Child Fatality Review Teams

In 1989, of the 55,861 known deaths of children in the United States aged 14 or younger, more than three-fourths occurred in children under the age of 2. Approximately a third of the deaths of children under age 2 were unexpected, including those due to sudden infant death syndrome (SIDS) or trauma or deaths that were otherwise unexplained (American Academy of Pediatrics, 1994).

In 1994, 972 children in 34 states were confirmed as child abuse or neglect deaths. Projecting this figure to the remaining states, an estimated 1,271 children, approximately 3 per day, died from abuse and neglect in 1994. However, even conservative estimates place the actual number of child abuse and neglect fatalities at 2000 (Wiese & Daro, 1995).

Some basic information appears constant in the data reported to date. About an equal number of children died due to abuse and to neglect. The majority of deaths (88 percent) are children under five. Nearly half (46 percent) are children less than a year old.

Virginia's statistics are similar to national trends. In 1991, 34 Virginia children were known child abuse fatalities. Child abuse or neglect deaths numbered 32 in 1992, 43 in 1993, and 27 in 1994. Thus, in recent years in Virginia, a child dies because of abuse or neglect every 8 to 14 days. As in national statistics, the vast majority are under five and two-thirds are under two years of age. Abuse cases appear to outnumber cases of fatal neglect in Virginia's data with about 40 percent of fatalities due to neglect.

Statistics

It has been estimated that 85 percent of child deaths from abuse and neglect are misidentified as accidental, disease-related or due to other causes. Misidentification "arises from poor medical diagnoses, incomplete investigations, and widespread flaws in the way deaths are recorded on death certificates, in crime reports, and by the child protection system" (U.S. Advisory Board on Child Abuse and Neglect, 1995, p.24). While experts disagree about the extent of the problem, there is general agreement that the actual incidence of child abuse deaths is poorly documented (Thigpen & Bonner, 1994). Not only are the numbers of abuse-related child deaths unknown, but there is not even an accurate count of U.S. children who die and the cause of their deaths (M/CAP, 1994).

The nation's first multi-agency team began in Los Angeles County in 1978. Michael Durfee, M.D., concerned that child homicide victims were being missed, set up a system to retrieve cases from coroners' records. He was later joined in his efforts by a public health nurse with a background in working with child abuse cases. Together, they began to establish a protocol for review of potentially suspicious child deaths (Durfee, 1994).

From Durfee's efforts, Los Angeles County began an Interagency Council on Child Abuse and Neglect (ICAN) in 1978 to review child deaths. This was the country's first official multi-agency child death review team. A second team was formed in San Diego County in 1982. By 1989, California had about a dozen operating child death review teams and teams were also being established nationwide, spurred by the first national conference on fatal child abuse and neglect, sponsored in 1985 by the National Center (NCCAN) and the National Committee to Prevent Child Abuse (NCPCA). Interest nation-wide in child death review teams has also increased due to efforts of the

Team Formation and Roles

Child fatality review teams were formed due to concern about the lack of detection and reporting of child deaths due to abuse or neglect. Presently, 48 states have some type of death review committee.

Continued on page 3
Keeping Kids and Parents Cool Over the Holidays

With all the holiday excitement, both kids and parents can become overwhelmed. Although parents may feel that their parenting abilities are more in the spotlight over the holidays, it is often wise to lower your expectations for your children’s behavior. It’s hard enough to be on one’s best behavior 24 hours a day in “normal” times, but during the holidays when families are often overtired—and over-wired—it can be impossible. Talk to children ahead of time about which toys they might share with cousins or visitors. Remind them to show their good manners to Grandma and prepare them for any oddities among friends or family—like Uncle Charley’s loud voice or Aunt Violet’s perfume. A family album can be utilized to “preview” relatives that the children may not remember.

Above all, remember to take good care of yourself and your holiday spirit. A good way to do this, and one in which your entire family can participate, is to share the cheer of your holiday with someone less fortunate.

1. Make a family holiday calendar. Together, choose special events to mark on it.

2. Hold onto routines. Keep meals, naps and bedtimes at the usual times.

3. Prepare children for changes. Discuss behavior expectations, strange relatives, new situations.

4. Organize traveling plans and let children help.

5. Plan stress relievers for yourself. Sit down. Phone a friend. Sing a carol!

Contact PCAV at:
P. O. Box 12308
Richmond, VA 23241
(804) 775-1777
(800) 257-VCAP
FAX (804) 775-0019

Prevent Child Abuse, Virginia

Happy Holidays from
Prevent Child Abuse, Virginia

Funded through a grant from the Family and Children’s Trust Fund of Virginia

APSAC
American Professional Society on the Abuse of Children
407 S. Dearborn St., Suite 1300
Chicago, IL 60605
(312) 554-0165
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APSAC is a private, non-profit interdisciplinary society for professionals working in the field of child abuse and neglect. Their major goal is to promote effective interdisciplinary coordination and practice. They support research, education and advocacy efforts. Membership benefits include a 40 page quarterly publication, The APSAC Advisor, the Journal of Interpersonal Violence, discounts on conferences and training materials, the opportunity to participate in Task Forces establishing national interdisciplinary practice guidelines, free copies of guidelines produced by Task Forces and the opportunity to build interdisciplinary coalitions with professional peers. Membership rates are from $35 to $100, depending upon income level.

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American Bar Association and the American Academy of Pediatrics. These associations jointly received a Robert Wood Johnson Grant in 1989-91 to create model documents for laws, policies and protocols for implementing teams (Durfee, 1994).

Child fatality review teams review child deaths. A team can be "internal," reviewing child deaths as they relate to a particular agency. "External" teams consider the activities of all agencies. The most useful teams are both multi-agency and multi-disciplinary. The blend of expertise and knowledge of diverse professions can assist in understanding the causes of a child death (M/CAP, 1994).

Team members typically are drawn from health, public health and legal professions. Members often include representatives from: law enforcement, CPS, medical examiner/coroner, prosecutor, public health doctors, mental health specialists, educators and pediatricians. Additional members on a case by case basis might include emergency medical technicians, fire department personnel, preschool teachers and emergency room staff.

Child fatality teams differ from infant mortality review teams. Infant mortality teams are composed of medical and health professionals and limit the scope of their work to infants. Reviews are based on medical records and notes from staff interviews with parents. The reviews are anonymous, with team members unaware of the identity of the child and family (M/CAP, 1994).

Child fatality review teams may address several purposes. Teams may focus upon:
- Investigation
- Service Planning
- System Study
- Data Collection
- Prevention

Teams with a clear purpose have the greatest chance of success. All other organizational decisions flow from the purpose(s) of the team (M/CAP, 1994).

Geographic area varies. A state team is needed if the primary purpose is to study and implement changes statewide. Investigative teams whose purpose is to improve and facilitate the investigation of a child's death are generally local teams (M/CAP, 1994).

Ideally, the team examines all deaths of children under 18. Due to limited resources, it is more usual that the team will limit review to deaths from certain causes, unexplained deaths, suspicious deaths, and/or deaths of children known to CPS. Cases are chosen from coroner's records or public health records. Cases can also be referred to the team by member agencies.

Teams have been "housed" in various locations. Typical sponsoring (or "lead") agencies include CPS, law enforcement, the prosecutor's office, the governor's office, public health, the medical examiner's office or an advocacy office for children (M/CAP, 1994).

Standard Investigatory Guidelines

There is no uniform system throughout the United States for investigation of infant and child deaths. Many jurisdictions lack appropriately trained pathologists, inter-agency collaboration for information sharing and a surveillance system to evaluate data regarding infant deaths. As a result, progress in understanding SIDS is inhibited, causes of child abuse or neglect fatalities go undetected, familial genetic diseases remain undiagnosed, public health threats may be unrecognized and inadequate medical care is not detected (American Academy of Pediatrics, 1994).

One of the most useful activities of a team is the development of guidelines and procedures for child fatality investigations. Interested readers can check resource reviews for published protocols. The American Academy of Pediatrics guidelines are especially pertinent.

A basic component in determining cause of death is an autopsy. Also needed is a thorough investigation of the crime scene and interviews of children and adults in the environment. The team needs to check for criminal history as well as prior reports of child abuse. The child's medical history may provide essential information. Paramedics who responded to a 911 call might be helpful, as well as relatives, neighbors and community agency staff. Family history and a review of information from relevant agencies and health care providers is needed.

A complete autopsy consists of both an external and internal examination of the body, microscopic examination and toxicologic, microbiologic and other appropriate studies. The autopsy should be performed by a forensic and/or pediatric pathologist, using a standardized protocol for infant or child deaths (AAP, 1994).

Investigation of the circumstances of the death should include a scene investigation and interviews of family members. Investigating officers need training in both death investigation and issues of family grief (AAP, 1994).

Interagency cooperation and review of all relevant records and data is a necessary part of the death investigation. Relevant records should include, at minimum, medical records from birth, social services and CPS records, emergency and paramedic records and law enforcement reports (AAP, 1994). A centralized data base could facilitate the identification of preventable child deaths.

A child death review team should, according to the American Academy of Pediatrics (1994), evaluate the death investigation process, examine difficult or controversial cases, and monitor death statistics and certificates.

Benefits of a death review team include:
1) quality assurance of death investigation at the local level,
2) identification of barriers to death investigation,
3) enhanced inter-agency cooperation,
4) improved allocation of resources,
5) enhanced awareness and education on the management and prevention of infant and child deaths,
6) better data about causes of child deaths, and
7) improved accuracy of death certificates.

Virginia's Response

In 1989, the General Assembly requested that the Department of Children coordinate a multidisciplinary study on child abuse and neglect fatalities. This study was highlighted in VCPN, Fall 1996, Volume 32 ("Child Abuse Fatalities"). The study group reviewed 90 child maltreatment fatalities for the years 1986-89 and also studied statistics in both Virginia and other states.
Review Teams

Continued from page 3

b) Establish local, regional and state-level child death review teams.
c) Establish programs for prevention and education on issues of child maltreatment fatalities.
d) Create training to improve the investigation of infant and child deaths.

In the 1994 legislative session, Senator Gartlan and nine other patrons introduced Senate Joint Resolution No. 174. In the House, Delegate David G. Brickley introduced House Bill No. 627. SJR 174 requested that the Secretary of Health and Human Resources and the Secretary of Public Safety study the feasibility of establishing an Infant and Child Death Review Advisory Committee. HB627 amended the Medical Examiner Code, mandating the creation of a Child Fatality Review Advisory Committee. HB627 also amended the Social Services Code to provide for the release of records to multidisciplinary teams, development of formal cooperative agreements between local departments of social services and local law enforcement, and the adoption of protocols for criminal investigation. Both documents directed that a team/task force study and develop procedures to ensure that child deaths occurring in Virginia are reviewed in a systematic way.

"The Department of Health was designated as the lead agency for the study," remarks Gartlan. "Dr. Marcella Fierro, Chief Medical Examiner, was in charge of the study group. Her reputation and her relationship with law enforcement were crucial in the success of the endeavor," asserts Gartlan.

The results of the study were published this year (Senate Document No. 51. "A Study of the Child Death Review and Advisory Committee", see review, this issue). Several key recommendations were made.

One crucial point was to recommend that all child death reviews be retrospective, after investigation is complete. "The focus," explains Senator Gartlan, "is to identify trends concerning how and why children die."

Dr. Fierro adds, "We will be looking at specific groups of child deaths in order to identify factors amenable to change. Then, strategies for prevention and education will follow." Gartlan explains that the team will review accidental deaths, as well as unexplained deaths, abuse and neglect deaths, and deaths of children by suicide. "We were able to define SIDS (sudden infant death syndrome) in a way that was acceptable to the medical community," says Gartlan. He continues, "All SIDS deaths will be autopsied. It is a way to give parents peace of mind and remove any cloud of suspicion from them. Even if the medical examiner cannot identify a pathological condition, inflicted harm can be ruled out."

Virginia's team will meet quarterly. Only one statewide team is mandated by the current legislation (although nothing prevents localities from forming teams to meet local needs). The first formal review is scheduled for 1996. Informal reviews this year will test systems and protocols.

"The team is not part of the investigative process for the case of the investigation," stresses Dr. Fierro. "The team review is a records review, begun only after the investigation is ended." While the team has been given the power to obtain all records, records will remain completely confidential.

According to Dr. Fierro, the hope is that the team will become the impetus for a statewide computer child death database. Review of data should identify risk events for child death that are amenable to prevention strategies. The review process should also reveal training deficiencies that can be remedied by educational efforts. Components can be added to curricula of emergency medical service providers, child protective services, medical examiners, fire fighters, police and law enforcement. "I expect the General Assembly to hold us to our purpose," states Dr. Fierro. "We must focus on what strategies will reduce each type of death."

Marcello Fierro, M.D.
Chief Medical Examiner

Hope for the Future

Durfee (1994) holds forth many hopes for future directions. He envisions more elaborate systems for information sharing so that cases can be managed across county, state and national boundaries. He hopes that systems for supporting siblings, other family members and professionals will appear. He predicts that
professional training will be more formalized and more frequent.

Durfee would like to see the efforts of child death review teams broaden to include all preventable deaths of children. Non-fatal severe physical abuse cases and cases of fatal domestic violence might also benefit from the analysis a team can provide.

Finally, Durfee foresees that intervention and prevention programs will follow the new understandings gained from team work. Systems intervention after a death will be surpassed by early intervention before death.

Virginia's team appears uniquely adapted and conceived to work towards Durfee's vision. The work of Virginia's Child Fatality Review Team offers hope for reducing child fatalities.

References Available Upon Request

SIDIS Versus Child Abuse Fatalities

Space did not permit a summary about distinguishing Sudden Infant Death Syndrome from child abuse fatalities. Interested readers are referred to chapter 5 in "Child Abuse: Medical Diagnosis and Management" by Robert M. Reece, M.D. (see review, VCPN, Volume 45) and the American Academy of Pediatrics statements (see review, this issue).

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**Governor's Advisory Board on Child Abuse and Neglect Resolution**

WHEREAS, the unnatural, sudden and unexplained deaths of children in Virginia constitute a tragedy that has not been adequately studied or understood in this Commonwealth; and

WHEREAS, in 1989 the Commonwealth of Virginia began studying the issue of child fatalities, and in particular the deaths of children due to child abuse and neglect;

WHEREAS, certain members of the Governor's Advisory Board on Child Abuse and Neglect helped to focus the attention and the energies of the Board on the potential benefits to the Commonwealth's children from comprehensively studying child fatalities in Virginia; and

WHEREAS, in 1993 the Governor’s Advisory Board on Child Abuse and Neglect co-sponsored the Symposium on Child Maltreatment Fatalities in Virginia, which produced four recommendations regarding data collection, establishment of child death review teams, prevention and education programs, and training; and

WHEREAS, following that Symposium, the 1994 General Assembly passed Senate Joint Resolution 174, which established a task force on child fatality review; and

WHEREAS, that task force produced recommendations which led to the passage of Senate Bill 901, which establishes a State Child Fatality Review Team and provides for the systematic study of certain child deaths in Virginia, for the development of improved procedures and techniques in such study, and for the creation of prevention and education programs based upon the findings of such study; and

WHEREAS, the Core Working Group for the task force devoted many long hours of diligent and effective work to help make the passage of this legislation possible, to the benefit of future generations of Virginia’s children and parents;

NOW, THEREFORE, BE IT RESOLVED by the Governor’s Advisory Board on Child Abuse and Neglect that Marcilla Fierro, M.D., Ms. Rita Katzman, Ms. Francine Ecker, Ms. Diane Maloney, Ms. Dorothy Hollahan and Mr. Ronald Hyman, members of the Core Working Group, are hereby recognized and commended for their extraordinary effort on behalf of Virginia’s children and families.

John Oliver, Chairman 9-22-95

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**A Study of the Child Death Review and Advisory Committee (House Document No. 51) by Marcilla F. Fierro, M.D. and committee, 1995, 46 pages, free of charge.**

Available from: Division of Legislative Automated Systems, P.O. Box 654, Richmond, VA 23205, (804) 786-6984.

This report summarizes the findings of a study by the Secretaries of Health and Human Resources and Public Safety. The study determined the feasibility of establishing an infant and child death review and advisory committee. The Task Force recommended a single statewide review team with a broad scope of study to include violent deaths, child abuse and neglect deaths, and accidental and suicidal deaths of children.

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Copies of the report and executive summary, a 15 second TV and a 30 second Radio PSA created for the Board by Pollis Advertising/ N.Y. may be requested from the U.S. Advisory Board on Child Abuse and Neglect, (202) 690-7059 or ordered from the NCCAN Clearinghouse.

This document is the result of two and a half years of investigation about child abuse and neglect fatalities. The advisory board has summarized their findings from a comprehensive national study of child maltreatment deaths. The report sets forth 26 recommendations aimed at saving children's lives by improving accountability for identifying and reporting child abuse fatalities, promoting prevention services, ensuring more effective prosecutions of caretakers who murder children, increasing training of legal and medical professionals, assuring that children's safety is a priority in all child and family services programs and developing a structure for a national focus to prevent child abuse fatalities.

Available from: NCCAN Clearinghouse, P.O. Box 1182, Washington, D.C. 20013-1182, (703) 385-7565 or (800) FYI-3366, FAX: (703) 385-3206.

Child Maltreatment 1993: Reports From the States to the National Center on Child Abuse and Neglect, 1995, 98 pages, #21-10058.

This report highlights findings from a national data collection and analysis program. The research is a collaborative effort between the states and NCCAN. "Child Maltreatment 1993" is NCCAN's fourth consecutive annual report.

Available from: NCCAN Clearinghouse, P.O. Box 1182, Washington, D.C. 20013-1182, (703) 385-7565 or (800) FYI-3366, FAX: (703) 385-3206.

The APSAC Advisor Special Issue on Child Fatalities, Randall Alexander, MD., Ph.D., guest editor, 1994, Vol. 7, No. 4, 60 pages, $3.


This issue offers a thorough update of knowledge and practice in dealing with child fatalities. Articles include child death review teams, sudden infant death, falls, head injury, fatal neglect, psychological characteristics, and the roles of CPS and law enforcement.


The workgroup was created for developing recommendations for a federal role in guiding the implementation of a consistent and systematic mechanism for child fatality review at the local, state and national level. A series of recommendations, along with a rationale for each, addresses issues such as team composition, scope of duties, data collection, training, protocols, cultural sensitivity and financing.


On February 16 and 17, 1994, an audience of over 6500 professionals tuned in to the first national training conference exclusively devoted to multi-agency child fatality review teams. This synopsis describes benefits of a multi-agency approach to child fatalities, organizational issues, confidentiality and the roles of team members. Two appendices deal with prosecution issues.


This is a reference guide for those researching criminal child abuse legislation. State statutes and relevant laws are compiled. This resource is updated annually.


This collection includes all statutes (except tribal and military) that mandate autopsies in child death cases and legislation mandating or authorizing the creation of child death review teams. The compilation is updated annually.

Available from: National Center for Prosecution of Child Abuse, 99 Canal Center Plaza, Suite 510, Alexandria, VA 22314 (703) 739-0321, FAX (703) 549-6259, (800) 765-8560 (Nebraska, Ohio, and Virginia only).
Project Link: Reaching Out To Substance-Using Pregnant Women

“Many pregnant women whose lives are affected by substance abuse” states Aida Rivaderena, Project Link State Coordinator, “come from families with a history of addiction. In addition to their addiction, they often have housing problems, employment difficulties, relationship problems, health difficulties, nutritional problems and educational deficits.” Rivaderena continues, listing nearly two dozen services that programs reaching out to this population need to offer. “There is no way that any single agency can address all these needs,” emphasizes Rivaderena.

In order to reach these high-risk mothers-to-be, five agencies have pooled their resources and expertise at the state and local level, implementing Project Link. Through community services boards, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMR SAS) offers prevention services, substance abuse treatment and infant early intervention. The local departments of health offer prenatal care, well baby clinics, WIC program (food supplements) and family planning. The local departments of social services offer child protective services, case management, ADC, food stamps, foster care, respite care and assistance with housing. The local cooperative extension services offer home management skills, parent education and money management training. The Virginia Commonwealth University School of Social Work contributes expertise in evaluation and data collection. A comprehensive evaluation of the project is being conducted by the College of William and Mary.

Five sites have been chosen to replicate the model. These are Newport News, Virginia Beach, Fredericksburg, Charlesville and Roanoke. A half million dollars have been designated to coordinate and enhance existing services. A collaborative approach is used to facilitate early identification, cross agency referral, services planning and case management. The grant funds the costs of transportation, child care and “resource mothers.”

The philosophy espoused by Project Link is a non-punitive approach. “This is not a minor issue,” states Rivaderena. “It is the crux of the issue.” Another key part of the grant is to supply support in the form of “resource mothers” who work with a family beginning in pregnancy until the infant is two years old. Rivaderena explains that the client does not necessarily have to be in substance abuse treatment to obtain a “resource mother.” “We are hoping that by establishing a trusting relationship, these high-risk pregnant women will obtain the motivation to enter treatment,” she explains.

To help increase collaboration and meet the multiple needs of the at-risk pregnant women, a manual has been developed. It contains information about referral, a sample assessment, a protocol for drug-use-history screening interviews, a summary of confidentiality rights, a psycho-social history form, and an observation checklist, information about common “street” drugs, criteria for categorizing drug-use patterns and examples of record-keeping.

Recent legislation requires physicians and public health clinics to endeavor, through skillful interviewing, to detect at-risk pregnant women early. Through Project Link, substance abuse consultation is provided in maternity and family planning clinics. Substance-using pregnant women receive priority attention for services. Risk assessment and service plans are completed and involve the client’s input as much as possible.

Since October, 1991, over 800 clients have been enrolled in Project Link. Outcome data is highlighted in the year evaluation report which is available upon request.

Project Link is an ambitious undertaking that endeavors to impact upon a complex problem. Those desiring more information about substance-exposed babies are referred to VCPN, volume 33. Those wishing more information about Project Link or materials to assist in assessing pregnant women who are using substances can contact Aida Rivaderena, Project Link State Coordinator, DMHR SAS, Office of Prevention, P.O. Box 1797, Richmond, VA 23214, (804) 786-2615, FAX (804) 371-6179.


Children are the tragic footnote of the drug abuse of the 1980’s. Chemical dependency is a dominant factor in the need for child protective services intervention. Few issues provoke more controversy or frustration than substance abuse by pregnant women. There is little disputation about the danger to mother, fetus and other children in the home. However, controversy surrounds the question of intervention. Dinsmore describes the prosecutorial dilemma by examining the pros and cons of each of the major issues in this debate.
Treatment Outcome for Families Who Abuse or Neglect

THE CHALLENGE

Since the early 70's efforts have been made to treat abusing or neglecting families rather than simply removing children from their home. Treatment is thought to be a better alternative than removal of children for several reasons. First, children are usually attached emotionally to their parents and may not want to be removed. Secondly, while removal can have positive effects, there are also negative effects for both the child and the family. Third, abusive or neglectful parents may be young and able to have more children. Finally, treatment can be cost-effective, compared to placing children out of their homes.

Early treatment efforts suggested that some families referred because of abuse or neglect were not amenable to treatment. In some cases, leaving children with their parents put them in danger of further abuse or neglect and even resulted in fatalities. Other families responded well to treatment interventions.

This article will examine characteristics of families who abuse or neglect in order to determine which families are more likely to benefit from treatment. Methodology for treatment outcome studies will be examined. Finally, results of outcome studies will be summarized. This article will appear in two parts. Examination of causative factors, research methods and risk factors will be covered in this issue. The next VCPN will discuss treatment outcome studies and will feature Virginia programs as well as selected programs with national recognition.

EARLY EFFORTS

While maltreating families are heterogeneous, some characteristics appear frequently in samples of families referred because of abuse or neglect. Further, the presence of certain characteristics, or their degree of severity, may help determine the safety of the home and the likelihood of treatment success. Therefore, a discussion of family dynamics is warranted.

The Abusive Parent

Martin's (1976) early review of the literature suggested that there are characteristics shared by abusive parents. He cites Steele (1975) who worked extensively with a wide variety of abusing parents and found eight common characteristics. These were immaturity and dependence, social isolation, poor self-esteem, difficulty seeking or obtaining pleasure, distorted perceptions of the child, fear of spoiling the child, belief in the value of punishment, and an impaired ability to empathize with children.

Other early researchers Martin reviewed found extensive psychopathology and sociopathy in abusive families. For example, Smith, Hanson and Noble (1975) studied the parents of 134 abused children, finding that 29 percent of the fathers and 11 percent of the mothers had criminal records. Seventy-six percent of the fathers and 64 percent of the mothers had "abnormal personalities" in comparison to 14 percent of parents from the control group.

Spinetta and Rigler (1972) suggested that most of the early experts on child maltreatment agreed that: (a) abusive parents were often mistreated as children, (b) abusive parents shared common misunderstandings with regard to the nature of child rearing and looked to children for satisfaction of their own needs, and, (c) only a few abusive parents displayed psychotic tendencies.

Merrill (1962), focusing upon personality problems, suggested that maltreating parents fall into one of three categories. These were: (1) Parents with continuous and pervasive hostility and aggressiveness; (2) Parents with characteristics of rigidity, compulsiveness, lack of warmth, lack of reasonableness and minimal pliability in thinking and belief. These parents tended to reject their children, felt self-righteous and defended their right to act in an abusive manner toward their children; (3) Parents who tended to be passive and dependent. This group was unassuming, nonaggressive and reticent. They competed with their children for affection from their spouse. They were depressed, moody, unresponsive, unhappy, and immature. Merrill's early typology hints at the diversity in maltreating parents which continues to complicate research efforts.

In addition to personality characteristics, some attention was directed in early studies to demographical data. Issacs (no date) summarized early literature regarding demographic characteristics of abusing parents. These included: a high incidence of divorce, frequent separation and unstable marriages, premartial conception, unemployment, insufficient education, inadequate housing, geographical mobility, and, larger than average family size. Differences in demographics led to speculation that stress factors might play a significant role in abusive behavior.

Subsequent studies have offered very similar findings. For example, Dubowitz, et al. (1987) found that their sample of abusing mothers were more likely to be impoverished, to be on welfare, and to have no phone or car than mothers in the control group. In addition, abusing mothers were less likely to be Caucasian or married. Those who were married were less likely than control mothers to be living with their spouse. Abusing mothers were more likely to have experienced harsh discipline as children. Abusers expressed a lack of support and lacked access to recreation. In the same study, fathers in abusive families were found to be younger and less educated than fathers in the control group. They were also more likely to be unemployed or employed in unskilled jobs than the control fathers.

The eight common characteristics mentioned in Martin's early review of the literature are supported by many recent
researchers, (Azar et al.; 1984; Caplan et al., 1984; Evans, 1980; Gelles, 1989; Whipple & Webster-Stratten, 1991). Indeed, data from current confirmed cases continues to document characteristics noted in early research.

A literature review by Walker, Banner and Kaufman (1988) cited predisposing characteristics as a personal history of abuse and neglect as a child or witnessing family violence. Abusive parents were described as low in empathy, often holding unrealistic attitudes and expectations and inept or inconsistent in child management practices.

Some recent researchers examined the presence of cognitive or affective disorders in abusing parents. Taylor, Norman, Murphy, and Jellinek (1991) examined the court records of 206 seriously abused and neglected children and their families. Over half the parents were diagnosed as having emotional disorders and/or low IQ scores. "When records documenting alcohol or substance abuse only were added, fully three quarters of these families had at least one parent who met DSM III criteria for a diagnosed disorder" (p. 397).

Milner and Chilamkurti (1991), in their extensive review of the literature, also found a relationship between alcohol and drug use and child maltreatment. They report that alcohol use, especially at high levels, is related to the severity of aggression. They also note a surprising lack of research investigating the relationship between child abuse and substance abuse.

The Department of Social Services (DSS) of the Commonwealth of Virginia reports statistics annually. Statistics from July 1, 1992-June 30, 1993 include characteristics similar to those reported in research studies. DSS reports that 24.4 percent of Virginia's maltreating families have emotional or mental problems. The most commonly cited characteristics for maltreating families are lack of knowledge of child development (25.9 percent), lack of support system (20.4 percent), and a lack of knowledge of a child's particular problem (11.8 percent). Data also indicated that 16.9 percent of abusers were known to be abused in childhood and that 12.4 percent were known to be a victim of spouse abuse. Alcohol abuse was indicated for 23.5 percent of the families, with other substances playing a role in 14.8 percent. Stressors experienced by Virginia's maltreating families include financial problems (48.3 percent), housing problems (27.2 percent), and marital problems (21.0 percent).

The Child

People prefer to think that children do not contribute to the possibility of maltreatment occurring. In fact, within the same family some children are more likely to be physically abused than others.

Martin, in an early study, (1976) suggests the child's role in abuse dynamics has at least six different aspects:

1. Some children have attributes which make them difficult to parent. For example some babies have a limited capacity to be a "good" baby and/or to meet parental expectations. The child who is colicky or fretful does not reinforce a parent's loving affect.

2. Certain events affect the mother-child bond. These include a difficult pregnancy or desertion of the mother by her partner during pregnancy. A mother may blame the baby for such difficulties, increasing the risk for maltreatment.

3. There may be a disruption in the parent attachment process. Research has shown that immediate contact between parent and newborn positively influences parents' behavior toward the child. Therefore, it is not surprising that premature children (who may have been physically isolated from parents while in intensive care) have greater likelihood of being mistreated than full-term children. Disruption in attachment may also occur with such events as maternal or newborn illness, or significant stressors in the parents' life.

4. The child may not match parental expectations (or the parents' expectations may be unrealistic). For instance, a child may be a male when the parent desired a female. The parent may desire a dynamic, blue-eyed blond but gave birth to a quiet child with green eyes and brown hair. Or, as the child develops, the parents' wish for a supremely intelligent child may be met with a child of average ability.

5. Parental interaction with the child may be directly related to the child's developmental stage. Some parents cannot relate to a dependent infant but do better with a more adventuresome toddler, or vice-versa. Others are not able to deal with the emerging testing of limits displayed by the adolescent.

6. A child may deliberately or unconsciously, covertly or overtly provoke anger by acting out, resulting in physical abuse from the parent. Acting out by children may be due to identification with and modeling of a violent parent, or acting out may be the most expedient technique the child has for getting a parent's attention. An abused child may equate punishment with love. Possibly the child has been treated as "bad" for so long that this idea is incorporated into the self-concept and the child behaves accordingly. (An alternative explanation says the abusive parent simply misinterprets or misperceives normal child behavior and responds with abuse instead of redirection.)

More current research has expanded upon these early ideas. Dubowitz et al. (1987) found abused children were less likely to enjoy good health, were socially immature and were lacking in age-appropriate self-help skills. In addition, mothers of abused children reported them to be more difficult to manage. Indeed, any factor that renders a child difficult to manage may increase risk of abuse (Walker, Banner & Kaufman, 1988).

Other child variables associated with abuse appear to be age (with young children more likely to be abused than older children), gender (with male children slightly more likely to be abused than girls), higher risk to children born to unwed mothers and increased risk of abuse when there is a separation of child and mother in infancy (Kaplan, et al., 1984).

Most studies concerning child factors which may cause a child to abuse use a descriptive and/or retrospective design. The few prospective studies suggest that child characteristics have some

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predictive power, but are not the most salient variables. The critical question, according to Ammerman (1990) is one of cause and effect. Do physical characteristics contribute to maltreatment or are they simply results or symptoms caused by maltreatment?

Ammerman (1990) does review many well-controlled, experimental studies which demonstrate that escalating coercive interaction between parent and child leads to increased conflict in abusive families. He cites these as “compelling evidence that coercive parent-child interactions are a major component in the etiology and continuation of child abuse” (p. 210). While the child is clearly a contributor to the abuse, Ammerman maintains that the child is not necessarily the instigator. Once the pattern of escalating conflict is in place, however, the child plays an active role in maintaining the abusive relationship.

The Department of Social Services for the Commonwealth of Virginia collects information concerning the child victim’s history and characteristics on initial intake. For the largest number, 52.3 percent, no special characteristics were identified at intake. The special characteristics most often noted were behavioral problems (16.7 percent), emotional disturbances (11.7 percent) and learning disabilities (7.2 percent).

The Neglectful Parent

While there is overlap between abuse and neglect, often neglect occurs without physical abuse. A wide variety of parental characteristics have been associated with neglect (Green, 1991). In neglectful families, prominent psychiatric, physical, social and cognitive impairments interact with poverty and substandard living conditions.

Polansky and associates (Polansky, Hally & Polansky, 1975) were among the first to summarize research about neglect. They cited factors of parental pathology, breakdown of the nuclear family, the impact of cultural values, and the intergenerational cycle. In a more recent review of literature Green (1991) cites a study by Polansky et al. (1968) which describes five types of neglecting mothers. The first group, “the apathetic-futile”, appear to be most prevalent. These mothers, physically and emotionally deprived themselves as children, are too overwhelmed to recognize the needs of their children. They often leave young children alone and fail to play with them. These mothers are lonely, have poor interrelationships, and are incompetent in many areas of living. The other four types are: “the impulse-ridden”, “mentally retarded”, “reactively depressed” and “psychotic”.

As a group, neglectful mothers appear more likely than either normal or physically abusive mothers to experience unplanned pregnancy and neglectful mothers begin bearing children at an earlier age (Zuravin & Starr, 1991). Neglectful mothers are more likely to be unmarried or lack a partner living in the home. They have the highest rates of alcoholism, antisocial personality and chronic physical illness. Neglectful parents typically neglect all their children, rather than targeting a certain child. Effects of neglect are more likely to be life-threatening for infants and very small children who can not fend for themselves.

EARLY THEORY ON CAUSES OF MALTREATMENT

A list of characteristics is only a small beginning to understanding factors and causes of child maltreatment. Early observations led to fragmented research efforts to understand underlying causes.

In the 1970’s and 1980’s, many causal models for child abuse and neglect were proposed. One idea was that abusive parents had personality disorders or mental illness. (Blumberg, 1974; Gil, 1973; Merrill, 1962; Spinetta & Rigler, 1972; Steele & Pollack, 1974; Wright, 1980). Learning, especially through intergenerational modeling, was a popular idea (Dubowitz et al., 1987; Egeland et al., 1987; Newberger et al., 1986; Spinetta & Rigler, 1980; Steele & Pollack, 1974; Straus, 1980). Disruption in attachment was hypothesized as a cause (Ainsworth, 1960; Gil, 1973; Kennell, Voos & Klaus, 1976; Klaus & Kennell, 1980; Scott, Asch & Lowell, 1974). Researchers examined inappropriate expectations and lack of knowledge about child development (Jacobsen & Shaker, 1979; Strauss & Spinetta, 1984; Spinetta & Rigler, 1980; Steele & Pollack, 1974; Walters, 1989; Wood-Schuman & Cone, 1986). Stress factors and the resulting frustration were cited (Dubowitz et al., 1987; Gelles, 1980; Gil, 1973; Giovannini & Billingsley, 1970; Johnson & L’Esperance, 1984; Koch & Thomas, 1986; Strauss, 1980; Walters, 1989). The role of difficult children was further examined (Ammerman, 1990; Herrenkohl, Herrenkohl & Egolf, 1982). Finally, cultural and societal norms permitting or encouraging abuse were discussed (Straus, 1979; Walters, 1989).

Early research efforts that focused on single ideas resulted in a set of conceptually unrelated propositions and hypotheses (Herrenkohl, 1990). While most were supported by some empirical data, none offered a comprehensive model to explain child maltreatment. Further, the data on each single variable was inconsistent, with some studies offering support and others finding no differences between abusive subjects and controls (Herrenkohl, 1990).

For example, the proposal that abusive parents lack knowledge of child development and harbor unrealistic expectations for their children has yielded what, at first, appeared to be conflicting information. Several researchers questioned parents about knowledge of developmental norms and found no differences between the samples (studies reported in Herrenkohl, 1990). However, if “expectation” is defined as tolerance for child behaviors, the data does support the idea of “unrealistic expectations”. For instance, Bradley and Peters (1991) found that their sample of abusive parents accepted no responsibility for negative parent-child interactions, attributing their abusive responses to the child’s behavior. In addition, they minimized their child’s contribution to positive parent-child interactions.

A study by Shider, Reid, Kavanaugh and Baldwin (1987) found that abusers tended to misreport children’s behavior, describing common behaviors in very negative terms. While this finding supports the idea that abusive parents have a low tolerance for typical child behaviors, the authors note two other possible data interpretations. One is that abusive parents may be reacting to their label and defending themselves by describing their children as difficult. Another possibility is that abusive parents may fail to track their children well and only notice the most aversive behaviors.

Expectations may interact with parental behaviors to produce ineffective parenting strategies. For example, Kavanaugh et
al. (1988) found that abusive parents in their sample were less likely to respond positively to their children than were non-abusive parents. Abusive parents tend to respond significantly less frequently to their child's invitation to interact than do non-abusive families.

Wolfe (1989) elaborated on abusive parents' interactive styles with their children. Abusive parents used few behaviors that facilitated parent-child interaction and displayed little positive affect during interactions with their children. Wolfe's findings are similar to those of Schindler & Arkowitz (1986) who found that abusive mothers responded significantly less frequently to their children and praised appropriate behavior significantly less often than did control mothers.

A qualitative study of six families (3 abusive, 3 non-abusive) by Majonis (1991) found that social interaction between parent and child was a crucial variable. Abusive families participated in only one pattern of social interaction, (interpersonal conflict) rather than two patterns found in non-abusive families (mutual decision-making and complementary role social interactions). The non-abusive parents offered information, helped set goals, encouraged cooperation, gave instructions, offered rewards and assisted the other parent. They modeled patience and self-control.

Thus, a construct such as “lack of knowledge and unreasonable expectations” is complex, being influenced by many other factors such as a parent’s emotional state, motivations, basic intelligence, problem-solving abilities, influence of drugs or alcohol, health status, general level of coping and presence of stressors. It is apparent that theories or models about the causes of abuse need to specify relevant constructs carefully and also address the inter-relationships between constructs (Herrenkohl, 1990).

Rethinking initial findings is more than an intellectual exercise. For example, if the overall level of stress were considered the cause of abuse, then casework services to reduce stress would be an appropriate strategy. If, however, more specific stresses such as social isolation or tolerance of inconsistent child behavior were theorized to be responsible for abuse, then services directed at those specific stresses would be needed to lower the risk of reabuse (Herrenkohl, 1990).

Specificity has relevance for evaluating treatment outcomes. If treatment has not been directed towards the specific factors causing the abuse, but instead has offered a generic approach, lack of progress may lead one to falsely conclude that the family is simply unable or unwilling to improve. Likewise, a particular intervention may be very effective with one family but ineffective with another due to the differing characteristics of the family.

**TOWARDS COMPREHENSIVE THEORY**

It appears likely that abuse is multidetermined, that is, no single factor will be sufficient to explain its occurrence. Even in earlier years, researchers were proposing models which combined several factors when explaining abuse.

Gelles (1973) was one of the first to suggest a multi-factor model, citing stress, social isolation and the parents’ upbringing in his model. Garbarino (1976, 1981) suggested an “ecological model” which combines individual, family and sociocultural variables. Wolfe (1987) proposed a model in which parent-child interactions over time change into abusive behavior. Multidimensional models are similar in considering how parent and child characteristics along with environmental and cultural factors converge to provide the opportunity for child maltreatment to occur. Belsky’s model was selected as an example.

Belsky (1980) suggests that in order to analyze child maltreatment, one must conceptualize the problem as “a social-psychological phenomenon that is multiply determined by forces at work in the individual (ontogenic development) and the family (the microsystem), as well as in the community (the exosystem) and the culture (the macrosystem) in which both the individual and the family are embedded” (p. 320).

As noted earlier, abusing parents possess specific characteristics. In addition, childhood maltreatment coupled with high levels of stress in their adult lives increase the probability that vulnerable parents will engage in maltreatment. Parents may have lacked opportunities to care for other children, depriving them of prior practice in the role of caretaker. They may be ignorant of the sequence and timing of events in child development. The degree to which each or any characteristic or predisposition increases risk is unknown and, perhaps, individual specific.

**The Macrosystem**

The family's social system and community influence child maltreatment as well. The world of work can effect the family through unemployment or through work place stress. Lack of social networks can play a role. Abusing families tend to be isolated from social supports, sometimes by their own actions as they appear unable to form and keep friendships. Without such supports, there is no informal means of help available. The exosystem, then, can increase stress or fail to support an already stressed family system.

**The Exosystem**

The family’s social system and community influence child maltreatment as well. The world of work can effect the family through unemployment or through work place stress. Lack of social networks can play a role. Abusing families tend to be isolated from social supports, sometimes by their own actions as they appear unable to form and keep friendships. Without such supports, there is no informal means of help available. The exosystem, then, can increase stress or fail to support an already stressed family system.

**The Microsystem**

The family unit itself appears to be instrumental in the occurrence of child maltreatment. Previously described child and adult characteristics interact to increase risk for maltreatment. In addition, the spousal relationship may contribute to incidents. When a parent's needs are not being met, he or she may turn to a child for nurturance and support. If the child is unable to meet these needs, the parents' anger can result in abuse. Or, children may be viewed as intruders in the spousal relationship, therefore incurring the wrath of a parent. Thus, parent/child issues and behaviors can interact in many ways to make child maltreatment possible.
American Public Welfare Association

A Commitment To Change, by The National Commission on Child Welfare and Family Preservation, 1991, 37 pages. $5.00 ($5.00 for APWA members).


In 1986 the American Public Welfare Association (APWA) formed the National Commission on Child Welfare and Family Preservation. The organization reflects APWA's commitment to families in contemporary society and to the need for a strong family policy.

This publication is the result of the commission's efforts to listen to experts across the nation who are concerned about the shortcomings of the child welfare system. They provided suggestions for programs that support troubled children and their families.

The document outlines the commission's directions, approaches, and the investments necessary to support the healthy functioning of families and communities.


It became clear to members of the National Association of Public Child Welfare Administrators that they must begin to define success in child welfare programs. Thus began the National roundtables on outcome measures in child welfare. The first roundtable was held in 1987, and the second in 1994. This publication is a compilation of presentations made at the 1994 Roundtable session.

One finds a variety of useful information in this publication. First, there are presentations of experiences on child welfare outcome measures from Colorado, Texas, California and Utah. Then, there is a listing of outcome measures related to four targets: child safety, family continuity/family preservation, child functioning and family functioning. These were developed through all-day work sessions by conference participants. Third, there is a section which covers measurements to be considered when developing outcome measures for child welfare service. Finally, a set of appendices offer contacts of practitioners actively working in this area.


For several years, the American Public Welfare Association and The Children's Division of the American Humane Association have convened annual Roundtables on CPS Risk Assessment. Their purpose has been to provide an opportunity for sharing information about developments, implementations and research about CPS Risk Assessment.

Over the years many topics have been presented. In these volumes, representatives from Tennessee, Rhode Island, Colorado, and Texas present risk assessment models. Concerns about cultural issues related to risk assessment are addressed. Up-to-date research information about implementation problems, interpretation, and application is offered. These are but a few of the topics discussed during these roundtable sessions. These two publications are hard copy documents of the sessions held. They provide a wealth of information for those who could not attend and serve as important reminders for those who could.

CHILD NEGLECT INDEX

The index was designed to serve as a short instrument (single page) that could be easily completed following a standard child welfare investigation. The index contains six scales for assessing neglect: supervision, nutrition, clothing and hygiene, physical health care, mental health care and developmental/educational care.

More information, including reliability and validity data, may be obtained from: Nico Trocme, Faculty of Social Work, University of Toronto, 246 Bloor St. West, Toronto, Ontario, M5S 1A1, (416) 978-5718, Nico@fsw.utoronto.ca.
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intervention? This decision-making is termed “risk assessment”.

RISK ASSESSMENT

Risk assessment is an ongoing process. Initially upon referral, a child protective services (CPS) worker must decide whether or not the child is in danger in the home and address the immediate needs of the family. Once it is determined that child maltreatment has occurred, the CPS worker must access ongoing risk to the child. Speaking at the Seventh National Roundtable on CPS Risk Assessment, representatives from Rhode Island illustrate the continual process that is necessary. “...most families came into our system because of risk and stayed because of need. We therefore needed to measure risk not just at time of placement but throughout the life of a case” (Squadrino & Wagner, 1994, p.64).

Research has identified several variables thought to be important for risk assessment. Workers tend to base decisions to remove the child on the child’s age (younger children are thought to be more at risk of reabuse), the severity of the current incident (the more severe the incident, the more likely the worker is to place the child), and the functioning and cooperation of the primary caretaker. Also influential are socioeconomic level, the degree to which a family is experiencing problems, general household management, the presence of environmental hazards, family insight, the father’s interest in and affection for the child, the amount of time a child spends with the abusing caretaker, the family’s ability to use outside resources, family size, the child’s experience of previous placements, the history of previous maltreatment, and the parent’s history of abuse (Perleger, et al., 1988; Herrenkohl, et al., 1979; Holman, 1983; Marks, et al., 1989, 1988; Meddin, 1984; Murphy, et al., 1991; National Center on Child Abuse and Neglect, 1991; Ritter, 1994).

Several clinical instruments have been developed to predict risk of child maltreatment. Early efforts included The Michigan Screening Profile of Parenting (Helfer, Hoffmeister & Schneider, 1978) and the Childhood Level of Living Scale (Polansky, Chalners, Buttenwieser & Williams, 1978). Other clinical instruments were developed in the 1980's. These include the Child Abuse Potential Inventory (Milner, 1986), the Adult-Adolescent Parenting Inventory (Bavolek, 1984), The Parenting Stress Index (Abidin, 1990), and the Child-Well Being Scales (Magura & Moss, 1986). Interested readers can request VCPN, Volume 10, for

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more information about risk assessment.

Other risk assessment tools have been created by states specifically for use by local child protective service units. Some of the better known efforts include the SMART system (used in Texas), CANTS and CYCIS (Rhode Island), and CARF (Pennsylvania). Information regarding recent efforts of states in creating risk assessment tools is available from the American Public Welfare Association and American Humane Association. A summary of the yearly Roundtable conference on CPS Risk Assessment is published annually (see reviews of the Seventh and Eighth Roundtables, this issue).

It is important to note, however, that even when children are removed from home, removal is generally temporary, and for a short period of time (Rutter, 1994). Thus risk assessment is a vital part of treatment planning, as workers design interventions to lower risk factors so children and families can either remain together or be reunited in a timely fashion.

RESEARCH CHALLENGES

Before exploring the efficacy of treatment for maltreating families, let us consider some issues related to outcome studies. The goal of all human service interventions is to have a beneficial effect on those served. But, how does one measure the degree of treatment success? “Measuring the outcomes of service is at once the most important and the most difficult aspect of evaluating an intervention program” (Jones, 1991, p.159).

What is an outcome? An outcome is change as a result of some intervention. In human services, ideally one compares the condition of a person or family receiving a specific service or treatment to the condition of that person or family if they had not received the service. “This, of course, is unknowable since a person cannot both receive and not receive the same service...” The change that represents the efficacy of a service is not the discrepancy between the before and after states of the individuals receiving the service, but the unavailable discrepancy between their condition at the same point in time with and without the service” (Jones, p.161). Herein lies one problem in determining efficacy.

How, then, are outcome studies structured? One option is a “before and after” design, where certain variables are measured before the intervention and again after the intervention. The assumption, then, is that any positive change is a result of the intervention. This assumption, however, may not be warranted. For instance, change may be a result of an unmeasured variable such as maturation of the child or parent. Families who enter treatment are often in a state of crisis. Crisis means disequilibrium. The usual response to crisis, with or without formal intervention and treatment, is to move toward equilibrium. Therefore, it is not sufficient proof to state that a family is functioning better after intervention than before. Rather, as noted before, the question to be answered is whether or not the family is functioning at a higher level after the intervention than they would have been without the intervention, and did the service accelerate the achievement of improved functioning. Thus, a “before and after” research design, while cost effective and expedient, may not provide credible results (Jones, 1991; Rossi, 1992).

A second research design uses a control group. Control groups are “much stronger than the before-after approach for attempting to simulate the comparison of persons with and without a service at the same point in time” (Jones, 1991, p.161). However, this approach is only as strong as are the similarities between the two groups and whether assignment to groups is random (Jones, 1991; Rossi, 1992).

With these two basic research designs, there are at least three ways to measure treatment interventions: case events, family/individual change, and client satisfaction.

CASE EVENTS

Case events are objective, officially recorded changes in status. Two case events used as a criterion for success or failure are entry of children into foster care and an additional substantiated report of child abuse and neglect. One strength of case events as outcome measures is that they require no interpretation or judgement. A second strength is that the events often embody the major goals of the intervention and can therefore be relevant indicators of the success of the program.

On the negative side, goals such as avoidance of foster care or avoidance of any further maltreatment may be unachievable. The use of a case event also implies that this event has the same significance for all cases.

However, abusive or neglectful families are heterogeneous and have differing degrees of risk for reabuse. Thus, an additional incidence of abuse or neglect is likely to have different implications for different families. For example, one family may fail to maintain proper supervision while another family repeats an incidence of severe physical abuse. While both situations are “reabuse”, the damage to the child and the risk for further abusive incidents may be very different. Likewise, placement of a child outside the family may actually be the best outcome in a particular case and be unrelated to whether or not the intervention is effective.

Another weakness is that case event measures are insensitive to the amount of improvement or deterioration that preceded (or possibly precipitated) the event. For instance, a family may show considerable positive change, but have another abusive incident, while another family deteriorates but avoids a specific abuse incident. Finally, variables other than treatment may influence placement. These include differing standards for placement and differing alternatives available to families (Magura and Moses, 1986).

FAMILY/INDIVIDUAL CHANGE

A second option is to measure the family or individual’s change on certain variables. This is the kind of measure most frequently encountered in outcome research. One of the strengths of this method of measurement is that the goal of the intervention is clear. However, a weakness is that it may be difficult to find agreement about how to measure improvement in a variable such as “isolation”.

The dearth of standardized measures for family change is frequently cited as a criticism of child maltreatment research. In fact, a recent survey of 101 child maltreatment researchers (Hanson et al., 1995) revealed that virtually all researchers used unstandardized instruments at least occasionally. The main reason for use of unstandardized measures was that standardized instruments do not yet exist. Since child abuse research is a relatively new area, it is to be expected that the field is in the early stages of measurement development (Hanson et al., 1995).

A second weakness is reliability and validity of the tools used to measure change. It is very hard to identify measures of family and individual functioning that are both objective and valid. To illustrate the point one could render aspects of parental functioning more objective by counting the number of times that events occur, for instance leaving a child unattended. But confronted with actual cases, one quickly learns that a parent’s presence does not equal supervision, and a parent’s absence does not equal neglect” (Jones, 1991, p.178).

Reliability and validity are further compromised because many instruments used in studies of maltreating parents have been investigator- or study-specific.
Health Problems of Foster Children

After the initial medical evaluation, continued medical care is often needed. Virtually every study on the health status of foster children has revealed a high incidence of chronic health problems (40 to 76 percent) (Ludwig & Kornberg, 1992). At the time of placement, most children have experienced inadequate medical and psychosocial care (Hochstadt, et al, 1987). Overall, health problems of foster children are similar to or exceed those of disadvantaged (low socioeconomic) groups.

Compared to the general population, foster children are 3 to 7 times more likely to have a chronic health problem, 3 times more likely to have a hearing problem, 4 times more likely to be anemic and 7 to 12 times as likely to have a behavioral, emotional or psychiatric problem (Ludwig & Kornberg, 1992). Vision problems are twice as likely in foster children than the population at large, ranging from 9 to 36 percent. In one study, incorrect prescriptions were found for 61 percent of foster children with glasses. Another 29 percent of those with glasses had unnecessary prescriptions (reported in Ludwig & Kornberg, 1992).

Contagious or treatable infections (including sexually transmitted diseases) are found frequently. So are dental problems, cardiovascular difficulties, pulmonary problems, dental neglect, skin problems and speech difficulties. Weight below the fifth percentile, short stature, small head circumference and lead poisoning have been noted. Many foster children are not current with immunizations and foster parents rarely receive previous provider or immunization records (Hochstadt, et.al, 1987; Ludwig & Kornberg, 1992).

According to Ludwig and Kornberg (1992), the frequency and severity of physical, psychiatric, behavioral and school-related problems, many of which are treatable, make medical examination and screening of foster children imperative. Flaherty and Weiss (1990) describe a joint project between CPS and an urban teaching hospital in Chicago. A total of 5,181 children were evaluated prior to foster care placement. Emphasis was placed on documenting abuse and neglect as well as screening for medical problems. Additional instances of abuse and neglect were identified and documented. Forty-four percent of children had undiagnosed medical problems, including anemia, otitis media, STD's and lead poisoning. Flaherty and Weiss note that children who have been abused or neglected may have a variety of medical problems not apparent to social workers or nonmedical professionals investigating the allegations.

Since most health care for foster children is initiated by foster parents, training foster parents to recognize health problems is crucial (Kavaler & Swire, 1983). Practical problems such as transportation, babysitting and locating Medicaid providers increase the difficulty of attending to health needs of foster children.

Departments of social services are often lacking in specific guidelines for medical evaluations. Recently, the Child Welfare League of America published recommendations for medical, dental and psychological evaluations that should be performed for all foster children within one month of placement. Guidelines for ongoing, routine medical care of foster children are also lacking, and inadequate continuous care compounds the problems at entry (Hochstadt, et al, 1987).

Strategies for improvement:
- All foster children should receive a routine medical evaluation within one month of placement.
- Dental screening and arrangements for routine preventative dental care need to be made.
- Given the high incidence of ocular injury in abused children (Annable, 1994, cites 6 to 24 percent), screening by an ophthalmologist may be indicated.
- Foster parents should be trained in the recognition of health problems. They also should be given a list of providers and instructions for arranging appointments.
- A “Health Passport” (see separate article) or similar record keeping system should allow both the foster parent and the agency to maintain an up-to-date, accurate record of health care and health problems.
- One individual or center should be designated to co-ordinate the health care of each foster child.
- Agencies should create guidelines for ongoing preventative health care and clarify responsibilities for arranging for and keeping follow-up appointments.

Improving Health Care for High-Risk Children

“Foster children go from home to home and no medical information comes with them”, states Carole Jenny, M.D. of Denver’s Children’s Hospital. “Medical care needs to be part of the ongoing treatment plan”.

Concern about highly mobile high-risk children such as many who are medicaid or in the foster care system led a medical team headed by Dr. William Frankenburg of the University of Colorado to propose a new approach. The use of a “Health Passport” is now standard for mobile children who do not maintain a family pediatrician.

A “Health Passport” is a book that includes all the child’s health records. Health providers keep their usual records but also record in the book a brief summary of care. Upon entry into foster care, a complete physical examination is performed. All health needs dental, physical, emotional and social needs are documented, along with treatment recommendations. The “Health Passport” accompanies the child and is brought to the health provider each visit so it can be updated. The “Health Passport” follows the child from placement to placement.

“Some of these children have complicated medical histories,” explains Dr. Jenny. “When a child comes to the emergency room having trouble breathing due to an asthma attack, the “Health Passport” provides the needed background to treat that child effectively. A new foster parent may not know about prior allergic reactions to medication or other crucial medical history that is essential to the physician.”

More information about establishing a “Health Passport” system is available from Carole Jenny, M.D., The Children’s Hospital, 1056 East 19th Ave., Denver, CO, 80218 (303) 861-6919.

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developed by guesswork, troubled by poorly defined constructs, and lacking in links between the instrument and its underlying theoretical model. When measures have been used more frequently, they have not been utilized consistently from study to study, making comparisons between studies difficult or impossible (Mash, 1991; Michaelson, 1993).

Client Satisfaction
Client satisfaction surveys are a measure of the relationship of the client to the provider. As such, they are more akin to measuring process than outcome. However, client satisfaction surveys are often included in outcome studies. They are a good source of information as to clients’ perception of services and change. They are not, however, a substitute for more objective outcome measures. “A satisfied client does not necessarily mean an improved client, and an unsatisfied client does not necessarily mean an unimproved client... The major contribution of client satisfaction measures (in the strict sense of the term) is to screen for gross patterns of dissatisfaction and to identify, through open-ended items, problems from the client’s perspective that might not otherwise be obvious (e.g., not enough parking on Tuesday afternoon)” (Jones, 1991, p.179).

Data sources
Data can be derived from multiple sources. Important sources of data are the family, the caseworker, and collateral parties such as teachers or CPS workers. Unfortunately, most outcome studies use only data from families and caseworkers. While data from collaterals is very useful as an independent check, this data may be difficult to obtain because of confidentiality or the burden this places on the third party.
Multiple sources of data may increase credibility, if obtained independently. However, a multiple indicator approach to client outcome is the exception in published studies (Magura & Moses, 1986).

SUMMARY
One need only to peruse a sample of outcome research literature to identify many methodological problems. Often studies contain very small sample sizes. There is a significant lack of studies with control groups. In an appreciable number of studies with control groups, random assignment is lacking. In general there is a lack of agreement about measures for risk of placement. Families are not always comparable because the wide variety of problems which bring families to services. Many assessment tools are not standardized or lack validity. Some studies base findings on worker reports alone or client self-report alone. There is a significant lack of studies with long term follow-up. These methodological problems make generalizing findings very difficult.

In conclusion, measuring therapy outcome is not an easy task. Jones (1991) suggests that fifty years of attempts to develop outcome measures has brought us no closer to a consensus about measuring tools or criteria. However, program directors find value in ongoing evaluation, clearly defined and limited goals, use of standardized tools for measuring change, and efforts to understand the effects of a service on a specific population rather than worrying about generalizing results to the greater population (Thyer, 1993).

The next issue of VCPN will review treatment outcome research. A sample of Virginia’s service providers have been surveyed. A few exceptional state and national programs will be featured. Ideas for cost-effective intervention will be offered.

References Available Upon Request