BACKGROUND BRIEFING REPORT
WITH SEMINAR PRESENTATIONS

CHILD MALTREATMENT AND THE FAMILY

By

M. Anne Powell, M.S.W.

April 1994

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This Background Briefing Report was prepared by the California Family Impact Seminar (CAFIS) to accompany the April 20, 1994 policy seminar entitled *Child Maltreatment and the Family*.

The California Family Impact Seminar provides nonpartisan information to government officials and policymakers concerning issues affecting children and families in California. CAFIS is a project of the California State Library Foundation, which is committed to preservation of the cultural heritage of California, and is sponsored by the State Library California Research Bureau which performs policy research for the Governor and the State Legislature. CAFIS is affiliated with the federal Family Impact Seminar in the AAMFT Research and Education Foundation and is a part of the national network of state Family Impact Seminars.

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CALIFORNIA FAMILY IMPACT SEMINAR
Promoting a family perspective in policies and programs.

State policymakers are challenged today by a host of family issues and problems that need to be addressed within the context of limited resources. There is a growing body of research on families, and on the numerous programs that seek to address family-related problems. Unfortunately, policymakers often do not have access to this current research and may instead rely on information that is out-of-date, biased, or inaccurate. This problem is exacerbated in California by the loss of state policy analysis resources due to ongoing budget cuts in the legislative and executive branches.

The ***California Family Impact Seminar (CAFIS)*** is a nonpartisan policy research and education project that seeks to provide accurate current information on family issues at state and local levels. ***CAFIS*** forums and briefing papers present cutting edge research on health and social indicators, and the development, implementation, and evaluation of public and private policies and programs.

***CAFIS* Goals**

- Provide state policymakers with up-to-date, solution-oriented, and objective information on family policy issues from a family perspective;

- Provide a forum for frank and open consideration of various policy dilemmas and policy options;

- Facilitate productive communication among state legislators, legislative policy staff, gubernatorial staff, state agency officials, and state agency policy staff, with program professionals, policy experts, and researchers from throughout the United States; and

- Generate a family-centered approach to information, moving from a categorical program focus on the individual child or parent to one that evaluates the issue or problem and potential solutions within the context of the family.

- Assist policymakers and governing institutions to develop effective family-centered policy.

***CAFIS* Seminar Format**

Each year ***CAFIS*** holds a series of four to six seminars in Sacramento specifically designed to educate and inform state legislators and executive branch officials and their policy staff and to provide a forum for focused discussion. The current range of issues includes violence, child maltreatment, health care reform, family preservation, foster care, poverty, and literacy. The topics are chosen with guidance from the ***CAFIS*** Board of Advisors and the ***CAFIS*** Steering Committee

Seminars are two hours in length. The first portion of the seminar is devoted to presentations by a panel of recognized experts who discuss research findings and program experiences at the federal, state, and local levels, and review a range of policy options. The presentations are followed up with a question-and-answer period allowing for discussion among the panelists and participants. Each seminar is accompanied by an in-depth Background Briefing Report and followed up with a Seminar Presentation Summary.

CAFIS is a project of the California State Library Foundation and is sponsored by the California Research Bureau, which conducts policy research for both the legislative and executive branches of state government. The 1994 seminar series is supported by grants from the Henry J. Kaiser Foundation and the Stuart Foundations.

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Introduction

Child maltreatment encompasses various kinds of child abuse and neglect. Volumes have been written about every aspect of child maltreatment—the causes, effects, and prevention or treatment.

This Report summarizes what is currently known about child maltreatment and presents a basic overview of associated issues. The report is written to accompany the California Family Impact Seminar (CAFIS) seminar, *Child Maltreatment and the Family*, held on April 20, 1994.

Chapter I provides a brief historical overview of child maltreatment, including some discussion of definitional complexities. Chapter II gives a summary of child maltreatment trends throughout the country and within California. Chapter III contains an overview of what is known about the short and long-term affects of child maltreatment. This section discusses why child maltreatment is of concern to the community and government. Chapter IV is an overview of what is known about the families in which child maltreatment occurs, including the main factors associated with and thus believed to place a child at risk of maltreatment. Finally, Chapter V examines community programs designed to prevent, intervene, and treat child maltreatment.

For readers who desire more information about child maltreatment, suggested readings are listed at the end of the document. The list includes *California's Process for Resolving Allegations of Child Abuse or Neglect*, a recent publication of the California Research Bureau, which is cited widely in Chapters II and V of this report.

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CHAPTER I: DEFINING CHILD MALTREATMENT

An Historical Overview

In the 19th century, families moved from rural areas or immigrated from other countries in search of economic advancement, and experienced the breakup of the extended family structure and rapid social change. The economic changes that came with industrialization—the disruptions of families, child labor in factories, and the growth of working and poverty classes—led to significant changes in the family experience.

Until the 1870s maltreatment of children was not a part of public debate in the United States. Extreme brutality was handled on a case-by-case basis by the courts under the judicial (or criminal justice) system. Less severe cases may have upset some people, but child-rearing decisions were considered the prerogative of parents, particularly fathers.

The Protective Society

A very different "modern image" of childhood grew out of a number of significant social changes that began in the late 19th century, the most significant being the advent of formal, civic education, the rise of a partly urban, commercial society, and the expansion of an upper middle class in which the wife and children did not work. With these mothers and children no longer needing to work, the idea of a "protected childhood" emerged. This became the standard against which the parenting practices of others were compared and fueled the view of child maltreatment as a social problem.

The "protective society" movement fostered concern for the welfare of children throughout all classes of society. Social reformers, often from the more privileged classes, were concerned about the moral development of children growing up in the impoverished families of the urban slums. Poverty was believed to be an unfit environment for children. Public concern was not so much for the immediate suffering of the children but rather for the long-range impact on their moral development into law-abiding citizens. So, similar to policies for orphans and other destitute children, these organizations advocated removing maltreated children from their family and placing them in juvenile reformatories and orphanages. Thus began the policy of placing abused and neglected children in foster care (Daro, 1988).

The case of Mary Ellen Wilson, in 1874, was a catalyst which led to the establishment of the first secular community organization for the prevention of child maltreatment. A "friendly visitor" discovered that this girl was being regularly bound and beaten by her stepmother. Outrage over the incident precipitated the Society for the Prevention of Cruelty to Animals to form the New York Society for the Prevention of Cruelty to Children. This organization later became what is now known as the American Association for Protecting Children, a division of the American Humane Association.

Maltreated children were generally treated the same as the vast majority of dependent children (those who were destitute because their parents died or could not support them). They were removed to orphanages and foster homes or, until child labor was outlawed, apprenticed or indentured. For decades this remained the case. However, as cash assistance programs emerged in the 1930s, the need for programs for destitute children diminished. As a result, the majority of the dependent children population was increasingly composed of the abused and neglected.

The Aid to Families with Dependent Children (AFDC) program was designed initially in the 1930s to provide aid to women with children who were widowed or abandoned. AFDC has been expanded considerably over the decades to provide assistance to unmarried women with children and to certain intact families.

Mandated reporting by physicians of suspected physical abuse cases was first required in the 1960s. Recognition by the medical community of the "battered child syndrome" led to a nationwide campaign to acknowledge and intervene in such cases. These laws were expanded to include reporting of other types of suspected child abuse and neglect by a broad range of professionals who come into contact with children, including teachers, photo lab processors, day care providers, and law enforcement officers.

Both state and federal governments have become increasingly active in responding to child maltreatment. Beginning in the 1970s, programs were established to curb the incidence of child maltreatment. These efforts are due largely to research by child maltreatment prevention advocates into the causes of child maltreatment and an increasing public awareness and intolerance of the problem.

Factors Affecting the Definition of Child Maltreatment

Child maltreatment includes the terms "child abuse and neglect." It encompasses physical abuse, sexual abuse, physical neglect, emotional neglect (increasingly referred to as psychological maltreatment), educational neglect, and medical neglect. Defining the type of maltreatment depends in part on the status of the child or the consequences of the parents' behavior or both. Parental behaviors—actions of commission and omission—are an important aspect of the definition. Depending upon the reason for the parental behavior, the result is either neglect or abuse. For example, lack of adequate food, clothing, or shelter because of inadequate financial resources is considered neglect, while withholding food, clothing or shelter from a child as a form of punishment or for other reasons could constitute physical abuse.

Individual Versus Societal Interests

Defining child maltreatment is complex and controversial: "It all depends on to whom you are talking and what they are talking about" (Giovannoni, 1989). Child maltreatment exists in the context of and in relationship to societal and cultural norms. Yet, defining maltreatment is of central importance, as the definition directs the discussion of incidence, etiology, and treatment, and directly impacts the reporting system, intervention, treatment programs, research and policy development.

The definition of what constitutes child maltreatment has significant implications for the child and the parent. Such a determination leads to, at worst, the permanent severing of the parent-child relationship; at best, it involves the supervision of the family by a child protective services (CPS) agency. American society regards independence and autonomy as a basic social value or right of the individual and the family. The involvement of government in looking out for the interest of the child is, from the parents' perspective, at odds with this value. However, society has also charged government with the responsibility to protect the welfare of children as individuals (Giovannoni, 1979). Thus, government must balance the interests of the parent and of the child.

It would seem reasonable to expect that child maltreatment be clearly defined and understood, particularly by the professionals responsible for the welfare of children. However, the importance of the general societal values of independence and autonomy mitigates against a more precise and unequivocal definition. To define child maltreatment is to determine what are the minimum expectations of parents and the limitations of parental authority.

There is general agreement throughout society that withholding adequate food, shelter, or clothing from a child is considered maltreatment. However, there are some communities that view this as situationally appropriate and, therefore, consider attention to such circumstances an intrusion into the private life of the family. Thus, there is a continuing struggle to define and legislate the boundaries of private family life that are subject to government regulation.

Cultural Considerations

In today's multicultural society, there are multiple—and conflicting—views as to what behavior does or does not constitute child maltreatment. These views are strongly influenced by cultural beliefs. Sensitivity to and awareness of cultural beliefs are important when assessing abuse.

For example, a recent study comparing the attitudes of Chinese Americans with those of Hispanics and European Americans (whites) about child maltreatment suggests distinct cultural differences. Chinese Americans are more tolerant of a wide range of parental conduct and are less likely to ask for an investigation of or assistance with child maltreatment problems (Hong & Hong, 1991). Review and analysis of a significant number of child maltreatment cases of families in Northern California found that new immigrant parents frequently view the behavior of children attempting to adopt American cultural behaviors, such as playing with peers after school, as disrespectful and meriting harsh punishment (Lutheran Social Services of Northern California, 1993). A recent National Public Radio broadcast reported that, while 11 percent of the population of Los Angeles County is of Asian and Pacific Islander descent, those communities are represented in only 1 percent of the county's child protective services (CPS) agency cases. The researchers believe that child maltreatment is present in greater numbers, but attribute the low reporting and intervention rate to cultural factors. Those cultural factors included a belief in strong parental control of children, and a concern that seeking assistance for suspected child maltreatment would mean a loss of face for both the parent and the community. These views are more widespread among new immigrant families.

One of the few studies which examines Asian and Pacific Islander refugees and immigrants reported five factors associated with child maltreatment in their communities (Ima & Holm, 1991):

- Native country traumas such as torture, especially among refugees, may mean a higher likelihood to maltreat children;
- The use of strict traditional child rearing practices, particularly severe physical punishment;
- The relative visibility of the child and family to educational and social service professionals makes the observation of maltreatment more likely;
- The loss of social support systems present in their country of origin; and
- As newcomers, relative inability to cope with cultural conflicts.

Low incidence of reported child maltreatment may also be due in part to successful informal interventions by highly respected members of these communities, such as physicians.

The researchers also express concern about the weakening of parenting practices among newcomer immigrants. Due to past cultural and negative life experiences, they are uncomfortable with and are generally intimidated by government. The newcomers perceive government as siding with their children, who may be adopting American modes of behavior that are outside of traditional norms.

Professional Definitions

Each of the different professions involved in the child maltreatment field—primarily legal, medical, and social service professionals—apply different and, in some ways conflicting, definitions of child maltreatment. Each definition exists for a different purpose, is premised on the underlying principles and theories unique to each profession, and reflects the varying views of the communities within which they carry out their work. The conflict among these various professions, while sometimes the result of differing perspectives as to the problem and how best to address it, most often stems from who they perceive to be their primary responsibility—the child, the family, or both. Thus, it can be difficult for these groups to reach consensus.

The following discussion briefly examines the three most common professional definitions of child maltreatment, their underlying principles, and some of the issues that arise from the differing definitions.

Legal Definition. Historically, legal definitions of child maltreatment focused on parental failure, and less on the condition of the children. However, the courts' consideration of child maltreatment cases has evolved over time, and the cases are handled differently than most other matters. The courts tend to view their role as that of addressing the child's needs, seldom

charging parents for the commission of a crime. It is in this context that the practice of including these children under dependency actions evolved, with the children made wards of the court.

There are three areas of child maltreatment statutes: criminal, dependency, and reporting (see David Illig, 1994 for further discussion). There are wide variations among states in each of these areas. Reviews of these statutes throughout the country describe them as "vague." Even in states with statutes that have clear definitions of conditions under which investigation and intervention is warranted, the statutes regularly include catch-all phrasing that enables court intervention.

Development of a legal definition has not been without controversy. There is a portion of the legal community, particularly attorneys who represent parental interests, that is not comfortable with a perceived vagueness in current statutory definitions of child maltreatment. The question is what standards should be used to interpret the laws. The need for a clear legal definition stems from a desire to precisely define the consequences and behaviors encompassed in the statutes in order to guide the exercise of legal and judicial authority. However, many judges prefer vaguer definitions that leave some discretion in cases that do not fall within prescribed categories of maltreatment yet merit protective action.

In 1970, the American Bar Association and Institute of Judicial Administration established the Juvenile Justice Standards Project (Nelson, 1984). The project proposed eliminating the terms "abuse" and "neglect," substituting instead the term "endangered child." The proposed definition of an endangered child specified that a child suffering from one of six kinds of harm, each with observable and serious consequences. For example, the criteria of "parental negligence" was limited to situations in which the neglect resulted or was likely to result in physical injury. Similarly, "sexual abuse" was limited to cases in which the child was "seriously harmed physically or emotionally." However, the proposed "endangered child" criteria was never adopted by the American Bar Association, nor enacted by any of the states. Failure to adopt the standards is primarily the result of judicial opposition to the restrictive criteria. However, portions of the standards have been enacted by some states, including California (Wald, 1988).

The continuing tension between the advocates of more rigorous legalistic procedures and precise definitions, and those who want to preserve the historical role of the court as a civil mediator, is present today in California. Over the past several years, there have been numerous attempts to make significant changes in the role of the court as it pertains to child dependency hearing procedures. Inherent in this debate is a tension between the needs of the child and the assignment of parental blame. The difficulty is in balancing societal interests in a child's well being with the individuality and privacy rights of the parents.

Medical Definition. The purpose of a medical diagnosis is to identify and understand a patient's medical condition, locate the cause, and develop a course of treatment. The medical profession's interest in child maltreatment emerged among pediatricians in the 1960s as the technology enabled them to better detect certain types of injuries, particularly intentional injuries. The diagnoses most commonly cited include "battered child," "non-accidental trauma," "failure to thrive," and "neglect." These definitions of child maltreatment have served to redefine this social problem as a medical condition.

While initially involved with medical diagnosis and treatment, physicians also led an organized effort that promoted adoption of mandatory child abuse reporting laws by physicians in every state. Reporting issues are explored in greater detail below. Another result of this medical activism was the creation of a new public agency, the National Center on Child Abuse and Neglect within the United States Children's Bureau.

Social Services Definition. Social service professionals define child maltreatment as it relates to their responsibility for investigation and identification. Initially, non-governmental organizations were primarily concerned with child maltreatment, and investigated and intervened in suspected cases. The principal organization was the American Association for Protecting Children (AACP) in the American Humane Association, and the scores of local and state organizations affiliated with AACP. However, once federal and state statutes were enacted, probation officers, who already assisted with the dependency cases of orphaned and destitute children, were also charged with investigating and resolving child maltreatment cases. In the 1960s, public child protective services (CPS) agencies assumed these responsibilities. It is now the responsibility of CPS agencies to receive reports of child maltreatment, investigate to determine the merit of the case, and, if warranted, to intervene on behalf of the child. Meanwhile, the mission of private organizations like AACP has shifted to the treatment and prevention of child maltreatment.

CPS agency professionals, social workers for the most part, once had a great deal of discretion in identifying and alleging maltreatment. However that discretion has been narrowed by increasingly precise statutory definitions.

The social service professionals who focus primarily on child maltreatment treatment and prevention apply yet another definition. They often define child maltreatment from a child development perspective. For example, child neglect is a "condition in which a caretaker fails to provide one or more of the ingredients deemed essential for developing a person's physical, intellectual, and emotional capacities;" children in need of protection are described as "children who have not been provided with the love, care, guidance and protection a child requires for healthy growth and development." Social service professional definitions also include a description of parental behaviors that are predicted to interfere with a the child's development.

Reporting Requirements and Definitional Conflicts

Mandatory reporting laws apply to a wide variety of professionals who, in the course of their work, come into contact with children—doctors, nurses, school administrators and teachers, psychologists, social workers, photographic film processors, and day care providers. The purpose of the reporting laws is to bring child maltreatment to the attention of CPS agencies. However, because the definitions of child maltreatment employed by mandated reporters differ, there are inconsistencies in these reports.

As discussed above, each of these professions has a different perspective and interest in child maltreatment, leading to conflict between the various disciplines which has direct consequences for the child, the family, and the legal systems. For example, the developmental definition employed by social service professionals results in a much lower threshold for intervention, and is

in direct conflict with the legal definition of "child endangerment." And while the medical community acknowledges the role of the legal and social service systems in child maltreatment, physicians often see them as secondary to the medical needs of the maltreated child. In addition, the medical community sometimes is concerned that intervention by legal and social service professionals will interfere with the medical treatment of the child. Research into these issues is presented in Chapter II of this report.

California Definitions

The following definitions are applied in California (State Department of Social Services, 1992):

Sexual Abuse

The victimization of a child by sexual activities. These activities include, but are not limited to, molestation, indecent exposure, fondling, rape, and incest.

Physical Abuse

A physical injury which is inflicted by other than accidental means on a child by a caretaker or other individual living at the same residence of child. Physical abuse includes willful cruelty, unjustifiable punishment, or corporal punishment/injury to a child.

Severe Neglect

The negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or allows the child to be placed in a situation where his/her person or health is endangered. This would include, but not be limited to intentional failure to provide necessary medical care, adequate food, clothing or shelter.

General Neglect

Negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, or supervision where no physical injury to the child has occurred.

Emotional Abuse

The nonphysical mistreatment, the results of which may be characterized by disturbed behavior on the part of the child such as severe withdrawal, regression, bizarre behavior, hyperactivity or dangerous acting-out behavior. Such disturbed behavior is not deemed, in and of itself, to be evidence of emotional abuse. Emotional abuse includes willfully causing or permitting any child to suffer, inflicting mental suffering, or endangering a child's emotional well-being.

Exploitation - The act of forcing or coercing a child into performing activities for the benefit of the caretaker (defined as the parent or caretaker) which are beyond the child's capabilities or which are illegal or degrading.

Caretaker Absence or Incapacity - The absence of caretaker due to hospitalization, incarceration, or death; incapacity of caretaker to provide adequate care for the child due to physical or emotional illness, disabling condition, or compulsive use of alcohol or narcotics.

CHAPTER II: CHILD MALTREATMENT TRENDS

A Word of Caution About the Numbers

Government-collected child maltreatment statistics include only those cases of maltreated children which are reported to child protective services (CPS) agencies. There are a significant number of cases that are not reported. Several factors contribute to under-reporting. First, some situations are not recognized as maltreatment, usually because the observer is unfamiliar with what constitutes maltreatment. Other cases are not reported because the observer may not want to get involved or may lack faith in CPS agencies to intervene appropriately. There are also instances in which reports are legitimate but maltreatment cannot be substantiated to the degree CPS believes is necessary to justify intervention. Furthermore, in many locales, there are not sufficient resources to receive and investigate these reports (Zellman, 1992).

Studies also reveal that a general lack of knowledge about, and ability to recognize child maltreatment contributes to under-reporting. For example, the 1981 National Incidence and Prevalence of Child Abuse and Neglect study found that health care professionals working in hospitals reported only about two-thirds of the cases that they actually considered to be suspicious. A study at The Johns Hopkins University School of Medicine revealed the under-reporting that was attributed to a lack of knowledge about the biomechanics and pathology of childhood injuries (Wissow & Wilson, 1992). Enhanced familiarity with this information was shown to improve the ability of health professionals to recognize intentional injury and, thus, to report it. The study also found that providing physicians with epidemiological data describing unintentional injuries (often caused by various types of accidental falls) produced a marked improvement in the physicians' ability to subsequently distinguish between intentional and unintentional injuries.

A six-state survey of professionals who are mandated by law to report suspected cases of child abuse and neglect revealed additional factors that significantly influence reporting and the perceived incidence of child maltreatment. Some of the professionals tended to more frequently recommend investigation of cases in which the child was reported to be young or had been severely abused, when the perpetrator was described as lazy or angry, or when the family was described as poor (Zellman, 1992). These findings are in part supported in an analysis of data from the 1980 and 1986 National Study of the Incidence and Prevalence of Child Abuse and Neglect (Ards & Harrell, 1993). This study found that:

- Older victims were less likely to be reported;
- Reporters tended to employ a hierarchy as to the type of maltreatment reported, with sexual abuse at the top of the list, followed by physical and emotional abuse, physical and emotional neglect, and, lastly, educational neglect; and
- Race, sex, and income did not play a role in whether or not a case was reported to CPS.

Another contributing factor to under-reporting is the lack of clearly defined terms and guidelines for reporting suspected cases to CPS agencies by mandated reporters. Reporters are considered

critical to the effectiveness of CPS agencies' mission to identify, substantiate, and serve maltreated children. Yet the national survey of these reporters found them to be generally dissatisfied with local and state CPS agencies' policies and personnel, and unsure of the benefit to be gained from reporting (Zellman & Antler, 1990; Zellman, 1990). Specifically, the degree to which mandated reporters actually make reports is directly linked to their perception of the effectiveness of the local CPS agency. Perceived poor handling of the severe cases which were reported to CPS agencies re-enforced this negative view, which was attributed to the agencies' lack of sensitivity and skills. Unfortunately, none of the CPS agency personnel interviewed believed it was important to resolve these problems. The researchers observe this as a logical response given the fact that CPS agencies lack sufficient staff and resources to attend to the suspected cases already reported.

A Canadian study of teachers conducted in 1987-88 found that they preferred informal intervention to formal reporting of suspected cases (Tite, 1993). Based on prior research-finding of poor reporting by teachers, the study attempted to understand this phenomenon. Under-reporting was found to be attributed to:

- The view that some forms of mild physical abuse are acceptable;
- Cautiousness in reporting—assuring there is sufficient supportive evidence for the report;
- Formal reports were made only after attempts to resolve the problem informally has failed; and
- A case-by-case approach to assessments that is strongly shaped by classroom circumstances.

In summary, most observers of child abuse reporting conclude there is under-reporting of suspected child maltreatment cases. However, some analysts believe that this view is incorrect and that the reverse is true—child maltreatment cases are over-reported. Citing the fact that only 40 to 45 percent of the cases reported are subsequently substantiated, these analysts view the increasing activity in this field as a troubling reflection of government's intrusion into the privacy of the family. Of particular note is Douglas J. Besharov, the first director of the National Commission on Child Abuse and Neglect (NCCAN) and now at the American Enterprise Institute. He believes that over-reporting is unacceptably high and is growing rapidly.

National Statistics

The number of reported cases of child abuse and neglect has more than doubled in the past decade. The American Association for Protecting Children (AAPC), a division of the American Humane Association, found that the number of cases reported by states increased from 669,000 in 1976 to 2,178,000 cases in 1987—more than a three-fold increase. Since 1987, the National Committee for Prevention of Child Abuse (NCPCA) and National Center on Child Abuse and Neglect (NCCAN) have found that reported child abuse and neglect has continued to increase.

NCCAN established the National Child Abuse and Neglect Data System (NCANDS) to collect and analyze data on an annual basis from every state and Washington, D.C. (NCCAN, 1991). In 1990, 1.7 million cases representing an estimated 2.6 million children were reported to state and local CPS agencies. In 1991, the last year for which data is available, the number increased to 1.8 million of reported cases representing 2.8 million children—an increase of 2.4 percent (this is a net increase; the 5 percent increase is adjusted for a 2.6 percent increase in the child population).

Of the data reported by 48 states in 1991, 41 percent of the reported cases—862,639 children—were substantiated. This represents a 3.7 percent net increase over 1990. Among these cases, 44 percent suffered neglect, 24 percent physical abuse, 15 percent sexual abuse, 6 percent emotional maltreatment, 2 percent medical neglect, and the remaining 9 percent other or unknown forms of maltreatment.

Forty-five states reported data on the types of maltreatment that victims suffered. (Since some states do not treat the categories as mutually exclusive, the total of all categories exceeds the total number of cases reported by these same 45 states).

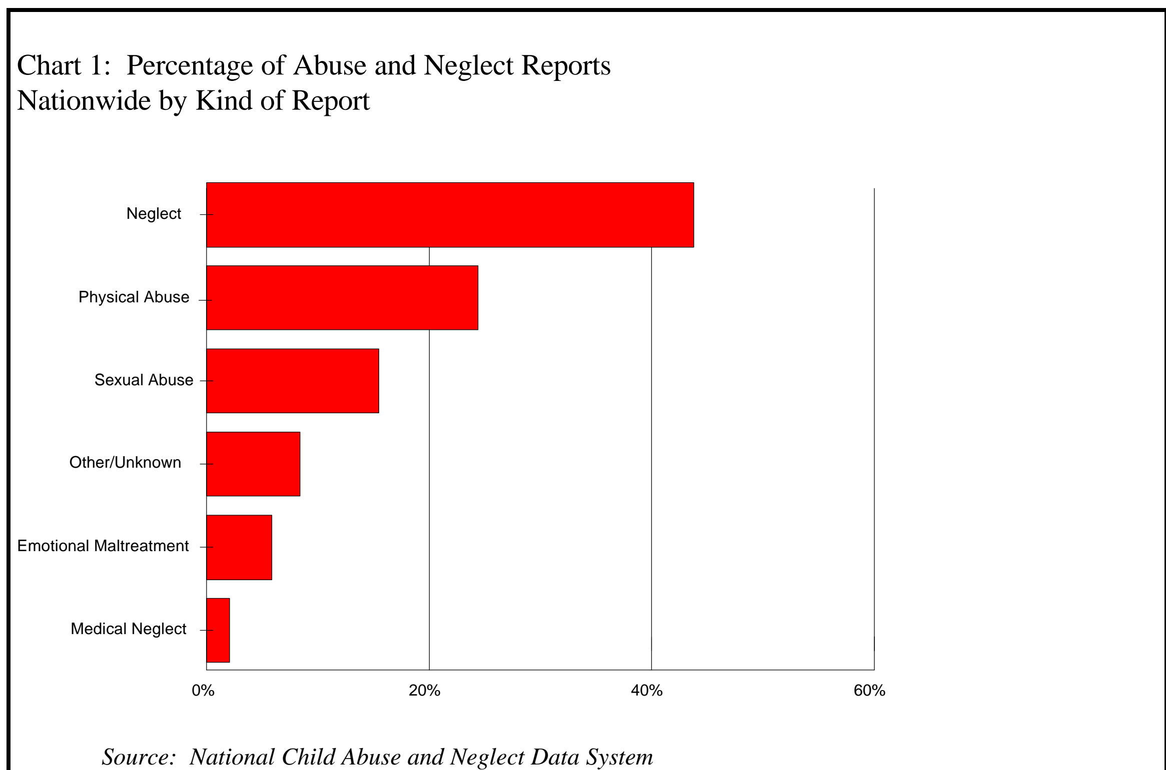
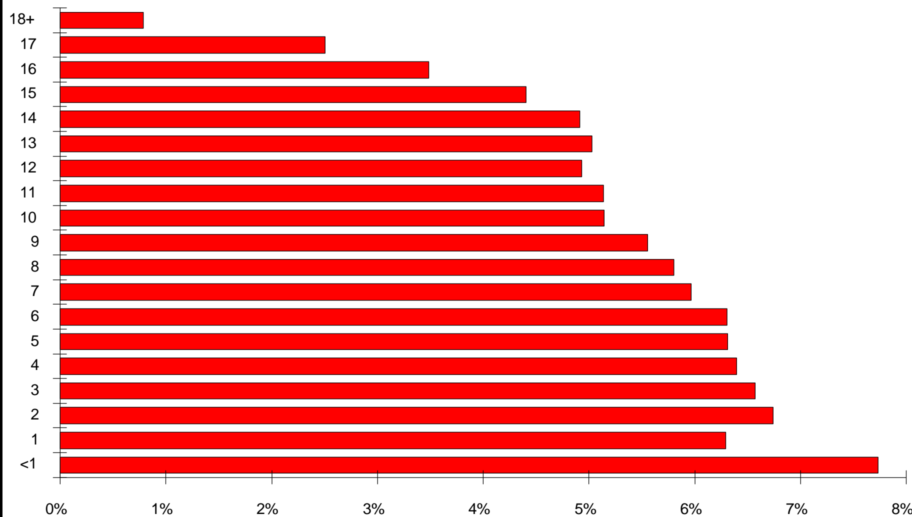


Chart 2 shows that the percentages of victims are fairly evenly distributed across most age intervals. The median age is 7 years. The highest percentage for any age (7.6 percent of the total) is for under one year of age. Forty-one percent of the reported cases nationwide were substantiated.

Chart 2: Reported Cases of Child Maltreatment
By Age Nationwide, 1991



Source: National Child Abuse and Neglect Data System

Based on the data from 45 states that reported gender, 53.2 percent of the victims are female and 46.2 percent are male (the gender of .6 percent of the cases was not reported). These numbers are nearly identical to those reported in 1990.

Forty-two states reported the race/ethnicity of victims in 1991: 55 percent were white, 26 percent black, and 9 percent Hispanic. However, because some of the states with major Hispanic populations did not report race and ethnicity, 9 percent may be a significant under-representation of this ethnic group. There are other ethnic groups for which information was not available—American Indian and Asian American in particular.

Child Deaths

Forty-five states reported 1,081 children died of child maltreatment in 1991. However, many states noted that the number of cases reported represent an under-reporting of cases, as the numbers do not include an analysis of coroner's reports or child death review teams.

In 1989, one study concluded that 9 children were victims of homicide each day (Fingerhut, 1991). Children under five, for whom the homicide rate was 2.5 per 100,000, have a high homicide rate primarily due to parental and caretaker neglect and abuse. Black and male children are also at greater risk for homicide. Only 13 percent of these deaths involved a firearm. There appears to be general consensus that these numbers represent a significant under-reporting of child maltreatment-related fatalities (Maternal and Child Health Bureau, 1993; Scholesser, Pierpont, & Poertner, 1992). It is suggested that careful attention is necessary to determine an accurate number of fatalities. This requires the establishment of multi-disciplinary death review

teams to examine all cases for cause of death and to collect demographic data on victims and perpetrators. The information could serve as the basis for establishing a more reliable estimate and improve understanding of the underlying problems present at the time of death. This information is a necessary prerequisite to designing prevention and early intervention programs to address the problem.

A study of deaths in Dade County, Florida (which includes Miami) was conducted over a 30-year period ending in 1986. The study revealed that many children died at the hands of their parents or caretakers. Specifically, it found that:

- 74 percent of the child victims lived in low income neighborhoods—only 8 percent were from middle class communities (18 percent were unknown);

- 68 percent of the perpetrators were male;

- The rate of homicide was highest during the first month of life and dropped off dramatically each year through age 14;

- Mothers were responsible for 86 percent of the deaths that occurred during the first year of a child's life;

- 78 percent of the young children died at the hands of their parents, as compared to 58 percent of the older children;

- Very few children of any age were killed by strangers or persons not known by the victim;

- Children age one month to five years were more likely to be killed as a result of injuries inflicted by parents responding to noxious behavior (crying or disobedience); and

- A very small percentage of children (7 percent neonates and 10 percent of school-age children) showed evidence of prior maltreatment.

California Trends

National data reveal that, of the 8,163,000 children residing in California in 1991, 302,834 reports of child maltreatment were made representing 416,757 children (NCANDS, 1991). 71,226 of these children (only 17 percent) were subsequently substantiated to have been maltreated. This is significantly lower than the national average of 41 percent of reported cases being substantiated.

Table 1: California Child Maltreatment Cases, 1991

Type of Abuse	Reported	Substantiated	Percent Substantiated
Total	416,757	71,226	17%
Physical abuse	204,404	38,236	19
Physical neglect	367,200	3,332	1
Medical neglect	17,266	-0-	0
Sexual abuse	129,697	25,055	19
Emotional maltreatment	49,12	4,347	9
Other	69,290	-0-	0
Unknown type of maltreatment	1,251	256	20

Source: National Child Abuse and Neglect Data System

The California data also reveal that:

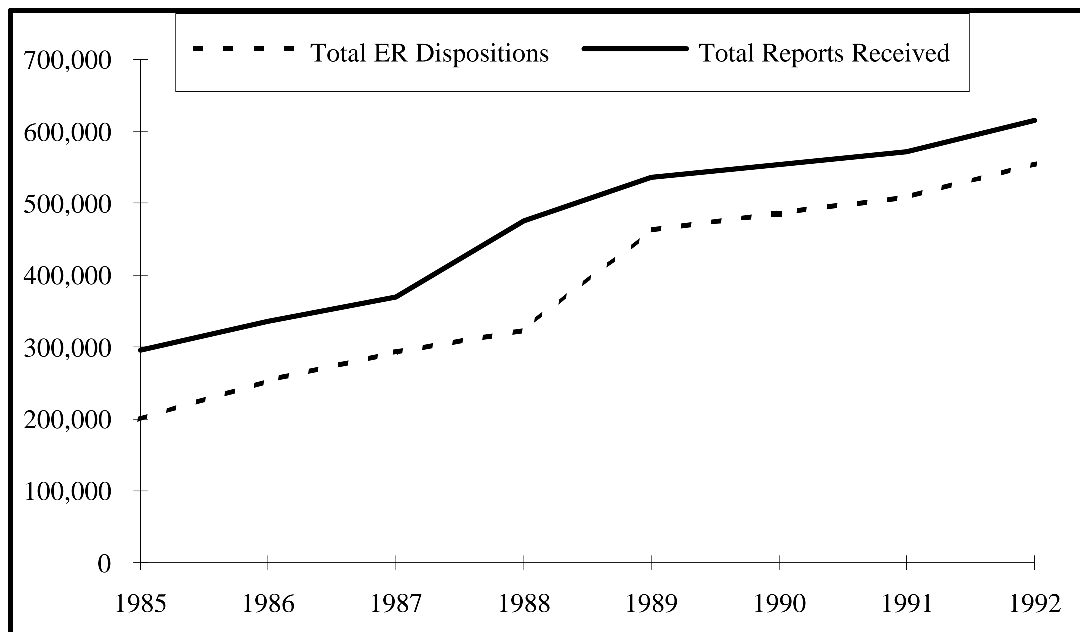
- 28,725 (40.5 percent) of the maltreated children were males; 41,681 (58.7 percent) were females, and the gender of 564 (.8 percent) children was not known; and
- Only 100 deaths were reported statewide.

Unfortunately, the state did not report detailed data to NCCAN about the source of reports of suspected maltreatment, the number of investigations by disposition, or the relationship of the perpetrator to the victim.

California Research Bureau Analysis

David Illig of the California Research Bureau recently reviewed and analyzed state incidence and service data (*California's Process for Resolving Allegations of Child Abuse and Neglect*). The following three charts are taken from Mr. Illig's report with his permission. Chart 3 shows that the number of child abuse and neglect reports has grown by 108 percent, from 295,650 in 1985 to 615,602 in 1992. Of the allegations reported in 1992, about 72 percent were either screened out over the phone (not responded to in person) or handled informally by Child Welfare Services (CWS) social workers. The comparable number for 1985 was about 67 percent of all child abuse or neglect reports. This increase in the proportion of reports that are disposed of either by phone screening or by informal means is in large part due to budget constraints facing counties.

Chart 3: Child Abuse or Neglect Reports and Emergency Response Dispositions



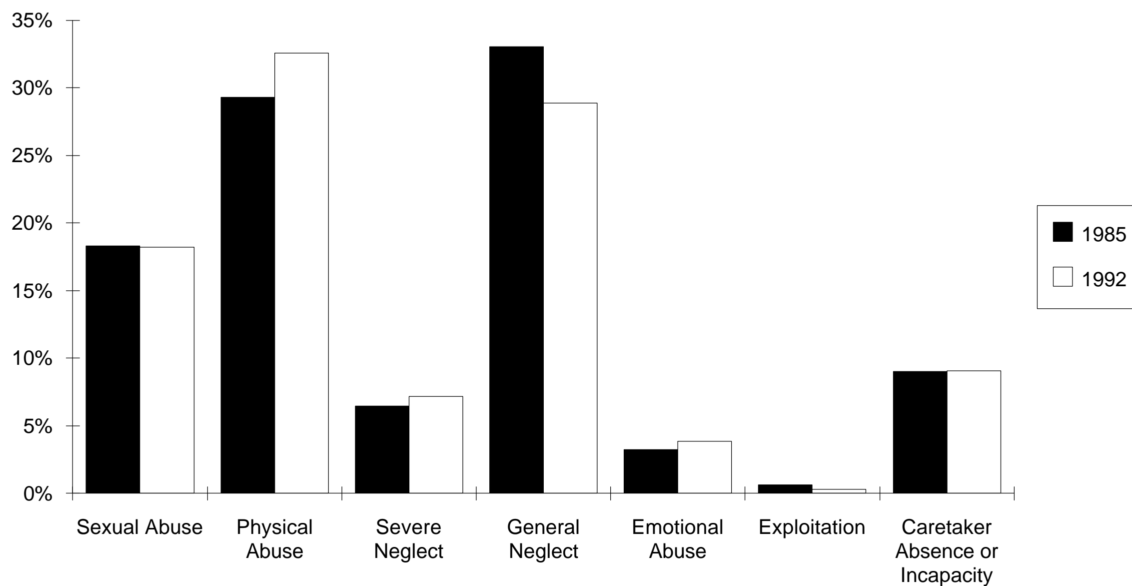
Source: California State Department of Social Services

Some of the growth in the number of California reports can be attributed to population growth, and some is due to increased reporting by persons who are now required by state law to report suspected abuse or neglect. A portion of the growth in reports can also be attributed to a number of factors that affect the functioning of families. These include:

- Increased use of illegal drugs;
- Increased out-of-wedlock births to teen parents; and
- General economic pressure on families.

Underlying these factors is the more general concern that the increase in reports of child abuse and neglect reflects a breakdown of the family structure, especially in low-income neighborhoods.

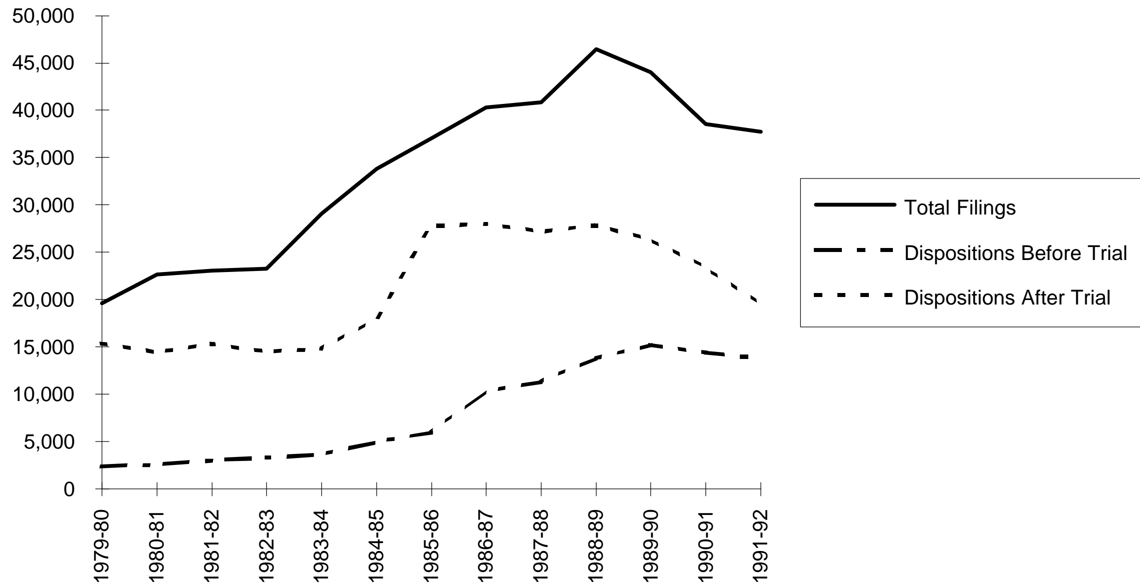
Chart 4: Percentage of Abuse and Neglect Reports by Kind of Report



Source: California State Department of Social Services

Chart 4 shows the proportion of abuse and neglect reports by type. There has been little change in the relative proportions of abuse or neglect reports between 1985 and 1992. To the extent there is a trend, it is that physical abuse has increased relative to general neglect and now is the most frequent type of report. Sexual abuse remains the third most frequent type of report at 18 percent of the total. Some practitioners suggest that there is some variation between counties in the kinds of abuse or neglect which are reported. Several county associations, including the County Welfare Directors Association, estimate that in fiscal year 1988-89 approximately 70 percent of the foster care placements resulted from parental neglect, incapacity or absence.

Table 6: Dependency Court Filings and Dispositions



Source: California Department of Justice

While California data indicate a continued increase in the number of reported cases of child maltreatment, some experts believe that this number would be even higher if county CPS agencies still employed the same definitions used in 1989. Due to significant reduction in state funding for county CPS agencies in 1989, these agencies no longer recognize, investigate, nor serve certain types of abuse and neglect. CPS agencies have also instituted informal screening mechanisms so as to prioritize reports and respond to the most pressing cases. In subsequent years, CPS resources throughout California have been reduced further. Professionals responsible for reporting suspected child maltreatment are experiencing reduced response by CPS to their reports. As a consequence, they are, except in the most serious cases, less likely to report suspected cases (Zellman, 1992). This was confirmed in a 1991 NCPCA study. That study found that, while the percentage of substantiated child abuse and neglect cases increased, the number of children that were actually served decreased from 78 percent in 1990 to 63 percent in 1991.

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CHAPTER III: CHILDREN AT RISK

This section examines the consequences of child maltreatment on the affected children. Based on a review of current research, it is evident that the consequences of child maltreatment are widespread, varied, and are present long after the period of maltreatment. There are both short- and long-term consequences of child maltreatment. The theoretical basis for distinguishing between short-term and long-term consequences is modeled on studies of the effects of child sexual abuse conducted by Canadian scholars (Beitchman, 1991 & 1992; Trute, Adkins & MacDonald, 1992). Short-term consequences are those consequences which occur during childhood, including adolescence. Long-term consequences are present in adulthood. The manifestations of consequences in adulthood are often consistent with those that occurred in childhood. However, the childhood consequences are often referred to as behavioral problems. By adulthood the consequences are clearly indicated by identifiable problems which have physical, psychological, and socio-economic impacts on the victims.

Research Limitations

There are limitations in studying the consequences of child maltreatment (Beitchman, 1991). First, the causative relationship between child maltreatment and subsequent consequences is difficult to measure. Second, circumstances which often occur with maltreatment can also have a high correlation to the consequences. An example of this is the connection between mental illness and poor school performance. A maltreated child who is mentally ill is at risk for low achievement in school. Is this a result of the mental illness or maltreatment? It is likely to be the result of both. Thus, to isolate the consequence that is specifically the result of maltreatment is difficult. Despite this limitation, there are studies in which the high correlation between maltreatment and consequences has been validly demonstrated.

Three other limitations affect the study of child maltreatment. First, victims of maltreatment are reluctant to self-report or to acknowledge that maltreatment has occurred. In a study of 11,660 college students over a nine-year period, only 26 percent of those individuals who had experienced severe physical abuse labeled themselves as physically abused (Knutson & Selner, 1994). Maltreatment is usually under-reported because self-labeling is low; consequently, victims not previously reported will rarely be studied (Moeller, 1993). Second, studies of long-term maltreatment are conducted after the fact and are dependent on the accuracy of victims' recall of past traumatic events (Moeller, 1993). This recall is very subjective and can change over time. Third, studies of the consequences of maltreatment generally over-represent females and under-represent males (Briere & Runtz, 1993; see also selected references for studies restricted to women).

Despite these limitations, recent research findings have greater measurable validity than previous studies conducted in the 1960s and '70s. One factor which has improved is the use of control groups (Beitchman, 1991; Briere & Runtz, 1993). Another factor is the stronger methodological basis for current research and increasing use of demographically similar control groups. These

research improvements increase the validity of results, invite replication of studies, and establish a baseline of data for longitudinal studies.

Short-Term Consequences

Short-term consequences tend to be categorized in two ways: by the type of maltreatment or the age of the victim. The following discussion divides short-term consequences into three categories: preschool-aged children, school-aged children, and adolescents. Types of abuse and duration of abuse are be discussed in relation to the consequences.

Preschool Children

In a study of preschool children who had previously been documented as having been maltreated, the following characteristics were identified as significantly different from a control group of nonabused preschool children (Vondra, 1990):

- Poorer receptive language;
- Less competence in cognitive or physical skills; and
- Less able or willing to follow directions in carrying out early school-like tasks without one-on-one supervision.

Other studies indicate that children with histories of neglect exhibit the following characteristics (Crittenden, 1992 & Drotar, 1990; Beitchman, 1990):

- Attachment disturbances;
- Anxious or avoidant patterns of behavior with others; and
- Withdrawn.

The developmental stage of preschool children makes some behavioral measurement difficult to conduct. Consequences which occur in school-aged children may also be present in preschool-aged victims, but have not been validly measured.

School-aged Children

Studies of pre-adolescent, school-aged children indicate wider behavioral disturbances as a consequence of maltreatment. Several studies have found differing behavioral responses depending on the type and duration of maltreatment. The research base is large enough to divide this discussion into consequences which are the result of a particular type of maltreatment.

Sexual Abuse. The following consequences of child sexual abuse have been found (Beitchman, 1991; Elliott, 1991; Briere & Runtz, 1993; Dubowitz, 1993; Mannarino & Cohen, 1991; Wozencraft, 1991):

- Long-term and short-term post traumatic stress disorder (PTSD). Symptoms of PTSD include flashbacks, nightmares, sleep disturbances, and poor concentration;

- Inappropriate sexual or sexualized behavior, such as excessive masturbation;
- Behavior problems such as depression, aggression, anti-social acts, and withdrawal;
- Anxiety; and
- Poor school performance.

Additionally, two studies have found that behavioral response to maltreatment does not significantly change in the short-term (Mannarino & Cohen, 1991; Dubowitz, 1993). Dubowitz postulated that children's behavioral response to sexual abuse does not go away over time. The short-term periods examined were four-, six-, and twelve-month follow-up studies. Another study of six- and twelve-month follow-up supported Dubowitz's hypothesis. Findings show that the use of force and sexual abuse (which includes intercourse or penetration) does significantly increase the number and nature of behavioral problems (Mannarino & Cohen, 1991; Beitchman, 1991).

Physical Abuse. The following are consequences of physical abuse identified by research ((Kurtz, 1993; Widom, 1992; Beitchman, 1991):

- Increased aggressive behavior and criminal behavior;
- Poor school performance as evidenced by victims repeating grades two times more frequently than a comparison group, more classroom behavior problems, and poor standardized test scores; and
- Evidence of behavioral problems such as a high degree of anger, anxiousness, and lack of self-control, all of which impede learning in school.

Emotional Maltreatment . The following consequences of psychological abuse have been identified (Vissing, 1991):

- Higher rates of physical aggression;
- Delinquency; and
- Interpersonal problems.

Neglect. The consequences of neglect have been studied less than other types of maltreatment. One study indicates the following consequences of psychological abuse (Kurtz, 1993):

- The rate of school absence for neglected children was five times greater than that of a control group;
- The repeat of grades was two times greater than that of a comparison group; and
- Neglected children did not differ from non-maltreated children in socio-emotional adjustment.

Conclusions. Some global consequences of maltreatment can be drawn from the research. School-aged children will begin to perform poorly in school, have a tendency toward aggressive behavior, have low self-esteem, and exhibit behavioral problems. Later manifestations of these difficulties are evident in the consequences of maltreatment shown by adolescents.

Adolescents

By the age of adolescence, consequences of maltreatment are broader and have larger social impact. This is related to two factors: the increased sexual activities of adolescents and the increased crime-related activities of adolescents (juveniles in legal terminology). The following findings are separated by types of abuse. However, some studies suggest that many children are subject to more than one type of abuse. Typically, when a child is the victim of multiple types of abuse the number of problems or the severity of the problems increase. Longer duration of maltreatment also leads to more types of problems and an increased severity of consequences (Beitchman, 1991).

Sexual Abuse. The following consequences of sexual abuse were evident (Boyer & Fine, 1992; Elliott; Beitchman, 1991):

- Post traumatic stress disorder (PTSD);
- Low self-esteem, guilt, and self-blame;
- Depressive or schizoid tendencies and anxiety;
- Suicidal ideation and suicide attempts;
- Increased incidence of teen-age pregnancy;
- Teen-age mothers who had been abused were three times more likely to maltreat their own children; and
- Increased sexualized behavior which may include prostitution, compulsive masturbation, and likelihood of pregnancy.

Physical Abuse. The following consequences of physical abuse were found (Lewis, 1988; Widon, 1992):

- 53 percent higher likelihood to be arrested for a criminal act than a nonabused juvenile;
- 38 percent higher likelihood to be arrested for a violent crime than a nonabused juvenile; and
- Of 14 juveniles condemned to death in the U.S., 12 had been brutally, physically abused. The mean age at the time of the offense was 16 years 6 months.

Other Types of Abuse or Multiple Abuses. The following consequences of other types of abuse and multiple forms of maltreatment were evident (Vissing, 1991; Widom, 1992)

- Victims of physical abuse and neglect, on average, began committing crimes at a younger age, committed more crimes, and were arrested more frequently than the comparison group;
- Neglect alone was significantly related to violent criminal behavior;
- Verbal abuse led to higher rates of physical aggression, delinquency and interpersonal problems; and
- Verbal abuse *and* severe physical abuse *significantly* increased rates of aggression, delinquency and interpersonal problems.

Conclusions. The consequences of maltreatment as exhibited by adolescents show an increase of violent and self-destructive acts committed by victims. From this it can be inferred that the older the victim the greater the potential for harming others and the higher the cost to society in increased crime, teen-age pregnancy, and poor school performance.

Long Term Consequences

Sexual Abuse

The following consequences of sexual abuse were evident (Beitchman, 1991 & 1992; Briere & Runtz, 1993; Saunders, 1992; Swett & Halpern, 1993;):

- Higher likelihood of abusing their own children;
- Suicidal ideas and behavior when exposed to force or violence;
- Mental illness, depression, and/or anxiety;
- Increased substance abuse;
- Eating disorders; and
- Post traumatic stress disorder (PTSD) was present an average of 30 years after the initial assaults.

Physical Abuse

The following consequences of physical abuse were identified in the research literature (Martin & Elmer, 1992; Swett & Halpern, 1993; Widom, 1992):

- High level of unemployment and low-skill employment ;
- Health problems such as mental illness and physical disabilities; and
- Increased criminal behavior in females.

Other Abuse

The following consequences of abuse were evident (Downs, 1992; Lewis, 1989; Moeller, Bachmann & J. R. Moeller, 1993; Widom, 1992):

- Father-to-daughter verbal abuse is predictive of female alcoholism or alcohol-related problems;
- Neglect increases the likelihood of female adult criminal behavior by 77 percent over non-abused females;
- Females who experienced two or more types of abuse reported: significantly lower employment satisfaction; 50 percent higher rate of hospitalizations for health problems, and; lower perception of psychological well-being; and
- Higher rates of violent criminal behavior among victims of abuse who also have cognitive impairment, psychotic symptom, or neurological dysfunction.

Conclusions

In summary, long-term global consequences of maltreatment include: serious psychological disorders; increased criminal behavior; predisposition to victimize offspring; poor employment prospects; and serious medical and substance abuse problems. Again, victims of multiple types of abuse have a greater number of and enhanced severity of abuse-related consequences. Despite increased public awareness of child maltreatment, the researchers report that transgenerational abuse still continues and comment on the theory of abuse known as the "cycle of violence."

CHAPTER IV - WHO IS AT RISK?

Risk Factors for Child Maltreatment

A number of significant studies have been undertaken over the past decades to determine the causes of child abuse. While few studies are completely conclusive, the following table best captures those conditions commonly identified as enhancing and mitigating the risk for child maltreatment.

TABLE 2: Risk Factors for Child Maltreatment

FACTORS ENHANCING RISK	FACTORS MITIGATING RISK
Poverty Unemployment Social isolation Mobility Economic insecurity Recent job loss Lack of social support Low education Poor self-concept Low self-esteem Crowded housing Greater potential for interpersonal conflict (including family violence) Limited child care opportunities Cultural traditions emphasizing physical discipline Dual wage-earners Limited emotional and material resources Low job satisfaction Higher alienation/lack of extended family or other supports Higher levels of alcoholism, drug abuse, and depression Poor health status of parent Disabled child Child maltreatment victim Single parent	Value children Adaptive skills Support from extended family Religious beliefs Strong parent-child attachment Proficiency in mobilizing and using resources Intolerance of abusive parenting practices Strong sense of family loyalty

Source: Larson, Doris, & Alvarez, 1990.

As part of their review of suspected child maltreatment reports, CPS agency staff use risk assessment tools that measure the presence of these factors. As with other aspects of child maltreatment, the factors are subject to continual review and revision.

The Demographics of Families in Which Child Maltreatment Occurs

The background and social characteristics of the children and families vary by type of abuse. An extensive analysis of national data revealed a number of significant findings (Jones & McCurdy, 1992). The study results are displayed in Table 3.

Table 3: Demographic Indicators of Families

VARIABLES	Total	Physical Abuse	Sexual Abuse	Emotional Abuse	Physical Abuse
Number of Children Studied	2,814	829	483	387	1115
Age					
0-2	21.4	19.1	6.8	11.4	32.9
3-5	17.0	14.0	20.9	11.1	19.5
6-9	21.6	23.0	25.5	19.1	19.7
10-12	13.1	13.0	18.4	14.7	10.3
12+	25.0	29.7	28.4	42.1	14.1
Unknown	2.0	1.2	---	1.6	3.5
Sex					
Male	45.7	54.3	15.9	47.8	51.5
Female	53.9	45.6	83.9	51.4	48.0
Unknown	0.4	0.1	0.2	0.8	0.5
Race					
White	49.5	50.5	54.9	57.6	43.6
Black	30.4	26.7	25.9	25.8	36.8
Other	17.7	20.7	17.4	13.4	17.1
Unknown	2.3	2.1	1.9	3.1	2.5
Age of Mother					
12-19 years	4.1	3.9	1.4	2.6	6.0
20-25 years	17.1	17.9	12.8	8.3	21.3
26-34 years	30.8	26.9	30.8	32.6	33.2
35-70 years	21.0	19.9	23.6	35.9	15.6
Unknown	26.9	31.5	31.3	20.9	23.9
Employment Status of Mother					
Employed F/T	21.1	24.7	23.8	25.8	15.6
Employed P/T	5.1	5.3	5.6	5.7	4.5
Looking for Work	13.3	10.5	12.0	13.2	16.0
Not in Labor Force	34.5	30.2	25.5	39.8	39.7
Unknown	26.0	29.3	33.1	15.5	24.2
Age of Father					
12-19 years	0.5	0.4	0.2	0.5	0.7
20-25 years	4.4	6.0	4.1	2.1	4.0
26-34 years	13.9	14.5	19.0	12.4	11.7
35-70 years	15.7	20.0	19.5	24.5	7.8
Unknown	65.5	59.1	57.1	60.5	75.7

Income					
<$15,0000	55.3	46.8	47.6	55.0	65.0
$15,000 & >	21.9	28.7	31.5	28.9	10.2
Unknown	22.8	24.5	20.9	16.0	24.8
Employment Status of Father					
Employed F/T	24.5	32.6	27.7	31.5	14.6
Employed P/T	2.9	2.3	3.5	3.1	3.0
Looking for Work	4.9	4.3	6.0	4.1	5.1
Not in Labor Force	6.3	5.2	4.8	10.6	6.4
Unknown	61.4	55.6	58.0	50.6	70.9
AFDC					
Yes	30.9	20.4	21.7	29.7	43.1
No	39.9	44.3	47.0	50.1	30.0
Unknown	29.2	35.4	31.3	20.2	26.8
Family Composition					
Two Parent	39.8	46.4	47.6	45.5	29.5
Female Head	30.3	25.6	26.1	25.3	37.3
Male Head	3.4	4.2	3.1	2.6	3.2
Unknown	26.5	23.8	23.2	26.6	30.0
Number of Children					
1 child	23.0	28.3	24.6	17.6	20.1
2 children	29.1.	28.6	32.3	31.8	27.1
3 children	20.4	18.3	20.5	23.5	20.8
4+ children	20.0	16.6	16.4	20.2	23.9
Unknown	7.6	8.1	6.2	7.0	8.1
County Size					
Large SMSA	45.5	47.9	51.8	35.9	44.4
Other SMSA	46.4	44.6	41.8	53.7	47.2
Non-SMSA	8.1	7.5	6.4	10.3	8.4
Perpetrator					
Parent/Sub living in	22.6	22.0	7.9	21.4	30.0
home	4.6	6.2	9.3	4.1	1.6
Parent/Sub not in	7.7	10.7	12.4	7.5	3.6
home	9.2	7.5	30.4	5.2	2.8
Paramour of parent	55.8	53.7	40.4	61.8	62.1
Other					
Unknown					
Age of Perpetrator					
12-19 years	2.1	2.8	4.3	1.0	0.9
26-34 years	6.2	6.0	10.1	2.6	5.8
20-25 years	13.0	12.1	15.3	10.9	13.5
35-70 years	12.8	13.4	21.1	14.5	8.2
Unknown	66.0	65.7	49.1	71.1	71.7
# of Times					
Maltreated	58.6				
One time	25.9				
Two times	15.5				
Three times					

Source: Jones and McCurdy, 1992

The data was carefully analyzed to determine the directional relationship between all the variables recorded. The most significant findings were that:

- Physical neglect continues to be the most frequently reported type of maltreatment (at approximately 55 percent), followed by physical abuse, sexual abuse and emotional maltreatment.
- The likelihood of various forms of neglect occurring decreases as children get older.
- Children under three suffer physical neglect more often than any other form of maltreatment and children age five and under experience the highest amount of physical neglect.
- Children between the ages of three and five are the most likely to experience sexual abuse. This is a significantly younger age than previously reported, due most likely to the sampling methodology used for this study. The finding is supported by the experience of one major treatment center which reported that 25 percent of their clients are age five and under. It is also consistent with the belief that sexual abuse generally has been occurring for quite some time before it is reported.
- The mother's age is strongly correlated with the type of maltreatment children experience. Children with young mothers have the strongest likelihood of being physically abused; older mothers are more likely to emotionally mistreat their children, as opposed to physical abuse or neglect.
- Race correlates with two types of maltreatment. Black children are at higher risk than white children to be neglected, while white children are at higher risk of sexual abuse. Minority status has little influence on the likelihood of neglect occurring.
- Children from one-parent families (which are predominantly female-headed households) with annual incomes below $15,000 are significantly more likely to be neglected. However, unemployment and receipt of AFDC are not directly correlated to neglect. Neglect does appear to be a problem of economics.
- Children who are physically and sexually abused are more likely to live in large urban counties. This is also true to a lesser extent for children suffering from physical neglect. Children in large counties are at greater risk than children in smaller counties.
- Neither the mother's age nor the size of the family is associated with the increased likelihood of maltreatment.

Another study found that the rate of child abuse in single-parent homes is almost twice as high as that found in two-parent homes (Sack, Mason & Higgins, 1985).

The Study of National Incidence and Prevalence of Child Abuse and Neglect (NIS-1), published in 1988, found that family income and family size were significant risk factors for child maltreatment. This same study revealed that child maltreatment was seven times more likely to occur in families with incomes under $15,000 than in families with higher incomes.

Illegitimacy.

A study of adolescent males on probation found that illegitimate birth was associated with negative consequences for cognitive development (Walsh). This was particularly true for illegitimate males whose mothers remained unmarried. The researchers concluded that these circumstances also were conducive to higher levels of abuse and neglect than is found in more traditional families. With an estimated 800,000 illegitimate births occurring each year in the U.S., these findings have very significant implications.

Migrant Farmworkers

A study of child maltreatment among the children of migrant farmworkers, a population disproportionately impacted by extreme and sustained poverty, found that these children are at a significantly increased risk of child maltreatment (Larson, Doris, & Alvarez, 1990). The study, conducted in five states, reported that the rate for child maltreatment among migrant farmworker families varied from 5.1 to 40.2 per 1,000 children, or 1.5 to 6.4 times the rate reported for the general populations in each state.

Substance Abuse

Substance abuse has become an increasingly significant problem among the families of abused and neglected children. Incidence statistics for 1989/1990 range from 100,000 to 370,000 throughout the country. The wide variation is due to the different estimating methodologies used. According to the National Committee for Prevention of Child Abuse (NCPCA), an estimated 675,000 children were seriously mistreated by an alcoholic or drug-abusing caretaker (NCPCA, 1989). NCPCA estimates that substance abuse is a factor in 20 to 90 percent of child maltreatment reports.

Substance abuse and child maltreatment is particularly associated in the epidemic of perinatally drug-exposed infants. A study of the relationship between prenatal exposure to drugs and parenting stress and child maltreatment found that the mothers of drug-exposed infants have higher levels of stress than other caretakers of the infants, and significantly higher stress levels than caretakers of infants not exposed to drugs. The researcher concluded that the combination of the mothers' child-related stress level and the special problems and needs of drug-exposed infants made for a high probability that maltreatment would occur. It is concluded that CPS agency intervention is appropriate and recommended (Kelley, 1992).

Spouse Abuse

The U.S. Surgeon General reported at a Workshop on Violence and Public Health, (in October 1985) that children are at increased risk of injury in a violent household, in part because they may be caught in the middle while trying to protect a victimized parent. Violence in the home is strongly linked with other negative outcomes. According to the National Women Abuse Prevention Project:

- A 1984 study found that battered mothers were 8 times more likely than other mothers to abuse their children (Walker, 1984);

- Children from violent homes are at higher risk of alcohol and drug abuse and juvenile delinquency;

- Children in homes where domestic violence occurs are physically abused or seriously neglected at a rate 1,500 percent higher than the national average in the general population;

- Research results suggest that battering is the single most common factor among mothers of abused children; and

- Although the link between child maltreatment and domestic violence has been well established, this data is not collected by child protection services agencies.

Abuse in Residential Care Settings

Some researchers suggest that child maltreatment complaint rates may be twice as high in out-of-home residential settings than for children living with their own families (Rabb & Rindfleisch, 1985; Rindfleisch & Ray, 1984). The perpetrators may be either a custodian/parent or another child/resident. A recent study found that (Blatt, 1992):

- Children maltreated in residential care settings were older than children maltreated in familial settings;
- Younger staff were more likely involved in incidents than older staff;
- Male staff were more likely involved than female staff; incidents more likely to occur during off hours; and
- Incidents that did occur during normal business hours were likely to be registered more quickly than after hour incidents.

Another study (Spencer & Knudsen, 1992) reports that:

- Maltreatment rates are higher in full-time facilities (foster homes, residential homes [group homes], state institutions, and hospitals) as compared to part-time facilities (e.g., day care and schools);
- In foster homes, physical abuse is the most common form of maltreatment;

- Sexual abuse is more likely to occur in other types of facilities (residential homes, state institutions, and hospitals) than physical abuse; and
- Sexual abuse is over two times as likely to be reported in foster homes and over 30 times as likely in residential homes than in the child's own home.

TABLE 4: RISK OF CHILD MALTREATMENT IN OUT-OF-HOME CARE SETTINGS, 1987 - 1990

TYPE OF FACILITY	CUSTODIAL PERPETRATORS	CHILD PERPETRATORS
Foster Homes	78%	6%
Residential Homes	25	70
State Institutions	45	50
Hospitals	33	67

Source: Spencer & Knudsen, 1992.

There were also important age differences depending on the institutional settings.

Table 5: Average Age of Resident In Maltreatment Cases

SETTING	AGE
Foster Home	10.8 years
School	12.3
Residential Homes & Hospitals	13.9

Source: Spencer & Knudsen, 1992.

The conclusion reached in this study is that children in out-of-home residential settings are not removed from the risk of abuse or neglect. This conclusion raises serious questions about current policies generally followed by child welfare agencies. Two alternatives are suggested: (1) increase the child-staff ratios (a costly option); or (2) keep the child with the family of origin while providing resources to improve the standard of living, along with timely personalized social support and specific educational services.

Additional research is recommended to identify and understand the variables associated with child maltreatment in residential care settings. Staff training and turnover rates, for example, may be important. This information would be particularly useful for county CPS agencies. A better understanding of the circumstances under which child maltreatment occurs in out-of-home settings would enable CPS agencies to better screen facilities and train staff.

CHAPTER V: PREVENTION AND EARLY INTERVENTION PROGRAMS

An Historical Overview

Historically, maltreated children were not accorded any special treatment because of abuse or neglect, but were treated the same as other needy children (those who were destitute either because their parents had died or could or would not support them). For the most part, they were placed in orphanages and foster homes or, until child labor was outlawed, apprenticed or indentured. As in-home public relief programs for destitute children and their families expanded, the majority of the dependent children population became increasingly composed of the abused and neglected.

Federal Programs

Aid for Dependent Children. The federal government's first child welfare program was Aid For Dependent Children (AFDC), Section IV of the Social Security Act of 1935. In its original form, the program provided assistance to families in which the father had died or had abandoned the family. As with other portions of the Social Security Act, funding and administration of this cash assistance program was (and continues to be) shared with the states. Consequently, the states have had a great deal of discretion in the administration of AFDC. AFDC is an entitlement program which guarantees assistance to all eligible families.

In 1961 two significant changes in the federal AFDC program took place. First, the "Fleming Rule," issued by the U.S. Department of Health, Education, and Welfare, required states to provide assistance to all financially eligible families. Until then, some states had denied aid to "unsuitable" households. This rule also required states to provide assistance to eligible families to improve their living conditions and to place the children in out-of-home care when necessary. That same year, Congress expanded the AFDC program to include a foster care component, providing payments for the care of poor children who required out-of-home care.

Until the 1960s federal programs were primarily cash assistance programs, consistent with the societal view that child maltreatment was a result of poverty. However, in 1961 the federal government began to acknowledge that cash assistance alone was not going to address the needs of all of these families. This change in federal policy was largely a result of research conducted by the American Humane Association (1955) which documented the prevalence of child maltreatment throughout all social classes. Concurrently, a medical diagnosis for child abuse was established and an effort was undertaken by the medical community to focus attention on the problem. These efforts culminated in the enactment of federal and state mandated child abuse reporting laws in the 1960s. In 1963 California enacted laws requiring physicians to report suspected physical abuse to county welfare agencies. The statutes were expanded significantly in the 1960s and 1970s to include reporting by other professionals and other types of maltreatment.

Aid For Dependent Children - Foster Care. The foster care program component of AFDC was enacted in the 1970s. The number of children placed in foster care grew dramatically when statutory changes made in the 1980s expanded eligibility. Greater public awareness of child maltreatment also contributed to the significant increase in the number of children placed in foster homes.

Child Abuse Prevention and Treatment Act. In 1974 the federal government enacted the first nationwide program directly aimed at addressing child maltreatment, the Child Abuse Prevention and Treatment Act of 1974 (CAPTA). CAPTA required states to establish mandatory reporting systems. Until the late 1980s, reauthorization of CAPTA included frequent increasing in funding. CAPTA is not an entitlement program; activities exist only to the extent funding is available.

Child Abuse Prevention, Adoption and Family Services Act. In 1988 the federal government enacted other legislation to prevent child abuse. The Child Abuse Prevention, Adoption and Family Services Act expanded prevention and early intervention efforts by creating the National Clearinghouse for Child Abuse Information, and establishing advisory efforts at local, state, and federal governmental levels. The advisory organizations include: the U.S. Advisory Board on Child Abuse and Neglect; the state and local Inter-Agency Task Force on Child Abuse; and the National Center on Child Abuse and Neglect (NCCAN). NCCAN's charge is to expand public awareness through voluntary and community organizations, to conduct research, and to sponsor demonstration projects to better understand and improve management and treatment of the problem.

Adoption Assistance and Child Welfare Act. A number of factors led to the enactment of the Adoption Assistance and Child Welfare Act:

- The increasing number of children in foster care;

- The length of time children spent in foster care during dependency proceedings (referred to as "foster care drift") was becoming excessive and costly. (Foster care drift refers to the practice of placing children in foster care ostensibly on a temporary basis, yet these children actually stay in foster care for long periods of time, often including moves from home to home without any long-term resolution of their circumstance. This practice has been found to be harmful to the children.); and

- The emerging consensus among child maltreatment experts and advocates that efforts should be made to reunify families.

Independent Living Program. Research findings in the early 1980s and surveys of homeless shelters beginning in the mid-1980s found that adolescent youth emancipated from long-term foster care were not acquiring the education, job training, or personal coping skills required for a successful transition to adult life. As a result, the Independent Living Program was established to provide assistance to foster care children aged 16 and older. Under this program, states are authorized to provide a range of services designed to improve the prospects for long-term foster care children to live independently after they leave foster care.

Family Preservation and Support. The Family Preservation and Support Services (FPSS) Act is the most recent federal legislation which addresses child maltreatment. Enacted in September 1993, FPSS represents an important shift in federal policy and funding to a strategy of family-focused prevention and early intervention services which address the underlying issues associated with child maltreatment. "Family preservation" is defined as alternative services that are of an intensive, short-term nature and are provided to the family in the home. The goal is to improve the ability of families to cope with personal, financial, and other crises, and to attend to the needs of the children in a home setting without removal to out-of-home care. The range of services is designed to reverse problems that, if left unattended, could place children at risk of maltreatment (NCSL, 1994). FPSS is a capped entitlement program.

California Programs

Mandated Reporters and Reporting Data Systems. In 1965 and again in 1974, California enacted extensive mandated reporting statutes that specify who is required to report suspected child maltreatment cases to local child protective services (CPS) agencies. In addition, in keeping with the requirements of the federal CAPTA, California operates a Statewide Index of Child Abuse to monitor and support child abuse reporting efforts.

Child Welfare Services. Chapter 978, Statutes of 1982 (SB 14, Presley) conformed California's system for resolving child abuse or neglect cases to federal legislation. In 1987, Chapter 1485 (SB 243, Presley) made a number of changes which tightened out-of-home placement:

- Termination of parental rights and removal from the home was made dependent on a finding that the child is in danger;
- The definition of physical abuse was narrowed;
- The primary goal of the dependency system was defined as preservation of the family; and
- The priority for out-of-home placement with a relative over a foster home was re-emphasized.

Most recently, California has enacted family presentation programs to reduce the number of maltreated children placed in out-of-home care and to address the multiple needs of these children and their families. The legislation is based on the significant increases in the number of children placed in out-of-home care, and on increasing recognition that children entering the out-of-home care system in recent years have greater needs than was true earlier (Ten Reasons, 1990). For example, the length of stay in foster care increased 43 percent between 1985 and 1988, and the proportion of children needing intensive group home services increased 58 percent between 1985 and 1989.

Family preservation programs were initially authorized as a demonstration project in three counties (AB 558, Hannigan). State statutes authorizing all counties to establish family preservation programs, funded from a portion of their allocation of state foster care funding, were enacted in 1990, 1991, and 1992 (Chapter 1117, Statutes of 1990; Chapters 91 and 868, Statutes of 1991; Chapter 717, Statutes of 1992 - all authored by Bronzan).

Current Programs

Child maltreatment programs typically address one or more of three areas (NCCAN, 1993):

- Prevention and education (primary prevention);
- Intervention (secondary prevention); and
- Treatment (tertiary prevention).

Prevention and Education Programs

These programs are directed at the general population with the goal of preventing maltreatment from occurring. Public education, particularly through the media, is designed to raise the awareness of the general public and decision makers about the significant dimensions of child maltreatment.

There are a wide array of activities targeted at families in which there is a risk of child maltreatment occurring (see Chapter IV for a description of the indicators). Most of these activities are designed to address other specific needs and problems, and therefore do not initially appear to have any relationship to child maltreatment. However, by serving to support the efforts of parents to provide adequate care for their children, these programs have proven very effective in preventing child maltreatment. They include:

- Accessible maternal and child health care;
- Public education that includes age-appropriate life-skills training for both children and parents; and
- Parks and recreation programs to enhance physical, intellectual, social, and emotional development, and for after-school supervision.

Intervention Programs

These programs target families in which one or more of the indicators highly associated with child maltreatment are present and child maltreatment is occurring. These activities encompass a range of strategies:

- Poverty assistance, primarily in the form of income supplements and food; affordable housing, health care, and child day care; education; job training; and employment opportunities;
- Early childhood education programs such as Head Start;
- Home health visitation;
- Family planning;
- Parent skills training; and
- Strengthening social network supports.

Treatment Programs

Treatment of child abuse encompasses a broad array of services, including those described as "prevention" and "intervention" services. In addition, local CPS agencies can refer family members for mental health services, drug treatment, and other services which address the acute issues which are the source of the family problem. If it is determined that a child needs an alternative living arrangement, CPS may elect to remove the child to out-of-home placement.

Program Funding and Mandates

Federal Programs. Federal programs encompass a broad range of activities, including cash assistance for low income families, service programs for targeted populations, and outreach and prevention programs that serve both targeted populations and the broader population (see preceding discussion for a more detailed description). The role of the federal government has been to prescribe the services to be provided and to whom, and provide some or all of the funds required to deliver these services.

Federal funding is awarded directly to states by formulae or, in the case of entitlement programs, according to caseloads. In addition, some programs utilize a competitive grant application process, which is the only means by which non-state agencies traditionally gain access to federal funds. There are a number of federal programs that by design or legislative history are administered by states as formula-driven or competitive grants to local and community agencies.

California Programs. As with federal programs, state programs also encompass a broad range of similar activities—cash assistance for low income families, service programs for targeted populations, and outreach and prevention programs that serve both targeted families and the broader population. The state also provides funding utilizing the formula, caseload-driven, and grant-making processes. The state prescribes services to be delivered and provide some or all of the funds for delivering those services.

Program Mandates. There are significant differences in the federal-state relationship as compared to the relationship between the state and local governments.

Due to the constitutional autonomy afforded states, the federal government cannot mandate that services be provided or that a problem be addressed by a state. However, the federal government can and does prescribe, as a condition of participation in a federal program, who is to be served and how. It is a common criticism that states are being forced by the federal government to do something. This perception is attributable to several things. First, some mandates do result from federal and state court orders (such as serving illegal immigrants). Second, participation in a federal program is generally desirable because federal funds can significantly assist in addressing state problems. However, the strings attached to federal programs can result in significant costs to the state.

State and local relationships are less co-equal, since local governments generally do not have standing in the U.S. Constitution. California does in fact mandate that local jurisdictions serve

specific populations. In the health and humans services area, the most well known and far reaching of these mandates is Welfare & Institutions Codes Sections 17000 and 17001. Together, these statutes charge counties with the responsibility for the health and human service needs of the indigent as the "provider of last resort." Thus, regardless of state funding, counties must provide health and welfare services to those in need. In large degree this responsibility is mitigated by state and federal programs and funds. Regardless, however, counties do remain ultimately responsible for the indigent. Thus, changes in state and federal programs and their funding levels can have a significant impact on California local government.

In addition to statutory mandates, there are other significant pressures placed on local government to deliver program services established by the state and federal government. In California, the constitutional requirement that all local mandates enacted since the late 1970s be funded by the state is enforced through a difficult mechanism and exacerbated at times by negative rulings by the Commission on State Mandates. Thus, while technically requirements and programs enacted by the state and mandated for local government require full funding, there are many instances in which this funding is provided in part or not at all.

Federal Programs Implementation

Federal Programs. The federal system has been compared to a marble cake, in that responsibilities for establishing and administering programs flow unevenly through federal, state, and local layers. State and local agencies have significant responsibilities and considerable leeway in implementing federal programs. For example, funding for federal child maltreatment programs is directed to the California State Department of Social Services (SDSS), county child protective services (CPS) agencies, and/or local community based organizations (CBOs).

Child Abuse Prevention and Treatment Act (CAPTA). The federal Child Abuse Prevention and Treatment Act (CAPTA) provides grants to SDSS to promote local child abuse and neglect prevention programs and to support mandated child abuse and neglect reporting laws. In California these activities are managed by the Office of Child Abuse Prevention. SDSS contracts with private nonprofit organizations which actually provide services, such as CPS staff training.

Adoption Assistance and Child Welfare Act. SDSS receives federal funds to provide assistance to families who adopt children with special needs and to fund an administrative structure to resolve dependency cases more quickly. Administrative requirements include:

- Periodic case reviews;
- Efforts to reunite families; and
- Movement to "permanency planning" for children in out-of-home placements after 18 months. "Permanency planning" requires a determination as to whether a child is able to be adopted, should move to a long-term living arrangement with a relative, or will be placed in long-term foster care. Seldom does a child return to a parent at this stage in the process.

As part of its mission to protect children, the program requires that reasonable efforts be made to prevent the placement of a child in foster care. Family maintenance or reunification are to be attempted first, with the expectation that services be provided to prevent out-of-home placement. If reunification fails or is not possible, children are then to be moved, as quickly as possible, to long-term, stable placements, including adoption or foster care.

Administered by SDSS, local CPS agencies are actually responsible for investigating and substantiating child maltreatment reports and for the provision of services to families in which children are identified as maltreated and in need of assistance. Foster care is provided by state licensed individual family and group homes and by foster family agencies who are paid a set rate based on the type of services provided.

Independent Living Program (ILP). Federal funds are awarded to SDSS to provide a range of services designed to improve the prospects for long-term foster care children who live independently after they leave foster care. Services include: health promotion, housekeeping, money management skills, decision-making skills, job training, tutoring, and personal presentation and social skills.

Family Preservation and Support Services Act. The Family Preservation and Support Services Act (FPSS) is a new entitlement grant to the states for family support and preservation (Matsui, 1993). Grants may be awarded for the following activities, among others:

- Research, evaluation, and technical assistance;
- Enhanced match for automated data systems;
- Extension of the Independent Living Program;
- Training for agency staff and foster and adoptive parents;
- Social Services Block Grant Expansion.

SDSS has until federal fiscal year (FY) 1995 to develop a five-year community-based plan that will describe how family preservation and family support services will be promoted. Sixty million dollars was authorized nationwide for expenditure for federal FY 1994, to increase to $150 million, $225 million, $240 million, and $255 million in 1995, 1996, 1997, and 1998, respectively. California is estimated to receive $6.8 million, $16.31 million, $24.54 million, $26.31 million, and $28.1 million for each of these years (American Public Welfare Association, 1993).

FPSS funding is targeted at the following program outcomes:

- Family preservation programs for abused and neglected children at risk of out-of-home placement; and
- Community-based family support programs for caretakers at risk of abusing and neglecting their children.

Other Federal Programs. There are a number of other federal programs that also provide some services and funding to assist with child maltreatment. These include:

- Temporary Child Care for Children with Disabilities and Crisis Nurseries Act;
- Social Services Block Grant (Title XX of the Social Security Act). (However, in California these funds are used exclusively for the In-Home Supportive Services Program);
- Community Services Block Grant (CSBG); and
- Alcohol, Drug Abuse and Mental Health Block Grant.

State-Sponsored Programs

Children's Trust Fund. Funds are collected through a tax check-off option on state income tax returns. These funds are used to supplement CAPTA funding and for other prevention activities. The Office of Child Abuse Prevention (OCAP), which manages these funds, oversees grants for primary prevention programs in schools and other local community settings. In addition, OCAP:

- Monitors and evaluates prevention programs;
- Disseminates information about maltreatment prevention, identification, and treatment; and
- Supports research and data collection projects related to child abuse prevention.

Child Welfare Services Program. Counties are required to have a department responsible for investigating allegations of child abuse or neglect, and for providing support services to families and children. CWS services include:

- Screening abuse or neglect reports;
- Investigating abuse or neglect allegations;
- Removing children from dangerous home situations;
- Developing service plans and reports for the court;
- Overseeing efforts to maintain or reunify families; and
- Determining long-run disposition of dependency cases.

Prior to July 1993, these services were provided through the following four basic programs. In many counties, these programs may still be basically intact, since state regulations implementing a new case management plan approach were issued very recently.

Emergency Response (ER). The ER program is one of two preplacement services required under current law (Family Maintenance, discussed below, is the other). The ER program's primary functions are receiving and investigating reports of child abuse or neglect, providing intake services when children are removed from the home, and providing crisis intervention services. Counties are required to provide an in-person response 24 hours a day. Many counties have a limited capability to respond to reports and use established criteria for ranking priorities. As discussed earlier, many calls are screened out at this level. Crisis intervention services include limited counseling by a social worker or another counselor, transportation, and emergency shelter care for children or the family.

The CWS social worker may, in some cases, offer a family the option of a voluntary contract (discussed below) that allows the family to receive support services similar to those provided by the family maintenance program.

Family Maintenance (FM). This program provides voluntary or court-ordered services to children and their families in order to remedy abuse or neglect without separating children from their families. These services are provided for no more than 12 months. A county must provide a range of services that may include: counseling, emergency shelter care, temporary in-home caretakers, out-of-home respite care, parenting and homemaker training, and transportation.

Family Reunification (FR). This program provides support services to parents whose children have been removed from the home due to neglect or abuse, with the goal of reunifying the children with their families. Services can be provided for no more than 18 months and are an alternative to FM program services. A county must provide a range of services that may include: counseling, emergency shelter care, parenting and homemaker training, and transportation.

Permanency Planning (PP). The Permanence Planning program develops long-term plans for the placement of children who are not expected to be able to be safely reunified with their parents. In addition, the program provides case management and periodic administrative reviews of children who are not adopted and who remain in long-term foster care or in the home of a relative.

Informal Supervision. Child Welfare Service agencies have the discretion to offer family maintenance services without filing a dependency petition when a family admits to allegations of child abuse or neglect, and agrees to complete a negotiated service plan. Judges also can order informal supervision after a dependency petition has been filed by CWS. Social workers are unlikely to recommend this alternative if they determine that a child is in danger or if previous informal supervision plans have failed. Families who volunteer for informal supervision generally will not have dependency petitions filed against them unless subsequent allegations of abuse or neglect occur.

Informal supervision is seen by many practitioners (such as social workers, judges, lawyers and therapists) as preferable to juvenile dependency proceedings for resolving abuse or neglect allegations because those proceedings, while relatively informal, can become adversarial and disruptive to children. Since all parties are represented by an attorney who attempts to protect her/his client's rights, dependency court can be perceived as a forum for establishing guilt or innocence. For example, grandparents have used the proceedings as a way to argue custody issues. Perceptions and due process issues can preclude problem-solving.

Out-Of-Home Placement. Out-of-home placement is a critical link in the dependency process for maltreated children who are removed from their home. Some removals are temporary, while others are permanent. Removals can be traumatic for both children and parents. When a child is removed from his/her home, there are several placement options available. Current law directs CWS social workers to first place the child with the parent with whom the child is not currently residing or with a relative. If these preferences cannot be accommodated, the social worker must find a foster care provider.

- *Emergency Shelters*. In many counties, children who are removed from their home go first to a receiving home or emergency shelter. These places provide a safe environment within which initial interviews and medical exams can be performed. In addition, social workers at these shelters often make decisions regarding whether to place the child with a relative or in a foster home.

- *Home of a Parent or Relative*. In some cases, a parent maintaining a separate residence or a relative may be willing and able to care for a child until such time that the court determines that the child can be returned. Typically this is least disruptive, since the child is placed into a relatively familiar environment.

- *Foster Care*. When a suitable relative is not available, a social worker attempts to place the child in a foster home. There are two kinds of foster care providers. The first is a foster family home, in which a volunteer family (or single adult) agrees to care for the child. Foster family homes are licensed to accommodate up to six children. The foster family receives a small monthly allowance to cover some of the costs for each foster child. In many cases, families refuse to take difficult children, and some families will only take children with a high probability of adoption.

  The second type of foster care is a group home. These homes are not-for-profit institutions and are licensed as community care facilities. They care for and provide services to children in a group setting. Generally, these facilities take children who require higher levels of care and who may have behavioral or physical problems.

  Group homes also are used by juvenile justice authorities and mental health agencies as alternatives to placement in other institutional settings. Those children, whose needs and conditions may be quite different, are not segregated from the abused or neglected children in the same institutional setting.

New Case Management Approach. Chapter 1203, Statutes of 1991 (SB 1125, Presley) made important changes to CWS programs by eliminating the four programs discussed above. CWS agencies are now required to create a case plan for each dependent child that includes specific goals, and describes the services that will be provided to achieve those goals. The case plan is to remain in effect for the duration of the dependency proceedings, although it may be updated to reflect new information.

The Department of Social Services issued emergency regulations implementing SB 1125 on July 1, 1993, and submitted permanent regulations to the Office of Administrative Law on February 28, 1994. Emergency regulations require counties to continue reporting administrative data and to claim funds based on the "old" program designations. At the time this briefing book was written, it was unclear the extent to which SB 1125 has actually been implemented by counties.

Family Preservation Program (FPP). FPP provides intensive short-term services, including counseling, parent training, drug abuse treatment, and mental health services to families in which

child maltreatment is occurring. California counties employ a number of different program models, ranging from the "home builders" model piloted in Washington state, in which workers with small caseloads provide all the necessary services, to community-based multi-agency efforts that involve a case manager overseeing the provision of various services by numerous service agencies. Experience with these programs has led some practitioners to advocate for longer intervention periods of up to one year, with periodic follow-ups to provide support to families and to determine whether they need further services.

California statutes focus primarily on the financing mechanism, leaving program design to the individual counties. Each county is authorized, with the state's approval, to redirect a portion of the state share of projected foster care expenditures to family preservation services. Eligibility is limited to families in which the children would, without this intervention, be placed in out-of-home care. Unlike other components of the Child Welfare Services Program, these funds can be used for any service deemed necessary to improve family functioning, including such items as drug treatment, parent education, and home repairs.

California has nearly 10 years experience with Family Preservation Programs (FPP). However, only 14 counties have instituted FPPs, reportedly due to the significant 1992 change in the state-county funding ratio for foster care that placed additional financial responsibilities on the counties.

Adoption Assistance Program. Under California law, termination of parental rights is possible when children become dependents of the court, and if an adoption is likely to occur. Adoption is generally a more desirable long-term alternative to placement with a relative or to long-term foster care. Many children who have been through the dependency court, and are in need of a permanent placement, are not considered adoptable. Dependency proceedings can be lengthy, and the uncertainty caused by multiple short-term out-of-home placements can leave a child with emotional scars that may cause behavioral problems. In addition, children who are not infants, or are children of color, or who have developmental disabilities, or special physical needs, are more difficult to place in adoptive homes.

The federal Adoption Assistance and Child Welfare Act of 1980 established an Adoption Assistance Program in order to provide grants to families that adopt hard-to-place children. The Adoption Assistance Program is intended to make children with special needs, such as children who are victims of abuse or neglect, more adoptable, so they are less likely to remain in long-term foster care. Grants support the purchase of services such as counseling, specialized care needs, or parental training. Children in this program also are eligible for Medi-Cal for the duration of the Adoption Assistance grant.

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CHAPTER VI: SEMINAR

Child Maltreatment and the Family

Wednesday, April 20, 1994
8:30 a.m. - 10:30 a.m.
State Capitol
Sacramento, California

AGENDA

8:30 - 9:35 a.m. ***Welcome, introductions and seminar overview.***
Anne Powell, M.S.W.
Director, California Family Impact Seminar.

8:35 - 8:55 a.m. ***Trends in Child Maltreatment.***
Jill Duerr Berrick, Ph.D.
Project Director of the Child Welfare Research Center, U.C. Berkeley Family Welfare Research Group, Berkeley, California.

8:55 - 9:15 a.m. ***Consequences of Child Maltreatment.***
Diana Elliott, Ph.D.
Assistant Clinical Professor of Psychiatry, U.C.L.A. School of Medicine, and Acting Director of the Child Abuse Crisis Center, Harbor U.C.L.A. Medical Center, Torrance, California.

9:15 - 9:35 a.m. ***Effective Treatment of Child Maltreatment.***
Anthony Urquiza, Ph.D.
Clinical Associate Professor, Child Protection Center, Department of Pediatrics, U.C. Davis Medical School, Sacramento, California.

9:35 - 9:55 a.m. ***Effective Comprehensive Community-Based Prevention Models.***
Anne Baber Kennedy
CSR, Incorporated, Washington, D.C. Dr. Aitken and Ms. Kennedy, Deputy Project Director of the Comprehensive Community-Based Child Abuse and Neglect Prevention Programs evaluation project.

9:55 - 10:05 a.m. **BREAK**

10:05 - 10:30 a.m. ***Question and answer period.***

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PRESENTATIONS

M. Anne Powell, M.S.W., CAFIS Director

Introductions and Welcome

Good morning and welcome. Let me talk a little bit about CAFIS, California Family Impact Seminar. First of all, I want to acknowledge Charlene Wear Simmons. CAFIS is really Charlene's effort. Charlene is an Assistant Director with the California Research Bureau, the policy research arm of the State Library. It serves State Legislature and the Governor's office in performing policy research. In attempting to develop a family law component, Dr. Simmons learned of the National Family Impact Seminar, and basically is responsible for the project being established in California. She secured grants from two foundations to support four seminars in 1994. This is our first seminar.

The purpose of California Family Impact Seminar is to provide nonpartisan, unbiased information to legislative and executive branch staff and officials and to establish a forum for frank and open discussion about issues relating to family. There is a one-page summary in the booklet or in the packet that describes this in some more detail.

We are almost entirely privately funded by grants from the Stuart Foundations and Henry J. Kaiser Family Foundation. In addition to the grant support, we also receive significant in-kind and moral support from the California Research Bureau and its staff and the California State Library. What is unique about the California Family Impact Seminar is that we try to view issues from a family perspective—rather than from a client or individual perspective—and hopefully give people an opportunity to look at things in a different way than they have historically looked at them along program or individual client lines.

The format of the seminar project is to offer seminars and distribute a briefing report. One is provided in your packet.

What we are trying to do is very quickly have four panelists present some information about the issue, and then open it up to discussion. Between the presentations and the discussion there will be a very brief break, time permitting.

Each panelist has about fifteen or so minutes to make a presentation. We will follow the agenda that is in the packet. What I'd like to do now is take just a couple minutes and make some introductions.

First of all, Angi Wilson up here at the front is our transcriber. She is helping us to put together the seminar presentation summary, so she'll be here to do the presentation component of today's seminar. Also, I'd like to acknowledge Dean Misczynski who is the Director of the California Research Bureau and who's been very helpful and supportive of the project.

There are also a couple other individuals that have been consulted or serve on our steering committee that are particularly worth making note of. Dion Aroner, Chief Consultant to the Assembly Human Services Committee; Jack Hailey with the Senate Office Research. Dave Illig, also with the California Research Bureau. I am really pleased to see Steve Mayberg, Director of the Department of Mental Health. I feel it is quite an honor for us to have a director here today.

Let me just move very quickly into a few comments about the contents of today's seminar. We have a lot of ground to cover and it was a tall order to figure out how and what to include in our first seminar. In polling our steering committee members as to what was important to talk about, family violence was identified as a very high priority. In starting to research the issue I was disappointed to find there actually was very little written on family violence. It's either domestic violence, which looks at women, or it's child maltreatment. We chose to focus on the child maltreatment component because there's a lot more work that's been going on in that field relative to the family unit.

The briefing book provides an overview of the issue from an historical perspective and includes a listing of state and federal programs. What's really valuable about this seminar today is the opportunity it provides to gain some understanding from people in the field about what are the consequences, risks, trends, and activities in the field. I am particularly struck by the recent passage of the "three strikes, you're out" law, and quotations that have been made for years about how "nine out of ten prisoners were abused as children;" it will be interesting to learn from some of the researchers about the consequences—how they effect not only the child, but also the community at large. We will be hearing about a federal comprehensive community-based prevention program, and then, very briefly if time permits at the end, about the new Federal Family Preservation and Support Act.

Our first speaker is Jill Duerr Berrick. Dr. Berrick is from the University of California, Berkeley. Dr. Berrick will be talking about trends of child maltreatment in some detail, particularly in California.

Jill Duerr Berrick

Trends in Child Maltreatment

Thank you for inviting me today, and thank you for sponsoring this seminar on this very important topic. In the few brief moments I have with you today I want to talk a bit about trends in child abuse in the West, particularly in California, but also in comparison to the rest of the country. Much of the material I will be presenting today was compiled and analyzed by Ruth Lawrence-Karski, a Research Associate and doctoral student at the School of Social Welfare, U.C. Berkeley.

One of the first things that’s important to understand about child abuse and neglect, both in California and the rest of the country, is that the way we collect information about it is severely flawed. There are a number of problems with most states in the way they collect child abuse and neglect information (Lawrence-Karski, in press). California is no different in that regard. Our

system is very disjointed. We're not always clear in some counties whether the unit of analysis we're talking about is families or children. Sometimes we are not entirely clear whether we're getting duplicated reports or not, so that is fairly problematic.

In California, there is very little in the way of a linkage between our child abuse and neglect reporting system and our reporting system for foster care (Barth, Courtney, Berrick, & Albert, 1994), and obviously there should be a connection. There is a connection conceptually. There is a connection in terms of children who pass through the system, but we do not have very good data systems right now that merge the two. I am very hopeful about the new Child Welfare Services Case Management System which will be coming on-line at some point, that will begin to address this issue.

Since many of the states do not collect good information, one has to rely on different sources to understand what is going on in child abuse and neglect. What is interesting is that four different nationwide studies on the incidence of child abuse report very similar findings (Lawrence-Karski, in press).

Figure 1 shows that the number of cases of child abuse and neglect is increasing; and the slope is accelerating rather rapidly.[1] If you look at the decade from 1981 to 1991, you will see that there was an increase of about 83 percent across the country -- a very rapid rise.

California doesn't have particularly good data dating before 1985 (Barth, Berrick, & Courtney, 1990a). It's best to talk about 1985 and forward, when the most accurate data become available. What is most startling about the data is that the rate of increase was very exaggerated between 1987 and 1989 (see Figure 2 and Table 2[2]). There was a terrific growth in child abuse and neglect reports in this state during those years (Barth, Berrick, Courtney, & Pizzini, 1990; Lawrence-Karski, in press). It leveled off in the late 1980s and early 1990s. It has started increasing again and that, of course, is an area of great concern.

The increase from 1985 to 1991 in California was about 95%. In other words, it almost doubled. So, we are talking about a significant increase in the State of California that is greater than national figures would suggest. So, tremendous changes are occurring in the state. That is a good reason why the issue is being addressed today--because it really is a phenomenon that is changing rather rapidly.

When it is discussed in the media, people say there is an increase in the number of reports of child abuse and neglect, but they will also say, 'well yes, but the population is growing too; there are more kids to be reported on." While this is true, the data suggests that this increase is above the

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[1] Figure 1 is reproduced from the National Child Abuse and Neglect Data System, Working Paper 2, 1991 Summary Data Component (1993). U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, p. 26.

[2] Cited from: Lawrence-Karski, R. (in press). United States: California's reporting system. In N. Gilbert (Ed.) Combatting child abuse: International perspectives on reporting systems. New York, NY: Oxford University Press.

rate in proportion to the child population. The data in Figure 3 and Table 3[3] controls for the growing child population. It suggests that most recently, say in 1990, about 7 out of 100 children in the State of California were reported for child abuse every year -- an increase from 1985, when it was only about 4 children out of every 100 in the State (Lawrence-Karski, in press).

The next question is, "we have an awful lot of child abuse and neglect, but what does it look like in terms of the type of abuse and neglect? "Is there more neglect going on or is there more physical abuse?" "Is there more sexual abuse?"

In the late '80s there was a significant interest in the issue of child neglect. The number of child neglect reports increased very rapidly from 1987 to 1989 (Duerr, Berrick, & King, 1994). This evened out in 1990 and 1992, but it is rising again (See Figure 4 and Table 4[4]). Physical abuse certainly accelerated over these years, but at the same pace as most other types of maltreatment (Barth, Berrick, Courtney, & Pizzini, 1990). In general, part of what this suggests is that in almost all of these categories of abuse and neglect, except for exploitation (exploitation is an extremely small component of child abuse and neglect), the number of cases has essentially doubled or almost doubled (Lawrence-Karski, in press). In some cases it has more than doubled since 1985. That is of great concern.

Next, we need to answer the question, "of the hundred percent of reports you get every year, what proportion of all those reports are due to neglect, what proportion of all those reports are sexual abuse, and what proportion are physical abuse?" Although growth has occurred, generally in all areas, the composition of abuse and neglect has not changed dramatically (Barth, Berrick, Courtney, & Pizzini, 1990). For example, in 1985, about 18% of all reports were for sexual abuse. Now, in 1993, it is about 18% of all reports (See Figure 5 and Table 5[5]). Certainly sexual abuse has increased in the sense that we are getting more reports , and there certainly is increased child abuse and neglect, but sexual abuse is not contributing more to the overall child abuse and neglect caseload. Similarly, if you look at physical abuse, that consists of about 30% of the reporting. Neglect is divided into two categories. There is "general neglect" and "severe neglect." In terms of general neglect, we see about 30% of the caseload is "general neglect," whereas only about six or seven percent is "severe neglect" (Lawrence-Karski, in press).

We have found in some of our studies that for cases of severe neglect, it is most likely that the child was reported once before, for general neglect (Barth, Courtney, Berrick, & Albert, 1994). There is often a progression from general to severe neglect. Usually, kids don't just show up in

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[3] Cited from: Lawrence-Karski, R. (in press). United States: California's reporting system. In N. Gilbert (Ed.) Combatting child abuse: International perspectives on reporting systems. New York, NY: Oxford University Press.

[4] Cited from: Lawrence-Karski, R. (in press). United States: California's reporting system. In N. Gilbert (Ed.) Combatting child abuse: International perspectives on reporting systems. New York, NY: Oxford University Press.

[5] Cited from: Lawrence-Karski, R. (in press). United States: California's reporting system. In N. Gilbert (Ed.) Combatting child abuse: International perspectives on reporting systems. New York, NY: Oxford University Press.

the severe neglect category all of a sudden. There is usually some sort of pattern of previous reports and the neglect escalated and finally was acted on by the child welfare agency.

These categories of abuse and neglect also roughly approximate what is gong on in the rest of the country. What you see in California is very similar to what is found in the rest of the country in terms of the proportion of child abuse and neglect, and the types of abuse and neglect.

Well, what happens to all of these child abuse and neglect reports? We saw earlier that reports have increased from about 295,000 a year in 1985 to over 660,000 in 1993 in California. Of all of those reports that are now coming into that system, what happens to them in terms of county responses? Of all these child abuse reports that the system is receiving, very few of the families receive what we would probably traditionally call a "service," some sort of face-to-face ongoing service. And the proportion of cases that are closed almost immediately or very shortly after intake, has increased in the last few years (Barth, Berrick, & Courtney, 1990a; Barth, Berrick, & Courtney, 1990b; Lawrence-Karski, in press).

The proportion of cases closed due to an inappropriate report has risen from 26% to 33%. And the proportion of all cases being transferred to ongoing child welfare services has changed from 14% down to 10% (see Figure 6 and Table 6[6]). The likelihood of moving into the child welfare system has decreased somewhat over the last couple of years. Certainly there is a great deal in the literature that suggests that in California and nationwide, the Child Protective Services (CPS) system is being flooded with reports (Besharov, 1990; Finkelhor, 1990; Kamerman & Kahn, 1990; Lindsey, 1994) . Many child welfare agencies are unable to deal with these cases as they might have five or ten years ago.

Finally, I want to briefly share some data about child abuse and neglect, and foster care. Certainly I think it is important for one who is thinking about child abuse and neglect to always keep issues of foster care in mind, because they are connected in a very real sense. What the data show is the rate of increase in the foster care population in the State of California is similar to the rate of increase in child abuse and neglect cases (see Figure 7 and Table 7[7]).

Essentially, the growth in reports of child abuse and neglect has contributed to a large extent to the increase in the foster care caseload (Barth, Courtney, Berrick, & Albert, 1994). Another way to think about how many children are being served in the foster care system is if you look at the rate per hundred children. In 1986, about 6 kids per 1,000 were in foster care; now it is about 10

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[6] Data for Figure 6 and Table 6 are provided by the California Department of Social Services, SOC 291 form. Figure and Table can also be found in: Barth, R. P., Courtney, M., Needell, B., & Jonson-Reid, M. (1994). Performance indicators for child welfare services in California. Unpublished report. Berkeley, CA: Child Welfare Research Center, p. 21-22.

[7] Data for Figure 7 and Table 7 are provided by the California Department of Social Services, Foster Care Information System (FCIS), reconfigured at U.C. Berkeley into a longitudinal database as the U.C. Berkeley Foster Care Database. Figure and table can also be found in: Barth, R. P., Courtney, M., Needell, B., & Jonson-Reid, M. (1994). Performance indicators for child welfare services in California. Unpublished report. Berkeley, CA: Child Welfare Research Center, p. 18.

per 1,000 -- which is essentially 1 percent of the child population in California (Barth, Berrick, Courtney, & Pizzini, 1990).

About 7 percent of the child population is reported for abuse each year, and about 1 percent of the population is served in the foster care system per year. This is a very fluid system. Kids come into the foster care system; kids go out of the foster care system. Kids are reported for abuse; they are not acted on; sometimes they get reported again. Although there is some duplication in all of these numbers, I think it is fair to say the 1 percent and 7 percent numbers are fairly reasonable estimates of foster care and child maltreatment rates, respectively.

The final question that I think has plagued a lot of researchers in child abuse and neglect in the last couple of years is, "Why are we having such a tremendous increase in child abuse and neglect?" Unfortunately, we don't have the answer. But I can suggest some possibilities of what might be contributing to the dramatic changes in child abuse and neglect reports across the state. First of all, as you know, in the state of California we have had an increase in the numbers and the types of professionals who are mandated reporters (Berrick & Gilbert, 1991; Lawrence-Karski, in press). So, as we make our circle wider, increasing the universe of people who are now responsible for reporting child abuse and neglect, we are certainly going to have more people protecting children, more people overseeing children, more people involved in this problem, and more people aware of this problem (Barth, Berrick, & Gilbert, 1994). Last year I believe firefighters and animal control personnel were included in the categories of people who are mandated reports (Ca. Penal Code 11166.5) (Lawrence-Karski, in press), so the circle is getting wider.

Secondly, is there an increase in reportable types of abuse? In many cases we are changing what we might define as child abuse, as in the case of SB 243 (Presley) which narrowed the definition of physical abuse (Barth, Courtney, Berrick, & Albert, 1994; Lawrence-Karski, in press) We may be trying to narrow the definition of what it takes to get into the foster care system. However, we have not narrowed what it takes to be reported for child abuse. The definition is fairly open because if you spread your net wide enough you are certainly going to be protecting more children.

Thirdly, there has been an increase in public awareness (Berrick & Gilbert, 1991; Lawrence-Karski, in press). Many more know about child abuse today compared to 1984. The way society has begun to think about this problem has changed significantly. There has been a change in the threshold of what the public believes is acceptable parental behavior; what is acceptable in the way that parents behave towards their children.

Finally, there is the option that there has been an actual increase in the prevalence of child abuse or neglect, and that is the one where we really are not entirely sure. Certainly issues such as homelessness, poverty, and drug abuse, all contribute to child abuse and neglect, and so it is very likely, very possible, that there is an actual increase in the prevalence, due to some of these more systemic problems (Barth, Courtney, Berrick, & Albert, 1994; Lawrence-Karski, in press). Unfortunately, we do not have a means of testing this proposition empirically.

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[8] Copies of unpublished references by Barth et al., may be obtained from the Child Welfare Research Center, U.C. Berkeley by calling (510) 642-1899.

Diana Elliott

Consequences of Child Maltreatment

Children who have been abused are found to have disruption in various areas of thoughts, behavior, and affect. Unlike adult victims of crime, when crime happens to a child in the form of child abuse, it happens at a critical point in their life—when they are making assumptions about how they are in the world, what they believe about the world, how they cope with stress in the world, and what interpersonal styles they will have with other people.

Because of the time at which the trauma of child abuse occurs, there are a number of long-term consequences to the individual child, to the family, and to society. What you should know, though, is that the research in this area is at an infant stage. We do not have a clear causal connection between child abuse and the various long-term consequences that I am going to talk about. That could only be established by taking two groups of children; abusing one group, following them up, and then seeing what happens to them in relation to the other group. Obviously, we're not going to do that.

What is known or proposed is based on numerous studies that have produced very consistent information. When we look at children who have been abused and compare them to their nonabused cohorts, although the initial impacts of child abuse appear to abate in some individuals over time, there are other clusters of symptoms that actually seem to be nonexistent initially and then develop later on in adolescence and in adulthood. There appear to be different symptoms that develop in children, adolescents, and adults. They are probably best understood in clusters. The first cluster would be cognitive distortions about the world and themselves. The second would be emotional pain and distress. The third is post traumatic stress. The fourth cluster of symptoms is avoidance of pain; and the fifth would be interpersonal problems.

Cognitive distortions are based on the fact that people make assumptions about who they are, about others, about the environment, and about the future based on what they learn in childhood. When the experiences of children are by nature negative, if they have been abused, their assumptions and their self-perceptions typically reflect two things. First, they over-estimate the actual danger that they are likely to encounter in life—the adversarial nature of the system, whether it be school, family or their society. Second, these children under-estimate their capacity to deal with the world and their own self-worth. So their self-efficacy is vastly under-estimated compared to nonabused children.

Negative thoughts about who they are and the world are actually believed to be most related to the psychological abuse inherent in any other form of abuse. It is very difficult to conceive of sexually molesting a child, for example, and there not be some form of psychological component to that molestation, or to physically abuse a child and to not have, for example, the verbal statement of "you horrendous child" at some level. A lot of the cognitive distortions appear to be related to the cognitive information, verbal information, that is given to the child as they are being abused—about who they are as a person.

It also probably arises from not just the perpetrator, but also from society. Our response to victims has been, at best tolerance—sometimes actually assuming that this is the most logical thing to happen to an individual who is repeatedly told they are bad. There are several things that are logical to come out of that, but as a society we want people to not have to have the scars. We do not want to see the scars of their abuse. So society as well as the abuser stigmatizes the victim. Oftentimes at school they are labeled as bad children or acting-out children. Children are referred to me all the time because the child is physically acting out. This is because of their own abuse history and is a logical consequence. However, the child is now labeled as a bad child in this larger system.

A second large area of consequences is that of emotional distress. Depression is the most commonly reported symptom of any form of child abuse. The others would include anxiety and anger. These are very common consequences. In terms of depression, individuals who have been physically and sexually abused are four times more likely to have diagnosed at some point in their life to be severely depressed—a disorder that is treatable by psychologists and psychiatrists and requires very extensive intervention. It may come from sort of the chronicity of being abused within the family. Abuse is not a single instance like some other forms of crime are often single incidents. If you are physically abused, you are likely to be abused over a period of time. Child abuse by its very nature is threatening. That is why we intervene. Given that it is threatening it should not surprise any of us that anxiety disorders are very prevalent with individuals who have been abused as children. Survivors are five times as likely to have some form of an anxiety disorder as an adult or adolescent. It is more likely to happen as an adult than it is as a child.

Abuse-related anxiety involves a number of things, a major one of which is hypervigilance to danger, constant scanning of the environment to make sure that things are okay. Children that are in abused homes often learn to watch nonverbal and verbal signals. That is a good skill for them to develop during childhood, but, in adulthood they often misinterpret objective information in the world as harmful or at least potentially harmful.

Anxiety results in multiple somatic complaints. Our medical system is significantly impacted by victims experiencing abuse-related complaints. We know, for example, physical problems associated with child abuse include nausea, sleep disturbance, asthma, chronic muscle tension, back spasm, elevated blood pressure, and, in sexual abuse survivors, genital complaints. We see a vast array of symptoms that show up during adolescence and adulthood that can be at least correlated very strongly to child abuse. We have tended to overlook child abuse as one of the ideological factors in that arena.

Another very common consequence—and one not to be overlooked—is anger. If you hurt an individual long enough, they are going to become angry about it. We see it in multiple ways—from the very little child acting out behaviorally, to the adolescent rebelling, to the adult perpetrating further crimes. In children, anger is frequently expressed in behavioral problems such as fighting and bullying. They are more likely to be taken out of school or put in detention. Such problems likely represent an externalization of the child's distress as a result of being abused, the modeling of their parent's behavior, or even as a cry for help. The behavior often leads to social isolation and unpopularity, and can also result in, for example, physical abuse. Abused

adolescents have a 33% higher rate of committing physically violent crimes against another individual. Just by virtue of having been physically abused these children are 33% more likely to commit a violent crime as an adolescent than are their nonabused peers.

Less research has been done on adult survivors, but there is data that suggests there is a chronic irritability, a chronic sense that something is not right with their world. Male survivors tend to have an expectation of violence in relationships, and that may translate into a greater willingness to aggress against their partner or their spouse. The literature suggests that physical abuse is specifically associated with later perpetration of physical violence, and sexual abuse is associated with later perpetration of sexual violence. Although individuals who were abused are more likely to abuse someone also, the vast majority of abuse victims do not go on to perpetrate others either as an adolescent or as adult.

Another whole cluster of symptoms is something called post traumatic stress. Some survivors experience a numbing response—trying to block out the memory, or trying not to pay attention to the environment in which the abuse or the distressing event occurred—called hyperarousalness. There is a new study out that suggests that, in both children and adults, when a child is particularly physically and sexually abused, and possibly neglected, these children may actually have post traumatic stress syndrome (PTSD). While we would not have hypothesized it theoretically, these children exhibit the symptoms of intrusive memories to the abusive event, reliving the event. They then try to numb themselves from the event, which leads to this hypervigilance response. This results in lots of nightmares and flashbacks. What it ultimately does is create an approach/avoidance conflict. The flashbacks and the nightmares are an attempt to rework the trauma from childhood. The survivor flashes onto what the abuser might have done and sees the abuser's face. They will be interacting with someone who has some characteristics similar to the original abuser and the interaction may trigger the person to regress to childhood and relive the abuse experience.

The other part of this intrusive component is that most survivors do not want to stay in that state very long. It is not a fun place to be. So there is an attempt for the psyche to avoid. There is a whole cluster of symptoms present that are geared toward avoiding the internal pain of having flashbacks or intrusive images of what might have happened either sexually or physically.
Initially, the avoidance is quite helpful. But it is not helpful later on, such as when the child is in school trying to learn, to constantly be flashing back to their father beating them or whatever else might have gone on in their home the night before. So potentially it is helpful if they can avoid, if they can develop a mechanism to avoid what's going on in their mind. Unfortunately, by lessening the awareness in one area, most children and adults lessen the awareness in a vast array of areas. So they don't just block out the father's image; they also block out the teacher who is trying to teach them. When we see abused children having difficulties learning, it is probably related to this need to avoid being present for fear of reliving the abuse.

One type of avoidance behavior is called dissociation, where a person can not track thoughts, the feelings or the input that they are getting from their environment. But perhaps the best or the most dangerous avoidance mechanism would be drug use. We see significant drug and alcohol

use among victims of sexual, physical and neglect. Drugs are probably the best pain killer, if you have to avoid something, avoid the anxiety and/or depression.

The acute affects of alcohol and drugs are temporary, and they attenuate or eliminate the dysphoria from the child abuse. There are long-term negative consequences of drug abuse, and these do require intervention. However, to deal with the substance abuse of a survivor by punishing the substance addiction, we are going to miss what is actually the basis for that substance addiction and thus the opportunity to help with the underlying problem—post traumatic stress. The issue for the survivor has to be addressed first.

There is a great many interpersonal difficulties that are experienced among abuse survivors. Children who have been sexually abused tend to have many more sexually acting-out behaviors than both nonabused children and abused or neglected children. Children who have been physically abused tend to bully their peers and have much more difficulty developing relationships. Adolescents and adults molested as children are prone to go through more relationships, not maintain long-term relationships, have more short-term sexual activity; are more likely to have a number of different sexual partners than their nonabused peers, are at greater risk for unintended and terminated pregnancies; and are more likely to contract sexually transmitted diseases because of the increased sexual activity.

Child abuse doesn't occur in just the family. It's supported by a society at some level. We have to address the problem in the larger social context. There are social beliefs that may support child abuse. A recent study suggests that sexual abuse may actually be supported by society. In 1990 John Briere and Marsha Runtz found that a significant number of nonabused, non-incarcerated males reported that: 21% were sexually attracted to some small children; 9% had sexual fantasies involving children; and 7% would be likely to have sex with a child if they could avoid detection and punishment. So the presence of so many of such individuals in a high-functioning society suggests that at least the abuse of children is partially supported by society, that society endorses the exploitation of children at some level.

Dr. Anthony Urquiza

Effective Treatment of Child Maltreatment

Thank you very much. Anne Powell asked me to talk about my clinical and research experience regarding child maltreatment intervention. My immediate response was: "what research on treatment for child abuse?" I also sit on the initial review group that review funding requests to study violence and traumatic stress at the National Institute of Mental Health. We also review most of the grants that are geared towards violence and traumatic stress. If there was a grant that was written to treat child abuse, it would probably come to this group. Over the last three years that I have been on this group, we have had one grant that has addressed child sexual abuse, which has not been funded, and no grants that addressed child physical abuse, or child neglect. There are other agencies that address child abuse issues but in my particular situation—National Institute of Mental Health—no such requests have been submitted.

One of the overriding messages that I want to provide to you is that we do not have a wealth of information about what is an effective intervention for child abuse, abusive families, or for sexual abuse. I would like to say that we did. I would like to say that we had a couple of different approaches to use to deal with different types of families or different types of abuse. But we do not. There are lots of people who are doing research, treatment-oriented research. However, they tend to be rather small studies. By in large, they have not been replicated, and we just do not have a clear understanding about what is effective.

What I would like to talk with you about is what I believe to be some of the critical components that we need to provide as part of effective intervention. This view primarily comes from research in the fields of child development and psychology. Treatment with children is by in large very effective. Treatment with adults can by in large be very effective. However, when you put these together with regard to the physically or sexually abusive family or the neglectful family, we do not yet know about the effectiveness.

One of the questions I wanted to start off with is: "what do families do?" Let me explain why I am asking that question. Essentially, what families do is create people. As part of that process, as families, we invest a lot of time and energy in our children, our offspring. One of the measures of success is that we have these healthy productive people that we would like to see. A measure of unsuccessful families is that they create people who are maladaptive, who have sort of emotional or physical distress, maybe destructive or damaging, or are physically abusing themselves.

In this process of creating people, there may be a variety of factors: skill development; personality characteristics, developing values, and attitudes.

Child abuse occurs in the context of a relationship, and that is important to remember. You cannot be abused without a relationship. Even neglect is really the absence of a relationship, and we talk about neglect thinking there isn't somebody there. But neglect is a very active dynamic process. Neglect is not just being left alone; neglect is an active process. So child maltreatment occurs in the context of a relationship.

All relationships are transactional. That is, I am having a relationship with you right now. I am getting information from you; you are getting information from me. We feed off each other. Within a family and the parent/child relationship there are two parts. As clinicians it is our responsibility to respond to both sides of that relationship; and I will tell you why.

Child development basically tells us there is a cycle of interactions that, once stabilized, creates what we consider to be personality characteristics. We refer to this as straight traits or values belief systems—we have behaviors that are supported by certain people or avoided by other types of people.

If you are raised in a culture that is damaging—aggressive, punitive, molesting or neglectful—you are creating a person who, given that culture, you would normally expect to have all the problems with depression, post traumatic stress disorders, anxiety, and interpersonal problems.

Child abuse is not an absence of skills. Parents do not abuse children because they don't know how to do it any better. They don't abuse or molest children because they just have some sexual orientation to children. This is a relationship; it is an active dynamic process in which we are creating people. We have generations now in which adults are perpetrators or parents who are physically aggressive or neglectful. Skills are a part of it. Skills are a very important aspect of child neglect. You need to have basic skills, but you also need a lot more than just skills. You also need to have a lot more information, ability, and certain characteristics in order to be a capable parent.

Another aspect of this normal developmental process hasn't really been addressed thus far to any great extent in the literature, and it certainly has not been addressed in what we know about treatment: all interactions and relationships occur in a context, and the context or environment establishes a cultural foundation. The relationship or family culture is what is embedded. An example will make a bit more sense.

Activity settings are the architecture of everyday life. We all have activity settings. If you have children, you go through the process of getting them up in the morning, dressing them, getting them ready for school, helping them do their homework, bathing them, getting them ready for bed, doing laundry. At 2:15 this morning I was wide awake because my two-year old daughter happened to wake up. I was pretty irritated at 2:15 in the morning. That is a part of life, and a part of what I would call an activity setting. That process, that cultural process, is what relationships are embedded in.

For treatment intervention to be effective—and this is why I am talking about treatment in child development concepts—a couple of things must be done. First, we have to deal with the relationship that exists between the child and parent. Most effective interventions are not with parents by themselves, nor with children by themselves. You have to deal with the two people together, the family together, and sometimes incorporate siblings. You can not deal with just one or the other and expect to be effective.

You can not provide just skills or certain knowledge. You have to change the pattern of the relationship. If you don't change that pattern, then you have not been effective. You may actually change it in your clinic. I am actually a pretty good clinician when people come into my office. No one has ever abused their child in my office yet. What is important, however, is what happens when they go home. Using my earlier example, if it's 2:15 in the morning and the child is crying, the goal is that the parent no longer slap or kick their child because the child is crying--something that in the realm of these activity settings was the historical culture of that family.

So you have to deal with the relationship, not just with a person. You have to change the culture of the family; change not just a person but the way in which the family is structured. And you have to incorporate enough of this cultural context, this family context, so that the environment is shifted from a point of being an abusive relationship to a supportive, more healthy, constructive type of parent/child relationship. That is not an easy thing to do.

Essentially, what we are talking about is generalizing affects that we would find in a clinic or office so that they also take place in the home. And that is, as a researcher, one of the most difficult things that we have attempted. We are not just changing individuals. We can change individuals; treatment has shown us a variety of ways we can change people. Changing relationships is more difficult than changing an individual, and then changing the culture of a family is even more difficult.

There are lots of other different types of culture; the culture of a family in activity settings. It may also incorporate issues of social economic strata and of environment, like a neighborhood, academic settings, day care, and schools.

If you look at some of the common treatment intervention programs, and measure each of them against these issues of interaction, culture, and the changing of patterns, the concept of family preservation appears to encompass the intervention approach I have just discussed. This raises the question: "Is family preservation effective?" I do not believe this is really a relevant question. There are characteristics of family preservation programs that appear to be quite beneficial to abusive families. We have yet to see a well designed, well implemented evaluation of family preservation services, and I am not actually sure that we'll be able to do that because of the complexities of working with counties and child welfare agencies.

Family preservation services appear to be able to provide good skills, good crisis intervention, problem-solving skills, and to deal with issues of parenting, and communication. They have been fairly effective, according to some reports, at decreasing out-of-home placements and providing a continuity of care. So, in the measure of a sense of context then, preservation services are very promising at changing patterns of behavior since children remain in their homes so that there is a continuity of care; they are very promising.

One of the common beliefs is that we will have an outgrowth of family therapy that deals with physically abusive families. One of the frustrations that I have with traditional family therapy is that it happens in your office not at home. I can change behaviors in my office. I can get people to say the right things. I can get them to acknowledge that they have acquired some information. I have not yet seen family therapy intervention for child abuse that has been able to document such changes within a home setting.

You heard my criticism a few minutes ago about individual therapy. If we break down issues of child abuse and victimization, we have relatively good effectiveness in dealing with things like sleep disorders, depression, bedwetting, enuresis and copresis through individual therapy. These are common occurrences for certain types of children who have been abused, such as aggressiveness and conduct disorders. In isolation, we are pretty good at providing some amelioration of those types of symptoms by changing the behavior of the child to be more adaptive.

If you are talking about some specific types of abuse problems, such as post traumatic stress disorder (PTSD), the effectiveness of therapy in eliminating or reducing post traumatic stress disorder symptoms in children is unknown. PTSD is a very intractable constellation of symptoms

that seems to be pervasive in certain victims of child abuse, and it is a very difficult behavior change. It is one of those issues where insufficient research has been done.

Therapeutic foster care tries to change behaviors in relationships that are often or usually not in the context of the child's biological family. However, they still provide an opportunity to change behaviors within a context of relationships. There has been some research of therapeutic foster care that has demonstrated some effectiveness in treating common behavioral problems that abused children have, such as aggressiveness, oppositional disorders, defiance, and sleep disorders. Those types of things can be addressed.

What we essentially know from the research perspective is that we are quite capable of changing behavior for an individual, and are somewhat capable of changing behavior within the family. None of that has been applied to abusive families.

If you ask me about changing a particular behavior, I can give you a breadth of studies about depression in children, attention deficit, hyperactivity disorder, hyperactivity in children, of aggressive disorders, of conduct disorders. I can give you a series of research that documents rather conclusively that we can make some effective change in those areas. However, they have not yet been applied to abusive families; our current challenge is being able to document changes with abusive families and to document the generalizability and the stability of those changes with abusive families.

Anne Baber Kennedy

Effective Comprehensive Community-Based Prevention Models

When the National Center on Child Abuse and Neglect (NCCAN) funded the Comprehensive Community-Based Child Abuse and Neglect Prevention Programs in 1989, it initiated a very important chain of events. First, NCCAN encouraged community groups, ranging from hospitals and child welfare agencies, to universities and research organizations, to band together with other community forces to prevent physical child abuse and neglect.

Second, NCCAN engendered development of nine unique prevention models that incorporate several of the components that researchers and practitioners agree may avert child maltreatment. This set of programs provides a singular opportunity for the entire prevention field to learn which interventions, or combinations of interventions, seem to work to strengthen families and communities and ultimately to prevent child abuse child maltreatment.

NCCAN funded the nine organizations listed on the second page of your handout with approximately $200,000 per year for five years to mobilize and realign community resources to prevent child abuse and neglect. In addition, these projects either sponsor or implement themselves multiple-component interventions, including parent training, home visits, drop-in centers, support programs for teen parents, training to providers, and public awareness.

In funding these programs, NCCAN underscored its intent that communities, through coordinated neighborhood involvement, might be able to maintain the child abuse and neglect prevention programs as an integral community activity even beyond the grant period. As NCCAN intended, all of the nine grantees are attempting to build sustaining networks to support prevention in their communities. The methods used include: referral services; directories of social services agencies serving the target population; task forces and advisory councils composed of key members of local organizations, parents, residents, and even business leaders; joint program development and co-sponsorship of community events; the use of volunteers; community funding through "mini-grants;" the use of focus groups and needs assessments to formulate community consensus; and education and public awareness.

The nine communities selected by NCCAN to participate in this demonstration span ethnic and racial boundaries and urban, suburban, and rural locales. This variance provides an opportunity to learn about how multiple components, applied to differing target populations, work to prevent child abuse. CSR was awarded a competitive contract by the Federal Administration on Children, Youth and Families in October, 1992 to conduct a national evaluation of NCCAN's Comprehensive Community-Based Child Abuse and Neglect Prevent Programs—what we call the nine sister grantees, informally.

Briefly, CSR's mandate is to conduct a process evaluation of the community-based nature of these demonstration programs, and to conduct process and outcome evaluations of the interventions employed by each.

The overarching purpose of our evaluation was to make the contribution to the field about strategies to prevent child abuse and neglect. It is our intent that the results will provide resource information to practitioners, policymakers, legislators, and funding organizations. In addition, we hope to provide the child welfare community with a better understanding of how to evaluate community-based prevention programs, and to hopefully transfer some of that knowledge of how to conduct evaluations and the importance of conducting evaluations to the individual communities.

Evaluating a cluster of differing projects is clearly a challenge. A complication that is not singular only to this study is that while the programs contain a number of core similarities, they function in very different environments with unique target populations and distinct philosophies. Moreover, these projects are inherently complex as they interweave individual and community objectives and varying combinations of community interventions and activities.

Our research design relies on the collection of a combination of numerical and qualitative data uncovered through both traditional and naturalistic methods (see CSR handout). The more traditional methods include administration of standardized instruments by several of the grantees, including one program that is using a comparison group.

The less traditional methods include: open-ended discussions with key informants; focus groups; participant observation; and record review. Not only have we found that all these aspects have helped us as researchers to gain the cooperation and trust of the grantees, but there have been two

other unintended consequences. The information we gathered is far more honest and complete and deals with more down-to-earth, day-to-day project issues than we might normally see.

And secondly, the grantees and their collaborating partners are gaining from a transfer of our evaluation knowledge to their communities. We hope that they will be more willing and able to conduct their own evaluations in the future. In conducting a reality-oriented, pragmatic evaluation that involves our field staff, program staff, program participants, and collaborators, we have found that program evaluation can, in fact, become the praxis for program development and implementation; that is, it becomes the point where practice and theory meet to form pragmatic, informed interventions.

Of all of these methods of naturalistic inquiry, we have found that one is most important: listening. We attempt to take the "emic" view—that is, to learn to the degree possible, the "insider's" point of view. As one anthropologist discovered from his research in Africa, "you must learn to sit with people, you must learn to sit and listen." Our data processing and analysis will include descriptive and textual analysis, meta-ethnography, to compare results across programs and statistical analysis of quantitative data.

On the page four of the handout I have listed some of what we are finding to be the essential elements of these community-based prevention projects. There are two that I would add immediately. First, irrationally committed program staff. People who are willing to give out their home phone numbers to participants, to give out beeper numbers, who are on call constantly. And secondly, staff that is connected to the service community because they live in the same or similar community where they have a cultural experience that is similar to the target population, and they understand the languages, values, and norms of that community.

A well-defined target population is important. Many of these grantees started out saying that their population would be the entire county, the entire city of Philadelphia, the County of Allegheny, the County of Pennsylvania including the City of Pittsburgh. That is enormous and hopeless—especially when you are hoping to learn something in terms of research.

They have all downsized. They have begun looking at either a zip code, a particular census tract or a couple of census tracts, or they focus on an age, race, or ethnic group. All of these grantees have established locally-based advisory panels or task forces composed of usually directors, personnel staff of other social service agencies with whom they interact; often parents, and sometimes business leaders. Another thing that they have learned is that they need to have a project name that promotes the notion of positive change and does not use the phrase "child abuse and neglect."

Almost all of these programs started out with rather cumbersome titles: "the neighborhood coalition to prevent child abuse and neglect," things like that. These names are not only hard to remember, they are stigmatizing. People don't want to be involved with them. They don't want to have a label put on them. They don't want to walk in the door of an organization that says, "child abuse and neglect." They're more likely to connect with a more positive inviting name.

Alternatives that have come up in these nine projects are things like "Families First in Fairfax," "Project Maine Families," "I CARE," "Dorchester Cares."

For people to attend events or activities, it is necessary to provide the basics. The three basics appear to be child care, transportation, and food. The projects have found that it was necessary in the first year to conduct some sort of a basic needs assessment. They need to find out what their target population wants, not what a bunch of practitioners or researchers seem to think they might want.

And in some of these communities the staff have done some creative things to solicit community input, like conducting focus groups with teen moms, where they found out things that they didn't know or hadn't thought of before that these moms needed. They need to get their laundry done. They need to get their grocery shopping done. Time is very important in order to gain trust and sustainable community membership. With these projects they are finding that, while five years' funding is a long time in terms of government funding, it's really a minimum for program development.

Interventions need to recognize the cultural language and social uniquenesses of the population. It can be important and helpful to hire community members, including participants who have graduated from the program. And, finally, they have all agreed—some of them reluctantly—that it is important to integrate evaluation from the very beginning of the program.

The other part of our contract is not only doing the national evaluation. We are also providing technical assistance in helping the grantees do their own evaluations. We have focused on developing methods and also encouraging program approaches that are pragmatic, open-ended, flexible, and respect both the privacy and the desires of the participants. We found that focus groups are really a wonderful method for getting different viewpoints on issues and for discussing perceptions of a wide circle of individuals at a fairly low cost. You can bring in seven or eight moms and get them to begin talking about different things and one person's comment will trigger another's, and you can get some wonderful discussions where you really learn a lot about the program.

Participant observation is something borrowed from the anthropological field which allows us to less obtrusively observe and describe events as they occur, including who was involved, when the changes occur, why, and what the interaction was like.

We ask staff to record incidents showing the most and least successful encounters with participants. We encourage client satisfaction questionnaires, not that they tell a lot about effectiveness, but they can be an effective tool in figuring out how to change or just mold an intervention.

Pencil-and-paper instruments can be helpful. I'm a little more leery of them. Many times they are not culturally or linguistically appropriate to the target population. However, we have found some that are fairly usable.

Some of the individual-level outcomes that we can see already—although it is a little early—are moms or parents who have told us and our staff that they are better able to cope; they have learned new skills; they have connected with services, and/or that they have gotten past a crisis point as a result of a home visiting program that includes nurse home visits, visits with staff trained in social work and counseling, and referrals to other providers.

Last week I did a focus group in Columbus, Ohio, with a group of eight moms. One of them said, when she first started in the program, "I was afraid I was going to kill my son. I thought I would hurt him. He would not be quiet. He was defiant." Because the home visitor connected her with the County Mental Health and Mental Retardation Department, this mom was able to get her child tested for attention deficit disorder. The child is now taking Ritalin regularly and the nurse home visitor and the social worker are helping her learn not to blame herself and to cope differently with her child.

Another mother whose husband experiences extreme paranoia and depressive behaviors is terrified of her husband when he, as she told me, "had a spell." She called her home visitor at night at home and the home visitor told her basically to lock herself and her children up in a separate room and don't clean up the mess; the guy was just violent and ripping through the house. The next morning she gave her husband his medication and forced him to confront the damage in the house. She has worked consistently with the program staff to get social security benefits so that she can afford her husband's medication which keeps him from having these events and receive other benefits for her children. According to her, "the program staff have been my family...that's when I really learned what a friend is all about."

In another city, a very young mom admitted to a staff person: "I'm going to hurt my kids." The staff person said, "I know that feeling, why don't I have somebody check in with you." A year later, this mom now goes to teen programming classes at the YMCA every single day; she attends grantee-sponsored programs, and participates in child care. Just getting some of these young moms to drop their kids off at child care can be a very big deal.

Job acquisition or new skills training is another outcome. Two of the programs are tracking life skills acquisition by documenting how many participants move on to get a first job, a better job, or additional training. A couple of weeks ago, I learned about a group of moms in one of the programs. I think of the seven that I met with, one has been job hunting extensively and has been encouraged by the program with free bus passes; one is waiting to start a new job; one has started a social work program at a nearby college; and one plans to attend nursing school.

Other programs encourage their participants to come back and volunteer with the program. They have generally found that their participants are more than happy and willing to come back to somebody who has given them something. The program in Puerto Rico boasts a volunteer army of nearly fifty at any one time, and these are people who are at least half-time per week. It's just amazing.

They also teach parents to learn to operate within the social services system which can obviously be an intimidating structure, and for many of these families the prevention program itself becomes

their point of entry; that is the person they know and connect with and they can call when they have a problem, and then they can be pointed in the right direction.

I wanted to conclude with some of the "promising practices." I use that phase a little bit carefully, but at least there are unique practices that we are seeing. These are listed on the last page of the handout. The laundry program for teen moms, which came out of a focus group discussion where the mom said, "gosh, it's a real pain to drag our laundry out and drag our kids along to the laundromat." They don't have washer/dryers in their house, obviously, or their apartment. So once a week the program gets a van to pick up the moms at the YMCA; they put their kids in child care, take them to the laundromat, they give them quarters, everybody helps wash and fold, and then they take them back to the YMCA for lunch and usually just very informal discussion, and then they give them a ride back home. It's fantastic intervention.

Comprehensive community drop-in centers coordinate child care, support groups, and substance abuse counseling, nursing services, parent education, and home visits. Drop-in centers are being used in four of the programs. Home visiting is a very "hot" topic. The grantees are doing it in different ways. Some of them employ nurses, RNs that are involved in the home visits, some use social workers, some are more structured, and some are less structured types of home visit approaches. One of the things we are looking at is how home visitation seems to change the interactions.

Outreach through cable television, newsletters, and radio talk shows, parent education programs, including one program called Parent-to-Parent that is actually a support group of participants from a six-week parent education program; and the awarding of "mini-grants" to other neighborhood organizations, usually $2,000 or $3,000 to do a six-week class.

Some photography projects have been funded. A really interesting one was recently done in Portland, Maine, with the women who are involved in the laundry program. A professional photographer volunteered her time to do a series of gorgeous black and white family portraits. They are extremely dignified and beautiful. The women got this beautiful portfolio with these 8" by 10" portraits in it. It is a wonderful product that they can take home with them and the pictures can be used to open up discussions about what their families look like and to get some conversations going. With participant consent, some portraits were put on display in the public library. It made a lot of the families feel proud and it showed the community that their families look just like ours.

Handouts

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BIOGRAPHIES

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Jill Duerr Berrick, Ph.D.

Dr. Berrick is Director of the Child Welfare Research Center at the School of Social Welfare, University of California at Berkeley. Dr. Berrick has directed a number of research studies which focus on child abuse and neglect, child welfare, and family poverty. She has also presented the results of her work at numerous conferences and before various academic forums.

She has published in a wide variety of inter-disciplinary journals and is co-author or author of five books. They include:

Protecting Young Children From Sexual Abuse (Lexington, 1989 with Neil Gilbert, Nichole LeProhn, and Nina Nynan)

With Best Intentions (Guilford, 1991 with Neil Gilbert)

From Child Abuse to Permanency Planning (Aldine de Gruyter, 1994 with Richard Barth, Mark Courtney, and Vicky Albert)

Child Welfare Research Review (Columbia, in press, with Richard Barth and Neil Gilbert)

Faces of Poverty: Portraits of Women and Children on Welfare (in review)

Diana M. Elliott, Ph.D.

Dr. Elliott is an Assistant Clinical Professor of Psychiatry at the University of California, Los Angeles School of Medicine and the Acting Director and Director of Training and Research at the Child Abuse Crisis Center at the Harbor UCLA Medical Center in Torrance, California. In addition to her administrative and educational activities, she has an active clinical practice, seeing abuse victims at the Child Abuse Crisis Center and in her private practice.

Dr. Elliott has also published numerous articles in a wide variety of professional journals and presented papers on issues relating to child abuse before many professional associations. Dr. Elliott has also authored, co-authored or contributed to numerous books, including:

> Study Guide on Adult Survivors of Childhood Abuse (Newbury Park: Sage, in press, with J. Briere)
>
> Sexual Abuse in the Lives of Professional Women (Newbury Park: Sage)
>
> "Childhood Sexual Abuse", with L. Berliner, and "Special Issues in Psychotherapy with Adults: Dealing with the Trauma and the Self, with J. Briere, both in The APSAC Handbook of Child Maltreatment (Newbury Park: Sage, in press, J. Briere, L. Berliner, J. Bulkey & C. Jenney, Eds)
>
> "The Impact of Sexual Abuse on Victims and Families" with J. Briere, in The Future of Children (in press, C. Larson and D. Terman, Eds.)
>
> "Assessing the Impact of Violence on Adults," in Violent Victimization: An Overview by J. Briere (in press, San Francisco: Jossey-Bass)
>
> "Transference and Countertransference," with J. Briere, in Treating Women Molested in Childhood (in press, C. Classen, Ed.)
>
> "Studying the Long-Term Effects of Sexual Abuse: The Trauma Symptom Checklist (TSC) Scales", with J. Briere in Rape and Sexual Assault, Volume 3 (in press, New York: Garland, A. W. Bergess, Ed.)

Dr. Elliott received her M. Ed. in Educational Psychology from the University of Houston in 1986 and a Ph.D. in Psychology from Biola University in 1991.

Anne Bader Kennedy

Ms. Kennedy is a senior researcher with CSR, Incorporated, in Washington, D.C. She is Deputy Project Director of the evaluation of Community-Based Comprehensive Child Abuse Prevention Program, nine child abuse and neglect prevention projects funded by the National Center on Child Abuse and Neglect. She is also involved in several other CSR studies including a large cross-site evaluation of substance abuse prevention projects serving high-risk youth. Ms. Kennedy completed her graduate work in historical research methods at the University of Virginia; as an undergraduate she studied at Mary Washington College. She lives with her husband and yellow Labrador retriever in Silver Spring, Maryland.

M. Anne Powell, M.S.W.

Anne Powell is the Director of the California Family Impact Seminar, a family policy research and education project for officials and staff within state legislative and executive branches of government.

Ms. Powell has over 15 years experience in the health and human services field in both policy analysis and advocacy and in-service delivery. Her knowledge and experience covers a broad range of health and human service areas: reproductive health, family and child health, HIV disease, public health, environmental health, primary and acute care, emergency medical services, long-term care, mental health, substance abuse, programs for the homeless and indigents, child welfare, juvenile justice, and state and county government program governance.

Most recently, she led development at Sierra Health Foundation of their newest and largest undertaking, a ten-year $20 million children's health initiative, "Community Partnerships for Healthy Children," a community-based strategy to improve the health and well-being of infants and young children.

Ms. Powell was a principal consultant with former State Assembly Member Bruce Bronzan and the Assembly Committee on Health for five years, analyzing hundreds of legislative bills focusing on child health, reproductive health, HIV, long-term care, emergency medical services, family preservation, and state/county program realignment, and developing numerous legislative measures in these areas.

Between 1980 and 1988, Ms. Powell was a health planner with the San Francisco Department of Public Health, analyzing and advocating on the state and federal legislative and regulatory issues affecting a wide variety of programs, and performed program and operational planning for numerous programs throughout the agency.

Before receiving her Masters in Social Work in 1980, Anne worked as a medical social worker in a county hospital, and as a deputy probation officer serving juvenile offenders returning to their families from incarceration, hospitalization or out-of-home placement.

Anthony J. Urquiza, Ph.D.

Dr. Anthony Urquiza is a clinical psychologist at the Child Protection Center at the UC Davis Medical Center (UCDMC) in Sacramento and serves on the clinical faculty in the UC Davis Medical School Department of Pediatrics. He is the Coordinator of Psychological Diagnostic Services and is the Director of Research for the Child Protection Center.

The Child Protection Center provides medical evaluations, psychological assessments, and short-term therapeutic services for abused and neglected children. At the Center, Dr. Urquiza is developing a multi-disciplinary model to comprehensively assess children who have been abused and neglected.

Dr. Urquiza has extensive clinical experience with children, adolescents, and adults in a variety of inpatient and outpatient settings providing individual, marital, family, and group therapy, and parent training primarily relating to child maltreatment and family violence.

Dr. Urquiza has done a great deal of clinical research concerning family violence with an emphasis on child maltreatment, including sexual victimization of males, the treatment of sexually abused children and survivors of childhood sexual abuse, child sexuality development, and psychodiagnostic issues relating to child maltreatment.

Author of numerous articles published in violence-related professional journals, Dr. Urquiza is an Associate Editor for the Journal of Interpersonal Violence and the Journal of Pediatric Psychology.

Dr. Urquiza's work also involves examining family violence from the perspective of cultural competency, and has integrated these efforts into his work. This includes of clinical interventions for ethnic minorities, identification of ethnically diverse perspectives of families and development of cross-cultural empirical research methods. As a Danforth Fellow, Dr. Urquiza promotes graduate education for ethnic minorities, a goal of the Dorothy Danforth-Compton Fellowship Program. He has also assisted the National Center on Child Abuse and Neglect in the development of cultural and ethnic leadership in the field of child maltreatment.

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Acknowledgments

As this report is in large part a review of the literature, the work of many are included. I am particularly appreciative of David Illig, author of the California Research Bureau publication "*California's Process for Resolving Allegations of Child Abuse or Neglect,*" for his analysis of state child abuse and neglect data which is presented in this report. Also, data from reports published by the National Commission on Child Abuse and Neglect, the U.S. Advisory Board on Child Abuse and Neglect, the National Child Abuse Prevention Association, and the U.S. Maternal and Child Health Board's Child Safety Network are heavily cited. These and other works are listed in the Bibliography.

Ann Collentine assisted with summarizing research on the consequences of various types of child maltreatment. Assistance was also provided by the staff of the California Research Bureau in the California State Library, in particular Dr. Charlene Wear Simmons, who contributed the original guidance and energy behind the creation of the California Family Impact Seminar.

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