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The Provision and Utilization of Mental Health Screenings in New York State Child Advocacy Centers: A Statewide Survey

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Child Advocacy Centers (CACs) were designed to facilitate collaboration among agencies that are involved in the investigation of suspected cases of child abuse and neglect (Cross, Jones, Walsh, Simone, & Kolko, 2007). Prior to the establishment of the CAC model, there was concern that children were likely to be seen by staff at multiple settings and, therefore, had to repeat their story each time they met with a new investigator (i.e., law enforcement, medical, CPS) or professional involved with the care and treatment of the child. This process very possibly contributed to the trauma experienced by child abuse victims. Moreover, the information obtained from the child was not routinely shared between agencies and efforts were not always coordinated, resulting in extraneous obstacles and undue burdens with regard to achieving a successful outcome for the children involved (Jaudes & Martone, 1992).

To alleviate this repetition and lack of coordination, the CAC model was established with the expectation that it would improve child forensic interviewing processes following allegations of child abuse. Some features of the CAC model include coordination among multiple investigations, child-friendly interviewing locations, state of the art audio and video equipment (for some), and limiting redundant interviewing (Newman, Dannenfelser, & Pendleton, 2005). The CAC model is designed to bring the system to the child in a seasmlesss one-stop shopping experience, rather than dragging the child through the system (Wolfteich & Loggins, 2007).

Once the law enforcement officer or the child protection investigator brings the child to the CAC, a multidisciplinary team investigation (MDT) begins. The process includes a forensic interview of the child and the provision of core services. These services must minimally include a medical exam or treatment and specialized trauma-focused mental health and child victim advocacy. The interviews conducted within the CAC must be made by a trained interviewer who is part of the MDT. The interview needs to be observed by other members of the MDT who could benefit from the information, thus reducing the need for additional interviews. The interview is observed from behind a one-way mirror or via closed circuit video equipment installed in the interview room.

The first CAC was created in 1985 (Newman, Dannenfelser, & Pendleton, 2005). Today, there are nearly 800 CACs nationwide (National Children's Alliance [NCA], n.d.a). Most of the children brought to CACs are suspected victims of sexual abuse. Data from 2013 reveal that of the 294,000 children seen at CACs nationwide, 62% were suspected victims of sexual abuse, compared with the 17% suspected victims of physical abuse and the 7% that were suspected of being neglected (NCA, 2013a). The remaining cases comprised witnesses to interpersonal violence, drug endangerment, and other miscellaneous maltreatment experiences.

The vast majority—if not all—children seen at CACs are suspected of having suffered the kinds of adverse childhood experiences associated with mental health problems. These children, especially those who have endured sexual abuse, are likely to have elevated rates of mental health problems at the time of the investigation (e.g., Briggs & Joyce, 1997; Cheasty, Clare, & Collins, 1998) and an increased risk of developing a range of psychopathologies in the aftermath of the abuse (for those who were abused), including PTSD, depression, anxiety, and dissociation (e.g., Maniglio, 2009). Untreated, the effects of child abuse and neglect can profoundly influence the victims' physical and mental health, ability to regulate emotions and impulses, achievement in school, and the interpersonal relationships they form as children and as adults (Institute of Medicine and National Research Council, 2014).

Moreover, children identified as at risk of one type of maltreatment are likely to be at risk of other types in light of the data on polyvictimization. For example, in a nationally representative sample of 4,053 youth, Turner, Finkelhor, and Ormond (2010) found that almost 66% of the children were exposed to more than one type of victimization, 30% experienced five or more types, and 10% experienced 11 or more different forms of victimization in their lifetimes. They concluded that "poly-victims comprise a substantial portion of the children who would be identified by screening for an individual victimization type, such as sexual assault or witnessing parental violence" (p. 323).

Children seen at CACs who are not found to be victims of childhood maltreatment may still have untreated mental health issues due to other life stressors such as poverty, bullying, exposure to community violence, and a host of other bio-psychosocial factors that impinge on children.

Therefore, it should come as no surprise that another core function of CACs is to ensure that clients and their non-offending family members receive the appropriate mental health services (NCA, n.d.b). According to the standards set

forth by the National Children's Alliance (NCA), the national association and accrediting body for CACs, children seen by NCA-accredited CACs must have specialized trauma-focused mental health services routinely made available on site or through linkage agreements at no cost to the children or non-offending family members. Specialized trauma-focused services include, but are not limited to, trauma-specific assessment, including a full trauma history and use of standardized assessment tools. NCA (2011) acknowledged that without such a strict standard for intervention, many traumatized children seen by the CACs "will suffer ongoing or long-term adverse social, emotional, and developmental outcomes that may impact them throughout their lifetimes" (p. 24).

Despite the standards set forth by the NCA and the emphasis placed upon their significance, not all children seen at a CAC receive mental health services. For example, based on a set of data provided by the NCA (2013b), New York CACs served a total of 17,339 children in 2013, which is 6% of the national total of 297,761. Of those served by New York CACs, 51% of the children received counseling, compared with the national average of 27%, and an additional 24% of the children seen at New York CACs were provided with referrals to therapy, compared with the national average of 37%. These data suggest that there might be some limitations in the methodologies employed by CACs with respect to the screening and assessment of mental health problems of referred children.

The Current Study

The current study was designed to survey New York State Child Advocacy Centers (CACs) regarding their general mental health or trauma-specific screening procedures, or both, in order to determine the types of screening procedures being utilized and the degree to which they are found to be helpful during the initial investigation and evaluation process. We also wanted to identify some of the barriers to provision of mental health screenings and referrals in light of their importance for the well-being of children. Before appropriate referrals for mental health services can be made, there needs to be a process of identifying which children have mental health needs that require further assessment or mental health treatment.

Methods

Identification of Child Advocacy Centers

A list of all New York State CACs was provided by one of the authors and was used to identify the universe of potential survey participants. This resulted in a sample of 40 CACs, each in a different county (not all counties had a CAC that provided direct service and no county had more than one). The name of the director of the CAC and his or her contact information was included on the information provided.

Study Procedures

An introductory letter was sent via e-mail to the 40 New York State CAC directors or contact persons inviting them to complete a brief survey via an online survey software, Qualtrics. The letter explained that the survey was confidential but not anonymous. Between February 21, 2014, and April 14, 2014, 38 of the 40 potential participants completed the survey (a response rate of 95%).

The Survey

The 22-item survey asked the respondents to report on the CAC's mental health and trauma screening procedures for the children seen at their CAC. The survey asked a series of specific questions in the following four general topic areas: (1) What proportion of children evaluated at a CAC was screened for mental health problems, and what were the barriers? (2) What methods and measures were used for conducting mental health screenings? (3) How were the results of the mental health screenings shared and utilized? And (4) How satisfied were the CAC directors with the process of conducting mental health screenings?

Results

To address the first question, what proportion of children evaluated at a CAC was screened for mental health problems and what were the barriers, we found that all but two of the agencies offered mental health screenings to at least some children, and around 70% of the CACs reported providing on-site mental health/trauma screenings for at least half of the children seen at their CAC. None of the responding CACs provided mental health/trauma screenings to every child seen at the CAC. Table 1 presents reasons why a child might not have been administered a screening measure.

Table 1.

Reasons a Child Not Screened
(more than one reason could be endorsed)

Reason	N	%
Child or family refuses services	25	65.7
Child is too young	19	50.0
No disclosure of abuse	10	26.4
Lack of CAC resources	8	21.0
Already receiving services/screened	4	10.5
Only upon request	1	02.6

Almost two thirds of the respondents reported that some families refused assessments, and one fourth reported that when no abuse was found, a screening might not be conducted. One half reported that screenings were not conducted because the child was too young. A fifth reported lack of resources as the reason for screenings not being conducted.

With respect to the second research question, what methods and measures were used, we found that the vast majority of survey respondents (80%) reported that screenings were conducted by professionals from a wide range of mental health backgrounds. A few notable exceptions were reported, wherein screenings were conducted by law enforcement (one agency), an advocate (two agencies), medical personnel (one agency), or by child protective services (two agencies).

One half of the survey respondents reported using what they considered to be a validated screening tool or a validated trauma measure, or both. Within these 19 agencies, eight different tools were reportedly used as being valid measures.

As we could locate no single definitive listing of validated measures, we undertook a search of every listing of measures that are considered valid. We searched 13 databases of measures, including the following: The National Center for Posttraumatic Stress Disorder, the National Child Traumatic Stress Network, the Substance Abuse and Mental Health Services Administration, the California Institute of Mental Health. We created a combined listing of every measure that had been included in at least one database. As depicted in Table 2, of the eight measures reported by survey respondents as valid measures, six could be considered valid measures of child's behavior and functioning (i.e., were on at least one database) while two measures were not listed on any of the databases. One measure was not a measure of child behavior or functioning (the Trauma History Questionnaire).

Table 2.

Trauma/Screening Measures Utilized and Listed as "Valid" by Respondents

Measure	#Agencies	#Database
Child and Family Traumatic Stress Intervention (CFTSI)	2	0
Child PTSD Symptom Scale (CPSS)	4	5
Child Report of Posttraumatic Symptoms (CROPS)	2	2
Mood and Feelings Questionnaire (MFQ)	1	1
Posttraumatic Stress Disorder Reaction Index (UCLA-PTSD RI)	4	6
Trauma History Questionnaire (THQ)	6	3
Young Child PTSD Checklist (YCPC)	3	0
	4	2

The third question of the study asked how the results of the mental health screenings were shared and utilized. Agencies reported that results of the mental health screening were often, but not always, provided to the other members of the MDT team, as well as others outside of the MDT.

As shown in Table 3, two thirds of the agencies that conduct screenings (i.e., 36 of the 38 respondents) reported sharing the results with members of the multidisciplinary team. The same number reported that they shared the results with the family, and almost half of the agencies reported sharing the results with the child. Only four agencies (11.1%) said that they did not routinely share the results.

Table 3.

Recipient of Results of a Mental Health Screening (n=36)

Recipient	N	%
Multidisciplinary team (MDT) member	23	63.8
The child	16	44.4
The family	22	61.1
Outside agencies	09	25.0
Results are not routinely shared	04	11.1
Mental healthcare provider upon referral	02	05.5

We also asked survey respondents about the proportion of children who were referred for mental health treatment based on the results of the assessments. These data are presented in Table 4.

Table 4.

Percentage of Children Referred for Mental Health Treatment Based on Screening (n=36)

Percentage	N	%
100%	3	08.3
75% to 99%	11	30.6
50% to 74%	15	41.7
25% to 49%	4	11.1
1% to 24%	2	05.6
0%	1	02.7

One agency reported that no children were referred based on the assessment process, six agencies reported that between 1% and 49% were referred, 15 agencies reported that between half and three fourths of the children were referred based on the results, and 14 agencies reported that three fourths to all of the children were referred. We did not ask what the reasons were for not referring children.

The final question in this study related to how satisfied the agencies were with their mental health screening assessment procedures. First, we asked if the measures used were helpful for identifying children with mental health needs. A little over half (52.8%) of the responding CACs reported that they found the mental health screening measures to be "very important" for identifying children with mental health issues, and the remaining respondents reported that the measures were only "somewhat important." Next, we asked if the screening process as a whole was helpful for determining whether mental health services were needed. About half of the agencies found the process to be "very helpful" (48.4%), and about half reported it to be only "somewhat helpful" (48.4%). One agency reported that the screening process was only "a little helpful."

Discussion

Thirty-eight of 40 CACs in New York State responded to a survey about the mental health screening and referral process for children. Several notable findings were identified in the survey.

First, no agency reported screening all of the children. Thus, the agencies were missing an important opportunity to determine whether children—already at risk—were suffering from mental health problems and were in need of services. The reasons that screenings were not conducted on all of the children included the family resisting or declining the offer of a screening, the children being perceived to be too young to be screened, no disclosure of abuse, and lack of resources. Each of these reasons suggests an area for improvement in light of the high likelihood that all children referred to CAC may be at risk for mental health issues regardless of the status of the abuse investigation.

The most often-cited reason for not providing a mental health screening was that families refused assessments. This suggests that families are being presented with the opportunity for a screening without sufficient information to help them understand the risks and benefits of such a screening. They may be declining for reasons that can be overcome with sufficient information (e.g., fear of labeling the child, fear of traumatizing or stressing the child). Regardless of the reason, it is possible that the concerns could be resolved or overcome with sufficient information and engagement from the staff. There are known available engagement strategies and motivational interviewing techniques that may help to engage families and improve compliance with the mental health screening process (e.g., Gopalan, et al., 2010). Data were not collected about what process is used when parents refuse to have their children screened; however, it seems likely that in at least some of these situations, greater attention to how the screening is described and how initial resistance is handled would result in a higher proportion of children being screened.

The second most-often cited reason (half of the agencies) was that the child was too young to be screened. This suggests that information about appropriate screening methods for young children is not available to the staff at many CACs in this state. This is unfortunate because it is critical to assess young children for mental health problems, and problems identified earlier are more likely to be addressed than problems that remain untreated. Early detection is vital for achieving positive mental health outcomes (Albers, Kratochwill, & Glover, 2007). Moreover, a recent review of the literature identified four mental health screening measures designed specifically for children ages 3–5 years old that were reliable and valid (Feeney-Kettler, Kratochwill, Kaiser, Hemmeter, & Kettler, 2010). The findings in our data suggest that information about appropriate measures for young children should be routinely made available to CAC staff responsible for screening children to ensure that young children are not unnecessarily omitted from the process.

The third most-cited reason (one fourth of the agencies) was that no abuse was found. Thus, once the CAC performed its primary function of investigating child abuse allegations, some failed to perform an equally important function of screening children for mental health problems. These data reveal a misunderstanding about the potential for mental health problems to be present in the sample of children seen at the CAC, even those with unfounded abuse allegations. That is, other mental health issues might be identified if the child were screened at the CAC.

Another significant finding was that not all of the supposedly valid measures used to screen children seen at CACs actually were valid. There is no single listing of valid measures for assessing mental health of children. In fact, we identified 13 different compendia of such measures. Of the eight measures mentioned by the survey respondents as valid measures, six were listed in at least one of the compendia.

Also notable is that the results of the mental health assessments that were conducted at the CACs were not consistently shared with the team, the family, the child, or outside mental health providers. Reasons why these data were not routinely shared need to be investigated and suggest an important area for future work.

When asked what proportion of children was referred for treatment based on the results of the survey, a range of responses was provided. Three agencies said all children, while one agency reported that no children were referred based on the assessment process. The remaining agencies reported anywhere from 1% to 99%. In light of such variation, it might be helpful to understand some of the reasons why referrals are not made. It is likely that not all children need to be referred but equally likely that some children who should be referred are not.

A final notable finding is that only half of the agencies reported that the screening process was "somewhat" helpful for identifying children with mental health needs and about half reported that that the process itself was only "somewhat helpful" overall. Future research should endeavor to understand the myriad of reasons for this high rate of mid-level satisfaction.

Limitations

This survey had a high response rate (95%) but represents only 38 agencies, all of which are in a single state. It is important not to overgeneralize the findings. Replication of the survey in other states would go a long way to determining whether there are geographical patterns with respect to the mental health screenings of children in CACs

and the extent to which some of the troubling patterns observed here are reflected in national data as well. There is no reason to believe that staff working in New York State CACs are more likely to have difficulty engaging families or identifying appropriate measures. For that reason, the data should be considered by CACs around the country as potentially reflective of their own practice and can be used to spur self-analysis and improvement.

Implications and Directions for Future Treatment and Research

The following recommendations are offered:

First, all children and youth should be offered a screening for mental health problems regardless of the result of the MDT investigation because there could be other reasons for mental health problems in the child, regardless of a finding of maltreatment or disclosure of maltreatment. Just because a child was not validated as having been abused or neglected does not mean that the child did not experience maltreatment or inadequate parenting or adverse childhood experiences that may result in mental health issues. The investigation process itself may be a trigger for adverse experiences of the child, also suggesting that the child could benefit from mental health screening or treatment, or both.

Second, valid mental health screening tools should be made available and used by CACs. A compendium of possible measures by age of child, fee, length of time to administer the measure, scoring options, and so forth needs to be included in the compendium to facilitate the selection of proper measures by CAC staff.

Third, mental health screening tools specifically for children under age 6 should be made available and used by CACs. There is no need for this very young population of CAC clients to be omitted from the screening process.

Fourth, all staff responsible for conducting mental health screenings or making referrals for screenings at CACs should be trained to discuss their purpose and importance to decrease the likelihood of families refusing to cooperate.

Fifth, a qualified mental health practitioner—or someone supervised by such a person—should conduct the screenings and interpret the results whenever possible.

Sixth, CACs should be provided with information about evidence-based treatments (when available) and information about best practice when evidence-based treatment is not available. This information is helpful for treating children of different ages and developmental levels with various mental health issues and can be incorporated into their practice for treatment and for referring to treatment in the community.

Seventh, the National Children's Alliance should consider conducting a national survey to determine the extent to which the findings from this survey are applicable to other states across the country.

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Child Advocacy Center Survey

What's New and Who's Doing It: Implementing an Agencywide Resiliency Program

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Child abuse professionals know firsthand the impact their work can have on staff and teams. The term vicarious trauma is used to describe the effects of this work on individuals who are repeatedly exposed to the trauma of others. In child welfare organizations, where staff is repeatedly exposed to the stories of child abuse, the resulting trauma can be considered an occupational hazard (Bride, Radey, & Figley, 2007).

The American Counseling Association's Traumatology Interest Network (2011) defines vicarious trauma as "the emotional residue from hearing other people's trauma stories and becoming witness to the pain, fear, and terror the trauma survivor endured." Being witness to another's pain can cause the individual to see the world differently. Some individuals internalize the impact and suffer silently; others externalize it, impacting their co-workers and the families they work with. Many simply leave the field. In fact, the impact of exposure to trauma is a significant factor in the turnover among child welfare caseworkers, for whom the average duration of employment is less than two years (Salus, 2004).

In a study of 109 agencies in Texas serving victims of domestic violence, sexual assault, and child abuse, managers were asked what signs of burnout or secondary traumatic stress they observed in workers. Although many observed signs of stress in their staff, most commonly negative attitude (69%), managers stated that they did not know what they could do about it (Busch-Armendariz, Kalergis, & Garza, 2009). Most initiatives on compassion fatigue or vicarious trauma focused on self-care, not on what the organization could do to help its workers.

The effects of trauma influence an organization's identity and worldview in the same way that an individual's are influenced by personal trauma experience. According to Hormann and Vivian (2005), just as we intervene with an individual who has been traumatized, it may be necessary to intervene in an organization to enhance resilience. When an organization acknowledges the impact of trauma in the workplace and addresses it, stress decreases (Koeske & Koeske, 1989). Strengthening victim service providers' resilience will have a positive effect in the services they deliver (Lord & O'Brien, 2009).

Development of a Research-Informed Model

The Organizational Resiliency Model (ORM) was designed to help child abuse organizations address secondary traumatic stress in their staff. It was developed as a strengths-based, evidence-informed product, incorporating end-user involvement from beginning to end. The model resulted from a collaboration of 83 educators, researchers and academicians, and practitioners with experience in the child welfare field, victim services, curriculum development, and resiliency. The most critical partners and end users were 12 pilot sites: six children's advocacy centers (CACs), four court-appointed special advocate (CASA) programs, one program with both CAC and CASA components, and one state child protective services agency.

The pilot sites represented diverse geographic areas, and together they served more than 16,000 children under the age of 17 who had experienced sexual abuse, physical abuse, or neglect, or who were witnesses to homicide or violence. Two people from each pilot site were designated as "resiliency coaches," at least one of whom was in a management position with the authority to implement the model. The 24 resiliency coaches had a collective 374 years of experience in children's services, averaging 16 years each.

The model is a strengths-based approach that includes five core elements: Self-Knowledge, Sense of Hope, Healthy Coping, Strong Relationships, and Personal Perspective and Meaning. Policies, supervisory techniques, and training are used to implement specific strategies that support each element. Elements and their research bases are described as follows (Figure 1):

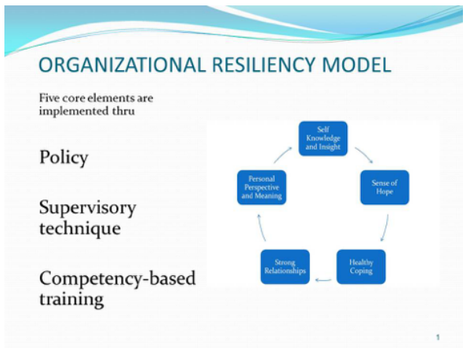

Figure 1. The Organizational Resiliency Model

Element 1: Self-Knowledge and Insight

People who can draw on self-knowledge and insight as a source of resiliency have self-esteem, a sense of control, and independence. A source of self-esteem can be one's own

pride in competence or ability to do the work they are doing. Research supporting this includes Bednar's (2003) findings that child welfare workers most likely to remain in their position despite burnout were those who came to the work with a sense of personal and professional mission, were well-matched to their position, or had flexibility to move to a more suitable position. Dickinson and Painter (2009) note the need for realistic recruitment strategies that accurately portray skills and attributes necessary for work and job previews, including impact of the work.

Element 2: Sense of Hope

A sense of hope means having optimism, along with a sense of humor and the ability to have fun. Optimism builds on the sense that adversity will be overcome and that action can be taken to affect outcomes. Humor and laughter help balance the negative aspects of the work.

The research basis for optimism is the landmark Kauai Longitudinal Study (Werner, 1982, 1993), a 40-year project that followed the development of 698 children born on the Hawaiian island of Kauai in 1955. The children were exposed to serious risk factors including perinatal stress, poverty, parental mental illness, alcoholism, chronic family discord, and family disruption. Despite these adversities, by age 32 one third of the high-risk children grew into competent, confident, and caring adults. A central factor that contributed to effective coping in adulthood appeared to be a feeling of optimism and hopefulness, a belief that adversity could be overcome.

Applying this concept of optimism and hope to the workplace, Peterson and Luthans (2003) studied 59 organizational leaders and found that high-hope leaders had more profitable work units and better satisfied employees who stayed longer than did the low-hope leaders.

Element 3: Healthy Coping

Organizations can contribute to healthy coping by acknowledging that the work affects child abuse professionals at a basic level (Senge, 1990). By acknowledging the impact of this work on staff, the organization helps normalize the effects of the work, provides a supportive environment, and gives permission for self-care (Bell, Kulkarni, & Dalton, 2003). A supportive organizational culture allows time for vacations, creates opportunities for varied caseloads, and provides time off for self-care activities.

Supervisors who acknowledge the impact on their workers are able to take steps to address negativity and change the organizational culture to one that supports resiliency. Workers' well-being, organizational commitment, and job satisfaction improve when they receive support for their emotional needs and job-related stressors from their supervisors (Mor Barak, Travis, Pyun, & Xie, 2009). Supportive supervision is a key factor in child welfare workers who are exhausted yet satisfied with their jobs (Stalker, Mandell, Frensch, Harvey, & Wright, 2007). The cornerstone of staff retention is the supervisory relationship (Yankeelov, et.al. 2009), which serves as a catalyst for regular evaluation of employee functioning, routine discussions of healthy coping, and adaptation of the work environment as needed to support healthy coping.

Element 4: Strong Relationships

Strategies for this core element focus on what the organization can do to strengthen relationships among staff and to identify obstacles to the role of relationship building in the workplace. These strategies are grounded in research about the importance of an organizational culture that supports workers, even while the work they are doing can have a negative impact.

Teams, for example, enhance the social networking aspect of building resilience and provide a training ground for better external collaboration (Munroe, et al., 1995). The amount of time collaborating with other professionals has been associated with increased satisfaction (Silver, Poulin & Manning, 1997). One study of child welfare workers found that those who felt included in decision making were less likely to disengage from their work (Travis & Mor Barak, 2010; Travis, Gomez, & Mor Barak, 2011).

Element 5: Personal Perspective and Meaning

Numerous references in the psychology and social work literature point to seeking meaning in one's working life as a source of resilience for those who persist, endure, and thrive in this work (Collins, 2007). Collins (2008) reported on two surveys of social workers in the United Kingdom that revealed high job satisfaction, in part due to making a difference in the lives of others and the community and to "being valued."

Results of the Pilot Test

After implementing the Organizational Resiliency Model for up to six months, resiliency coaches reported that 534 staff and 493 volunteers were exposed to ORM strategies. Signs of success reported by participants included the following:

- Increased discussions about stress and resiliency with colleagues and supervisors
- Interest in training on resiliency or compassion fatigue
- Increased opportunities for social events with colleagues
- Increased offers of flex time and mental health days

Seventy percent of resiliency coaches reported a reduced perception of turnover among their staff. Moreover, the coaches themselves gained a new perspective: In learning

how to build resiliency in others, they gained new insight into methods of sustaining their own resiliency:

> *Sometimes the vicarious trauma or the compassion fatigue is normalized. Now I have a greater level of advocacy about the need for this that is non-negotiable. That level of enlightenment opened other options for me that had not been on my radar.*

Eighty-three percent of the coaches reported that it was extremely likely that the model would remain an integral part of their organizations' operations.

Of course, the stressors affecting child abuse staff and volunteers are not limited to traumatic events. During the 8-month pilot period, for example, six of the 12 sites experienced budget cuts resulting in layoffs or mergers resulting in staffing changes. Nonetheless, resiliency coaches reported greater confidence in their ability to counter the risks from high caseloads and organizational change:

> *The stresses are still here, and in fact are greater. They're the highest in my tenure in this business. Would it have been worse if we didn't have this program? Absolutely, there is no question in my mind.*

Recent Research Supporting the Model

Since the Organizational Resiliency Model was conceived, research continues to support the theoretical basis for the model. In addition, practices associated with this research provide more examples of how to actualize the five core elements.

Gratitude and happiness are two ways to build strengths in the element of sense of hope. These attributes emerge from the positive psychology movement and stand on their own as strong foundations for resilience. The Greater Good Science Center (GGSC) at the University of California Berkeley is doing extensive research in this area, linking the practice of gratitude to a sense of well-being (Emmons, 2008). In fact, based on its research, the GGSC offers a full course, entitled The Science of Happiness.

The practice of mindfulness represents four decades of research and practice. Its focus on intention, attention, and attitude has strong ties to sense of hope and healthy coping; its focus on having a personal vision, goal, or aspiration––and living consistently with that––aligns with the self-knowledge and insight element of the ORM.

In a pilot study of resilience in nurses and midwives, Foureur and colleagues (2013) found that mindfulness practice helped further a "sense of coherence" in subjects, a process that aligns with the ORM element of personal perspective and meaning (i.e., knowing why you are doing the work). Similarly, Streb's team (2014) found that exploring the connection between a sense of coherence and high resilience offers promise in reducing PTSD symptom severity in paramedics. Related research by Samios and colleagues (2013) linking "compassion satisfaction," or feeling good about one's work, to resiliency also supports the element of personal perspective and meaning. Finally, meditation, deep in-practice wisdom, has a growing body of research to demonstrate its efficacy in supporting two ORM elements: healthy coping and personal perspective and meaning (Goyal, et al., 2014).

The Organizational Resiliency Model provides a rich starting point for continuing evaluation of the model and its usefulness to child abuse organizations. Findings showed that the ORM provided leaders with tools and knowledge to help their staff, but does using the ORM actually build resiliency? Further replication, implementation, and evaluation will bring us closer to a true evidence-based model.

The Organizational Resiliency Model In Practice

Since being part of the pilot for the ORM, the National Children's Alliance (NCA) and Children's Advocacy Centers (CACs) have continued to promote and implement the model. NCA is the national association and accrediting body for nearly 800 CACs and 49 state chapters. The mission of NCA is to help local communities respond to allegations of child abuse in ways that are effective and efficient and put the needs of child victims first. To achieve this mission, NCA recognizes that the health of service providers and a positive organizational climate directly impact service delivery to children and families (Glisson & Green, 2011).

> **The abuse of children should not lead to trauma in adults trying to help them.**
>
> **— Coach, Organizational Resiliency Model pilot site**

NCA became invested in the Organizational Resiliency Model out of a growing concern for high rates of turnover in Children's Advocacy Center staff and multidisciplinary team (MDT) members plus the lack of a system-wide, evidence-based response to trauma exposure. Moreover, acknowledging the accumulating evidence regarding the impact of chronic trauma exposure on child abuse professionals, NCA has included identification and response to vicarious trauma in its recently revised National Standards for Accreditation for Children's Advocacy Centers, which require CACs to promote MDTs' "well-being by promoting access to training and information on vicarious trauma and building resiliency" (NCA, 2015).

In recent years, CACs have promoted self-care of the individual as a way to combat vicarious trauma and burnout. However, little has been discussed regarding ways in which organizations can implement practices and policies that foster resiliency in the workforce. NCA chose to promote the Organizational Resiliency Model not only because it creates a "culture" of resiliency but also because it is based on a thorough literature review that identifies factors associated with resiliency.

The Baltimore Child Abuse Center (BCAC) was an early adopter of the Organizational Resiliency Model. BCAC serves approximately 1,000 children and families who allege abuse each year. BCAC has a staff of 22 individuals who perform a variety of jobs, including on-call crisis work at night, on weekends, and on holidays to respond to allegations of child abuse. Every individual employed at the Center has been exposed to the trauma, whether it is witnessing children and their families arriving in the Center's lobby or conducting forensic interviews.

In 2013, two BCAC representatives participated in Building Resiliency, a training program designed to promote the ORM. (For more information, please visit www.ovcttac.gov/ResiliencyTBR.) After sharing what they'd learned with the rest of the center's management team, the representatives brainstormed and developed various ideas and activities to support the model. The management team agreed to set aside 30–45 minutes during the monthly staff meeting to carry out these activities with the goal of fully implementing the program at their center. Figures 2–4 are some examples of program activities.

Self-Knowledge and Insight

The BCAC resiliency coaches customized a Jenga®-type game in which players removed a block from the tower for every negative aspect of their work and then rebuilt the tower using blocks representing positive resiliency strategies. (Visit https://www.youtube.com/watch?v=RBwQhjXhcy8 to see the game in action!)

Sense of Hope

Staff illustrated answers to the question, "What gives you hope"? on t-shirts. The shirts were hung above the center's intake board to remind staff members of their hopes and positive thoughts (see Figure 5).

Healthy Coping

A review of agency policies and practices resulted in a decision to avoid scheduling forensic interviews on Friday mornings, allowing time for staff to attend meetings or trainings or to catch up on their work before the weekend. Cook-offs focus on different food groups and allow staff to taste and savor a variety of healthy foods. Zumba®-type classes help staff blow off steam through strenuous (but fun) exercise.

Figure 2. A board in the kitchen explains each element and suggests appropriate activities.

Strong Relationships

Staff members were given a sheet of paper with instructions to write their name and describe themselves in words or drawings. Staff added positive things on one another's papers, which then were hung in their respective offices.

BCAC schedules progressive dinners and monthly happy hours away from the worksite; MDT partners are invited and often attend. Holiday potluck luncheons at the center allow staff to mix and mingle with their co-located colleagues.

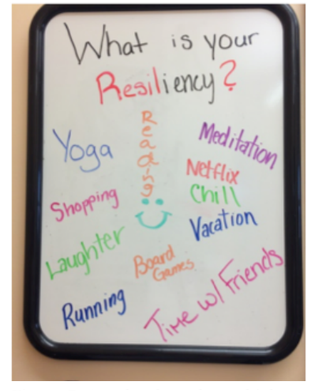

Figure 3. Another board on which people write their recent resiliency activities.

Personal Perspective and Meaning

During one meeting, staff members were asked to think about what makes them engage in the work, why they came to this field, and what keeps them there. They were then given journals and asked to write three positive things every day.

Figure 4. A "Butterfly Vision Board" on which staff members paste images of how it looks when BCAC achieves its mission.

Because the management at BCAC support and were able to operationalize the Organizational Resiliency Model, staff took on the tasks of planning agency-wide activities that reinforced the resiliency elements. As the program evolved, BCAC was no longer doing vicarious trauma training, but rather, they were implementing a resiliency program. This shift in thinking promoted creativity, and additional activities were developed to reinforce the five elements. Today, the elements of resiliency are incorporated in monthly all-staff meetings and in new programs for BCAC staff.

Figure 5. "Sense of Hope" T-shirts.

BCAC was fortunate to have staff and a management team that could see the value in investing this time into the resiliency of their workforce and recognize that intentional practice was necessary for success. BCAC has seen the positive impact of focusing on staff resiliency and recognizes the importance that all five elements play in staff efficacy, communication, and retention. The agency encourages staff members to use their vacation time, which they do because they have confidence that the job will be done while they are gone. Everyone is recognized for their dedication and the exceptional work that they do.

National Children's Alliance continues to train on and support the Organizational Resiliency Model as an effective way to build a culture of resiliency in Children's Advocacy Centers. NCA has featured this training at its Urban Forum (for the largest CACs in the country), held sessions at the annual NCA Leadership Conference, and presented at a variety of child welfare conferences. We continue to look for new ways to help Children's Advocacy Centers shift their focus from simply raising awareness of vicarious trauma to creating a culture of resiliency. We must build organizations that model the resiliency that is so critical for the children and families we serve.

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APSAC Position Paper on Allegations of Child Maltreatment and Intimate Partner Violence in Divorce/Parental Relationship Dissolutions

Kathleen Coulborn Faller, Ph.D.

After two years of collaborative work on the contested issue of Allegations of Child Maltreatment and Intimate Partner Violence in Divorce–Parental Relationship Dissolution, at its January 2016, meeting, the APSAC Board of Directors voted unanimously to accept a position paper. Input on the position paper came not only from two think tanks held at the 2014 and 2015 APSAC Colloquia, but also from professionals with the wide spectrum of views about this contested issue. The complete position paper can be found on the APSAC website at http://www.apsac.org.

The paper provides guidance for professionals about intervention in these cases, addresses in a detailed manner the issue of parental alienation, and suggests future directions with regard to these difficult cases.

Four Critical Intervention Issues

(1) It is APSAC's view that child safety must take precedence.

APSAC's position is that child safety is more important than parental right to child access and must be considered before "friendly parent" statutes are invoked.

(2) The position paper advises professionals to differentiate interpersonal violence investigation and assessment from child custody evaluations.

APSAC's position is that mandated professionals must investigate these cases with as much diligence as other allegations of child maltreatment and intimate partner violence. Decisions about the likelihood of interpersonal violence must be made before issues of custody and visitation are considered.

3) APSAC defines best practice for evaluation of allegations of interpersonal violence and relationship dissolution cases.

If the allegations of interpersonal violence are not resolved or appear inadequately addressed by the mandated investigators (child protective services, law enforcement), APSAC recommends a comprehensive family evaluation by mental health professionals with expertise in interpersonal violence and potential reasons for children's preference for one parent over the other. While taking into account professional and community practice and policy, APSAC provides guidelines about comprehensive evaluation of divorce/relationship dissolution allegations.

The position paper advises evaluators to rely upon multiple methods of data collection. In most cases, those methods are as follows: (1) document review, (2) interviews with all family members, (3) collateral contacts with professionals and others, (4) use of screening measures, and (5) psychological testing of parents and children. The paper urges caution regarding the use of parent-child interactions in the course of a comprehensive family evaluation because of their potential to cause child trauma and their limited utility in determining the likelihood of interpersonal violence. Evaluators are advised to consider multiple hypotheses for understanding the allegations of interpersonal violence, using a rule out approach for specific hypotheses, based upon the data gathered.

(4) The position paper discusses best practice for case management of marital–relationship dissolution cases with interpersonal violence allegations.

Comprehensive family evaluations may conclude with the following dispositions: (1) interpersonal violence likely, (2) interpersonal violence unlikely, or (3) interpersonal violence uncertain. In this way, APSAC provides guidance about decision making and case management for each disposition. Regardless of the conclusion, the child's best interest should determine issues of custody and visitation.

APSAC's Position on Parental Alienation

APSAC acknowledges that, when there are allegations of interpersonal violence in divorce–relationship dissolution cases, a hypothesis of Parental Alienation is often proposed. Because of this, the position paper describes the current status of the knowledge about parental alienation. APSAC concludes there is a lack of definitional clarity about Parental Alienation, there are questions about its appropriateness as a psychiatric diagnosis, and there is a limited empirical base to support the prevalence and characteristics of Parental Alienation.

The position paper contains an appendix that lays out definitions for Parental Alienation Syndrome, Parental Alienation Disorder, Parental Alienation Behavior, the Alienated Child, and the Estranged Child. Further, the position paper notes that Parental Alienation Syndrome or Disorder did not meet the criteria to be included in the *Diagnostic Statistical Manual-V*. Finally, the position paper contains an appendix that describes the limitations of the body of work on Parental Alienation, noting that there is

an abundance of literature on the topic, but most of what has been written is opinion, or lacks methodological rigor, or both.

Future Directions

(1) The APSAC position paper calls for new research on allegations of interpersonal violence in divorce–relationship dissolution, observing that there has been scant new research in the last 20 years.

(2) APSAC also recommends protocols and special courts for marital–relationship dissolution cases with interpersonal violence allegations. The position paper notes that special courts have been developed for infants who have to go into care and for substance abusing adults. The position paper also makes reference to the special courts used in Australia for allegations of interpersonal violence in divorce–relationship dissolution.

(3) Finally, the APSAC position paper calls for specialized training for professionals who encounter allegations of interpersonal violence in divorce–relationship dissolution cases. Professionals who require training include clinicians providing treatment to children in marital/relationship dissolution situations, judges handling domestic relations court cases, lawyers representing children and adults in domestic relations courts, child custody evaluators in the public and private sector, child protection investigators, and law enforcement officers.

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Dr. Faller has been a member of APSAC since its inception. Presently, she is a member of the APSAC Board and the Executive Committee. She chairs the Practice Guidelines Committee, the Publications Committee, and the APSAC Awards Committee.

At Issue: The Case for Calling it Peer Victimization and Aggression

Colleen Friend, PhD, LCSW

Introduction: The Importance of Making a Shift

We all gravitate to specific areas of practice for a reason. In the case of the author, it was due to the accounts of youthful relatives who had firsthand experiences with the problem widely known as bullying. I learned that being a child victim of this form of abuse is all consuming, hijacking one's academic and social growth, often at a critical developmental time. The child's lament of loneliness, sadness, and loss of self-esteem is very compelling. Since I have adopted peer victimization and aggression as an integral focus of my work, I have been moved by the number of colleagues who come to professional presentations, acknowledging that this has either happened to them in the past or is currently perplexing them because it is occurring with their children now. They have all been my teachers. I also wish to acknowledge the role of David Finkelhor in putting together a co-presentation we did at the APSAC Colloquium in 2015. Much of what is said here was drawn from his work.

Some of what we know about this problem comes from the front line and some is gleaned from the recent and past research. Both ways, it continues to command our attention; therefore, I am using this opportunity to reach APSAC practitioners though the *Advisor*. Given that the conclusions are somewhat controversial, it is up to you to see where you stand. Ultimately, I think the time has come to shift our consciousness, perception, and language from identifying this dynamic by the term bullying to calling it peer victimization and aggression.

Making the Case

First, let's ask, "What's in a name?" A name should be an accurate reflection of the concept it represents. A name is a label that can often shape the identity and behavior of those to whom it is applied.

Daniel Olweus (1994) defined the word bullying as a hypothesis for a phenomenon he was uncovering in his work with young students. Olweus' formulation is limited to two components: repeated activities, and acts occurring in the context of a power imbalance.

Several immediate concerns come to mind: What about one time serious acts of aggression, such as rape or assault, without a preexisting power differential? How are we defining a power differential? Is it gender, size, strength, or popularity? If a large popular girl repeatedly intimidates a smaller popular boy, what is the controlling dimension? As the intimidation or aggression progresses, one party might be legitimately intimidated, but this may not mean there was a power imbalance initially. In an attempt to clarify this ambiguity, Olweus explained that a power imbalance exists when it is difficult for the student being bullied to defend him or herself. What if the student is committed to nonviolence or fears a consequence for fighting back? What if the student is blindsided in an ambush? So this power imbalance criterion is hard to define and grasp clearly.

Since Olweus's work in the 1990s, bullying has been adopted wholesale by researchers, educators, and the public at large. The realities of life in the 21st century, coupled with recent research and reflections on prior historical movements, all offer cogent arguments for renaming the phenomenon as peer victimization and aggression.

Making the Case

We have learned a lot from recent research on how children experience aggression. In the Second National Survey of Children's Exposure to Violence (Turner, Finkelhor, Shattuck, Hamby, & Mitchell, 2015), we see the complexities of peer assault and victimization. For example, we know that many children experience polyvictimization, and as such incidents increase, so do their trauma symptoms, regardless of the power imbalance. Also in this research, we see that incidents with children can have aggravating elements that would potentially distort an initial power imbalance, for example, the addition of a weapon, sexual content, an internet component, or a bias slur (e.g., something said about sexual orientation). With the emergence of cyberbullying, one often cannot determine who is the initiator, let alone if there is a power imbalance. On top of that, the level of repeating is very difficult to gauge as the threats and insults are all available for rebroadcast. Thus, we should not limit this phenomenon of abuse among peers only to episodes that are repeated with a power imbalance. Both elements of the Olweus hypothesis seem to have outgrown their ability to describe what children currently experience.

There are some good bridges to the future, and we could build on past success in related fields when an initially narrow concept was broadened to allow more empirical definitions from research and clinical practice. In fact, many front line movements contain examples in which the defining of certain words became key to gaining broader acceptance and a more accurate portrayal of a phenomenon. The initial mobilization of researchers and advocates around rape and rape prevention gave way to broader terms such as *sexual*

assault and *sexual violence* in recognition of harm caused by nonpenetrating forms of sexual offense (Basile & Saltzman, 2002). Similarly, an initial focus on wife abuse in the early domestic violence movement has progressed to a more general emphasis on intimate partner abuse, which includes dating violence as well as the understanding that males may also be harmed. We moved into recognizing intentional child abuse injuries with the case of "the battered child syndrome" (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962) and then took that into the broader and current concept of child maltreatment. The term *mental retardation* was eliminated from the *Diagnostic and Statistical Manual-V* (American Psychiatric Association, 2013) and replaced with *intellectual disability*. All of these examples demonstrate that terms often start out being the best reflection of their time, but as the science progresses, we should hear arguments for opening up the concepts and then seeing where the dust settles, rather than insisting on an attachment to a name that has limited utility.

Another sense of urgency to consider a shift comes from children's and youth's perception of the situation. For example, when the Kaiser Family Foundation conducted a survey in 2001, asking children ages 8–15 what their "toughest issue" was, they found that bullying/teasing ranked number one over these other problems in descending order: drugs/alcohol, discrimination, pressure to have sex, racism, and AIDS. In presentations, I have shown parts of YouTube videos that portray real kids reacting to bullying (Fine Brothers Entertainment, 2011). In these videos, we hear children calling for "an act of Congress" to solve this problem because it is so harmful. They insightfully talk about bullies as being scared and abused and looking for an opportunity to engage an audience. The kids compassionately offer to help anyone who experiences bullying. Incredibly, all of them admit to having experienced the problem themselves. When we start with the child's point of view, it centers us on their sense of harm, urgency and seriousness. This is another precise reason why our current concept is so limited.

Recently, a study examined two large data sets (one from UK, one from USA) to compare the long-term adult mental health outcomes of child maltreatment (by adults) with being bullied by peers (Lereya, Copeland, Castillo, & Wolke, 2015). The researchers found that while children who experienced both forms of abuse were at increased risk for mental health problems, the children who were bullied by peers only were more likely to have worse overall mental health problems (anxiety and depression in both cohorts, self-harm in the UK cohort) compared with the group that experienced only child maltreatment (Lereya et al., 2015). While I acknowledge that there may be many explanations for these findings, I can conclude that the enduring effects of peer victimization are at least equivalent to the effects of child maltreatment. I applaud Lereya (2015) and colleagues' assertion that bullying is another form of child maltreatment.

Historically, child protection professionals have believed that parental maltreatment is most harmful to children, but this new finding suggests that bullying may, in fact, have even greater adverse effects, especially in terms of anxiety, depression, and self-harm. Although this interpretation may be debated within the field, at a minimum it calls for renewed consideration of bullying as a significant form of abuse. Substituting the term *peer victimization* for *bullying* could incorporate a harm intent for peers acting outside the norms of appropriate conduct as well as the relationship context. Such elements could help us approach these concepts with more openness and flexibility, increasing our sensitivity to what children are telling us and what research has now revealed.

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Journal Highlights

J. Bart Klika, MSW, PhD and Lisa Aronson Fontes, PhD

Projected Outcomes of Nurse Family Partnership Home Visitation During 1996-2013

In this article, Miller estimates the long-term impacts of the early intervention program, Nurse Family Partnership (NFP). Results from randomized controlled trials and program evaluation reports are used to understand how the 117,517 families involved in the NFP program between 1996-2013 will be faring, across 21 outcomes, by 2031.

NFP is a nurse home visiting program targeted toward first-time, low-income mothers. Participating mothers are engaged prenatally and nurse-delivered home visits continue through the child's second birthday. The goals of NFP are to improve prenatal and pregnancy outcomes for the mother and child, improve child health and developmental outcomes, and promote family self-sufficiency.

Using data from randomized controlled trials, evaluation reports, and consultation with the national office of NFP, Miller estimates that by 2031, implementation of the NFP program will prevent 500 infant deaths, 10,000 preterm births, 13,000 closely spaced second children, 4,700 abortions, 42,000 child maltreatment incidents, 36,000 intimate partner violence incidents, 90,000 violent youth crimes, 594,000 property or public order crimes, 36,000 youth arrests, and 41,000 person years of substance use. In addition, Miller projects reductions in maternal smoking during pregnancy, pregnancy complications, childhood injuries, use of subsidized childcare, along with improved child language development, increased rates of breast feeding, and increased compliance with immunization schedules. Finally, NFP will be responsible for reducing childhood Medicaid spending by 4.8 million person months and spending on Medicaid, TANF, and food stamps by nearly $3 billion (p. 765).

Miller notes a number of limitations of the current review including incomplete data across studies and outcome reports, variations in samples, and a limited number of evaluations tracking the highlighted outcomes. While critics could readily poke holes in the study methodology, the author is transparent and descriptive regarding the processes by which he arrived at his estimates.

We need not abandon the moral argument for the promotion of health and well-being of all children and families but can strengthen our call with data such as this to further demonstrate the social and financial impacts of early intervention programs such as Nurse Family Partnership.

Miller, T.R. (2015). Projected outcomes of Nurse Family Partnership home visitation during 1996-2013, USA. *Prevention Science, 16*, 765-777.

J. Bart Klika, MSW, PhD is an Assistant Professor of Social Work at the University of Montana and is the Senior Editor of the APSAC Handbook on Child Maltreatment (4th Edition). In addition, Dr. Klika is the co-chair of the APSAC Prevention Committee.

How Children Living with Domestic Violence are Harmed By and Resist Regimes of Coercive Control

This article enhances our understanding of the effects on children of living in a home where one parent figure (typically the father) abuses the other (typically the mother). This article is based on qualitative interviews with 15 mothers and 15 children living in the community (not in a shelter) who had separated from domestic violence perpetrators. The nonphysical aspects of the domestic violence, including psychological and financial abuse, isolation, jealousy, and monitoring, were found to "isolate, disempower, and constrain the worlds" of affected children .

One of the problems caused by the coercive control is that children in those households grew more isolated and therefore did not have access to the activities (e.g., sports, camps, or afterschool clubs) or people (from grandparents to coaches to peers) who could have helped strengthen their development and build their resilience. Drawing on direct quotes from the mothers and children, Katz also illuminates the ways the participants resisted coercive control and boosted each other's resilience through their interactions. The article includes a robust section of implications for practice and research, including focusing on the need to help mothers and children identify the ways their mother–child relationship and their relationships with others may have been distorted by the coercive control. This article takes us way beyond the "child witness of domestic violence" framework and is therefore a must-read for professionals who work with children.

Katz, E. (2016). Beyond the physical incident model: How children living with domestic violence are harmed by and resist regimes of coercive control. *Child Abuse Review. 25(1)*, 46-59.

Pacific Islanders and Child Sexual Abuse Disclosure

This authors describe an exploratory study based on qualitative interviews with eight women of Pacific Island descent who live in the Northwest United States. The women are all survivors of unwanted sexual experiences perpetrated by men and boys before the subjects turned age 18. They reported five major reasons they had either failed to disclose their abuse during childhood or had delayed disclosures: desire to protect their family, a cultural preference for maintaining silence about unpleasant issues, self-blame, belief that things in life are temporary (and therefore do not merit too much attention), and "belief that there are worse things in life." The authors report these and other findings and provide a few quotes in the participants' words. This short piece is a welcome addition to the sparse literature on child sexual abuse among Pacific Islanders.

Xiao, H & Smith-Prince, J. (2015) Disclosure of child sexual abuse: The case of Pacific Islanders, *Journal of Child Sexual Abuse, 24,* 369-384.

Lisa Aronson Fontes, PhD is on the faculty of the University of Massachusetts, Amherst and is the author of Interviewing Clients Across Cultures: A Practitioner's Guide (Guilford Press), among other publications.

Conference Calendar

June 1-4, 2016
AFCC 53rd Annual Conference
Modern Families: New Challenges, New Solutions
Sheraton Seattle, WA
608-664-3750
afcc@afccnet.org

June 4-7, 2016
National CASA/GAL Annual Conference
Gaylord National Resort and Convention Center
National Harbor, Maryland
800-628-3233
www.casaforchildren.org

June 21-25, 2016
24th APSAC Annual Colloquium
American Professional Society
on the Abuse of Children
Sheraton, New Orleans, LA
877-402-7722
apsac@apsac.org
www.apsac.org

July 25-29, 2016
APSAC Child Forensic Interview Clinic
American Professional Society
on the Abuse of Children
Seattle, WA
877-402-7722
apsac@apsac.org
www.apsac.org

August 26-31, 2016
21st International Summit and Training on Violence, Abuse & Trauma
San Diego, CA
858-527-1860, x 4031
IVATConf@alliant.edu
http://www.ivatcenters.org

September 27, 2016
15th ISPCAN European Regional Conference on Child Abuse and Neglect
Bucharest
303-864-5220
ispcan@ispcan.org
http://www.ispcan.org

October 3-7, 2016
APSAC Child Forensic Interview Clinic
American Professional Society
on the Abuse of Children
Norfolk, VA
877-402-7722
apsac@apsac.org
www.apsac.org

November 1-4, 2016
International Conference on Innovations in Family Engagement
The Kempe Center for the Prevention
& Treatment of Child Abuse and Neglect
www.thekempecenter.org
Amy.hahn@childrenscolorado.org

January 25-28, 2017
31st Annual San Diego International Conference on Child and Family Maltreatment
San Diego, CA
SDConference@rchsd.org
http://www.sandiegoconference.org

Washington Update

John Sciamanna, Executive Director, National Child Abuse Coalition

President Obama released his final budget for fiscal year 2017 on February 8. Opposition leaders proclaimed the budget was dead on arrival, but it still may help to influence some of the final policies for the new fiscal year that starts October 1, 2016. The new budget comes only weeks after a December deal for FY 2016.

Status of FY 2016 Funding

Generally, FY 2016 child welfare programs remained where they have been for several years with no increases in the two Title IV-B programs, Promoting Safe and Stable Families (PSSF) at $335 million for the 4 core programs, Child Welfare Services (CWS) at $269 million, CAPTA state grants at $25 million, Adoption Opportunities at $39 million, and Adoption Incentives at $38 million.

While CAPTA state grants remained frozen, $2 million was allocated to continue the National Survey of Child and Adolescent Well-Being (NSCAW), a longitudinal examination of children and families that have been investigated by child protective services. Many researchers and advocates see it as vital to obtaining a deeper understanding of child abuse and neglect.

There were some increases within the child protection arena. Court-Appointed Special Advocates (CASA) funding increased from $6 million to $9 million, and the Children's Advocacy Centers (CACs) funding increased to $20 million.

On a negative note, the Senate de-funded the $11 million for the Abandoned Infant program. Last year the Administration had proposed reforms to the program as part of a reauthorization, but Congress used that as a rationale to eliminate funding altogether.

Proposals for New 2017 Spending

Perhaps the biggest potential for bipartisanship in FY 2017 is the issue of substance abuse. Early details of the Administration's drug policy outlines $1.1 billion in new funding as part of the budget to expand treatment for, and prevention of, heroin and opioids addiction. Specific to the child welfare field, the Administration proposes to expand designated substance abuse regional partnerships through the Promoting Safe and Stable Families (PSSF) program when that is reauthorized later this year. The grants can be used for family-based treatment programs. The Administration proposal would increase the current funding from $20 million to $60 million a year. Additional issues covered by the Administration's February budget release include the following:

Level Funding for CAPTA and Other Child Welfare Services

Key programs included as part of the Child Abuse Prevention and Treatment Act (CAPTA) were all flat funded for 2017. State grants would remain at $25 million a year. Discretionary funding would receive an $11 million boost to $44 million, but that increase would be designated for some sex trafficking provisions implemented through the 2014 Preventing Sex Trafficking and Strengthening Families Act (PL 113-183), including the creation of a commission to study the issue.

The Community-Based Child Abuse Prevention Act (CB-CAP) would remain at $39.7 million. The Adoption Opportunities Act remains at $39 million. The Abandoned Infant program is eliminated.

The Administration requests $4 million to continue the National Survey of Child and Adolescent Well-Being. The Adoption and Kinship Incentive Fund is flat funded at $37.9 million. Last year, despite the $37.9 million appropriations, only $19 million was available for the latest incentives.

Focus on the Child Welfare Workforce

The Administration included in the budget a new strategy to expand and strengthen the child welfare workforce. The budget request would amend Title IV-E foster care and adoption assistance law to expand state access to current training funds.

The new proposal would reconfigure the required match for worker training dollars, with the goal of reducing the financial burden on states and encouraging them to support more caseworkers in obtaining a BSW or MSW degrees. The Administration also proposes an enhanced Title IV-E match for BSW/MSW caseworkers in a bid to achieve a better educated workforce.

Early Childhood Funding

Child care advocates are not pleased with the Administration's request for approximately $200 million in child care funding for FY 2017. The proposal comes on the heels of Congress's reauthorization of the Child Care and Development Block Grant (CCDBG). The reauthorization requires new background checks and a variety of safety measures, improved child care access, and higher quality standards. However, advocacy groups have calculated that it would take approximately $1.2 billion in new funding to carry out the new requirements without losing current child care coverage.

The administration also proposed increasing Head Start funding by $434 million, to $9.6 billion total, intended primarily to continue the expansion of Head Start to full day in some areas and the recent expansion of Early Head Start.

Where We Go From Here

The budget process has already slowed down. Last year's budget agreement set spending ceilings for both this year's budget and 2017. At this point, the appropriations process will look a lot like last year, but this year a final deal will be made in the shadows of a new President, a Supreme Court vacancy, and all the extenuating political ramifications.

2016 Congressional Session Short and Uncertain

Beyond appropriations debates it is unclear how much Congress will get done in a shortened session. By the late summer, one side or the other may see an advantage in delaying everything until a new President and Congress take over in January 2017. With that in mind, here is a rundown of a few key issues in 2016.

Child Welfare Reform

The Senate Finance committee was not able to take up a draft bill called the Families First Act before leaving last December. Some parts are still in flux, but it generally would allow Title IV-E funding on a limited category of substance abuse, mental health, and in-home parent support services and programs for up to 12-months, contingent on a child being considered a "candidate" for foster care. In addition, the bill would create new definitions of foster care and institutional care. Foster care would be defined as a home of six or fewer children with exceptions for siblings, disabilities, and other categories. The bill would allow funding for qualified residential treatment programs that meet certain conditions, including eventual accreditation. There would also be new oversight and care planning requirements for children in such facilities after a placement of two weeks. The legislation would also allow for some expanded supports to kinship families as part of the treatment strategy.

Reauthorizations

The Child Abuse Prevention and Treatment Act (CAPTA) expired last year and needs to be reauthorized along with the Community Based Child Abuse Prevention (CB-CAP) grants, the Adoption Opportunities Act, and the Abandoned Infants Act.

This package will be affected by the impending release of recommendations by the Commission to Eliminate Child Abuse and Neglect Fatalities. The task is not easy becaise there are challenges on how to best prevent child deaths, which officially total approximately 1600 each year. Those numbers, which many believe are a severe undercount, include only thefatalities of children known to child protection agencies and do not include some other systems, such as hospital reports unconnected to child protection. CAPTA is the main vehicle for action since it provides the data reporting requirements.

The CB-CAP and Adoption Opportunities programs generally do not undergo big changes, and funding has remained low and stable ($40 and $39 million respectively with sequestration cuts). Most challenged, however, is the Abandoned Infants program, which was de-funded in FY 2016. The program was originally designed to address infants who had been abandoned as a result of the AIDS and crack use epidemics of the 1980s. Some of these needs may be resurfacing because of the increased use of heroin and other opioids.

Two relatively big child welfare block grants are also due for reauthorization in 2016: Title IV-B part 1, Child Welfare Services ($269 million) and Title IV-B part 2, Promoting Safe and Stable Families (PSSF). Reauthorization could offer opportunities to better address the need for substance abuse treatment and strategies to strengthen the child welfare workforce.

Other legislation due for reauthorization includes the Juvenile Justice and Delinquency Prevention Act (JJDPA) and the Higher Education Act.

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News of the Organization

Michael L. Haney, PhD, NCC, CISM, LMHC

Register Today for APSAC's Child Forensic Interview Training Clinics in Seattle, WA and Norfolk, VA

Consistent with its mission, APSAC will present two Forensic Interview Training Clinics this year focused on the needs of professionals responsible for conducting investigative interviews with children in suspected abuse cases. Interviewing alleged victims of child abuse has received intense scrutiny in recent years and increasingly requires specialized training and expertise.

This comprehensive clinic offers a unique opportunity to participate in an intensive 40-hour training experience and have personal interaction with leading experts in the field of child forensic interviewing. Developed by top national experts, APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing, including a balanced review of several models.

Training topics include the following:

- How investigative interviews differ from therapeutic interviews
- Various interview models and an introduction to forensic interview methods and techniques
- Child development considerations and linguistic issues
- Cultural considerations in interviewing
- Techniques for interviewing adolescents, reluctant children, and children with disabilities
- How to be an effective witness

The 2016 Seattle, WA clinic will take place July 25–29 and the Norfolk, VA clinic will take place October 3–7. Details and registration are available at www.apsac.org.

Successful Institutes Held by APSAC in San Diego

Over 100 individuals participated in APSAC's Advanced Training Institutes on January 23-24 in San Diego, CA. The programs were part of the annual San Diego International Conference on Child and Family Maltreatment sponsored by the Chadwick Center.

Three APSAC institutes were featured:

- The Law and Psychology of Introducing Children's Statements in Court – Thomas D. Lyon JD, PhD, and John E.B. Myers, JD.
- Problematic Sexual Behavior in Children: Current Findings and Implications for Practice – Jimmy Widdifield, Jr., MA, and Elizabeth Bard, PhD
- Advanced Issues in Child Sexual Abuse – Barbara Knox, MD, and Debra Esernio-Jenssen, MD, FAAP

Register Today for APSAC's Colloquium in New Orleans

APSAC will host its 24th Annual Colloquium June 21–25, 2016, at the Sheraton New Orleans Hotel, New Orleans, Louisiana.

The Colloquium will feature Advanced Training Institutes, the Cultural Institute, and 83 institutes and workshops that address all aspects of child maltreatment including prevention, assessment, intervention and treatment with victims, perpetrators and families affected by physical, sexual and psychological abuse and neglect.

The educational goal of APSAC's Colloquium is to foster professional excellence in the field of child maltreatment by providing interdisciplinary professional education.

Participants will learn how to:

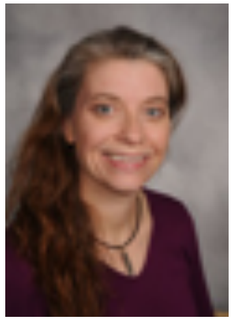
- Identify physical abuse, sexual abuse and neglect in children
- Treat abused and neglected children
- Apply model examination techniques for assessment of abused and neglected children
- Describe and utilize the most up-to-date information concerning working with abused and neglected children to improve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

Workshops have been designed for professionals in mental health, medicine and nursing, law, education, prevention, law enforcement, research, advocacy, child protection services, and all who serve children and families affected by child maltreatment and violence.

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

Meet APSAC'S President Elect

APSAC's Board of Directors will meet on June 21, 2016, not only to welcome new Board members but also its newest President!



Attorney, Tricia Gardner will replace APSAC's current President Frank Vandervort as President of APSAC this June at the 24th Annual Colloquium. Ms. Gardner is an Associate Professor at the University of Oklahoma Health Sciences Center in the Department of Pediatrics, and a licensed attorney. She currently serves as the Administrator and Director of Professional Education for the Section of Developmental and Behavioral Pediatrics. She also serves on the Oklahoma Children's Hospital Child Protection Committee and is a member of the Steering Committee for the National Center for the Review and Prevention of Child Deaths.

Currently, Ms. Gardner is the Chair of the APSAC Task Force on Child Fatalities, Co-Chair of the APSAC Professional Education Committee, and a participating member on the Policy Committee. She has been a member of APSAC since 1993 and served on APSAC's national Board of Directors from 1999–2001. She has also served as a Board Member and President of the Oklahoma State Chapter (OPSAC) of APSAC. From 2001–2004, she was the Operations Manager for APSAC and served as the lead manager of the organization. In that capacity, she organized and implemented the Annual Colloquiums, San Diego Institutes, and Forensic Interview Clinics. She also provided consultation and support to all committees of the APSAC Board and managed all of the APSAC publications (except *Child Maltreatment*).

In the past, Ms. Gardner served as Director of the Child Welfare Training Program for the State of Oklahoma and Administrator of the Oklahoma Child Death Review Board. In addition, she has been Adjunct Professor for the University of Oklahoma's College of Law and provided instruction for the Interdisciplinary Training Program on Child Abuse and Neglect.

Ms. Gardner is excited to lead APSAC into the future. "My vision for APSAC is for it to continue to expand on the path of being the premiere resource for professionals working with victims of child maltreatment though professional education, publications and policy."

New Position Paper Released

APSAC releases new position paper: *Allegations of Child Maltreatment and Intimate Partner Violence in Divorce–Parental Relationship Dissolution*. Download a copy by going to the website at www.apsac.org.

New White Paper Released

APSAC is thrilled to have been a partner with several trainers from national forensic interviewing programs across the country to produce the long awaited *Child Forensic Interviewing Best Practices White Paper*. Download a copy by going to the website at www.apsac.org.

APSAC Joins Leading Medical Organizations to Advocate for Children

APSAC has teamed up with several leading medical organizations in an amicus brief aimed at protecting child abuse pediatricians from being sued and, in turn, protecting children from maltreatment.

APSAC joined the American Academy of Pediatrics, the California Medical Association and the Ray E. Helfer Society in filing an amicus brief in the United States Circuit Court for the 9th Circuit in the case Jones v. Wang. The case involves

important questions of immunity for physicians who evaluate children for possible maltreatment. In the case, Dr. Claudia Wang was sued after she took reasonable and ethical steps in an effort to fully diagnose a child's injuries after the child appeared in the emergency room with skull fractures and numerous fractured ribs. Download a copy of APSAC's amicus brief from our website, www.apsac.org.

APSAC Encourages Members to Get Involved or Start a State Chapter

If your state does not have an APSAC state chapter and you are interested in forming one, please contact Laura Hughes or visit www.apsac.org.

APSAC Executive Director Michael L. Haney Retires

Dear Friends and Colleagues,

It is with mixed emotions that I announce my resignation as Executive Director for the American Professional Society on the Abuse of Children effective at the close of the 2016 Colloquium in New Orleans.

I have been a member of APSAC since 1995 and have had the great privilege of serving this organization as a member of the Board of Directors starting in 2006. I was honored to serve two terms as Vice President, and then in 2008-2009 as President of APSAC. The Board of Directors asked me to serve as Executive Director in 2011 and I have continued in that capacity and will, with assent from the Board, until New Orleans.

I want to thank all members of this Board and previous Boards for their support and patience during my time with APSAC. I believe as an organization we have made tremendous progress and will continue to do so. There are many exciting opportunities on the horizon and you will likely hear more about those at the New Orleans Colloquium.

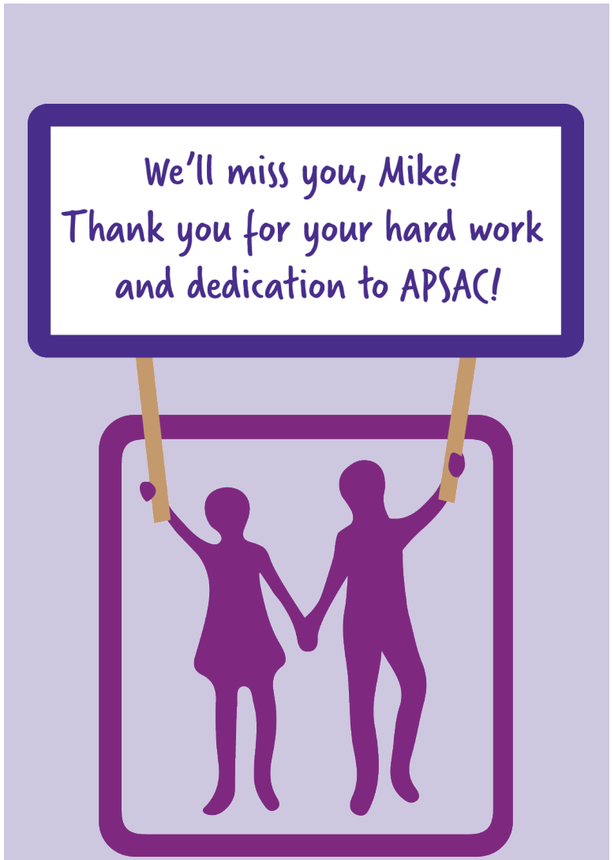
I wish that I had been able to meet each and every APSAC member personally and thank you for all that you do on behalf of children. While I know that's not quite possible, I will look forward to seeing as many of you as possible in New Orleans! As I promised my colleagues on the Board, I'm not going away and plan to stay involved. I recently was appointed as President of the Florida Chapter of APSAC so I suspect I'll stay busy!

Thank you again for the opportunity to work with you and serve you on behalf of APSAC.

Warmest wishes for your continued success and prosperity, and for that of the American Professional Society on the Abuse of Children.

Sincerely,

Michael L. Haney



State Chapter News

CAPSAC Announces Paul Crissey Research Award Winner

The California Chapter congratulates graduate student Wendella Wray of Loma Linda University, winner of this year's CAPSAC Paul Crissey Research Award. The proposed study is "A Wellness Telecoaching Intervention to Support Low SES Families in the Nurturing Parenting Program: A Randomized Controlled Trial." The purpose of the study is to examine whether adding weekly personalized telecoaching to the delivery of this evidence-based parenting program offers better results for low SES caregivers and parents with backgrounds of child maltreatment. The study will compare the effectiveness of NPP plus telecoaching with NPP alone, using a sample of 108 caregivers of children under the age of 5 in six cohorts, which will be randomly assigned to experimental and control groups. Ultimately, the study will explore whether caregivers and parents who receive the augmented program will be better equipped to care for their children in a healthier way.

IAPSAC Supports Conferences

The Iowa Chapter will provide sponsorship to three conferences:

» Protecting Families, April 1

» The 6th Annual Conference on Psychological Trauma & Juvenile Justice: Impact on Mind, Body, Behavior and Community Current Research and Practice Trends, June 6–8

» Child Protection: Our Responsibility, October 14

APSAC Officers and Board of Directors

APSAC Advisor Staff