On June 1, 2007, the Mayor’s Child Welfare Review Panel issued a report entitled “Protecting Philadelphia’s Children: The Call to Action.” The report examined the Philadelphia Department of Human Services’ child protection function and made important recommendations for change. Field Center Faculty Directors Cindy Christian and Carol Wilson Spigner served on the Panel.

In this calendar year, the Philadelphia Department of Human Services (DHS) expects to investigate about 15,000 reports of child abuse and neglect and will find about one-third of those reports to be valid. Subsequent to such a finding, the agency is responsible for deciding how a child can best be protected either in their own home or by placement. The protection of children is the responsibility of DHS but requires the involvement of the courts and the services of other public and voluntary agencies and families.

After extensive media coverage of child deaths, the Child Welfare Review Panel (CWRP) was created to examine the fatalities, monitor DHS’s action plan for child safety, review policies, procedures, and practice, and recommend changes. The Panel composed of residents of the city and national child welfare experts undertook a review of the hotline which receives reports, the investigation and decision making process, and the delivery of service to children in their own homes. The Mayor and executive branch have embraced the recommendations and begun the reform process. The Mayor-Elect is expected to continue the reform process.

After conducting a review of past studies, the current policies and hearing from nearly 800 persons, the CWRP framed the findings around fatalities, agency mission, practice, accountability, and leadership.

Fatalities: Of the fatalities under review, 50% had an open DHS case. Other children had been previously reported to the Department. The majority of the children who died were under the age of 6, with children between the ages of 0-3 months being the most vulnerable. In a number of cases, the parents had a history of maltreatment as children. A number of the deaths were the result of unsafe sleeping practices rather than maltreatment. The Panel found a strong child fatality review process but failure to implement the recommendations that resulted from the reviews.

Agency Mission and Values: The mission of DHS is unclear. The agency has come to be the resource of last resort and is expected to respond to unmet needs whether children are in danger or not. As a result, the focus on child safety and the protection of children has become diffused. The lack of clarity impacts community expectations, agency workers, and contracted services. The development of a mission statement and key values was recommended. It is suggested that the mission focus on child safety and the values should shape the way the agency works with children and their families.

Practice: The Panel found great variability in practice, with the service being determined by the capacity of a particular worker at a particular time. To address...
these inconsistencies, DHS has been asked to develop a safety assessment tool and train all staff in its use. Children under the age of five are to be seen within two hours when a credible report is made. A family team decision making process is to be established and implemented. In addition, a model of practice is required that guides the service delivery and decision making processes. There is a call for more frequent face-to-face contact by DHS with children.

**Accountability:** The accountability systems in DHS and among DHS and its providers are weak. The report recommends the use of outcome data to examine the performance of the agency and its providers. The contracting and monitoring process needs to be improved and providers should be monitored more frequently. Based on these actions, the agency is to publish annual performance reports. Additionally, the Mayor was asked to create a Community Oversight Board to assess progress on the recommendations and to report to DHS, the Mayor, and the citizens of Philadelphia.

**Leadership:** The Department of Human Services needs to increase its capacity to manage change by developing its leadership and managerial staff. Clarifying expectations and improving the supports available to front line workers are recommended. Community participation in promoting the safety of children is essential to the reform process. The CWRP calls for regular town halls and community forums to inform decisions and secure feedback.


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**FIELD CENTER WELCOMES NEW ADVISORY BOARD MEMBERS**

The Field Center is pleased to welcome two new members to its Advisory Board.

**Dr. Marilyn Benoit,** a child & adolescent psychiatrist who is in private practice in Washington, DC, is Past President (2001-2003) of the American Academy of Child & Adolescent Psychiatry. She initiated a collaborative relationship with the Child Welfare League of America to establish a national coalition of major stakeholders in the foster care system in order to improve mental health services to children in the system. She has served on the faculties of Howard and George Washington University and is a Clinical Associate Professor of Psychiatry at Georgetown University Medical Center, from where she received the Vicennial Silver Medal of Honor for 20 years of distinguished service. Dr. Benoit is a member of the Board of Trustees of the Child Welfare League of America, the Alliance for Childhood and of the Devereux Foundation. She is a nationally known advocate for children, and an international lecturer on children and adolescents’ mental health issues.

**Senator Emanuel Jones** was elected to Georgia’s State Senate in 2004, representing the 10th district. He serves on several committees and is currently Secretary of the Interstate Cooperation Committee. Senator Jones was instrumental in leading public outcry and changing the law that led to 17-year old Genarlow Wilson’s ten-year prison sentence for consensual oral sex with another adolescent. He is a deacon of the Shiloh Baptist Church and was named one of the “50 Most Influential People” from Who’s Who in Black Atlanta. Senator Jones is a former trustee for Henry Medical Center, past chairman of Henry County YMCA, past chairman of Henry County’s United Way Campaign and Partners in Education League of America to establish a national coalition of major stakeholders in the foster care system in order to improve mental health services to children in the system. He has served on the faculties of Howard and George Washington University and is a Clinical Associate Professor of Psychiatry at Georgetown University Medical Center, from where she received the Vicennial Silver Medal of Honor for 20 years of distinguished service. Dr. Benoit is a member of the Board of Trustees of the Child Welfare League of America, the Alliance for Childhood and of the Devereux Foundation. She is a nationally known advocate for children, and an international lecturer on children and adolescents’ mental health issues.

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The first Children’s Advocacy Center (CAC) was established in Huntsville, Alabama in 1985 by U.S. Representative Robert Cramer. This center was created to improve outcomes for child victims of maltreatment by re-focusing attention on the child and providing services for the non-offending family members. Since the establishment of the first CAC, the numbers of communities developing this model has grown dramatically. National Children’s Alliance, a membership organization, was established to address the need for guidance, training, and standards for the growing numbers of CACs (Chandler, 2000). By 2005, over 500 CACs had been accredited as full or associate members of National Children’s Alliance (Newman, Dannenfelser and Pendleton 2005).

Children’s Advocacy Centers are community-based programs devised to meet the unique needs of a community, so no two CACs are exactly alike. The National Children’s Alliance developed standards to ensure that different community-based centers are effectively meeting the needs of abused children and families through multi-disciplinary cooperation. These standards serve as a guide for communities in planning, organizing, administering, and maintaining program services and operations of CACs. The ten standards are: (1) Child-Appropriate/Child-Friendly Facility, (2) Multidisciplinary Team (MDT), (3) Organizational Capacity, (4) Cultural Competency and Diversity, (5) Forensic Interviews, (6) Medical Evaluation, (7) Therapeutic Intervention, (8) Victim Support/Advocacy, (9) Case Review, and (10) Case Tracking (Wolf, Chandler, and Pape, 2004).

The foundation of Children’s Advocacy Centers is the multidisciplinary team (MDT) with representatives from various disciplines: law enforcement, prosecution, victim advocacy, child protection, medical and mental health communities. The members of the MDT work together to provide children and their families with comprehensive services within a child-focused environment designed to meet the child’s needs.

The multidisciplinary team collaborates to make decisions about the investigation, treatment, organization and prosecution of child abuse allegations. A core goal is to avoid further victimization of the child victim by reducing potential trauma from the intervention systems created to protect them (Wolf, Chandler, and Pape, 2004).

The University of New Hampshire’s Crime against Children Research Center recently conducted a rigorous and comprehensive evaluation of Children’s Advocacy Centers. The study collected data from over 1000 cases of sexual abuse cases from four CACs and from comparison non-CAC communities. The study found that CACs had more coordinated investigations: police in CAC communities participated in 81% of child protective service investigations compared to only 52% of cases in non-CAC communities. More children received forensic medical examination through CAC coordinated services compared to non-CAC services (48% v. 21%). More referrals for mental health services were made for CAC cases compared to comparison community cases (60% v. 22%). In the CAC sample, parents and caregivers of the child victim were more satisfied with the investigation process and children were less likely to describe themselves as feeling scared (Crimes against Children Research Center, 2006).

In addition, Newman and her colleagues (2005) conducted a separate study surveying child protective service and law enforcement investigators from 28 different CACs on their reasons for using the CAC for child abuse cases. The respondents believed that the child-friendly facility of the CAC provided a critical alternative to conducting the interview at a police station or hospital. They described the facility as comfortable, nurturing, and secure, which encouraged self-disclosure and more accurate interview results from children. The respondents also stated that the CAC facilitated collaboration among the different disciplines, which in turn facilitated a quicker turn around in case investigations. Coordination and communication within the CAC helped establish a team approach to child abuse investigations and build better working relationships between the various disciplines.

Children’s Advocacy Centers have been found to contribute greatly to the welfare of children. Communities that have developed CACs have experienced improved outcomes of child abuse investigations, reduction in duplications of child interviews, more efficient medical and mental health referrals and services, and increased prosecution rates. By promoting greater appreciation and understanding of other disciplines, the multidisciplinary team engages in a more informed and holistic decision-making process. The comprehensive approach ensures that children receive child-focused and appropriate services in an environment in which the needs of children and families come first.

References
For the past year, as the head of Philadelphia’s Behavioral Health and Child Welfare Systems, it has become clear that while much progress has been made in collaboration between these two child-serving systems, we still have much more that we must do. This was highlighted by a recent incident where a 12-year old girl, addicted to crack cocaine supplied by her father, attempted to enter drug treatment. Delays occurred in this child receiving the care she needed because the two systems did not work together efficiently. While the particulars in this situation are complex and point to a number critical decision points that should have played out differently, the message is not one of point and blame, but rather of active problem solving that gets operationalized and leads to improved cross-system collaboration.

According to the Child Welfare League of America, approximately 60 percent of all children in out-of-home care have moderate to severe mental health problems. In fact, the very issues that often bring children into protective services are frequently related to mental health needs. In addition, a large proportion of youth served by the child welfare system have experienced significant trauma including abuse, neglect, domestic violence, and family separation, which adversely affect their mental health. Yet despite the extremely high level of need, nationally, less than one-third of children in the child protective system receive mental health services.

The final Report of the Mayor John F. Street’s Blue Ribbon Commission on Children’s Behavioral Health emphasizes that youth in the child welfare system are at increased risk for mental health problems and stresses the need to develop a comprehensive strategy to identify and provide early intervention and treatment services for these at-risk youth. Among its recommendations, the Commission cited the importance of working with at-risk youth in naturally occurring settings. In other words, rather than expecting these youth to independently access treatment programs, the system must become more flexible and, to the extent possible, provide treatment services in their neighborhood and other community settings.

I am pleased to report that the findings of the Commission have sparked a renewed effort in Philadelphia to both increase access to and improve the quality of mental health services for youth in the child welfare system. In January, the major child-serving systems including the Department of Human Services, the Department of Behavioral Health & Mental Retardation Services, the School District of Philadelphia, Family Court and others made a commitment to reduce the City’s reliance on residential care, particularly when that care is provided out of state. Furthermore, the city has received an award from the Robert Wood Johnson Foundation to help develop cross-system financing strategies that support this goal.

Cross-system collaboration is also occurring on the front lines. To ensure that youth in the child welfare system receive the services they need, several full-time Behavioral Health staff are located within DHS to help social workers identify appropriate treatment settings and to facilitate access to care for youth and their families. Moreover, the Departments of Behavioral Health and Human Services convene regular meetings to discuss the myriad of overlapping issues faced by the Child Welfare and Behavioral Health systems. One result of these meetings is a commitment to develop consistent expectations and standards for behavioral health service delivery, regardless of which system is funding the service. The Departments are also examining ways to jointly credential and monitor those providers.

Despite this progress, there remains much work to be done.

There is an acute shortage of providers who are equipped to deal with the complex range of issues faced by youth in the child welfare system. Consequently, even when issues are identified early, it is often difficult to find appropriate treatment. The supply of well-trained mental health professionals is inadequate and there are simply not enough graduates in the pipeline to keep up with the demand. As a result, there is a striking trend toward the use of professionals who lack specialty training in child mental health. In many cases, the individuals in treatment settings who spend the most time with children with mental health issues have the least amount of training.

Underlying the workforce shortage is the issue of money: the educational costs of training as a specialist are considerable and comparatively low wages are offered to the public sector mental health workforce. Thus it is imperative that we figure out how to better reimburse providers to allow them to hire and retain highly trained mental health care professionals; how to configure public sector clinical positions so they are appealing and truly integrated into a team approach, rather than isolating clinicians; and how to ensure ongoing clinical supervision and staff development. Furthermore, we need to insure that child welfare workers have a baseline understanding of the range of mental health issues (child and family) that they are likely to face in their work and have the training to appropriately identify them and help link their clients to supports and services.

Cross-system issues also affect access to and the appropriateness of care. Many times, the current process for getting appropriate care does not work well for children in the child welfare system. Too often, each system—child welfare, the courts, behavioral health, schools—although well intended fails to understand the policies and operations of each others system, legal mandates, regulatory requirements (state and federal), and custody and consent issues. Cross system collaboration must occur at the system level as well as the individual level. When it comes to planning for a child’s services, these systems need to be on the same page and balance the various needs of all of the systems. It will take all of us giving up some power and control in the interest of plans that work for the children and families we serve.

If we are serious about addressing the needs of the children and families in the child welfare system with mental health issues, we must institutionalize and sustain a collaborative response. Even though we were able to intervene and obtain treatment for the 12 year-old girl, our system should not rely on case by case problem solving. While Philadelphia is unique in the amount and type of cross-systems infrastructure that it has built over the years, we recognize that more work needs to be done. The good news is that the city is poised to push the envelope on what can be done. We have leaders and stakeholders—including families receiving care in our systems—in place who are committed to creating an outstanding system of care. The Philadelphia Compact which is implementing the Blue Ribbon Commission recommendations and leading these efforts, we believe, will guarantee long term commitment to achieving these goals.

INCREASED COLLABORATION NEEDED TO ADDRESS THE MENTAL HEALTH NEEDS OF YOUTH IN THE CHILD WELFARE SYSTEM

By Arthur C. Evans, Ph.D. Acting Commissioner Department of Human Services, Director Department of Behavioral Health and Mental Retardation Services
IN OUR OPINION

Arthur C. Evans Jr, Ph.D.

The following is an excerpt of testimony presented by Field Center Faculty Director Richard J. Gelles, Dean of the University of Pennsylvania School of Social Policy & Practice and Joanne and Raymond Welsh Chair of Child Welfare and Family Violence, before the Pennsylvania Senate Democratic Policy Committee on November 14, 2007.

This is a significant week in the history of child welfare and child welfare policy in the United States. Ten years ago this week, the United State Congress passed, and President Clinton signed, the Adoption and Safe Families Act of 1997. The Adoption and Safe Families Act of 1997 (Public Law 105-89) made child safety and permanency the paramount goals of the child welfare system.

The impact of the Adoption and Safe Families Act of 1997 has been an increase in yearly adoptions from 20,000 per year to more than 51,000 in 2005. The median length of time children stay in foster care has dropped from 20 months in 1999 to 15.5 months in 2005, while the percentage of children remaining on foster care for five years or longer has dropped from 17 percent in 1999 to 14 percent in 2005. The number of children in foster care dropped from 581,000 in 1999 to 514,000 in 2005—(U.S. Department of Health and Human Services, 2007). The changes for the Pennsylvania were:

<table>
<thead>
<tr>
<th>Year</th>
<th>Children in Foster Care</th>
<th>Median Time in Care</th>
<th>% in care more than 4 years</th>
<th>Number of Adoptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>23,070</td>
<td>19.6 mos</td>
<td>48.3%</td>
<td>1,516</td>
</tr>
<tr>
<td>2004</td>
<td>21,944</td>
<td>14 mos</td>
<td>n/a</td>
<td>1,898</td>
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</tbody>
</table>

Despite these improvements in the foster care system in the last 10 years, it is still true that the nation’s child welfare systems are in trouble. It is particularly significant to focus on “systems” because there is not one, single child welfare system in the United States, there are hundreds. Pennsylvania is a county-based system and thus has 67 systems.

Rethinking and Reforming the System

The time has come for new solutions.

First, it’s about Children

Legislative changes and system reforms must focus on “children” as the clients. Philadelphia is now beginning the process of initiating a program called “Family Group Decision Making.” While there are scant data that speak to the effectiveness of this program, it does hold the potential of better engaging families in the case planning process. However, there is no evidence that Family Group Decision Making actually improves the safety and well-being of children.

The lack of focus on children as the clients is evident in state’s legal definitions eligibility for Title IV E placement maintenance (55 Pa. Code §3140.112). Children in foster care who are eligible for Title IV E placement maintenance funds lose that eligibility when they turn 18 or 19 if they are in school. This means that when foster children reach the age of 18 or 19, they are “emancipated” and their foster families no longer receive federal and state support. While counties can file for “board extensions,” the idea that children who grow up in foster care are ready to live adult lives at age 18, is unrealistic. Emancipated foster children are at high risk for welfare dependency, homelessness, substance abuse, and crime. While there would be cost to extending children’s foster care board eligibility to age 18, this cost would in all likelihood be offset by welfare and criminal justice savings.

Conclusion

Given that the Commonwealth of Pennsylvania has a county-based child welfare system, there are limits on what the legislature can do to address system failings. Nonetheless, there are specific legislative initiatives and leadership initiatives that can be examined.

These initiatives include:

1. Raising the age of Title IV E maintenance eligibility to 21.
2. Examine the Pennsylvania Code and consolidate statutes and regulations pertaining to dependent children.
3. Urge the Department of Public Welfare to provide leadership with regard to:
   a. Child welfare workforce issues
   b. Child welfare decision-making, specifically the issue of adequate risk assessment
   c. Monitoring of dependent children, specifically implementing a statewide, linked data base that includes child welfare, criminal justice, and welfare data.
4. Examine alternatives to foster care placements, including consideration of residential education facilities and the elimination of placing dependent children in out-of-state institutional facilities.

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Congratulations to Field Center Faculty Director Alan Lerner on receiving the Jewish Social Policy Action Network’s 2007 JSPAN Social Justice Award.

FIELD CENTER ADVISORY BOARD PROFILE: ANNE MARCUS WEISS, MSW, LSW

Anne Marcus Weiss has had an impressive career in social work, and continues to make a significant impact in the field. Earning her BSW from Penn State, Ms. Weiss knew as an undergraduate that she wanted to pursue a career in social work. After completing her undergraduate degree, she immediately came to the University of Pennsylvania, from which she earned her MSW in 1981. After earning her degree at Penn, Ms. Weiss remained in Philadelphia for a few years and then moved to Baltimore and Cleveland, doing medical social work in hospitals in each city, prior to returning to Philadelphia. She is currently the Associate Director of Field Placement for University of Pennsylvania’s School of Social Policy & Practice. Six years ago, Ms. Weiss was offered a position on the Advisory Board of the Field Center for Children’s Policy, Practice & Research. Because this combined both her interest and background, she was thrilled with the opportunity and immediately accepted. Ms. Weiss has found the Field Center Advisory Board both an appealing and unique place to serve due to its inclusion and commitment to community involvement, education of both Penn students and the surrounding community, and its influence on policy at the local and national levels. Aside from her impressive record in social work, Ms. Weiss is also the mother of four children. She is very proud of the work that the Field Center has done since its founding and is excited for its impact in the future.

FIELD CENTER STUDENT PROFILE: BETTY KIM

Originally from the Los Angeles area, Betty Kim knew that she had an interest in social work early on in her education. As an undergraduate at UCLA, Betty concentrated in sociology and then continued her education at the University of Pennsylvania, where she currently is a candidate for a dual degree in social work (MSW) and social policy (MS in Social Policy) in 2008. Her internship in the Los Angeles court system, in which she gave legal information to self-represented litigants in small claims court and family court, largely reaffirmed her decision to work in the field of social policy and practice.

Betty’s interest in child welfare piqued last academic year, when she did her social work field placement at the Penn Alexander School and worked with Field Center Faculty Director and School of Social Policy & Practice Dean Richard Gelles. She became involved with the Field Center for Children’s Policy, Practice & Research the following summer. Betty is currently assisting with the development of a Child Advocacy Center in Montgomery County, and her work is largely research based. She loves that the Field Center provides her with the opportunity to meet with national experts in the field of child welfare on a weekly basis. In her spare time, Betty plays club field hockey and is the Vice President of the SP2 Student Council.

THE FIELD CENTER ANNOUNCES ITS FALL 2007 BREAKFAST SYMPOSIUM

Findings from the Multi-Site Evaluation of Children’s Advocacy Centers: Implications for Future CAC Development

Presenter: Lisa M. Jones, PhD

Lisa M. Jones, PhD is currently a Research Assistant Professor of Psychology at the University of New Hampshire and Faculty at the Crimes Against Children Research Center (CCRC) at UNH. She has conducted research on child maltreatment and the community response to victims for the past ten years and has numerous publications and presentations on topics such as trends in child abuse, child abuse investigations, multidisciplinary teamwork, and Children’s Advocacy Centers.

Tuesday December 4, 2007 from 8:30 to 10:30 AM
Penn Law School - Levy Conference Center, 3400 Chestnut Street, Philadelphia

Social Work CEUs and CLE credit for attorneys are available
For more information and to register, please contact the Field Center at fieldctr@sp2.upenn.edu or 215.573.5442
<table>
<thead>
<tr>
<th>DATE &amp; LOCATION</th>
<th>EVENT &amp; SPONSOR</th>
<th>CONTACT INFORMATION</th>
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</thead>
<tbody>
<tr>
<td>December 10–December 12, 2007 New Orleans, LA</td>
<td>Child Welfare League of America (CWLA) 2007 National Adoption and Foster Care Training Conference Shared Beliefs, Shared Values: Achieving Excellence in Adoption and Foster Care</td>
<td>Phone: (202) 942-0253 Email: <a href="mailto:mwillia@cwla.org">mwillia@cwla.org</a> Website: <a href="http://www.cwla.org/conferences/conferences.htm">www.cwla.org/conferences/conferences.htm</a></td>
</tr>
<tr>
<td>January 28–February 1, 2008 San Diego, CA</td>
<td>San Diego International Conference on Child and Family Maltreatment</td>
<td>Email: <a href="mailto:sdconference@rchsd.org">sdconference@rchsd.org</a> Phone: 858-966-4972 Website: <a href="http://www.chadwickcenter.org">www.chadwickcenter.org</a></td>
</tr>
<tr>
<td>February 25–February 27, 2008 Washington, DC</td>
<td>Child Welfare League of America (CWLA) 2008 National Conference Children 2008</td>
<td>Phone: (703) 412-2400 Website: <a href="http://www.cwla.org/conferences">www.cwla.org/conferences</a></td>
</tr>
<tr>
<td>March 12–March 14, 2008 San Francisco, CA</td>
<td>National Abandoned Infants Assistance Resource Center (AIA) Annual Conference Strengthening Connections</td>
<td>Email: <a href="mailto:aia@berkeley.edu">aia@berkeley.edu</a> Phone: (510) 643-8390 Website: aia.berkeley.edu/strengthening_connections/index.html</td>
</tr>
<tr>
<td>April 20–April 23, 2008 Minneapolis, MN</td>
<td>National Indian Child Welfare Association (NICWA) 26th Annual “Protecting Our Children” National American Indian Conference on Child Abuse and Neglect</td>
<td>Email: <a href="mailto:isla@nicwa.org">isla@nicwa.org</a> Phone: (503) 222-4044 Website: <a href="http://www.nicwa.org/conference">www.nicwa.org/conference</a></td>
</tr>
<tr>
<td>May 19–May 22, 2008 Milwaukee, WI</td>
<td>Prevent Child Abuse America 2008 Prevent Child Abuse America National Conference</td>
<td>Phone: (312) 663-3520 Website: <a href="http://www.preventchildabuse.org/events/index.shtml">www.preventchildabuse.org/events/index.shtml</a></td>
</tr>
<tr>
<td>June 3–June 6, 2008 Tucson, AZ</td>
<td>American Humane Association American Humane’s 2008 Conference on Family Group Decision Making</td>
<td>Phone: (303) 792-9900 Website: <a href="http://www.americanhumane.org">www.americanhumane.org</a></td>
</tr>
<tr>
<td>July 13–July 16, 2008 The Woodlands, TX</td>
<td>Foster Family-based Treatment Association (FTTA) FFTA 22nd Annual Conference on Treatment Foster Care</td>
<td>Email: <a href="mailto:shorowitz@ffta.org">shorowitz@ffta.org</a> Phone: (800) 414-3382 Website: <a href="http://www.ffta.org/conference">www.ffta.org/conference</a></td>
</tr>
<tr>
<td>July 16–July 20, 2008 Nashville, TN</td>
<td>National Technical Assistance Center for Children’s Mental Health/Georgetown University Center for Child and Human Development Training Institutes 2008: Developing Local Systems of Care for Children and Adolescents with Mental Health Needs and Their Families</td>
<td>Email: <a href="mailto:Institutes2008@aol.com">Institutes2008@aol.com</a> Phone: (202) 687-5000 Website: gucchd.georgetown.edu</td>
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We are grateful to the following individuals and corporations for their generous donations to the Field Center for Children’s Policy, Practice & Research.

Lisa Bieber  
Robert S. Blank  
Dr. Erwin A. Carner  
Children’s Hospital of Philadelphia  
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Joseph and Marie Field Foundation  
Glickenhaus Foundation  
Lynn Hubschman  
Mary Love  
Maida R. Milone  
Mark Ostroff  
Dr. Robert L. Sadoff  
Craig A. Snider  
Sonia Triester  
Anne Marcus Weiss  
Raymond and Joanne Welsh

Your tax-deductible donation to the Field Center for Children’s Policy, Practice & Research enables us to continue our critical work. Thanks to a challenge grant from the Joseph and Marie Field Foundation, gifts are matched on a dollar-for-dollar basis.

A self-sustaining entity, the Field Center relies on the generosity of those concerned with the welfare of vulnerable children to enable us to continue our critical work. A self-addressed stamped envelope is included for your convenience, or you can give a gift on-line by visiting www.sp2.upenn.edu and clicking “Give Online.” For more information, please contact Director of Development Nadina Deigh at (215) 898-5518 or deighn@sp2.upenn.edu.
NEWS FROM THE FIELD
Fall 2007

Newsletter Highlights...

- Increased Collaboration Needed to Address the Mental Health Needs of Youth in The Child Welfare System
- Field Center Awarded Grant From North Penn Community Health Foundation