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How Is Positive Parenting Defined and Measured? A Review of Literature

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ABSTRACT

More than 500 peer-reviewed studies that used the term "positive parenting" in the title or abstract, or both, were identified from a computer search. They were then coded to address three questions: (1) Were the three founders of the parenting approach referenced? (2) How was the term conceptually defined? and (3) How was the construct measured? Findings revealed that with only a few exceptions, the founders are not recognized or referenced in the academic parenting literature. Two-thirds of the studies did not offer a conceptual definition of the term, and measurement of the construct was inconsistent and frequently haphazard. Although positive parenting is a widely used term and has a strong theoretical basis, the empirical literature is not coherent in either its conceptualization or measurement of it.

Keywords: *Positive parenting, literature review, parent education*

The maltreatment of children is a widespread and serious public health concern. Over 500,000 U.S. children were deemed to be victims of maltreatment in 2022 alone (U.S. Department of Health and Human Services, 2024). In addition to these cases, a vast number of children experience sub-optimal parenting that also places them at risk for long-term poor developmental outcomes. For example, corporal punishment is a commonly used disciplinary strategy in the United States (Straus, 2010; Zero to Three & Bezos Family Foundation, 2016). A large corpus of research has established that despite its popularity, corporal punishment is ineffective at correcting child misbehavior, can cause physical injury, and can precipitate children's mental health and behavioral problems (Gershoff, 2010, 2013; Sege, 2018). Likewise, psychologically maltreating behaviors are harmful for children (e.g., Abajobir et al., 2017; Brassard, 2019; Norman et al., 2012; Spinazzola et al., 2014), even when parents engage in it at low levels (Yeung et al., 2023). Both corporal punishment and psychological maltreatment have been identified as an adverse childhood experience (Afifi et al., 2017; Felitti et al., 1998) and yet behaviors such as yelling, shaming, ignoring, and threatening to abandon a child as well as spanking continue to be frequently used parenting practices (Cuartas et al., 2019; Finkelhor et al., 2014).

Given the profound impact of problematic parenting on children's development, helping parents replace harmful practices, including corporal punishment and psychological maltreatment, with more effective strategies remains a critically important policy and programmatic goal for both the scientific and practice communities. Although several clearinghouses have identified evidence-based parenting programs (e.g., The California Evidence-Based Clearinghouse for Child Welfare), not all parents are aware of, have access to, or want to participate in a group parenting program (e.g., Rostad et al., 2018). Parents as well as the human service professionals who work with families need to have access to a directory of resources (including manualized programs, but also websites and books) that they can utilize and refer parents to in order to help parents better support and promote the health and well-being of their children.

The current review was undertaken as a first step in the creation of such a resource directory, with a particular focus on resources identified as embodying the childrearing philosophy known

as positive parenting, in light of its promise as a scientifically-based and widely popular parenting approach. For example, a Google search using the term *positive parenting* produces over a billion hits. An Amazon book search produced over 20,000 responses and a search on YouTube resulted in thousands of videos, many of which have garnered tens of thousands of views. It is clear that there is something compelling about the concept of positive parenting, a childrearing approach that was first popularized in the United States by parenting expert Jane Nelsen in her seminal book *Positive Discipline*, published in 1981. Nelsen herself credits the source of the philosophy to Rudolf Dreikurs (1964) and his mentor, Alfred Adler (1957; 1963).

The term positive parenting also frequently appears in the academic literature. However, to date little is known about how parenting researchers define and measure it. This lack of information was the impetus for the current effort, which emerged from discussions at the National Initiative to End Corporal Punishment (NIECP) and the Psychological Maltreatment Alliance (PMA), and among professionals in child welfare and maltreatment, about which parenting resources should be recommended to parents and professionals as an alternative to corporal punishment and psychological maltreatment. There was consensus among the professionals that, as a first step, a better understanding was needed about how positive parenting is conceptualized and measured in the scientific literature.

The study was designed to address the following three specific questions: (1) Do scientists who study parenting credit and reference Adler, Dreikurs, and Nelsen as the founders of the childrearing approach? (2) How is positive parenting conceptually defined? and (3) How is positive parenting measured?

Method

The authors conducted two PsychInfo searches for the years from 1986 to 2023. Each search resulted in a pool of possible articles, some of which were eliminated. The remaining articles comprised the sample for the study. For both searches the inclusion criteria were as follows: papers (1) written in the English language; (2) published in a peer-reviewed journal; and (3) containing the term *positive parenting* in the title (first search) or in the abstract (second search). Each search ruled out papers based on the following exclusion criteria: (1) It was not empirical (i.e., theoretical papers, policy papers, clinical descriptions, program descriptions, case studies, literature reviews, scoping reviews, feasibility studies, or meta analyses); (2) positive parenting was not included as a variable; and (3) the study sample did not consist of children with developmental disabilities or autism. The first search resulted in 164 articles, 24 of which were excluded, resulting in 140. The second search began with over 2,000 studies; the first 600 articles of which were examined to determine if they met the inclusion/exclusion criteria. Two hundred and twenty-three papers were eliminated based on the exclusion criteria, resulting in 377. The final sample comprised 140 from the first search and 377 from the second, 517 in all. These papers were all written in the English language with the term positive parenting in the title and/or abstract, and the construct of positive parenting was a variable that was measured in the study.

Data Extraction Methods

Each study was read by the first author and, for a reliability check, 7% of the studies were also read by the second author to extract data on the following 13 variables:

1. From what country was the sample drawn? (open-ended)
2. Was there a conceptual definition provided of the term positive parenting in the introduction to the paper (the portion of the paper prior to the methods section)? (0 = No, 1 = Yes)
3. If yes, what was the conceptual definition? (open-ended)
4. Was the positive parenting variable the independent variable, dependent variable, or both? (1 = IV, 2 =DV, 3 = Both)

5. Was the term positive parenting operationalized as participation in a specific parenting program? (0 = No, 1 = Yes)
6. If so, what was the name of the parenting program? (open-ended)
7. Was positive parenting operationalized through observations? (0 = No, 1 = Yes)
8. Was positive parenting operationalized through questionnaires/surveys? (0 = No, 1 = Yes)
9. Was positive parenting operationalized through interviews? (0 = No, 1 = Yes)
10. Was positive parenting operationalized through parent data? (0 = No, 1 = Yes)
11. Was positive parenting operationalized through child data? (0 = No, 1 = Yes)
12. What was the name of the positive parenting measure? (open-ended)
13. Which, if any, of the three founders of the positive parenting childrearing approach were cited in the paper: Alfred Adler, Rudolf Dreikurs, and Jane Nelsen? (open-ended)

Inter-rater reliability was determined using five articles prior to beginning the coding, which resulted in 95% agreement. Thirty-five additional articles were subsequently double-coded, resulting in 93.9% agreement. All disagreements were resolved through discussion and consensus.

The 517 articles in the study sample were published between 1986 and 2023. Roughly half were written by researchers in the United States studying U.S. families, while the remaining half were written by researchers from over 20 countries studying samples of families from around the world.

Results

What Percentage of Studies Reference the Founders

Only six of the studies (1.2%) recognized any of the three founders of the childrearing approach of positive parenting.

How Is Positive Parenting Conceptually Defined

Two thirds of the studies (n = 347, 67.1%) did not provide a conceptual definition of positive parenting. In most of these studies, the term positive parenting was used in a general way with the word *positive* functioning as a synonym for good (e.g., Dvorsky et al., 2021; Feinberg et al., 2021; Ziegler et al., 2020). In other studies, the word *positive* appears in the name of the program such as Triple P Positive Parenting Program (e.g., Bor et al., 2002; Clarke et al., 2013 Ozyurt et al., 2019), Video-Feedback Intervention for Positive Parenting (e.g., Hodes et al., 2017; Mendelsohn et al., 2018), or Rational Positive Parenting Program (David, 2014; David et al., 2014) but a definition of the concept did not appear in the introductions.

The remaining 170 studies (32.9%) did provide a conceptual definition of positive parenting. From these definitions, a list was created of the parenting behaviors specified, such as providing affection, being encouraging, monitoring, and supporting children. Two authors (AB and GH) sorted these 39 behaviors into the following seven categories with 95% agreement:

1. warmth and positive regard (e.g., affection, sensitivity, nurturance, acceptance)
2. investment of time and attention/engagement (e.g., paying attention, monitoring)
3. discipline (setting limits, consequences)
4. reliability (e.g., consistency)
5. specific parenting behaviors (e.g., eating meals together, listening)
6. teaching and education (e.g., reading together, providing a safe learning environment)
7. miscellaneous

These seven categories were derived solely from the list of 39 parenting behaviors and were not based on any *a priori* notion of what positive parenting should be. Each study was then coded to determine which of the seven categories was represented in that study's conceptual definition of the construct. These data are presented in Table 1.

Table 1

Frequency Distribution of the Categories of Parenting Behaviors Included in Conceptual Definitions Provided (n=170)

Category of Parenting	N	%
Warmth/Positive Regard	146	85.9
Involvement/Engagement	87	51.2
Discipline	30	17.6
Reliable and Consistent Interactions	10	05.9
Specific Behaviors	11	06.5
Teaching and Education	09	05.3
Miscellaneous	28	16.5

As can be seen, most researchers defined *positive parenting* as a form of parental warmth/positive regard. About half of the studies used definitions that included parental involvement and engagement in the child's life. Fewer than 20% included parenting behaviors related to the other five categories.

One third of the 170 study definitions included parenting behaviors from only one of the seven categories and two thirds included parenting behaviors from more than one category. About 40% of the studies included behaviors from two categories; about 17% included behaviors from three categories, and only a handful of studies included behaviors from more than three categories. The average number of categories included in these studies was 1.9 (*SD* = .83).

How Was Positive Parenting Measured

Positive parenting was assessed predominantly with questionnaires (*n* = 333, 64.4%). In one fourth of the studies, positive parenting was measured through observations, and in 1.9% of the studies, positive parenting was assessed with interviews with parents. In 69 (13.3%) of the studies, positive parenting was simply determined by parents' participation in a positive parenting program.

An astonishing variety of over 200 different questionnaires and observational measures were employed to operationalize positive parenting. The most commonly used measures were the Alabama Parenting Questionnaire (Frick, 1979), used with either the total score or subset of scales in 92 studies; the Parenting Scale (Arnold et al., 1993) relied upon in 24 studies; the Dyadic Parent-Child Interaction Coding System (DPICS) (Eyberg, 2005) used in 17 studies; the HOME (Caldwell & Bradley, 1984) used in 12 studies; and the Parenting Style and Dimension Questionnaire (Robinson et al., 1995) completed by parents in 9 studies. Fifteen measures appeared in between four and eight studies: Child Report of Parent Behavior Inventory (Schaefer, 1965), Parenting Practices Scale (Strayhorn & Weidman, 1988), Parenting Young Children (McEachern et al., 2012), Egma Minnen av Bardndosna Uppforstran (childhood memories) (Perris et al., 1980), Iowa Family Interaction Rating Scale (Melby et al., 1993), NICHD Early Child Care Research Network (NICHD, 1999), Parent Child Interaction Rating System (Belsky et al., 1995), Parenting Practices Interview (Webster-Stratton, 2001), Child Rearing Practices Report (Block, 1981), Parent Child Interaction System (PARCHISY) (Deater-Decker et al., 1997), Parental Acceptance Rejection Questionnaire (Rohner, 2005), Child Report of Parent Behavior Inventory (Schludermann & Schludermann, 1988), Emotional Availability Scale (Biringen, 2008), Parent Interaction Inventory (Dumas et al., 2009), and the Parenting Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978). An additional 183 measures appeared in fewer than four studies each.

The majority of studies (*n* = 443, 85.7%) used only one measure of positive parenting (including participation in the program); 44 studies (8.5%) included two measures; 24 (4.6%) used three measures; and six (1.2%)

used four or more measures. In 95 (18.4%) of the studies, researchers used an unnamed measure and failed to describe it.

To determine which of the seven previously identified categories of parenting behaviors were covered by the measures, the specific variables in the measures (questionnaires and observational coding systems) were examined. This was done because many of the measures—such as the Parent Behavior Checklist (Fox, 1994), the Child Parent Relationship Scale (Pianta, 1992), or the Scale of Parenting Styles (Gafoor & Kurukkan, 2019)—had vague titles, and it was not clear what parenting behaviors were actually being measured. Moreover, even if better-known measures were used, such as the Alabama Parenting Questionnaire (Frick, 1979), some studies used all the subscales, while others used only a subset. It was thus necessary to examine the variables to determine what parenting behaviors were being assessed. We coded the variables into one of the seven parenting behavior categories: (1) warmth/positive regard; (2) involvement/engagement; (3) reliability; (4) discipline; (5) teaching skills; (6) specific behaviors; and (7) miscellaneous. These data are presented in Table 2.

Table 2

Categories of Parenting Measured for Studies Using a Measure (not including participation in the program as a measure) (n=443)

Category of Parenting	N	%
Warmth/Positive Regard	401	90.5
Involvement/Engagement	287	64.8
Discipline	166	37.5
Reliable and Consistent Interactions	54	12.2
Specific Behaviors	25	05.6
Teaching and Education	33	07.4
Miscellaneous	125	28.2

Almost all (n = 401, 90.5%) of the studies that used either a questionnaire or an observational coding system included variables related to warmth/positive regard when assessing positive parenting. About two thirds (n = 287, 64.8%) had variables related to involvement/engagement, and one third (n = 166, 37.5%) had variables that related to parental disciplinary behaviors. The remaining elements of parenting were measured much less often.

With respect to the number of categories of parenting behaviors measured, about one fifth of the studies (n = 103, 23.3%) included variables related to just one category; almost 30% (n = 144, 32.5%) had variables from two categories; about one fourth (n = 107, 24.2%) included variables from three categories; and only a handful of studies (n = 71, 16%) included variables from four or more categories. The average number of categories measured was 2.5 (SD = 1.2). A Pearson correlation was conducted between the number of categories included in the conceptual definition and the number of categories actually measured, which was found to be not statistically significant (r = .14, p > .05). Thus, there was no relationship between the number of categories included in the conceptualization of positive parenting and how many of these categories were actually measured in the study.

The final analysis examined the extent to which the studies demonstrated concordance between the conceptualization of positive parenting and how positive parenting was actually measured. These data are presented in Table 3.

Table 3

Consistency Between Conceptualization and Measurement

Category of Parenting	N	%
Warmth(n=146)	133	91.1
Involvement (n=87)	71	81.6
Discipline (n=30)	18	60.0
Reliability (n=10)	01	10.0
Teaching (n=9)	03	33.3
Miscellaneous (n=28)	12	42.9

Ninety-one percent of the studies that conceptualized positive parenting as involving warmth/positive regard actually did measure some aspect of warmth/positive regard. About eight in 10 of the studies that conceptualized positive parenting as involvement/engagement measured it that way. Fewer than two thirds of the studies conceptualizing positive parenting as discipline actually measured discipline. None of the other elements were measured with any degree of concordance.

Discussion

This study was conducted to determine how the term positive parenting is defined and operationalized in the academic literature. The goal of this effort was to take the first step in a multi-step project to create a resource directory of evidence-based parenting resources for parents and human service professionals who work with parents engaging in sub-optimal and problematic parenting and placing their children at risk of maltreatment. A number of important findings emerged from our review.

First, in 98% of the studies the founders of the childrearing approach were not recognized. In this sample of positive parenting papers, for one reason or another, almost all researchers failed to cite one or more of the three pioneers. It could be a lack of knowledge about the origins of the approach, a failure to give credit to the pioneers, or the researchers' belief that their approach did not have historical origins. Regardless, we believe that this particular childrearing approach is distinctive and researchers should recognize the origins of the construct and the foundational roles played by Adler, Dreikurs, and Nelsen in its development.

A second finding was that while researchers used the term positive parenting in their titles or abstracts, two thirds of them did not provide a conceptual definition. This common omission indicates that the term is being used in a generic and vague way that is not helpful in identifying specific childrearing behaviors that form the ingredients of positive parenting.

Third, of the studies that did define the term, the two most commonly cited elements were warmth/positive regard for the child and parental involvement/engagement. Fewer than one in six studies mentioned the other categories of positive parenting, including the category of discipline. This is noteworthy because the initial conceptualization of positive parenting, called positive discipline by Nelsen (1981), focused extensively on the importance of parental responses to children's perceived or real misbehavior.

A fourth finding from this review is that there is no consensus regarding measurement of positive parenting. Almost 200 different instruments were used in addition to 95 unnamed measures. Moreover, 69 studies did not assess positive parenting at all but, instead, used participation in a parenting program as a stand-in. There is virtually no uniformity or consistency as to how to assess positive parenting.

Fifth, there was a lack of concordance between how a study conceptually defined positive parenting and how this concept was measured. For example, although 30 studies recognized that disciplinary approaches could be useful for distinguishing parents who use positive parenting from those who do not, only 18 of these studies actually measured any aspects of discipline.

Taken together, although positive parenting is a widely used term and has a strong theoretical base, the empirical literature is not coherent in either its conceptualization or its measurement of positive parenting. Neither the essential elements of positive parenting nor their effectiveness in helping parents improve their parenting has been identified.

Recommendations and Next Steps

Based on these findings, three suggestions are offered:

First, when the term positive parenting is used, it should be made clear whether the term is referencing a specific approach to parenting as initially outlined in Nelsen (1981) or if the term is being used in a generic sense to connote good parenting. Such a distinction will avoid the considerable confusion that currently exists with the terminology. One option would be to follow the lead of Holden and colleagues (2017) and refer to Nelsen's approach as the "strong form" of positive parenting, in contrast to the "lite" manifestation referring more generally to good childrearing practices that may not actually be consistent with the founder's approach.

Second, it behooves researchers who use the concept of positive parenting to define it and measure it with valid and reliable measurement instruments that are consistent with the conceptualization they utilize.

Our third suggestion is for the creation of a directory of positive parenting resources that are evidence-based and reflect the childrearing approach following the conceptualizations of Adler, Driekurs, and Nelsen. This directory would serve as a clearinghouse for books, websites, and parenting programs. The directory would explain the degree to which a resource adheres to the various components of the "strong form" (i.e., consistent with the founders' approach) of positive parenting. The directory would identify the essential components of positive parenting and which programs best embody those elements.

Practice Implications

Practitioners in dozens of different parenting books and some websites have described positive parenting approaches using many different names. Adjectives such as gentle, peaceful, cooperative parenting have been used to capture this approach. Some of these parenting books (e.g., Markham, 2012) are very much in line with the conceptualization of the pioneers. However, other books are not. An authoritative directory that provides a reference guide of evidence-based positive parenting resources would do much to promote the childrearing approach. This directory can be made widely available both for parents and for professionals working in prevention, intervention, and treatment programs. Such a resource will be invaluable for professionals in their efforts to steer parents toward the best evidence-based positive parenting practices so they can promote their children's healthy growth, thriving development, and emotional well-being.

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Positive Parenting

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An Interview With Sharon Doty, MHR, JD: A Community-Based Approach to the Prevention of Child Sexual Abuse

Jennifer L. Kisamore, PhD; Erica Frazier, MS, LPC

Abstract

The current paper is based on an interview with Sharon Doty, MHR, JD, an expert in childhood sexual abuse prevention. Sharon and her team developed a unique approach to the prevention of childhood sexual abuse that involves educating adults about eight common behaviors that sex offenders use to groom children. Sharon's approach is designed to take the onus off children for protecting themselves by teaching adults how to intervene in potential instances of grooming and how to reduce the potential for grooming by not normalizing eight risky behaviors commonly used by sex offenders. Widespread adoption of interventions such as her Keeping Them Safe program hold promise for preventing child sexual abuse.

Keywords::*Child sexual abuse, Grooming, Community-based intervention, Faith communities, Sexual abuse prevention, Abuse-resistant environments*

Childhood sexual abuse is a pervasive problem with more than 25% of females and 5% of males reporting being sexually abused before the age of 18 (Finkelhor et al., 2014; Gewirtz-Meydan & Finkelhor, 2020). The current article is based on an interview with Sharon Doty, founder of Arpeggias, LLC, and developer of the *Keeping Them Safe* program, a unique approach to child sexual abuse prevention that educates community members about how to intervene to prevent risky behaviors that may foster child sexual abuse.

Advocating for Children's Safety

Sharon Doty as a Key Advocate

Sharon has been advocating for the safety of children for more than five decades. Her initial foray into these efforts came through volunteer work and subsequent staff positions in shelters and in early child advocacy programs throughout Oklahoma. Later, Sharon served on the CAP Action Committee for Oklahoma for more than 20 years, where she worked to bring awareness to the need for efforts and education aimed at the prevention of childhood sexual abuse in programs that provide services to children and families. She continues to serve as a member of the Oklahoma Work Group on the Prevention of Child Sexual Abuse. Sharon holds a master's and a JD degree from the University of Oklahoma. She has focused much of her law practice on advocacy for children and working to get support for adult survivors of child sexual abuse.

Preventing Child Sexual Abuse in Faith Communities

In 1997, based on her extensive work in the field, Sharon was asked to create and chair a team of experts to design an innovative approach to child sexual abuse prevention for parishes and dioceses in the U.S. Roman Catholic Church. Media attention has brought to light pervasive abuse in some

faith communities including, but not limited to the Roman Catholic Church and the Southern Baptist Convention. As described by Vieth (2023), sexual abuse went unchecked in some faith communities as a result of poor training to prevent such abuse, perpetrators' use of theology to support abuse, reliance on religious practices (e.g., confession) to justify not reporting abuse to the proper authorities, and the use of theology as a means to silence victims. Sharon sought to develop training to prevent future abuse in the Roman Catholic Church. She recruited a myriad of experts to her team, including Dr. Barbara Bonner and Dr. David Finkelhor, to develop a new approach to child sexual abuse prevention. Their work was sponsored by National Catholic Services, LLC.

Approaches to Preventing Child Sexual Abuse

The team's approach to preventing child sexual abuse was inspired by David Finkelhor's (1984) pivotal book *Child Sexual Abuse: A New Theory and Practice*. In that work, Finkelhor said four elements have to be present for child sexual abuse to occur:

- There has to be a person with a desire or willingness to engage in sexual contact with a minor,
- The person with this desire must do NOTHING to inhibit their own behavior,
- There must be an environment in which the abuse can occur, and
- The perpetrator must be able to overcome the child's resistance.

Empowering Children

The easiest of these four elements for the profession to impact was the last one. As a result, initial child sexual abuse prevention efforts were focused on empowering children to resist the overtures of someone who made them feel uncomfortable or scared. Those efforts aim to train children to protect themselves, such as by teaching them to "say words that mean NO, run away, and tell someone." According to Sharon, disseminating such training has been relatively easy because children are in school so they can be reached through school-based programs.

Early training programs for preventing childhood sexual abuse, however, were not limited to those designed to empower children to resist abuse. Training programs were also developed to teach adults how to recognize children who might have been abused, how to respond to disclosures of abuse, and how to report abuse to authorities. Training programs that focus on how to respond after abuse has happened are referred to by the Keeping Them Safe team as Immediate Response Training (IRT) programs. Given that these training programs for adults focus on responding to abuse, they were designed to stop abuse from happening *again*, rather than from preventing the abuse before it could start.

Safe Environments

To augment these two types of existing efforts, Sharon's team sought to address the missing piece of the prevention puzzle, creating environments not conducive to grooming by educating adults about child sexual abuse, teaching them how to recognize potential child sex offenders in the environment, and giving them tools to interrupt behavior that might be part of an offender's grooming process. The team sought to take the onus off children for preventing abuse while also preventing abuse before it could happen. Finkelhor's (1984) third condition had been notoriously hard to address. Although the CDC had provided 3 years of funding for community-based prevention programs in three states to create such environments, the research project was abandoned in 2009 due to lackluster results for interventions designed to educate adults about child sexual abuse prevention (S. Doty, personal communication, April 29, 2024). These results, however, did not deter Sharon and her team.

Awareness of the Grooming Process

A major part of the problem with creating abuse-resistant environments is the grooming process used by many child sex offenders. Identification

of instances of grooming is fraught with problems given the fact that "many behaviors used by perpetrators appear quite similar to behaviors seen in normal adult–child relationships" (Bennett & O'Donohue, 2014, p. 963). Sharon's team conducted extensive research, including root cause analysis of approximately 500 cases involving allegations of sexual contact between adults and children and personal interviews with 100 convicted child sex offenders. Through this analysis, the team discovered eight key behaviors that are commonly part of the grooming process (see Appendix). The team then developed a program designed to educate adults how to recognize these eight potentially risky adult behaviors. The program also teaches the adults how to intervene to interrupt the behaviors to ensure children are safe from potential sex offenders. The goal of the program was not to make accusations, but instead to protect children by interrupting potential instances of grooming. As mentioned, such behaviors (e.g., giving gifts without parental consent) may be part of innocent adult–child interactions; however, child sexual offenders use these very same behaviors to groom children, who often cannot ascertain the intentions of individuals engaging in these behaviors. Thus, the program seeks to educate community members to not normalize such behaviors, so that potential offenders cannot use these behaviors as part of the grooming process. The program that resulted from this collaboration was ready to implement when the 2002 article about child sexual abuse in the Church was published in the *Boston Globe* (see, e.g., Pfeiffer, 2008).

The eight behaviors identified by Sharon and her team in the late 1990s correspond to the results of recent research which sought to identify behaviors that have a high likelihood of being indicative of impending child sexual abuse. Jeglic et al. (2023) surveyed individuals who had and had not been sexually abused as children asking them to indicate which of 42 different behaviors they had experienced from the abuser versus an adult male with whom they had the most interpersonal contact before the age of 18. Though the eight behaviors identified by Sharon are more general than some identified by Jaglic et al. (2023), the behaviors identified by Sharon and her team—including but not limited to giving gifts (rewards), engaging in activities alone with a child, encouraging secrets, and creating separation between a child and their parents—were also identified by Jaglic et al. (2023) as those that were likely to moderately or highly differentiate between individuals who did and did not report experiencing sexually abuse before the age of 18.

Keeping Them Safe Program

Out of her work with the Catholic Church, Sharon has developed programs for use in other venues and has worked with countless organizations and other faith communities to implement adult-focused prevention education programs that are designed to educate everyone about risky behaviors that are part of the toolkit that child sex offenders use. The audience includes parents, grandparents, aunts, uncles, and caring adults who work with or support children. Educating a community of adults around children is important, as child sex offenders may seek not only to groom a child but also to groom the child's parents to gain access to the child (Berliner, 2018). In fact, Elliott and colleagues (1995) found that 20% of the offenders in their sample admitted they gained the trust of the child's family with the purpose of abusing the child. By educating a larger community about risky behaviors that are typically part of the grooming process, there is a greater possibly that an alert adult will intervene to interrupt a potential grooming situation. The programs Sharon and her colleagues developed are presented to adults who work or volunteer in venues throughout the community, including schools, day care centers, youth-based programs, and elsewhere.

Three Program Goals

Sharon's program, entitled Keeping Them Safe, is unique compared with other training programs. It uses either an interactive play format with additional specialized scenarios or a PowerPoint presentation and facilitated discussion. It trains adults in the community to watch for these behaviors in their

own interactions and those of others. The scenarios presented mimic common interactions that audience members may observe between adults and children. The program's focus has three major elements:

First, it teaches adults how to identify and recognize the eight key potentially risky adult behaviors.

Second, it teaches adults the importance of avoiding normalizing these behaviors in interactions with children.

Third, it teaches adults how to intervene and interrupt risky behaviors anytime and anywhere they see them.

By preventing any adult, regardless of intent, from engaging in these behaviors, child sex offenders no longer have a path through which they can engage children in the grooming process. For instance, Sharon trains people that it is not okay to give a child a gift without the parents' permission. If they see other adults giving children gifts without the parent's consent, they need to intervene and explain the risk of engaging in such behavior. Her program does not involve accusations, but instead, preventing situations that normalize possible openings for sex offenders to groom children. The goal of the Keeping Them Safe program is to make sure there is no opportunity for abuse to occur, by educating adults and teaching them what to pay attention to. The program shows adults that it is easy to intervene to prevent or interrupt situations that can facilitate the grooming process, even if the intent in a particular situation was honorable.

Impact of Sharon's Work

Sharon's work has had a tremendous impact on the Catholic Church and beyond. The original program Sharon and her team developed is now used in more than 125 Catholic dioceses in the United States, Latin America, the Greater Antibes, and Ireland. In total, more than five million adult Catholics have participated in the adult education program originally created by Sharon and her team and offered to Catholic communities by the National Catholic Services' VIRTUS Team.

Additionally, Sharon's later program, Keeping Them Safe, reduces the likelihood that trauma intervention will be needed, thus improving the general health of society. Specifically, Sharon's approach is designed to reduce sexual abuse of children within the faith community and beyond by teaching adults how to prevent abuse rather than only intervene after the fact or leave the responsibility for preventing abuse solely to the children themselves. The Keeping Them Safe program has been offered hundreds of times in an array of organizations, including churches, schools, youth-serving organizations, and day-care facilities. The program has been given as a community-wide presentation sponsored by Child Advocacy Centers and within Native American tribes. The design and flexibility of the Keeping Them Safe program allows it to be interwoven with other prevention programs to provide the best chance to protect children from predators. More recently, a version of the Keeping Them Safe program was developed for incarcerated women to help them remain active in their children's lives while in prison and during their transition back into society.

Preliminary research supports the Keeping Them Safe program as a means for educating community members about risky behaviors. Results of small program assessment indicated that even with only an initial presentation of the material, participants were significantly better able to identify and set aside myths about sex offenders, better able to recognize behaviors as non-risky that they had previously considered risky, and more likely to intend to intervene when they see potentially risky behaviors than they were prior to the training (Guard, 2017). They also learned to identify potentially risky adult behaviors, but given the limited sample size, the results did not quite reach statistical significance after only an initial presentation. The study concluded that there was some evidence that, after participating in Keeping Them Safe, participants are better able to discern risk in observed behaviors between children and adults.

Suggestions for Organizations

According to Sharon, creating safe environments takes persistence and creativity, but it can be done. Adults can be reached through online training, PTA meetings, and mandates made to adults working in youth-serving organizations, schools, and churches.

Developing Leaders Who Stress Community Participation

As Sharon noted, the main obstacle to such programs is leadership in these organizations; leaders need to be convinced that creating safe environments is crucial. Leaders may be swayed for different reasons. Sometimes it takes discussing statistics to convince leaders. This could include pointing out the costs of failing to act, which include the long-term damage to children and adults (e.g., ACE scores), the financial costs to the organizations of dealing with the aftermath of child sexual abuse, and the emotional toll that child molestation has on families and communities.

Other times, leaders can be convinced through necessity. For instance, if funding through the United Way or other major funders is contingent on organizations requiring that any program that serves children must include adult-focused prevention education for staff and participants, organizational leaders are apt to support such training.

Finding ways to engage adults is not impossible, but it is a challenge. Training such as the Keeping Them Safe program can be presented in any setting where adults are gathered, such as school programs and workplace meetings. For instance, schools can require all parents to complete the program as a condition of participating in or even attending events at the school. Legislation such as Oklahoma Statute §43-107.2 that current requires divorcing parents to attend certain classes (see "Actions where minor child involved," 1997) could be expanded to include the critical aspects of the child sexual abuse prevention program that focus on educating parents about the potentially risky adult behaviors that place children at risk of grooming. Sharon believes that one of the most important future directions of this effort is the creation of numerous ways to engage adults and mandate their participation. Based on her experience delivering the program, once adults have gone through the program, they see its value. It is getting them to attend the training in the first place that is the challenge.

The program now can be offered through online live training and is being developed into a self-directed training module. In its new format, it can be offered as an available training module for all employees in organizations through their Learning Management System (LMS). Organizations could require that all employees and volunteers complete the program at least every two years. Similarly, granting agencies can require completion of this type of education as a prerequisite for funding any program involving or serving children. Additionally, churches that have not done so can also require all those with regular contact with children to complete a training program that covers this information. Furthermore, when implemented in faith-based communities, the program can specifically address how theological practices (e.g., confession) and beliefs may facilitate child sexual abuse or prevent reporting of instances of abuse.

Encouraging More Research

While preliminary research has provided some support for the Keeping the Safe program in terms of helping adults identify risky behaviors, much more research is needed. For instance, the Catholic Church and other organizations should conduct more rigorous research to determine what aspects of the program are most effective and any areas of the program that could be improved.

Reflections

Jennifer Kisamore: I became aware of the Keeping Them Safe program and Sharon's work to prevent childhood sexual abuse when one of my students asked to conduct an evaluation of the Keeping Them Safe program as part of her graduate work (see Guard, 2017). I attended one of the interactive

plays and found the format interesting as well as educational. Sharon's group does a great job of showing how easy it is to intervene when risky behaviors are occurring. It was eye-opening to me to see how we may be unintentionally allowing sex offenders access to our children through risky behaviors that we have normalized. Since attending the Keeping Them Safe program, I've been able to intervene in situations and educate others when they are engaging in behaviors that put children at risk of harm.

Erica Frazier: I first learned about the Keeping Them Safe program when I met Sharon through our shared work on the CAP Action Committee. I was instantly intrigued and excited to learn about this innovative program that educated and empowered adults to protect kids from sex offenders by preventing sexual abuse from ever happening. In my community, all efforts have been focused on educating children, placing the responsibility on them to recognize and interrupt the attempts of sex offenders. Although I believe it is important to educate children on healthy boundaries and bodily autonomy, I have always felt that something was missing in this singular approach. I quickly signed up to be trained as a Keeping Them Safe facilitator with the hopes of impacting my community with the tools needed to create policies and practices to protect our youngest citizens.

Keeping Them Safe has helped adults take actionable steps to protect the children in their lives and communities, which is ultimately an investment in future outcomes. When adults learn about potentially risky behaviors, they are consistently surprised at how common some of these behaviors are and how easy it is to intervene without causing offense. The information in Keeping Them Safe provides practical ways to make significant impact in the lives of children. I believe that the ease of implementation and the sensible guidelines have helped this information be well-received by parents, grandparents, professionals, and others learning the program. For me, it is encouraging to know that there is an easy-to-understand method to equip adults to safeguard the children they come in contact with day to day. I believe that we all have a collective responsibility to create safe environments for children to grow and thrive.

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Appendix: Identifying Risky Behaviors to Prevent Child Sexual Abuse

Sharon and her team identified eight risky behaviors. When individuals without an intent to harm children normalize these behaviors, they present opportunities for sex offenders to gain access to and groom children for sexual abuse. The behaviors are as follows:

1. **Giving gifts without permission.** An adult giving gifts to children without obtaining parental permission is a risky behavior regardless of the intent. Sex offenders give gifts without permission and tell the children not to tell.
2. **Ignoring parents' rules.** When adults ignore a child's parents' rules, children are put at risk. Sex offenders seek to gain the child's trust and to separate the child from the parents or guardians by ignoring their parents' rules and encouraging the child to ignore them too.
3. **Encouraging secrets.** Sex offenders start with small secrets to interrupt parent–child communication with secrecy, which may later be used as intimidation. *Secrets* in this regard must be differentiated from *surprises*. Secrets are to never be told; surprises are to be told at a clearly identified later time, such as Christmas or on a birthday.
4. **Indulging children.** Indulging children includes allowing them to participate in activities or have items that parents or guardian might not allow and doing so without the consent or foreknowledge of the parents or guardians. This can be large and small things. For example, allowing children Internet access they don't have at home or giving them snacks parents don't allow. Again, secrecy is involved.
5. **Always wants to be alone with children.** Adults who always want to be alone with children are risky. Sex offenders want to be alone with children in places where they cannot be observed by other adults. They cultivate and arrange those liaisons to ensure privacy.
6. **Too much touching.** Touch between children and adults should be child-initiated. When adults engage in activities such as wrestling and tickling, they may normalize touch that exceeds the appropriate boundaries for touching children.
7. **Rules don't apply.** When an adult operates as if they can ignore the rules that apply to others, they are engaging in risky behavior. Operating outside of the bounds of socially accepted rules or refusing to obey new policies and procedures applies both in the sexual seduction of children and in general facets of life.
8. **Preference for children.** Enjoying working with children does not mean someone is a predator, but sex offenders are individuals who never tire of being with children. In fact, sex offenders always prefer being with children over being with other adults.

Addressing the Outliers: Urging Consensus in Child Sexual Abuse Evaluations

Hollye Gallion, MSN, PNP-BC, SANE-P; Leanna Dugan, MSN, CPNP, SANE-P; Hannah Kestner, DNP, CPNP; Lori Littrell, MSN, FNP-C, SANE-P

Abstract

Attached is a commentary written by the four nurse practitioners at Our Kids Center in Nashville, Tennessee. It was written as a response to and in support of "Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2023" authored by Kellogg, Farst, and Adams and published in September 2023. It further highlights the need for consistency in practice and evidence-based interpretation of findings in child sexual abuse forensic medical exams. Our Kids Center is an outpatient clinic of Nashville General Hospital and affiliated with Monroe Carell Jr. Children's Hospital at Vanderbilt. The nurse practitioners are adjunct faculty at the Vanderbilt University School of Nursing. In the 37+ years of providing care to children with concerns of sexual abuse, Our Kids Center has evaluated over 31,000 children and serves approximately 47 counties across middle Tennessee.

Keywords: *Child sexual abuse, Medical evaluations, Evidence based practice, Interpretation of medical findings, Forensic evaluation competency*

An updated version of the "Interpretation of Medical Findings in Suspected Child Sexual Abuse" was published in September 2023 (Kellogg et al., 2023) along with a supporting editorial by Starling (2023). Since its inception in 1992, it has been an ever-evolving, comprehensive review of research related to providing medical evaluations to children for whom there are concerns of sexual abuse. It has been published eight times over the course of 30 years by specialists in child abuse pediatrics. With each iteration, new research and practice recommendations are added to reflect scientific updates and improve trauma-informed care. This publication has been, and continues to be, an evidence-based guide for clinicians in the field of child maltreatment, highlighting recommendations for interpretation of medical findings and the testing, treatment, and interpretation of sexually transmitted infections (STIs). Despite these evidence-based recommendations, providers in this field repeatedly practice outside of these guidelines.

Problematic Practice

With the most recent update, there is an evident focus on the variation in rates of exam findings depending on examiner discipline, exam techniques, and interpretation criteria used. In the latest update, studies conducted over the last 20 years were reviewed and rates of anogenital injury for each were included (Kellogg et al., 2023). These studies were categorized according to whether they adhered to the "2018 Interpretation of Medical Findings" criteria. The prevalence of injury in acute exams varied widely (from 14.2% to 85%) and were higher when providers included findings such as redness, edema/swelling, and positive uptake of toluidine blue, which are not specific to or diagnostic of trauma. The rate of positive findings was lower when the exams were conducted by child abuse pediatricians or child abuse specialists (Kellogg et al., 2023).

A similar difference in accurately identifying and defining findings was previously observed in a 2012 survey conducted by Joyce Adams and colleagues. The study examined providers who evaluate children with concerns of sexual abuse and their ability to interpret normal and

abnormal exam findings. It sought to determine if and how education, experience, participation in peer review, and remaining up to date with child abuse literature influenced providers' interpretation of exams. General pediatricians, sexual assault nurse examiners (SANEs), and advanced practiced nurses who examined fewer than five children per month scored significantly lower than child abuse experts. The paper went on to say that providers who consistently perform multiple exams, stay up to date on child abuse research, and participate in expert peer review are more likely to correctly identify both normal and concerning findings on anogenital exams (Adams et al., 2012). Although access to care is paramount for children who have experienced sexual abuse, the goal of having a provider in every community, virtually ensuring a low patient volume, is not trauma informed. We must not place convenience over experience and expertise.

In our experience, there is a wide variation in the quality and accuracy of the content used in some child sexual abuse/assault training. There is content (assessment tools, exam techniques, and interpretation criteria) taught in some pediatric SANE courses that is outdated and unsupported by research. One such example is the Hymen Estrogen Response Scale (HERS), which is promoted as a useful tool to assess changes in the hymen and genital structures with pubertal development (Alexander et al., 2017). This tool is concerning given several of the variables such as "sensitivity to touch" and "distensibility" used in the scale to assess that estrogen's effect on the hymen would be painful and invasive if used in prepubertal females. Another such tool is the TEARS criteria (tears, ecchymoses, abrasions, redness or swelling), which includes non-specific diagnostic criteria, redness, and swelling as definitive for trauma (Baker & Sommers, 2008; Rossman et al., 2004; Rossman et al., 2021).

In the preface of *Child Sexual Abuse Assessment: SANE/SAFE Forensic Learning Series*, the authors stress that to provide the best care for their patients, one "must regularly supplement their base of knowledge and experience with continuing education, training, and review of current best practice in their field" (Speck et al., 2018, p. ix). After such a forward-facing call to evidence-based practice in the preface, there are several recommendations that are not standard of care and are either unnecessary and invasive to children or long outdated. The suggestion that the antiquated Woods' lamp be used as an alternative light source during acute exams is incorrect given that its specific light frequency has been shown to be ineffective (Eldredge et al., 2021). In the same course material, it is recommended to type anogenital warts in children (Speck et al, 2018, p. 29). Given warts are extremely common in children and both cutaneous and mucosal HPV subtypes can be found in the anal or genital region, wart subtyping is not helpful in differentiating sexual and non-sexual transmission (Kellogg et al., 2023) and is an unnecessary and painful procedure for children. There has always been variation in the training, qualifications, and practice of providers in this field. While the background of providers can remain diverse, there is a great need to come together on how we define injury/trauma and the research we use to support these definitions. Over the past three decades, there have been papers that are "outliers" and take an opposing view to what is currently held as scientific fact, such as the article by Hariton (2012) arguing that a child cannot be penetrated and have a normal genital exam or the 2007 paper by Goodyear-Smith opining that gonorrhea can be frequently transmitted in a nonsexual manner.

There are also publications that are seemingly helpful to new child abuse providers but are fraught with highly concerning recommendations. In *Child Abuse: Quick Reference* published in 2017, there are recommendations and statements that are not only inaccurate but also ethically questionable and break from empirically supported practice. These include recommendations such as using a small pediatric speculum on "peripubertal" girls, if under conscious sedation, to assess their transverse hymenal diameter to determine if a foreign body, such as an erect male penis, could fit; using a gloved finger to palpate a hymenal transection for scar

tissue; stating definitively that a burning sensation while passing stool following anal penetration is diagnostic of trauma; and that enlargement of the hymenal opening is concerning for residual trauma (Alexander et al., 2017).

Many of these "findings" have been repeatedly studied for the past 30 years. Providers in the field now know that many findings previously thought to be the result of trauma are nonspecific or normal variants of anogenital anatomy such as erythema, venous congestion, or the size and shape of the hymenal orifice (Berenson, 1998; Berenson et al., 2002; Heger et al., 2002[b] McCann et al., 1989; McCann et al., 1990; Myhre et al., 2001; Myhre et al., 2003). It appears that in recent years, there is a much greater divergence in child sexual abuse literature, best practices, exam recommendations, and findings. We have seen this "alternative" side of child sexual abuse literature passing for quality research seep into classrooms, exam rooms, and ultimately court rooms.

Our Recommendations

If providers are performing forensic medical exams in relationship with a Child Advocacy Center (CAC), there are basic medical standards that must be met for the CAC to be or remain accredited. In section 5 of the 2023 National Children's Alliance (NCA) standards, it states that providers must show documentation of their participation in continuous quality improvement activities and that all exams in which there are abnormal findings or findings "diagnostic" of trauma must be reviewed by an "advanced medical consultant." Furthermore, it stresses that the accuracy of the exam is critical not only for the safety and well-being of the child but also for the integrity of the investigative and judicial processes (National Children's Alliance, 2023).

We know that the history provided by the child is the greatest diagnostic clue that he or she has experienced sexual abuse. We know that most children delay in reporting; that most offenders are known and trusted by the family, and that evidence and injury are rare (Adams et al., 1994; Gallion

et al., 2016; Gewirtz-Meydan & Finkelhor, 2020; Heger et al., 2002[a] Heppenstall-Heger et al., 2003; Hornor et al., 2022; McCann, 1998; Smith et al., 2017; Thackeray et al., 2011). We also know that the more exams you perform the more accurate your diagnoses will be (Adams et al., 2012; Gavril et al., 2012), which is likely true of all professions, is it not? If so, why are expert providers in this field not demanding that training in forensic medical evaluations, including exam techniques, high quality digital imaging or video, STI testing, and the correct interpretation of any findings, be accomplished using evidence-based and peer-reviewed literature? We must build a better infrastructure for accountability to ensure best practices.

Beyond training, if a provider is unable to capture high-quality digital imaging on exam *and* have expert review on all cases, he or she is doing a disservice to the victims served in this field by continuing to practice without these supports. Research indicates that one of the most important factors in diagnostic accuracy over time is consistent expert review (Adams et al., 2012). The *National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric* mirrors these recommendations for evidence-based training; consistent peer review; mentoring by experts in the field; and ongoing education (U.S. Department of Justice [USDOJ], 2016). Without upholding these crucial components of our field, providers risk overcalling exam findings (Adams et al.,

2012; Campbell et al., 2010; Gavril et al., 2012; USDOJ, 2016). These false positives can lead to a miscarriage of justice and impact the natural resiliency of children and families.

Conclusion

We want to prevent a new generation of child sexual abuse providers from being trained inaccurately and practicing ineffectively. Despite their own good intentions, providers may misinterpret medical findings and negatively affect the outcomes for victims—emotionally, physically, and judicially—for years to come. As we move forward, it is incumbent upon both new and seasoned providers alike to adhere to evidence-based practice and hold each other accountable, regardless of education, years in the field, or number of exams performed. As Starling suggests in her editorial, widespread adoption of the scientifically rigorous Adams criteria could reduce error and improve diagnostic accuracy (Starling, 2023). We must all be on the same page, or it will be the families and children we serve that will pay the price. As the 2023 Update so eloquently stated, providers, regardless of discipline or experience, must work together to reach consensus on what is interpreted as anogenital trauma and agree to adhere to the research that underpins these findings (Kellogg et al., 2023). Now is the time.

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StepWise 360

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Abstract

The StepWise approach to interviewing is an evidence-based, memory-informed, semi-structured model for conducting investigative interviews that has been in use since the 1990s. In Canada, the StepWise approach to interviewing is widely recognized as a leading model for interviewing children and youth in the criminal and child protection context. The StepWise 360, the latest iteration, incorporates new theoretical, empirical, and practical developments in the field. A key feature of the StepWise 360 is that it is adaptable to various types of investigators, such as police, child protection workers, or mental health specialists, to gather reliable information from victims, witnesses, suspects, and clients of all ages. Each step of the StepWise model is discussed within the context of relevant empirical literature. Methods to tailor the interview to each interviewee in a client centered, trauma-informed manner, and deal with present real-world limitations are discussed.

Keywords: *StepWise, StepWise 360, child interview guidelines, forensic interview, types of interview questions, funnel approach to interviewing, interview steps, interview training*

The StepWise Interview, developed by Dr. John Yuille in the 1980s in collaboration with lawyers, clinicians, and law enforcement, was one of the first evidence-based interviewing approaches created for interviewing children (Yuille et al., 2009; Yuille, 1996). The approach continues to follow the best-practice guidelines of the American Psychological Association (APA; 2006) (e.g., utilizing open-ended questions, conducting practice narratives, and rapport building) and the National Children's Alliance standards (2023) (e.g., utilizing multidisciplinary teams during investigations, conducting case reviews, and tailoring the interview with cultural context). To uphold these standards, StepWise is continually updated (most recently to StepWise 360) in response to new lab and field research. The StepWise 360 is currently used by many law enforcement and child protection agencies throughout Canada (Brubacher et al., 2018).

The StepWise 360 and its previous iterations have developed over the last three decades in tandem with many similar forensic interviewing guidelines such as the APSAC Practice Guidelines (APSAC Taskforce, 2023), the Enhanced Cognitive Interview (ECI; Fisher & Geiselman, 1992; Paulo et al., 2013), the National Institute of Child Health and Human Development (NICHD) protocol (Ahern et al., 2019; Lamb et al., 2007; Karni-Visel et al., 2019), CornerHouse protocol (Anderson et al., 2010), ChildFirst protocol (previously *Finding Words*, developed in collaboration with the National Center for Prosecution of Child Abuse and Cornerhouse; Farrell & Vieth, 2020), the 10-Step Interview (adapted from the NICHD protocol; Lyon, 2014), the NCAC Child Forensic Interview (National Children's Advocacy Center, 2019), and others. Because each approach draws from a shared literature and best-practice guidelines, there is significant overlap among forensic interviewing models. For example, all approaches encourage rapport building, beginning the discussion of the topic of concern with broad, open-ended questions, avoiding leading and suggestive questions, and so on. However, there is some disagreement on the best way to structure a forensic interview. The NICHD takes a more structured approach that provides a script and instructions, while others, such as Cornerhouse, ChildFirst, and the StepWise 360, take a more flexible semi-structured approach.

The Problem of Adherence—Teaching, Resources, and Continuing Education

The structured approach of the NICHD was motivated largely by the lack of adherence of even trained forensic interviewers to best-practice guidelines (see discussion in Lamb et al., 2008). As such, Lamb and colleagues developed a scripted protocol (which includes what to say) to guide interviewers into following best practices (see Orbach et al., 2000). The NICHD protocol has been empirically validated and shown to increase the completeness and accuracy of children's reports (Lamb et al., 2007; Orbach et al., 2000). It has since been modified to enhance emotional support for interviewees (Ahern et al., 2019; Karni-Visel et al., 2019).

The StepWise has always followed a semi-structured (rather than a structured) approach to forensic interviewing. We advocate for a semi-structured approach to ensure that each interview can be catered to different contexts and interviewees. For instance, some interviewees may have a cultural background that requires a culturally-agile approach. Being culturally-agile means recognizing that each person has a unique history influenced by their cultural background, which may impact their behavior, language use, and social norms. We acknowledge, however, that semi-structured approaches, like the StepWise, may require relatively more interviewer training, although protocol adherence is an issue faced by all models irrespective of whether they are structured or semi-structured. Ongoing training is often needed to address this challenge, specifically *interviewer drift*—falling back on bad habits (Lamb et al., 2002a; Mitcheson et al., 2009; Read et al., 2013).

We work to address interviewer drift in two ways. First, we advocate for (and offer) ongoing training, refresher courses, job-relevant resources, and training guides to supplement StepWise 360 training. Indeed, intensive training followed by continued learning have been shown to improve interviewer drift (Lamb et al., 2002b). Second, we use evidence-based learning strategies derived from both basic research on learning and memory and research on education and teaching pedagogy in our training. Next, we discuss three such strategies, content scaffolding, generative learning, and spacing (though further strategies are employed, we constrain the discussion to these points for brevity).

Content scaffolding involves tuning the learning support to the knowledge and skills of the learner and continually monitoring comprehension (Azevedo et al., 2011; Chi et al., 2001; Theelen & van Breukelen, 2022). In StepWise training, we move slowly from the basics of formulating effective questions, to memory-informed interviewing, to transcripts and exercises related to specific steps of the StepWise 360, to videos of multiple steps, ending with a live practice interview. Thus, the material builds on itself from the ground up. Regular question periods and end-of-day comments and feedback allow instructors to continually monitor comprehension and adapt learning strategies to the needs of the learners. Finally, real-world examples of concepts are tailored to the existing knowledge and context that each learner comes with (e.g., a social worker will come in with a different knowledge base, context, and aim than a police officer). Thus, our approach is consistent with a content-scaffolding approach to teaching.

Another learning strategy that is used in StepWise 360 training is *generative learning*. Decades of research has shown that learner-generated content is remembered better than read or provided information, with meta-analysis showing that the fewer constraints that are put on what is generated, the stronger the generation effect (McCurdy et al., 2020). Trainers employ generative learning by querying learners on concepts and providing the opportunity for small-group exercises before explaining and reinforcing the relevant empirical research in a lecture format. Learners thus generate the ideas both in small groups and in self-reflection exercises rather than through passive learning alone.

Consistent with psychological research on distributed practice (i.e., spacing effects) and long-term retention of information, trainers also provide distributed learning by *spacing* out learning both on a daily scale (inserting pop quizzes and various formative assessments) and

a weekly scale (revisiting important topics after one or more days from initial learning) that have been shown to improve retention (Cepeda et al., 2006; Son & Simon, 2012).

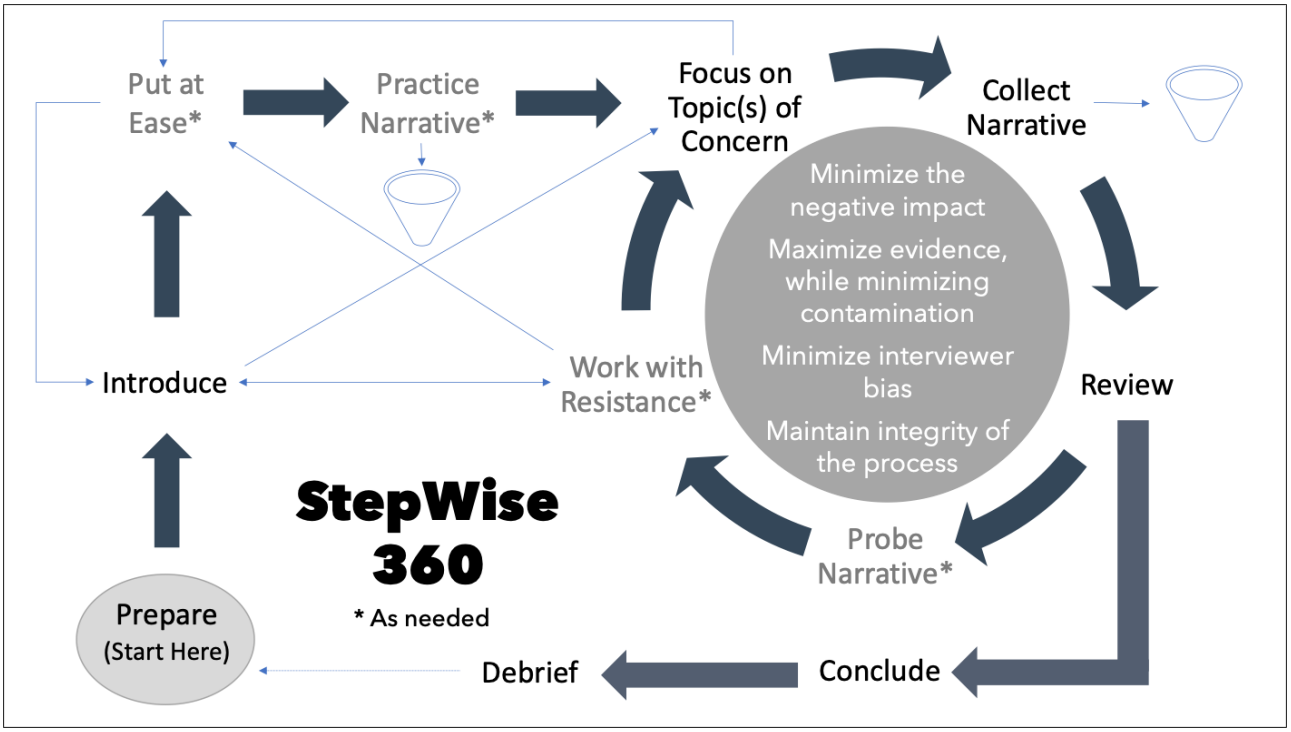
The semi-structured approach demands more interviewer expertise than do fully structured interview formats. Though some amount of interviewer drift will occur, we take a pragmatic approach by employing best practices in teaching and learning and following up with organizations to support continuing education to minimize interviewer drift as much as possible.

Overview of the StepWise 360

The StepWise 360 was designed with four goals in mind: (a) to minimize the negative impact of the interview on the interviewee, (b) to minimize interviewer bias, (c) to maximize evidence while minimizing evidence contamination, and (d) to maintain the integrity of the process (as defined by the workplace context). The StepWise 360 includes 11 steps (see Figure 1) designed to achieve these goals. As we will illustrate, steps are labelled as *mandatory* or *as needed*. The *wise* of StepWise 360 refers to the wisdom to know when and how to modify the structure, steps, and strategies to meet the unique needs of clients, the distinctive features of cases, and the different requirements of our workplace contexts, including those caused by often-limited resources (i.e., time and workload constraints). The goal is to provide interviewers with a flexible approach so that they can conduct the best interview possible within the contexts of the real world while acknowledging that there is no such thing as a perfect interview. Believing that interviewer development is an ongoing process, rather than an end goal, learners are encouraged (and provided the resources) to continue their training on the job, conduct self-evaluations, and participate in formalized peer review.

In the remainder of this paper, we provide a description of each of the *steps* of the StepWise 360, discuss the empirical literature that supports the steps, and provide examples of how to tailor various steps. A detailed instruction of how to carry out each step is beyond the scope of this paper. Instead, we aim to provide enough detail to describe the structure and value of each step while illustrating the evidence base for the StepWise 360.

Figure 1: The Progression of a StepWise 360 Interview



Note. An asterisk indicates that the step is completed on an "as-needed" basis.

Describing the Steps of the StepWise 360

Prepare Step (Mandatory)

Objectives and Strategies

The first step to any interview is to prepare. The objective of the Prepare step is to gather information about the client, case, and context, develop a semi-structured interview plan, and set up the place and time of the interview. Some research about the interviewee (from primary caregivers or other sources) will be required to anticipate cultural, developmental, physical, and/or emotional needs prior to the interview. Accommodating these needs starts with selecting the best available location and time to conduct the interview. Preparing also means reviewing relevant policies and procedures as well as learning and developing hypotheses about the case to ensure that workplace requirements are being met. Rohrabaugh and colleagues (2015) offer a useful review of considerations during the preparation phase of an interview.

Rationale for a Mandatory Prepare Step

The Prepare step is necessary and mandatory first to uphold the American Psychological Association's (2003) guidelines for maintaining cultural competence. Specifically, background research is necessary to uncover culturally unique language, symptoms, norms, gender roles, and social class structures (see Rioja & Resenfeld, 2018, for a review). Learning about an interviewee's culture, developmental level, mental health, and physical needs respects their individual differences and can aid in understanding their interviewing behaviors (APSAC Taskforce, 2023; National Children's Advocacy Center, 2019; Poole & Lamb, 1998; Russell, 2004; Walker et al., 2013).

The Prepare step is also useful for rapport building. A common rapport building strategy in many forensic interviewing protocols is to ask open-ended questions about a neutral topic to assess the needs and verbal competence of the interviewee (Anderson et al., 2010; Hershkowitz, 2011; Price et al., 2016). Researching the cultural background, needs, and hobbies of the interviewee can help with a baseline assessment of verbal competence as well as to plan an appropriate topic for rapport-building discussions (neutral topics are useful for both the Put at Ease step and the Practice Collecting the Narrative step, both discussed shortly).

Finally, the Prepare step is useful for bias mitigation. A growing number of studies have shown that confirmation bias—the propensity to confirm one's pre-existing belief—can impact both the search for and the interpretation of information and is a significant issue for forensic investigators (Kassin et al., 2013; Nickerson, 1998; Rassin et al., 2010; Zhang et al., 2022). Hindsight bias —the propensity to overestimate the likelihood of an event once outcome information is known— has also been identified as an issue in forensic psychology and law (see Giroux et al., 2016, for a review). The literature on bias mitigation suggests that considering multiple hypotheses is a useful strategy for reducing hindsight bias and confirmation bias (Anderson, 1982; Arkes et al., 1988; Carli & Leonard, 1989; Hirt & Markman, 1995; Lord et al., 1984; van Brussel et al., 2020; see Larrick 2004 and Neal et al., 2022, for reviews). The Prepare step provides this opportunity, as investigators can (and should) generate multiple hypotheses about the case prior to meeting with the interviewee. This practice is encouraged by academics, existing forensic interviewing protocols, and policymakers (Anderson et al., 2010; APSAC Taskforce, 2023; Kassin et al., 2013; Rahrabaugh et al., 2015). This is a mandatory part of the StepWise 360 Prepare step given research showing that professionals often have poor insight into their biases and how to manage them (Zappala, et al., 2018).

Tailoring the Prepare Step

As we will illustrate, preparation can lead to information about your interviewee that is useful for tailoring other steps (e.g., Introduce step; Work with Resistance step, etc.). Although available information about interviewees will vary across contexts, the more complex a case is, the more time should be spent preparing (Yarbrough et al.,

2013). For example, when interviewing a child, contacting a parent or guardian before the interview is recommended to ensure that the interview is tailored to the developmental and emotional needs of the child being interviewed. Although preparation is important, we acknowledge that there are situations in which interviewers will have very little time to prepare. However, we argue that there is always time for *some* preparation (e.g., setting up the room, generating hypotheses).

Introduce Step (Mandatory)

Objective and Strategies

The Introduce step is an opportunity to explain the purpose of the interview, the process that will be followed, and the policies involved in a trauma-informed manner that respects informed consent. Interviewers should introduce everyone in the room, including their role, and explain the purpose of the interview, note taking and recording, and the rights of the interviewee, all while using language that is appropriate for the developmental level and culture of the interviewee. It is also the first opportunity for the interviewer to check in with the interviewee to ensure that their needs are met.

Rationale for the Introduce Step

One of the main goals of the introduce step is to create a safe, predictable, collaborative environment where the interviewee can make an informed decision to participate and feel comfortable providing a complete and accurate report. Establishing safety, trust, collaboration (where possible), empowerment, and role clarity and managing power imbalances are all consistent with trauma-informed best-practices (see Goldenson et al., 2022, for a review). Providing interviewees with a brief description of how the interview will proceed, an explanation of any recording equipment, and key policy requirements is also a recommended best-practice (National Children's Advocacy Center, 2019). Predictability is often reassuring to anxious individuals and those experiencing acute trauma reactions (Haskel & Randall, 2019).

Tailoring the Introduce Step

A semi-structured approach allows interviewers to adapt this step: (a) to their context (e.g., victim vs. suspect interview; workplace policies) to maintain the integrity of the process and (b) to the developmental, cognitive, and/or emotional level of the interviewee in order to conduct a client-centered interview (Ballard & Austin, 1999; National Children's Advocacy Center, 2019; Poole, 2016; Walker et al., 2013).

For example, imagine a police officer is interviewing a youth. The manner in which the roles are explained will vary depending on the youth's age, as well as the youth's personal, familial, or cultural history with law enforcement. Past negative experiences with law enforcement could be addressed by focusing on the officer's role in providing the youth every opportunity to share what happened in their own words rather than focusing on their role in maintaining public safety. If the youth has felt unfairly treated by the police in the past, the latter might produce reluctance. Note how information gathered in the Prepare step can be useful here.

Put at Ease Step (As Needed)

Objectives and Strategies

The main objective of the Put at Ease step is as it sounds—to allow everyone in the room to settle. This step should be employed as needed when interviewing someone displaying stress, anxiety, or reluctance. By reluctance, we mean an interviewee's inability or unwillingness to converse with the interviewer or talk about certain topics. In the StepWise 360, reluctance due to discord and strong emotions are addressed in this step, while ambivalence-related reluctance is tackled in the Work with Resistance step (discussed later). At minimum, the interviewer engages in a conversation or activity to assess the interviewee's baseline level of communication and develop rapport. The interviewer can return to this step at any point in the interview.

Rationale for the Put at Ease Step

The Put at Ease step is placed third in the order of interview steps to highlight the importance of identifying and addressing reluctance early in the interview process (Blasbalg et al., 2019; Lewy et al., 2015). When reluctance is present, the interviewer should try to identify its source, as different types of reluctance should be addressed differently. For example, trauma-related avoidance will need a different approach than reluctance due to a lack of rapport with the interviewer or ambivalence about sharing incriminating or sensitive information (Haskel & Randall, 2019; Miller & Rollnick, 2002; Vrij et al., 2014).

Practice Collecting the Narrative Step (As Needed)

Objectives and Strategies

In the Practice Collecting the Narrative step, the interviewer demonstrates the types of questions they will ask and shows the interviewee the level of detail in the answers that they are seeking. The interviewee is asked to discuss a personally relevant event from their past (often identified during the Prepare step) or a neutral topic such as what they have done prior to the interview. While discussing the event, the interviewer inserts interview instructions (commonly known as "ground rules") that illustrate the differences between the style of questions and expectations in an interview compared with those in a conversation with respect to the depth, breadth, and accuracy of their report, as well as features of an interview that might otherwise be misinterpreted (e.g., "If I ask a question more than once it isn't because I don't believe you, I just want to make sure I get it right.").[1] Ideally, interview instructions are gradually inserted from the start of the interview as relevant examples come up in the discussion, allowing the interviewer to explain the instructions with an example that is personally relevant to the interviewee. However, certain mandatory instructions (such as correcting the interviewer if they make a mistake) may need to be explained by the end of this step if a natural example does not arise (see Anderson et al., 2016).

Rationale for the Practice Collecting the Narrative Step

Experimental and field research with children suggests that practice narratives can lead to more details and higher accuracy during the substantial portion of interviews (Hershkowitz, 2011; Price et al., 2013; Roberts et al., 2004; Whiting & Price, 2017). Discussion of neutral episodic events during narrative practice has been shown to be particularly effective. Specifically, Price and colleagues (2016) showed that the NICHD protocol, which includes discussion of hobbies and interests followed by a discussion of a neutral episodic event, was superior to the Memorandum of Good Practice model, which doesn't stipulate that the event should be episodic (e.g., school, television, etc.). Specifically, children interviewed with the NICHD protocol produced more productive responses to open-ended prompts about events during the substantive portion of the interview.

Although they were first a part of child interview guidelines, the benefits of practice and using interview instructions during the interview can be beneficial for adults as well (Ali et al., 2020; Vrij et al., 2014). Specifically, Ali and colleagues (2020) showed that adults and older adults who were provided with interview instructions and practice performed better than those without interview instructions and practice in response to difficult-to-answer questions. Participants also provided subjective reports of their experiences during practice, which included improved emotion management, familiarization with the interview process, less inclination to fill in gaps in memory (i.e., guessing), and greater comfort providing qualifying information about things they were unsure about. That said, Brubacher and colleagues (2015) have cautioned that the efficacy and best approach for implementing specific interview instructions are still in their infancy.

[1] Based on feedback from our Indigenous partners, we have adopted the term "interview instructions" rather than "ground rules" in an effort to decolonize our language.

Practice narratives also increase predictability, which is important for trauma-informed interviewing (Haskel & Randall, 2019) and help the interviewer gauge an interviewee's baseline functioning and response style. Thus, the interviewer can tailor the interview to the strengths and needs of the interviewee (Rohrabaugh et al., 2015). Practice narratives can also reveal hot spots (i.e., a change in response style that might indicate a point of importance or an inconsistency in the statement, or between the statement and evidence) and, consequently, indicate possible topics to follow up on later (Palena et al., 2019; Yarbrough et al., 2013). Finally, practice can help address ambivalence by moving interviewees slowly from less difficult topics (e.g., What was going on in your life around that time?) to the topic of concern (e.g., What happened the night you were arrested?). In the process, the interviewer may be able to test hypotheses about offence dynamics and the interviewee's motivation to disclose (Poole & Lamb, 1998).

The Focus on the Topic of Concern (Mandatory)

Objectives and Strategies

The Focus on the Topic of Concern step prompts the interviewee to talk about the topic(s) under investigation in the least leading way possible. The structure of questions flows from broad, open-ended questions that explore the interviewee's *free narrative* (e.g., "Tell me what you are here to talk about today.") to increasingly focused, open-ended prompts that cue the general context (e.g., tell me what happened last weekend) or the general topic of investigation (e.g., "Tell me what happened with Trent last weekend.").

Rationale for This Step

The approach described above follows evidence-based best-practice guidelines being used by many forensic interviewing models (i.e., moving from broad, non-leading cues to more focused cues as needed; APSAC Taskforce, 2023). To help interviewers prepare and deliver such cues in a logical, predictable, and defensible manner, we also provide them with increasingly focused categories of cues (free narrative to general context to general topic). By teaching interviewers how to narrow in on a topic of concern in this way (as opposed to only providing them with specific prompts), we equip them with a technique that can be adapted to a variety of situations and contexts.

Tailoring This Step

When discussing the topic of concern, broader prompts are typically used with victims (e.g., "Tell me what you came here to talk about.") than with suspects (e.g., "As you know, you've been charged with X. Tell me about that."). If reluctance is anticipated, interviewers can prepare different prompts unique to the case at hand. If these fail to cue the topic, interviewers can move to other steps (e.g., Put at Ease; Work with Resistance) depending on the type of reluctance encountered, or pause the interview and attempt it another day (APSAC Taskforce, 2023). Closed questions are avoided, unless required by policy. For example, a closed question—such as "Did your uncle hit you?"—may be asked in the child protection context when abuse is suspected, and when the child appears reluctant. "Yes" responses are to be followed by broad, open-ended questions (e.g., "Tell me more about 'x.'")

When multiple topics are to be covered, interviewers should give thought to the order of topics. This may be done from a trauma-informed lens by allowing the interviewee to choose the order of topics (e.g., from least to most distressing; Haskell & Randall, 2019), or with the aim of eliciting information (e.g., from topics that the interviewer already knows about to less familiar topics; Oleszkiewicz et al., 2014).

Collect the Narrative and Review Steps (Mandatory)

Objectives and Strategies

The Collect the Narrative step focuses on gathering the memory evidence in a manner that minimizes contamination. Again, the structure of questions flows from broad to increasingly focused,

beginning with open-ended questions that elicit the interviewee's free narrative (e.g., "Tell me everything that happened."; "What else happened?"), to slightly more focused questions that elicit missing details (e.g., "Tell me what you were feeling when…"), to more focused, open-ended cued-recall prompts that ask the interviewee to elaborate (e.g., "How did he hit you?"; "Describe where in the house the hitting took place."), or clarify (e.g., "What does "sexing" mean?") their statement. We call this process of moving from broad to focused questions *funneling.*

Interviewers are tasked with exhausting the interviewee's free narrative from beginning to end without interrupting and only moving down the funnel as needed to flesh out—as needed—details about Time, Reaction, Object, People, Intent/Impact, Conversation, Action, and Location (TROPICAL). To help the interviewer and interviewee stay focused, different parts (or scenes) of the free narrative are labelled in the interviewee's own words. Each part is then funneled, preferably in an order chosen by the interviewee. During the Review step, interviewers review their notes to see what is missing and then decide on next steps, either individually or in collaboration with a monitor.

Rationale for These Steps

The structure of questions described above follows evidence-based best-practice guidelines (e.g., start with broad, non-leading open-ended questions to exhaust free recall; cue missing information with non-leading open-ended prompts; flesh out details as needed with cued-recall prompts; review) that are consistent across forensic interviewing models (Ahern et al., 2019; Anderson et al., 2010; Farrell & Vieth, 2020; Fisher & Geiselman, 1992; Karni-Visel et al., 2019; Lamb et al., 2007; Lyon, 2014; Newlin et al., 2015; Yarbrough et al., 2013; Yuille et al., 2009). Somewhat unique from other approaches is the specific way in which we (a) funnel, moving from questions that elicit the free narrative, to questions that elicit missing details to questions that ask the interviewee to elaborate and clarify; and (b) focus recall on one labeled part or detail at a time. The former is supported by research on effective and ineffective question prompts (APSAC Taskforce, 2023), including research showing how questions about perceptions and conversations can elicit missing information without compromising the quality of the statement (Henderson et al., 2023), and the latter, by new developments in research using the Enhanced Cognitive Interview (ECI; Geiselman et al., 1986) protocol. For example, recent adaptations of the ECI have tested the Category-Clustering Recall (CCR) mnemonic in which witnesses focus on one category of information at a time (objects that were at the crime scene; the actions that occurred during the crime; the sounds and voices that they remember, etc.) and provide a report of each. Consistently across studies, adding CCR to the protocol increased the number of correct details reported without affecting accuracy (Ma et al., 2021; Paulo et al., 2016; 2017; 2021; Shahvaroughi et al., 2020; Thorley, 2018). Our approach to funneling draws off the same fundamental strategy, though the exact questions and order of questions may differ from CCR.

Tailoring the Collect the Narrative Steps

This step should be tailored to the aim of the interview: It should be shorter when the aim is to gather essential facts during a preliminary interview, and longer when the aim is to exhaust memory as part of a comprehensive interview. Irrespective of the type of interview being conducted, interviewers must listen for the type of memory being discussed (episodic vs. repeated event memory) and adjust their questions accordingly (Brubacher et al., 2014). To minimize interviewer-caused errors, broad and focused questions should be adjusted to the developmental level of the interviewee (APSAC Taskforce, 2023). To build a strong case, hypotheses about the case should be tested with appropriate questions.

Probe the Narrative Step (As Needed)

The Probe the Narrative step is meant to be used in response to issues with memory retrieval or to test hypotheses about incomplete or suspicious disclosures (e.g., the interviewee has reported something that contradicts evidence). The strategies

and tools used in this step can assist an interviewee to retrieve additional details from their memory or allow the intentionally deceptive interviewee to provide clearer evidence of lies. This step requires more advanced interviewing skills, such as knowing how to use more focused (and sometimes leading) questions, ask questions about evidence in a strategic manner, ask unanticipated questions, use drawings or floor plans, and cue memory in novel ways (Derksen & Connolly 2023; Fisher & Geiselman, 1992; Hartwig et al., 2014; Newlin et al., 2015; Vrij et al., 2010). If used improperly, the strategies and tools used in this step can increase the negative impact on the interviewee or contaminate memory evidence. For example, using context re-instatement can be triggering for traumatized victims, and using backwards recall or floor plans can be too difficult for children or adults with specific disabilities (Haskell & Randall, 2019). Hence, the Probe the Narrative step should only be used if necessary. If undertaken, it should be conducted in a mindful and cautious manner that is tailored to each interviewee.

Work with Resistance Step (As Needed)

The Work with Resistance step was added to address the fact that any interviewee might feel ambivalent about, and therefore appear resistant to, talking about the topic(s) of concern, regardless of whether they are a victim, witness, or suspect. Resistance can take various forms such as refusing to talk, being deceptive, being uncooperative or aggressive, and so on. This step is placed toward the end of the interview for a couple of reasons: (1) to give interviewees the opportunity to freely provide their version of events, and (2) to give interviewers the opportunity to gather sufficient evidence of an interviewee's resistance so that they can effectively address it.

The Work with Resistance step requires more advanced interviewing knowledge and skills: (1) how to challenge hot spots in a manner that demonstrates compassion and promotes autonomy (e.g., "I noticed that every time I ask you about what's happening at home, you look sad, turn your body toward the door, and talk less. If you're uncomfortable talking about what's happening at home, you can just tell me you aren't ready to talk about that. That's ok."), (2) an understanding of motivational interviewing and how to apply it to the context at hand (e.g., change the course of the discussion away from the topic of concern and onto identifying and neutralizing the causes of the resistance; highlighting the benefits of disclosing; identify strategies that would facilitate this process; Miller & Rollnick, 2002; Tedeschini & Jung, 2018), (3) how to present evidence strategically (e.g., introduce evidence about a known topic of concerns to start the disclosure process and motivate the client to talk about other suspected concerns; introduce less significant evidence to initiate a disclosure, while preserving more significant evidence for court; Hartwig et al., 2014), and (4) how to conduct the interview in a trauma-informed manner (e.g., make the interview process more predictable by telling the client early on that you have information to discuss with them later, empower the client through choices as to when and how to discuss this information, and tailor the evidence presentation to minimize its negative impact on the client; Haskell & Randall, 2019; Hervé, 2024).

This step needs to be prepared and executed in a deliberate and thoughtful manner. If strategies are not used to minimize negative impact (e.g., traumatic memories are introduced haphazardly), the interviewer runs the risk of psychologically harming the client. Further, if the interviewer executes these strategies in a leading manner, this may contaminate the memory evidence (and degrade the prosecutorial value of evidence in the process). Therefore, training, practice, and peer feedback are necessary to ensure these steps are executed in a non-leading manner that minimizes negative impact.

Conclude and Debrief Steps (Mandatory)

The main objective of the Conclude step is to end the interview in a conscientious manner so that a positive working relationship is maintained with the interviewee. This requires the interviewer to carefully decide when to conclude the interview and how to best conclude it. With regard to the former, the interviewer might conclude the interview

because the aims of the interview have been achieved or because the interviewee is becoming fatigued. With regard to the latter, the interviewer should make it clear when the interview has been concluded by, for example, bookending it (e.g., "We are done talking for today."). This is a simple way to help reorient the interviewee to the present, after a period of recalling past events, which are often emotionally charged. The interviewer should thank the interviewee for attending the interview and provide information about next steps, which may be to go and reunite with the parent or support person. Some interviewees may require time to return to baseline functioning. Strategies for accomplishing this are similar to those used to build rapport in the Put at Ease step and may include a discussion of a neutral or positive topic or (when interviewing a child) an activity, such as drawing or puzzles (National Children's Advocacy Center, 2019).

Once concluded, the interview should be debriefed, which is to ensure the well-being of all parties involved. This step should start with debriefing the interviewee and anyone else involved in the interview (e.g., support person, interpreter). The reason for this is to connect people with necessary resources. Indeed, CSA survivors in particular are often in need of mental health services (Anderson, 2016; Bonomi et al., 2008; Dube et al., 2005; Walrath et al., 2003). This is also an opportunity to build a communication plan, how the interviewer will follow up with the interviewee to provide investigative updates.

Next, the case should be debriefed with the monitor or supervisors. This is key to identifying issues with the case that require further investigation, time-sensitive evidence that needs collecting, or safety concerns that need to be managed (Anderson, 2016; Newlin et al., 2015; National Children's Advocacy Center, 2019). When the client and case have been debriefed, this step provides the interviewer the opportunity to seek immediate feedback on their interviewing skills. As discussed earlier, peer reviews and feedback can help promote learning and protect against interviewer drift (Lamb et al., 2002b; Mitcheson et al., 2009). Moreover, consulting with peers can provide interviewers with emotional support, as many of the topics discussed in forensic interviews can be distressing for the interviewer (Horvath et al., 2020; Newlin et al., 2015).

Conclusion

Aside from dedicated child forensic interviewers working in child and youth advocacy centers, most forensic interviewers are tasked with interviewing a wide range of clients, from children to adults and victims to suspects. Furthermore, many interview contexts require flexibility and adaptability. Be it workload constraints, public safety concerns, time constraints, or lack of resources (just to name a few), forensic interviewers need to make tough decisions to conduct the best interview possible. Interviews also need to be adapted to the strengths, cultural history, and developmental level of the interviewee and should be trauma informed. This requires interview planning, knowledge, expertise, and experience. Ongoing training is needed to accomplish this.

The StepWise 360 offers this flexibility. The methods of the StepWise 360 are evidence-based and updated to be consistent with the current state of the art in empirical research, while StepWise training programs offer tools for career-long training and development.

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Improving Advocacy for Children Placed in Congregate Care Facilities

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Abstract

This commentary argues for a shift in how child welfare advocates and lawyers represent youth placed in congregate care facilities and for ending the practice of placing youth in out-of-state congregate care facilities.

Congregate care facilities, and especially for-profit facilities, have recently come under intense scrutiny for abuses occurring within their walls. Advocates working directly with youth need to better understand their clients' congregate care experiences as well as the remedies that are available for these young people when they have experienced harm. These remedies include reporting abuses to the proper authorities and watchdog agencies, initiating civil actions, participating in systemic reform efforts, and engaging in legislative advocacy. Further, no child should be placed in out-of-state congregate care facilities, which are costly, subject to less oversight, and far from youths' advocates, communities, and support networks.

Keywords: *Foster Care Abuse, Child Welfare Facility Violations, Residential Treatment Facility Abuse, Youth Advocacy in Residential care*

Recently, congregate care facilities housing youth in foster care, particularly for-profit facilities, have come under intense scrutiny for abuses and rampant misconduct occurring within their walls. In July 2022, the U.S. Senate Committee on Finance along with the U.S. Senate Committee on Health, Education, Labor, and Pensions launched an investigation into allegations of abuse and neglect at facilities operated by four companies: Universal Health Services (UHS), Acadia Healthcare (Acadia), Devereux Advanced Behavioral Health (Devereux), and Vivant Behavioral Healthcare (Vivant)[1] (U.S. Senate Committee on Finance, 2022).

In a 2024 U.S. Senate Committee Report, entitled *Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Facilities*, the Committee found that, as part of their operating models, the four providers ". . . optimize per diems by filling large facilities to capacity and maximize profit by concurrently reducing the number and quality of staff in facilities" (U.S. Senate Committee on Finance, 2022, p. 3). Children in these congregate care facilities

> suffer harms such as the risk of physical, sexual, and emotional abuse at the hands of staff and peers, improperly executed and overused restraint and seclusion, inadequate treatment and supervision, and non-homelike environments. These harms amount to acute safety concerns and have long-term effects, including suffering, trauma and even death. (p. 3)

Many of the report's findings were not news to advocates or the thousands of children and families involved in our child welfare system. This report came after years of allegations of abuse and misconduct

[1] Sequel Youth and Family Services (Sequel) is another for-profit operator of congregate care facilities. In the past several years, Sequel has faced a mass of closures and announcements from multiple states that they would no longer send children to Sequel facilities. The Committee's report focused on Vivant, because

> [i]n 2017, the CEO of Sequel, Jay Ripley, sold a majority stake in the company to a private equity firm. In 2021, after being plagued by reporting on abuse and neglect allegations, Sequel sold 13 facilities to a newly-incorporated company, Vivant . . . , also founded by Jay Ripley. Vivant retained many members of Sequel leadership and its footprint has significant overlap with Sequel's. (U.S. Senate Committee on Finance, 2022, p. 6)

at facilities operated by these companies. All four operators accept children with the most severe needs, who are the hardest to place and who are some of the most vulnerable children in foster care.

Concerns About Congregate Care Facilities for Youth

Universal Health Services

In 2016, *BuzzFeed News* ran a story on UHS, a publicly traded Fortune 500 company and the nation's largest psychiatric hospital chain, exposing the company's practice of unethically locking up patients and engaging in dangerous cost-cutting measures to maximize profits (Adams, 2016; Lurie, 2023a). Subsequently, in July 2020, the Department of Justice announced that UHS had agreed to pay $117 million to resolve allegations of billing for medically unnecessary inpatient behavioral health services and for failing to provide adequate and appropriate services (U.S. Attorney's Office, Eastern District of Pennsylvania, 2020).

Despite this, 38 states continued to send children in foster care to UHS's psychiatric facilities "more than 36,000 times between 2017 and 2022," and "31 states spent more than $600 million on the treatment" of youth in foster care at UHS facilities (Lurie, 2023b, para. 8). According to Ron Davidson, a psychologist who spent two decades investigating psychiatric facilities, youth in foster care are "a gold mine" for UHS (Lurie, 2023b, para. 4).

> Foster children make for profitable patients for the same reasons they're so vulnerable: There's rarely an adult on the outside scrambling to get them out, and often, they don't have anywhere else to go. Plus, Medicaid typically foots the bill. (para. 5)

In line with this, while at UHS facilities, children's

> claims echo allegations that have come up in damning government and media investigations about UHS for years: that the facilities improperly use physical force and chemical restraints, fail to provide adequate treatment and staffing, admit patients who don't need to be there to begin with, and bill insurance for unnecessary services over excessive lengths of time. (para. 3)

Acadia

Acadia, a for-profit company that operates 586 behavioral health facilities, has also faced allegations from multiple states of engaging in child abuse (McDermott, 2019). For instance, in 2019, an Acadia facility in Montana, which housed not only children from Montana but also from other states, including Oregon and Alaska, acknowledged that use of chemical restraints on children—the practice of injecting children to control them—was a "customary" practice (McDermott, 2019, para. 3). Reporting revealed that injections and use of seclusion happened both frequently and for years (McDermott, 2019).

In 2016, children from Alaska reported they "did not like injectable medication (IM) and when they receive an IM they go to bed and sleep all day" (McDermott, 2019, para. 14). Both Oregon and Alaska's child welfare agencies noted problems in 2016, but initially no meaningful changes were instituted (McDermott, 2019). Two years later, in 2018, a former staff member reported that children were injected with Haldol mixed with Thorazine or Benadryl so often that "staff used to joke around and call them 'butt darts' […] and 'booty juice'[2]"

[2] Haldol is a drug used to treat schizophrenia and Tourette's syndrome and Thorazine is an anti-psychotic mediation used to treat schizophrenia and manic depression in adults and severe behavioral problems in children (McDermott, 2019).

(McDermott, 2019, paras. 20, 24). Concerns about Acadia eventually became so severe that Oregon's Department of Human Services announced in 2019 that it would no longer send children to any facility run by Acadia (McDermott, 2019).

Devereux

Devereux, a non-profit company founded in 1912, operates hospital and residential programs, including for youth in foster care, across the country. In 2020, the *Philadelphia Inquirer* reported that "despite bringing in $467 million in annual revenues, Devereux understaffed its campuses and failed to adequately supervise its patients and staff members, who all too often disappeared for hours and slept through shifts" (Wexler, 2024, para. 27). Dozens of children housed at Devereux facilities have also experienced sexual abuse by staff, resulting in a recent class action lawsuit (Dodson, 2023).

Sequel/Vivant

Sequel facilities across the country have subjected youth to various forms of abuse, even killing one child. In April 2020, seven staff at a Sequel-operated facility in Michigan killed a 16-year-old boy after he threw a sandwich at another boy. The staff tackled him to the ground and piled on top of him, cutting off his breathing (Palomino & Tiano, 2021; Kingkade & Rappleye, 2020). This came after years of reports of abuse and violations at the facility (Kingkade & Rappleye, 2020).

Several months later, in December 2020, NBC News dubbed Sequel's youth facilities "a profitable 'death trap'" (Rappleye et al., 2020). Sequel's annual revenue exceeded $200 million, and as of 2017, 90% of that revenue came from Medicaid,[3] Medicare, and 500 federal, state, and local programs (National Disability Rights Network [NDRN], 2021a). "Sequel has been called 'a national magnet for some of the most vulnerable children in foster care, mental health and juvenile justice systems'" (NDRN, 2021a, p. 58).

In the wake of numerous reports of abuse, Washington, California, Oregon, and Minnesota stopped sending children to Sequel's treatment centers (Gilbert, 2022). As a result, since 2019, Sequel has closed 14 of its 36 residential treatment centers. Seven of those happened amid investigations into the facilities (O'Grady, 2022).

Demands for Reform

Ultimately, in 2021, after a flood of investigative reports, outcries for state child welfare reform, and one horrifying story after another of children harmed in congregate care facilities, more than a quarter-million people signed a petition calling on the federal government to ban for-profit companies from caring for children in foster care (Tiano, 2021).[4]

Advocates and reporters lamented that our county had created "an industry addicted to per diem payments that has a profound vested interest in falsely claiming, both to itself and to everyone else, that the children in their care are simply so troubled that no family can handle them and so troubled that they have to be institutionalized for a long, long time" (Wexler, 2024, para. 31). The business model of these operators "banks on governments' incapacity to create safe places for their most vulnerable children" (NDRN, 2021a, p. 8).

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[3] For instance, states pay Sequel $275 to more than $800 per day per child, and Medicaid reimburses Sequel for medical and mental health treatment (Kingkade & Rappleye, 2020).

[4] But problematic facilities are not limited to those operated by for-profit companies (although they are especially bad). For instance, Devereux is a non-profit company. Other non-profit facilities have garnered negative media exposure for their mistreatment of vulnerable youth, including New York's Pleasantville Cottage School, Rhode Island's St. Mary's Home for Children, Arkansas's The Lord's Ranch, and Indiana's Pierceton Woods (Wexler, 2024). And in New York, dozens of agencies operating congregate care facilities—most of which are non-profits—are "seeking a taxpayer bailout" to cover the costs of settling lawsuits brought by children abused while in those placements (Wexler, 2024).

An Overview of the Issue

Definition of Congregate Care

Congregate care is defined as group care in non-family settings and includes emergency shelters, group homes, institutions, residential treatment centers, and psychiatric facilities (Zhou et al., 2021). "[C]linical guidelines suggest that 'congregate care be reserved for the short-term treatment of acute mental health problems'" (NDRN, 2021a, p. 18). In other words, congregate care is supposed to be limited for youth with the highest needs, and the placements, which comprise the least family-like settings, are supposed to be for the shortest periods of time necessary.

These group placements are subject to state licensing requirements, requirements under the Family First Prevention Services Act (2018) if they qualify as a Qualified Residential Treatment Program or one of the remaining three categories of child caring institutions under the law (*see infra* III.F), and additional federal requirements if they qualify as a Medicaid Psychiatric Residential Treatment Facility ("PRTF"). This regulatory scheme is intended to provide critical guardrails around how these facilities function, ensuring they are safe, appropriate, and effective placements for children. For instance, PRTFs must be accredited by the Joint Commission, an organization that sets standards and accredits healthcare organizations in the United States (The Joint Commission, 2024) or another accrediting organization with comparable standards (Centers for Medicare & Medicaid Services, 2024b). They must also complete and submit yearly Attestation Statements to the State Medicaid Agency and report "serious occurrences," including serious injuries to residents and suicide attempts, among other things (Centers for Medicare & Medicaid Services, n.d.).

When used properly and at the appropriate time in a child's life, congregate care placements can play an important role in our child welfare system and can help children with severe needs. The Center for Child Welfare Data aptly explained, "[h]igh-quality, tailored congregate care placements with strong program models and highly qualified practitioners do serve as an important placement alternative for children and youth with complex clinical needs who require a short-term stay in a treatment facility" (Zhou et al., 2021, p. 1).

Overreliance on and Unjust Use of Congregate Care

However, too often congregate care placements are not used in their intended manner. Instead, we send too many children in foster care to congregate care facilities that are ill-equipped to meet their needs, for too long, and when those children do not require such a restrictive placement setting.

When foster care systems fail to develop robust placement arrays for children—with enough kinship placements, foster family placements, and therapeutic foster family placements—congregate care facilities become "a 'go-to' option for the responsible placing agencies" (NDRN, 2021a, p. 18). The same is true when states fail to develop the necessary array of services for children. When "there are insufficient treatment alternatives, children with mental healthcare needs are often placed into inpatient treatment settings such as for-profit [residential facilities]" (NDRN, 2021a, p. 18).

For instance, in West Virginia, the Department of Justice found that the state was harming children by unnecessarily placing them in residential facilities (Gupta, 2015). Similarly, a federal lawsuit in North Carolina alleged that the state's child welfare agency unnecessarily confines children in foster care with disabilities in psychiatric residential treatment facilities instead of providing less restrictive community-based options (Children's Rights, 2024). Further, the Department of Justice recently found that Alaska—where there are "[m]ore than three times as many kids in foster care as there are licensed foster homes"—was violating the Americans with Disabilities Act because behavioral health resources were so deficient in the state (Lurie, 2023a, para. 31).

According to a recent study, from January 1, 2012, to December 31, 2019, of children entering foster care

for the first time, 20% had at least one congregate care placement (Zhou et al., 2021). Moreover, when children were placed in foster care more than once, the proportion of time placed in congregate care increased (Zhou et al., 2021).

Congregate care also disproportionately affects older youth and children of color. Thirteen-to-15-year-olds make up two fifths of the daily census and 16- to 17-year-olds make up one fourth (Zhou et al., 2021). Black and Indigenous children are also more likely both to enter foster care and be sent to congregate care facilities (Lurie, 2023a). African American children were the most likely to be placed in congregate care initially, making up 16% of the daily census (Zhou et al., 2021).

Mismanagement and Problematic Practices at Facilities

In addition to sending too many children to congregate care facilities, we also place children in facilities that are mismanaged and engage in abusive practices. This happens, in part, because many facilities are financially incentivized to keep costs low (O'Grady, 2022). Sequel's leadership, for example, noted that you can make money by keeping staffing costs low (O'Grady, 2022). "Sequel Co-Founder Jay Ripley emphasized the importance of government clients to the company's business model: 'We focused on public pay because we figured kids are always going to have issues and they're always going to get in trouble, and again, the government has to figure out a way to take care of them'" (O'Grady, 2022, p. 14).

With this comes dangerously low staff-to-child ratios at the facilities, sometimes in violation of state policies. For instance, leadership at UHS hospitals claimed that "corporate bosses pushed them" to cut staff—at the expense of patients—to reduce costs and increase profits (Adams, 2016). Additionally, Colorado residential facilities reported "unprecedented" workforce shortages in 2021 (Brown, 2021a). These staffing shortages should come as no surprise when facilities across the country pay as low as $11 to $15 per hour with no employment benefits (NDRN, 2021a; O'Grady, 2022).

The low pay attracts unqualified candidates as well for these critical jobs. For instance, unqualified staff have been responsible for providing mental health services to youth (NDRN, 2021a). In one for-profit facility, one counselor was originally hired as a cook and lacked any documentation demonstrating that they were qualified to provide counseling services (NDRN, 2021a). Unqualified, overwhelmed, and overworked staff are more likely to harm children. At Sequel facilities across the country, there were reports of physical abuse by staff, as well as sexual abuse, denial of medical care, and emotional abuse, including encouraging children to kill themselves (Rappleye et al., 2020).

The harms of under-staffing cannot be overstated. Children have died by suicide and self-harm in understaffed facilities (NDRN, 2021a). Child-on-child abuse and elopements have also occurred because of inadequate oversight (NDRN, 2021a). And predatory staff, with fewer eyes on them, can more easily target and abuse children.

Children Are Harmed in Congregate Care, Yet Agencies Fail to Act

Children suffer trauma in inappropriate and dangerous congregate care placements (Lustbader et al., 2021; NDRN, 2021a). "Congregate care settings for children have been found to increase exposure to trauma and to negatively impact educational outcomes" (NDRN, 2021a, p. 15). Children in congregate care lack adult and community connections; have fewer permanency options and, therefore, face an increased risk of interactions with the criminal justice system and of experiencing homelessness; risk experiencing sex trafficking, including by being recruited while at congregate care facilities; and have poor educational outcomes. They are also at risk of being abused by peers and staff.

Unfortunately, the harms children suffer in congregate care often go unreported. Sara Gelser, an Oregon state senator observed,

> I'm convinced that we have other kids for whom the same thing is true, we just haven't reported on them. And we haven't had hearings about them, and it's hard to find them, because they're locked away in faraway places, where you have to be on an approved visitors list to get to the children and the children don't necessarily know that what's happening to them isn't right. They probably think that they deserve it. And that's perhaps the saddest part of all, that they don't even know they can ask for help and that they deserve so much better than what we're doing to them. (McDermott, 2019, paras. 56–57)

But even when problems are identified, too often nothing is done. When state and county agencies choose inaction even in the face of horrific allegations of abuse, they miss the opportunity to remedy serious problems, and they place children at significant risk of harm. They also send a message to children that they should remain silent. For instance, after a slew of reports of abuse at UHS facilities, child welfare agencies repeatedly failed to take meaningful action to protect children:

- Hill Crest Behavioral Health Services had 1,055 foster admissions from 2017–2022 even though internal videos released by *BuzzFeed News* in 2017 showed staff "beating and dragging" youth.
- At North Star Behavioral Health, there were 546 admissions after federal investigators reported elopements, assaults, and "a patient who went 40 days without a therapy appointment."
- At Provo Canyon, 467 children were admitted even though in 2018 an Oregon youth was injected with Haldol 17 times over three months.
- And 243 youth were admitted at Texas NeuroRehab Center even though state compliance records documented improper use of restraints, understaffing, and a nurse in 2015 engaging in sexual conduct with a child in care. (Lurie, 2023b)

Further, in Colorado, it took nearly three years to shut down the problematic Ridge View facility, which housed both youth in foster care and in the delinquency system. Ridge View was put on probationary status in 2018, but in 2019, Colorado announced it would not revoke its license. That same year new complaints of abuse and neglect surfaced, and the facility was again put on notice of potential licensing violations. In 2020, state officials again declined to act (Brown, 2021b).

A *ProPublica* investigation, which involved the review of thousands of pages of police reports and interviews with children in foster care and their families, "found that even when police and facility employees documented allegations of harm, officials responsible for the children did not always see or act on those reports" (Jackson & Eldeib, 2021, para. 10).

The National Disability Rights Network (2021a), a non-profit membership organization for federally mandated Protection and Advocacy (P&A) agencies for individuals with disabilities, commented,

> This recent focus on these facilities has resulted in tepid and scattered attempts at state legislation and oversight efforts, and a wave of reporting by media and advocacy by facility survivor groups and youth advocates, including high profile celebrity survivors. The fact that advocacy has not resulted in more change may be both a testament to the power of this industry and the lack of a functional service system of community-based mental health supports that can provide alternatives. Placing children in these facilities, especially once a state has notice of reported failures, is a violation of the states' obligation to act *in loco parentis* (in the place of a parent), ensuring the safety of children in their care. (p. 9)

These harms are more pervasive at facilities operated by problematic operators that accept many out-of-state children, including UHS, Acadia, Devereux, and Sequel[5]/Vivant. Children at these facilities reported peer-on-peer assaults, neglect, seclusion, chemical restraints, withholding of necessary medical care, physical, psychological and sexual abuse by staff, and disgusting conditions, including feces and blood smeared on the walls and floors of children's rooms (Lurie, 2023b; NDRN, 2021a). Yet they remain in business.

Increased Risk of Harm at Out-of-State Placements

Children are at heightened risk of maltreatment when they are placed out of state. If children are placed in congregate care, ideally, they are placed in state, close to their advocates, families, communities, support networks, and workers within the foster care system who are supposed to be helping them. Some states, however, have a horrible practice of shipping children out of state.

For example:

- According to a lawsuit filed against West Virginia's child welfare agency, the state "institutionalizes 71 percent of foster children between the ages of 12–17 and sends a substantial number of foster children to out-of-state residential facilities, many of which are for-profit" (*Jonathan R. et al. v. Justice et al.,* 2023). As of August 31, 2019, the state had placed 314 children in out-of-state institutions (*Jonathan R. et al. v. Justice et al.,* 2023).
- In a lawsuit filed against Oregon's child welfare agency, the plaintiffs alleged that the state increased its reliance on out-of-state placements (*Wyatt B. et al. v. Brown et al.,* 2021). As of March 2018, Oregon placed 50 children in out-of-state congregate care facilities (*Wyatt B. et al. v. Brown et al.,* 2021). A year later, it placed 86 children in other states, including in facilities in Arizona, Arkansas, Idaho, Illinois, Iowa, Montana, Oklahoma, Pennsylvania, Tennessee, Utah, Washington, and Wyoming (*Wyatt B. et al. v. Brown et al.,* 2021).
- Illinois also saw an increase in out-of-state placements. "The number of wards sent away from Illinois grew steadily from 19 in 2011 to 56 in 2018, according to federal data" (Jackson & Eldeib, 2021, para. 18).
- And in late 2021, Colorado's Ombudsman stated that the state was "in a bad loop," as residential centers were closing because of licensing violations or low funding, which resulted in the state sending children to out-of-state facilities (Brown, 2021a, para. 12).

Placing children out of state should be a last resort after all other options have been considered and exhausted. But it often is not (Gupta, 2015; Disability Rights North Carolina, 2022). When children are placed in out-of-state congregate care facilities, there is less oversight, less accountability, and an increased chance of children experiencing maltreatment in care. For example, home states do not license out-of-state facilities and, therefore, lack the same quality controls as they have over in-state facilities.

[5] "As of 2019, approximately one quarter of Sequel's 2,000 residents had crossed state lines for treatment and the residents came from more than 40 states" (NDRN, 2021a, p. 58).

Officials in Illinois, for example, acknowledged, "[T]hey sent wards out of state to private facilities despite having limited capacity to monitor the children's care and safety" (Jackson & Eldeib, 2021, para. 9). In Illinois,

> DCFS officials said the agency typically checked to see if the license of an out-of-state facility was in good standing before placing children there but acknowledged they had no reliable system to check for subsequent sanctions. Illinois has sent children to Resource Residential Treatment Facility in Indianapolis even though Indiana officials have halted placement of their own state wards there three times since 2017, citing violence and inadequate staffing at the facility. (paras. 38–39)

"During this period, DCFS had specific monitoring requirements for out-of-state facilities" (Jackson & Eldeib, 2021, para. 42). A child's caseworker "was supposed to walk through the facility at least every six months" and "monitors had to visit at least every quarter" (para. 42). But according to a 2019 state report, more than 20% of these mandated visits did not take place (Jackson & Eldeib, 2021).

Children in out-of-state congregate care facilities are also isolated. They are far from their communities and support networks, and child welfare experts state that such placements "can weaken family bonds and disrupt a child's development" (Jackson & Eldeib, 2021, para. 13). Moreover, it is difficult for caseworkers, service providers, and advocates to visit children in person when they are placed far away. As a result, it is challenging to decipher whether children are truly safe in out-of-state facilities.

Recent Legislation Alone Has Not Resolved These Issues

Recognizing the widespread challenges facing our country's child welfare systems, in 2018 the President signed the Family First Prevention Services Act (P.L. 115-123) into law.[6] The goal of the law is to enhance services for families so that children could remain at home, while also reducing our reliance on congregate care placements. Among other things, the FFPA creates federal funding for preventative services, provides a partial reimbursement for kinship navigator programs, strengthens services for older youth, and places payment limits on congregate care placements (Bipartisan Budget Act of 2018).

The FFPA specifically encourages child welfare agencies to place children with families, rather than in congregate care placements. To accomplish this, the FFPA establishes criteria for placing youth in congregate care facilities. Children are only permitted to be placed in congregate care facilities if they have been assessed to have needs that would require such a placement.

Additionally, the FFPA creates four categories of non-family placement settings: (1) Qualified Residential Treatment Programs ("QRTPs"); (2) settings specializing in providing prenatal, post-partum, or parenting supports for pregnant or parenting youth; (3) supervised independent living for young people over the age of 18; and (4) residential care for youth who were or are at risk of sex trafficking (American Academy of Pediatrics [AAP], 2023). The most common type, QRTPs, are child caring institutions that provide "a trauma-informed model of care designed to address the needs . . . of children with serious emotional or behavioral disorders or disturbances" (Centers for Medicare & Medicaid Services, 2024a, para. 11).

Since the FFPA went into effect, many states have reduced the use of congregate care. However, not all states have QRTPs, those with QRTPs have limited beds at in-state QRTPs, and some send children to out-of-state QRTPs (AAP, 2023). As of June 2023, QRTP staff training and quality were an issue, as was the need for funding to transition existing congregate care facilities to QRTPs (AAP, 2023).

[6] The effective date of the FFPSA varied by jurisdiction. For instance, child welfare systems receiving federal funding could request a delayed effective date of up to two years for provisions relating to congregate care placements. As such, the impact of the law was not immediate.

A Chapin Hall study found that "[t]he use of QRTP as an individualized and quality treatment intervention, as opposed to a standardized placement, has yet to be realized. Concerns about the accountability, quality, and sustainability of the QRTP workforce stymy the implementation of individualized, trauma-informed treatment" (AAP, 2023, p. 3). Moreover, there was a "perceived lack of change in QRTPs from pre-existing congregate care culture and practice" (p. 3).

As a result, while the goals of the FFPA are laudable, policymakers and child welfare agencies are still grappling with how to successfully implement the law, and children are still unnecessarily languishing in inappropriate and dangerous congregate care placements.

Congregate Care Solutions

Advocates Roles in Addressing Abuse in Facilities

Advocates for children are uniquely positioned to help children who are harmed or at risk of harm in congregate care facilities. The type of advocates who are assigned to represent and work alongside children in foster care vary by jurisdiction. In some jurisdictions, such as New York City, children are assigned attorneys who engage in direct advocacy, advocating for exactly what their clients want. In others, children are assigned *guardians ad litem*, who advocate for whatever is in the children's best interest. In still others, non-lawyers, including volunteers such as Court-Appointed Special Advocates, are primarily responsible for meeting with children and filing court reports.

Regardless of the type of advocate, any time an advocate is assigned to a child in foster care, they need to monitor whether that child is placed in a congregate care facility and understand whether the facility has a history of abuse or problematic practices. For instance, if a facility is owned by UHS, Acadia, Devereux, or Sequel/Vivant, that should raise an immediate red flag. Advocates should receive training on how to research facilities, and organizations advocating for children should collect data on facilities, so they can identify any concerning trends.

Furthermore, advocates need to inquire whether children are safe in their congregate care placements. This will require ongoing training on how to build trusting relationships with children and how to effectively ask questions that will elicit truthful responses. For instance, advocates can learn about interview techniques from forensic interviewers, social workers, or attorneys who specialize in working with children. This should include learning how to create a neutral and child-friendly meeting environment where children will feel safe and at ease; clarifying whether conversations are confidential and explaining what that means in age-appropriate terms; asking open-ended and non-leading questions; and following up with "what," "when," where" and "how" questions. Advocates will also want to ensure they are not asking questions in a way that will re-traumatize a child.

These check-ins should be done at regular intervals and memorialized, so if a case is passed along to a new advocate, the history is clear. Advocates should also make every effort to visit clients in private—outside the earshot of staff and other youth—in their placements. Advocates should operate under clear guidelines regarding when, where, and how visits with their clients are conducted.

Further, if a young person discloses abuse or misconduct in a congregate care facility, advocates need to understand how to advise their client. This will of course depend on the advocate's role and whether they are acting in a child's best interest or engaging in direct advocacy. Advocates also need to be mindful of any mandatory reporting obligations they might have.

To give the best advice, on the one hand, advocates need to understand which options are available to young people outside of advocacy in the underlying child welfare proceedings (which are undoubtedly important). This is key. Although one-off cases

of institutional abuse can partially be addressed directly through children's foster care cases, these other avenues offer a remedy to widespread and pervasive problems. Indeed, by effectively taking advantage of these other avenues, advocates can push jurisdictions, for instance, to remove all children placed in predatory and abusive facilities, and they can force bad actors to shutter their doors.

On the other hand, if we continue down our current path, and simply advocate for a placement change when abuse occurs in each child's individual foster care case, we will find ourselves playing a game of whack-a-mole—facing similar allegations of abuse at the same facilities over and over, but with different child victims. Children entrusted to the care of our child welfare systems deserve better. These other avenues of advocacy include filing reports with the authorities, such as child protective services and law enforcement, and contacting watchdog agencies, including local ombudsman offices and local P&As.

Protection and Advocacy agencies, if operating effectively, can be particularly helpful. They were created by Congress in the 1970s to advocate for people with disabilities in every state. Among other responsibilities, P&As are allowed under federal law to monitor and investigate congregate care facilities that serve people with disabilities, including youth in foster care (NDRN, 2021a). P&As have the authority to enter for-profit and non-profit facilities without advance notice, "giving P&As a unique ability to see first-hand conditions faced by people with disabilities" (NDRN, 2021a, p. 15).

> "If a P&A finds evidence of potential abuse or neglect, the P&A may commence an investigation. At that point the P&A may access resident records, facility records, and other information. P&As may choose a facility to monitor because the P&A has received complaints about the facility or because the facility is part of a regular rotation for routine monitoring." (p. 15)

P&A investigations have led to the removal of children from facilities, heightened state oversight of problematic facilities, and corrective actions. They have also played a role in the closure of problematic facilities (NDRN, 2021a). Therefore, it is logical for local advocates to develop a good working relationship with their local P&A.

Children may also have legal claims and the ability to file a civil lawsuit against the operator, abusive staff, and the child welfare agency that placed and left them in the harmful placement. These claims are typically rooted in tort and civil rights claims, including claims under the Fourteenth Amendment, and federal statutory claims, including for discrimination based on their disabilities under the Americans with Disabilities Act and the Rehabilitation Act, among others. The lawsuits have the power to ensure a child is kept safe, to compensate victims for the harms they have suffered, to punish bad actors, and to draw public attention to misconduct.

For instance, on March 28, 2024, an Illinois jury awarded $535 million to a minor who was sexually assaulted in a UHS facility (Simon Law, PC, 2024). Multiple lawsuits were also filed against Sequel TSI of Tuskegee, an Alabama facility where one child died by suicide and another experienced sexual, physical, and verbal abuse by staff and other residents (Hitson, 2023; Siemaszko, 2022). And in Maryland, two lawsuits were filed against a facility where children were allegedly subjected to decades of abuse, including rape (Worthington, 2024).

If advocates notice a pattern (and advocates should communicate with one another to better identify trends and problematic practices), they should consider participating in legal action to spur systemic change. Non-profit organizations, such as A Better Childhood, Children's Rights, and P&As engage in this type of litigation.[7] A Better Childhood (https://www.abetterchildhood. org/) and Children's Rights (https://www.childrensrights.org/in-the-courts) have filed lawsuits alleging violations of children's rights in

[7] The ACLU had also taken on these types of cases in the past (ACLU of Illinois, n.d.).

jurisdictions across the United States, and P&As have participated in some of these lawsuits and have also filed their own, including in North Carolina (Disability Rights North Carolina, 2022). These lawsuits depend on collaboration with local advocates who understand what is happening in their jurisdictions.

Advocates can also help clients by notifying state legislators and policymakers. For instance, a lawyer in Oregon testified before the Oregon Senate Human Services Committee on April 11, 2019, that she was "horrified and scared for my client's safety," after finding out staff at an Acadia facility in Montana was injecting a child she represented with Benadryl and other antihistamines to chemically restrain her and locking her in seclusion (McDermott, 2019, para. 1). That advocate successfully petitioned to have her client removed from the facility and her advocacy also brought a wave of media attention on the facility's concerning practices (McDermott, 2019).

It is critical that children and those advocating on their behalf understand the range of options available to address abuses in congregate care. By collecting data, identifying trends, and speaking out and bringing awareness to these issues, advocates will be better positioned to take the necessary actions to hold wrongdoers accountable and effectuate meaningful change.

Ending Out-of-State Congregate Care Placements

Additionally, children should not be sent to out-of-state congregate care facilities. Sending youth out of state is a sign of a deeply flawed system. It means a state has a severely deficient placement and service array and has no available and appropriate placement for a child anywhere in the state.

On top of the increased risk of harm children face when placed out of state, it is difficult to get accurate information as to what is happening to children out of state. Because of the distance and lack of transparency, children are often cut off from their support networks and the advocates who are best positioned to identify whether they are being harmed in those placements. Further, advocacy groups like P&As, who play an important role in ensuring accountability on the part of those organizations working with youth, also struggle to monitor a child's placement in another state (NDRN , 2021a). And a child's home state lacks licensing authority over out-of-state facilities.

States can legislate to end the practice of placing children in out-of-state congregate care facilities. For instance, in 2021, California banned the practice of sending youth in foster care to out-of-state residential treatment programs following media reports on abuse at these facilities (Palomino & Tiano, 2021). Those reports found that California sent "thousands of children" to programs run by Sequel Youth & Family Services. At Sequel facilities in Michigan, Iowa, Wyoming, Arizona, and Utah, children reported physical and sexual abuse at the hands of staff (Palomino & Tiano, 2021). Instead, money is now being set aside to develop local programs for California youth (Palomino & Tiano, 2021).

Other Improvements

There are, of course, many other steps we can take, including having more transparency and increased federal oversight tied to federal funding, as contemplated under the FFPA, and better data collection and use of that data. We could suspend Medicaid payments to facilities that have a history of abuse and neglect, better enforce state licensing requirements, and prohibit owners of problematic facilities that have closed from opening new facilities under the guise of new business entities (NDRN, 2021a; NDRN, 2021b). We could also implement the recommendations by the Senate Committee (U.S. Senate Committee on Finance, 2022). Although a full analysis of these measures is outside the scope of this commentary, such an analysis is worth considering.

Conclusion

The recent public attention on abuses within the congregate care facilities housing our nation's most vulnerable children must spur action. We must build upon and improve how advocates represent youth placed in congregate care facilities. Advocates need

to understand where children are placed and what children's experiences are in congregate care. They also need to understand the array of remedies available to children who have experienced harm. Equipped with this knowledge, children, their loved ones, and their advocates have the power to achieve justice and effectuate lasting change—sparing other children from suffering similar abuses.

Moreover, no child should be placed in out-of-state congregate care facilities. Children are at an increased risk of harm in these placements, and they lack meaningful access to their advocates, communities, and support networks. When children are isolated in this manner, they often have nowhere to turn if they are abused.

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Journal Highlights

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Briggs, E., Hanson, R., Klika, J. B., LeBlanc, S., Maddux, J., Merritt, D., ... & Barboza, G. (2023). Addressing systemic racism in the American Professional Society on the Abuse of Children publications. *Child Maltreatment*, 28(4), 550–555. https://doi.org/10.1177/10775595231191394

In this article, leaders in the American Professional Society on the Abuse of Children (APSAC) describe steps being taken to advance diversity, equity, inclusion and justice (DEIJ) in the organization and its publications, including *Child Maltreatment* (*CM*), APSAC's flagship journal. The aims and scope of *CM* were revised to explicitly state the journal's commitment to anti-racist research, and applications for editorial positions on *CM* now include questions regarding commitments to DEIJ. A special issue on the topic has also been planned for 2025. The guidelines and manuscript rating form for *CM* peer reviewers will include an assessment of how well articles address issues of DEIJ, and *CM* will create a training for the journal's editorial board to help implement these changes. The APSAC Board of Directors Publications Committee commits to develop a confidential survey on DEIJ and administer it to the *CM* Editorial Board annually, to assess the demographic composition of the *CM* Editorial Board. The Editor in Chief arranged for a meeting of journal editors at a recent ISPCAN Congress to discuss this and other topics. In addition, the APSAC Publications Committee will convene a meeting of allied journals to discuss a unified strategy for increasing DEIJ in child maltreatment research.

Gewirtz-Meydan, A. (2024). Traumatized sexuality: Understanding and predicting profiles of sexual behaviors using childhood abuse and trauma measures. *Child Maltreatment*, *29*(2), 350–363. https://doi.org/10.1177/10775595221148425

Adults who have been sexually abused as children can react by becoming overly sexual, with difficulties such as intrusive fantasies and problems controlling one's sexuality (hypersexuality). They can also react with decreased sexual interest and/or difficulty achieving sexual satisfaction (hyposexuality). This study examines these connections in a sample of Israeli men and women recruited through Facebook and Instagram to complete an online survey. The survey assessed whether participants had a childhood history of sexual abuse and had experienced PTSD and/or mood disorders. It also assessed their sexual behavior. Latent profile analysis identified four groups in the sample: (1) a group that was within usual ranges on sexual behavior (n = 343); (2) hyposexual individuals (n = 213), (3) porn users (with somewhat problematic porn use (n = 73); and (4) hypersexual porn users (n = 27). Hypersexual porn users had experienced significantly more emotional abuse, physical abuse, and sexual abuse in childhood, and had higher levels of PTSD, anxiety, and depression. Porn users and hypersexual porn users were more likely to engage in sex for coping and because of peer pressure, and hypersexual porn users were also more likely to engage in sex for physical enhancement and partner approval. The authors suggest that therapists working with hypersexual porn users need to be prepared to address childhood abuse, PTSD, and mood problems.

Guastaferro, K., Linden-Carmichael, A. N., & Chiang, S. C. (2024). Association between child maltreatment and substance use disorder across emerging adulthood. *Child Maltreatment*, *29*(2), 340–349. https://doi.org/10.1177/10775595231154545

Young people who have experienced child maltreatment are at significantly greater risk of developing a substance use disorder, which emerges most frequently between the ages of 18 to 25. This study aimed to pinpoint the particular age at which youth who have been maltreatment are most at risk. The authors analyzed a sample of 5,194 young adults who participated in the National Epidemiological Survey on Alcohol and Related Conditions. The authors employed time-varying effect statistical models to examine the relationship between maltreatment and substance use by youth age. The greatest risk was at age 19, when youth who had a history of child maltreatment were at three times greater odds of having a substance use disorder in the past year. The authors suggest that this finding can be used to help target prevention efforts.

Fessinger, M. B., McAuliff, B. D., Aronson, E., & McWilliams, K. (2024). Attorneys' experiences, perceptions, and plea recommendations in child sexual abuse cases. *Law and Human Behavior*, *48*(1), 13–32. https://doi.org/10.1037/lhb0000551

This research explores factors related to how prosecutors decide to offer and defense attorneys decide to recommend guilty plea deals in child sexual abuse cases. The authors conducted a survey of a database of 3,131 attorneys they had compiled and received responses from 232 prosecutors and 271 defense attorneys. Among the factors that attorneys reported affected their judgment of children's credibility were additional allegations against the defendant, the child receiving a formal forensic interview, children's consistency across their reports about the abuse, ongoing custody battles between parents, and recantation. The most important factor that attorneys reported as an influence on their case recommendation was consistency of the evidence. Also, consistency of evidence was a significant predictor of attorneys' judgment of the likelihood of conviction in a hypothetical child sexual abuse case they reviewed. Overall, evidence strength and the perceived likelihood of conviction were the driving factors behind attorneys' decisions to offer or recommend a plea to a defendant in a child sexual abuse case. This study underlines the importance of effective evidence collection in child sexual abuse cases.

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