe sadism, had a violent family surrounded by a criminal cultural milieu and had serious PTSD, then the outcomes were poor and monitoring was recommended.[123]

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1 Debra Whitcomb reported that although 75% of street prostitutes had been abused, 57% lived at home when they were first sexually exploited. Although there has been some suggestion that victims of abuse runaway from home and subsequently become involved in survival prostitution, causality is unclear. Exploitation is not necessarily associated with homelessness. Source: Preliminary research findings presented at the Meeting the Challenges of Criminal Justice Research and Evaluation, sponsored by the National Institute of Justice, U.S. Department of Justice, July 21, 1997, Washington D.C.

with at-risk populations in general (with victims of abuse and neglect being a subset of that category). The relative effectiveness of abuse-specific versus non-specific interventions is unknown.

Existing outcome research on whether interventions are effective has significant methodological limitations such as small sample sizes, lack of control or comparison groups, or no follow-up concerning further victimization.[132] Additionally, "common assessment strategies have not been used across different interventions, making it difficult to know what works for whom."[133]

Despite these limitations, several intervention strategies (for example, multi-systemic, cognitive-behavioral, family preservation, therapeutic day care, therapy and a supportive adult) have demonstrated promising outcomes for treatment effectiveness. "One well-researched approach, multi-systemic therapy, has had excellent results for adolescents with delinquent behavior."[134] Short-term cognitive-behavioral modeling[135] has been an effective treatment for PTSD.[136] Family preservation, although not consistently effective, may work more often with physically abused children than with neglected children.[137] Additionally, some evidence suggests that therapeutic day care positively impacts the developmental progress of physically abused children[138] in the areas of fine and gross motor skills, cognitive development, social and emotional functioning, and language development.[139] Therapy and relationships with supportive adults have also been shown to break the "cycle of violence." Egeland found that women who had been severely physically abused as children and received at least a year of therapy during childhood or had a supportive relationship with an adult during childhood did not currently abuse their own children.[140]

The type of strategy is not the only factor that contributes to effective interventions. Length of intervention has also been studied. Some results suggest that more than 10 meetings, whether insight-oriented, group or family-centered, lead to greater treatment effectiveness for at-risk families.[141] This finding is supported by other researchers who call for long-term treatment and follow-up.[142]

Many current intervention strategies are based on resiliency theory. This theory outlines the mediating factors that can protect a child from the negative outcomes of CAN. A review of the leading research in this area provides a list of individual, family and community protective factors.

Part III: Examination of Existing Intervention Strategies

From the many interventions researched, three have been profiled in this section. These interventions have been selected to depict how intervention programs use theory to design practice and because of their promise as effective intervention strategies for CAN. Most of the interventions selected were created explicitly to stop CAN and/or domestic violence as well as to restore the victims and/or family. (See Exhibit 1-3 in Paper #1.) Others, such as school-based interventions, are designed to improve academic achievement in at risk populations generally, but also address issues of CAN.

The Gilday Center: Roxbury, Massachusetts - founded in 1972

Director: Janice Higgins, LICSW

Assistant Director: Mary Watson Avery, M.S.

I. **Description:** Family Preservation/Therapeutic Daycare Program

A. A nonprofit agency and center funded by private donors, United Way, Associated Day Care Services, and contracted by Massachusetts Department of Social Services.

B. Designed to prevent out-of-home placement by providing parents and children with emotional safety and support, pursue the best interest of each family, and educate parents about child development and their own personal development.

C. Provides services to infants and toddlers 6 weeks to 2.9+ years old who have substantiated experiences of abuse and neglect (51As) [+ six weeks]. Current enrollment 14 children: 6 african american; 3 multi-racial; 4 hispanic; 1 caucasian.

D. Provides a limited number of slots to the community (not protection cases) in which it is based (Mission Hill Housing Development).

II. **Theoretical Framework:**

A. Program is guided by development theories of early childhood, focusing on social, emotional, physical, and cognitive skills.

B. Attachment and Social Learning Theory guide the structure of the interventions with parents and children to help them establishsecure attachments through the cognitive-behavioral practices of observation and modeling, and active parent instruction.

C. Resiliency theory informs child interventions which are based on each child's response to the trauma s/he has experienced.

1 hour

c. **Social Session:** Freeform with snacks — Opportunity for parents to interact with each other and the center staff.

d. **Individual Session:** Center Director may provide one-on-one counseling with a parent if the parent has need and is not receiving such services elsewhere.

B. Children: May enter the daycare after being referred by DSS or through the voucher system* for low-income families. Ideally 12 (daycare) slots are for DSS cases and 4 slots are for voucher facilities.

1. **Developmental milestones:** individual education plans for every child based on both the assessment and observation.

2. **Interventions (clinical):** Pair Play Project

a. Case-by-case interventions based on child, abuse history/experiences, exposure to substances, relationship with parents, and level of resiliency.

b. Center practice regarding attachment and resiliency.

(1) provide a sense of security and belonging as all children have picture of self/home at table; maintain constancy (e.g., sleep in same place every day).

(2) observe children in play and facilitate play.

(3) provide mixed age groups.

(4) help children transition to new placement/preschool.

* Voucher slots are filled by Mission Hill community members who are not currently involved with DSS, but have qualified for voucher — typically a strong family situation.

C. Providers

1. **DSS Child Protection Worker:**

a. Makes referral, accompanies parent to first meeting.
b. Conducts a standard/uniform evaluation every 6 months.
c. Holds multiple meetings between evaluations to check progress of child/parent/family.

2. **Daycare Workers:** All are qualified by the Office for Children (OFC) in Early Childhood Education (teacher/lead teacher), with at least a Bachelors, some Masters and are bilingual.

a. One-on-one supervision with director bi-weekly; mental health support by consultation.

b. Weekly team meeting (2 teams, each classroom is a team).

(1) specific issues in classroom: behaviors, hygiene.

D. DSS responsible for follow-up and evaluations — Gilday has not developed any longitudinal follow-up and does not have any specific statistical outcome data on specific subjects.*

* Gilday does have anecdotal outcomes and individual case studies completed by graduate student interns. DSS does not have follow-up and evaluation reports.

Casa Myrna Vazaquez: Boston, Massachusetts, founded in 1976

Director of Education and Training: Debra Robbin

Coordinator of Children's Services: Chris Bucco

Director of Support Services: Patricia Cullen

I. **Description:** Domestic Violence Shelter for Women and Children

A. A nonprofit agency with multi-level public and private funding from: United Way; Massachusetts Department of Social Services; Hart McKinney; HUD; Mass Bar Foundation; Crime Victim's Assistance; and an Emergency Shelter Grant.

B. Designed to stop domestic violence and child abuse in the community and in families, to protect individuals, and provide survivors with the necessary support to prevent future violence and victimization.[2]

C. Provides emergency, short-term, and long-term shelter, treatment, and advocacy for victims of domestic violence and their children. Serves 35-40 women and 60-65 children in its residential programs.

D. Provides support services to community members (non-residential) through a crisis hotline, mental health services, and education and training outreach to corporations, community, and victims.

II. **Theoretical Framework:**

A. Attachment theory informs the structure of the program which recognizes the importance of the mother-child bond and facilitates the development of positive and healthy relationships and functioning by providing shelter and support to both .

B. Social Learning theory guides the work of advocates who collaborate with mothers to secure services for both themselves and their children.

2 Do not provide services for women who are the primary perpetrators of child abuse.

B. Intervention Methods:

1. **Children:** children of all ages are accepted at the shelter and complete age-appropriate screenings and assessments for early intervention and referrals.

    a. Direct childcare provided on the premises: art therapy and play therapy in addition to early childhood development focused on cognitive, emotional, physical and social skills.

    b. Children's advocates work with child and parent to secure necessary education, medical, and social support for the child.

    c. Children may also receive individual or group counseling, either onsite, or community, school or hospital-based, if necessary.

2. **Parents:** complete mental health intake to identify personal and parenting needs.

    a. Advocates work with mothers to secure housing, economic, legal and protection assistance.

    b. Counseling may be individual or group; parents may participate in art therapy.

    c. Referrals for mental health needs and substance abuse treatment.

3. **Providers:**

    a. **Children's Advocates:** background in early childhood education and development; experience with childhood trauma.

        1. Provide direct childcare.

        2. Direct art therapy, play therapy and referrals for early intervention.

        3. Provide mothers with Individual Parenting Support to help mothers:

            a. Understand how children have been effected by domestic violence and/or child abuse.

            b. Address the need of their children while in the shelter.

    b. **Women's Advocates:** experience in and understanding of domestic violence and abuse issues.

        1. Complete assessments Mental Health Intake.

        2. Identify other necessary assessments (substance abuse).

        3. Collaborate with mothers to secure education, medical, legal, mental health, and social services for herself and child.

C. Provides services to 20-40 middle school students with a focus on sixth and seventh grade prevention and intervention and a limited follow-up component for eighth grade students who participated in the program previously.

D. At least twenty-five percent of students receiving services through the program have been involved with the court through the Department of Social Services and/or the Department of Youth Services for abuse and neglect or through a Child in Need of Services Petition (CHINS).

II. **Theoretical Framework:**

A. Program is founded on resiliency theory and is a "developmental intervention focused on the capacities of children to overcome problems," utilizing multiple methods to enhance the unique strengths of each child.

B. The ecological approach is also a fundamental part of the program which attempts to connect the student and his/her parents to the necessary supports in school (peers and teachers) the community, and with other providers in the student's life.

C. Cognitive-behavioral theories and theories of moral development guide the everyday activities of the prevention practitioners in class and counseling.

III. **Objective:** To provide students at risk with support to prevent academic failure, anti-social and delinquent behavior, and to promote self-efficacy, interpersonal, and academic success.

A. Students: Help students develop a commitment to school, improve academic achievement, develop positive social relationships, and bridge the fragmented spheres of family, school, and community.

B. Parents: Facilitate school-home communication and provide parents and families with support.

C. Community: Establish partnerships with the community in supporting at-risk students and families and incorporate community-based services as an intervention option.

IV. **Method:** An entire "cluster" of students in the same grade complete initial assessments to identify students at risk, with those identified being matched with a prevention practitioner. Students may be self-referred or referred by teachers, prevention practitioners, and student support services.

A. Students: Complete further detailed assessments, and the prevention practitioner designs an intervention program with the student, based on assessment results and contextual understanding of the student's strengths and coping skills.

1. Classroom: assist students identified and other students in the classroom with academic work.

2. Counseling: work with student outside of classroom (refer for further evaluation with psychiatrist if needed).

V. **Assessments:** To measure student progress in terms of academic performance, social skills development, psychological and emotional development and maturity.

A. An entire cluster (96) of students in grade six or seven complete:

1. Youth Self Report For Ages 11-18 (Achenbach 1-91 edition).

2. BECK's Inventory For Depression.

B. Student's identified as at-risk (32) complete:

1. **Harvard RALLY Project Student Information Questionnaire** - provides detailed family, nationality, medical, school (including special needs and standardized test scores), disciplinary history, and *court involvement* information.

2. **Student Profile** - highlights the student's interests, school/personal goals, home/family/interests, school and community services.

3. **Teacher's Report Form** (Achenbach 1/91 edition) - provides detailed academic performance, perspective on academic and social development, IQ, readiness and/or aptitude testing, motivation, self-control.

4. **Harvard-Taft Classroom Behavior Scale** - completed by director or psychiatrists through direct observation of the student to provide a third perspective and completed periodically throughout the year to note progress.

C. **Parent Contact Form** - completed by the prevention practitioner each time contact/conversation with parent occurs, noting the purpose, information gathered, impressions, and plan for action.

VI. **Outcomes:** Follow-up data for 6 eighth grade students who participated in the project in seventh grade is being collected and analyzed.

A. Project Status - project is in the third phase:

1. Phase one: implementation in the seventh grade cluster (1995/1996);

2. Phase two: creation/introduction of new assessment tools (student questionnaire) with seventh grade and follow-up with first group (1996/1997);

3. Phase three: implementation in the sixth grade (1997/1998) and follow-up with eighth grade students.

B. Quantitative - creating a database for follow-up through grades, disciplinary action/involvement, and attendance.

C. Qualitative - academic and personal development.

1. Improved peer/peer and adult/peer relationships and interactions.

Endnotes

1. See Paper # 1 in this series, "Managing the Consequences: An Overview of Intervention Strategies for Victims of Child Abuse and Neglect," 2.

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Background Paper #3:

Policies, Practices and Statutes Relating to Child Abuse and Neglect

Kerry Murphy Healey, Ph.D.
Abt Associates Inc.

October 3, 1997

Introduction

Interventions to manage the consequences of child abuse and neglect (CAN) operate in the institutional context of State and Federal laws, the bureaucratic structures and procedures adopted by each State's child child welfare agencies; local policies; and each State's criminal justice system. Each of these may constrain or facilitate intervention in child abuse and neglect. This paper considers the role of each of these influences on child abuse and neglect policies and services, reviews current innovations in the field and concludes with an overview of proposed reforms to the child protection services system.

Responsibility for child protection and welfare is reserved by the Constitution for the States. Each State's system of child protection is a complex web of services and regulations constructed of State statutes, voluntary acceptance of federal funding and oversight, State department of social services policies, court mandates and local regulations and agreements.

- **Federal legislation**, through restricted funding streams, indirectly influences and constrains State-level CAN programming and child protective services (CPS) procedures while providing an overlay of similar program goals and case management procedures across State systems.
- **State statutes** define child abuse and neglect, identify mandatory reporters and reporting procedures and specify the overall structure of CPS in the State.
- **Policies and procedures** for intervening in CAN, including how reports are screened, investigated and assessed; cooperation with other agencies, including the criminal justice

Appendix D.3

Michigan Family Risk Assessment for Neglect

			Score
N1.	Current Complaint is for Neglect		
	a. No	0	
	b. Yes	2	____
N2.	Number of Prior Assigned Complaints		
	a. None	0	
	b. One or More	2	____
N3.	Number of Children in the Home		
	a. Three or Fewer	0	
	b. Four or More	2	____
N4.	Number of Adults in Home at Time of Complaint		
	a. Two or More	0	
	b. One/None	3	____
N5.	Characteristics of Female Caretaker (check and add for score)		
	a. Not Applicable	0	
	b. ___ Lacks parenting skills	1	
	c. ___ Lacks self-esteem	1	
	d. ___ Apathetic or Hopeless	2	____
N6.	Caretaker(s) Socially Isolated or Withdrawn or Involved in Harmful Relationships		
	a. Neither Caretaker	0	
	b. One Caretaker	2	
	c. Both Caretakers	3	____
N7.	Female Caretaker Has a History of Alcohol or Drug Abuse		
	a. No	0	
	b. Yes	3	____
N8.	Amount of Current Household Income		
	a. Over $2,000 Per Month	0	
	b. $600 to $2,000 Per Month	1	
	c. Under $600	2	____
N9.	Perpetrator's Motivation to Change		
	a. Motivated and Realistic	0	
	b. Unmotivated	1	
	c. Motivated but Unrealistic	2	____
		TOTAL SCORE	____

Child Protective Services, Child Welfare and the Criminal Justice System: Case Processing from Report to Intervention[5]

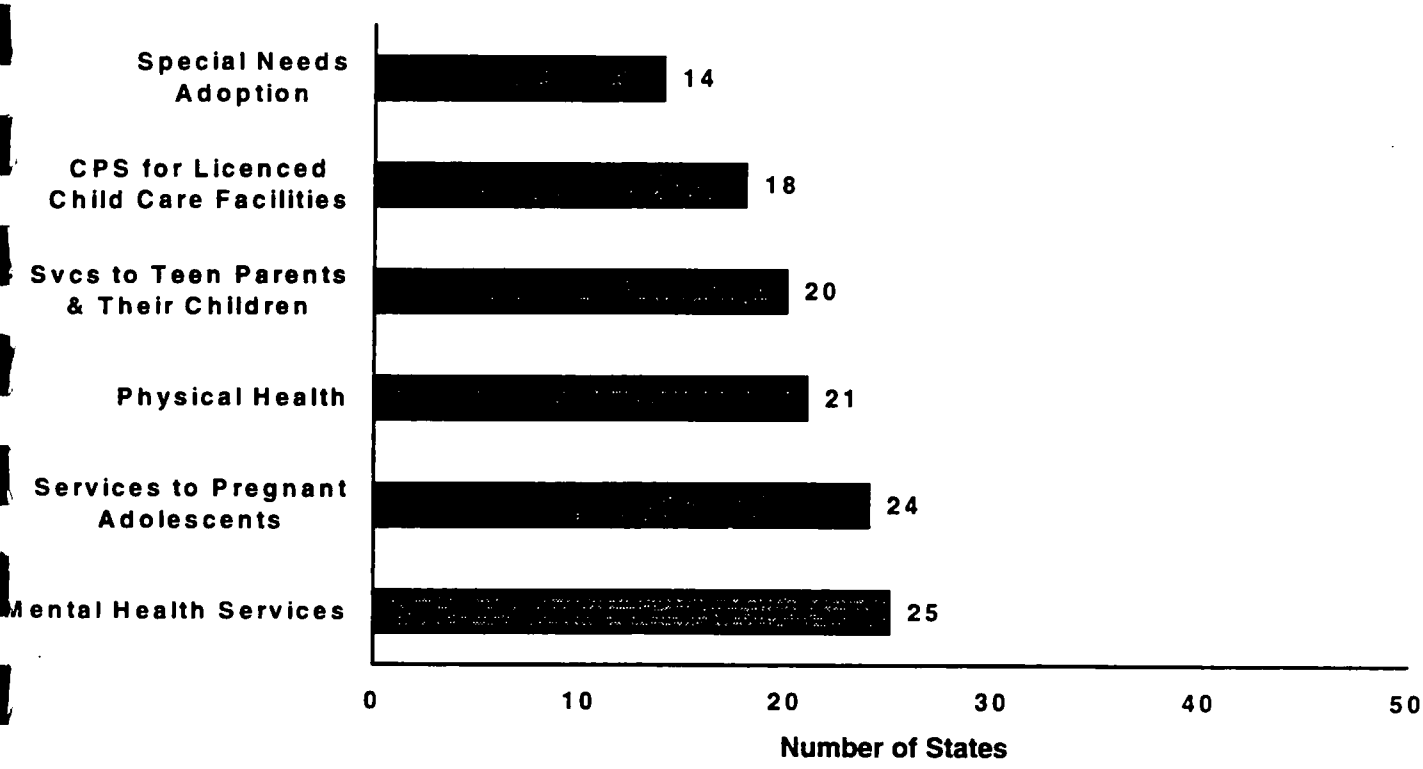
In 1995, more than three million reports of child abuse and neglect were received by State-level child protective services agencies.[6] Since the introduction of mandatory reporting laws in the 1960s, the burgeoning number of child maltreatment reports has stretched the CPS system to its limits--increasing from just 4 reports per 1000 children in 1975 to 47 reports per 1000 children in 1994.[7] The actual number of CAN cases is thought to be even larger: other CAN victims who may not be reflected in the number of reports received by State CPS agencies include children of military personnel or Native American children, who are protected under other systems.[8] This section attempts to describe how a typical State CPS system responds to and processes reports of abuse and neglect. While there are many differences between States--as well as between counties or localities within each State--many share core practices.

Screening Reports of Abuse and Neglect

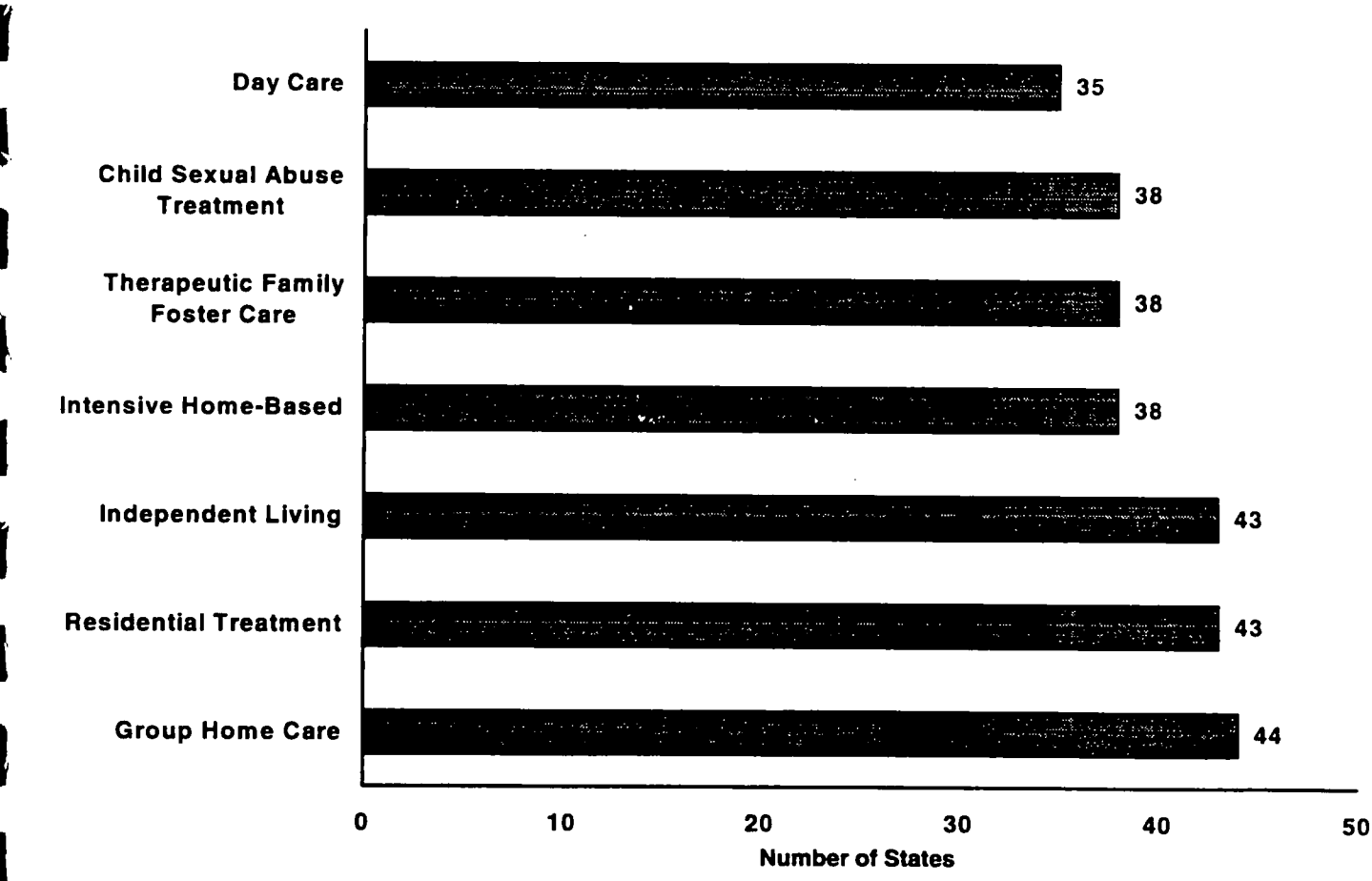
Reports of child abuse and neglect frequently involve families in crisis. Which agency (if any) responds greatly depends on the nature of the crisis or reported incident, the degree of danger to the child, and the availability of services. Child abuse may be reported first to the police, who may investigate and/or refer the case to child protective services. Alternatively, CAN reports may be received directly by CPS, who then screen reports to decide whether law enforcement investigation is appropriate (most often, in cases of sexual abuse or severe physical abuse or neglect.) Crimes against children by strangers are investigated by law enforcement but may not meet the criteria for intervention by CPS (see below). Commonly, no attempt is made to assess the overall service needs of the family at the time of a report. Instead, screening criteria are used to limit investigations to reports involving emergencies to which the system must respond to ensure the safety of the child. In most States, CPS screens according to the following three criteria:

1. Reports must concern children under 18 years old;
2. The reported abuser must be responsible for the health and welfare of the child (e.g., a parent, caretaker or guardian); and
3. The report must allege abuse or neglect constituting evidence of harm to the child or a risk or threat of harm to the child.[9]

Exhibit 3-1B
Services Delivered by Other Divisions Within the Public Child Welfare Agency



Exhibt 3-1C
Services Delivered by Contract Providers



Source: American Public Welfare Association, *Factbook*, 1990.

for proper investigation and intervention, and the assessment skills of some social workers. No one explanation for the great variation in rates of substantiation has gained general acceptance.

Approximately 20 percent of investigated cases involve severe CAN requiring criminal prosecution and/or civil proceedings to remove the child from the home. In the remaining open cases (80 percent), the child is judged to be safe at home with the provision of services; typically a family needs assessment is conducted and a service plan is developed consisting of periodic calls or visits from a case worker and, possibly, the provision of some support services or referrals.[14] These services and referrals may be provided directly by CPS workers, by related child or family welfare agencies or by private community-based contractors (see exhibits 3-1A to 3-1C.) Within the 80 percent judged to be safe at home, a small portion of especially high risk families may be singled out to receive intensive family preservation services.

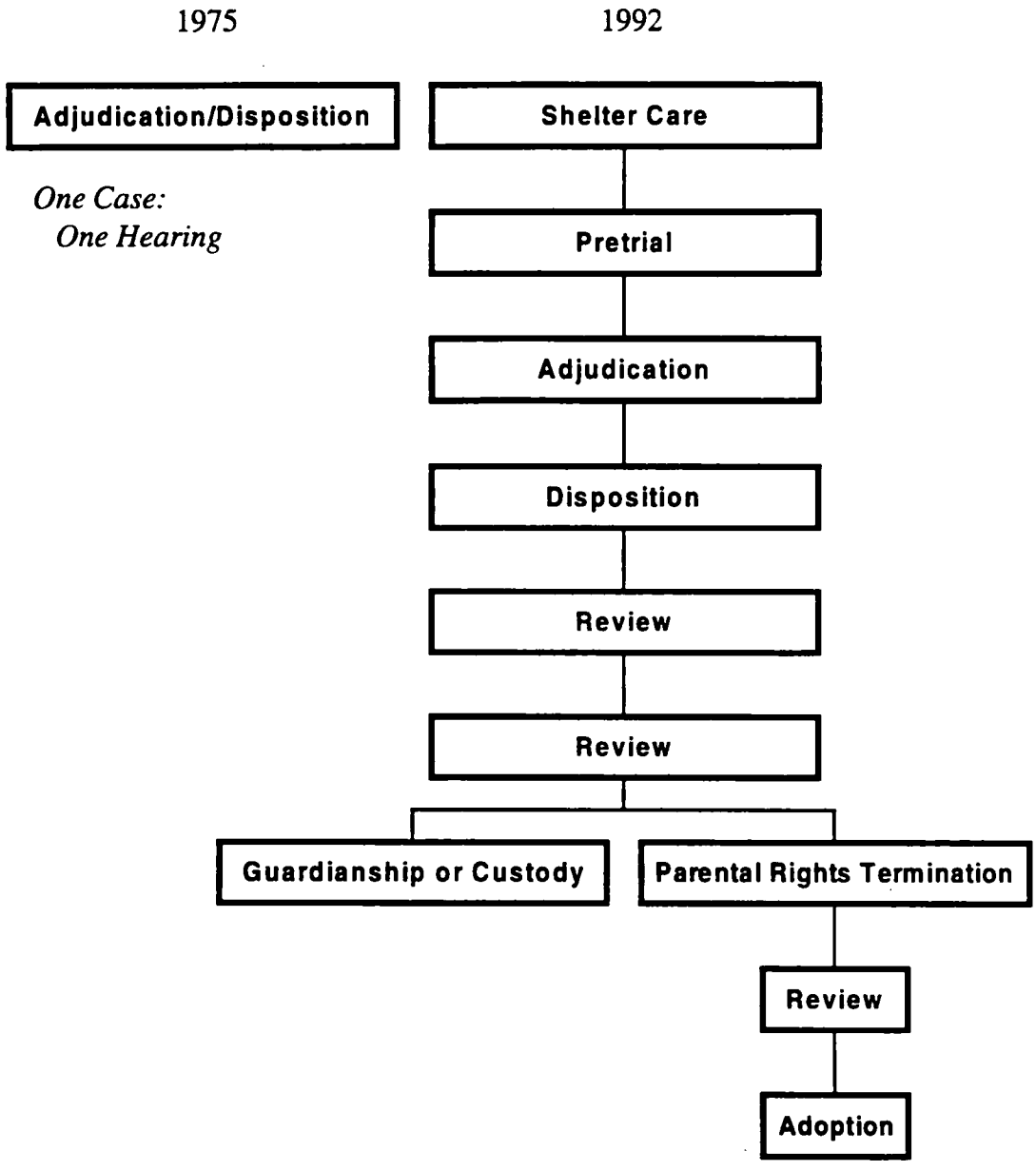
Intensive Family Preservation

As of 1991, 31 States had piloted family preservation programs, and Federal and State legislative interest in family preservation programming remains high (see below.)[15] In jurisdictions that have intensive family preservation programs, case screening includes the identification of families of children who are at *imminent risk* for out-of-home placement. High-risk families are provided with a social worker with a limited case load (as few as two families) for four-to-six weeks of intensive intervention. (Systems differ, one jurisdiction offered a modified version of intensive family preservation that allowed for larger case loads and a longer service period of three months.) The services are home-based, family centered, community-centered, crisis oriented and intended to enhance family functioning and empower families to solve their own problems.[16] Homebuilders, one of the most common family preservation models, expects social workers to provide an extensive and diverse group of services including parent effectiveness training, emotion management, interpersonal skills building, assertiveness training, clinical assistance and referrals, advocacy and a range of practical and material assistance such as, money management, job assistance, academic training, and assistance in building informal support networks. At the end of the intervention, successful cases are transferred back to CPS workers with regular case loads for follow-up.

Children in Out-of-Home Placement

In the most severe cases, CPS requests temporary custody of the child in the family, probate, juvenile or district court. The child may be placed in foster care or in kinship care (if the relative's home is

Exhibit 3-2
Typical Sequence of Hearings:
For Child in Foster Care Who Cannot be Returned Home



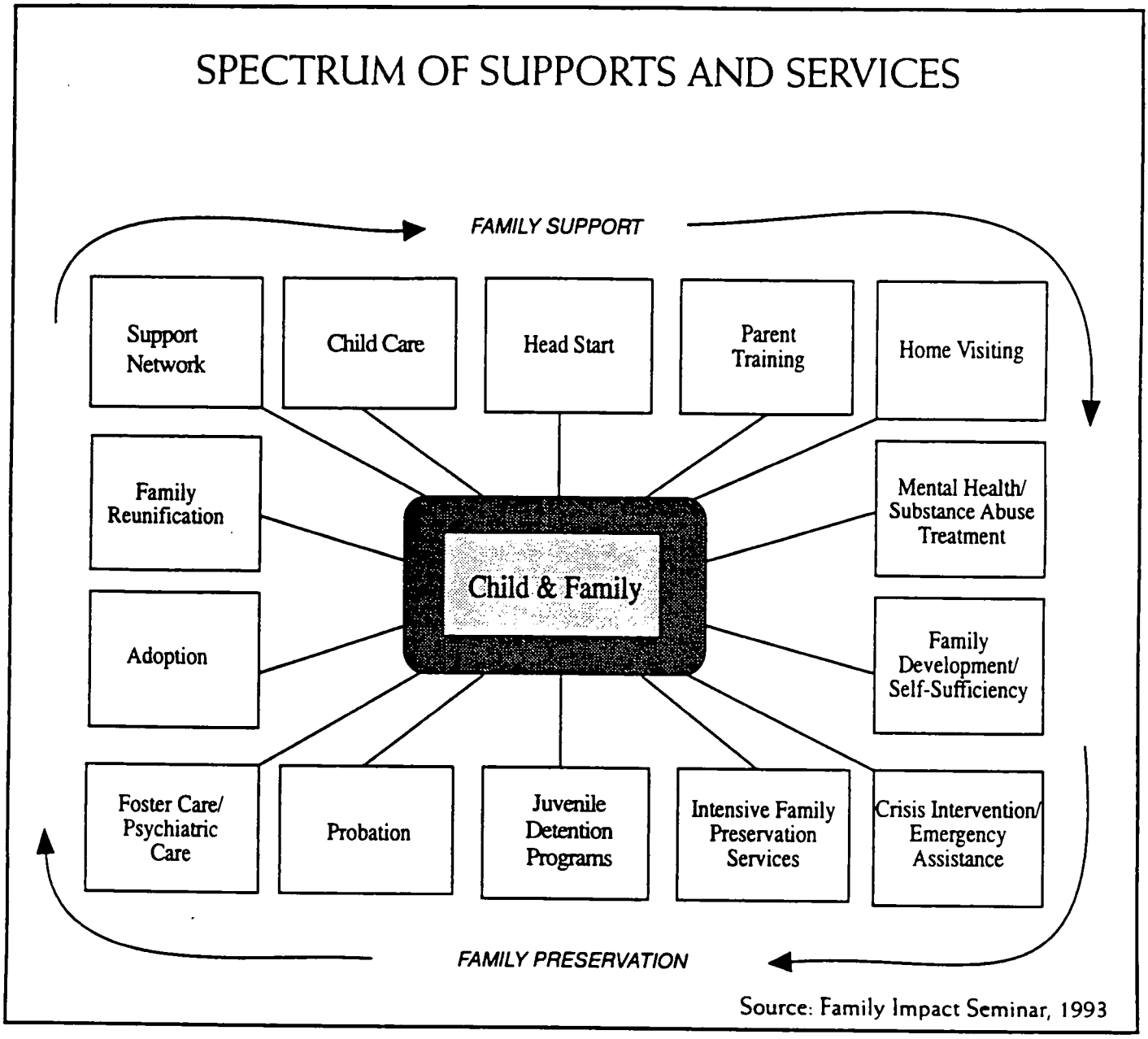
Source: Hardin, Mark, H. Ted Rubin, and Debra Ratterman Balser, A Second Court that Works: Judicial Implementation of Permanency Planning Reforms." Washington, D.C.: ABA, 1995.

Another frequently debated issue is the "explosion" of children entering and languishing in foster care. The foster care crisis may be a red herring: the number of children in foster care per 1000 children increased only 55 percent between 1980 and 1994, while reports of CAN increased 161 percent during the same period.[21] In addition, the re-classification of extended family members who had previously received Aid to Families with Dependent Children (AFDC) support for caring for abused and neglected children as funded kinship foster care providers may have created an artificial "surge" in foster care utilization.[22] Finally, as Schuerman points out, caution is needed in interpreting national compilations of substitute care statistics due to incomplete data from some States and data that are not comparable between States.[23] More research is needed to determine the average length of stay in substitute care, recidivism and the proportion children in kinship care before conclusions should be drawn about whether foster care is being misused.

Federal Legislation and Child Welfare

The Federal government's impact on child welfare policy must be indirect because the U.S. Constitution reserves domestic relations and family law for the States. Because participation in Federal programs is voluntary, the program requirements imposed by Federal legislation on funding recipients do not violate the Constitution. The influence of Federal legislation is, nonetheless, quite powerful. For example, federal funding under the Adoption Assistance and Child Welfare Act of 1980 ties foster care funding to the requirement that "reasonable efforts" be made to preserve families before children are removed from their homes. The "reasonable efforts" provisions of the 1980 Act provided a springboard for the piloting of intensive family preservation initiatives across the country and focused CPS resources on family reunification and permanency planning. In addition, the 1980 Act required a case plan for each foster child and reviews to insure that it is being followed. As discussed above, these practices and priorites provide a common thread connecting otherwise disparate State and local CPS systems. Federal legislation not directly addressing child abuse and neglect can also affect State CPS systems. For example, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) that replaced Aid to Families with Dependent Children (AFDC) and related programs with block grants to States known as Temporary Assistance to Needy Families (TANF), raised concerns among some observers that families losing AFDC, food stamp, or Social Security Income (for children with disabilities) are likely to become consumers in the already over-extended child welfare and protection system.[24] Other key Federal child welfare legislation includes:[25]

Exhibit 3-3


SPECTRUM OF SUPPORTS AND SERVICES
FAMILY SUPPORT
Support Network
Child Care
Head Start
Parent Training
Home Visiting
Family Reunification
Mental Health/ Substance Abuse Treatment
Child & Family
Adoption
Family Development/ Self-Sufficiency
Foster Care/ Psychiatric Care
Probation
Juvenile Detention Programs
Intensive Family Preservation Services
Crisis Intervention/ Emergency Assistance
FAMILY PRESERVATION
Source: Family Impact Seminar, 1993

Other Forms of Abuse Prohibited by Statute

The traditional legal phrase "endangering welfare" is much broader than most modern definitions of child abuse and neglect, encompassing physical abuse, neglect, abandonment, criminal non-support, psychological maltreatment, passive abuse (such as the "non-offending" parent who fails to intervene in or report abuse or neglect), or contributing to the delinquency or truancy of a minor. Statutes using this language currently are being replaced with ones using more precise definitions that define these offenses separately.

Psychological Maltreatment

Psychological abuse or maltreatment is beginning to be addressed in the criminal codes of some jurisdictions. Psychological maltreatment is an implicit component of all forms of child abuse, and this is defined in terms of the outcomes of abuse for the child: "any abuse, physical or verbal, that results in behavioral, developmental, or psychological problems in the child."[27] Five types of psychological maltreatment are identified in some statutes:

- Spurning (verbal degradation/ rejection);
- Terrorizing (verbal or situational threats);
- Isolating (confinement);
- Exploiting and corrupting (encouraging antisocial behavior); and
- Denying emotional responsiveness.[28]

As of 1991, 21 States include severe psychological maltreatment in their child abuse statutes.

Abandonment

Abandonment is given different definitions in the civil and criminal law. Under civil law it is a ground for the termination of parental rights. Its most common definition in civil law is "parental conduct indicating a conscious disregard of the obligations of parenthood."[29] The common definition under criminal law is far more literal: The parent or legal custodian must desert the child "intending permanently to abandon the child."[30]

- Mental health and social workers;
- Law enforcement or criminal justice professionals (including lawyers, judges, guardians *ad litem*, corrections personnel); and, in most States,
- Photographic processors.[32]

The circumstances under which reporters are obligated to contact child welfare officials vary, but all include reason to believe a child has been abused or neglected. A few statutes clarify for film processors and physicians what sorts of events need to be reported. Most commonly, the death of a child must be reported, and any venereal disease or pregnancy in young children must be reported.

Privileged communications

Statutes generally contain a clause on privileged communications. In this regard, there is great variation between statutes. In 12 States, the clergy, when receiving confession or counseling a member of their religion, are specifically exempted from mandatory reporting requirements. In six other States, clergy are specifically compelled to report suspected child abuse, regardless of the source of information or context in which the information was disclosed. There is also disagreement concerning attorney-client privilege: the majority of State's are either silent on the point or specifically affirm clients' rights to privileged communication with their lawyers, but four States suspend attorney-client privilege in the case of suspected child abuse.

Innovative provisions

A few more modern and innovative statutes name as mandatory reporters battered women's counselors, substance abuse counselors or victim advocates. While these persons would be included under the "any other person" clause of a number of statutes, naming them is consistent with current research that points to the co-occurrence of child abuse with partner abuse and child abuse and neglect with substance abuse.

Special Reporting Procedures

A number of States have special reporting procedures relating to drug-exposed infants and child fatalities.

in the near future.[36] Other States, such as New Hampshire, South Carolina and South Dakota have instituted similar changes without legislation. Most models emphasize thorough family assessment leading to a two or three-tiered system intended to segregate cases requiring investigation and court-involvement (as well as services) from those families needing only services. The goal of differentiated response is to make child welfare and service provision central to CPS and to reduce unnecessary and stigmatizing investigations that may alienate families in need of services.

Florida—Florida has instituted sweeping changes to reduce State-level CPS regulations, devolve more policy-making power to counties, and to establish a dual-track response system that separates the investigative function—now handled by law enforcement—from the family-centered services that now typify CPS in Florida. Both investigative track and assessment track families receive the same services, however, the courts oversee the investigative track cases to insure child safety. At the heart of the new system is the elimination of the traditional dual function of CPS (investigator/service provider), to allow social workers to focus on developing more supportive and less adversarial relationships with children and families receiving services. To establish the separate and supportive role of CPS, first contact with investigative track families is made by both a police officer, who investigates the allegations, and a Family Services Response System case worker who is there as a service provider. (See Appendix A.1)

Missouri—Missouri has funded five pilot projects testing a dual track case management system that separates investigation of child abuse and neglect reports from family assessment and service provision. The idea behind the Missouri dual track system is to insure that resources are available promptly to both types of cases, not only the most serious cases. Like Florida's system, the Missouri pilot programs will use law enforcement officers to investigate serious cases of child abuse and neglect, while CPS workers simultaneously offer services to families without assigning blame. Participating Departments of social services will be asked to restructure costs to fund community-based service provision. Evaluations of the pilot programs will be provided to the State legislature with a view to expanding the system State-wide. (See Appendix A.2)

Virginia—In 1996, the Virginia legislature directed the Department of Social Services to establish a three-year program in three to five areas of the State piloting a multiple response system to reports of child abuse and neglect. Like Florida and Missouri, the Virginia

The first Child Advocacy Center was founded in Alabama in 1985. Today the National Network of Children's Advocacy Centers has 124 full member programs, 12 State chapters and 73 associated member agencies. A further 200 programs are in development across the country. CACs are located in a variety of settings—in the community, in prosecutor's offices and hospitals—and receive funding from many sources, including the U.S. Department of Justice's Office for Juvenile Justice and Delinquency Prevention (OJJDP) and the Office for Victims of Crime (OVC). A number of CACs limit their services to victims of child sexual abuse, others will accept a limited number severely physically maltreated children as well. These priorities reflect a desire to target services to those populations most likely to be involved in criminal investigations and prosecutions. As States and counties reform their CPS systems to formalize the role of law inforcement in investigative track CAN cases, the CAC model merits consideration for broad replication because it provides a mechanism for the appropriate involvement of law enforcement and prosecutors with victims of CAN.

Travis County, Texas, Child Protection Team

The Travis County, Texas, Child Protection Team is a collaboration between the district attorney's office, the county sheriff's office (with their victim services division), the Austin Police Department (with their victim services division), the Travis County Children's Advocacy Center and the Texas Department of Protective and Regulatory Services. The Child Protection Team executive committee recognizes that each of these agencies contributes to child protection and welfare and that collaboration among agencies will reduce child revictimization by investigative agencies, optimize information sharing and result in more efficient and appropriate case management (see Appendix B for interagency agreements.) The Child Protection Team staff—which is housed together and hopes to move its office closer to the county's CAC—includes one senior prosecutor, a police officer, a sheriff and social workers from child protective services. According to Assistant District Attorney LaRu Woody, Director of the Family Justice Division, team members work together to investigate physical and sexual abuse allegations. Advantages to the system include shared information, cross-disciplinary expertise, the ability to interview the victim only once and increased coordination between lawyers handling civil and criminal cases concerning the same child or family. Woody observed that team members shared general knowledge as well as case information; for example, experienced law enforcement officers were able to assist newer social workers who were unfamiliar with CAN investigations.

The Massachusetts' Department of Social Services (DSS) has undertaken a number of initiatives to better protect and serve abused and neglected children in homes where the mother is also a victim of domestic violence.[40] First, eleven domestic violence specialists are based in local DSS offices to consult on cases, cultivate community services for battered women and children and, in some instances, provide direct services. Second, a pilot program featuring interagency teams comprised of representatives of DSS, law enforcement, battered women's programs, batterer interventions, the courts, hospitals and visitation centers, meet regularly to formulate holistic service plans for cases involving multiple victims. Third, DSS has developed training and protocols for DSS workers to help them identify and intervene safely and effectively in cases involving domestic violence as well as child abuse. Finally, clinical supports for victims of domestic violence and their abused children were offfered, including evaluation services, batterer programs, visitation centers and psycho-educational groups for DSS-involved battered women.

Of the 22,000 cases reviewed by social workers and their supervisors in 1994, 10,500 (48 percent) were identified as involving domestic violence. The interagency pilot program evaluation suggests that services may reduce out-of-home placement for children with battered mothers (between 11.6 and 12.8 for cases in the pilot program compared to 15.2 percent Statewide.) The cost of the Domestic Violence Program is approximately 1.1 million annually, of which 40 percent is State-funded and 60 percent is Federally funded through the Family Violence Prevention and Services Act (FVPSA). An additional 9.7 million is provided by DSS for shelter services.

Proposals for System-wide Reforms

Advocates for system-wide reforms have proposed a number of modifications to the current system and offered models ranging from guidelines for structured assessment and management of CAN cases, to the reorientation of child protective services toward a community-based model and judicial models to expedite permanency planning.

Using Structured Assessment and Case Management

The National Council on Crime and Delinquency has established the Children's Research Center (CRC) to promote research and evaluation concerning child welfare systems and to assist agencies to develop highly structured case management, risk assessment and needs assessment systems.[41] The CRC works with State and local agencies to develop customized actuarial tools to predict risk of future

Exhibit 3-4

CHARACTERISTICS OF THE CURRENT AND PROPOSED APPROACHES TO CHILD PROTECTION

	Current Approach	Community Partnership Approach
CHILD PROTECTION 1. Case entry/case finding	• Mandated reports mix cases that are appropriate and inappropriate for CPS agency attention (roughly 50% of cases coming to CPS now are unsubstantiated) • Little or no preventive assistance is offered, so reporting is often the only option	• Mandated reports to the CPS agency are more appropriate because community alternatives exist to which many families can be referred • Targeted interventions for families likely to become CPS referrals are available before families are referred or reported
2. Assessment/investigation	• "One-size-fits-all" investigation of a specific incident • Investigations do not include comprehensive family assessment • Law enforcement haphazardly involved, with little likelihood of eventual prosecution of even serious offenders	• CPS agencies can respond in several ways, based on needs and the severity of reported abuse/neglect • All cases receive comprehensive family assessment, after initial screening • Law enforcement systematically involved in all investigations of serious physical and sexual abuse; more frequent prosecution for serious offenders
3. Service provision	• Few services available, even when the investigation is complete; capacity to customize services to a family's individualized needs is limited • Control of services is highly centralized • Natural helping networks (friends, neighbors, etc.) have little role with CPS, and are often hostile to it	• The community partnership ensures families have access to a customized array of services, supports, and opportunities; health care providers, child care resources, schools, and other community institutions are sentinels to detect risk • Substance abuse, domestic violence, and other key services are expanded and better coordinated • The community partnership involves community supports and natural helping networks extensively, including family, extended family, neighbors, and other helpers

COMMUNITY PARTNERS: EVENTUAL ROLES AND RESPONSIBILITIES

STATE LEVEL

State Agencies

Health
Education
Mental Health/Substance Abuse
Employment
Social Services/Welfare
Law Enforcement/Courts

State Human Services Cabinet

State CPS Agency

Responsibilities

- Statewide standards
- Provide adequate funding to local systems, statewide
- Provide technical assistance
- Oversee protective interventions statewide
- Hold local systems accountable for outcomes

LOCAL LEVEL

Members

Community Agencies
Faith Communities
Parents
Health Providers
Child Care Providers
Schools
Police
Courts
Civic Leaders
Substance Abuse Providers
Employment and Training Agencies

CPS Agency

Community Partnership for Child Protection

Responsibilities

- Establish community goals for child protection
- Administer differential response system and assessment
- Develop neighborhood-based delivery system
- Assure adequate funding
- Engage community and disseminate information
- Link to broader governance entities

NEIGHBORHOOD LEVEL

Members

Community Agencies
Faith Communities
Parents
Health Providers
Child Care Providers
Schools
Police
Courts
Civic Leaders
Substance Abuse Providers
Employment and Training Agencies

Neighborhood Services Network | Neighborhood Services Network | Neighborhood Services Network

Responsibilities

- Provide prevention, early intervention and intensive services

Source : Frank Farrow with the Executive Session on Child Protection, "Child Protection: Building Community Partnerships," John F. Kennedy School of Government, Harvard University

found in typical juvenile court functioning through efficient, professional staffing and well-organized court procedures that target the functions required of juvenile courts in child protection cases by State and Federal law.

In particular, experienced or well-trained staff was key to the court's superior functioning. Long-term judges, who receive approximately 180 new child protection cases per year, handle each case assigned to them from the primary hearing through the termination of parental rights and adoption. In addition, once a judge has been involved with child protection hearings concerning one child in a family, all other cases concerning siblings are assigned to the same judge. Another important staffing policy involves the use of "hearing coordinators" who present legal and social service files to the court and who are responsible for recording case hearing information, scheduling next hearing dates, and coordinating materials and parties for future hearings. Researchers also noted a unified sense of purpose between court staff, prosecutors and child welfare workers. Court procedures were designed to minimize waiting and scheduling uncertainty for social workers, parents and lawyers.

A second principle which characterized the court was an emphasis on strict adherence to demanding hearing schedules and prompt and thorough attention to cases. The hearing schedules imposed by the court were generally more swift than those required by State and Federal laws, and no case was ever allowed to go off-calendar--at each hearing the next hearing date was set. Finally, researchers concluded that the intensive hearings held early in a case created both financial advantages and benefits to the child: the average stay in foster care was reduced to approximately one year and the court costs associated with each case were reasonable (approximately $2,000.)

Conclusion

The legal, institutional and practical constraints on interventions for victims of child abuse and neglect are many. However, the widely shared consensus that reforms are needed is generating a wealth of innovative practices and pilot projects that may point the way for the development of better systems in the near future. Of particular interest are reforms that emphasize the use of interdisciplary teams to guide case management--such as the Massachusetts domestic violence initiative and the Travis County, Texas, interagency Child Protection Team. Another encouraging trend is the co-location of services and efforts to provide neighborhood-based services to victims of CAN and their families. Finally, the shift in Federal funding priorities toward the provision, through State grants, of support for a

Endnotes

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2. Wang, C.-T. and D. Daro, "Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1996 Annual Fifty State Survey," National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse, working paper #808, April 1997: 11.

3. Ibid: 10.

4. Interview with Cathrine Ayoub, Professor, Harvard Graduate School of Education and Clinical Director, Boston Juvenile Court Clinic, June 1997.

5. This section relies on descriptions provided in: Waldfogel, J., "Toward a New Paradigm for Child Protective Services," unpublished paper, Kennedy School of Government, Harvard University, April 1996; American Humane Association, "Twenty Years After CAPTA"; Sagatun, I., *Child Abuse and the Legal System*, Chicago: Nelson-Hall, 1995: 35-63; as well as interviews with practitioners Wisconsin, West Virginia, Massachusetts and Oregon.

6. Child Welfare League of America, "Children '97: Embracing the Future" (statistical summary), unpublished typescript, p.1.

7. Waldfogel, "Toward a New Paradigm for Child Protective Services": 2.

8. Ibid.

9. American Humane Association, "Twenty Years After CAPTA":16.

10. Waldfogel, "Toward a New Paradigm for Child Protective Services": 6. The American Humane Association points out that as high as this number is, a 1986 study by the U.S. Department of Health and Human Services suggested that cases investigated by CPS agencies annually may represent only 35 percent of those children actually endangered by abuse and neglect. American Humane Association, "Twenty Years After CAPTA": 19.

11. Waldfogel, "Toward a New Paradigm for Child Protective Services": 6.

12. American Humane Association, "Twenty Years After CAPTA": 21.

13. Ibid: 23.

14. Waldfogel, "Toward a New Paradigm for Child Protective Services": 5-7.

15. Smith, S.L., "Family Preservation Services: State Legislative Initiatives," National Conference of State Legislatures, unpublished report, June 1991.

16. Schuerman, J.R., T.L. Rzepnicki, J.H. Littell, *Putting Families First: An Experiment in Family Preservation*, New York: Aldine de Gruyter, 1994: 18-19.

31. In 1963, Henry Kempe published a landmark article in the *Journal of the American Medical Association* identifying the "battered child syndrome." Waldfogel, "Towards a New Paradigm of Child Protective Services": 11.

32. U.S. Department of Health and Human Services, "Reporting Laws: Mandatory Reporters," Child Abuse and Neglect State Statutes Series (Number 2), National Clearinghouse on Child Abuse and Neglect, December 31, 1995.

33. U.S. Department of Health and Human Services, "Reporting Laws: Reporting Drug-Exposed Infants," *Child Abuse and Neglect State Statutes Series* (Number 8), National Clearinghouse on Child Abuse and Neglect, December 31, 1995; U.S. Department of Health and Human Services, "Reporting Laws: Reporting Suspicious Deaths," *Child Abuse and Neglect State Statutes Series* (Number 7), National Clearinghouse on Child Abuse and Neglect, December 31, 1995; and U.S. Department of Health and Human Services, "Reporting Laws: Mandatory Autopsies and Child Death Review Teams," *Child Abuse and Neglect State Statutes Series* (Number 13), National Clearinghouse on Child Abuse and Neglect, December 31, 1995.

34. National Conference of State Legislatures, Childrens and Families Program, "Legislative Trends in Child Protective Services Reform," information sheet, n.d., (current to 1996.)

35. Information for this section was drawn from the following sources: National Conference of State Legislatures, Childrens and Families Program, "Legislative Trends in Child Protective Services Reform": 1; National Council of Juvenile and Family Court Judges, *Family Violence Legislative Update*, n.p., 2 (1996); Schecter, S. "Model Initiatives Linking Domestic Violence and Child Welfare," unpublished paper prepared for the conference *Domestic Violence and Child Welfare: Integrating Policy and Practice for Families*, Iowa School of Social Work, June 8-10, 1994; and the National Conference of State Legislature's *State Legislative Summary Series*, "Children Youth and Family Issues," for 1992, 1994 and 1996.

36. Ibid. See also, National Conference of State Legislatures, "Background Information Packet: Reconsidering Child Protection," Annual Meeting, July 30, 1996.

37. Pennell, J. and G. Burford, "Widening the Circle: Family Group Decision Making," *Journal of Child and Youth Care*, 9(1) (1994):1-11; American Humane Association, "Family Group Decisiion Making: A Promising New Approach for Child Welfare," *Child Protection Leader*, July, 1996.

38. Telephone interviews with Oregon social workers and site visit with Ted Keys, developer of the Oregon Family Unity Meeting Model, July 1997; observation of a Family Unity Meeting, July 19, 1997.

39. National Council of Juvenile and Family Court Judges, *Family Violence Legislative Update*: 9.

40. "Massachusetts DSS Protects Children by Protecting Mothers," *Synergy* (a publication of the National Council of Juvenile and Family Court Judges), 2(1) (Summer 1996):6-8; "Domestic Violence Protocol for CPS" (Protocol #PR-95-002), issued 2/13/95, Department of Social Services, Massachusetts.

Appendix A

Examples of State-Level Legislation Mandating the Creation of Dual-Track CPS Systems

Appendix A.1

Florida—Summary of Model Child Protection Legislation

MODEL CHILD PROTECTION LEGISLATION
STATE OF FLORIDA
REPORT TO NATIONAL COUNCIL OF STATE LEGISLATURES
OCTOBER 21, 1995

1992 LEGISLATURE REQUIRED DEPARTMENT TO PREPARE A CHILD PROTECTION STRATEGIC PLAN
(Chapter 92-58, Laws of Florida)

- Called for decrease in focus on technical aspects of child protection and an improved responsiveness to the needs of children and their families.
- Required broad community planning process to gather input and build consensus.
- Establishment of a Child Protection Strategic Plan that articulates values, goals, reform recommendations, statutory and policy changes.
- Creation of Health and Human Services Boards (HHSBs) in each district to provide budget and policy oversight for all department programs.

1993 LEGISLATURE AMENDED CHAPTER 415, FLORIDA STATUTES, TO ADD PART III, FAMILY SERVICE RESPONSE SYSTEM
(Chapter 93-25, Laws of Florida)

Ground breaking legislation allowing communities and the department to develop "differential community systems" for child protection.

- Known as the Family Services Response System (FSRS - Part III, Chapter 415, F.S.), this alternative method is intended to offer a non-adversarial and highly individualized responses to child abuse and neglect.

States that policies and procedures that provide for child protection intervention through the department's family services response system should be based on the

path to a quick reunification or permanent placement and, to the extent possible, be grounded in outcome evaluation results that demonstrate success in the reunification or permanent placement process.

Improves procedural protections for children and parents.

- Provides procedures that will allow for a more effective and properly balanced termination of parental rights process when reunification efforts have failed.

- Provides procedures for the development of a case plan when the parents are unwilling or unable to participate. Provides that the unwillingness or inability of a parent to participate in the development of a case plan shall not prohibit the filing of a petition for dependency or for termination of parental rights.

- Adds to the definition of abandonment a provision stating that the incarceration of any person responsible for the care of a child does not prohibit a finding of abandonment.

- Provides additional requirements to ensure that persons entitled to notice are properly served with a summons to a hearing.

  Requires that when an affidavit of diligent search has been filed, the petitioner must continue to search for and attempt to serve the person for whom the affidavit has been filed until excused from further search by the court.

Improves media access in high profile cases.

- It allows HRS to petition the court for an order for the immediate public release of records of the department which pertain to the investigation of abuse, neglect, abandonment, or exploitation of the child or vulnerable adult who suffered serious bodily injury.

Discourages false reporting

- It allows HRS to aggressively respond to false reports of child abuse or neglect by allowing HRS to impose a fine, not to exceed $1000.00 for each violation, on a person who knowingly and willfully makes a false report.

Clarifies and strengthens law enforcement role

- Clarifies that law enforcement has the lead in conducting criminal investigations of child abuse and neglect.

- Creates two pilot projects where local sheriffs will work with HRS to restructure the way both agencies respond to reports of child abuse and neglect when a criminal investigation occurs simultaneously with a child protection assessment.

- Establishes an 11 member Task Force on Family Safety that is charged with examining the improved coordination among child welfare system, domestic violence programs and law enforcement (report due December 1, 1996).

Informational documents available upon request:

Detailed analyses of each bill passed
Child Protection Strategic Plan, December 1992
Child Protection Strategic Plan Status Report, 1993
Family Services Response System, March 1995

For further information, please contact:

Linda F. Radigan
Assistant Secretary
Children and Family Services
2811 Industrial Plaza Drive
Tallahassee, Florida 32301
Telephone: (904) 488-8762
FAX: (904) 487-0688

Appendix A.2

Missouri—Solicitation for Proposals for Demonstration Sites (5)

DFS

SB 595

A Child Protection System

Community Partnership and Collaborative Effort

Missouri Department of Social Services

II. PRINCIPLES OF SENATE BILL 595 CHILD PROTECTION SYSTEM

The underlying principle of the Child Protection System, as embodied in Senate Bill 595, is that the families coming to the attention of the Division of Family Services have different intervention needs and require flexible responses from the division and the community in order to protect children and meet the needs of the family. This proposed system establishes a demonstration initiative to assess the impact of utilizing two different methods (or a "two-track" approach) of intervening when there is a report of child abuse or neglect. SB 595 requires the division to investigate some reports of abuse and neglect, but allows a family assessment in cases that would not be considered, if true, a criminal violation. This section identifies the philosophical basis of this legislation.

- Parents have the primary responsibility for, and are the primary resource for their children.
- All child welfare intervention by state and community agencies has as its first goal, the welfare and safety of the child.
- The Child Protection System must be designed to be child-centered, family-focused, community-based, and culturally sensitive.
- The Division of Family Services will collaborate with the community to identify, support, and treat families in a family-supportive, non-threatening manner, in both Investigative and Family Assessment situations.
- A Family Assessment approach, stressing the strengths of the family, identifying and treating the family's needs, and assuring the safety of the child, is the appropriate approach for cases not requiring law enforcement involvement or the removal of the child.
- Neighborhoods and communities are the primary source of opportunities and supports for families, and have a primary responsibility in assuring the safety and vitality of their members.
- Only a comparatively small percentage of current Child Abuse and Neglect reports are criminal in nature or will result in the removal of the child or alleged perpetrator.
- Division of Family Services staff who co-investigate serious Child Abuse and Neglect reports with law enforcement, must be competent in law enforcement procedures, fact finding, evidence gathering, etc., as well as effective social intervention and assessment.

III. KEY COMPONENTS OF SENATE BILL 595 CHILD PROTECTION SYSTEM

Once the demonstration sites are selected, the procedure for handling reports of child abuse and neglect will be changed for those sites. This section describes the key components of the demonstration project. This section is not intended to provide definitive procedures that will be followed, but to provide the reader with a general understanding of the components and some decisions that have been finalized.

A. Transfer of Cases from the Child Abuse and Neglect Hotline

Reports of child abuse and neglect received by Hotline staff will be forwarded to the demonstration sites. The definitions of abuse and neglect have not changed. Therefore, except for the expansion of the definition of "those responsible for the care, custody, and control of the child" that was previously identified for DFS staff, the families that DFS serves under the "two-track" system are essentially the same that DFS currently serves.

B. Referral Screening Process

Demonstration sites will be responsible for screening reports received from the Hotline and classifying those reports as either Investigation or Family Assessment reports. The classification criteria and policy to assure uniformity in classification is under development and will be provided to the demonstration sites in a manual and in staff training. Sites will need to identify how they would implement this screening process.

For the purpose of this discussion, the following guidelines will be used to determine whether a report from the Hotline will be classified as an Investigation or a Family Assessment:

1. Parameters of Investigation Cases

Investigation cases are those where the acts of the alleged perpetrator, if confirmed, are criminal violations and/or where the action/inaction of the alleged perpetrator may not be criminal, but which if continued would lead to the removal of the child or the alleged perpetrator from the home.

Investigation cases will include:

- Reports of serious physical, medical or emotional abuse and serious neglect cases where a referral for criminal investigation is warranted;

In a small percentage of cases it will be determined that it is more appropriate for an investigation case to be handled through the Family Assessment approach and vice versa. One of the primary goals of the demonstration project is to perfect the initial screening function to assure that this transfer is kept to an acceptable minimum. However, SB 595 acknowledges that some cases must transfer due to information obtained during the Investigation/Family Assessment. The statute requires cases to be transferred, as appropriate.

The demonstration sites will need to develop a process to assure appropriate transfer of cases when a transfer is necessary. A component of this transfer process should be discussion with the screening staff prior to or at the time of transfer. When such transfers are made, they are to be done in the least disruptive way possible for the family and should minimize service delivery interruption.

The statute also requires the commencement of an investigation if during or after the family assessment, the family refuses voluntary services and it is determined that such services are necessary to reduce the high risk of future abuse or neglect.

E. Community Collaboration

The Child Protection System will promote the safety of children and the integrity and preservation of the family. All community resources and the division are to collaborate in providing support, assistance and services to children and families. This collaboration is to result in the identification of comprehensive local services and assure access to those services for children and families where there is a risk of abuse or neglect. This collaboration will involve local law enforcement in conducting investigations, community agencies in facilitating a family assessment approach with families not requiring an investigation, and a variety of local resources in providing treatment services.

F. Independent Evaluation

The statute requires that an independent (non-DFS) evaluation be conducted according to accepted objective research principles to determine the effectiveness of this approach in intervention. The results of this independent evaluation will be used to assess the "success or failure" of the two-track approach to Child Protection Services.

G. Legislative Approval of Statewide Implementation

The Division of Family Services is required to submit to the General Assembly, by January 1, 1998, documentation sufficient to determine if the two-track system should be implemented statewide.

The proposal must include a discussion of how the classification process will assure that Investigations/Family Assessments will be initiated within 24 hours, including weekends and holidays.

It is expected that some of the reports will switch between Investigation and Family Assessment tracks. However, the classification process must have as one of its goals to minimize the necessity of this reassignment. The proposal must discuss how the cases will be transferred between tracks.

D. Staff Assignment

The demonstration sites will need to determine how they will assign staff to conduct Investigations or Family Assessments. As stated earlier, a minority of the reports will be Investigation while the majority will be Family Assessment. The site will need to decide how staff will be assigned. The proposal should indicate if staff will be assigned as generalists (conduct Investigations and do Family Assessments/FCS) or specialists. Other options, suggested by demonstration sites, will be considered.

The proposal should indicate the number of staff in the site and the number that will be dedicated to the project. It should also include a discussion of how staff will be assigned, especially if multiple counties are included in the site. For example, there may be a plan to use regional investigation teams. The proposal should discuss why a particular plan was adopted.

Your staff assignment plan must be able to:

1. Initiate all Investigations/Family Assessments within 24 hours of receipt of the report from the Hotline (or 72 hours in cases of educational neglect);

2. Conclude Investigations/Family Assessments within 30 days;

3. Effectively transfer cases between tracks, when necessary, without delay in service delivery;

4. Assess family strengths, needs, and risk to the child in all cases on an on-going basis;

5. Make contact in order to initiate third-party treatment services immediately (within 48 hours of the time that the service need is identified); and

6. Describe how the staff assignment plan will assure continuity in service delivery for families and children.

G. *Public Education and Awareness*

Describe steps that will be taken to advise and inform the community of the demonstration site and the impact that is expected. How will site staff explain the difference between the new "two-track" process and the current system of division intervention? Once the sites have been selected, technical assistance will be provided.

H. *Evaluation Criteria*

The division will be contracting for an independent evaluation of the demonstration project. The evaluation will address the program outcomes and results that the site believes are important to be measured to determine the success or failure of the "two-track" system. Additional criteria to be evaluated for all sites will be developed in addition to site-specific criteria. The proposal should address the outcomes or results expected from the successful implementation of the legislation in the site, and how the site will cooperate and work with the independent evaluation.

Appendix A.3

Virginia—Statute Establishing a Multiple Response System

CHAPTER 856

An Act to amend the Code of Virginia by adding in Chapter 12.1 of Title 63.1 a section numbered 63.1-248.18, establishing a child protective services multiple response system.

[H 36]

Approved April 9, 1996

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 12.1 of Title 63.1 a section numbered 63.1-248.18 as follows:

§ 63.1-248.18. Establishment of pilot multiple response system.

A. By March 1, 1997, the Department shall establish a multiple response child protective services system in at least three but no more than five areas of the state selected by the Department. Areas may be composed of any combination of one or more counties or cities or both counties and cities. The multiple response system is designed to protect children at risk by effective use of available community resources. When appropriate, families will be offered services through the local department or through community agencies to promote safe, positive relationships within families by emphasizing prevention and assistance; or when otherwise appropriate, local departments will investigate, in conjunction with law-enforcement agencies pursuant to memoranda of understanding, allegations of child abuse or neglect for appropriate intervention or follow up action. The Department shall develop criteria for the selection of pilot areas which shall include an assessment of the effectiveness of the area's plan for community involvement in child protective services and a determination of whether local departments in the area have effective agreements with law-enforcement agencies and the attorney for the Commonwealth ensuring interagency cooperation.

By November 1, 1996, the Department shall submit to the House Committee on Health, Welfare and Institutions and the Senate Committee on Rehabilitation and Social Services a report outlining the plan for the multiple response system, including copies of any requests for proposals and the criteria developed for selection of pilot areas.

The pilot programs shall be subject to the provisions of this chapter, State Board regulations and Department policies except to the extent that such regulations and policies are inconsistent with the provisions of this section.

The State Board shall promulgate regulations to implement the provisions of this section to be effective within 280 days of July 1, 1996.

B. Upon receipt of a report of child abuse or neglect, the local department, after making an initial assessment shall determine whether the appropriate level of intervention is (i) investigation, (ii) family assessment and services or (iii) referral by the local department for services even though the report does not meet the definition of abuse or neglect. The Department shall develop an assessment instrument which shall be used to determine the appropriate level of intervention. A report may be reclassified at any time during the local department's involvement with the case.

C. The local department may investigate any report of child abuse or neglect but the following reports of child abuse or neglect shall be investigated regardless of the outcome of the assessment: (i) sexual abuse, (ii) child fatality, (iii) abuse or neglect resulting in serious injury as defined in § 18.2-371.1, (iv) child has been taken into the custody of the local department of social services or (v) cases involving a caretaker at a state licensed child day center, religiously exempt child day center, regulated family day home, private or public school, or hospital or any institution.

D. Cases determined to be appropriate for investigation shall be investigated in accordance with the provisions of this chapter. Investigations shall be completed within forty-five days of receipt of the report. However, upon written justification by the local department, such investigation may be extended

Appendix B

Travis County, Texas, Child Protection Team Organizational Documents

B.1 Executive Committee Agreement

B.2 Interagency Agreement

Appendix B.1

Executive Committee Agreement

TRAVIS COUNTY CHILD PROTECTION TEAM

EXECUTIVE COMMITTEE AGREEMENT

THE CHILD PROTECTION TEAM WILL HAVE AN EXECUTIVE COMMITTEE MADE UP OF DESIGNATED REPRESENTATIVES FROM THE MEMBER ENTITIES. THE PURPOSE OF THIS COMMITTEE WILL BE TO PROVIDE THE TEAM WITH A MULTI-DISCIPLINARY GOVERNING BODY TO ADDRESS TEAM ISSUES. THE COMMITTEE'S PRIMARY FUNCTION WILL BE TO MAKE JOINT DECISIONS ABOUT PROTOCOLS AND PROCEDURES AND MATTERS OF POLICY AFFECTING TEAM OPERATIONS.

THE FOLLOWING MEMBER ENTITIES WILL BE REPRESENTED ON THE EXECUTIVE COMMITTEE: TRAVIS COUNTY DISTRICT ATTORNEY'S OFFICE, AUSTIN POLICE DEPARTMENT, TRAVIS COUNTY SHERIFF'S OFFICE, TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER, AND THE TEXAS DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES.

EACH MEMBER ENTITY WILL HAVE DESIGNATED REPRESENTATIVES ON THE COMMITTEE WHO MAY ATTEND AND PARTICIPATE IN THE CPT EXECUTIVE COMMITTEE MEETINGS. EACH ENTITY WILL DESIGNATE ONE PRIMARY VOTING DELEGATE, FOR A TOTAL OF FIVE VOTING DELEGATES, WHO WILL REPRESENT THE MEMBER ENTITY AND HAVE THE AUTHORITY TO ACT ON BEHALF OF THE ENTITY IN A BINDING FASHION. THE DELEGATE WILL HAVE ONE VOTE PER PERSON WHEN MAKING DECISIONS DETERMINING POLICY AND PROCEDURE. EACH MEMBER ENTITY WILL ALSO DESIGNATE AN ALTERNATE VOTING DELEGATE TO VOTE IN THE ABSENCE OF THE PRIMARY VOTING DELEGATE.

BEFORE ANY ACTION CAN BE TAKEN BY A VOTE, THERE MUST BE AT LEAST

CPT EXECUTIVE COMMITTEE DELEGATES

** DENOTES THE PRIMARY VOTING DELEGATE FOR THE ENTITY
* DENOTES THE ALTERNATE VOTING DELEGATE FOR THE ENTITY

DISTRICT ATTORNEY:

** DIRECTOR OF FAMILY JUSTICE DIVISION
* CHIEF PROSECUTOR, CHILD PROTECTION TEAM
CAC PROSECUTOR, CHILD PROTECTION TEAM

AUSTIN POLICE DEPARTMENT:

APD INVESTIGATIONS:

** DEPUTY POLICE CHIEF, COMMUNITY RESPONSE BUREAU
* DEPUTY POLICE CHIEF, CRIMINAL INVESTIGATIONS BUREAU
LIEUTENANT, CHILD ABUSE SECTION
SR./SGT., CHILD ABUSE SECTION
SR./SGT., CHILD ABUSE SECTION

APD VICTIM SERVICES:

DIRECTOR, VICTIM SERVICES
SUPERVISOR, VICTIM SERVICES

TRAVIS COUNTY SHERIFF'S OFFICE:

** CAPTAIN (CUTLER)
* _____
_____

TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER:

** EXECUTIVE DIRECTOR
PROGRAM COORDINATOR
CLINICAL DIRECTOR

TEXAS DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES:

** LEAD PROGRAM DIRECTOR
* PROGRAM DIRECTOR, INVESTIGATIONS
INVESTIGATIONS SUPERVISOR

Appendix B.2

Interagency Agreement

TRAVIS COUNTY CHILD PROTECTION TEAM
INTERAGENCY AGREEMENT

Child abuse is a significant social issue facing our community. In 1994, over 1300 confirmed cases of abuse and neglect were investigated in Travis County.

The system for dealing with child abuse in Travis County consists of a network of agencies with distinct individual mandates under the law but whose collective goal is the protection of children. The community, too, has a distinct, primary interest in the protection of children. The community and the agencies which deal with child abuse are strongly committed to a collaborative approach to the problem, to avoid the "revictimization" of children by the system itself and to better meet their respective mandates.

This revictimization occurs when the child victim is forced to tell his or her story over and over again to representatives in each agency involved in child abuse investigations. Such interviews often take place in strange and forbidding environments. Revictimization is further aggravated when the agency representatives do not communicate with one another. The child is often left with the feeling that, since the victimization by the system is worse than that which brought them into the system, they made a mistake in telling about the abuse in the first place; or worse still, the child tells of the abuse only to be returned to an abusive situation.

MEMBERSHIP

The Travis County Child Protection Team is made up of the following entities, with their respective legal mandates, roles, and responsibilities (description of agency roles is limited to responsibilities performed within the Child Protection Team):

AUSTIN POLICE DEPARTMENT

One of the mandates of the Austin Police Department is to investigate all criminal cases of physical abuse and neglect of children 14 years of age or younger, and sexual abuse of children younger than 17 years of age, occurring in the city of Austin, Texas. Responsibilities include the gathering and preservation of evidence to ensure a prosecutable criminal case. This includes interviewing and taking statements of witnesses and suspects, evidence collection, scene preservation and the preparation and execution of search and arrest warrants. The Department also provides necessary immediate crisis intervention in the form of crisis counseling and follow-up to children and families involved in the criminal justice system. The Department's counselors also conduct forensic interviews of child victims or witnesses. A "forensic interview" means an interview conducted for the purpose of gathering accurate information relevant to a civil or criminal investigation of child abuse or neglect for evidentiary purposes. The forensic interview will follow guidelines established to meet evidentiary requirements.

enforcement with all aspects of criminal investigations, including assistance with grand jury subpoenas, search warrants and charging decisions; facilitating the coordination of investigations and services for families involved in the child welfare and criminal justice systems; and reviewing all criminal child abuse cases for presentation to the grand jury, closure, or return for further investigation.

TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER

The Children's Advocacy Center represents the investment of the community in the future of its children. The mission of the Center is to provide the place where members of the community can show their commitment to our children through community involvement or participation in the intervention, coordination and delivery of services to children. As a non profit, facility-based community organization governed by an independent Board of Directors, the Center provides the voice of the community in its efforts to protect children. The facility serves as a neutral, child-friendly environment for interviewing children about abuse or neglect. Through collaboration with other Team members, the Center seeks to prevent the re-victimization of the child by the system by minimizing the trauma surrounding the interview and reducing the number of times a child must be interviewed. Advocacy Center counselors conduct forensic interviews of child victims or witnesses. The Center provides counseling and support services, information and referral for services to families,

establish its own authority to act by virtue of a rule-making agreement. (see attached) The purpose of this Committee will be to provide the Team with a multi-disciplinary governing body to address Team issues. The Committee will, at a minimum, address the following issues:

1) The Committee will establish regular meetings to provide a consistent means of communication and a forum for discussing Team issues. The Committee will also select a chairperson for the Executive Committee to serve as convenor and chair of the Executive Committee's meetings;

2) The Committee will develop, approve and adopt written policies and procedures for the Team's collaborative operations;

3) The Committee will develop, approve and adopt specific goals and objectives to strengthen the mission of the CPT;

4) The Committee will develop, approve and adopt written performance measures to measure CPT achievements;

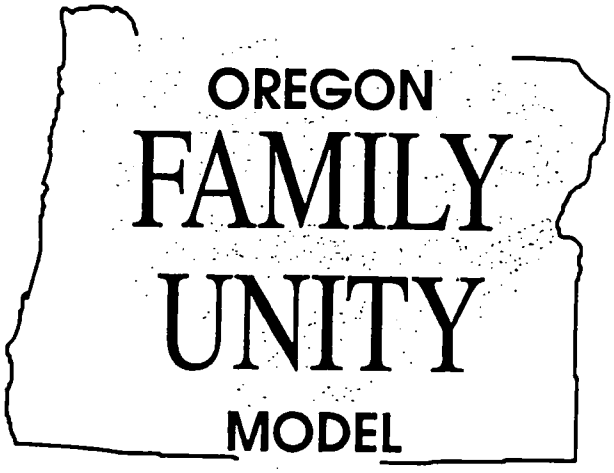
5) The Committee will prepare and maintain Executive Committee reports reflecting the collaborative effort. The reports will be distributed to management of member agencies on a regular basis.

Each entity named in this agreement is a full member of the Child Protection Team.

The members agree that interviews of children twelve years of age and younger will be conducted at the Children's Advocacy Center. Interviews of children older than twelve at the Center are encouraged. The choice of interviewer for all children will be

Appendix C

Oregon Family Unity Model Pamphlet



An option to consider for strengthening families.

To strengthen families and increase safety, security and stability for children.

Appendix D

Sample Children's Research Center Assessment Tools

D.1 Alaska Child Protection Abuse Scale

D.2 Michigan Family Assessment of Needs

D.3 Michigan Family Risk Assessment for Neglect

Appendix D.1

ALASKA CHILD PROTECTION ABUSE SCALE

		Score
1.	Number of Prior Reports of Abuse	
	None	0
	One	1
	Two	2
	Three or More	4 ____
2.	Number of Prior Placements Outside of Family Residence	
	None	0
	One or More	1 ____
3.	Number of Abuse/Neglect Types Noted in Current Referral	
	One	0
	Two or Three	2
	Four or More	3 ____
4.	Number of Adults in Home (18 Years of Age or Older)	
	Two or Fewer	0
	Three or More	2 ____
5.	Number of Children in Home	
	Two or Fewer	0
	Three or More	2 ____
6.	Either Caretaker Abused as Child	
	No	0
	Yes	2 ____
7.	Caretaker History of Drug/Alcohol Abuse	
	None	0
	One Caretaker	1
	Both Caretakers	3 ____
8.	One or Both Caretakers Previously Convicted of a Felony Offense	
	No	0
	Yes	1 ____
9.	Caretaker(s) Primarily Involved in Negative Social Relationships	
	No	0
	Yes	2 ____
10.	Caretaker(s) History of Depression	
	None	0
	Significant, long term episodes by either caretaker	1
	Episode(s) include suicide attempt by either caretaker	3 ____
11.	Cooperation with Agency Demonstrated by Perpetrator/Caretaker(s)	
	Not Applicable	0
	Cooperative	0
	Uncooperative	1
	Hostile/Threatening	3 ____
12.	View of Abuse by Non Perpetrator/Caretaker(s)	
	Not Applicable	0
	More Serious than Agency	-2
	Consistent with Agency View	0
	Less Serious than Agency	2 ____
		TOTAL RISK SCORE ____

Appendix A

Selected Individuals Interviewed for the Child Abuse and Neglect Background Papers

Selected Individuals Interviewed for the Child Abuse and Neglect Background Papers

Interviews with and materials provided by the following experts, researchers, policymakers and practitioners contributed significantly to the Child Abuse and Neglect Background Papers. Some individuals were interviewed in person, others by telephone; a number were contacted more than once. All interviews were conducted between June 1 and September 12, 1997.

Marylee Allen
Director
Child Welfare and Mental Health
Children's Defense Fund
Washington, D.C.

Catherine Ayoub, R.N., Ed.D.
Children and the Law
Harvard Graduate School of Education
Cambridge, Massachusetts

Dan Brewer, M.A., C.M.H.C.
Ina Maka Family Program
Seattle, Washington

Chris Bucco
Coordinator of Children's Services
Casa Myrna Vazquez
Boston, Massachusetts

Gale Burford, M.S.W., Ph.D.
Memorial University of Newfoundland
School of Social Work
St. Johns, Newfoundland
Canada

Rosemary Chalk
Board on Children,Youth and Families
National Research Council
Washington, D.C.

John M. Hagadorn, Ph.D.
University of Illinois-Chicago
Chicago, Illinois

Darlene Kordich Hall, Ph.D.
York University
North York, Ontario
Canada

Paul Hodlin, L.I.C.S.W.
Assistant Director
Boston Juvenile Court Clinic
Boston, Massachusetts

Sue Horbach, M.A.
Director
Early Childhood Family Education
Duluth, Minnesota

Ted Keys
Program Coordinator
Family-Based Services
Services to Children and Families
Salem, Oregon

Sherrie Lookner
Director
Childcare for Department of Social Services
Massachusetts DSS
Boston, Massachusetts

Gil Noam, Ph.D.
Director
Responsive Advocacy in for Learning and Life in Youth (RALLY)
Harvard Graduate School of Education
Cambridge, Massachusetts

Anne Peretz, L.I.C.S.W.
Founder and President
The Family Center
Somerville, Massachusetts

Rosalie Walls
Executive Director
ACT II Child and Family Services
Coquitlam, British Columbia
Canada

Mary Avery Watson, M.S.
Assistant Director
Gilday Center
Roxbury, Massachusetts

Jeffery N. Wherry, Ph.D.
University of Missouri
St. Louis, Missouri

Cathy Spatz Widom, Ph.D.
School of Criminal Justice
State University of New York at Albany
Albany, New York

Debra Witcomb, Ph.D.
Educational Development Center
Newton, Massachusetts

Nina Williams-Mbengue
National Conference on State Legislatures
Denver, Colorado

Laru Woody
Assistant District Attorney
Director, Family Justice Division
Austin, Texas

Appendix B

National Organizations Concerned with Child Abuse and Neglect Contacted for the Background Papers

National Organizations Concerned with Child Abuse and Neglect

The following national organizations were contacted and provided information which was helpful in the preparation of the Child Abuse and Neglect Background Papers.

American Bar Association Center on Children and the Law

American Professional Society on the Abuse of Children

Child Welfare League

Children's Defense Fund

Family Violence Prevention Fund

National Academy of Sciences

National Center for Children in Poverty

National Center for Missing and Exploited Children

National Clearinghouse on Child Abuse and Neglect

National Conference of State Legislatures

National Council of Juvenile and Family Court Judges Family Violence Project

National Network of Child Advocacy Centers

National Organization for Women Legal Defense and Education Fund