PART 4

Best Practices in Child Maltreatment Prevention and Intervention

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Executive Summary

Victimization of children in the United States remains at an appallingly high rate, despite some decline over the past decade (Finkelhor & Jones, 2006). The latest Child Maltreatment Report shows an estimated 872,000 children were determined to be victims of child abuse or neglect in 2004. However, reported and substantiated cases of maltreatment are a fraction of the actual instances of abuse and neglect.

Identifying and substantiating maltreatment of children relies heavily on how abuse and neglect are operationally defined. The difficulties with defining types of maltreatment (i.e., physical and sexual abuse, neglect) and constructing valid, reliable, and useful measures of it has been, and continues to be, a major concern for researchers, practitioners, and policymakers. A commonly used definition in professional literature and in practice is the one set forth in the Child Abuse Prevention and Treatment Act (CAPTA) (1996). CAPTA defines child abuse and neglect as: "….at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."(n. p.)

Progress is being made in identifying antecedents and consequences of child maltreatment, as well as in the development and provision of efficacious prevention and intervention services. Identifying antecedents and consequences is important because they represent targets for prevention and intervention, and evidence-based practice offers some assurance of efficiency and effectiveness.

Antecedents to maltreatment include, but are not limited to, lack of emotional attachment, poverty-related stresses and afflictions, substance abuse, and psychiatric disorders. Consequences for the maltreated child include posttraumatic stress disorder (PTSD), depression, personality disorders, and poverty.

Because these antecedents and consequences reside in different systems at various levels (e.g., individual, family, community), an ecological framework seems to offer the most useful explanation of child maltreatment. The ecological framework attributes child maltreatment to interrelationships between several factors from different systems. Because child maltreatment is multicausal, *best practices* must deal with the sum total of many influences on the problem of maltreating children.

The purpose of this report is to identify *best practices* discussed in the professional literature on child maltreatment. *Best practices* are determined by the magnitude, definitions, types, antecedents, consequences, theory, and research associated with child maltreatment. These factors are discussed extensively in this review of *best practices.*

Assessment of children and parents is a very important aspect of *best practices* in designing intervention plans for families of maltreated children. Assessment identifies targets for intervention, provides information about readiness and ability to change, and indicates progress in and outcomes of treatment.

Another *best practice* discussed in the literature is how to conduct a forensic interview to obtain accurate information about maltreatment from children and adults involved. A particularly well-received program for teaching interviewing skills is known as *Finding Words*. The *Finding Words* program is composed of a range of topics, including child development, linguistics, and issues with memory and suggestibility. The specific skills needed in interviewing are discussed in detail in this report. The National Institute of Child Health and Human Development also developed an evidence-based investigative interview protocol to help forensic interviewers adhere to professional guidelines when interviewing alleged victims.

B*est practices* in treatment have been identified by a panel of national experts in a recent report (Kauffman Best Practices Project, 2004). The three very best protocols identified by the panel of experts included Abuse-Focused Cognitive Behavior Therapy for child physical abuse, Parent-Child Interaction Therapy, and Trauma-Focused Cognitive Behavior Therapy. These three protocols, along with many others found in the literature, are discussed in a narrative review format with references cited. Protocols include interventions with children, offenders, and families.

Since neglect is treated in the literature as separate from physical and sexual abuse in terms of antecedents, consequences, and intervention, it is discussed under a separate heading in this report. Neglect is the most common form of child maltreatment in the United States. A mounting approach to neglect that has empirical support is the use of recovery coaches to increase access to drug abuse services, improve substance abuse treatment outcomes, shorten length of time in substitute care placement, and positively affect child welfare outcomes, including increasing rates of family reunification. Recovery coaches regularly work with families in their home and in drug treatment agencies and they make joint home visits with child welfare caseworkers and other agency staff.

Systemic changes to address child maltreatment are presented from the literature, including but not limited to smaller caseloads, more staff education and training, providing local Child Protection Teams more autonomy, investigating case-processing for biases, developing transitional-living facilities for youth, requiring parents to pay for out-of-home care, mandating a Guardian ad Litem, provision of prevention services, use of funding experts, and offering foster parent training.

Finally, Victor Vieth and his colleagues have summarized some cutting-edge strategies for ending child maltreatment that are receiving wide attention. A major strategy advocated by these researchers is comprehensive training in universities and professional schools of students who will be working with maltreated children (e.g., lawyers, social workers, police, teachers). They especially emphasize training in forensic interviewing and in working with families as the most promising strategies.

Introduction to the Problem

The latest Child Maltreatment Report shows an estimated 872,000 children were determined to be victims of child abuse or neglect in 2004.

Among those children victimized, more than 60 percent experienced neglect, about 18 percent were physically abused, 10 percent were sexually assaulted, and 7 percent were emotionally maltreated. Another 15 percent of cases were associated with "other" types of maltreatment.

Victimization of children in the United States remains at an appallingly high rate, despite some decline over the past decade (Finkelhor & Jones, 2006). The National Child Abuse and Neglect Data System was developed by the Children's Bureau of the U.S. Department of Health and Human Services in partnership with the states of this country to collect annual statistics on child maltreatment from state child protective services (CPS) agencies. Their latest Child Maltreatment Report (http://www.acf.hhs.gov/news/ press/2006/Child_Maltreatment_2004.htm) shows an estimated 872,000 children were determined to be victims of child abuse or neglect in 2004. Furthermore, they indicate that the rate of victimization per 1,000 children in the national population has dropped from 13.4 children in 1990 to 11.9 children in 2004. Among those children victimized, more than 60 percent experienced neglect, about 18 percent were physically abused, 10 percent were sexually assaulted, and 7 percent were emotionally maltreated. Another 15 percent of cases were associated with "other" types of maltreatment, based on specific state laws and policies.

The highest rates of victimization (16.1 per 1,000) were among children between birth and three years of age, and among girls in comparison to boys. African-American, Pacific Islander, and American Indian or Alaska Native children had the highest levels of victimization, with rates of 19.9, 17.6, and 15.5 per 1,000 children, respectively. Approximately 10.7 and 10.4 per 1,000 White and Hispanic children, respectively, were maltreated. The lowest rate of victimization (2.9 per 1,000 children) was among Asian children.

In 2004, an estimated 3 million referrals to CPS agencies throughout the United States were made because of concern for the welfare of approximately 5.5 million children. Sixty-three percent of these referrals were accepted for investigation or assessment. More than half (about 56 percent) of all referrals for child abuse or neglect were made by professionals (e. g., educators, law officials, mental health personnel), while the others were reported by family members, friends, and other persons in nonprofessional roles.

Reported and substantiated cases of maltreatment are a fraction of the actual instances of abuse and neglect, and they are a product of social constructions or concepts defined by a particular society.

Approximately 30 percent of the referrals investigated had at least one substantiated instance of abuse or neglect, whereas about 60 percent of the reports were found to be unsubstantiated. The remaining 10 percent of referrals were closed for various administrative reasons. It should be noted at this juncture that reported and substantiated cases of maltreatment are a fraction of the actual instances of abuse and neglect, and they are a product of social constructions or concepts defined by a particular society.

Vieth, Bottoms, and Perona (2005) write, "There is, in the United States today, a culture permitting child abuse to thrive. As a result,

- Victims do not feel empowered to report their abuses.
- Mandated reporters often fail to report abuse, no matter how clear the evidence.
- Allegations that are reported are often screened out with little or no investigation.
- When investigations are conducted, many of the front line responders are inadequately trained and/or inexperienced in handling maltreatment cases and abuse is therefore not well documented or successfully prosecuted.
- When child abuse is eventually documented, the victims are typically older and have needlessly endured years of abuse.
- Child abuse prevention efforts are woefully under-funded and are not present in any meaningful sense in most communities in our country." (p. 2)

Despite these formidable challenges and barriers to identifying and responding to child maltreatment, Victor Vieth argues in a book entitled *Ending Child Abuse* (Vieth et al., 2005, pp. 6-7) – co-published as Journal of Aggression, Maltreatment, and Trauma, Volume 12, Numbers 3/4, 2006 – that this country can end child abuse in the next three generations, or 120 years. Just as polio was eradicated by healthcare professions, Vieth maintains that child welfare professionals can bring an end to child abuse through concerted collaborative work and improved training. Vieth's thought-provoking ideas on necessary changes in practices and policies have received considerable recognition in the professional literature and they are discussed at the end of this report under the heading Discussion and Conclusions.

The purpose of this report is to identify *best practices* discussed in the professional literature for addressing child maltreatment.

The purpose of this report is to identify *best practices* discussed in the professional literature for addressing child maltreatment. *Best practices* are shaped by the magnitude, definitions, types, antecedents, consequences, theoretical frameworks, research, and policies associated with social problems, in this case maltreatment of children.

Issues in Defining the Problem of Child Maltreatment

Identifying and substantiating maltreatment of children relies heavily on how abuse and neglect are operationally defined. Historically, defining child maltreatment has gone through several iterations since it became the focus of concentrated research in the early 1990s (Herrenkohl, 2005). The difficulties with defining types of maltreatment and constructing valid, reliable, and useful measures has been, and continues to be, a major concern for researchers, practitioners, and policymakers (Finkelhor & Jones, 2006; Herrenkohl, 2005; Toth & Cicchetti, 2006).

Indeed, while there are no commonly accepted systematic procedures for describing the maltreatment experience, there is an emerging consensus on the dimensions of maltreatment that need further explication and examination (English, Bangdiwala, & Runyan, 2005). The commonly accepted dimensions include severity, frequency, chronicity, duration, type, age of onset, and perpetrator type (English et al., 2005; National Research Council, 1993). For example, the preponderance of evidence indicates that different types of maltreatment need to be distinguished and treated separately, since each type has distinct antecedents and consequences (Crittenden, Claussen, & Sugarman, 1994; Higgins & McCabe, 2000; Hildyard & Wolfe, 2002). At the same time, however, determining type is complicated when there are several episodes of maltreatment over a period of time (Kinard, 1998). Should children who experience varied types of maltreatment at different points in time be classified together with children who experience the same forms in a single episode? Classification becomes even more complex when multiple types are considered along with levels of severity and duration during different developmental stages in the life span (England et al., 2005).

Research indicates that varied outcomes are associated with different types and levels of severity of maltreatment (Brown

& Kolko, 1999; Manly, Kim, Rogosch, & Cicchetti, 2001). Researchers do not agree on how to characterize these dimensions of maltreatment. Some investigators maintain that standards of severity should vary for different types of maltreatment (Bolger, Patterson, & Kupersmidt, 1998; McGee, Wolfe, Yuen, Wilson, & Carnochan, 1995), whereas other scholars posit that severity should be assigned based upon the developmental period in which the child experienced the maltreatment (Cicchetti, 1989).

Existing longitudinal studies typically account for the frequency of maltreatment across the life span of a child. However, most studies do not account for the timing or the pervasiveness of the maltreatment experience across developmental periods, nor do they account for differences that may be related to one-time incidents versus ongoing chronic ill-treatment (Bolger & Patterson, 2001; England et al., 2005; Manly et al., 2001).

Definition of Child Maltreatment

Despite the identification of issues and dimensions of the problem, there is no consensus on operational definitions or measures of maltreatment of children (England et al., 2005). Defining and measuring abuse and neglect remain a work in progress (Finkelhor & Jones, 2006; Toth & Cicchetti, 2006). A commonly used definition in the professional literature and in practice is the one set forth in the Child Abuse Prevention and Treatment Act (CAPTA) (1996) , Public Law 104-235) (http://www.yesican.org/definitions.html).

The Child Abuse Prevention and Treatment Act defines child abuse and neglect as: "….at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

The Child Abuse Prevention and Treatment Act (CAPTA) (1999), Public Law 104-235), as it has been amended and reauthorized in October, 1996, (http://www.yesican.org/ definitions.html), defines child abuse and neglect as: "….at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm." (n. p.)

CAPTA defines physical abuse as the inflicting of physical injury upon a child. Physical abuse includes burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. The parent or caretaker may not have intended to hurt the child, and the injury may not have been an accident. It

may, however, have been the result of over-discipline or physical punishment that is inappropriate to the child's age.

Emotional abuse (also known as: verbal abuse, mental abuse, and psychological maltreatment) is defined by CAPTA as acts or the failures to act by parents or caretakers that have caused or could cause, serious behavioral, cognitive, emotional, or mental disorders. This can include parents/caretakers using extreme and/or bizarre forms of punishment, such as confinement in a closet or dark room or being tied to a chair for long periods of time or threatening or terrorizing a child. Less severe acts, but no less damaging are belittling, using derogatory terms to describe the child, and habitual scapegoating or blaming.

Sexual abuse, according to CAPTA, includes fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, and sexual exploitation. To be considered child abuse these acts have to be committed by a person responsible for the care of a child or by someone related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Finally, CAPTA considers neglect to be the failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. Physical neglect can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or coats). It may also include abandonment. Educational neglect includes failure to provide appropriate schooling or special educational needs, or allowing excessive truancies. Psychological neglect includes the lack of any emotional support and love, never attending to the child, spousal abuse, and drug and alcohol abuse, including allowing the child to participate in drug and alcohol use.

Antecedents and Consequences of Maltreatment

The eminent scholars Toth and Cicchetti (2006) note, "The problem of child maltreatment provides a venue in which the integration of research, practice, and social policy should transpire in an almost seamless manner" (p. 863). However, policy and practice often have not been informed by evidence because of ideological and political positions, as well as a desire to solve problems before the time-consuming research process is completed (Finckenauer, 2005). Increasingly, as research has accumulated, evidence-based policies and practices are being advocated and implemented in all fields, including child maltreatment (Finkelhor & Jones, 2006; Toth & Cicchetti, 2006). Significant progress is being made in identifying antecedents and consequences of child maltreatment, as well as in the development and provision of efficacious prevention and intervention services (Cicchetti & Manly, 2001; Cohen, Mannarino, Murray, & Igelman, 2006). Antecedents and consequences represent targets for prevention and intervention, and evidence-based practice offers some assurance of efficiency and effectiveness.

> Significant progress is being made in identifying antecedents and consequences of child maltreatment, as well as in the development and provision of efficacious prevention and intervention services. Antecedents and consequences represent targets for prevention and intervention, and evidence-based practice offers some assurance of efficiency and effectiveness.

Antecedents of child maltreatment include, but are not limited to, lack of emotional attachment, poverty-related stresses and afflictions, substance abuse, psychiatric disorders, sexual addictions, lack of social supports, and pervasive violence in neighborhoods and more generally in society (see review, Freisthler, Merritt, & LaScala, 2006). Different combinations of these antecedents are evidenced in individual cases and their effects vary according to the dimensions of maltreatment discussed earlier, such as types, severity, age of onset, and duration of abuse or neglect (see section, Issues in Defining the Problem, pp 1-2).

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The most useful conceptual framework for understanding and intervening in the child maltreatment problem seems to be the ecological model developed by Bronfenbrenner (1979). This ecological model postulates that hierarchical levels of systems, beginning with a single individual and expanding to include the family, community, and society, influence individual behavior such as child maltreatment. The ecological framework explains how interactions between various systems (e.g., family and community) affect maltreatment (Belsky, 1993). For example, one explanation states that the lack of formal or informal social support in

neighborhoods contributes to feelings of social isolation among families, but this isolation leads to maltreatment only during times of family crisis (Belsky, 1980). In other words, it is the interaction between isolation and familial crisis that precipitates maltreatment rather than either condition alone. It is these interactions or interrelationships that must be understood in designing efficient and effective prevention and intervention programs.

An ecological framework provides the most useful model for a *best practices* approach to empirically-based prevention and intervention (Freisthler et al., 2006). *Best practices* must deal with the sum total of influences on the problem of maltreating children.

In this report, an effort is made to synthesize the findings of studies of children, families, and communities to derive an ecological framework for understanding child maltreatment. An ecological framework provides the most useful model for a *best practices* approach to empirically based prevention and intervention (Freisthler et al., 2006). *Best practices* must deal with the sum total of influences on the problem of maltreating children. For example, it is well-documented that impoverished neighborhoods are at high risk of child maltreatment (Coulton, Korbin, & Su, 1999; Freisthler, 2004; Freisthler, Needell, & Gruenewald, 2005). However, it is the interplay between several factors that make impoverished neighborhoods at risk, including prevalence of unemployment, stress induced by lack of personal and social resources, out-migration of businesses and community leaders, residential instability, lack of child care, and percentage of female-headed households (Coulton, Korbin, Su, & Chow, 1995). It should be noted at this juncture that the findings on family structure, such as female-headed families, are inconsistent across studies (Freisthler et al., 2006).

Neighborhoods with more bars and more drug possession incidents per population are related to higher rates of child abuse and neglect (Freisthler, 2004; Freisthler et al., 2005). Freisthler et al. (2004) found a differential relationship between alcohol availability and type of child maltreatment. Neighborhoods with higher densities of off-premise alcohol outlets had higher rates of physical abuse. By contrast, child neglect was positively related to greater concentrations of bars and pubs in neighborhoods.

These community or neighborhood influences interact with many other ecological factors, including the type of maltreatment, the child's developmental stage, the chronicity and severity of the injuries, temperament and interpretation of the victim, and family dynamics (Stubenport, Greeno, Mannarino, & Cohen, 2002). Many of these ecological

factors mediate or moderate the effects of maltreatment on the deleterious outcomes that are discussed in the next paragraph. That is, these factors lessen, intensify, or interact with the effects of maltreatment on outcomes. For example, residential instability intensifies the effect of chronic maltreatment on depression and suicidal attempts (Auslander et al., 2002; Benda, 2005; Brent et al., 2002).

As early as 1994, Finkelhor & Dziuba-Leatherman (1994) wrote a seminal article that identified the need to develop a field of child victimology to clarify the complex interplay of the factors that affect the outcomes of maltreatment in children's lives. Despite the lacunae in knowledge about the precise interrelationships between various ecological factors, there is a mounting empirically-based literature that describes developmental patterns seen among victimized children (Finkelhor & Jones, 2006; Weitzman, 2005). Experiencing abuse and neglect during childhood has been consistently linked to an increased risk for impaired psychological, behavioral, and social development (Cicchetti & Lynch, 1995; Cicchetti & Toth, 1995; Margolin & Gordis, 2000).

At the same time, numerous studies have indicated great variation in the effects of maltreatment (Rind, Tromovitch, & Bauserman, 1998; Salzinger, 1999). For example, although depression, substance use, aggression, criminal behavior, and sexual problems are more prevalent among adults who have been maltreated during childhood than among their counterparts, nearly a quarter of children who are ill-treated evidence no long-term symptoms (McGloin & Widom, 2001).

Consequences of child maltreatment for children and adolescents include elevated rates of posttraumatic stress disorder (PTSD), depression, personality disorders, conduct problems, oppositional behavior, attention deficits, suicidal ideation and attempts, aggression, crime, substance abuse, and other socio-emotional problems

Whereas some children are quite resilient in the face of maltreatment, many suffer negative consequences. The sequelae of child maltreatment have been well-documented in comprehensive reviews of the literature, and they affect people well into adulthood (Arellano, 1996; Browne & Finkelhor, 1986; Watts-English, Fortson, Hooper, & De Bellis, 2006; Read, 1997). Consequences of child maltreatment for children and adolescents include elevated rates of posttraumatic stress disorder (PTSD), depression, personality disorders, conduct problems, oppositional behavior, attention deficits, suicidal ideation and attempts, aggression, crime, substance abuse, and other socio-emotional problems (Auslander et al., 2002; Benda &

McGovern, 2006; Brent et al., 2002; Cohen, Mannarino, Murray, & Igelman, 2006; Doyle & Bauer, 1989; Johnson et al., 2002; Kilgore, 1988; Miller, 1990; Mulvihill, 2005; Reinherz, Paradis, Giaconia, Stashwick, & Fitzmaurice, 2003; Watts-English et al., 2006; Westenberg & Garnefski, 2003; Widom; 1989, 1992). Child maltreatment, especially physical abuse, is even associated with aberrations in brain development and physical illness (Cohen et al., 2006; DeBellis et al., 1999; Walker et al., 1999).

For adults, histories of child maltreatment are related to increased health risk behaviors, serious medical illnesses, and psychiatric disorders.

For adults, histories of child maltreatment are related to increased health risk behaviors, serious medical illnesses (Felitti et al., 1998), and psychiatric disorders (Edwards, Holden, Felitti, & Anda, 2003; Horwitz, Widom, McLaughlin, & White, 2001; Walker et al., 1999; Widom, 1999). The deleterious and protracted nature of outcomes associated with child maltreatment signify an urgency in identifying, disseminating, and implementing effective psychosocial treatments for maltreated children and their families. Therefore, the remainder of this report is devoted to summarizing current empirical knowledge regarding programs and services for these children and their families.

Issues in Reviewing Best Practices

General Issues

Discussion of *best practices* or the most effective prevention and intervention strategies is more complicated and multifaceted than it would appear to the casual observer (Cohen et al., 2006; Saunders, 2003). Indeed, children who experience child sexual, physical, or emotional abuse and/or neglect are also typically exposed to domestic or community violence. Therefore, many researchers and practitioners recommend addressing these seemingly disparate experiences as a single constellation or syndrome of problems. (Cohen et al., 2006; Saunders, 2003; Slep & O'Leary, 2001). Additionally, although treatment models generally are based on broad theories (e.g., cognitive behavioral, psychodynamic), they are usually designed for particular maltreatment and violence-exposure experiences (Cohen et al., 2006).

However, recent research indicates many, if not most, children have been exposed to multiple forms of maltreatment and violence, and they seem to respond well to a relatively few more generic intervention programs (e.g., Cohen,

Deblinger, Mannarino & Steer, 2004; Cohen et al., 2006; Saunders, 2003). For example, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was originally developed for sexually abused children, and yet it has been used successfully with children exposed to multiple traumata, with children subjected to terrorism on September 11, 2001 (Hoagwood et al., 2006), and with children who have experienced domestic violence (Cohen et al., 2006). Increasingly, studies suggest that effective intervention models may target specific symptom clusters, developmental levels, and/or level of severity and chronicity more than specific types of maltreatment/trauma experiences (Chadwick Center for Children & Families, 2004; Cohen et al., 2006; Saunders, Berliner, & Hanson, 2004).

The following narrative review of psychosocial programs reflects the perspective of multiple traumas and generic treatments. It is based on a thorough examination of professional literature, and on the collaborative work of the National Crime Victims Research and Treatment Center at the Medical University of South Carolina and the Center for Sexual Assault and Traumatic Stress at the Harborview Medical Center, University of Washington. The aim of that collaborative work was to develop guidelines for the assessment and treatment of child victims of sexual and physical abuse and their families (Saunders et al., 2004). Neglect is discussed separately from abuse, since the literature indicates that this distinction is substantively meaningful (Jones, Finkelhor, & Halter, 2006).

Purpose and Goal of the Review

The purpose of this review was to identify prevention and intervention protocols and procedures that are well-grounded theoretically, clinically, and empirically.

The purpose of this review was to identify prevention and intervention protocols and procedures that are well-grounded theoretically, clinically, and empirically. The principal goal of the review is to describe important characteristics of program procedures and protocols commonly used with maltreated children and their families in a concise and consistent manner that is easily accessible by professionals. The review is not intended to be exhaustive or comprehensive; rather, it is designed to cover approaches that have empirical support, widespread practitioner endorsement, and long-standing theoretical grounding (e. g., psychodynamic theory). In essence, this is a narrative review of what are often called *best practices* (Cohen et al., 2006).

Identifying *best practices* is a necessary but not sufficient step in the process of disseminating and applying the most efficacious strategies to avoid and remedy abuse and neglect of children. Another critical step in that process is finding ways to motivate practitioners to actually use theoretically sound and empirically supported strategies.

Social service practitioners, for the most part, have wide latitude in choosing intervention strategies to use with their clients. Informing front-line practitioners about theoretically sound and empirically supported strategies is a key element in encouraging the use of *best practices.*

The ideal developmental process for *best practices* would entail the following steps. Initially, an innovative treatment (or strategy) protocol would be developed and used cautiously in clinical settings. Further development of the protocol would be reflective of the learning curve experienced in the clinical setting. Typically, an anecdotal or case study clinical literature develops describing the protocol and the response of clients with whom it has been used. At some point, leading professionals decide that the protocol is sufficiently well-developed and has potential for mass utilization. Efficacy studies are then conducted under carefully controlled conditions to determine if the protocol is useful with the intended client population. If the protocol is found to have sound empirical support when used in highly controlled – often academic – settings, effectiveness studies are conducted in more "real world" treatment delivery settings using front-line practitioners. The utility of the protocol then can be tested in conditions like those in which most clients are seen. If the protocol is shown to be efficacious and effective, it is then disseminated to practitioners for universal use.

In contrast, the more common process in developing treatment protocols is origination in clinical settings, and then wide dissemination through workshops, seminars, and conferences with no empirical examination. Many novel intervention approaches gain wide acceptance through the *popular press,* including published books containing case studies and anecdotal accounts. Another common process involves disseminating treatment protocols after their efficacy has been tested, but prior to effectiveness studies being conducted. Actual effectiveness studies of prevention and intervention with child maltreatment cases are relatively rare (Chadwick Center for Children & Families, 2004; Cohen et al., 2006; Saunders et al., 2004).

The fact is the ideal process of establishing the effectiveness of protocols is often protracted over several years and is very expensive financially. Given the exigency of preventing and eradicating child maltreatment, it is untenable for practitioners to wait for treatment strategies to be fully examined. As a result, there always will be a significant lag between clinical use and extensive empirical testing of psychosocial prevention and intervention programs. Therefore, soundness of theoretical grounding and anecdotal accounts from experts have been used in lieu of systematic evidence by practitioners.

In this review, evidence-based practices are chosen over other services when they exist. Otherwise, the bases for reviewing practices are clearly identified. Only practices that have been endorsed by recognized experts are reviewed. Fortunately, there is a growing research literature that tests the efficacy of interventions with maltreated children (e. g., Berliner & Saunders, 1996; Cohen & Mannarino, 1996, 1998; Deblinger, Lippmann, & Steer, 1996; Deblinger, Steer, & Lippmann, 1999; Finkelhor & Berliner, 1995; Hanson & Spratt, 2000; Kolko, 1996a, 1996b; Saunders et al., 2004).

Assessment in Cases of Child Abuse

Assessing Children

Assessment is a *best practice* that should inform treatment plans tailored to the problems and needs of individual family members and the family as a system.

A basic principle underlying clinical practice is that assessment should precede the initiation of intervention. Assessment is a *best practice* that should inform treatment or service plans tailored to the problems and needs of individual family members and the family as a system (Saunders et al., 2004). The rationale is that key problems can be identified and more effectively remedied by interventions that are specifically designed for the particular problems present. Periodic assessment also is needed to gauge progress and to identify any emerging problems. Child maltreatment cases have special characteristics that must be addressed in assessment. Since many abused children continue to live with the caregivers or siblings who have hurt them or in families where domestic violence occurs, understanding the level of risk for harm in the child's environment and subsequent safety planning are the first steps in assessment in abuse cases. Evaluation of risk identifies what structural and contextual interventions may be necessary (e.g., separation, professional supervision, chaperone program), as well as

initial treatment targets (e.g., parental substance abuse, behavior management skills, anger control).

Assessment of family members' perceptions and readiness to change is another key ingredient in developing a meaningful intervention plan.

Assessment of family members' perceptions and readiness to change is another key ingredient in developing a meaningful intervention plan. Optimal family therapy requires some degree of cooperation and willingness to change on the part of family members, even if this means not interfering with the treatment plan (Cohen & Mannarino, 1998). Parent- or caregiver-child relationship quality is a critical part of any maltreatment case and should be a target of assessment. Assessment and treatment must pay attention not only to the offender-victim portion of the relationship, but also the parent-child aspect (Saunders & Meinig, 2000). Parent or caregiver attachments are especially relevant because insecure attachments often accompany maltreatment either as a precursor or a result (Hanson & Spratt, 2000). Insecure attachments are theorized to set the stage for lifelong problems in relating to others since children acquire working models for interpersonal relationships from within their families. Assessment of attachment style in the clinical setting is generally based on the reports of children and parents about the quality of the relationship, as well as observations of parent/caregiver-child interactions (Bowlby, 1988; Hanson & Spratt, 2000)

Familial characteristics and interaction patterns also have been found to be integrally related to maltreatment. Several studies have found that families in which abuse occurs are generally more socially isolated, more authoritarian and rigid in their interaction patterns, prone to abuse substances, and more likely to report marital discord and sexual dissatisfaction. These family dynamics appear to at least facilitate, if not provide the impetus, for maltreatment of children (Saunders et al., 2004). Therefore, marital and family system characteristics and interactions are appropriate targets of clinical assessment and intervention.

As discussed in the section labeled Antecedents and Consequences of Maltreatment, substantial research has documented the types of problems frequently experienced by maltreated children. These common problems include, but are not limited to, fear, anxiety, posttraumatic stress disorder, depression, sexual difficulties, poor self-esteem, stigmatization, distrust, cognitive distortions, difficulty with affective processing, aggression, disruptive behavior, and interpersonal deficits. These problems and others should be

assessed carefully using the most valid assessment tools available because the nature and severity of problems vary substantially from one child to another. Maltreated children vary in symptoms from exhibiting no problems to being severely disturbed (Saunders et al., 2004). However, the absence of measured problems may be the result of active symptom suppression by the child, avoidance coping strategies, or resilience of individual children (Cohen et al., 2006). Moreover, research shows that some of these asymptomatic children will have a delayed onset of disturbance, which can take several years to manifest (Saunders et al., 2004). Therefore, assessment should consider risk factors for the development of future problems, as well as present difficulties (McCloskey & Walker, 2000).

Assessment should evaluate not only the potential problems that are the direct result of abuse, but also pre-existing and concomitant difficulties as well. Abuse-specific (e.g., self-blame, guilt) and abuse-related (e.g., stigmatization, shame) attributions are associated with increased distress and may lead to conditions such as depression, low self-esteem, and impaired socialization that are common in abused children. Furthermore, some problems are more common with certain forms of maltreatment, such as sexual dysfunction among victims of sexual abuse (Friedrich, 1993) and anger management troubles among children who have been physically abused (Saunders et al., 2004).

The importance of systematic diagnostic interviews and standardized behavior checklists to assessing problems and treatment of child maltreatment cannot be overemphasized. Research over the last several years dramatically demonstrates how easily incorrect diagnoses and misinformation can characterize child maltreatment cases (Wakefield, 2006). Incorrect diagnoses and information leads to inadequate treatment at best, and can contribute to harmful interventions in the worst case scenario. Therefore, guidelines for interviewing children are presented under a separate heading, following a discussion of well-established behavior checklists.

Established assessment instruments provide a standardized and structured approach to measuring important dimensions, such as severity and longevity, of problems to be targeted in intervention (Berry, Cash, & Mathiesen, 2003). Standardized assessment instruments also are valuable in making alterations in treatment plans, measuring progress, and

alterations in treatment plans, measuring progress, and determining outcomes.

determining outcomes (Corcoran & Fischer, 2000).

Several assessment instruments have been developed specifically for measuring abuse-related problems and have been validated with abused children. The following assessment instruments are recommended by experts in the professional literature as among the very best measures (see review, Saunders et al., 2004):

- Child Abuse Potential Inventory (Milner, 1986);
- Child and Adolescent Functional Assessment Scale (Hodges, 1997);
- Child Behavior Checklist (Achenbach, 1991);
- Child Sexual Behavior Inventory (Friedrich, 1998a);
- Children's Impact of Traumatic Events Scale (Wolfe & Gentile, 1991);
- Child's Attitude towards Mother Scale (Hudson, 1982);
- Child's Attitude towards Father Scale (Hudson, 1982);
- Fear Survey Schedule for Children–Revised (Ollendick, 1978);
- Index of Self Esteem (Hudson, 1982);
- Kovacs' Children's Depression Inventory (Kovacs, 1992);
- Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985);
- Symptom Checklist-90-Revised (Derogatis, 1983);
- Trauma Symptom Checklist for Children (Briere, 1996);
- Trauma Symptom Inventory (Briere, 1995).

Assessing Parents

Screening for parental or caregiver disorders and family characteristics that may impact children's adjustment and caregivers' capacity to cooperate with treatment is an essential element of assessment.

Screening for parental or caregiver disorders and family characteristics that may impact children's adjustment and caregivers' capacity to cooperate with treatment is an essential element of assessment. For example, parental or caregiver depression and substance abuse are specific disorders that, when present, will substantially undermine their abilities to provide assistance to their children in the aftermath of abuse and referral to child protection authorities. When indicated, professionals serving abused children should refer parents or caregivers to appropriate interventions as part of a comprehensive treatment plan (Saunders et al., 2004).

Offending parents or siblings, especially in the case of sexual abuse, may suffer from a variety of disorders that require specific interventions. In the case of physical abuse, these may be assessed in terms of attitudes toward the use of violence and the repertoire of behavioral skills parents possess for responding to child misbehavior. In sexual abuse cases, degree of responsibility taken for the abuse, attitudes about the harmful consequences, skills deficits, and empathy are frequent targets for treatment. In addition, certain pathologies, sexual deviance, and antisocial or psychopathic characteristics are predictive of recidivism or re-offending. Standards for assessment methods for sexual offenders have been promulgated by the Association for the Treatment of Sexual Abusers (2001) and may involve the use of psycho-physiological technologies such as the polygraph and penile plethysmography. Sexual offender treatment is generally considered an area of specialty practice that requires highly specialized knowledge and training.

Treatment Planning as a Best Practice

> There should be a clear linkage between assessment results, the treatment plan, and evaluation of outcomes wrought by intervening. A seamless connection should be apparent between all activities involved in each phase of the intervention.

There should be a clear linkage between assessment results, the treatment plan, and evaluation of outcomes wrought by intervening. A seamless connection should be apparent between all activities involved in each phase of the intervention, from assessing existing problems to evaluating outcomes achieved by the treatment. Each problem identified in the assessment phase should be addressed by specific treatment strategies that are evaluated by explicit methods, including measures of problems, services, and outcomes (Bloom, Fischer, & Orme, 2005).

The treatment plan is the conceptual model that depicts the pattern of interrelated problems, deficits, and assets presented by each ecological system – including individuals, family, and the community – and the coordination of intervention strategies that will be used to achieve designated outcomes. Each of the components of this treatment plan should be measured with valid instruments to allow a comprehensive evaluation of the factors involved in the intervention efforts. For example, without accurate measures of severity of problems, any amelioration of problematic conditions cannot be evaluated. Likewise measures of intervention activities are necessary to determine the amount or quality of the services (assistance) provided (Bloom et al., 2005).

Feedback and discussion of the various results from measures and intervention activities with family members are important aspects of the assessment process. Intervention with families of maltreated children is multifaceted and involves the use of several interdisciplinary professionals. In many cases, police and other justice officials, human service caseworkers, social workers, substance abuse counselors, nurses, and physicians are involved, and a comprehensive treatment plan should include the objectives and activities of each professional. A *best practice* is having a treatment plan that clearly specifies the goals, objectives, activities, coordination of activities, measures, and outcomes. Furthermore, treatment plans should be evaluated both in terms of progress and outcomes. For example, a cognitive therapy for depression could be evaluated before completion of the treatment to see if satisfactory progress is being achieved. These periodic checks on progress allow for adjustments during the course of treatment.

A particularly relevant issue, often not discussed, to *best practices* is the acceptability of a treatment plan to families. While there are circumstances in which treatment plans need to be developed and implemented without the approval of some or most family members (e.g., offending member objects to interventions to prevent harm to child), intervention should be sensitive to the culture, religion, and values embraced by the family (Saunders et al., 2004). Intervention should represent a balance of sensitivity to these issues and professional judgment about the best course of treatment.

Interventions as Best Practices

The clinical literature describing possible treatment approaches in cases of child abuse is extensive (Cohen et al., 2006; Finkelhor & Jones, 2006; Saunders et al., 2004). The preponderance of this literature describes procedures that have been developed by individual clinicians and are widely used by other practitioners in different settings (Chadwick Center for Children & Families, 2004; Saunders et al., 2004). While many of these treatments meet some of the criteria for selection in this review, relatively few have been tested empirically. Owing to the immensity of the literature, every treatment protocol that has been proposed for use with child abuse cases could not be included in this review (Mowbray & Holter, 2002).

Furthermore, many of these protocols overlap considerably and contain the same basic elements. To avoid redundancy, only the most prominent example from overlapping protocols is selected in this review. Other criteria for selection of protocols include: 1) evidence-based practices for child maltreatment, 2) empirically established practices in other populations that are used with maltreated children as well, 3) commonly used treatments that are well-described and well-endorsed by recognized practitioners in the field, 4) treatments that are well-grounded in theory and endorsed by recognized experts, and 5) interventions that have support based on anecdotal accounts and case studies from well-known practitioners.

Interviewing Maltreated Children

Assessments and investigations of maltreatment are done by interviewing alleged victims. There are best practices for conducting interviews with children identified in the literature on maltreatment (Vieth et al., 2005). Typically, children interact with adults in contexts where questions are asked to determine if children have certain knowledge that the adults already possess. By contrast, when children are questioned about maltreatment, they generally are the sole or primary source of information about the suspected experience. Children's understanding of the interviewers' rather atypical expectations therefore has a significant impact on their ability to be competent informants. Children's meta-linguistic abilities (e. g., ambiguity detection and resolution) are paramount in forensic interviews because they need to recognize what the interviewers want to know, report information clearly, monitor the success of their responses, and modify content and/or presentation as necessary to ensure understanding on the part of the adult. Young children, in particular, typically respond to questions from adults with considerable brevity. Such responses are not particularly useful in forensic interviews where victims need to elaborate details of maltreatment experiences (Lamb, Sternberg, & Esplin, 2000; Lamb et al., 2003). Forensic interviewers must therefore help children function as informative conversational partners without compromising the accuracy of the information elicited.

The brevity of children's spontaneous reports may in part reflect deficient meta-linguistic (e.g., discerning intonations) abilities (Walker & Warren, 1995). Interventions developed to ameliorate the difficulties children have providing satisfactory narratives without adult support include the use of a practice interview, explicit training in the essential components of informative narratives before recalling the target events, and prompting by interviewers for forensically relevant categories of information (Lamb & Brown, 2006). Sternberg et al. (1997) demonstrated that open-ended questions and prompts for elaborative responses in a practice interview about a neutral event (e.g. a recent birthday) increased the amounts of information reported in response to the first prompt regarding the alleged abuse. In terms of best practices, a practice interview is recommended for forensic interviewers (Lamb & Brown, 2006), because it: 1) provides opportunities to enhance rapport between children and interviewers, and 2) prepares children for the task at hand by demonstrating what level of detail is expected in their responses and illustrating the style of questioning interviewers may use to help them achieve it.

Children usually attribute superior knowledge to adult interviewers as well, and thus may refrain from reporting all they know, assuming that interviewers already know or understand what they are reporting. Children may also respond inaccurately because they infer that interviewers would prefer particular responses and are attempting to be cooperative, rather than to communicate their actual experiences (Lamb & Brown, 2006). In the forensic context, therefore, interviewers must be sensitive to the possibility that children may overestimate the interviewers' prior knowledge and that the children may view them as authority figures with which they need to be compliant. In order to facilitate comprehensive and accurate reporting by children, for example, interviewers should emphasize that they do not know the details of the children's experiences, that it is important for the children to tell as much as they know, and that it is okay for children to disagree with or correct the interviewers if they make mistakes (Sternberg et al., 2002).

Research indicates that even very young children – from about four years of age – can provide meaningful information about their experiences when interviewed in a careful and supportive manner (Lamb et al., 2003). However, the accuracy of the information depends on the interview methods. Accounts elicited from young children using open

ended questions ('tell me what happened') that tap recall rather than recognition memory are typically briefer, but no less accurate, than those provided by older children (e.g. Lamb, et al., 2000). The completeness of these initially brief accounts can be increased if interviewers use the information provided by children in their first spontaneous utterance as prompts for further elaboration (e.g. 'you said the man touched you; tell me more about that touching'; Lamb et al., 2003). Too often forensic interviewers ask very specific questions ('did he touch you?') that draw upon recognition rather than recall memory. Specific questions typically elicit less accurate responses than open-ended prompts, and they increase the likelihood of erroneous information and a reluctance to admit a lack of information (Lamb & Brown, 2006). Questions requiring a simple "yes" or "no" are particularly likely to elicit bogus responses, especially when interlocutors ask "leading questions" or convey a preference for certain responses (Lamb & Brown, 2006).

Young children do not spontaneously employ retrieval strategies to help them recall and report everything they know. Hence, current professional guidelines for *best practice* advocate the use of open-ended prompts to elicit as much recall from children as possible before moving to non-leading specific questions to clarify and elaborate on necessary information (Lamb & Brown, 2006). The use of prop items (e.g. real items, scale models, toys, dolls, photographs) may increase the similarity between the event and the retrieval condition (interview) and thereby enhance recall by providing reminders of the event, or provide opportunities for children to overcome linguistic deficits by demonstrating rather than telling what they remember. At the same time, use of props has to be done cautiously and more as confirmation than the sole source information because they can lead to incorrect and exaggerated responses (see review, Salmon, 2001). For example, children have been asked to draw while talking about the event of interest. This technique increases the amount of information children report verbally about both positive and negative events (Lamb & Brown, 2006). Similarly, cognitive techniques such as mental context reinstatement, involving guiding children to mentally reconstruct the setting in which the event occurred, appear to help children retrieve as much information as possible (Hershkowitz, Orbach, Lamb, Sternberg, & Horowitz, 2001).

Much has been written about the degree to which children's responses may be influenced by adult interviewers (Bruck &

Ceci, 1999). Children typically perceive adult interviewers as authority figures, and so may acquiesce to their suggestions or misconstructions of events. As well, the source of information must be monitored to be certain that children are reporting what they experienced rather than what they have been told or imagined (Lamb & Brown, 2006). Garven, Wood, Malpass, and Shaw (1998) demonstrated that suggestive questions reinforced by social pressure (telling the children that other children had told, giving praise, criticizing responses, repeating questions, and inviting speculation) significantly elevated the rate at which children made false reports and acquiesced to misleading questions.

Two decades of research on children's ability to reliably describe their experiences resulted in a general consensus regarding the *best practices* of conducting forensic interviews with children. The NICHD protocol covers all phases of the interview with maltreated children and is designed to translate evidence-based recommendations into operational guidelines in order to enhance the retrieval of informative, complete, and accurate accounts of alleged incidents of abuse by young victim/witnesses.

Two decades of research on children's ability to reliably describe their experiences resulted in a general consensus regarding the *best practices* of conducting forensic interviews with children (Lamb & Brown, 2006). The National Institute of Child Health and Human Development's (NICHD) investigative interview protocol was developed to help forensic interviewers adhere to professional guidelines when interviewing alleged victims (Orbach et al., 2000). The NICHD protocol covers all phases of the interview with maltreated children and is designed to translate evidence-based recommendations into operational guidelines in order to enhance the retrieval of informative, complete, and accurate accounts of alleged incidents of abuse by young victim/witnesses. This is accomplished by creating a supportive interview environment (before substantive rapport building), adapting interview practices to children's developmental levels and capabilities (e.g. minimizing linguistic complexity and avoiding interruptions), preparing children for their tasks as information providers (by clarifying the rules of communication and training children to report event-specific episodic memories), and maximizing the interviewers' reliance on utterance types (e.g. invitations) that tap children's free recall. When following the protocol, interviewers maximize the use of open-ended questions and probes, pose focused questions only after exhausting open-ended questioning modes, use option posing questions (including yes/no questions) only to obtain essential information later in the interview, and eliminate suggestive practices.

Finally, interviewers are also encouraged to use information provided by the children as cues to promote further recall retrieval. In essence, the protocol is thus designed to maximize the amount of information elicited using recall

prompts. The structured interview protocol is designed to minimize contamination of children's accounts. Interviews are conducted to make assessment for treatment as well as to investigate allegations of maltreatment.

Child-Focused Treatment Protocols

National Best Practices Project Findings

With the specific goal of identifying *best practices* in treating child abuse, the Chadwick Center for Children and Families at Children's Hospital in San Diego obtained funding from the Ewing Marion Kauffman Foundation to conduct the *Best Practices Project.* The following intervention protocols were identified as best practices by a team of experts assembled from The *Best Practices Project, The National Call to Action: A Movement to End Child Abuse and Neglect* (www.nationalcalltoaction.com), and the Substance Abuse and Mental Health Services Administration's *National Child Traumatic Stress Network (www.nctsnet.org/ nccts/nav.do?pid=hom_mai)* (Kauffman Best Practices Project, 2004):

> 1) Abuse-Focused Cognitive Behavior Therapy for child physical abuse (AF-CBT; Kolko & Swenson, 2002);
> 2) Parent-Child Interaction Therapy (PCIT; Eyberg, 1988); and
> 3) Trauma-Focused Cognitive Behavior Therapy for child sexual abuse (TF-CBT; Cohen & Mannarino, 1993).

Abuse-Focused-Cognitive Behavior Therapy for child physical abuse (AF-CBT; Kolko & Swenson, 2002) represents an integration of behavior therapy and cognitive-behavior therapy procedures to target child, parent, and family characteristics that are associated with abusive experiences. Emphasis is placed on altering the family context that maintains coercion and aggression; therefore, children and parents participate in individual sessions as well as parent-child sessions and sessions for the entire family (Kolko & Swenson, 2002). AF-CBT has been investigated in randomized controlled clinical trials with school-aged children and their parents (Kolko, 1996). Measures of child, parent, and family outcomes were collected from parents, children, and therapists at pre- treatment and post-treatment as well as three-month and one-year follow-ups. Social service records also were reviewed through one-year follow-

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With the specific goal of identifying *best practices* in treating child abuse, the Chadwick Center for Children and Families produced the *Best Practices Project.* The three very best practices included:
1) Abuse-Focused Cognitive Behavior Therapy for child physical abuse;
2) Parent-Child Interaction Therapy; and
3) Trauma-Focused Cognitive Behavior Therapy for child sexual abuse.

up (Kolko, 1996; Kolko & Swenson, 2002). Results showed significant improvement in child, parent, and family outcomes among persons treated with AF-CBT in comparison to those who received a traditional psychodynamic treatment.

Parent-Child Interaction Therapy (PCIT; Eyberg, 1988) is designed as a short-term intervention for families of children between the ages of 2 and 7 experiencing externalizing behavior problems as a result of maltreatment. This parent training program has two discrete phases, Child-Directed Interaction and Parent-Directed Interaction, described by Eyberg (Eyberg, 1988; Eyberg & Calzada, 1998) and Hembree-Kigin & McNeil (1995). In the first phase, Child-Directed Interaction, parents are taught to integrate traditional play therapy skills with the behavioral principle of differential attention. Specific play therapy skills are taught to parents that include increasing praise, reflection, imitation, description, and enthusiasm, while decreasing commands, questions, and criticism. Parents are then coached in how to apply the skills in a manner to increase appropriate and decrease inappropriate child behavior by attending to prosocial behavior (e.g., sharing, taking turns) and ignoring mild disruptive behavior (e.g., whining). Goals of this first treatment phase include strengthening the parent-child relationship, building the child's self-esteem, increasing the child's prosocial behaviors, and enhancing the parent's skills. These goals are pursued, in part, through therapist didactic instruction, modeling, and role-play. However, the primary instruction of parents is through direct coaching in skill application.

In the Parent-Directed Interaction phase of PCIT, the same teaching modalities are used to educate parents on behavior modification principles such as giving effective commands, engendering compliance, and using time-out effectively. Attention is paid to tailoring skills to the individual needs of each parent-child dyad. Typically, the two phases of treatment are completed in 10 to 14 weeks, although there is considerable variability from one family to another. Predetermined sets of skill mastery criteria have been established for each treatment phase, and parents must demonstrate mastery of skills for treatment to progress.

Outcome research on PCIT shows decreases in behavior problems among children and in stress among parents, increases in parental skills, lessened psychopathology, and diminished child maltreatment (see Gallagher, 2003;

Herschell, Calzada, Eyberg, & McNeil, 2002).

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is designed to reduce children's negative emotional and behavioral responses and correct maladaptive beliefs and attributions related to the abusive experiences. It also aims to provide support and skills to help nonoffending parents cope effectively with their own emotional distress and appropriately respond to their children (Cohen & Mannarino, 1993; Deblinger & Heflin, 1996). TF-CBT is based on the premise that symptoms develop and are maintained by conditioned and learned behavioral responses as well as maladaptive cognitions. The model emphasizes the interdependence of thoughts, behaviors, feelings as well as physiological responses. Thus, interventions designed to target any one of these areas of functioning are expected to indirectly impact on adjustment in the other areas of functioning as well. The treatment protocols are found in Cohen and Mannarino (1993) and Deblinger and Heflin (1996).

The treatment focuses on conditioned emotional associations to memories and reminders of the trauma, distorted cognitions about events, and negative attributions about self, others, and the world. Nonoffending parents are included in the treatment process to enhance support for the child, reduce parental distress, and teach appropriate strategies to manage child behavioral reactions. In the latter stages of therapy, family sessions that include all members may also be conducted to enhance communication. Trauma-focused CBT has been proven effective for children exposed to a variety of traumatic events and has received the strongest empirical support from studies with abused children (American Academy of Child and Adolescent Psychiatry, 1998).

Other Best Practice Interventions for Maltreated Children

Trauma-Focused Integrative-Eclectic Therapy (IET) is an ecological intervention based on data suggesting that persistent effects of trauma and maltreatment are best understood as a function of the child's thoughts, familial relationships, and the environmental context. It is designed to create a safe and nurturing environment, enhance the quality of parent-child relationships, and assist the child or teenager in the acquisition of more accurate or useful self-perceptions

and coping strategies. The treatment protocols are detailed in Friedrich (1995, 1998b).

IET is based on a number of principles from developmental psychopathology (Cicchetti, 1989). First, the child is embedded in the family and environmental context, and the security of parent-child attachment is a key to the child's adaptive functioning and resilience in the face of adversity (Hanson & Spratt, 2000). A second principle is that maltreatment experiences are dysregulating (Siegel, 1999) and directly responsible for a number of problems that must be addressed, such as depression and suicidal tendencies. Finally, the developing organism is increasingly an observer of self, and accuracy of self-perception will facilitate long-term coping and healthy attitudes and behaviors. IET is grounded in a substantial body of research (Friedrich, 1995).

Cognitive-Behavioral and Dynamic Play Therapy for Children with Sexual Behavior Problems and Their Caregivers (Bonner, Walker, & Berliner, 1999a. 1999b, 1999c) are two group-treatment approaches designed for children and the care givers of children ages 6 to 12 who exhibit sexual behavior beyond normal child sexuality, which causes problems in the child's functioning. Children who have been maltreated often develop sexual behavior problems. Protocols are detailed in Bonner et al. (1999a, 1999b, 1999c).

Cognitive-behavior therapy is based on the theory that behavior results from complex cognitions involved in information processing, such as beliefs, attributions, and decision-making processes. The cognitive-behavioral approach relies on behavior modification principles for group management and incorporates strategies directed at cognitive rules, decision making, impulse control, and education. It is highly structured and uses a teaching-learning model.

The rationale for the use of dynamic play therapy is that children with sexual behavior problems may be experiencing intense negative emotions stemming from sexual, physical and/or emotional abuse, neglect, and/or other trauma. Inappropriate processing and expression of these feelings may result in sexual behavior. Play therapy assumes that play is the child's natural medium for expression and is a vehicle for emotional processing and behavior change. The spontaneous interactions combined with the controlled conditions in a play-therapy setting provide a means for achieving goals that therapists have identified as critical in

working with children with sexual behavior problems (Gil & Johnson, 1993). These goals include helping children gain insight into their own behavior; increasing children's ability to observe and appreciate other people's feelings, needs, and rights; helping children to understand their needs and values and to develop their own goals and internal resources; increasing children's ability to meet their needs in socially appropriate ways; and increasing children's connectedness to positive others and building internal strengths that support future growth. The dynamic play therapy approach used in this program incorporates aspects of client-centered and psychodynamic play therapies. The client-centered aspects help instill self-efficacy and self-worth in the participants. The psychodynamic aspects help ensure productive interactions between group members and increased self-understanding or insight. Both approaches have been found equally effective in reducing children's sexual behavior problems in a two-year follow-up (Bonner, Walker, & Berliner, 2000). The treatments consist of twelve once-weekly sessions.

Cognitive Processing Therapy (CPT) is a brief, structured, cognitive-behavioral treatment designed to treat posttraumatic stress disorder (PTSD) and associated features such as depression (Calhoun & Resick, 1993; Resick & Schnicke, 1993). CPT is a therapy consisting of exposure to the traumatic memory, training in cognitive restructuring, and modules on topics that are most likely to be affected by maltreatment. CPT has been developed to help trauma victims 1) understand how thoughts and emotions are interconnected, 2) accept and integrate the traumatic experience as an event that actually occurred and cannot be ignored or discarded, 3) experience fully the range of emotions attached to the event, 4) analyze and confront maladaptive beliefs, and 5) explore how prior experiences and beliefs both affected reactions and were affected by the trauma. Empirical support for CPT is summarized by Bonner, Walker, & Berliner (2000), and protocols are detailed in Calhoun & Resick (1993) and Resick & Schnicke (1993).

The goals of CPT are twofold. One goal is exposure to the traumatic memory. Although exposure is important because it helps to activate the client's fear-structure, it does not provide direct corrective information regarding misattributions or maladaptive beliefs (Resick & Schnicke, 1993). Therefore, a cognitive component is added to address these issues. The

cognitive component is based on the theory that traumatic experiences are often problematic because the new information often does not fit into existing schemata. Without a way to understand and categorize the experience, the strong emotions associated with traumatic experiences are left unprocessed. In addition, when individuals encounter new information that is inconsistent with preexisting beliefs or schemata, one of two things can occur: assimilation or accommodation. Assimilation involves distortion of new information so that such information is consistent with schemata, while accommodation involves altering schemata because of the new discrepant information. Over-accommodation occurs when schemata are changed at an extreme level as a result of the traumatic experience. Assimilation and over-accommodation are problematic because they often lead to self-blame, guilt, manufactured emotions such as embarrassment or shame, or dysfunctional cognitions. One goal of CPT is to help clients move from using these strategies to using accommodation while processing cognitions related to the traumatic experience. Evidence for the effectiveness of CPT is reported by Resick (1992; Resick & Schnicke, 1992).

Abuse-focused Cognitive-Behavioral Treatment is a cognitive-behavioral intervention for children and physically abusive parents that targets beliefs and attributions about abuse and violence, and teaches skills to enhance emotional control and reduce violent behavior (Kolko & Swenson, 2002). This cognitive-behavioral treatment is based on the application of social learning principles of altering the reciprocal influences between parents and children to promote and enhance prosocial interactions and diminish and eradicate deviant and harmful behaviors.

Interventions based on the social-situational model have emphasized instruction and training in new skills in various domains that relate to cognitive, affective, and behavioral development. In working with physically abusive families, such techniques have been directed toward enhancing non-abusive discipline, anger control or stress management, and contingency management. Children and parents received separate therapists who implement parallel protocols based upon social learning principles designed to address their cognitive, affective, and behavioral-social repertoires. Evidence in support of this treatment is summarized by Kolko (1996b; Kolko & Swenson, 2002), and the treatment protocol

is detailed by Kolko & Swenson (2002).

Resilient Peer Training Intervention (RPT) is a school-based intervention for young abused children that is based on an ecological model and uses competent peers and parent helpers to increase children's social competence (Fantuzzo, Weiss, & Coolahan, 1998). RPT is designed to enhance the development of social competencies for vulnerable children by capitalizing on the strengths of resilient peers and the natural support provided by teachers and parent volunteers in a therapeutic preschool or Head Start classroom environment. A number of studies have supported the effectiveness of the RPT intervention for socially isolated, low-income preschool children who have been maltreated (Fantuzzo, Sutton-Smith, Atkins, & Meyers, 1996). The treatment protocol is detailed by Fantuzzo et al. (1998).

Among other best practices found in the professional literature is Trauma-focused play therapy, which allows children to externalize their internal world in play.

Trauma-Focused Play Therapy is a psychotherapeutic intervention that uses play as a mechanism for allowing abused children to use symbols (toys) to externalize their internal world, project their thoughts and feelings, and process potentially overwhelming emotional and cognitive material from a safe distance (Gil, 1991, 1996, 1998). Play has been chronicled as a vehicle to help children with tasks such as mastery, problem-solving and conflict resolution, communication, affective expression, cognitive stretching, developmental strides, and relational issues (Saunders et al., 2004). Therapists carefully select toys that will allow the child to symbolize or literally recreate elements of the trauma experience so that it may be processed and integrated. Treatment protocols are presented by Gil (1991, 1996, 1998).

Play allows traumatized children to expose themselves to the scenario they may fear, avoid, or misunderstand (Gil, 1991). Through this external reconstruction, they are able to assuage and manage otherwise overwhelming and fragmented affect and cognition. Trauma-focused play often gives way to affective discharge, cognitive evaluation, and frees up psychic or emotional energy that is bound by traumatic memories. The trauma-focused play therapist witnesses the child's reality, provides unconditional acceptance of the child's feelings, thoughts, and reactions, challenges cognitive distortions and promotes empowerment and resiliency. Play therapy has received little empirical research, but it is widely supported by well-respected practitioners (Saunders et al., 2004).

Adolescent sex offender treatment is an intervention most often carried out in a specialized program and usually contains a variety of cognitive behavioral techniques.

Adolescent Sex Offender Treatment is an intervention most often carried out in a specialized program and usually contains a variety of cognitive behavioral techniques that are designed to change offense supportive beliefs and attributions, improve handling of negative emotions, teach behavioral risk management, and promote pro-social behavior.

A variety of treatment approaches have been used with youth that have committed sexual offenses. These approaches include general mental health treatments such as individual psychotherapy, family therapy, and inpatient milieu therapy. As well, there have been many treatment programs focused on delinquency, including Multi-Systemic Therapy (MST), boot camps, and group homes for adolescents. Finally, there are programs designed specifically for, and limited to, adolescent sex offenders that include cognitive-behavioral group therapy for adolescent sex offenders, relapse prevention, arousal reprogramming techniques, and inpatient treatment programs for youthful sex offenders. Many of these adolescent sex-offender specific programs have been based upon models used in treating adult sex offenders. However, it should be recognized that adolescent sex offenders, as a group, are different from their adult counterparts and generally do not have the same kinds or levels of sexual deviancy and psychopathic tendencies as many of their adult counterparts (Association for the Treatment of Sexual Abusers, 1997).

Presently, there is no clear scientific evidence to favor any particular treatment approach or even to demonstrate that adolescent sexual offender treatment is unequivocally effective. At the same time, detected sexual recidivism averages under 10% across a variety of treatment approaches, follow-up times, and recidivism measures (Alexander, 1999). This recidivism rate is considerably lower than rates observed for most other adolescent problematic behaviors such as drug abuse and other forms of delinquency (Saunders et al., 2004). Despite the limited scientific outcome research, there are commonly accepted clinical practices. For example, many adolescent sexual offenders are seen in specialized offender-specific programs that include peer group therapy and use some variety of cognitive behavioral approach (Burton et al. 1996; Eastman, 2004). There also is evidence to favor the MST approach (Swenson et al. 1998). It is generally agreed that involving families and significant others in treatment is beneficial.

The following documents contain protocol descriptions of the most often used programs for adolescent sexual offenders:

- Henggeler, S.W., Swenson, C.C., Kaufman, K., & Schoenwald, S.K. (1997). *MST Supplementary Treatment Manual For Juvenile Sexual Offenders And Their Families*, Provided to the Institute for Families in Society, University of South Carolina by the Family Services Research Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina.

- Kahn, T.J. (1996*). Pathways: A Guided Workbook for Youth Beginning Treatment*. Orwell, VT: Safer Society Press.

- Kahn, T.J. (1996). *Pathways: Guide for Parents of Youth Beginning Treatment*. Orwell, VT: Safer Society Press.

- Marsh, L.F., Connell, P., & Olson, E. (1988). *Breaking the Cycle: Adolescent Sexual Treatment Manual.* Available from St. Mary's Home for Boys, 16535 SW Tualatin Valley Highway, Beaverton, OR 97006.

- O'Brien, M.J. (1994). *PHASE Treatment Manual*. Available from Alpha PHASE, Inc., 1600 University Ave., West, Suite 305. St. Paul, MN. 55104-3825.

- Steen, C. (1993). *The Relapse Prevention Workbook for Youth In Treatment*. Orwell, VT: Safer Society Press.

Parent-Child or Family-Focused Treatment Protocols

> Attachment-trauma therapy is a multidimensional intervention with the primary goal of creating or restoring a secure primary attachment relationship for the child and caretaker.

Attachment-Trauma Therapy is a multidimensional intervention with the primary goal of creating or restoring a secure primary attachment relationship for the child and caretaker using positive affective and sensorimotor interactions designed to establish an environment of safety and attunement within which the child and parent are helped to process the traumatic event (Hanson & Spratt, 2000; James, 1994). Research and clinical experience demonstrate that the quality of the attachment relationship influences all aspects of a child's development (Hanson & Spratt, 2000). The trauma of maltreatment can cause a myriad of developmental problems, including abnormal neurological and structural brain development, deficient language, difficulty with affect regulation, and poor interpersonal skills (Cicchetti, 1989; Crittenden & Ainsworth, 1989). Treatment protocols are presented by the Association for Treatment and Training in the Attachment of Children (2006) and James (1994). There is no specified duration of treatment.

Therapy is designed to build a foundation of security in the relationship, create emotional and physical attunement, promote emotional competency, reduce stress, increase communication and trust, enhance awareness and insight, help children master traumatic experiences, augment authentic communication and generally strengthen the attachment bond (e.g., empathic identification) (James, 1994). Attachment treatment is receiving mounting empirical support (Association for Treatment and Training in the Attachment of Children, 2006; Curtner-Smith et al., 2006; Hanson & Spratt, 2000).

Behavioral Parent Training encompasses several treatment protocols that target behavior disordered children and their families. They typically use a short-term behavioral intervention that usually involves teaching parents skills based upon behavior theory designed to increase child compliance, decrease child disruptive behavior, and minimize coercive interactions between parent and child at home and in other settings. Child behavior problems often have a reciprocal relationship to maltreatment, being the antecedent as well as the consequence. Treatments designed to change parenting practices are, therefore, considered risk reduction strategies as well as responses to the children's behavior problems. There are several different approaches to Behavioral Parent Training, and a recent review of these treatment "packages" found empirical support for their efficacy (Brestan & Eyberg, 1998). The usual duration of treatment is six to eight weeks, but this varies considerably.

Parent training programs based on Patterson and Gullion's (1968) protocol manual *Living with Children*, for example, rely on operant principles of behavior change and teach parents to monitor targeted deviant behaviors, monitor and reward incompatible behaviors, and ignore or punish deviant behaviors of the child. This approach is based on Patterson's coercion theory (1982) and is designed to interrupt the coercive patterns of interactions that are hypothesized to occur between parents and children with conduct disorders. A review conducted as part of the American Psychological Association's (APA) Division 12 Task Force on Effective Psychosocial Interventions judged Patterson's treatment as meeting the stringent criteria for "well-established" psychosocial interventions for childhood disorders (Brestan & Eyberg, 1998).

Forehand and McMahon's (1981) Social Learning Parent Training approach is outlined in their manual, *Helping the Noncompliant Child*. The Social Learning Parent Training approach teaches parents to modify maladaptive parent-child interactions by learning how to attend to positive behavior and effectively deal with child disruptive behavior. Based on existing research, the APA Division 12 Task Force rated this treatment as meeting the criteria established for "probably efficacious" psychosocial interventions for childhood disorders (Brestan & Eyberg, 1998).

Kazdin's Parent Management Training (PMT) is based on a conceptual model that accounts for the parenting practices

and parental cognitive processes that serve to reinforce and maintain disruptive behavior disorders among children (Kazdin, Siegel, & Bass, 1992). This 16-session treatment approach was originally based on Patterson's *Living with Children* program, but was broadened to include cognitive correlates to child antisocial behavior. Kazdin's Cognitive-Behavioral Problem-Solving Skills Training (PSST) approach is a manual-based treatment for children with antisocial behavior targeting the cognitive processes that mediate the child's maladaptive interpersonal behavior (Kazdin et al., 1992). Treatment outcome research has found that although PMT alone decreased child antisocial behavior problems, PMT combined with PSST was more effective at the follow-up assessment (Kazdin et al., 1992). The APA Division 12 Task Force judged the combined PMT and PSST treatment to meet the criteria established for "probably efficacious" psychosocial interventions for childhood disorders (Brestan & Eyberg, 1998).

Focused Treatment Interventions (FTI) is a protocol of sequential treatment interventions focused on increasing child safety, reducing risk, and clarifying responsibility in child maltreatment cases. Treatment protocols are articulated by Ralston (1982, 1998; Ralston & Swenson, 1996; Lipovsky, Swenson, Ralston, & Saunders, 1998). FTI is designed for use in a coordinated multidisciplinary community system of care. The goals of FTI are to identify and reduce barriers to child safety and protection following the disclosure or discovery of maltreatment and to prevent future abuse. The sequential nature of the interventions is based on Finkelhor's (1984) preconditions of motivation, internal, external, and child factors as applied to a protective family system.

FTI is based on guiding principles from the empirical literature on the impact of child maltreatment, on child protection state and federal mandates, and it supports the overarching goal of family reunification with preconditions of child safety and personal responsibility for behavior. A uniform and comprehensive forensic and clinical assessment in response to suspected maltreatment involving the non-offending caregiver and child victim provides a baseline of history and experience of the child and family. The assessment process is based on the underlying philosophy that parents and adults are responsible for child protection; the empirical literature regarding techniques for forensic interviewing (discussed above under the heading Assessment in Cases of Child Abuse); and the American Professional Society on the Abuse of Children guidelines for conducting psychosocial assessments and forensic interviews in cases of child maltreatment (American Professional Society on the Abuse of Children, 1997).

The FTI model focuses on specific factors that created risk to the child and family and identifies the required behavioral outcome to reduce that risk. Rather than providing a menu of services that require participation to be considered successful, the FTI focuses on identifying risk factors and required behavioral change and uses input from the caregiver regarding what will be needed to make the required change. For example, when alcohol use is identified as a barrier to child safety/protection, the FTI directs a specific change in alcohol use behavior. The caregiver is involved in what will be required to stop using alcohol in support of the safety and protection of their child. The interventions involved focus the responsibility for change on the caregiver (client) and places the responsibility for providing the resources to support that change on the larger social service system. Length of intervention typically is from six to twelve months, depending on severity and complexity of problems. Empirical support for the approach is found in Swenson and Ralston (1997).

Family resolution therapy is a protocol that seeks to develop a long-term familial context and functional processes where children can be safe from abuse, yet continue, if possible, to benefit from some type of relationship with their abusive parents.

Family Resolution Therapy (FRT) is a protocol that seeks to develop a long-term familial context and functional processes where children can be safe from abuse, yet continue, if possible, to benefit from some type of relationship with their abusive parents. This long-term familial outcome may range from family reunification and maintenance of an intact family, to family separation with unsupervised visitation, to family separation with supervised visitation, to dissolution of the parent-child relationship. FRT employs psycho-education and cognitive therapy procedures to change distorted thinking among and between all family members about the abuse experiences and beliefs that supported the abusive context. It employs family therapy techniques to alter the homeostatic organizational functioning, internal boundaries, and external boundaries (i.e., social isolation) of the family system that tended to support and enable the abuse. It employs behavioral management and collateral monitoring techniques to assess, change, and monitor behavior among all family members (particularly the offending parent) and the family system as a whole that may signal a relapse to problem behavior patterns, abusive behaviors, and abuse supportive behaviors.

FRT attempts to change familial behavior by altering the familial structure and power hierarchy, changing daily family processes, introducing new ways of conducting familial relationships, and carefully monitoring how new behaviors are implemented in the family. It makes use of behavioral contracts and collateral surveillance of family functioning and individual behavior, as well as psychotherapeutic modalities. Protocols and available supportive evidence are detailed by Saunders & Meinig (2000, 2001). There does not appear to be extensive empirical evaluation of this protocol, but it is well-received by practitioners (Saunders et al., 2004). The duration of intervention is from six to eighteen months.

Integrative Developmental Model for Treatment of Dissociative Symptomatology is a multifaceted child and family intervention model for children with dissociative symptoms that emphasizes interrupting automatic dissociative withdrawal, teaching the child alternative communication strategies and affect management techniques, and teaching the family new interactive patterns. Maltreated children often exhibit symptoms such as trance states, forgetfulness, fluctuating behavior including rapid regressions and rage reactions, and belief in vivid imaginary friends or divided identities (Silberg, 2000). Traumatic events in the child's life may precipitate these adaptations as ways to cope with a dysfunctional environment. These adaptations may be understood as difficulties in the normal developmental integration of self-capacities (Siegel, 1999; Putnam, 1997).

Treatment involves emphasis on self-awareness and affect-regulation and encouraging the child to take responsibility for actions that initially are perceived by children as outside their control. Interactions with the child emphasize acceptance of all affects, behaviors, or dissociated states and the encouragement of self-acceptance as a first step towards self-management. Development of positive fantasy for providing self-soothing illustrates to the child that fantasy, such as belief in malevolent imaginary entities, can be under the child's control. Recent research suggests that children with disorganized or avoidant attachment styles may be particularly at risk for developing dissociative symptomatology (Ogawa et al. 1997). Thus, enhancing parent-child attachment patterns and communication becomes important. Treatment emphasizes the identification of stimuli that may elicit dissociative responses such as parent-child interaction patterns that are reminiscent of previous traumatic episodes in which attachment was threatened. Family interventions involve enhancing reciprocity in communication, encouraging direct expression of feeling and avoiding the reinforcement of regressive coping (Silberg, 2001). The therapist models for the child and family interactive styles that encourage wholeness, responsibility, and tolerance for the expression of feelings. The treatment protocol and the limited research are described by Putnam (1997), Silberg (2000, 2001), and Wieland (1998). The duration of treatment is from six to 24 months.

Multi-Systemic Therapy (MST) is a treatment model that targets key factors within the youth's social ecology that relate to problem behavior and provides multiple, evidence-based interventions. The theoretical foundation underlying MST is based on causal modeling studies of serious antisocial behavior (Henggeler, 1991) and social-ecological (Bronfenbrenner, 1979) and family systems (Haley, 1976; Minuchin, 1974) theories of behavior. Behavior is posited to be the result of multiple *causes* that reside in different ecological systems (e.g., family, peer, school, community) in which the youth is involved. Thus, the scope of MST interventions is not limited to an individual youth or the family system, but includes difficulties within and between other systems.

In multi-systemic therapy, a professional moves into a family (either literally or figuratively) and becomes the "case manager" or coordinator who ensures that the identified problems are addressed fully by a team of professionals from different agencies.

Assessment is a preeminent aspect of MST in identifying the systemic factors that are contributing and reinforcing maltreatment of children. This assessment is done from an ecological perspective wherein efforts are made to determine interrelationships between factors that reside in different systems. These factors then become the targets for the intervention plan. For example, substance abuse and lack of anger control may be the product of unemployment, lack of child care and other social supports, and feelings of despair and depression. Hence, MST would involve the coordinated efforts of a team of interdisciplinary professions to find employment, child care and other support, and therapy for depression. In a comprehensive model of MST, a professional (often a social worker) moves into a family (either literally or figuratively) and becomes the "case manager" or coordinator who ensures that the identified problems are addressed fully by a team of professionals from different agencies. It is the central coordination and continued contact that separates this approach from other similar arrangements. This protocol is more fully discussed by Henggeler, Schoenwald, Borduin, Rowland, & Cunningham (1998). Duration of interventions vary greatly depending on the number and complexity of problems (six-month to one-year interventions are not unusual).

Extensive research supports the short- and long-term clinical effectiveness of MST as well as its potential to produce significant cost savings and capacity to retain families in treatment. In comparison with control groups, MST has consistently demonstrated improved family relations and family functioning, improved school attendance, decreased adolescent drug use, 25% to 70% decreases in long-term rates of rearrest, and 47% to 64% decreases in long-term rates of days in out-of-home placements (e. g., (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999; Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Pickrel, & Brondino, 1999; Henggeler et al., 1998; Schoenwald, Ward, Henggeler, & Rowland, 2000).

Parent-Child Education Program for Physically Abusive Parents is a home- or clinic-based intervention designed to establish positive parent-child interactions and childrearing methods that are responsive to situational and developmental changes and reduce parents' reliance on power-assertive methods that can turn into verbal and physical abuse. Like other therapies for individuals and families discussed in this report, this one is often used with the MST framework just presented.

Child physical abuse occurs most often during periods of stressful role transition for parents, such as unwanted child births, the postnatal period of attachment, times of family instability and disruption, or following chronic detachment from social supports and services (Wolfe, 1999). This approach is derived from attachment theory, with its emphasis on early relationship formation, and social learning theory's principles of behavioral and cognitive learning. Training parents in effective childrearing methods is based on practical applications of learning principles: educating parents about very basic contingency management principles (e.g., reinforcement, punishment, consistency); modeling for the parents new ways of problem solving and increasing child compliance; and rehearsing the desired skills in non-threatening situations, (Becker et al., 1995).

The goals of intervention entail the development of strong positive childrearing abilities by strengthening the early formation of the parent-child relationship, improvement in the parents' abilities to cope with stress by developing a support system, and the development of the child's adaptive behaviors. This protocol is described in detail by Wolfe (1991). Outcome studies do show support for the effectiveness of this intervention (Wolfe, Sandler, & Kaufman, 1981; Wolfe et al., 1982; Wolfe, Edwards, Manion, & Koverola, 1988).

Intensive Family Preservation Services (IFPS) is a brief, home-based multiple component intervention designed to prevent out-of-home placements of children when it is tenable, and to reduce risk for child maltreatment by changing behaviors and increasing skills of caregivers. Treatment components are primarily cognitive-behavioral strategies.

> Intensive family preservation services is a brief, home-based multiple component intervention designed to prevent out-of-home placements of children when it is tenable, and to reduce risk for child maltreatment by changing behaviors and increasing skills of caregivers.

Parental skill deficits, psychiatric disorders, child behavior problems, and dysfunctional or violent relationships often characterize families of maltreated children. The *Homebuilders* program and similar programs use a cognitive behavioral framework to explain the variety of behavioral dysfunctions. The intervention approach consists of the individualized in-home application of a variety of cognitive behavioral and skill-building strategies that target the specific problems that are identified as creating an imminent risk for out-of-home placement. The specific strategies used have extensive empirical support (Ammerman, Kolko, Kirisci, & Blackson, 1999; Patterson, Chamberlain, & Reid, 1982). The general model includes service provision in the client's home, engagement and relationship building through behavioral assessment of client strengths, goal-oriented service planning, cognitive-behavioral parenting and problem skills training, and building social support networks. Protocols are presented by Kinney, Haapala, and Booth (1991), Tracy, Haapala, Kinney, and Pecora (1991), and Whittaker, Kinney, Tracy, and Booth (1990). Duration of intervention is typically three to six months.

A substantial amount of research has been conducted on IFPS interventions including several large randomized trials. Although a large majority of treated cases avoid placement, most studies do not find a statistically significant difference in placement rates, suggesting that many of the families referred for the service were not actually at imminent risk for placement (Fraser, Nelson, & Rivard, 1997). Evidence

suggests that the use of IFPS appears to accelerate family reunification (Fraser, Walton, Lewis, Pecora, & Walton, 1996). The preponderance of evidence suggests that the overall rates of subsequent child maltreatment tend to be low in both treated and untreated groups in these trials. However, there are studies that show IFPS does lower the risk of subsequent maltreatment (Westat, Inc., Chapin Hall Center for Children, & James Bell Associates, 2001). Results of a recent large scale randomized trial in three states showed that where differences were found on family functioning and child problems, the majority favored the IFPS intervention (Saunders et al., 2004).

Parent-Child Interaction Therapy (PCIT) is a behavioral and interpersonal dyadic intervention for children (ages 2-8 years) and their parents or caregivers that is focused on decreasing externalized child behavior problems (e.g., defiance, aggression), increasing positive parent behaviors, and improving the quality of the parent-child relationship.

The conceptual framework underlying PCIT postulates that foremost among the many factors contributing to child maltreatment is the nature of the parent-child relationships. Parents tend to be critical and coercive toward children and to have ineffective disciplining strategies, whereas children generally are aggressive, defiant, and resistant to parental direction (Kolko, 1995, 1996a, 1996b). These negative reciprocal relationships often escalate to the point of severe corporal punishment and physical abuse (Urquiza & McNeil, 1996).This protocol is designed especially for the problems (factors) that have been identified as contributing to physically abusive parent-child dyads (Eyberg, 1988). It provides an in vivo opportunity to alter the pattern of interactions within abusive relationships, and it serves as a mechanism to directly decrease negative affect and control, while promoting greater positive affect and discipline strategies. The interventions combine elements of family systems, learning theory and traditional play therapy. The emphasis is on restructuring parent-child patterns rather than on modifying behaviors per se (Hembree-Kigin & McNeil, 1995). Protocols are presented by Hembree-Kigin & McNeil (1995) and Urquiza & McNeil (1996). The duration of treatment varies, but is prescribed for about 12 weeks. Evidence in support of PCIT is provided by Borrego & Urquiza (1998), Borrego, Urquiza, Rasmussen, and Zebell (1999), and Eyberg (1988).

Physical Abuse-Informed Family Therapy (FT) is a family systems intervention for children and physically abusive parents that seeks to reduce violence and improve child outcomes by promoting cooperation, developing shared views about the value of noncoercive interactions, and increasing skills of family members.

This family-ecological model views child physical abuse from a systemic perspective emphasizing the interrelationships among individual, family, and social support factors (Belsky, 1993). Treatment seeks to address various child (e.g., feelings), parent (e.g., poor empathy, physical punishment) and/or family issues (e.g., role reversal). Most interventions involving family therapy (FT) or multiple services directed toward the family system have not been formally evaluated (Wolfe & Wekerle, 1993). Family-centered services have been associated with improvements in child developmental status, parenting skill, and family relationships (Culp, Little, Letts, & Lawrence, 1991). FT is designed to enhance family functioning and relationships in accord with the ecological model approach to child maltreatment (Belsky, 1993). Treatment seeks to enhance the cooperation and motivation of all family members by promoting an understanding of coercive behavior, teaching the family positive communication skills and how to solve problems together. The treatment has been shown to be superior to routine community service in reducing violence and improving child outcomes (Kolko, 1996c). The protocol is articulated by Kolko and Swenson (2002), who state that the duration of treatment is from 12 to 24 sessions.

Parents United is a clinically based, integrated treatment program which provides direct clinical services as well as a variety of non-clinical support for victims, offenders, adults molested as children, and their significant others.

Parents United (Child Sexual Abuse Treatment Program) is a clinically based, integrated treatment program which provides direct clinical services as well as a variety of non-clinical support for victims, offenders, adults molested as children, and their significant others. The foundational premise is that all individuals affected by sexual abuse will benefit from a variety of supportive, adjunctive services in addition to formal clinical treatments. Variations on psycho-education, support, enhancement of interpersonal skills, and cognitive behavioral techniques are used as primary interventions.

Parents United is a nonprofit, membership driven organization which provides mostly nonclinical support functions for the program. These functions include child care, attendance records, speakers bureaus, support person registry, literature on the program, orientation of membership, etc. Each Parents United Chapter has a clinical sponsoring agency responsible for all treatment services. The treatment protocol is spelled out in Child Sexual Abuse Treatment Services (1994). Parents United seems to have strong support from practitioners, but it has not been subjected to rigorous research (Saunders et al., 2004).

Offender Interventions

Parents Anonymous (PA) is an organization designed to strengthen at-risk and abusive parents or adults in parenting roles through mutual support, shared leadership, and personal growth. The ongoing, open-ended groups offer the opportunity to learn new skills, transform attitudes and behaviors, and create lasting change.

PA is based on the tenet that through participation in groups parents learn to identify and build on their strengths, increase their ability to deal with stress, expand their social support networks, and develop realistic expectations of themselves and their children. Parents are encouraged to take responsibility for their own problems and give and receive support from one another to find solutions. PA groups provide support, a safe and caring environment, encouragement to parents for taking charge of their lives and their families, and opportunities for attitude change and the integration of new knowledge and skills. Providing opportunities to develop friendships reduces isolation. The three essential components needed to create long-term behavioral change are the opportunity to: 1) examine attitudes and childrearing practices and learn new skills and behaviors, 2) practice newly learned skills and behaviors within the safety of the group and at home, and 3) incorporate the new skill or behavior into their daily life. PA groups are ongoing and open ended, and the protocol is detailed by Rafael and Pion-Berlin (1996, 1999). The limited outcome data support Parents Anonymous as an effective intervention (Pion-Berlin & Polinsky, 2000).

Adult Child Molester Treatment uses cognitive behavioral and adjunctive therapies to help child sexual offenders

develop the motivation and skills to stop sexual offending by replacing harmful thinking and behaviors with healthy thoughts and the skills to make choices that will reduce risk. Specialized treatment typically includes individual or group therapy with additional intervention through education of, and monitoring by, collaterals in an offender's environment.

According to the Association for the Treatment of Sexual Abusers (2001), sexual molestation of children is a treatable though not curable behavior problem, and most offenders require external motivators to successfully complete the treatment process. Sexual child abusers are described in the literature as a heterogeneous group who often have a variety of psychological problems or psychopathology (Salter, 1995). Many child molesters have committed additional types of sexual offenses, and intra-familial offenders may well have extra-familial victims as well (Salter, 1995). Child molesters with male victims show higher recidivism rates than those with only female victims (Alexander, 1999; Hanson, 1997). Albeit evidence suggests multiple etiological pathways to sexual offending, effective intervention focuses on modifying those factors that support the desire, capacity, and opportunity to offend. Cognitive behavioral approaches are currently considered the most effective methods of treatment, with pharmacological, educational, skills-building, self-help, and other methods used as adjuncts to treatment regimens (Association for the Treatment of Sexual Abusers, 2001).

An analysis of 79 treatment studies found that treatment of child molesters by Relapse Prevention and other cognitive behavioral approaches reduced known recidivism rates to 8.1%, compared to 18.3% for other treatment approaches and 25.8% for untreated molesters (Alexander, 1999). Throughout the literature are statements that there is no known effective treatment for the psychopathology exhibited by the majority of sexual offenders (Saunders et al., 2004). Dysfunctional core beliefs and ongoing distorted thinking are used by the offender to justify and facilitate the sexual offense behavior. Some offenders turn to sexual fantasy and offending in response to specific disinhibitors, such as negative affective states, while others actively approach offending as an ego-syntonic goal (Ward, Hudson, & Keenan, 1998). Psycho-physiological assessment techniques (e.g., plethysmography, polygraph) are useful, as most offenders use considerable denial and minimization of part or all of their offense history and arousal patterns. These self-defense mechanisms

complicate both accurate initial assessment and ongoing evaluation of treatment progress. The most effective treatments address the specific elements of the offender's beliefs and feelings that lead to sexual offending behaviors and relapse (Saunders et al., 2004). According to the literature, the typical duration of treatment is one to two years (Saunders et al., 2004), although it must be kept in mind that there are no known *cures.* A major treatment protocol is described by the Association for the Treatment of Sexual Abusers (2001).

Concluding Remarks on Treatment for Child Abuse

Overview
Child victims of physical or sexual abuse very often have complicated histories of multiple victimization and trauma, and present a complex pattern of disorders and problems that may or may not be the result of abuse (Saunders et al. 2004). The multifaceted nature and history of abuse in most cases presents challenges to assessment and treatment. Therefore, practitioners typically modify and blend the various protocols just discussed to treat specific cases.

Generally, the interventions with the most empirical support tend to be based on behavioral or cognitive behavioral theoretical approaches, utilize behavioral and cognitive intervention procedures and techniques, and are directed at the individual and the family. As noted, many of these protocols share specific treatment procedures and techniques (e.g., cognitive restructuring, exposure procedures, behavioral management skills) that are applied to problems aside from child maltreatment.

As a generalization, evidence-based practice is goal-directed and designed to address measurable problems identified through systematic assessment of children and their families. Problems are defined so that they can be identified and verified by validated assessment measures. Once the problems are defined and measured, a treatment plan can be developed to ameliorate or alleviate them, and the effect of the intervention can be assessed over time.

Evidence-based practice typically is structured with specific procedures and techniques that are clearly linked to the desired outcome. Other than rapport building and engaging the client in the therapeutic procedures, intervention efforts are almost exclusively devoted to resolving the problems identified by assessment. The steps in the treatment plan often are designed sequentially to build progressively toward the desired outcome. The linkages between these steps and the outcome goals are usually clearly specified.

Empirically supported treatments usually emphasize skill building to manage emotional distress and behavioral disturbance. Children are taught specific skills for self-regulation of their thinking, affect, and behavior. Parents are taught skills for managing children. Treatment components often are variations of basic cognitive-behavioral techniques and usually include didactic procedures such as psycho-education, expressive procedures such as exposure therapy, cognitive procedures such as cognitive restructuring, and child behavior management techniques.

Treatments based on research typically use techniques involving repetitive practice of skills with feedback from the therapist. Practice occurs both within treatment sessions and between sessions in the home, school, or community. The use of role-playing and homework is common. These learning strategies maximize the likelihood that newly acquired skills will generalize to every-day life.

Best Practice Models for Neglected Children

Neglect versus Abuse

Neglect is the most common form of child maltreatment in the United States. Owing to the high incidence rate and estimated number of victims suffering from neglect, service providers need to be cognizant of the most effective service models available for working with children and families experiencing neglect. Child neglect is more common, lasts longer, and has longer-term consequences than physical abuse for children (Berry, Charlson, & Dawson, 2003). Although many of the interventions and treatment strategies available to parents are similar or the same for both abuse and neglect, certain factors are more common or more potent in the developmental pattern of neglect than of abuse. Therefore, best practices in interventions with neglect reflect these differences. Among structural factors, for example, neglect is more common among young single mothers living in poverty with little or no familial and other social support (Berry, Charlson, & Dawson, 2003).

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Characteristics Associated with Neglect

Young single mothers who are living below the poverty line are at the greatest risk of child neglect (Wells & Tracy, 1996). Furthermore, a rigorous study conducted by Rossi, Schuerman, and Budde (1999) found that when young mothers had some form of income, family preservation services were more likely to be offered or recommended, whereas out-of-home care was provided to families with little or no income. This differential treatment is in part due to the fact that children living in poverty are much more likely to be exposed to family and community violence, to experience difficulties at school, to live in neighborhoods pervaded with risk-taking behaviors, and generally to have less access to familial and other social supports (Tracy & Pine, 2000). Once children are removed from their home, many social service agencies or courts require proof of consistent employment, among other things, in order for family reunification to be possible (Berry, Charlson, & Dawson, 2003). Employment is therefore considered a corollary parenting skill, and one that should not be ignored in the array of intervention services. If unemployment is a reason for child placement, it also should be a target of intervention.

> Young single mothers who are living below the poverty line are at the greatest risk of child neglect.

The literature identifies several interaction patterns that characterize families of neglected children. They often have fewer affirming parent–child interactions, more unresolved conflict, less positive communications, marital discord, and deficient empathy and warmth towards family members

In addition, the literature identifies several interaction patterns that characterize families of neglected children. They often have fewer affirming parent–child interactions, more unresolved conflict, less positive communications, marital discord, and deficient empathy and warmth towards family members (Gaudin, Polansky, Kilpatrick, & Shilton, 1996). Approximately one-third of the mothers who neglect their children are victims of domestic violence. An in-depth longitudinal study conducted by McGuigan and Pratt (2001) found that families experiencing domestic violence during a child's first 6 months of life were twice as likely to have a substantiated account of neglect during the child's first 5 years. Moreover, children directly witnessed 85 percent of all assaults made against their mothers (Brookoff, O'Brien, Cook, Thompson, & Williams, 1997). These children were often seen emulating violent behaviors through actions such as punching or strangling the household pet (Brookoff et al., 1997). Therefore, interventions discussed under the heading Parent-child or Family Focused Treatment Protocols are recommended in the literature for families that neglect children.

Because research has been more common among mothers than fathers, much more is known about neglectful mothers. Several studies have found that many of these women were also neglected during childhood, and the most frequent problems among them are social isolation, psychiatric disorders, and substance abuse (Cowen, 1999). Regarding social isolation, research is clear that mothers, and also fathers, are at high risk of child neglect when they are the primary caregiver and are also isolated with limited or no social support (Berry, Charlson, & Dawson, 2003). A major responsibility of social service agencies is the building and facilitation of social supports. In developing social support networks, professional discretion has to be exercised because there are dysfunctional and harmful familial and other social systems.

Child neglect often is the consequence of parental mental disorders such as depression, high levels of stress, personality disorders, suicidal ideation, and dissociation.

According to Bellis, Broussard, Herring, Moritz, and Benitez (2001), child neglect often is the consequence of parental mental disorders such as depression, high levels of stress, personality disorders, suicidal ideation, and dissociation. A study of five home-based programs in six different states revealed that about 56 percent of out-of-home placements for neglected children involved coexisting substance abuse and mental disorders (Menahem & Halasz, 2000). Substance

abuse and mental disorders not only contribute to neglect, but they also serve as major barriers to treatment compliance, and parents who suffer these disorders tend to be overly reliant on children for emotional support and for child care (Dore, 1999).

Parents who abuse drugs and/or alcohol are approximately four times more likely to neglect their children than parents who are not substance abusers.

Alcohol and crack/cocaine are considered to be the primary drugs-of-choice of parents who neglect their children, followed by methamphetamines and marijuana (Bartholet, 1999). Parents who abuse drugs and/or alcohol are approximately four times more likely to neglect their children than parents who are not substance abusers (Kelleher, Chaffin, Hollenberg, & Fisher, 1994). Substance abuse is a major family problem for about half of the children placed in the custody of the child welfare system. Once in the system, no single factor causes more problems with treatment compliance than parental substance abuse. Substance abuse compromises nearly every aspect of the role of parent, and it often coexists with unemployment, mental incapacitation, lack of social supports, and even homelessness (Berry, Charlson, & Dawson, 2003). As a result, it is typically very difficult to engage and retain substance-abusing parents in child welfare services because they have so few internal (e.g., inner motivation, self-efficacy) and external resources (e.g., childcare, transportation) (Ryan, Marsh, Testa & Louderman, 2006).

A comparison of clients who received regular substance abuse treatment to those who received additional linkage services (i. e., transportation, childcare, and outreach) found that the latter showed increased use of child welfare services and decreased substance abuse.

Because of these barriers to successful intervention, child welfare systems are in the throes of developing practice models that incorporate both substance abuse treatment and child welfare services (Berry, Charlson, & Dawson, 2003; Ryan et al., 2006). Despite evidence that indicates substance abuse treatment is effective for clients who remain in treatment for at least three months, only a few studies have examined treatment effectiveness for clients involved in the child welfare system (Ryan et al., 2006). One such study by Marsh and colleagues (2000) used a nonequivalent control group design to examine the effectiveness of enhanced services for substance-abusing women in the Illinois child welfare system. A comparison of clients who received regular substance abuse treatment to those who received additional linkage services (i. e., transportation, childcare, and outreach) found that the latter showed increased use of child welfare services and decreased substance abuse.

Using the same sample, Smith and Marsh (2002) examined the effect of matching client-identified needs with services to

meet those needs. They found that matched counseling services (domestic violence, family counseling) were related to reports of reduced substance use, whereas matched social services (housing, job training, legal services) were positively associated with clients' satisfaction with treatment. These studies indicate the benefits of substance abuse treatment for reducing substance use by women with children involved in the child welfare system. Moreover, these studies begin to identify the specific services and service delivery strategies required to effectively integrate substance abuse treatment into child welfare practice.

Family reunification remains a major goal for child welfare systems because it emphasizes the primacy of parent-child attachments and the role of the biological family in human connectedness (Maluccio & Ainsworth, 2003). However, this has been a difficult goal for addicted parents in the child welfare system to achieve. Service linkage mechanisms that connect clients to services from different systems are critical in integrated models designed to promote family reunification among clients who abuse substances. Linkage mechanisms include ad hoc referrals, case management services, coordinated location of services, screening child welfare clients for substance abuse, and cross-training staff in child welfare services and drug treatment (see review, Maluccio & Ainsworth, 2003). These practices are beginning to demonstrate success in the effective reunification of families with an addicted parent (Maluccio & Ainsworth, 2003).

The use of recovery coaches is intended to increase access to substance abuse services, improve substance abuse treatment outcomes, shorten length of time in substitute care placement, and positively affect child welfare outcomes, including increasing rates of family reunification.

For example, recently the Illinois AODA (alcohol and other drug abuse) Waiver Demonstration Project tested a model of intensive case management using recovery coaches (Ryan et al., 2006). The use of recovery coaches is intended to increase access to substance abuse services, improve substance abuse treatment outcomes, shorten length of time in substitute care placement, and positively affect child welfare outcomes, including increasing rates of family reunification. To achieve the outcome goals, recovery coaches engage in a variety of activities, including comprehensive clinical assessments, advocacy, service planning, outreach, and case management. The clinical assessments focus on a range of problem areas, such as housing, parenting, domestic violence, mental health, and family support networks. Advocacy is used to assist parents in obtaining benefits and in meeting the responsibilities and mandates associated with the benefits. Outreach activities ensure that recovery coaches work with

substance-abusing families in their communities. Recovery coaches regularly work with families in their home and in AODA treatment agencies and they make joint home visits with child welfare caseworkers and AODA agency staff. At least one recovery coach is always on call during evenings, weekends, and holidays to address emergencies. Recovery coach services are provided for the duration of the case in child welfare (and beyond at times), and coaches regularly share information with child welfare and juvenile court personnel to inform dispositional decisions (Ryan et al., 2006).

Recovery coaches are an innovative mechanism for overcoming the significant barriers that presently exist between child welfare services and substance abuse treatment systems.

For example, child welfare agencies tend to focus primarily on the children in their service-delivery, whereas AODA treatment programs focus almost exclusively on the parent as the primary client. The recovery coach model attempts to resolve these competing foci by employing coaches at an agency (Treatment Alternatives for Safe Communities in Illinois) that is independent of child welfare and AODA treatment programs. The coaches then work with child welfare and AODA treatment staff to ensure that intervention is aimed at both the child and the family. Training of recovery coaches covers all phases of AODA treatment, including relapse prevention; fundamentals of assessment, including DSM-IV classification; child welfare services; treatment planning; client-tracking systems; case management; and counseling (Ryan et al., 2006).

Using very sophisticated statistical analyses, the results of Illinois AODA Waiver Demonstration Project indicate that families receiving recovery coach services were more likely to achieve family reunification than their counterparts who did not receive these services. Specifically, the odds of achieving reunification were 1.28 times greater for families assigned to the recovery coach group (Ryan et al., 2006). This study is very valuable because the likelihood of achieving family reunification for substance-abusing parents normally is extremely low. Indeed, one study shows that 86% of the children of substance abusers who entered the child welfare services system in 1994 failed to return home before January 2002 (approximately 7.5 years) (Budde & Harden, 2003, reported in Ryan et al., 2006). While no one intervention can be expected to completely resolve all the problems associated with reunification for substance-abusing families, recovery coaches seems to offer considerable potential for coordinating services between interdisciplinary professionals that have the expertise to successfully address particular problems such as

housing, drug abuse, and mental health.

Systemic Changes to
Address Child Maltreatment

The remainder of this report discusses specific *best practices* recommended in the professional literature to address child maltreatment in the larger ecological systems (Veith et al., 2005). These recommendations are based on evidence as well as well-established practices reported in the professional literature.

Several studies confirm the necessity of reasonable caseloads for public child welfare workers to effectively investigate and serve abused and neglected children and their families.

1. Several studies confirm the necessity of reasonable caseloads for public child welfare workers to effectively investigate and serve abused and neglected children and their families (Vieth et al., 2005). The Child Welfare League of America (1998) recommends caseloads of 12 active investigative cases per month for each worker, 17 children per worker with no more than 1 new case assigned for every six open cases for ongoing caseloads, or 10 active ongoing cases and four active investigations per caseload for workers with mixed caseloads (i. e., ongoing and closed cases). Also, supervisors should be responsible for no more than five workers.

The Government Accounting Office (GAO, 2003) found that high caseloads are one of the leading causes of caseworker turnover. Large caseloads and worker turnover have been found to delay the timeliness of investigations and limit the frequency of worker visits with children, hampering agencies' attainment of some key federal safety and permanency outcomes (GOA, 2003).

Studies also support requiring Department of Health and Human Services line staff to have human service degrees.

2. Studies also support requiring Department of Health and Human Services (DHHS) line staff to have human service degrees, such as Bachelors in Social Work (BSW), and child welfare supervisors should hold a Masters in Social Work (MSW) degree or a bachelor's degree with five years of child welfare experience. The responsibilities of the child welfare worker require skills in engaging and interviewing children and families, assessing the safety of children and the strengths and abilities of the parents, monitoring case progress, ensuring that essential services and supports are provided, and facilitating the attainment of the desired permanency plan for children in a timely fashion (Folaron, Hostetter & Decker, 2003). The assessments and decisions made by line staff often

have profound impacts on the lives of children and their families. Staff needs to be well-trained, guided by skilled and available supervisors, and assisted with adequate and up-to-date technology.

Evidence indicates that pre-service training should be required for all line staff of the Department of Health and Human Services (DHHS) before they carry a caseload of families involved in child neglect or abuse.

3. Evidence indicates that preservice training should be required for all line staff of the Department of Health and Human Services before they carry a caseload of families involved in child neglect or abuse. In addition, preservice training should be followed by close monitoring and supervision. Supervisors who have no current or previous hands-on child welfare field experience should participate in a shadowing experience of no less than two weeks and be mentored by field personnel through hands-on field experience for a period of no less than one year (Vieth et al., 2005).

Within the first year, every staff member, including supervisors, should receive training in diverse assessments, working with families of neglected and abused children, making and supporting foster placements, and cultural and racial sensitivity. New supervisors should receive clinical supervision for at least one year. According to a recent statewide study, it takes approximately two years for new hires in child welfare to learn what needs to be done in their jobs and to acquire the knowledge, skills, abilities, and values to work independently (Ellett, 2001). A statewide study in Indiana found that over half of the workers who had six or more years experience in child welfare services did not feel very competent in case management, collaboration, sexual abuse interventions, or moving children towards permanency (Folaron et al., 2003).

States have created an executive committee to collaborate with the DHHS in the development of strategic plans to enhance the child welfare system.

4. States have created an executive committee to collaborate with the DHHS in the development of strategic plans to enhance the child welfare system, in identifying cutting-edge practices in child welfare, and in serving as a conduit to coordinate communication between the boards and agencies in the state concerned with child welfare issues. The committee is made up of professionals from several different disciplines (e.g., medical, psychiatric, social work) to provide expertise in offering best practices to DHHS and affiliated agencies.

5. States are forming local Child Protection Teams (CPT) with true autonomy and authority to monitor the work of all

services provided to maltreated children and their families. CPTs are multidisciplinary teams composed of professionals who are knowledgeable about child abuse and neglect such as attorneys, judges, social workers, and medical professionals. The argument is that agencies that deal with life and death issues of children and families should have an effective oversight review system. To the extent it is possible, efforts should be made to assure that child protective teams operate consistently from county to county.

Researchers have found that children of color not only enter foster care at a higher rate but they stay longer, leave at a slower rate than White children, and are less likely to be reunified with their families.

6. Researchers have found that children of color not only enter foster care at a higher rate but they stay longer, leave at a slower rate than White children, and are less likely to be reunified with their families. These disparities exist despite evidence that there are "no differences in the incidence of child abuse and neglect according to racial group" (The Pew Commission on Children in Foster Care, 2004, p. 50).

More research is needed to determine what factors are causing the overrepresentation of children of color in the child welfare system. Also, research is needed to assess the cultural sensitivity of assessment or screening tools and procedures, as well as the effectiveness of cultural competence training. Some states are providing funds for an active research agenda to address these issues.

7. States are developing and implementing transitional living services for youth in out-of-home care who are turning 18 years of age or being emancipated from the child welfare system. Transitional living services are intended to assist adolescents with plans for employment, education, housing, health care, and other adult responsibilities.

8. In some states, laws are being amended to require the placing agent to show that the available medical, educational, and psychological information and social history on the birth parents and child has been provided to the adoptive parents. The purpose of these amendments is to reduce the number of disrupted adoptions by apprising adoptive parents of any issues that might suggest a need to seek professional support and services.

9. Increasingly, parents are required to pay child support for children in out-of-home care, in accordance with the parents' ability to pay. The argument is that parents should acknowledge their responsibilities for the childcare through

some level of payment that depends on income level. Parents living on welfare or who otherwise have little or no income may be exempted from this requirement.

10. States are requiring that every child who is found to be a Child in Need of Services (CHINS) be represented by a Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA). Persons in either of these positions must be well-trained, screened carefully, and supported in their work with children by a program certified by established standards. Responsibilities of these positions include conducting independent reviews of a child's situation and submitting formal recommendations to the court. GAL/CASAs generally are responsible for only one to two children to provide adequate time to come to know the children and their families, investigate the child's circumstances, advocate at court hearings through written and verbal presentations, and monitor the family's compliance with the court order (Bilchik, 1997).

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) views GAL/CASA as both a safety net for abused and neglected children as well as an essential ally in delinquent prevention (Bilchik, 1997). The GAL/CASA program is endorsed by the National Council of Juvenile and Family Court Judges and The American Bar Association (The Pew Commission on Children in Foster Care, 2004).

Preventative programs and interventions that educate parents on issues of childhood development and support and strengthen the family unit seem to be the fastest growing programmatic efforts in some states.

11. Preventative programs and interventions that educate parents on issues of childhood development and support and strengthen the family unit seem to be the fastest growing programmatic efforts in some states. Home-based and other community services work in tandem to enhance the strengths of families and to resolve problems that have been identified. Minimal standards for service availability and accessibility are needed to ensure commensurate services from one county to another.   Standards also address issues such as substance abuse, domestic violence, and multigenerational problems that are sometimes overlooked in the assessment and service delivery.

Prevention services are needed to support families before a crisis occurs or before the dissolution of a family. The American Academy of Pediatrics (2001) suggests that support and assistance with parenting skills are often needed, and it recommends that families be referred to parent support

groups, respite care, and home health services as needed.

Another best practice is the use of funding *experts* to assist agencies and departments with grant writing and funding sources.

12. Another best practice is the use of funding *experts* to assist agencies and departments with grant writing and funding sources. States also streamline the processes for determining eligibility and provide incentives for agencies to work together to fund services.

Case managers and other staff who provide direct services to children and their families typically do not have the time or expertise to write grants and identify funding resources. Experts can play a vital role in grant-writing and locating the best funding possibilities; they are especially valuable in interagency funding. That is, many children require multiple assessments and services from different professionals and agencies. Thus, agencies need to be encouraged to "braid" or blend funding to provide services to children. Interagency collaboration needs to be encouraged not only for a more seamless provision of services that extend beyond the expertise and resources of any one agency, but also to make more efficient use of local, state, and federal funding. Nowhere is the need for interagency services greater than for children with disabilities.

States are increasing the availability of Medicaid waiver services to families with children who have disabilities.

13. States are increasing the availability of Medicaid waiver services to families with children who have disabilities. The ultimate goal is to eliminate the lengthy list of families that are waiting for services.

In July 1999, the U. S. Supreme Court issued the Olmstead v. L. C. (Public Law 98-536) 527 U.S. 581 (1999) decision. The Olmstead decision clearly challenges federal, state, and local governments to develop cost-effective community-based services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Many states are not in compliance with the Olmstead decision because of the long waiting lists of individuals with disabilities for Medicaid waivers. Medicaid Waivers, unlike the general Medicaid program, are not an *entitlement.* Rather, individuals must meet specific criteria to be eligible for a Waiver, and a limited number of Medicaid Waiver "slots" are available at any time. Thus, families who apply for services for a child may not receive needed supports for many months, or even years. Yet, children with disabilities often present unique and more severe challenges to parents because of their unusual needs and frustrations. As a result, children with an identified disability are 3.4 times more likely to be maltreated

than children without an identified disability (Sullivan &
Knutson, 2000).

The 2003 Child Abuse Prevention and Treatment Act
Amendments allow Federal Title I Funds to be used to make
improvements in how abuse and neglect cases of children
with disabilities or serious health problems are addressed (see
http://laws.adoption.com/statutes/child-abuse-prevention-and-
treatment-act-capta-amendments-of-1996.html).

14. Foster parent trainings, both preservice and in service,
should be standardized, mandated, and regularly scheduled.
An assessment system needs to be developed to identify the
ongoing training needs of foster parents on an annual basis.

For example, foster parent training and curriculum should be
standardized according to a set of competencies and based on
type of license issued. A system to assess a foster parent's
learning needs should be implemented so that learning needs
can be identified and training can be scheduled as needed. A
monitoring system needs to be in place to ensure consistency
of training delivery across counties.

Researchers find that training of foster parents results in
better care for the foster children, reduces disruption in
placements, improves foster parent retention, and promotes
reunification (Vieth et al., 2005).

15. Increasingly, professional licensing boards and entities
responsible for oversight of all healthcare providers, child
care providers, psychologists, social workers, educators,
attorneys, law enforcement, first responders, and other
professionals who regularly work with children are adopting a
renewable training requirement in child abuse and neglect.

Professional licensing boards have the authority to ensure that
professionals in their respective disciplines have the
education and training in basic theories, practices, and
policies necessary to work effectively with children and
families in the child welfare system. Professional
collaboration and multidisciplinary, cross-system training will
improve the services for abused and neglected children and
their families by aiding professionals in their understanding
of each other's roles and how they each fit into the child
welfare system (The Pew Commission on Children in Foster
Care, 2004).

16. Information-sharing computer systems between agencies improves the sharing of knowledge and data on cases across service providers in the state and provides much more comprehensive data sets for researchers and policymakers who are trying to make improvements in the statewide service-delivery systems. Too often critical data is stored in bureaucratic silos in formats that are virtually inaccessible to researchers and policymakers. Too, child welfare workers complain that 50% to 70% of their time is spent in trying to enter data in antiquated technology (GAO, 2003). Staff also complain that reports are not always understandable, reliable or accurate. Therefore, technology needs to be updated and training on data entry and report writing is essential.

Some states are establishing a research and training institute to conduct and compile research on child abuse prevention and intervention, disseminate information, develop and provide training, and identify and promote best practices models.

17. The literature and some states discuss establishing a Research and Training Institute for the Prevention of Child Maltreatment to conduct and compile research on child abuse prevention and intervention, disseminate information, develop and provide training, and identify and promote best practices models. The institute would provide information and training services to all professionals who work with abused or neglected children.

Discussion and Conclusions

Discussion

As vividly chronicled by Vieth, changes in responses to child maltreatment are long overdue. He cites a study showing that 65% of social workers, 53% of physicians, and 58% of physician assistants were not reporting all cases of suspected abuse.

In this section of the report, ideas for ending child abuse from Vieth et al. (2005) and others in the literature are discussed. As vividly chronicled by Vieth (Vieth, 2005, p. 9), changes in responses to child maltreatment are long overdue. For example, Vieth (2005) cites a 1990 study finding that only 40% of maltreatment cases and 35% of the most serious cases known to professionals were in fact reported to child protection agencies as mandated by law. One decade later, another study finds that 65% of social workers, 53% of physicians, and 58% of physician assistants were not reporting all cases of suspected abuse. A third study of teachers finds that only 11% of teachers would report abuse if students told them that another teacher has touched their genitals.

According to research, there are several reasons why people do not report suspected maltreatment, including but not limited to, lack of evidence, concern about whether the abuse actually occurred, apprehension about ramifications, and a

desire to maintain copasetic relations (Vieth, 2005). Ambiguity in some mandated reporting statutes also contributes to underreporting of child maltreatment. However, even when laws are clear, lack of training among professionals and laypersons on what constitutes maltreatment plays a substantial role in failure to report instances of child abuse (Vieth, 2005).

Even when instances of maltreatment are reported, most reports will not be investigated.

Even when instances of maltreatment are reported, most reports will not be investigated.   Vieth et al. (2005) report that about a third of all reported cases of child maltreatment are ever investigated. Furthermore, the majority of investigated cases are not substantiated, yet a high percentage of these cases end up being reported again and substantiated at a later date. In Missouri, for example, approximately 80% of the child maltreatment cases were not substantiated in a recent study, and yet this large number of initially unsubstantiated victims comprised more than three quarters of the victims that were later reported to child welfare (Drake, Jonson-Reid, Way, & Chung, 2003).

In their *battle plan* for ending child maltreatment, Vieth and his associates unequivocally assert that every university must teach the necessary skills to make high quality reports of maltreatment to students entering professions with mandated reporting.

In their *battle plan* for ending child maltreatment, Vieth and his associates (2005, p. 15) unequivocally assert that every university must teach the necessary skills to make high quality reports of maltreatment to students entering professions with mandated reporting. For example, teachers, social workers, and physicians should have required courses on how to conduct forensic interviews (according to principles discussed under the heading Interventions as Best Practices in this report) and gather objective evidence in circumstances of child maltreatment. In Minnesota, the American Prosecutors Research Institute (APRI) has partnered with Winona State University to adopt this plan for training students entering the human services profession. Vieth et al. also propose that professionals already in practice should be mandated to receive training in investigating and reporting child maltreatment cases. Vieth (2005) states that professions need to…

Front line interviewers must have basic training on child development, linguistics, memory and suggestibility and other issues impacting on the child interview.

"Develop state of the art forensic interviewing courses such as APRI/Corner House's Finding Words. Front line interviewers must have basic training on child development, linguistics, memory and suggestibility and other issues impacting on the child interview. Interviewers must have a thorough understanding of how the dynamics of abuse will impact the interview. An older child, for example, may not

view herself as a victim or may have guilt over her
'compliance' with the act. Irrespective of age, children should
be interviewed as part of a forensic interviewing protocol that
is supported by research." (p. 16).

According to Vieth and his colleagues (2005), there are
several national and state organizations that offer quality
forensic interview training, including the American
Professional Society on the Abuse of Children (1997), the
Cincinnati Children's Hospital Medical Center (2006), and
First Witness (2006). In Minnesota, APRI's National Center
for Prosecution of Child Abuse partnered with a child sexual
abuse evaluation and training center (Corner House) to
develop a forensic interview training program known as
Finding Words (Vieth et al., 2005)**.** *Finding Words* is unique
in training teams instead of individuals, and these teams
include prosecutors. Their argument is that since the
investigative interview may have to be defended in court, the
prosecutor must have the same knowledge of interviewing
skills as investigators. Also, the prosecutor who may call a
child to testify in court must be skilled in asking questions
that a child can answer accurately. The *Finding Words*
training program can be found at:
http://www.ndaa.org/pdf/finding_words_2003.pdf.

The *Finding Words* program teaches a range of topics,
including child development, linguistics, and issues with
memory and suggestibility. During the training, participants
interview a child and receive feedback from other students
who witnessed the interview, and they discuss and role-play
several different scenarios involving hypothetical cases of
maltreatment in terms of different aspects of forensic
interviewing. Believing that every state must have a quality
forensic course that is locally taught, APRI in Minnesota
launched a program in 2003 entitled *Half a Nation by 2010* to
teach other states how to implement a locally run Finding
Words project (Walters, Holmes, Bauer, & Vieth, 2003). This
nationwide program may be found at:
http://www.ndaa.org/pdf/finding_words_2003.pdf. States
that have participated in this program include Georgia,
Illinois, Indiana, Kansas, Maryland, Mississippi, Missouri,
New Jersey, Ohio, and West Virginia.

> The *Finding Words* program teaches a
> range of topics, including child
> development, linguistics, and issues
> with memory and suggestibility.

Vieth observes that universities generally and professional schools in particular (teaching, law, social work, medicine, nursing) are not offering courses that specifically address theories, research, practices, and policies related to child maltreatment.

Vieth et al. (2005, p. 18) note, …"If APRI reaches its goal of completing the project in 25 states by the end of the decade, hundreds of thousands of children victimized by abuse or neglect will be empowered to share their experiences at a much younger age because the system will be better able to address their needs." They also assert that every university must teach child protection professionals (e.g., police, social workers, medical personnel) necessary investigation skills. According to Vieth et al., students should learn: 1) skills of forensic interviewing of all participants (abused, abuser, non-offending parent, other family members) in abuse situations; 2) protocols for interdisciplinary team work; 3) ways of finding corroborative evidence; and 4) how to present evidence in a mock trial. This training is needed by all professionals involved in maltreatment cases, including attorneys, social workers, physicians, nurses, teachers, and other human service staff. Vieth (2005) observes that universities generally and professional schools in particular (teaching, law, social work, medicine, nursing) are not offering courses that specifically address theories, research, practices, and policies related to child maltreatment. Professional schools design a curriculum that addresses a wide range of knowledge and skills rather than a specialized body of understanding and practices. Vieth (2005) cites several well-known professors who attest to the fact that their prestigious schools do not offer any courses that teach students how to work with cases of child maltreatment. He notes that students are not even taught how to conduct forensic interviews and conduct investigations. Instead, professionals are left to learn these skills on the job, and even on the job there is no formal training in most agencies.

Students also must learn how to work meaningfully with families impacted by maltreatment.

Students also must learn how to work meaningfully with families impacted by maltreatment. Intervention with families is very complex and yet essential to prevention and treatment in maltreatment cases, including but not limited to, teaching parenting, marital therapy, developing attachment, reinforcing boundaries, drug treatment, and addressing financial matters. However, these highly specialized skills are not being systematically taught in universities or agencies in courses on child maltreatment (Vieth, 2005).

Vieth et al. (2005) also emphasize the importance of working with the faith-based community. Religion and spirituality play a major role in many families. According to a recent Gallup Poll in America (Princeton Religion Research Center, 2004), 59% of adults nationwide say religion is a very important part of their lives. An additional 26% of Americans say religion is fairly important to them, and 15% of respondents say religion is not very important. Familiarity with religious and spiritual beliefs and practices is critical to cultural sensitivity in working with cases of child maltreatment. For example, the use of anatomical diagrams and dolls may be highly offensive to certain religious denominations, and some faith communities are opposed to traditional medical care or secular counselors.

Familiarity with religious and spiritual beliefs and practices is critical to cultural sensitivity in working with cases of child maltreatment.

In addition, faith communities can assume an important role in child protection. Vieth et al. (2005) point out that religion often plays a vital role in social movements such as their efforts to end child maltreatment. They challenge the faith community, along with human service professionals, to assume the leadership in organizing the various services needed by families that maltreat children to present a more coordinated and comprehensive response to the problem. Presently, services are fragmented and, at best, loosely connected. For example, housing, transportation, childcare, and mental health services typically are provided by separate agencies that have limited if any contact. The fragmentation and lack of coordination of intervention efforts results in inadequate, inefficient, and duplicative services. Moreover, affordable housing often is located where there is no childcare, or mental health and drug treatment facilities are located in areas inaccessible to public transportation needed by families of neglected and abused children.

In addition, faith communities can assume an important role in child protection.

On a larger scale, the lack of any national day care system in America has resulted in what Zigler and Styfco (2000) characterize as a "…hodgepodge of childcare centers, family day care homes, babysitting by neighbors and relatives, for-profits, nonprofits, regulated and underground services" that means several years of *non-care* before a child enters kindergarten. In this regard, Portwood (2005) observes:

On a larger scale, the lack of any national day care system in America has resulted several years of *non-care* before a child enters kindergarten.

> While efforts to support parents and to provide
> them with needed education and/or services
> recognize…that certain resources are required
> to parent effectively, the extent of the multiple

difficulties (e.g., poverty, limited education) that many individuals face is sometimes overlooked. Currently, there are not many programs that seek to prevent maltreatment by helping families to escape poverty. While there are some programs that encourage teen parents to return to school or to obtain further training, this component is often absent from programs targeting older parents…".
(pp. 69-70)

> In response to research on attachment and early bonding, many healthcare facilities have made institutional reforms related to childbirth practices.

Portwood goes on to note that some programs have been developed recently to help parents achieve financial independence; however, these programs have not been evaluated to see if they have effects on child care. Adult caregivers may also be reached through the health care system. In response to research on attachment and early bonding, many healthcare facilities have made institutional reforms related to childbirth practices, such as classes to prepare parents for birth, directly involving parents in the whole process, encouraging lots of parent-child contact from the time of birth, and promoting visits from extended family members (Portwood, 2005). Prenatal visits, perinatal prevention programs, and well-child visits give health care professionals many opportunities to provide education, guidance, and referrals to parents. Training these professionals is essential to the sensitivity and knowledge needed to prevent and reduce child maltreatment.

Conclusions

In conclusion, one of the most, if not the most, powerful tools in the prevention of child maltreatment is public policy (Portwood, 2005; Vieth, 2005), especially in regard to systemic changes in the ecology of child maltreatment. However, the Child Abuse Prevention and Treatment Act (CAPTA), enacted in 1974, remains the sole federal program aimed specifically at child maltreatment prevention (http://laws.adoption.com/statutes/child-abuse-prevention-and-treatment-act-capta-of-1974.html).

As originally enacted, CAPTA defined child abuse and neglect; established the National Center on Child Abuse and Neglect (http://www.casanet.org/library/abuse/nrccan.htm); established basic state grants for prevention and treatment; provided money for demonstration grants to identify, prevent, and treat child abuse and neglect; and founded an advisory

board to coordinate the federal response to maltreatment. CAPTA has been reauthorized several times since 1974, with most of these reauthorizations aimed at expanding the law (broadening the definition of maltreatment). The 1996 reauthorization is particularly noteworthy because several small grant programs were consolidated into a large prevention initiative known as the Community-Based Family Resource and Support (CBFRS) program. CBFRS is the major prevention component of CAPTA, which provides funding of various community-based family support programs designed to prevent child maltreatment, including parenting classes, substance abuse treatment, mental health services, respite care, and domestic violence services. However, Portwood (2005) points out that the impact of CAPTA has been seriously hampered by the lack of adequate funding.

> Another federal policy that could impact child maltreatment is health care reform that is focused on making health care affordable and accessible to all families.

Another federal policy that could impact child maltreatment is health care reform that is focused on making health care affordable and accessible to all families, which could prevent infant mortality and medical neglect. The development of welfare policies that seek to keep children out of poverty and ensure the availability of affordable childcare, transportation, and housing would have measurable impact on reducing child maltreatment.

In this regard, a particularly novel approach is to create family resource centers that have services available from a number of different agencies, a one-stop shopping center where parents can go and receive a range of needed services. These centers can encourage families to use services that they would not seek on their own. Having a case manager available to coordinate the different services from various agencies can make this effort more efficient and effective (Vieth et al., 2005). There is evidence that these centers are effective in reaching several families, but they are not used by the more isolated families (Vieth et al., 2005).

> Foremost among the promising approaches to child maltreatment prevention are parent education programs that contain a home visiting component.

Foremost among the promising approaches to child maltreatment prevention are parent education programs that contain a home visiting component (Portwood, 2005). According to Vieth et al. (2005), the programmatic factors that contribute to the success of these education interventions include: 1) initiation of services before or as close to birth of the first child as possible, 2) services that focus on the child's particular developmental stage, 3) sufficient time

commitments (i.e., more than six months), 4) an emphasis on social supports and the skill needed to asses these supports, 5) a balance of home- and group-based alternatives, and 6) recognition of cultural differences in family functioning and the nature of parent-child interactions. In contrast, ineffective programs tend to be implemented poorly, are insufficient to meet needs, and lack enough duration.

Home visitation is considered possibly the best single intervention devised so far. Hawaii offers home visitation to families at birth in their hospitals, where all residents have health care services. Other states offer screenings in the hospital to identify potentially dangerous familial conditions that may lead to maltreatment of children. There is substantial evidence in support of home visitation and early identification of families that maltreat children (Vieth et al., 2005). Evidence indicates that children who have been in home visitation programs are healthier, have less developmental delays, and achieve more than their counterparts.

Churches can and do play a major role in home visitation and providing social support networks more generally for parents. Every parent needs support in raising children and many parents who end up maltreating children do not have resources for support. Churches often act as the surrogate family for parents who need resources and support.

Veith et al. (2005) indicate that there are two particularly notable parent education and support programs. One is the Olds model (Olds, Henderson, Chamberlin, & Tatelbaum, 1986), and the other is the Healthy Families Model (Breakey & Pratt, 1991). Both programs have received extensive empirical support and have been used for several years in various settings by different practitioners. These programs rely on early and frequent home visits, provision of care within the context of a therapeutic and supportive relationship, established curriculum, modeling of effective parenting, and connecting families to the appropriate services in the community.

Vieth et al. (2005) also note that many factors combine to contribute to child maltreatment. It follows therefore that a combination of interventions at different levels (e.g., parent-child attachment, marital counseling, childcare, transportation, employment) are needed to address the complexity of this social problem. Solutions are not simple,

cheap, or quickly achieved. They require the coordination of services from many interdisciplinary professionals at several different agencies over a protracted period of time.

One of the most critical aspects in intervention is the coordination of services among staff within and between agencies. Far too often families and children receive fragmented and incomplete services because professionals work in isolation from each other. There needs to be a case manager that makes sure that interventions are systematically planned and implemented through the coordinated efforts of professionals involved in a case. The family resource centers discussed earlier are an excellent example of making sure coordination of services actually occurs.

Another critical aspect of intervention is the focus or emphasis of the efforts. One of the most if not the most essential intervention is establishing relationships. The attachment literature makes it clear that children need to attach or bond to an adult to feel secure, and this security is necessary to social development (Bowby, 1988; Cicchetti, 1989). Without attachment, children have delayed development, psychological problems, and social difficulties that continue into adulthood (Hanson & Spratt, 2000). Children also must have direct services, such as therapy or group counseling, rather than services being provided only to parents. Child assault services such *good-touch/bad touch* or *go tell* in schools are worthwhile, and should be encouraged, but they should not be viewed as alternatives to other prevention efforts such as home visitation, screening at birth in hospitals, and family service centers. Many children will not report abusers for a variety of reasons, especially caregivers.

Prevention and intervention are further complicated by the dearth of research on efforts designed to reduce and eradicate maltreatment of children.

Prevention and intervention are further complicated by the dearth of research on efforts designed to reduce and eradicate maltreatment of children (Portwood, 2005). Moreover, existing studies tend to be plagued with methodological problems, including the use of unverified measures (Portwood, 2005). Published evaluations of programs typically provide little or no information about program components and processes that led to outcomes. Many promising interventions have yet to be empirically examined. As observed by Melton (2002), child protection policy is largely based on untested assumptions and anecdotal accounts from practitioners.

Fortunately, a thorough and comprehensive set of guidelines (attached) on evaluating Child Advocacy Centers (CACs) has been written by Jackson (2004).

Fortunately, a thorough and comprehensive set of guidelines on evaluating Child Advocacy Centers (CACs) has been written by Jackson (2004). Her expose presents necessary details in easily understood terms and although it focuses on CACs, it can be used as a guide for program evaluation more generally. It is a valuable model for conducting much needed program evaluations in the future. Program evaluations are essential to distinguishing *best practices*. Ultimately, at issue is whether programs are effective in reducing and eradicating child maltreatment, and effectiveness must be determined objectively with rigorous methodology. Anecdotal accounts and conventional wisdom are not reliable and valid enough to be the final word or basis upon which to make decisions about implementation or continuation of programs that are costly and may be ineffective, or even harmful. The consensus in the professional literature in several fields is that evidence-based practice is the goal of social intervention (Rossi et al., 1999).

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