

Chapter Ten

Issues in Understanding and Treating Trauma Victims

The Design and Implementation of an Evaluation to Assess the Impact of a National Network for Serving Children who have Experienced Trauma: Is the Whole More than the Sum of its Parts?

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Introduction

Children's mental health as a whole has received increased national attention and has become the focus of a number of national reports and studies in recent years, in part due to trends and events such as the dramatic increase in youth violence in the early 1990s; school shootings in the late 1990s; and the aftermath and aftereffects of the devastating events of 9/11 in 2001. Comprehensive national reports such as the 1999 *Surgeon General's Report on Mental Health* (USDHHS, 1999) and others have included repeated recommendations that future research and evaluation, and associated resources, be targeted toward filling gaps in knowledge in our understanding of children's mental health. Many of these reports collectively emphasize interdisciplinary approaches and a developmental perspective in accomplishing this goal, as well as the urgency of translating science to policy and practice to ensure that programs and interventions are empirically based and disseminated. Many share other key principles and components in their recommendations, such as the importance of creating effective interagency relationships among the key child-serving systems; developing a network of services organized along a continuum of care, offering a broad array of services; building interdisciplinary research and evaluation infrastructure; involving families in all phases of the planning and delivery of services; developing interventions that are developmentally appropriate; and creating service systems that are designed to respond to the needs of culturally diverse populations.

As the recent New Freedom Commission Report has suggested, without a coordinated and sustained effort to address the gaps in children's mental health science and practice, many children will miss an opportunity for care and recovery from traumatic experiences, as well as a chance "to live, work, learn, and participate fully in their communities" (NFC, 2003). In building a "bridge" between science and services the National Child Traumatic Stress Initiative (NCTSI) has the potential to simultaneously fulfill many priority needs identified by a consensus of experts, including the need for implementation of evidence-based interventions and information on their effectiveness when implemented in a community-based service setting.

The NCTSI was established in 2001 to improve access to care, treatment, and services for children and adolescents exposed to traumatic events and to encourage and promote collaboration between service providers in the field. As a part of the NCTSI, grants have been awarded by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration to establish the National Child Traumatic Stress Network (NCTSN). Through these funds, a 70-member Network (45 current grantees and 25 previous grantees) has been created across the United States to raise the standard of care and improve access to services for traumatized children and their families.

Methods

As a part of its Congressional mandate (established by Public Law 106–310 Children's Health Act of 2000), the National Child Traumatic Stress Network (NCTSN) has been engaged in local evaluation efforts, including the collection of preliminary site-specific evaluation data. Additionally, in 2004, the NCTSN began piloting a Core Data Set across the participating Centers, marking the beginning of a process that will yield more comprehensive and detailed information regarding populations served and their outcomes. In collecting additional information through the cross-site evaluation, the NCTSN will be strengthened by expanding information about its own performance, effectiveness and efficiency, a key objective of the Government Performance and Results Act (GPRA) and an inherent NCTSN program requirement.

ORC Macro and their partners, Walter R. McDonald & Associates, Inc. (WRMA), the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI), and several expert consultants in children's mental health were funded to design and implement the Cross-site Evaluation of the National Child Traumatic Stress Initiative. The evaluation design, which includes eight study components, expands upon an existing National Child Traumatic Stress Network (NCTSN) management and evaluation infrastructure; involves data collection efforts directed by NCTSN centers and ORC Macro; utilizes multiple modes of data gathering, including Web-enabled surveying; includes consumer and provider respondents; and includes technical assistance and training to funded centers to assist in their portion of the evaluation's implementation.

The first year of the Cross-site Evaluation contract was a collaborative design and development year. Federal, Network center, consumer, and content expert stakeholders collaborated with ORC Macro in their development of a cross-cutting comprehensive evaluation approach that could systematically and robustly be implemented across pre-existing and future-funded center grantees. The logic model developed to guide the Cross-site Evaluation is included as Figure 1.

The NCTSI cross-site evaluation design focuses on the organization, collaborative efforts, function and impacts of the NCTSI as a whole, and draws upon the body of existing literature in multiple disciplines relevant to trauma treatment and services for children and families, including program evaluation conducted by the grantees to assess the effectiveness of the NCTSN in meeting the intent of Federal appropriations and its own stated goals. The overarching purpose of the Cross-site Evaluation is to assess the impact of the multilevel NCTSN on the access to care and quality of care for children exposed to trauma with four broad and guiding goals:

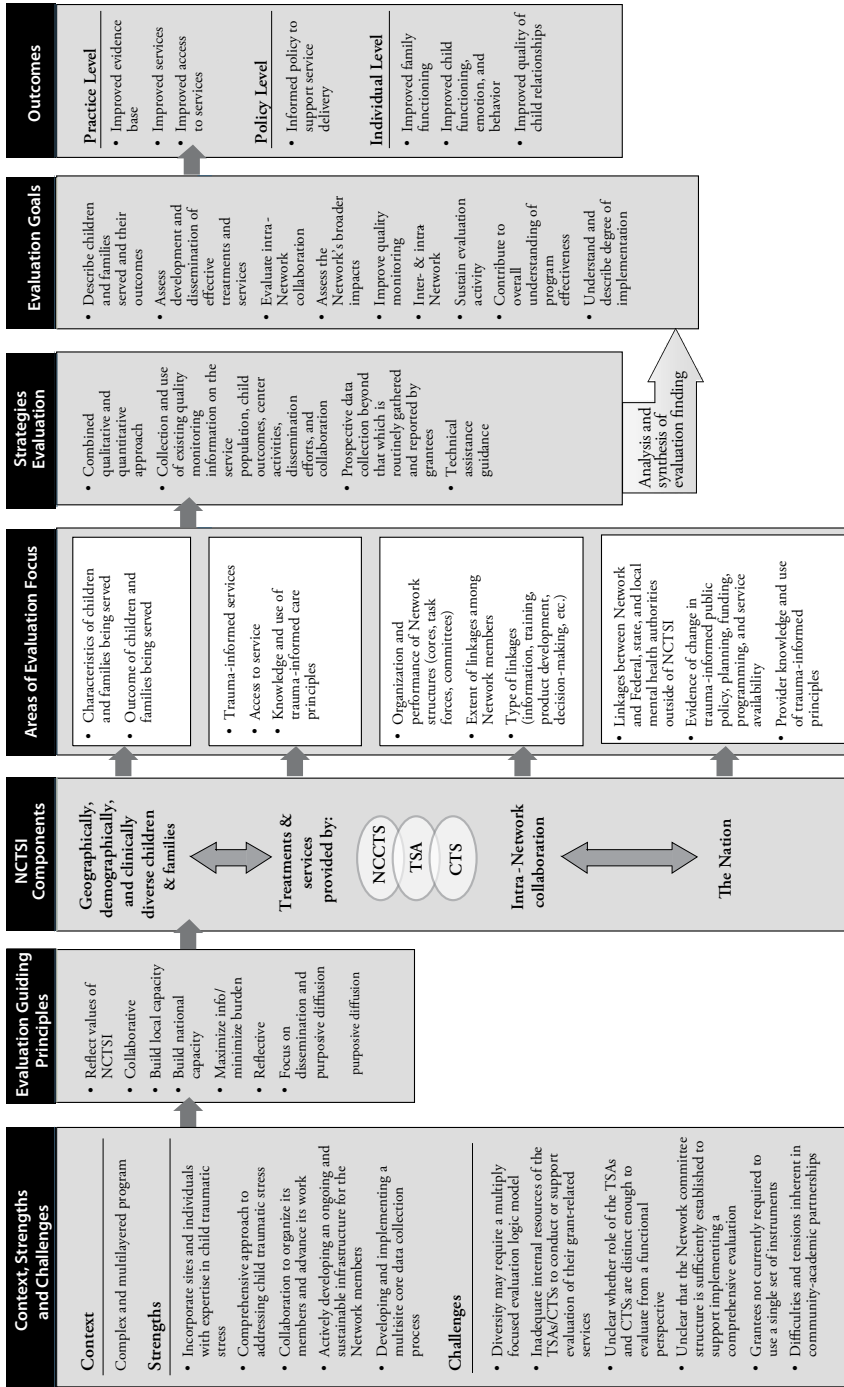
- Describe the children and families served by NCTSN and their outcomes
- Assess the development and dissemination of effective treatments and services
- Evaluate intra-Network collaboration
- Assess the Network's broader impacts beyond the NCTSN

The specific goals of the cross-site evaluation are to describe the children and families served by the NCTSN centers; describe the behavioral and clinical outcomes of children of children served; describe services utilized; assess the development and dissemination of effective products, treatments, and services; assess intra-Network collaboration; and assess the Network's impact beyond the NCTSN. The eight study components of the Cross-site Evaluation include: (1) Descriptive and Clinical Outcomes of Children Receiving Direct Clinical Mental Health Services, (2) Satisfaction with Direct Clinical Mental Health Services, (3) Provider Knowledge and Use of Trauma-informed Services, (4) Product/innovation Development and Dissemination, (5) Adoption of Methods and Practices, (6) Network Collaboration, (7) National Impact of the NCTSI, and (8) Utilization of the National Registry of Evidence-based Programs and Practices (NREPP).

Conclusions

There are many inherent and well recognized challenges in the development, design, and implementation of large scale federally funded cross-site evaluations (e.g., Holden, Stephens & Santiago, 2005; Howell & Yemane, 2006). Unique to Network evaluation such as this, is the added challenge associated with understanding if the impact of a Network rests solely on the merits of improved outcome among children being served. Consideration of this question, in addition to the complexity associated in gathering and disseminating information through evaluations designed to mirror the complex multi-faceted nature of federally funded programs, will result in more educated consumption of the information disseminated through these efforts, as well as the development of future evaluation designs of similar depth and breadth.

Figure 1
Cross-Site Evaluation of the National Child Traumatic Stress Initiative Logic Model:
Building a Bridge Between Science and Services and Between Services and Future Research



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Symposium

Children in Child Welfare Systems: Reentry, Perpetration, and Mental Illness

Symposium Introduction

Brigitte A. Manteuffel

Designing and implementing appropriate community level interventions for children and families experiencing child maltreatment and involved with the child welfare system requires knowledge of conditions that impact outcomes and maltreatment events. Three distinct but related studies are presented that examined reentry into child protective services (CPS), male perpetration, and mental illness for this population. All three studies present data concerning characteristics of children and families, comorbidity, and the interaction of outcomes and services. Implications of the research for treatment, community engagement, and policy are introduced for discussion.

Chair

Brigitte A. Manteuffel

Authors

John D. Fluke et al.

Gila S. Shusterman et al.

Anna Krivelyova et al.

Rereporting and Recurrence of Child Maltreatment: Findings from NCANDS

John D. Fluke, Gila R. Shusterman, Ying-Ying T. Yuan, & Dana Hollinshead

Introduction

Most children who are subjects of a report of maltreatment to the State or local child protective services (CPS) agency are involved just once with CPS during their lives. Other children are referred more than once and their referrals result in repeated investigations or assessments (rereporting). Some of these children are found to have been victimized or revictimized (recurrence). This study addresses rereporting and rereporting with victimization, to gain a better understanding of the circumstances surrounding children with repeated involvement with CPS. The study follows children for up to five years, using a multiyear, multistate case-level National Child Abuse and Neglect Data System (NCANDS) data set that spans the time period from 1998 to 2002.

The study focused on modeling the relative risk of factors associated with rereporting and rereporting with victimization that are available from the NCANDS data (Fluke, Shusterman, Hollinshead, & Yuan, 2005). The following general categories of factors were examined for their impact on a child experiencing any single rereport and rereport with victimization: child demographics; circumstances of maltreatment; family and child risk factors; and outcomes of intervention.

A key question is whether the factors associated with a child who is rereported are similar to those associated with a rereported child who is victimized. Another area of inquiry was the extent to which the provision of services was associated with either of these subsequent events.

Method

NCANDS case-level data consist of CPS investigation events at the child level. Only reports that receive an investigation or assessment response from the agency are included. Each record in the data file is referred to as a report-child pair. This indicates that there is a record for each child in each report that receives an investigation or assessment. Each report has a unique identification (ID) and many children can share the same report ID. Each child has a unique ID, thus the report-child pair is uniquely identified by the combination of its report and child IDs.

The number of States that voluntarily submit these data to the Children's Bureau under NCANDS increased from 11 States in 1993 to 42 States in 2002. For each investigation, CPS makes a disposition decision, which involves determining whether or not a child or children have experienced or are at

risk of maltreatment. A child is considered to be a victim of maltreatment if he or she has at least one maltreatment type coded as substantiated, indicated, or alternative response victim.

Compiling a data set consisting of multiple years of data involved two stages: (a) evaluating the quality of State submissions, and (b) using the data from States that met the analytic requirements to develop a single database. Nine States met the basic criteria for inclusion.

Data from all States were combined into a single file. Finally, data extracts were developed to support specific analyses. Further examinations of the data were conducted to address potential compatibility issues for specific analyses, and States may have been excluded accordingly.

The data analysis focused on four categories of events related to children. The first two pertained to all children in the data set, regardless of the disposition of their first investigation. Rereported (i.e., a subsequent investigation was conducted) and Rereported with Victimization (the subsequent investigation resulted in a disposition of victim) were the two categories. The second two dependent variables pertained only to children in the data set who were identified as victims in their first investigation. Victims who were rereported and victims who were found to have a recurrence (i.e., victims subsequently victimized again) were studied.

Findings regarding time to rereport events were obtained descriptively using a survival analysis technique called life tables. Cox regression or proportional hazards analysis, a form of multivariate survival analysis, was used to arrive at findings regarding factors that are associated with rereporting. A type of event history analysis that focuses on counts of multiple repeated events called trajectory analysis was used to address patterns of reentry.

Findings

Research questions and key findings are as follows:

What proportion of reported children were rereported, and when? (see Figure 1)

- Approximately one-third of children were rereported and a little more than 10% were rereported with victimization within five years.
- Most subsequent reports occurred within a few months after the initial report.

What proportion of child victims had a recurrence of maltreatment, and when? (see Figure 1)

- Among victims, almost 35% were rereported and 17% became victims again within five years.
- Most subsequent victimizations occurred within a few months after the initial report.

*What factors were associated with children who were rereported over a period of time?*¹

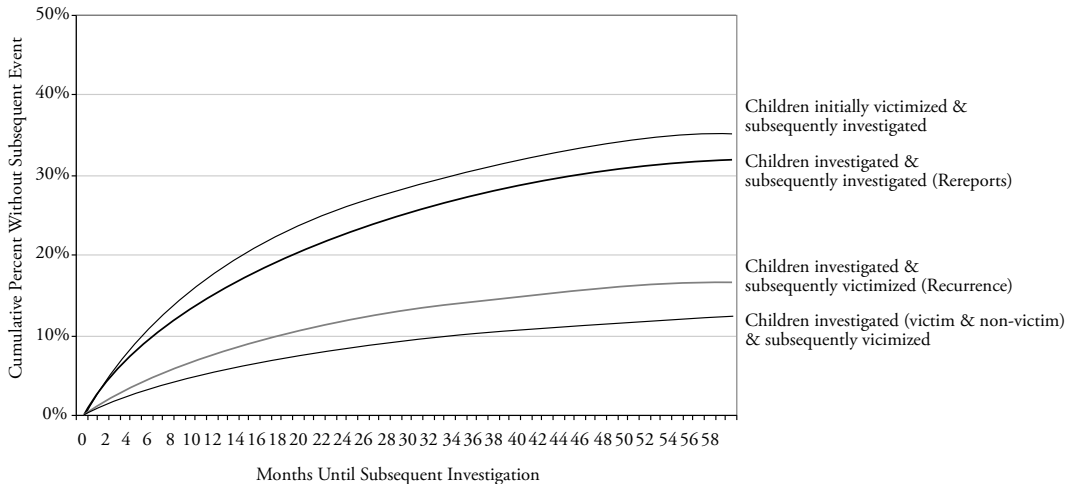
- Reports by medical and law enforcement personnel were associated with a lower likelihood of rereporting.
- Younger children had more rereports compared with older children.
- Males were at lower risk compared to females.
- White children were more likely to be rereported compared with African-American and Hispanic children.
- Children who received services were more likely to be rereported than children who did not receive services. However, children who were found to be victims in their initial report, and who received services, were less likely to be rereported compared with nonvictims who received services.

What factors were associated with children who were rereported with victimization over a period of time? (see Table 1)

- Initial conditions with respect to report source, age of child, child sex, and child race were similar to all rereported children. Similarly, the provision of services included both the main effects of increased risk and the interaction with victimization status and services.

¹Data available upon request.

Figure 1
Percentage of Children with Subsequent Reports Over Time
(Nine States)



- Children who had at least one intervening rereport that did not result in victimization were at increased risk of eventual subsequent victimization.

Multiple Rereports

This study also examined how many subsequent events occurred for an individual child, and the impact of the passage of time and the age of the child on this number of events. A total of 803,320 children who were initially reported during 1998 and 1999 in nine States were included in the analysis.

Time from Initial Report. This analysis examined how many events per child occurred for each six-month period after the first report. The number of subsequent CPS rereports per child declined steadily during each additional six months of follow-up. For all reported children, the average number of subsequent reports was 0.13 per child during the first six months of follow-up, whereas the number dropped to 0.05 reports during months 31–36.

Conclusion

Findings from this study highlight needed areas of improvement in the system of intervention, such as a focus on the small group of children who experience a brief period of intense involvement with the CPS system. This study also underscores the perplexing issues surrounding the use of rereporting and recurrence as performance measures for CPS. For example, the increased chances of rereporting and recurrence appears to be tied to providing services. Ideally, the analysis will help to facilitate the design and implementation of more effective and targeted services, and help in focusing continued inquiry regarding children who are at risk.

Table 1
Factors Associated with Rereporting with Victimization
(N = 495,900)

<i>Variables</i>	<i>Factor Categories</i>	<i>Risk Ratio with Rereporting with Victimization</i>	<i>P</i>
Source of Initial Report	Social and Mental Health Services	1.0000 ^a	0.0000
	Medical Personnel	0.8125	0.0000
	Law Enforcement or Legal Personnel	0.8818	0.0000
	Education Personnel	0.9971	0.9206
	Daycare and Foster Care Providers	0.8739	0.0245
	Nonprofessional and Other	1.0461	0.0552
	Unknown	1.0512	0.2939
Child Age at Initial Report	Infants	1.0000 ^a	0.0000
	1–Year Olds	0.9600	0.1282
	2–4	0.8030	0.0000
	5–7	0.7231	0.0000
	8–10	0.6507	0.0000
	11–13	0.6302	0.0000
	14–18	0.4291	0.0000
	Over 18	0.1572	0.0014
	Unknown	0.1553	0.0000
Child Sex	Female	1.0000 ^a	0.0000
	Male	0.7015	
Child Race & Ethnicity	White only	1.0000 ^a	0.0000
	American Indian and Alaskan Native only	1.1740	0.0000
	Asian and Pacific Islander only	0.6869	0.0001
	African-American only	0.8965	0.0000
	Hispanic	0.8795	0.0000
	Other and multiple race, non-Hispanic	1.3751	0.0000
	Unable to determine and missing	0.4427	0.0000
Child With Indication of Disability	No	1.0000 ^a	0.0000
	Yes	1.5198	
Caretaker Abuse of Alcohol	No	1.0000 ^a	0.0000
	Yes	1.2209	
Child's Initial Investigation Victimization Status	Nonvictim	1.0000 ^a	0.0000
	Victim	1.7293	
Postinvestigation Services Provided	No	1.0000 ^a	0.0000
	Yes	1.7508	
Child Placement in Foster Care	No	1.0000 ^a	0.0000
	Yes	4.2588	
Interaction of Victimization and Postinvestigation Services	No	1.0000 ^a	0.0000
	Yes (child victim and services provided)	0.8370	
Interaction of Victimization and Placement in Foster Care	No	1.0000 ^a	0.0000
	Yes (child victim and placed)	0.1987	
Intervening nonvictim report prior to subsequent victimization	No	1.0000 ^a	0.0000
	Yes (child rereported previously)	1.2474	

^a Reference Category

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Fluke, J. D., Shusterman, G. R., Hollinshead, D., & Yuan, Y.T. (2005). *Rereporting and recurrence of child maltreatment: Findings from NCANDS*. Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Male Perpetrators of Child Maltreatment

Gila R. Shusterman, John D. Fluke, & Ying-Ying T. Yuan

Introduction

A lack of research on fathers and other male perpetrators who come to the attention of the child protective services (CPS) system hinders the advancement of future policy and practice initiatives. While many more women than men access child welfare services, nearly half of child maltreatment perpetrators were men, according to national data for 2002 (Shusterman, Fluke, & Yuan, 2005). Of these male perpetrators, just over half were biological fathers, and the other half were nearly equally split among (a) other men in “surrogate father” roles, such as stepfathers and mothers’ boyfriends, and (b) nonfathers, such as relatives, friends, and day care providers. A greater understanding of the extent to which fathers and other males maltreat children, and of the risks for child maltreatment by male perpetrators, will allow social service agencies to provide the outreach, education, and support necessary to prepare and support fathers in their parental responsibilities.

This research utilized a unique multistate data set of 180,502 perpetrators identified by the child protective services (CPS) system during 2002. The relationship of the perpetrators to the child victims, as well as whether the perpetrator acted alone or with another person, was considered along with demographic characteristics of victims and circumstances of the maltreatment.

The key research questions for this study were the following:

1. How do male perpetrators compare with female perpetrators in terms of their relationships to their victims?
2. What specific patterns of child maltreatment are associated with male perpetrators, acting alone or with the victim’s mother?
3. From a multivariate perspective, to what extent do the age and sex of the child victims, the number of child victims, and the type of maltreatment explain the variation in the types of male perpetrators?

Methods

Case-level data from 18 States from the 2002 National Child Abuse and Neglect Data System (NCANDS) were used to create the data set for this research¹. Data on all reports, children, and maltreatments were merged and recoded to represent the categories of reports, children, and maltreatments associated with each unique perpetrator. The NCANDS collects both gender and relationship of the perpetrator, and matches each perpetrator to other perpetrators. These variables were merged to create categories such as “biological father acting alone,” or “male nonparent acting with mother.” Data were screened to exclude perpetrators with missing data on either gender or relationship, or who were identified as having multiple, incongruous relationships with the same child, such as biological father and stepfather. Perpetrators with a combination of relationships were excluded. The resulting data set included 180,502 unduplicated perpetrators.

Findings

Male Perpetrators Compared with Female Perpetrators

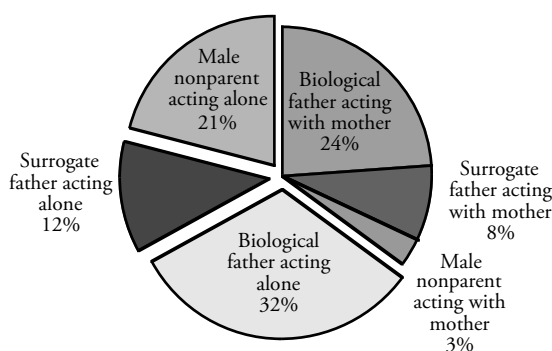
Forty-four percent of the unique perpetrators in the data set were male. More than half of all male perpetrators (55%) were biological fathers. The second largest group was male nonfathers (25%), who included male relatives and male nonrelatives. Surrogate fathers (including mothers’ boyfriends, stepfathers, and adoptive fathers) accounted for 20% of male perpetrators. Among female perpetrators, 87% were biological mothers, 10% were nonparents, and the remaining 3% were stepmothers, adoptive mothers, or fathers’ girlfriends.

¹These states were: Colorado, Delaware, Iowa, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, Mississippi, Montana, New Mexico, Ohio, Oklahoma, Texas, Utah and Virginia.

Patterns of Child Maltreatment Associated with Male Perpetrators

Male perpetrators in separate categories included: biological father with mother; father surrogates (a combination of stepfathers, adoptive fathers, and mothers' boyfriends) with mother; male nonparent with mother; biological father acting alone; father surrogate acting alone; and male nonparent acting alone. Figure 1 shows the relative proportions of each of these groups among all male perpetrators. Among all male perpetrators, 65% acted alone. Among biological fathers, 57% acted alone, and among father surrogates 59% acted alone.

Figure 1
Male Perpetrator Categories



Age of Child Victims

Because many perpetrators were associated with multiple children, the age of the youngest child victim was used for analyses. Biological fathers acting with mothers were associated with much younger child victims than were any of the other male perpetrator groups; nearly 60% were associated with children age three or younger. Surrogate fathers and nonparents acting alone were associated with older victims; approximately 40% of perpetrators in these groups were associated only with children age 12 and older.

Sex of Child Victims

Perpetrators were categorized as having been associated with girls, boys, or both boys and girls. A similar pattern was found for male perpetrators acting alone or with the victims' mother. Biological fathers were approximately evenly distributed in the proportions that were associated with only girls or with only boys. The proportion of perpetrators associated only with girls increased among surrogate fathers, and increased further for male nonparents. The proportion of perpetrators associated with only girls was largest for male nonparents acting alone (68%).

Number of Child Victims

More than half of all male perpetrators were associated with only one child victim, however, the likelihood of being associated with multiple children decreases steadily as the perpetrator's level of integration with the mother and the family decreases. Among biological fathers acting with mothers, 46% were associated with two or more children. Among male nonparents acting alone, only 17% were associated with two or more children.

Type of Maltreatment

Among all the perpetrators acting with the mother, the predominant maltreatment type was neglect, although this was most pronounced among biological fathers, for whom 70% were responsible only for neglect. Compared with biological fathers, surrogate fathers acting with the mother were associated less with neglect (46%), but more with physical abuse (18%), sexual abuse (9%), and multiple maltreatment

(22%). Approximately 78% of nonparents acting alone were associated only with sexual abuse. Biological fathers acting alone were associated in similar proportions with neglect (40%) and physical abuse (34%). Surrogate fathers acting alone were associated in similar proportions with physical (42%) and sexual abuse (35%).

Multivariate Analyses

The multinomial logistic regression model assessed the likelihood that a male perpetrator was a biological father, surrogate father or nonparent acting with the mother, or a biological or surrogate father acting alone, rather than a nonparent acting alone. In general, the model confirmed the findings from the bivariate analyses that biological fathers and other male perpetrators acting with mothers were more likely to be associated with younger children, and with more than one child. Neglect was associated more with biological fathers, and male nonparents were more likely to be associated with sexual abuse, regardless of whether they acted alone or with the child's mother. Physical abuse was associated more often with perpetrators acting alone.

Conclusion

The NCANDS data provide a comprehensive view of the range of child maltreatment circumstances among CPS populations, and remain an important resource in developing more effective prevention, intervention, and treatment approaches for victims and perpetrators of child maltreatment, as well as those at risk for becoming one or the other.

The findings from this research support the case for targeting prevention and treatment interventions for child maltreatment to men as well as women. If services are provided only in the home or in the context of the child's family, men who maltreat children but who are not living in the child's home may not benefit from these services. Nearly two-thirds of all male perpetrators acted alone, rather than with the child victim's mother. Further efforts to reach out to these men and involve them in services to prevent continued maltreatment are critical.

While the male perpetrator categories show unique patterns of child maltreatment, sometimes the relationship itself distinguishes the pattern and sometimes the association or lack of association with the mother distinguishes the pattern. The classification scheme presented could be refined and combined with more information about victims, and ultimately families, resulting in a data driven classification scheme of CPS populations for whom specific and targeted interventions may be designed.

The six groups examined here can be viewed as having decreasing levels of integration with the family, from biological father acting with the mother to male nonparent acting alone. It is possible that any of the perpetrators acting with the mothers, even the nonparents, may be more tied in to the family than even the biological fathers acting alone. This is evidenced by the number of children with whom they are associated. Both biological and father surrogates acting with the mothers were mostly associated with neglect, but when they acted alone, they showed very different patterns—biological fathers divided between physical abuse and neglect, while father surrogates divided between physical and sexual abuse. Potentially different strategies for intervention are needed for male perpetrators who have acted alone than those that are offered to the mother and father together. Also, these analyses point to some differences between biological and surrogate fathers that may demand different interventions.

References

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Characteristics of Children Referred from Child Welfare, their Service Use and Clinical Outcomes in Systems of Care

Anna Krivelyova, Ebony R. Montgomery, & Bhavana Sukumar

Introduction

Children involved with child welfare agencies are more likely to receive mental health services (Farmer et al., 2001) than children in the general population. Many of the circumstances such as physical and sexual abuse, maltreatment and a family history of domestic violence, lead to child welfare agency intervention and contribute to the development of certain mental health disorders (Burns et al., 2004). The Comprehensive Community Mental Health Services for Children and Their Families Program of the Center for Mental Health Services (CMHS) funds communities to develop systems of care for youth with serious emotional disturbance. The program promotes the development of service delivery systems that are integrated across all child-serving agencies (i.e., child welfare, juvenile justice, special education) for the provision of services that are individualized to meet the needs of children with an array of mental health diagnoses. This program has funded 121 system-of-care communities since 1994 throughout the United States and its territories.

This study describes the demographic and clinical characteristics of children referred to funded systems of care from child welfare agencies and compares them to children referred to systems of care from all other sources. In addition, it examines their service use during the first 12 months following entry into services.

Methods

Participant

The 3,997 total participants used for analysis were taken from the longitudinal outcome study of the national evaluation of the Comprehensive Community Mental Health Services Program for Children and Their Families. They represent all children with available data for the measures included in the current study.

Measures

The measures used included descriptive data from the Descriptive Information Questionnaire, DSM-IV diagnoses (American Psychiatric Association, 1994) from the administrative record, service use data from the Multi-Sector Service Contacts (MSSC; Macro International, Inc., n.d.) Questionnaire, education outcomes from the Education Questionnaire and two clinical outcome measures: the Child Behavior checklist (CBCL; Achenbach, 1991) and the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998). The CBCL is designed to assess the child's competencies and any problems a child may experience behaviorally and emotionally. The BERS measures the child's strengths and competencies through the child's behavior.

The Reliable Change Index (RCI) is used as a quantitative indicator of meaningful clinical change and compares clinical scores at two different points in time to indicate whether a change in scores reveals clinically significant improvement, stability, or deterioration. RCIs were used to measure changes in clinical outcomes, school performance, and school attendance. Chi-square tests were used to test group differences in the dichotomous measures and *t*-tests were used for continuous measures.

Results

Descriptive Characteristics

Nearly 9% of children in systems of care were referred from child welfare agencies (Table 1). Compared to children referred from other sources, these children were more likely to be male; to

be physically abused, sexually abused, or both; and to have used residential treatment or inpatient psychiatric hospitalization services within 12 months prior to entry into the system of care. They were also more likely to have run away without their caregiver knowing their whereabouts, to have a family history of domestic violence, to have a parent convicted of a crime, and to have a family member with a history of substance abuse.

Table 1
Descriptive Characteristics of Children Entering Systems of Care by Referral Source

<i>Individual Characteristics</i>	<i>Referred from Child Welfare Agency (n = 343)</i>	<i>Referred Through Other Sources (n = 3654)</i>
Mean Age	12.1	12.1
Male**	43.4%	30.5%
White	58.0%	62.3%
DSM-IV Diagnosis		
Substance Abuse	6.1%	6.5%
Psychosis	4.4%	3.2%
Mood Disorder*	29.7%	35.1%
Autism	1.8%	2.2%
Anxiety Disorder	5.0%	5.7%
Adjustment Disorder*	13.4%	10.0%
Post Traumatic Stress Disorder	11.7%	8.6%
Impulse Control*	6.1%	3.9%
Oppositional Defiant Disorder	25.4%	27.5%
ADHD	39.4%	40.8%
Conduct Disorder	9.3%	8.7%
Disruptive Behavior Disorder	4.1%	5.8%
Personality Disorder	2.3%	1.2%
Mental Retardation	3.2%	3.3%
Learning and Related Disorders	3.5%	5.6%
Child History		
Received outpatient mental health services prior to intake	72.0%	73.1%
Received school based mental health services prior to intake	59.2%	61.0%
Received mental health day treatment services prior to intake	16.0%	15.2%
Received residential treatment mental health services or inpatient psychiatric hospitalization prior to intake	37.6%	26.4%
History of physical abuse**	37.0%	22.8%
History of sexual abuse**	31.2%	20.8%
History of both sexual and physical abuse**	19.2%	10.8%
History of run away attempt **	40.2%	31.1%
History of suicide attempt	15.2%	16.7%
History of substance use	17.2%	18.1%
Sexually Abusive to Others**	12.5%	6.9%
History of domestic violence**	60.1%	49.3%
Family History		
History of mental illness among biological family members	60.1%	58.5%
Parents Convicted of a Crime**	56.3%	47.5%
Family history of substance abuse**	70.3%	63.3%
Clinical Measure		
CBCL Internalizing problems in the clinical range*	53.1%	59.2%
CBCL Externalizing problems in the clinical range	76.7%	74.5%
CBCL Total problems in the clinical range	74.3%	77.8%
BERS below average	54.8%	57.1%

* $p < .05$; ** $p < .01$

Children referred from child welfare were less likely to be diagnosed with mood disorder, but were more likely to be diagnosed with adjustment disorder and impulse control disorder. At intake, these children also were significantly less likely to have internalizing problems in the clinical range than children referred from other sources, as measured by the CBCL.

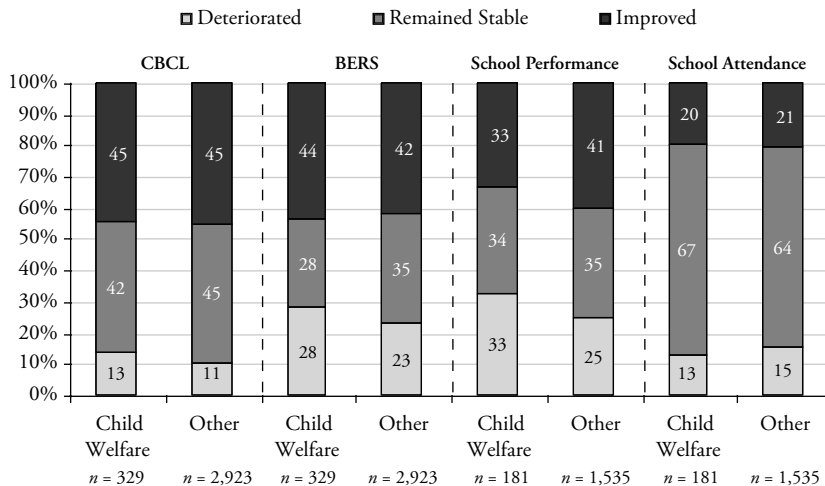
Service Use

Youth ($n = 2120$) referred from child welfare were more likely to use therapeutic group home services (9.9% vs. 4.5%, $p < .001$) and group therapy (41.9% vs. 32.4%, $p < .01$) six months after entry into the system of care and were more likely to use family preservation services 12 months after entry into system of care (17.6% vs. 11.2%, $p < .01$). At both 6 and 12 months following entry into systems of care, youth referred from child welfare were more likely to use residential treatment center services (6 months: 13.5% vs. 6.9%, $p < .001$; 12 months: 13.1% vs. 7.8%, $p < .01$), therapeutic foster care (6 months: 12.2% vs. 3.2%, $p < .001$; 12 months: 10.8% vs. 3.2%, $p < .001$), independent living services (6 months: 7.2% vs. 2.1%, $p < .001$; 12 months: 7.7% vs. 2.7%, $p < .001$), transportation services (6 months: 29.7% vs. 23.1%, $p < .05$; 12 months: 27.0% vs. 21.2%, $p < .05$), and respite services (6 months: 21.2% vs. 14.3%, $p < .01$; 12 months: 20.3% vs. 13.0%, $p < .01$).

Change in Outcomes over Time

Examination of clinical and educational outcomes revealed that the majority of children served by systems of care maintained stability or improved 12 months after entry into services (see Figure 1). The analysis also revealed that a significantly larger percentage of children referred from child welfare deteriorated in the BERS clinical measure ($p < .05$) and school performance ($p < .05$) than children referred to the program through other sources.

Figure 1
Reliable Change in Clinical and Educational Indicators
from Entry into Systems of Care to 12 Months by Referral Source



Conclusions

The system of care appears to provide a therapeutic environment for all children served, as evidenced by the majority of children from all referral sources who either remained stable or improved. Upon entry into the system of care, children referred from child welfare agencies do not exhibit more severe clinical symptoms. However, they are likely to have experienced more risk factors (e.g., history of abuse).

Results indicate that children served in systems of care experience services that are individualized to meet their unique needs. The services used more frequently by children referred from child welfare appear to reflect their greater likelihood of reported child and family risk factors. Their relatively higher frequency of use of 24 hour residential treatment services potentially reflects the instability of their families' living situations at entry into services.

While the majority of children referred from child welfare and from other sources exhibited stability or improvement in outcomes, some children referred from child welfare agencies still experienced certain challenges in their ability to perform in school, as well as with their emotional strengths, behaviors and competencies. This exposes a need for additional focus to be directed toward advocating for the provision of specific services and support systems that will enable children involved with child welfare to improve their level of functioning as it relates to educational performance and emotional strengths and competencies. Future research will explore factors predicting deterioration in these outcomes among youth involved with child welfare agencies.

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Symposium Discussion

Brigitte A. Manteuffel

Data used in this symposium come from two national databases, NCANDS and the National Evaluation of the System of Care, yet draw similar conclusions about the need for additional research to be focused on the development of more targeted services for children and families involved in the child welfare system. When looking at the characteristics surrounding the rereporting of child welfare children who have been victimized, children who receive services are more likely to be rereported than children who did not receive services. Children who have been victimized at the hands of a male perpetrator alone are less likely than children victimized by a male perpetrator acting with the mother to receive services provided in the home or family environment. Two-thirds of male perpetrators of maltreatment of children in the child welfare system act alone. Therefore, it is necessary that services are developed to reach this generally inaccessible population of male perpetrators. Analysis of outcomes of children with behavioral and emotional problems showed that children referred to systems of care from child welfare have a greater likelihood of child and family risk factors yet show similar levels of stability or improvement in outcomes compared to children referred to the system of care from other sources. Services to improve educational outcomes and emotional and behavioral strengths and competencies for children referred from child welfare are still needed.

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Special Topic Discussion

Addressing Suicide Issues in Systems of Care

Sylvia K. Fisher
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Background

According to the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC), more than 30,000 Americans commit suicide every year. Suicide is the third leading cause of death among young people ages 15-24 years and the fourth leading cause of death among children 10-14 years in the United States (US Public Health Service, 1999). Research indicates that more than nine out of ten children who commit suicide have a pre-existing mental health problem. Recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) released data indicating that approximately 900,000 youth had made a plan to commit suicide during their severe or most recent episode of major depression; 712,000 attempted suicides occurred during such an episode of depression (Bowen, 2005). The data, extracted from the 2004 National Survey on Drug Use and Health, asked youth ages 12-17 about symptoms of depression, including thoughts about death or suicide. Over 7% of youth ages 12-17, 1.8 million youth, had thought about killing themselves during their worst or most recent episode of major depression. Unfortunately, many teens do not disclose their depression or suicidal ideation to mental health professionals and do not seek help for their problems.

There is also evidence to indicate that the rates of suicide may be substantially higher among different subgroups of children and youth. For example, suicide rates among young African American males (15-19 years) increased by 105% between 1980 and 1996 (O'Donnell, O'Donnell, Wardlaw & Stueve, 2004). According to the U.S. Surgeon General, the rate among Native youth ages 15-24 is more than three times higher than the national average. In some parts of Indian Country, especially the Great Plains, it is even much higher. Hispanic youth are the fastest-growing segment of the U.S. population, accounting for 48% of the total Hispanic population and 26% of Hispanic suicides (CDC, 2004). Cody (n.d.) reports that gay, lesbian, bisexual, and transgender youth (14-24 years) attempt suicide at a rate 2-3 times higher than their heterosexual peers. Some studies indicate that the rate of attempted suicide for transgender youth is higher than 50% (Cody, n.d.).

Implications for Systems of Care

In their study of suicide, Walrath, et al. (2001) found that a relatively large proportion (21%) of children in systems of care (SOCs) have a history of attempting suicide; this finding was similar to that reported in other studies of youth receiving community or outpatient mental health treatment within the literature (Indians.com News, 2005). Although there is a very low incidence of suicide in SOC, the devastating consequences of completed suicides among SOC youth mandates that an integrated and comprehensive plan be established within the SOC program to address the issue of suicide. Despite its low incidence within the target population of children and youth in SOC, suicide is still a growing concern among today's SOC youth, particularly within certain vulnerable populations, including Tribal, Latino, African-American, and GLBTQ (e.g., gay, lesbian, bisexual, transgender, and questioning) youth. It would be useful to identify strategies that directly address suicide-related behavior and reduce the potential for negative suicide outcomes. In addition, a more precise ideation and measurement of suicidal outcomes would be beneficial.

In order to identify and help prevent suicides among SOC youth, useful and appropriate protocols must be instituted at various levels (including the clinical and policy levels). These protocols should also serve to facilitate the identification of early risk indicators of suicidal behavior and trends within these groups. Great improvement in the areas of research, program development, evaluation of symptoms, and communication is required in order to achieve success in measuring and preventing instances of suicide within the SOC program.

Method

The goal of this Special Topical Discussion session was to collect feedback and suggestions from participants regarding the possible components of such a plan, the utility of a plan, and how such a plan could be instituted and evaluated effectively.

The following action steps were identified as part of an integrated approach to addressing the issue of suicide in SOCs and served as a point of discussion for session participants: (1) developing a policy statement addressing the topics of suicide across SOC communities, including an articulation of policy focusing on prevention, intervention, and postvention; (2) determining the most appropriate methodological protocols to measure suicidal outcomes; (3) identifying program planning and development issues from a prevention perspective; (4) establishing how to intervene with families after a completed suicide; (5) examining how national and local evaluation efforts could be used as resources in addressing the issue of suicide in systems of care; and (6) instituting a continuous quality improvement protocol to ensure that policy and procedures are continually monitored and that strategies are developed to institute changes as-needed.

Results

Comments and feedback received from session participants included:

- establishing a partnership with educational systems as a method of instituting prevention activities;
- training front-line staff to read signals, secure trust, and promote relationships to benefit youth so interventions can be incorporated during SOC program participation;
- examining evaluation data on suicidal outcomes to identify where and with whom suicidal ideation and the potential for suicide-related behavior exists so action-driven protocols can be put into place immediately;
- identifying high-risk children by doing work with SOC sites (this might entail having protocols in place both at the site-and program-levels);
- addressing suicide in a “safe and sound” manner to maximize positive results;
- informing and involving law enforcement on an as-needed basis;
- considering secondary traumatization as a part of postvention strategy and instituting protocols to address the needs of family members and others who have been secondarily traumatized;
- offering culturally-appropriate spiritual interventions for Tribal communities and leaders where youth suicides have been particularly virulent;
- considering mortuary staff as possible partners in a program plan and a source of information and techniques for identifying common suicide-related behaviors;
- addressing homicide and other sources of child loss (e.g., accidents, illness, etc.) as part of a comprehensive plan;
- determining what technical assistance SOCs can provide to affected individuals, families, and communities;
- informing wraparound assistance and formal and informal supports after a child death that would encompass the needs of family and others in the child’s sphere;
- collaborating with the National Center for Suicide Prevention to identify appropriate and successful prevention policies; and
- involving Project YES (Miami) and American Association of Suicidology & Parent Support Network & CDC & School Nurses Association in activities to develop this coordinated approach to the issue of suicide in SOCs.

Feedback received from participants was very useful and represented broad-based perspectives on this difficult issue. The suggestions offered by participants will be integrated into the planning process and will eventually be incorporated within a final plan for addressing suicide in systems of care. Feedback will be collected from interested parties from a multiplicity of other venues as a part of an ongoing information-gathering process. As a next step, a meeting addressing suicide issues in SOC is planned for early September, 2006, to identify strategies that can be implemented program-wide in the areas of prevention, intervention, and postvention.

The results of this activity will yield a culturally-appropriate, sensitive, and tailored approach to the issue of suicide within the areas of prevention, intervention, and postvention and serve to meet the needs of children, youth, families, and communities.

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Violence Exposure Rates and Trauma Symptoms among Rural Youth

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Introduction

Urban communities have traditionally been the focus of studies examining the prevalence of community violence and its effects on school-age youth (Buka, Stichnick, Birdthistle, & Earls, 2001; Stein, Jaycox, Kataoka, Rhodes, & Vestal, 2003; Warner & Weist, 1996). The rates of violence exposure in such communities have been linked to a variety of emotional problems for children, including anger, depression, anxiety, and traumatic stress (Singer, Anglin, Song, & Lunghofer, 1995). While inner-city communities are attempting to manage growing rates of violence, rural communities are not immune. Although often perceived as “safe havens” from violence (Slovak & Singer, 2002), recent literature has indicated that violence exposure rates may be higher than previously thought in America’s rural communities (Sullivan, Kung, & Farrell, 2004).

Rural youth are often exposed to multiple risk factors (Spoth, Goldberg, Neppl, Trudeau, & Ramisetty-Mikler, 2001), similar to their urban counterparts, resulting in poorer health and reduced access to services (Cutrona, Halvorson, & Russell, 1996; Elliott & Larson, 2004; Sears, 2004). These risk factors, compounded with violence exposure, increase the likelihood of emotional disturbance, such as traumatic stress. Assessing the level of violence exposure among rural youth can inform violence prevention and intervention services to reduce symptoms and improve functioning.

Method

Clinical researchers from the National Rural Behavioral Health Center (NRBHC) at the University of Florida, in cooperation with the Columbia County School District, administered a violence exposure questionnaire to 1,468 middle and high school students in Columbia County, Florida. The county is an economically depressed and educationally disadvantaged rural region, with levels of poverty, illiteracy, crime, and a lack of basic health care that far exceeds the state averages (Florida Department of Health, 1998). Resources for children and their families are inconsistently available and there are numerous barriers to access, particularly for mental health services that address trauma.

Measures

As noted above, researchers participated in the annual administration of the Risk Incidents for Schools Inventory (RISCI; Radunovich & Wiens, 2005) to middle and high school students in the Columbia County School District. The survey is anonymous and assesses, among other at-risk behaviors, the frequency of violence exposure. Specifically, it asks about being either a victim or witness to various forms of violence, including threats, hitting/slapping, and weapon violence in the past 12 months.

Subsample

To determine the need for a school intervention program for students exposed to violence, the association between violence exposure and rates of traumatic stress was assessed among a sub-sample of middle school students. A brief screening instrument containing modified versions of the Life Event’s Scale (LES; Singer et al., 1995) and Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001) was administered to 140 students. The LES assesses violence exposure by asking students to rate on a Likert-type scale the frequency with which they have either witnessed or been the victim of verbal threats, hitting/slapping, beatings, or weapon violence in the past 12 months.

In the original LES, students are asked these questions in different contexts, including school, the neighborhood, or home. The present version collapsed items across location, resulting in nine items. The original CPSS is a 30-item self-report scale assessing Posttraumatic Stress Disorder (PTSD) symptoms. In this brief version, only seven items with high sensitivity and specificity were administered. Both the LES and CPSS have been used by Stein and colleagues (Stein et al., 2003) to screen for violence exposure and PTSD symptoms. The abbreviated versions, containing 16 total items and known together as the Short Violence and Trauma Screen (SVTS), are being validated by Stein and colleagues as a brief screener to efficiently assess levels of violence exposure and traumatic stress in school settings.

Results

A total of 1,468 RISCl protocols were analyzed. The sample included students in the 6th through 12th grades, ranging in age from 11 to 18 years. Student ethnicity was consistent with county demographics. A majority of students were Caucasian (69%), followed by African American (19%), Latino/Hispanic (4%), mixed origin (4%), Asian/Pacific Islander (1%), and Native American (<1%), and there were more females (53%) than males.

The majority of students (74%) reported being exposed to violence in the past 12 months. More students reported being exposed to violence at school (62%) than in their neighborhood (46%) or at home (20%). Levels of violence exposure did vary by age, with 14 year-olds reporting the highest rates, followed by 13, 15, and 12 year-old students. The middle school grades, 6th through 8th, reported the highest exposure (see Figure 1). Rates of exposure by ethnicity were similar for all groups except the Asian/Pacific Islander students, the majority of whom reported no violence exposure (60%), as opposed to the other groups who all reported significant exposure. Contrary to previous literature on violence rates, there was no significant difference between male and female reports of exposure.

The SVTS was administered to a subset of 6th and 7th grade students ranging in age from 11 to 14 years. The violence rate was similar to the overall sample, with 76% of students reporting significant exposure during the past 12 months. Of primary interest was the level of traumatic stress reported by these students. For those that reported significant violence exposure, defined as a raw score of 3 or higher on LES items, 38% also reported symptoms of traumatic stress, as defined by a raw score of 4 or higher on the CPSS items (Figure 2).

Figure 1
RISCl Total Violence Exposure by Grade

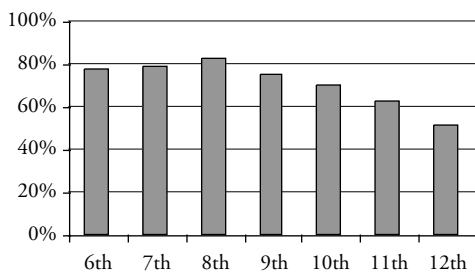
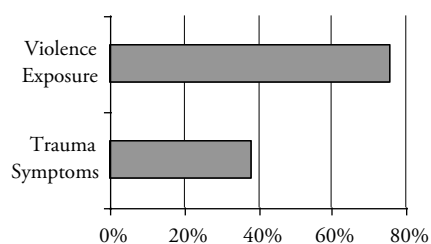


Figure 2
SVTS Violence Exposure and PTSD Symptom Rates



Conclusion

Violence prevalence rates in this rural community are consistent with recent literature that indicates rural youth are reporting higher violence rates than previously expected. Such findings underscore the need to improve access to violence prevention and mental health programs aimed at decreasing the negative effects of violence. The majority of students reported violence exposure in at least one setting in the past year. Surprisingly, the school had the highest rates of exposure relative to the neighborhood or home, which highlights the importance of school-based or school-linked services that can reach children and families in under-served areas with limited resources.

Increasing intervention programs, however, will be ineffective unless students who would benefit are identified. The rate of PTSD symptoms among the present sample of students with violence exposure was alarmingly high. Many of these students would go undetected and untreated if traditional referral sources alone were utilized. Through the use of a brief screening measure like the SVTS, large groups of students can be screened in a matter of minutes. This method can identify students who may be experiencing anxiety or traumatic stress, but who may not present with externalizing symptoms and therefore not come to the attention of teachers or school staff.

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A Collaborative Effort to Disseminate Evidence-Based Research on Children Who Witness Domestic Violence

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Acknowledgements: This research was conducted by INNOVATIONS in Community Research and Program Evaluation of Cincinnati Children's Hospital Medical Center in collaboration with the YWCA Hamilton County Family Violence Prevention Project, Cincinnati, Ohio.

Introduction

The national focus on providing integrated and evidence-based mental health care for children has resulted in many challenges with respect to the implementation of services in the “real world.” As agencies strive to take evidenced-based research (EBR) from the bench side to the bed side, they find a number of constraints, including: a lack of available funds to support staff training and to pay for technical assistance after the training, a lack of available staff to provide coverage for staff members who are being trained, and difficulty evaluating program fidelity and effectiveness. To address these constraints, many organizations have utilized a train-the-trainer approach in which staff receive information about the EBR and train others from their agencies or the community. Staff members acting as trainers may include social service workers, counselors or court magistrates. This approach can be cost-effective and practical, and may produce systems level changes as many providers across the community are trained.

Evaluation of a train-the-trainer program is essential to determine how effective trainers are at disseminating the EBR and the subsequent impact the EBR has on the community. This summary highlights a collaborative training effort across a broad range of service providers (e.g., 411 operators, community mental health workers, court advocates, school personnel, Children's Law Center, and Mental Retardation and Developmental Disabilities) in an effort to make a systems-wide impact to prevent violence against children. Specifically, this paper will discuss (1) the strengths and limitations of utilizing training evaluation to disseminate EBR; (2) how evaluation data can be used to demonstrate change at the individual and agency level; and (3) how this data can also be used to inform public policy and assess community impact over time. The Children Who Witness Domestic Violence Initiative (CWWDV) will be used to illustrate how evaluation data can be used to show individual, agency, and systemic impact.

Strengths and Limitations of Using Training Evaluation to Disseminate EBR

Different models of training evaluation have been proposed, but the majority of training evaluations adhere to Kirkpatrick's model (Kirkpatrick, 1994). According to this model, optimal evaluation of a training program occurs at four levels: (1) Reaction; (2) Learning; (3) Transfer of Learning; and (4) Systems Impact. As with all evaluation methodologies, strengths and weaknesses can be identified; below are those specific to utilizing training evaluations to measure success in disseminating EBR.

Strengths

- Measures (e.g., satisfaction surveys) provide insight into trainers' engagement, biases, and the successes and limitations of the train-the-trainer program. They can also provide information that allows for improvements to the curriculum (formative evaluation).
- Training evaluations can provide evidence that change has occurred at the individual and agency level which can motivate trainers to conduct trainings.
- These evaluations help to provide evidence of change at the agency level by demonstrating that participants implemented the EBR. This data can be used to develop a public policy agenda.

Limitations

- Since evaluation of a train-the-trainer program usually occurs right at the end of the program, participants may not have had time to reflect on the training and use it in the “real world.” Thus, changes to the program based on trainer post-feedback may be premature.
- Evaluating whether trainers have mastered the curriculum and are effectively training others can be time consuming. Consulting or contracting with experts in this area may be helpful in developing a valid measure of learning.
- Measuring systems impact can be time consuming, and may require significant expertise to implement.

Example: Using Evaluation Data to Demonstrate Change at the Individual and Agency Level: Children Who Witness Domestic Violence Initiative (CWWDV)

Background. Agencies in Cincinnati have formed a collaborative effort to disseminate evidence-based research for at-risk children across Hamilton County. The Hamilton County Family Violence Prevention Project (FVPP) strategic initiatives address the following forms of family violence: Abuse of People with Disabilities; Child Abuse; Elder Abuse; and Intimate Partner Abuse. The long-term goal of the Children Who Witness Domestic Violence Initiative (CWWDV) is to build the capacity of Hamilton County to address the needs of children who witness domestic violence. As a first step, the CWWDV developed an evidenced-based curriculum and initiated a train-the-trainer program which focuses on educating professionals in the community to identify and refer children who have witnessed domestic violence (DeBellis & Putnam, 1994; Trickett & McBride-Chang, 1995; Watts-English, Fortson, Gibler, Hooper, & DeBellis, 2006; Zink et al, 2004).

Method

In an effort to determine the effectiveness of this train-the-trainer program, the following were evaluated: trainer effectiveness, participant knowledge, skills and attitudes, and participant implementation. The proposed outcome is that community-based trainers can effectively disseminate the information across the county and this can become a model for other states hoping to address the problem of children who witness domestic violence within their communities.

Thirty-five trainers representing 16 mental health, school-based, and social service agencies throughout Hamilton County were trained in March 2004. Each trainer completed an application that was reviewed by the CWWDV Board, which consists of representatives from the collaborating agencies. These trainers conducted a total of 63 training sessions from March 2004 to July 2005 for community-based professionals. A total of 1,034 persons attended the training sessions. Data were available on 334 participants. Participants for training sessions were recruited by trainers (e.g., members of their agency), CWWDV board members, or other domestic violence organizations. Participants were selected to participate if they met the following criteria: conducted educational presentations and trainings as a part of their job, had a sound understanding of domestic violence, and were committed to conducting at least five trainings on CWWDV on behalf of the FVPP during the next 12-18 months.

The train-the-trainer curriculum was developed by experts in the field of family violence and focused on three main areas: understanding the impact of witnessing domestic violence on children; recognizing the signs of witnessing domestic violence and identifying children who have witnessed domestic violence; and creating a supportive environment for children who witness violence to decrease their risk factors for engaging in future acts of violence themselves.

Results

Using SPSS 12.0 (Norusis, 2004), all data were analyzed independently by a team of psychologists and staff members from INNOVATIONS in Community Research and Program Evaluation of Cincinnati Children’s Hospital Medical Center.

Trainer effectiveness was evaluated utilizing a workshop evaluation. Results of the workshop evaluation indicate that 88.4% of participants rated workshops as meeting all objectives and 92.8% of participants reported that their level of understanding of issues related to domestic violence and children increased after the training.

Participant knowledge, attitudes, and skills were assessed utilizing a pre-post test evaluation. Results of the evaluations showed that 94.6-98% of target audience members experienced an increase in awareness, were knowledgeable of a best practice, and understood signs and symptoms children who witness domestic violence may exhibit.

Participant implementation was assessed via the workshop evaluation. Specifically, participants were asked how they would utilize the information gained in the workshop ($N = 334$). Results are summarized in Table 1.

Additionally, one agency mandated training for all employees on this topic. An on-line follow-up survey was emailed to participants to assess their success at implementing the activities introduced through training. Results from the follow-up survey ($N = 22$) are included in Table 1.

Table 1
Participant Ratings of Implementation Activities

<i>Implementation Activity</i>	<i>Percentage Reported Plan to Implement At Post-Test (N = 334)</i>	<i>Percentage Reported Implemented Activity At Follow-Up (N = 22)</i>
Make referrals for children who witness domestic violence to appropriate agencies	48%	50.0%
Share information from this training with staff and/or friends	55%	95.5%
Request training for staff and/or friends	15%	59.1%
Request additional reading material or resources from trainer	11%	9.1%
Use patience/empathy when working with parents/children who have witnessed domestic violence	55%	100.0%
Recommend a policy that new staff members receive training in domestic violence	15%	22.7%
Start a program for children who witness domestic violence	6%	4.5%
Advocate for a policy for identification and intervention with children who witness domestic violence	15%	27.0%
*Other: Inform; Continue education in this area of child abuse; Incorporate ideas into daily interaction with all persons; Loved it; Make sure all staff know who the contact person is for domestic violence, is it the psychologist, principal, teacher, etc.	3%	0.0%

* This was an open-ended item on the survey

Discussion

This paper highlights how a train-the-trainer approach may be implemented collaboratively across mental health, social service, and school based agencies to disseminate the EBR. Currently, CWWDV data indicate that trainers are effectively disseminating the information. Participants appear to be gaining knowledge and skills that will help them to identify and refer children who witness domestic violence. CWWDV has effectively assessed change at the individual (trainee) and agency levels and has helped the community to understand and promptly address this problem. The efforts of this endeavor have also increased local access to resources within the community and promoted community engagement around this issue.

This project serves as a model for how local government and community-based agencies can work together to address the problem of children witnessing domestic violence in their community. This collaboration has increased access to information and resources in this area. Future plans include a provider network and training sessions targeted toward one group (e.g., home visitors). In addition, evaluation data from this type of project can be used to leverage additional funding for larger or more targeted prevention efforts. In addition, evaluation data can be summarized and made available to agencies as a way of increasing awareness about family violence and evidence-based treatments.

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Mental Health Correlates of Fatal Child Maltreatment: Findings from Florida Child Abuse Death Review Cases

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Introduction

An ongoing study, involving a collaboration between the University of South Florida Louis de la Parte Florida Mental Health Institute and Children's Medical Services in the Florida Department of Health, has been examining specific adult characteristics and how they relate to becoming a child abuse perpetrator. The current study provides an overview of the Florida statewide multidisciplinary, multi-agency child death review system, and explores results of the research on fatal child maltreatment cases that occurred over a four-year period (1999-2002) in the State. Mental health risk and protective factors associated with perpetrators and child victims were examined. These factors have been explored to better understand the etiology of child abuse. Such information may be useful in reviewing alleged abuse cases and in determining appropriate interventions. This knowledge may assist professionals in designing prevention programs that have a higher likelihood of being effective.

Design and Procedure

The study design consisted of a two-group comparison: a group of children who died as a result of abuse and a group of children who died as a result of neglect. There was no statistically significant difference between the groups when compared by gender, age, minority status, or presence of mental health or any other medical problems.

Data were collected through reviews of the records of children who died in Florida during the period January 1, 1999 to December 30, 2002 as a result of child abuse or neglect and who also had at least one prior report of child maltreatment. This sample included all available records and totaled 126 cases. These child death review files consisted of Department of Children and Families (DCF) records as well as other available documentation, such as the autopsy report, medical records, law enforcement report, social services history, and media coverage. Variables from the review process included the child's cause of death, perpetrator characteristics, family dynamics, and history of involvement with social services. The researchers triangulated case record data with information from administrative datasets to better gauge existing risk and protective factors among perpetrators of child maltreatment as well as the child victims (e.g., mental health issues or substance abuse). In the final stage of analysis, Geographic Information System (GIS) indicators were used to compile, process, and analyze the data for the child abuse study. Most of these data were at the level of individual counties, but more detailed enumeration areas or locations were used where available and deemed pertinent. This summary focuses on the findings related to mental health correlates in the fatal child abuse cases.

Analytic Approach

Bivariate descriptive analyses were performed to describe the sample. Statistical analyses consisted of survival analyses (Cox, 1972) and logistic regression. Specifically, the percentages were obtained from Life Tables using the Kaplan-Meier procedure (Kaplan & Meier, 1958). Among child fatality cases, predictors for abuse versus neglect related death were analyzed using competing-risks survival analysis (Singer & Willett, 2003). The competing-risks survival analysis allows for modeling the rate at which particular types of events occur in time (Hachen, 1988). We distinguished between two types of child death: death as a result of abuse and death as a result of neglect. These two types of events are examples of competing risks. We assumed conditional independence of these risks, such that the risk of dying from abuse and the risk of dying from neglect are mutually exclusive. In a competing-risks context, censored

observations are referred to those participants who either did not experience the event by the end of the study or experienced a competing event. Because all children died by the end of this study only event censored observations were used in the analysis. Specifically, children who experienced a competing event (i.e., died from neglect) were included in the analysis as censored observations. The dependent measure was the number of years between birth and subsequent death of the child as the result of either abuse or neglect. Logistic regression analyses were used to examine the probabilities of experiencing abuse or neglect that resulted in death. Odds ratios were calculated to estimate the likelihood of death related to abuse or death with each predictor. All statistical tests were performed at the $\alpha = .05$ level of significance.

Sample Description

A total of 126 cases were included in the analysis. All cases of fatal child maltreatment in a 4-year period (i.e., 1999 through 2002) that were reviewed by the Florida Child Abuse Death Review team ($N = 126$) were included in the sample. There were considerably more males (61%) than females in the sample (39%). The racial composition of the whole sample was 51% Caucasian, 37% African American, 10% Hispanic, and 2% Other. At the time of death the average age of the children was 4 years ($M = 3.81$, $SD = 4.24$), ranging from birth through 17 years. About 17% of children in the sample were under 1 year of age. Approximately 12% of children had behavioral health problems, including developmental delays, and approximately 18% of the sample had medical or physical problems. Most children (65%) were seen by community agencies, and one third of children in the sample were enrolled in childcare prior to death.

The highest proportion of death cases took place in Broward County (9.5%) and Miami-Dade County (8.7%). The majority of children in the sample (63%) were at home at the time of death, and in 32% of cases either an adult or a child witness was present.

Results

Life Tables Findings

Life Table analyses indicated that among the study sample 15% of minority children died before the age of 1 compared to 9% of nonminority children. Approximately 33% of children who had mental health problems died before the age of 5; however, 83% of children who did not have mental health problems suffered a fatal maltreatment incident during their early childhood. The median length of life for children without mental health problems was approximately two and a half years compared to 12.5 years for children who had mental health problems. Life Table analyses also indicated that for the group of children who had health problems the median time to death was 4 years compared to 13 and a half years for those who did not have medical problems.

Competing-Risks Survival Analysis

In the competing-risks survival analysis, the initial analysis was based on the model where children who died from neglect were treated as censored observations. Gender, minority status, presence of physical problems, and presence of mental health problems were included in the model as predictors. Table 1, Model 1, presents results from a multivariate analysis for children who died from abuse only. As indicated in the Table, presence of mental health problems and minority status were significantly associated with the likelihood of dying from abuse. In particular, minority children were almost 1.7 times more likely to die as a result of abuse than non-minority children ($OR = 1.68$, $p < .05$). Conversely, children with identified mental health problems were two and a half times less likely to die from abuse than children who did not have identified behavioral health concerns ($OR = 2.52$, $p < .05$).

As recommended by Singer and Willett (2003) the same set of predictors was included in the second model where children who died from abuse were treated as censored observations (see Table 1, Model 2). Similar to the results obtained in the first model (i.e., when only children who died from abuse were

examined), children who had mental health problems were almost 3 times (Odds Ratio = 2.87, $p < .01$) less likely to die from neglect than children without behavioral health concerns. However, minority status was not significantly associated with death from neglect.

In the “global” model, presence of mental health problems was the only predictor significantly associated with fatal child maltreatment (see Table 1). Specifically, children who had mental health problems were two and a half times less likely to die by the age of 17 (Odds Ratio = 2.68, $p < .05$) than children who did not have an identified behavioral health issue. Therefore, it appears that the identification of mental health needs can have a protective function in safeguarding children by creating greater community visibility and involvement with the child and family.

Table 1
Multivariate Models for Abuse & Neglect

Risk Factors	Cox Regression Model Parameters			95% Confidence interval for risk ratio	
	B	Wald $\chi^2(1)$	Odds Ratio	Lower	Upper
Multivariate Model 1: Abuse Cases Only (N = 126)					
Gender	0.35	0.02	1.04	0.62	1.73
Minority Status	0.52	3.83*	1.68	0.99	2.83
Mental Health Problems	-0.93	4.77*	0.40	0.17	0.91
Physical/medical Problems	-0.32	0.76	0.73	0.36	1.49
Multivariate Model 2: Neglect Cases Only (N = 126)					
Gender	0.11	0.17	1.12	0.65	1.93
Minority Status	-0.13	0.20	0.88	0.51	1.53
Mental Health Problems	-1.06	6.75*	0.35	0.16	0.77
Physical/medical Problems	0.12	0.14	1.13	0.60	2.13
Multivariate Cox Regression Model: Factors Associated with Child Death (N = 126)					
Gender	0.08	0.19	1.09	0.75	1.58
Minority Status	0.22	1.27	1.24	0.85	1.80
Mental Health Problems	-0.99	11.33**	0.37	0.21	0.66
Physical/medical Problems	-0.08	0.12	0.92	0.58	1.47

Note: * $p < .05$. ** $p < .01$.

Logistic Regression Analysis Findings

When bivariate relationships between predictor variables and the type of death were examined using logistic regression, minority status, being seen by a community agency, and being at home at the time of the fatal maltreatment incident were significantly associated with the type of death (see Table 2). However, when multivariate analyses were performed, being seen by a community agency was the only variable that predicted a specific type of maltreatment that resulted in death, Wald $\chi^2(1, N = 126) = 4.07, p < .05$ (see Table 3). In particular, if the child was seen by a community agency he/she was almost 2 and a half times (2.4) more likely to experience an abuse-related death.

Table 2
Bivariate Relationships Between Predictor Variables and Abuse Resulted in Death (N = 126)

<i>Logistic Regression</i> Variables	Beta	df	Wald χ^2	Odds Ratio	95% Confidence interval for risk ratio	
					Lower	Upper
Age	-0.01	1	0.11	0.99	0.92	1.06
Gender	0.05	1	0.02	1.05	0.51	2.14
Minority	0.71	1	3.84*	2.04	1.00	4.14
Mental Health Problems	-0.26	1	0.22	0.77	0.26	2.27
Physical/medical Problems	-0.56	1	1.39	0.57	0.22	1.45
Any Health problems	-0.38	1	0.86	0.68	0.30	1.54
Child seen by community agencies	-0.86	1	5.02*	0.42	0.20	0.90
Child enrollment in childcare	0.22	1	0.33	1.24	0.59	2.59
Presence of child witnesses	-0.53	1	1.75	0.59	0.27	1.29
Presence of adult witnesses	0.04	1	0.01	1.04	0.35	3.08
Presence of any witnesses	-0.43	1	1.27	0.65	0.31	1.38
Home location of the incident	0.77	1	4.23*	2.16	1.04	4.52

Note: *p < .05.

Table 3
Predictors of Abuse Resulted in Death: Multivariate Model (N = 126)

<i>Logistic Regression</i> Variables	Beta	df	Wald χ^2	Odds Ratio	95% Confidence interval for risk ratio	
					Lower	Upper
Minority	0.63	1	2.75	1.87	0.89	3.93
Child seen by community agencies	-0.79	1	4.07*	0.45	0.21	0.98
Home location of the incident	0.56	1	2.04	1.75	0.81	3.79

Note: *p < .05.

Discussion

The tragedy of fatal child maltreatment has galvanized efforts to transform child maltreatment prevention policy, and the examination of cases involving child deaths due to abuse or neglect is an essential component in developing preventive interventions for families. While there is variability across the cases, an analysis of trends points to relevant issues that may affect outcomes for vulnerable children and their families.

The findings suggest that the presence of mental health problems among children had a significant negative association with fatal child maltreatment. It appears that identification of mental health needs of children can have a protective function in safeguarding children by creating greater community visibility and involvement with the child and family. Mobilizing resources at the local and state level to enhance identification and intervention practices for children with mental health correlates may increase the likelihood of improvements in the service system to benefit the health and well being of children and families.

Conversely, minority status and being seen by a community agency were significantly associated with abuse related fatal child maltreatment. This trend provides important information on the extent to which current services and community resources are effective and culturally appropriate. Prevention and treatment interventions for child maltreatment need to be differentially targeted toward various populations in order for a large proportion of perpetrators to benefit from these efforts. For example, male perpetrators who are not biological fathers are more commonly associated with physical abuse; therefore, in-home services may be missing the opportunity to involve men who maltreat children but are not living in the home.

The death of a child is a sentinel event in a community that can mobilize action and foster a response to the contributory factors associated with these incidents. Although fatal victimization of children comprises a heterogeneous class of events, conceptualizations of this public health issue can be clarified through ongoing research into the complex interplay of correlates. This knowledge may subsequently contribute to creative and effective policies that expand the capacity to promote child well being as a community norm and mobilize communities to take notable action in the form of support, education, and organizational practices for the benefit of children and their families.

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Transforming Multi-System Response to Child Sexual Abuse: Theory-Based Administrative Team Development

Rosalyn M. Bertram

Introduction

Investigation, prosecution and treatment of child sexual abuse is proscribed by legally mandated roles with overlapping or complementary responsibilities for police, protective services, prosecutors, family court and service providers. Kansas City's Child Protection Center was established in 1996 to improve response to families when child sexual abuse was reported. As part of forensic evaluations the Center conducted "collaborative case reviews" as means to integrate these agencies' efforts. This case-by-case approach to systems integration functioned adequately until funding cuts, staff turnover, and politically sensitive cases damaged trust and reviews collapsed in conflict. By 2003 efforts to improve multi-system response to child sexual abuse had stalled.

A consultant from the University of Missouri-Kansas City (UMKC) School of Social Work was engaged through Kids Safe funds by Heart of America United Way to re-establish a basis for inter-agency collaboration through the Center. A theory-based model for building collaborative teams was applied. This model emerged from research in a Chicago area Center for Mental Health Services grant (Bertram & Bertram, 2003; Malysiak-Bertram, Bertram Malysiak, Rudo, & Duchnowski, 2000) that built upon developmental disabilities research on team development (Eno-Hieneman, 1997; Anderson, Russo, Dunlap, Albin, 1996; Bombara & Knoster, 1995). These studies suggested theory-based team development and ecological systems theory formed a useful base to structure collaborative efforts and emphasized that effective teams first define goals, information sharing and decision-making rules to create a basis for strengths-based ecological assessment and intervention (Bertram & Bertram, 2003). However, these studies had focused upon direct practice with families. This project offered the opportunity to evaluate this theory as a basis to forge common structure and direction from an administrative level across multiple systems engaged with the same population. The following theory-based constructs guided that effort:

- The power and challenge of collaborative models of practice is that they bring together differing perspectives of a situation.
- Team composition affects assessment and outcomes.
- To effectively engage differing perspectives requires clear team structure.
- Team efforts are best structured through four sets of related agreements: overall goals, rules of operation, ecological assessment of assets and constraints culminating with agreement on current status (a systemic hypothesis of problems-in-context), and plan development, implementation & evaluation

Method

For this project, key administrators from the Kansas City Police Department's Victims Crimes Unit, Jackson County Children's Division of Missouri's Department of Social Services, Jackson County Family Court and Prosecutor Office, the Child Protection Center, Children's Mercy Hospital, and the Director of Community Programs for Heart of America United Way were interviewed to clarify the history of their efforts to improve multi-system response to child sexual abuse and to prepare them to create a collaborative team structure through four sets of agreements. Their agreements are described below.

Overall Goals

Participants agreed that they would work together through the Child Protection Center to provide timely, efficient, co-investigation of child abuse allegations and to inform decisions each agency must make to support children and families in a culturally competent manner.

Rules of Operation

Administrators agreed it was necessary to share information about practice with families, agency policy, resources, and projects. They classified discussions by whether they were confidential, simple information sharing, exploratory, or decision-making. Decision-making rules included a menu of options in the event that talking to consensus or voting seemed problematic. Dissenting perspectives were recorded. If a decision wasn't productive, dissenting viewpoints could be revisited. Conflict resolution procedures were established.

Ecological Assessment and Status

Their assessment was ecological and multi-layered, examining their agencies' direct practice with families, multi-system administrative interactions that should provide guidelines for that practice, and a community level in which their agencies could contribute to change in laws or funding. Composition, information needed, roles and responsibilities, assets and constraints were assessed for each level of multi-system activity.

Most team planning processes move directly from assessment into designing interventions (Bertram & Bertram, 2003; Bertram, in review). This theory-based team development required assessment to culminate by building agreement on current status. This step provides opportunity to examine assumptions and ideas about how participants make meaning of the assessment which otherwise might remain unstated and potentially divisive. Their status agreement was:

"We lacked clarity for different levels of our activities. This contributed to confusion on roles & responsibilities. We lacked shared means to ensure systematic, efficient information gathering as well as shared guidelines for decision making. This compromised our best intentions to enhance our assets and address constraints."

Plan of Action and Evaluation

This agreement was used with their overall goals to target constraints and develop interventions in a multi-system plan of action. Despite altered team composition when some administrators changed jobs, and a fiscal crisis when the new Governor cut funds for child protection, the following action plan was completed within one year:

1. Define best practice from initial report, through investigation, forensic evaluation, and collaborative review for prosecution and referral for services.
2. Write a shared protocol that defines roles and responsibilities in this practice.
3. Write a shared manual that provides detailed guidance for these roles and responsibilities.
4. Provide joint training to present these new guidelines for staff performance.
5. Identify quality assurance data points within this protocol for inclusion in a shared database that administrators review together monthly to evaluate practice fidelity and inform further multi-system improvements.

A UMKC Center for the City grant provided funds for the shared database and semi-structured interviews with participants to evaluate use of this theory to refine multi-system response to child sexual abuse. Interviews were analyzed, seeking points of convergence or divergence of perspective.

Findings

Interviews confirmed premises of key theoretical constructs while evaluating systems integration and collaboration efforts before and after application of this theory-based team development. Initial data suggest that although this theory was developed around teamwork with families, its core constructs applied well at an administrative level to refine multi-system responses in child welfare. Key perspectives shared by all administrators follow.

Prior to Theory-Based Team Development

- All participants reported little collaboration occurring. Attempts to integrate responsibilities were often revisited as each agency advocated for its perspective and goals.
- Participants reported no explicit rules for information sharing or decision-making. They assumed discussions would forge understanding and votes would resolve differences on direction. When this failed, participants became suspicious and revisited decisions, stalling their work.
- Since the inception of the Center, no multi-systems strengths-based assessment had been conducted. Conflict clouded their vision. They lacked trust.

After Theory-Based Team Development

- Clarity, trust, and the sense they could influence another agency emerged from developing and working toward shared goals within rules they had created. Shared goals and rules provided direction and structure for collaboration in assessment.
- Working toward shared goals within shared rules in a mutual process of assessment clarified each agency's concerns and helped identify assets overlooked in their conflict. This gave previously pessimistic administrators hope because there was something from which to build.
- Culmination of assessment with a current status agreement encouraged them to consider why they had been stuck in conflict. Using it with shared goals to prioritize steps in a plan of action contributed to ownership and successful implementation of their plan despite separate funding streams, supervisory structure, and agency mandates.

Conclusions

Establishing a meaningful system of care from legal mandates and separate funding streams is difficult even when guided by value-based principles. Data from these interviews and successful fulfillment of each strategy in these administrators' plan affirmed key constructs of this theory and its use in multi-system change efforts in child welfare. Practical steps guiding this theory may prove useful to collaborative development of logic models and systems transformation efforts for other client populations. However, further tests lie ahead. Administrators are completing annual revisions to the four sets of agreements to structure further systems refinement. In 2006 they will examine monthly reports from their shared database on protocol implementation. Reports will inevitably suggest an agency lags in protocol implementation. This will provide another test of the theory and the structure administrators created through applying it.

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Transforming Supervision to Support Collaborative Team Efforts in Child Welfare

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Introduction

Child welfare interventions are typically focused through expert practice models of crisis intervention and case management. However, within these models, staff members apply a potpourri of theories that may not address contextual correlates of child abuse and neglect (Samantrai, 2004). Driven by tight legal decision-making timelines, child welfare interventions often overlook, fail to engage, or actually constrain strengths in the families and their communities (Melton & Barry, 1994). Staff supervision in child welfare strongly focuses upon meeting timelines and addressing crises in the most problematic cases, often on a “catch-as-catch-can” basis. Supervisors have little training in clinical supervision and have usually not been exposed to structured, theory-based approaches to enhance staff members’ abilities to more fully engage families and their community to foster family resilience and to protect children (Minuchin, Colapinto, & Minuchin, 1998).

This paper presents the organizational framework and baseline data from a Kansas City Missouri child welfare pilot project initiated in 2005 that has engaged over thirty staff and six supervisors in a theory-based transformation of child welfare practice and supervision focused upon staff and team development and model fidelity. The project applies lessons from developmental disabilities research on theory-based team development (Eno-Hieneman, 1997; Anderson, Russo, Dunlap, Albin, 1996; Bombara & Knoster, 1995), and lessons from a Center for Mental Health Services (CMHS) grant site on supervision of ecological, strengths-based, collaborative team practice (Bertram & Bertram, 2003; Malysiak-Bertram, 2001). In 2006-7, this project will produce two theory-based instruments to support this transformation: one measuring model-pertinent staff knowledge and skills, and the other measuring team composition, structure, focus, and cohesion. Both instruments will be tested and integrated into supervision. In 2007-2008 these instruments will act as measures of staff development and model fidelity in an examination of child and family outcomes. Results will inform our understanding of organizational, supervisory, and practice elements necessary to foster collaboration with families and their communities in the legally mandated context of child welfare.

Method

Before initiating this project a thorough historical analysis of the child welfare system was conducted, including the theory and paradigm base of its practice, supervision, and organizational structure, as well as the persistence of its initial assumptions about abuse that were later contradicted by examinations of the client population. This analysis helped project leaders establish realistic expectations and timelines for transforming supervision and for staff development. This step and subsequent pre-implementation activities mirror core components of project feasibility identified by Fixsen, Naoom, Blase, Friedman, and Wallace (2005) in their meta-analysis of implementation research.

Through winter 2005, supervisors from the project site refined training developed in a CMHS grant (Malysiak-Bertram, Bertram-Malysiak, Rudo, & Duchnowski, 2000) to address legal complexities of child welfare practice, and met with the guardian ad litem office and family court to secure support. Guardian ad litem staff and all project site Children’s Division staff participated in project orientation. Five subsequent training sessions presented guiding constructs of theory-based team development, ecological system theory, and the family life cycle. These following constructs now guide practice and supervision on cases opened since April 2005:

- Team composition affects assessment and outcomes.
- The power and challenge of collaborative models of practice is that they bring together differing perspectives of the family situation. This requires clear team structure.

- To clarify roles and responsibilities child welfare teams are organized into three sub-systems. The core team is composed of those who best know the family or influence use of needed resources. They meet more frequently, especially in the beginning of a case. Working in tandem are two other sub-systems, an extended team (those engaged with family in specific interventions), and a legal team composed of judges, lawyers, and guardian ad litem who share legal responsibilities, but who also have less intimate or frequent knowledge of the family.
- Sub-systems of the team are made cohesive through a structure of four agreements: (1) ultimate goals, (2) rules of operation, (3) ecological assessment of assets and constraints culminating with agreement on current status, and (4) plan development, implementation & evaluation.
- Team goals and rules create the basis for collaboration in assessment, planning, and interventions. Team members identify information necessary to achieve their goals, how to share it, how to make decisions, especially when they cannot agree, and how to resolve conflict.
- Effective assessment includes assets, competencies, constraints and challenges in the home, school and community aspects of family life. It includes a status agreement about patterns of interaction within and between systems that allow problem behavior to continue.
- Changing these patterns to achieve team goals is the basis for plan development using assets and competencies as levers for change.
- Information gathered from evaluating plan implementation and outcomes is used to refine team composition and structure.

Supervision and Staff Development: New Structures and Theory-Based Measures

Training alone does not facilitate change from expert to collaborative models of practice (Bertram & Bertram, 2003; Cupit Swenson, Randall, Henggeler, & Ward, 2000). In addition to a systematic theory-based focus in weekly scheduled supervision, project leaders guide staff in weekly learning groups to re-enforce these theory-based constructs, and a separate group for supervisors supports their own development. Cases are reviewed in both individual and group supervisory formats examining the manner in which teams develop and work within their structure of sub-systems and agreements. Beginning in February 2006, the project began to test and apply two theory-based instruments. One measures model fidelity (team composition, structure, focus and cohesion) and one measures model pertinent staff knowledge and skills. These instruments allow systematic comparison of team development with development of staff knowledge and skills. In 2007-8 data from both instruments will be compared with Children's Division child and family outcome data as part of overall project evaluation.

Baseline Data

Before training began, two graduating University of Missouri—Kansas City MSW students evaluated project site practice and supervision through a survey of 54 Children's Division and guardian ad litem staff. These data produced no surprises and reflected patterns identified in the historical analysis of child welfare. Though many family members might be invited to team meetings, few came, fewer participated, and fewer still were involved in decision-making. Goals were established and decisions made primarily by the guardian ad litem or by Children's Division staff. Ad hoc supervision tended to focus upon the most problematic cases, staff morale, or policy guidelines. Staff knowledge of ecological systems theory or theory-based team development and their ability to develop a systemic hypothesis of problems in context was limited.

As expected, it's been difficult for supervisors to provide set times to guide staff development in a structured, case-by-case manner. The intensity of concerns regarding child safety and legal timelines, as well as staff turnover, pull supervisors back toward ad hoc, crisis-oriented patterns of supervision. Two months post-training, only half of the staff had been engaged in weekly scheduled, systematic, theory-based supervision focused upon team and staff development. Nevertheless, supervisors met their target to consistently provide such supervision in the fall of 2005, and supervisors embraced live observation of staff efforts as the most potent means to enhance staff knowledge and skills. In so doing, they have overcome barriers to transformation of supervision identified when this model was examined in a CMHS grant (Bertram & Bertram, 2003; Malysiak-Bertram, 2001).

A key dynamic noted in the first year of the project has been vulnerability and exposure that characterize the shift from expert to collaborative models of practice. Supervisors and their staff were revealing their practice to each other and were guiding team development in a significantly different manner without yet having full confidence in their abilities to do so. Constant efforts were necessary to maintain a positive, strengths-based focus on both supervisor and staff development in both group and individual learning formats. More experienced staff with decades of child welfare practice were often the most hesitant to change, requiring project leaders to reframe core constructs of the theory-based team development into the worker's language without compromising its key differences.

Initial data from testing the instrument that measures team composition, structure and cohesion are encouraging. Many identified in the baseline survey of practice as making most team decisions (Guardian ad Litem) have tended to verbalize discontent with how teams were now structured, yet their responses to instrument questions showed remarkable cohesion with other members of the team. Conversely, those who in the baseline data had the least influence on decision-making (family members) have tended to demonstrate more engagement and commitment to the changed team structure and process, while their responses to instrument questions also show remarkable cohesion with other members of their team.

Conclusions

Key aspects of implementation research identified in a recent synthesis of the literature are integrated in this project including feasibility assessment, defining core implementation components related to training and supervision, evaluation and fidelity, and addressing organizational context and external influences (Fixen, et al, 2005). Initial organizational lessons about transforming child welfare practice and supervision to support collaborative team efforts may be relevant to others engaged in systems transformation, particularly in systems with legal responsibilities. Deeper lessons in staff and team development will emerge as theory-based measures are systematically applied and integrated into supervision.

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