CHAPTER 6

Initial Assessment or Investigation

Caseworkers feel pressure from many different directions—children, families, statutory and agency expectations, and themselves. Family members who are reported to child protective services (CPS) typically feel embarrassed, defensive, angry, confused, threatened, and helpless. As families experience these feelings, they need the CPS caseworker to provide them with information to understand what they are accused of, what may happen, what the next steps are, what they can expect from the agency, and what they are expected to do. The agency expects the caseworker to meet the statutory deadlines by quickly gathering information about the children and family and determining if maltreatment occurred, the likelihood that it will occur again, and the threat of immediate serious harm to the child. At the same time caseworkers should manage their own fears and doubts—Is the child really safe? What else could I have done?[41]

This chapter describes the purposes of the initial assessment or investigation—to gather and analyze information in response to CPS reports, to interpret the agency's role to the children and families, and to determine which families will benefit from further agency intervention. After interviewing all parties and gathering all relevant information, CPS caseworkers must determine whether maltreatment has occurred and can be substantiated. In most States, CPS staff are mandated by law to determine whether the report is substantiated or founded (meaning that credible evidence indicates that abuse or neglect has occurred) or whether the report is unsubstantiated or unfounded (meaning that there is a lack of credible evidence to substantiate child maltreatment—but does not mean it did not necessarily occur). Depending on State law, CPS agencies usually have up to 30, 60, or 90 days after receiving the report to complete the initial assessment or investigation. A major part of the initial assessment or investigation includes determining whether there is a risk or likelihood of maltreatment occurring in the future and whether the child is safe (not at risk of imminent, serious harm). In addition, CPS caseworkers must decide whether ongoing services to reduce risk and assure child safety should be provided by the CPS agency or other community partners. This chapter addresses the following:

- Effective initial assessment or investigation characteristics
- Initial assessment or investigation decisions
- Initial assessment or investigation processes
- Interviewing techniques
- Community involvement
- Special practice issues

Effective Initial Assessment or Investigation Characteristics

In cooperative investigations, CPS workers form an alliance with both the children and family. In a well-handled investigation, the worker:

- Involves the children and family during the exploration of the allegations to gain their perceptions of the allegations;
- Focuses on the children's, the parent's, and the family's strengths and resources; their plans for building protective factors; and past and present actions to protect the children;
- Listens carefully to the family's experience to make sure they know they have been heard and understood;
- Demonstrates sensitivity and empathy regarding the anxiety experienced by the children and family;
- Communicates clearly and openly CPS's statutory role;
- Focuses on small steps, making sure the children and family understand each one;
- Involves the children and family in the decisions that affect them by providing choices and opportunities for input;
- Demonstrates flexibility in the interview;
- Focuses on gathering comprehensive information rather than trying to identify solutions, which is best left for later in the casework process.[42]

Initial Assessment or Investigation Decisions

To make effective decisions during the initial assessment or investigation process, the CPS caseworker must have competent interviewing skills; be able to gather, organize, and analyze information; and arrive at accurate conclusions. Critical decisions that must be made at this stage of the CPS process include the following:

- Is child maltreatment substantiated as defined by State statute or agency policy?
- Is the child at risk of maltreatment, and what is the level of risk?
- Is the child safe and, if not, what type of agency or community response will ensure the child's safety in the least intrusive manner?
- If the child's safety cannot be assured within the family, what type and level of care does the child need?
- Does the family have emergency needs that must be met?
- Should ongoing agency services be offered to the family?

Decision Point One: Substantiating Maltreatment

The substantiation decision depends on the answers to two questions: "Is the harm to the child severe enough to constitute child maltreatment?" and "Is there sufficient evidence to support this being a case of child maltreatment?"[43] Even in those cases lacking evidence, CPS caseworkers should still document information since unsubstantiated reports may eventually show a pattern that can be substantiated. Due to varying State regulations regarding the expungement of records, this may not be possible for all agencies.

Upon completion of the initial assessment, the caseworker must determine the disposition of the report based on State laws, agency guidelines, and the information gathered. CPS agencies use different terms for this decision–substantiated, confirmed, unsubstantiated, founded, or unfounded. To guide

caseworker judgment in making the substantiation decision, each State has developed policies that outline what constitutes credible evidence that abuse or neglect has occurred. Most States have a two-tiered system: substantiated-unsubstantiated or founded-unfounded. Some States have a three-tiered system of substantiated, indicated, or unsubstantiated. The indicated classification means the caseworker has some evidence that maltreatment occurred, but not enough to substantiate the case.

At this point in the decision-making process, caseworkers should ask themselves:

- Have I obtained enough information from the children, family, and collateral contacts to adequately reach a determination about the alleged abuse or neglect?
- Is my decision on substantiation based upon a clear understanding of State laws and agency policies?
- Have I assessed the need for other agency or community services when CPS intervention is not warranted?[44]

The following sections discuss substantiation decisions for different types of maltreatment—child neglect, physical abuse, sexual abuse, and psychological maltreatment.

Determining Child Neglect

Determining child neglect is based on the answers to two questions: "Do the conditions or circumstances indicate that a child's basic needs are unmet?" and "What harm or threat of harm may have resulted?"[45] Answering these questions requires sufficient information to assess the degree to which omissions in care have resulted in significant harm or significant risk of harm. Unlike the other forms of maltreatment, this determination may not be reached by looking at one incident; the decision often requires looking at patterns of care over time. The analysis should focus on examining how the child's basic needs are met and identifying situations that may indicate specific omissions in care that have resulted in harm or the risk of harm to the child.[46]

Affirmative answers to the following questions may indicate that a child's physical and medical needs are unmet:

- Have the parents or caregivers failed to provide the child with needed care for a physical injury, acute illness, physical disability, or chronic condition?
- Have the parents or caregivers failed to provide the child with regular and ample meals that meet basic nutritional requirements, or have the parents or caregivers failed to provide the necessary rehabilitative diet to the child with particular health problems?
- Have the parents or caregivers failed to attend to the cleanliness of the child's hair, skin, teeth, and clothes? It is difficult to determine the difference between marginal hygiene and neglect. Caseworkers should consider the chronicity, extent, and nature of the condition, as well as the impact on the child.
- Does the child have inappropriate clothing for the weather and conditions? Caseworkers must consider the nature and extent of the conditions and the potential consequences to the child.
- Does the home have obvious hazardous physical conditions? For example, homes with exposed wiring or easily accessible toxic substances.
- Does the home have obvious hazardous unsanitary conditions? For example, homes with feces- or trash-covered flooring or furniture.
- Does the child experience unstable living conditions? For example, frequent changes of residence or evictions due to the caretaker's mental illness, substance abuse, or extreme poverty?
- Do the parents or caregivers fail to arrange for a safe substitute caregiver for the child?

- Have the parents or caregivers abandoned the child without arranging for reasonable care and supervision? For example, have caregivers left children without information regarding their whereabouts?[47]

While State statutes vary, most CPS professionals agree that children under the age of 8 who are left alone are being neglected. It is also agreed that children older than 12 are able to spend 1 to 2 hours alone each day. In determining whether neglect has occurred, the following issues should be considered, particularly when children are between the ages of 8 and 12:

- The child's physical condition and mental abilities, coping capacity, maturity, competence, knowledge regarding how to respond to an emergency, and feelings about being alone.
- Type and degree of indirect adult supervision. For example, is there an adult who is checking in on the child?
- The length of time and frequency with which the child is left alone. Is the child being left alone all day, every day? Is he or she left alone all night?
- The safety of the child's environment. For example, the safety of the neighborhood, access to a telephone, and safety of the home.

Determining Physical Abuse

In determining whether physical abuse occurred, the key questions to answer are "Could the injury to the child have occurred in a nonabusive manner?" and "Does the explanation given plausibly explain the physical findings?"[48] The caseworker must gather information separately from the child, the parents, and other possible witnesses regarding the injuries. The following questions may help determine if abuse occurred:

- **Does the explanation fit the injury?** For example, the explanation of a baby falling out of a crib is not consistent with the child having a spiral fracture. It is important to know the child's age and developmental capabilities to assess the plausibility of some explanations. It is also crucial to receive input from medical personnel and exams.
- **Is an explanation offered?** Some caregivers may not offer an explanation, possibly due to denial or an attempt to hide abuse.
- **Is there a delay in obtaining medical care?** Abusive caregivers may not immediately seek medical care for the child when it is clearly needed, possibly to deny the seriousness of the child's condition, to try to cover up the abuse, or in hope that the injury will heal on its own.

Caseworkers must also examine the nature of the injury, such as bruises or burns in the shape of an implement, e.g., a welt in the shape of a belt buckle or a cigarette burn.

Determining Sexual Abuse

In addition to the factors mentioned in determining physical abuse, the caseworker should ask the following questions to determine whether sexual abuse has occurred:

- Who has reported that the child alleges sexual abuse? For example, caseworkers should be alert to separated or divorced parents making allegations against each other.
- What are the qualifications of the professional reporting the physical findings? For example, if the health care providers do not routinely examine the genitalia of young children, they may mistake normal conditions for abuse or vice versa.
- What did the child say? Did the child describe the sexual abuse in terms that are consistent with their developmental level? Can the child give details regarding the time and place of the incident?
- When did the child make a statement or begin demonstrating behaviors suspicious of sexual abuse and symptoms causing concern? Was the

child's statement spontaneous? Has the child been exposed to adult sexual acts?

- Where does the child say the abuse took place? Is it possible for it to have occurred in that setting? Is it possible that the child is describing genital touching that is not sexual in nature? For example, bathing the child.[49]

Determining Psychological Maltreatment

Psychological maltreatment has been given relatively little serious attention in research and practice until recently. There are many reasons for this, including problems with inadequate definitions, failure to establish cause-and-effect relationships, and the difficulty of clarifying the cumulative impact of psychological maltreatment.[50] In order to determine if psychological maltreatment or emotional abuse occurred, caseworkers must have information on the caregiver's behavior over time and the child's behavior and condition. Caseworkers must determine whether there is a chronic behavioral pattern of psychological maltreatment, such as caregivers who place expectations on the child that are unrealistic for the child's developmental level, threaten to abandon the child, or direct continually critical and derogatory comments toward the child. There also must be indicators in the child's behavior suggestive of psychological maltreatment; however, the child's behavior alone is often insufficient to substantiate a case. Caseworkers must determine whether the child has suffered emotional abuse. The following questions may help determine if psychological maltreatment has occurred:

- Is there an inability to learn not explained by intellectual, sensory, or health factors?
- Is there an inability to build or maintain satisfactory interpersonal relationships with peers or adults?
- Are there developmentally inappropriate behaviors or feelings in normal circumstances?
- Is there a general pervasive mode of unhappiness, depression, or suicidal feelings?
- Are there physical symptoms or fears associated with personal or school functioning, such as bedwetting or a marked lack of interest in school activities?[51]

Demonstrating a causal connection between the caregiver's behavior and the child's behavior is often difficult to substantiate. This minimally necessitates that the caseworker observe caregiver-child interaction on several occasions, as well as be informed from other sources' observations (e.g., school personnel, relatives, and neighbors).

Decision Point Two: Assessing Risk

Risk factors are influences present in the child, the parents, the family, and the environment that may increase the likelihood that a child will be maltreated. Risk assessment involves evaluating the child and family's situation to identify and weigh the risk factors, family strengths and resources, and agency and community services.[52] While risk assessment has been an integral part of CPS since the field's inception, the formalization of the process and decision-making, through the development of risk assessment instruments, has taken place just within the last 12 to 15 years.[53]

This section describes risk assessment models and its key elements, the analysis of risk assessment information, special cases of risk assessment (when substance abuse or domestic violence coexist with maltreatment), and cultural factors for consideration.

Risk Assessment Models

The majority of States use risk assessment models or systems that are designed to:

- Guide and structure decision-making;

- Predict future harm and classify cases;
- Aid in resource management by identifying service needs for children and families served;
- Facilitate communication within the agency and with other community stakeholders.[54]

Exhibit 6-1 presents additional detail of the types of risk assessment information in each area.

Exhibit 6-1
Risk Assessment Information

Maltreatment

- Caregiver actions and behaviors responsible for the maltreatment
- Duration and frequency of the maltreatment
- Physical and emotional manifestations in the child
- Caregiver's attitude toward the child's condition and the assessment process
- Caregiver's explanation of the events and effects of the maltreatment

Child

- Age
- Developmental level
- Physical and psychological health
- Temperament
- Behavior
- Current functioning
- Child's explanation of events and effects, if possible and appropriate

Caregiver(s)

- Physical and mental health
- History
- Current functioning
- Coping and problem-solving capacity
- Relationships outside of the home
- Financial situation

Exhibit 6-1
Risk Assessment Information

Family Functioning

- Power and issues of control within the family
- Interactions and communications among family members
- Interactions and connections with others outside the family
- Quality of relationships
- Problem-solving ability[55]

Analysis of Risk Assessment Information

Caseworkers analyze the information collected to determine what information is significant as it relates to the risk of maltreatment. The following are suggested steps for assessing risk:

- Organize the information by defined category (e.g., education level, stressors);
- Determine if there is sufficient and believable information to confirm the risk factors, strengths and resources, and their interaction;
- Use the risk model to assign significance to each of the risk factors and strengths.[56]

The caseworker groups this information into an overall picture of the family and its dynamics and analyzes it to assess the current level of risk of maltreatment. This dictates the next steps in service provision and interaction with the family.

Risk Assessment in Cases of Substance-abusing Families

Risk assessment in these cases also examines the extent of substance use, its impact on lifestyle, and its impact on parenting. The following scales are often used to assess risk in families where there is substance abuse:

- **Parent's commitment to recovery.** This scale assesses a parent's stage of recovery, willingness to change behavior, and desire to live a life free from alcohol and other drugs.
- **Patterns of substance use.** This scale assesses the parent's pattern of alcohol and other drug use—ranging from active use without regard to consequences to significant periods of abstinence.
- **Effects of substance use on child caring.** This scale assesses the parent's ability to care for his or her children and meet their emotional and physical needs.
- **Effects of substance use on lifestyle.** This scale assesses a parent's ability to carry out his or her everyday responsibilities and any consequences that may have for the family.
- **Support for recovery.** This scale assesses parent's social network and how that network may support or interfere with recovery.[57]

The Child Welfare League of America (CWLA) suggests some questions caseworkers can ask regarding alcohol and other drug abuse to facilitate risk assessment in these cases:

- Do you use any drugs other than those prescribed by a physician?

- Have you ever felt you should cut down on your drinking or drug use?
- Has a physician ever told you to cut down or quit the use of alcohol or drugs?
- Have people annoyed you by criticizing or complaining about your drinking or drug use?
- Have you ever felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or drug in the morning ("eye opener") to steady your nerves or to get rid of a hangover?
- Has your drinking or drug use caused a family, job, or legal problem?
- When drinking or using drugs, have you had a memory loss or blackout?[58]

Risk Assessment in Cases in Which Partner Abuse and Child Maltreatment Coexist

The following factors should be considered to assess risk in cases where partner abuse and child abuse and neglect coexist:

- An abuser's access to the child or adult victim
- The abuser's pattern of abuse
  - Frequency or severity of the abuse in current and past relationships
  - Use and presence of weapons
  - Threats to kill the victim or other family members
  - Stalking or abduction
  - Past criminal record
  - Abuse of pets
  - Child's exposure to violence
- The abuser's state of mind
  - Obsession with the victim
  - Jealousy
  - Ignoring the negative consequences of the violence
  - Depression or desperation
- Individual factors that reduce the behavioral controls of either the victim or abuser
  - Abuses alcohol or other substances
  - Uses certain medications
  - Suffers from psychosis or other major mental illnesses
  - Suffers from brain damage
- A victim, child, or abuser thinking about or planning suicide
- An adult victim's use of physical force or emotional abuse
- A child's use of violence
- Situational factors
  - Presence of other major stresses, such as poverty, loss of a job, or chronic illness
  - Increased threat of violence when victim leaves or attempts to leave abuser
  - Increased risk when abuser has ongoing or easy access to victims
  - Physical inability of nonabusing parent to protect child due to assault
  - Nonabusing parent's fear of leaving or inability to leave due to economic status or lack of place to go
- Past failures of response systems (e.g., courts, law enforcement) to react appropriately.[59]

The following are areas to assess with a child regarding partner abuse and child maltreatment:

- **Pattern of the abusive conduct.** What happens when your parents (the adults) fight? Does anyone hit, shove, or push? Are serious threats made? Does anyone throw things or damage property? Has anyone used a gun or

knife? When was the last big fight between your parents?

- **Impact of domestic violence on the adult victim.** Has anyone been hurt or injured? Is your mom or dad afraid? How do your parents act after a bad fight? Have you ever seen the police or anyone come over because of their fights? Have you seen injuries or damaged property?

- **Impact of domestic violence on the child.** Have you ever been hurt by any of their fights? What do your brothers or sisters do during fights? Are you ever afraid when your parents fight? How do you feel during a fight? After the fight? Do you worry about the violence? Do you talk to anyone about the fights? Do you feel safe at home? Have you ever felt like hurting yourself or someone else?

- **Child's protection.** Where do you go during their fights? Have you tried to stop a fight? Have you ever had to take sides? In an emergency for your parent or yourself, what would you do? Who would you call? Have you ever called for help? What happened?

- **Child's knowledge of danger.** Has anyone needed to go to a doctor after a fight? Do the adults use guns or knives? Do you know where the gun is? Has anyone threatened to hurt someone? What did the person say?[60]

Cultural Factors in Risk Assessment

Caseworkers should integrate cultural sensitivity into the risk assessment process by:

- Considering the family's cultural identification and perception of the dominant culture;

- Inquiring about the family's experience with mainstream institutions, including CPS and other service providers in the community;

- Assuring clarity regarding language and meanings in verbal and nonverbal communication;

- Understanding the family's cultural values, principles of child development, child caring norms, and parenting strategies;

- Gaining clarity regarding the family's perceptions of the responsibilities of adults and children in the extended family and community network;

- Determining the family's perceptions of the impact of child abuse or neglect;

- Assessing each risk factor with consideration to characteristics of the cultural or ethnic group;

- Considering the child and family's perceptions of their response to acute and chronic stressors;

- Explaining why a culturally accepted behavior in the family's homeland may be illegal here.[61]

Decision Point Three: Determining Child Safety

A child is considered unsafe when he or she is at imminent risk of serious harm. Safety is an issue throughout the life of a case. The Adoption and Safe Families Act (ASFA) requires that States assess and assure a safe environment for children in birth families, out-of-home placements, and adoptive homes. It is important to remember that determining the risk of maltreatment and the child's safety are two separate decisions. Children may be at risk of harm some time in the future (risk assessment) and they may currently be safe (no threat of imminent serious harm). The following sections describe the key safety decision points, the steps for arriving at the safety decision, and the development of a safety plan.

Safety Decision Points

There are two key decision points during the initial assessment or investigation in which the child's safety is evaluated. During the first contact with the child and family, the caseworker must decide whether the

child will be safe during the initial assessment or investigation. The question caseworkers must ask themselves is, "Is the child in danger right now?" Caseworkers assess current danger by searching for factors in the family situation and caregiver behavior or condition, including emotions, physical circumstances, and social contexts. Examples include: young children with serious injuries that are inconsistent with the caregiver's explanation; children in the care of people who are out of control or violent; and premeditated maltreatment or cruelty.

The second critical time for evaluating safety is at the conclusion of the initial assessment. This safety assessment follows the determination of the validity of the report and the level of risk. Caseworkers must determine:

- Whether the child will be safe in his or her home with or without continuing CPS services;
- Under what circumstances a case can be diverted to community partners;
- Under what circumstances intensive, home-based services are necessary to protect a child;
- Whether the child needs to be placed in out-of-home care.

To determine safety at this point, the caseworker uses the findings of the risk assessment. The caseworker identifies the risk factors that directly affect the safety to the child; the risk factors that are operating at a more intense, explosive, immediate, or dangerous level; or those risk factors that in combination present a more dangerous mix. The caseworker weighs the risk factors directly affecting the child's safety against the family protective factors (i.e., strengths, resiliencies, resources) to determine if the child is safe.[62]

Steps for Arriving at the Safety Decision

The sequential steps for arriving at the safety decision include:

1. Identifying the behaviors and conditions that increase concern for the child's safety, and considering how they affect each child in the family.
2. Identifying the behaviors or conditions (i.e., strengths, resiliencies, resources) that may protect the child.
3. Examining the relationship among the risk factors. When combined, do they increase concern for safety?
4. Determining whether family members or other community partners are able to address safety concerns without CPS intervention.
5. Considering what in-home services are needed to address the specific behaviors or conditions for each risk factor directly affecting the child's safety.
6. Identifying who is available (CPS or other community partners) to provide the needed service or intervention in the frequency, timeframe, and duration the family needs to protect the child.[63]
7. Evaluating the family's willingness to accept and ability to use the intervention or service at the level needed to protect the child.

If the services or interventions are not available or accessible at the level necessary to protect the child, or if the caregivers are unable or unwilling to accept the services, the caseworker should consider whether the abusive caregiver can leave home and the nonoffending caregiver can protect the child. If not, the caseworker should consider whether out-of-home care and court intervention is needed to assure the child's protection.

Development of a Safety Plan

The safety plan and the case plan have two different purposes. The interventions in the safety plan are designed to control the risk factors posing a safety threat to the child. Interventions in the case

plan, however, are designed to facilitate change in the underlying conditions or contributing factors resulting in maltreatment. To control the risk factors directly affecting child safety, the safety interventions must:

- Have a direct and immediate impact on one or more of the risk factors;
- Be accessible and available in time and place;
- Be in place for the duration of the threat of harm;
- Fill the gaps in caregiver protective factors.

In identifying safety interventions and developing a safety plan, CPS caseworkers are required to make reasonable efforts to preserve or reunify families. Child safety is the most important consideration in these efforts. ASFA also states that when certain factors are present (e.g., abandonment, torture, chronic abuse, some forms of sexual abuse, killing of another person or the child's sibling, or termination of parental rights for another child), they constitute enough threat to a child's safety that reasonable efforts are not required to prevent placement or to reunify the family. The sequence of least intrusive to most intrusive safety interventions include:

- In-home services, perhaps combined with partial out-of-home services (e.g., daycare services);
- Removal of abusive caregiver;
- Relative or kinship care;
- Out-of-home-placement.

When possible, the safety assessment should be conducted jointly with the family; it may not, however, be safe to include the perpetrator. The safety plan also should be negotiated with the family. This accomplishes the following:

- Caseworker and caregiver can assess the feasibility of the caregiver following the safety plan.
- Caseworker can be assured that the caregiver understands the consequences of his or her choices.
- Caregiver is provided with a sense of control over what happens.
- Caregiver is able to salvage a sense of dignity.[64]

Decision Point Four: Determining Emergency Needs

Child maltreatment is often not an isolated problem; many families referred to CPS experience multiple and complex problems, often at crisis levels. Due to any number of these problems that may be identified during the initial assessment or investigation, the CPS caseworker is often in the position of determining whether a family has emergency needs and of arranging for emergency services for the child and family. Examples of emergency services can include:

- Medical attention
- Food, clothing, and shelter
- Mental health care
- Crisis counseling

Decision Point Five: Offering Services

The decision that a caseworker makes at the end of the initial assessment or investigation is whether a family should be offered ongoing child protective services or other agency services. Who is offered services and on what basis that decision is made depend on the guidelines and availability of services that vary from State to State and sometimes county to county. In some cases, the decision is made based on whether a report is substantiated. In other instances, the decision to offer services is based on the level of perceived risk of maltreatment in the future since substantiation alone is not the best predictor of future maltreatment.

Noninvestigative or Alternative Responses

Traditionally, CPS agencies are required to respond to all reports of child maltreatment with a standard investigation that is narrowly focused on determining whether a specific incident of abuse actually occurred.[65] States are attempting to enhance CPS practice and build community partnerships in responding to cases of child maltreatment. One changing area of CPS practice is greater flexibility in responding to allegations of abuse and neglect. A "dual track" or "multi-track" response permits CPS agencies to respond differentially to children's needs for safety, the degree of risk present, and the family's need for support or services. Typically, in cases where abuse and neglect are serious or serious criminal offenses against children have occurred, an investigation will commence. An investigation focuses on evidence gathering and will include a referral to law enforcement. In less serious cases of child maltreatment where the family may benefit from services, an assessment will be conducted. In these cases, the facts regarding what happened will be obtained, but the intervention will emphasize a comprehensive assessment of family strengths and needs. The assessment is designed to be a process where parents or caregivers are partners with the CPS agency, and that partnership begins with the very first contact. States that have implemented the "dual track" approach have shown that a majority of cases now coming to CPS can be safely handled through an approach that emphasizes service delivery and voluntary family participation in addition to the fact finding of usual CPS investigations.[66] CPS can switch a family to the investigative track at any point if new evidence is uncovered to indicate that the case is appropriate for investigation rather than assessment.[67]

Initial Assessment or Investigation Process

To make accurate decisions during the initial assessment or investigation, caseworkers must:

- Employ a protocol for interviewing the identified child, the siblings, all of the adults in the home, and the alleged maltreating parent or caregiver;
- Observe the child, the siblings, and the parent or caregiver's interaction among family members, as well as the home, the neighborhood, and the general climate of the environment;
- Gather information from any other sources who may have information about the alleged maltreatment or the risk to and safety of the children;
- Analyze the information gathered in order to make necessary decisions.

Using Interview Protocols

The initial assessment or investigation of alleged maltreatment of children requires that CPS respond in an orderly, structured manner to gather sufficient information to determine if maltreatment took place and to assess the risk to and safety of the child. Employing a structured interview protocol ensures that all family members are involved and that information-gathering is thorough; increases staff control over the process; improves the capacity of CPS staff to collaborate with other disciplines; and increases staff confidence in the initial assessment or investigation conclusions. If at all possible, family members should be interviewed separately in the following order:

- Identified child
- Any siblings or other children in the home
- Alleged perpetrator
- All other adults in the home separately
- Family as a whole

Depending on the circumstances of the report, it must be determined whether it is in the child's best interest for the CPS worker to initiate an unannounced visit to interview the parent or to contact the parent to schedule an interview.[68] If the child is out of the home at the time (e.g., the child is at school), the process should begin with an introduction to the parent(s) to explain the purposes of the initial assessment or investigation and, if required by law, request permission to interview all family members individually, beginning with the identified child. It is important to remember that the safety of the child is of paramount importance in every case. If there is concern that talking with the parents first or obtaining their permission to interview the child places the child at risk of imminent harm, then the CPS caseworker should proceed in a manner that assures the child's safety. All family members should be interviewed alone to establish rapport and a climate of trust and openness with the caseworker, which is designed to increase the accuracy of the information gathered. A benefit noted across professional boundaries regarding the use of individual interviewing protocols is that it enables the caseworker to utilize information gathered from one interview to assist in the next interview.

Planning the Interview Process

Based on the information gathered at intake, each initial assessment or investigation should be planned with consideration given to:

- Where the interviews will take place;
- When the interviews will be conducted;
- How many interviews will likely be needed;
- How long each interview will likely last;
- Whether other agencies should be notified to participate in the interviews.

Interviewing the Sources

During the initial assessment or investigation process, caseworkers should conduct interviews with the following individuals:

- **Identified child victim.** The purpose of the initial interview with the identified child is to gather information regarding the alleged maltreatment and any risk of future maltreatment, and to assess the child's immediate safety. Because CPS's purpose is beyond just finding out what happened with respect to any allegations of maltreatment, the interview with the child addresses the strengths, risks, and needs regarding the child, his or her parents, and his or her family.
- **Siblings.** Following the interview with the identified child, the next step in the protocol is to interview siblings. The purpose of these interviews is to determine if siblings have experienced maltreatment, to assess the siblings' level of vulnerability, to gather corroborating information about the nature and extent of any maltreatment of the identified child, and to gather further information about the family that may assist in assessing risk to the identified child and any siblings.
- **All of the nonoffending adults in the home.** The primary purpose of these interviews is to find out what adults know about the alleged maltreatment, to gather information related to the risk of maltreatment and the safety of the child, to gather information regarding family strengths or protective factors, and to determine the adults' capacity to protect the child, if indicated.
- **Alleged maltreating parent or caregiver.** The purpose of this interview is to evaluate the alleged maltreating caregiver's reaction to allegations of maltreatment as well as to the child and his or her condition, and to gather further information about this person and the family in relation to the risk to and safety of the child.

Exhibit 6-2 Examples of Information to Obtain During Initial Interviews				
Topic Area	**Interview with the Identified Child**	**Interview with the Siblings**	**Interview with All Nonoffending Adults in the Home**	**Interview with Alleged Maltreating Parent or Caretaker**
The Alleged Maltreatment	• Description of what happened with respect to the alleged maltreatment, when and where it occurred, and who was present • Child's current condition • Type, severity, and chronicity of the maltreatment • Effects of maltreatment (e.g., extreme withdrawal, fear of parents) • Identity of others who have information about the child's condition and the family situation	• Information about alleged maltreatment • Maltreatment they have experienced and, if so, how, when, where, how often, and for how long	• What the adults know about the alleged maltreatment • Feelings regarding the maltreatment and about CPS • Acceptance or rejection of the child's version of what might have happened and who the adult deems responsible • Capacity to protect the child (if indicated) and his or her opinion about the vulnerability of the child	• Description of what happened in relation to alleged maltreatment • Response to the incident(s) and to CPS • Access to the child

Exhibit 6-2
Examples of Information to Obtain During Initial Interviews

Topic Area	Interview with the Identified Child	Interview with the Siblings	Interview with All Nonoffending Adults in the Home	Interview with Alleged Maltreating Parent or Caretaker
The Child	• Child's characteristics (e.g., age, developmental level, physical or mental handicaps, health, mental health status) • Child's behavior and feelings • Child's relationship with peers, family, and others • Child's daily routine (e.g., school, home life)	• Information that could not be obtained from the identified child or confirmation of information gathered during the initial interview	• Feelings, expectations, and perspective about the identified child and siblings • Empathy for the child's condition and experience • Description of the child's feelings and behaviors	• View of the child and the child's characteristics and condition • Relationship with the child and others in the family

Exhibit 6-2
Examples of Information to Obtain During Initial Interviews

Topic Area	Interview with the Identified Child	Interview with the Siblings	Interview with All Nonoffending Adults in the Home	Interview with Alleged Maltreating Parent or Caretaker
The Family	• Asking who resides in the home • Child's relationship with and feelings toward the parents or caregivers and siblings • Child's perception of the relationships among others in the household • Child's perception of how family problems are addressed and how the family communicates	• Siblings' characteristics, behaviors, and feelings • Further information about the parents (e.g., feelings and behaviors frequently exhibited, problems, child rearing measures, and parents' relationships outside the home) • Further information about the family's functioning, dynamics, demographics, and characteristics	• Relationship to the child and to the alleged maltreating caretaker • Approach to and view of parenting • How decisions are made in the family, and who usually makes decisions about the children • Types of discipline they considered appropriate • Who is involved in child care responsibilities in the family	• Approach to parenting, expectations, and sensitivity to children • Roles and functioning in the family • Methods of communication and level of affection • Who usually makes decisions about the children in the family • Discipline the family considers to be appropriate

Exhibit 6-2
Examples of Information to Obtain During Initial Interviews

Topic Area	Interview with the Identified Child	Interview with the Siblings	Interview with All Nonoffending Adults in the Home	Interview with Alleged Maltreating Parent or Caretaker
The Family (continued)	• Description of who's involved in child care responsibilities (e.g., extended family, informal kin) • Child's perception of the family's identification with a tribe, race, or larger cultural group • Child's perception of the family's rituals, traditions, and behaviors • Child's description and perception of what happens when parents or caregivers fight		• How cultural beliefs are incorporated in family functioning • Role religion plays in the family, and how it affects child-rearing practices • Family's rituals, traditions, and behaviors • Roles in the family and family functioning • Communication and expressions of affection • Demographics about the family, including financial status and other factors that may be stress producing • Presence of domestic violence or partner abuse	• Responsibility for child care • Cultural beliefs incorporated in family functioning • Role religion plays in the family and how it affects child rearing • Family's rituals, traditions, and behaviors • Description of demographics about the family, including financial status and other factors that may be stress producing • Presence of domestic violence or partner abuse

Exhibit 6-2
Examples of Information to Obtain During Initial Interviews

Topic Area	Interview with the Identified Child	Interview with the Siblings	Interview with All Nonoffending Adults in the Home	Interview with Alleged Maltreating Parent or Caretaker
The Environment	• Child's description of where they go during parent or caregiver fights, whether they have tried to stop a fight, and who they would call for help • Description of the neighborhood, available resources, and the degree of crime or violence	• Child's description of where they go during parent or caregiver fights, whether they have tried to stop a fight, and who they would call for help • Description of the neighborhood, available resources, and the degree of crime or violence	• Description of the neighborhood, available resources, and the degree of crime or violence	• A description of the neighborhood, available resources, and the degree of crime or violence
The Adult or Caretaker			• Approach to solving problems, ability to deal with stress, use of drugs or alcohol • History as a child (positive and negative memories), educational and employment history, any criminal activity, or history of physical or mental health problems	• Present emotional state, particularly in terms of the possibility of further harm to the child • Approach to solving problems, dealing with stress, using drugs or alcohol, coping • View of self

Exhibit 6-2
Examples of Information to Obtain During Initial Interviews

Topic Area	Interview with the Identified Child	Interview with the Siblings	Interview with All Nonoffending Adults in the Home	Interview with Alleged Maltreating Parent or Caretaker
The Adult or Caretaker (continued)			• Relationships with others, memberships in clubs, or other activities • View of support network in his or her life, relationships with extended family, and the climate of the neighborhood and community	• History as a child and an adult, including any mental health or health problems, criminal history, etc. • Relationships outside the home, supports, memberships, and affiliations • Willingness to accept help (if needed)

Examples of the types of information that a caseworker should gather from each of these sources are presented in Exhibit 6-2.

Obtaining Information from Other Sources

Other sources may have information that will help in understanding the nature and extent of the alleged maltreatment and in assessing the risk to and safety of the child. According to CWLA's *Standards for Service for Abused or Neglected Children and Their Families*, other potential sources include, but are not limited to, professionals such as teachers, law enforcement officers, and physicians. Other community agencies, institutions, caretakers, or individuals known to the child and the family, such as relatives and neighbors, also may be consulted.[69] It also may be advisable to run a criminal background check on all adults in the home to ascertain prior abuse or other illegal activity. To protect the family's confidentiality, however, interviews or contacts with others should not be initiated without cause. The family also may disclose other persons who may have information about the alleged maltreatment or about the family in general. These contacts should be pursued within the constraints of the State law that mandates the scope of the initial assessment or investigation or, if indicated, clients may give permission for others to be contacted.

Following Up with the Children and Family

Following the completion of the interviews, the caseworker should reconvene the child and family, as appropriate, to:

- Share with them a summary of the findings and impressions;
- Seek individual responses concerning perceptions and feelings;
- Indicate interest in the children and family;
- Provide information about next steps, including whether ongoing services will be offered and whether court intervention will occur;
- Demonstrate appreciation for their participation in the process.

Interviewing Techniques

Part of the caseworker's responsibility is to increase the likelihood that the family will engage with the agency and follow a recommended course of action. This section describes techniques for interviewing and observing children and families. Exhibit 6-3 delineates principles underlying motivational interviewing.

Exhibit 6-3
Principles Underlying Motivational Interviewing

Principle	Description	Guiding Beliefs
Expressing Empathy	**Expressing empathy** involves communicating warmth and using reflective listening during every contact with the family members. The caseworker should use reflective listening to understand the family member's feelings and perspectives without judging, criticizing, or blaming. Acceptance is not the same thing as agreement or approval of the abusive or neglectful behavior. The crucial attitude is respectful listening to the family member with a desire to understand. Through the expression of respect and acceptance, caseworkers engage the client and embrace the child or adult's self-esteem.	• Acceptance facilitates change • Skillful, reflective listening is fundamental • Ambivalence is normal
Developing Discrepancy	**Developing discrepancy** is creating and amplifying in the family member's mind a discrepancy between present behavior and broader goals. This means helping the family member to see the discrepancy between where they are and where they want to be. This can be triggered by the family member's awareness of the costs of the present behavior. When a person sees that a behavior conflicts with important personal goals, change is likely to occur.	• Awareness of consequences • Disconnect between present behavior and important goals will motivate change
Avoiding Arguments	**Avoiding argumentation** is important in lessening resistance. What caseworkers want to do is increase the family member's awareness of problems and the need to do something about them. When caseworkers encounter resistance, they may need to stop their current approach because they are likely to be "fighting against the resistance" and may therefore need to take another approach. Caseworkers also need to avoid labeling the children and family.	• Arguments are counterproductive • Defending breeds defensiveness • Resistance is a signal to change strategies • Labeling is unnecessary

Exhibit 6-3 Principles Underlying Motivational Interviewing		
Principle	**Description**	**Guiding Beliefs**
Rolling with Resistance	**Rolling with resistance** requires the caseworker to acknowledge that reluctance and ambivalence are both natural and understandable. Caseworkers need to help the children and family consider new information and new perspectives. To do this, caseworkers turn a question or problem back to the children and family to help them discover their own solutions. This is based on the assumption that the person is capable of insight and that he or she can solve his or her own problems. This may not be possible, however, in all circumstances because of a variety of factors including cognitive impairment, mental illness, or substance abuse.	• Momentum can be used to good advantage • Perceptions can be shifted • New perspectives are invited, not imposed • The child and family are a valuable resource in finding solutions to problems
Supporting Self-Efficacy	**Supporting self-efficacy** means supporting the child or adult's belief in his or her ability to carry out and succeed with a specific task. The caseworker's task is to help increase the person's perceptions of his or her capability to cope with obstacles and succeed in changing their behavior.	• Hope and faith are important elements of change • Children and families can be helped to discover solutions • Personal responsibility is the cornerstone for change
Asking for the Client's Perspective	**Asking for the client's perspective** means letting the client know that the caseworker wants to understand their view of the problems, conditions, and behaviors. When the caseworker seeks to understand the client's view of their situation, the client becomes more invested in the process and will view the caseworker as desiring to help them change.	• Children and families become more invested when they feel heard[70]

Interviewing Young Children

The primary goals of interviewing young children are increasing the accuracy and reliability of information, decreasing potential suggestibility, and minimizing trauma. Very young children are often more compliant, suggestible, and easily confused than older children. In addition to various emotions such as fear and anxiety, the accuracy of the interview is influenced by the child's age, understanding of events, interviewer style and demand for details, as well as by the structure and nature of questions.[71] Interviewing young children involves special considerations that include the use of age-appropriate interviewing techniques and tools to minimize the trauma of the initial assessment or investigation process. Use of these tools also increases the reliability of the information obtained. In addition, the child may have already had to go through numerous earlier interviews, which will affect the caseworker's interview. Since investigatory interviews determine the need for protection and can influence the legal viability and the outcome of court cases, only caseworkers trained in interviewing young children should conduct these interviews.

Basic Interviewing Principles

Regardless of what methods the caseworker uses to interview children, there are some basic principles to consider in all such interviews:

- Establish credibility and attempt to develop rapport with the child.
- Help the child relax by playing with available toys, sit with the child at his or her eye-level, and wait patiently until the child is relatively comfortable.
- Assess the child's understanding of key concepts that will help to establish credibility as the interview proceeds into sensitive areas.
- Reduce vocabulary problems by using the child's language and clarify any areas of confusion.
- Be attuned to the capacities and limitations of a young child as the interview progresses.

It is important to be aware of the child's level of comfort, and, if he or she becomes distracted or fidgety, take a break and continue the interview at a later time. The caseworker should directly address any fears that the child may have.

Developmental Considerations

Children go through a series of normal developmental stages and changes. Therefore, it is important to consider the following stages when interviewing young children:

- Preschool children's thinking is very concrete, and their ability to think abstractly is still developing. Since irony, metaphor, and analogy are beyond their grasp, it is very important not to assume that children understand concepts presented.
- Preschool children do not organize their thinking or speech logically. Instead, they say whatever enters their mind at the moment, with little censoring or consideration. Therefore, their narratives tend to be disjointed and rambling, resulting in the need for the interviewer to sort out relevant from irrelevant data; it is beyond the children's cognitive capacities to do this alone. It is important not to ask them leading questions, however.
- Preschool children's understanding of space, distance, and time is not logical or linear, generally. Their memory will not work chronologically, since they have not learned units of measurement. To help place the time of an incident, use reference points such as birthdays, holidays, summer, night or day, lunchtime, or bedtime.
- Issues of truth versus lying are particularly complex in the preschool years. Children in this age group may tell lies under two circumstances: to avoid a problem or punishment, or to

impress adults or get attention. Research varies, however, on whether children can manufacture stories based on information that they have not learned or experienced. Despite their occasional tendency to tell false stories, children in the preschool years usually do know the difference between fact and fantasy and between the truth and a lie. Gentle probing and nonleading questions from the interviewer will usually help children reveal what is true and what is false.

- Preschool children are generally egocentric. They think the world revolves around them and they relate all that happens to personal issues. These children do not usually think of what effect their actions will have on others, nor do they usually worry about what others think. As a result, interviewers of young children must be aware that children may be emotionally spontaneous in ways that are occasionally disconcerting to adults.

- The attention span of preschool children is limited. Long interviews are often not possible because the child simply cannot concentrate or sit in one place for long periods of time. The interviewer should be flexible, conducting several short sessions over a period of time.

- Many 2- and 3-year-olds are afraid to talk with an unfamiliar person without a parent present. The interviewer should work slowly to help children separate from the parent, when possible. If this process is difficult, the interview may need to begin with a parent present, working toward separate interviews at a later time once the child feels more comfortable. Interviewers should be flexible and follow a child's lead, as long as it is within the protocol and policies established by their agency.[72]

Techniques and Tools for Interviewing Young Children

The most important tool in any interview is individualizing the approach based on the circumstances and the child's developmental status and level of comfort with the interviewer. Planning for the interview should take the setting into consideration. The ideal interview setting is a comfortable room where stress is minimized for the child. The following should be employed in creating the setting:

- A neutral setting where the child does not feel pressured or intimidated. The alleged maltreating person should not be in the vicinity.

- A room with a one-way mirror. This enables one person to be with the child while other professionals who need information can observe.

- A small table and chairs or pillows or rugs for sitting on the floor.

- Availability of anatomical dolls, felt-tipped markers or crayons and paper, toy telephones, doll house with dolls, Playdough, puppets, etc.

Anatomically Correct Dolls

The use of anatomically correct dolls can be useful when interviewing children regarding alleged sexual abuse. Anatomical dolls have genitalia and breasts proportional to body size and appropriate to the gender and age of the child. The clothes the dolls wear can be easily removed and are appropriate to the child's age and gender. The uses of dolls include:

- **Icebreaker.** The dolls can be used to begin the conversation, cueing the child that the interviewer wants to talk about body parts. It can enhance the child's comfort level.
- **Anatomical model.** This is one of the most common uses of the dolls. The interviewer can use the dolls to determine the child's labels for different body parts. They can also be used to help the child show where any touching occurred.
- **Demonstration aid.** This is the most common function of the dolls. It enables the child to show behaviors that he or she has described to confirm the interviewer's understanding and help reduce any miscommunication. The dolls may be used with children who have limited verbal skills to help them show, rather than tell, what happened.
- **Memory stimulus and screening tool.** The dolls may trigger a child's recall of specific events of a sexual nature. The child may either demonstrate a specific sexual act while interacting with the dolls or have a strong negative reaction.[73]

Observing Young Children

Part of the process of gathering adequate information includes the caseworker's responsibility to observe the identified child, other family members, and the environment. Specific areas for observation are:

- Physical condition of the child, including any observable effects of maltreatment;
- Emotional status of the child, including mannerisms, signs of fear, and developmental status;
- Reactions of the parents or caregivers to the agency's concerns;
- Emotional and behavioral status of the parents or caregivers during the interviewing process;
- Interactions between family members, including verbal and body language;
- Physical status of the home, including cleanliness, structure, hazards or dangerous living conditions, signs of excessive alcohol use, and use of illicit drugs;
- Climate of the neighborhood, including level of violence or support, and accessibility of transportation, telephones, or other methods of communication.

Community Involvement

While CPS agencies have the primary responsibility for conducting initial assessment or investigation, other agencies or professionals may be integrally involved in the process.

Coordinating with Law Enforcement

Since CPS and law enforcement often work together in responding to child abuse and neglect (in some States, all abuse and neglect reports go initially to the police), it is vital for them to establish strong working relationships and collaborate effectively. A memorandum of understanding (MOU) and protocols should be established between CPS and law enforcement

For more information on reporting laws, see the State Statute series published by the National Clearinghouse on Child Abuse and Neglect Information available at: **www.calib.com/nccanch/statutes/index.cfm.**

agencies to identify roles and responsibilities as well as the circumstances that dictate when:

- Reports should be initiated and shared between agencies;
- Joint initial assessment or investigation should be initiated;
- Cases necessitate immediate notification to other agencies;
- Oral and written reports should be initiated and shared.

After an MOU or protocol is established, training should provide caseworkers with familiarity of the defined roles and responsibilities.

In addition, parameters should be established for cases where law enforcement assistance may be needed to remove a child or an alleged offender from the home, or when there is a concern for the caseworker's safety.

Involving Other Professionals

In addition to law enforcement, other disciplines often have a role in the initial assessment or investigation process:

- **Medical personnel** may be involved in assessing and responding to medical needs of a child or parent and perhaps in documenting the nature and extent of maltreatment.
- **Mental health personnel** may be involved in assessing the effects of any alleged maltreatment and in helping to determine the validity of specific allegations. They may also be involved in evaluating the parent's or caregiver's mental health status and its effect on the safety to the child.
- **Alcohol and other drug specialists** may be involved in evaluating parental or caregiver substance abuse and its impact on the safety of the child.
- **Partner abuse experts** may be asked to assist in examining the safety of the child in cases where partner abuse and child maltreatment co-exist. These professionals may also be involved in the safety planning process.
- **Educators** may be involved in providing direct information about the effects of maltreatment and other information pertinent to the risk assessment.
- **Other community service providers** who have had past experience with the child or family may be a resource in helping to address any emergency needs that the child or family may have.
- **Multidisciplinary teams** may be used to help the CPS agency analyze the information related to the substantiation of maltreatment and the assessment of risk and safety.
- **Other community partners** such as intensive, home-based service workers; parent aides; daycare providers; afterschool care providers; foster parents; volunteers; or relatives may be used to help the agency implement a plan to keep the child safe within his or her own home.

For additional information on community collaboration, check other Manuals in the series at: **www.calib.com/nccanch/pubs/usermanual.cfm.**

- **Juvenile court** may be involved in helping to assure the safety of the child and to provide continuing protective services to the child and family when the child's safety cannot be protected, and the parents or caregivers have refused agency intervention.

Special Practice Issues

There are several special issues related to the initial assessment or investigation phase—the effects of removal, caseworker safety, substantiation appeal hearings or reviews, investigation in institutional settings, and the safety of children in foster care.

Effects of Removal

In order to assure protection, CPS may have to remove the child or reach agreement with family members that the alleged offender will leave the family and have no unsupervised contact with the alleged victim. Removal of the alleged offender is a less intrusive intervention but it should only be used if the caseworker is certain that there will be no contact with the victim. The removal of a family member has a dramatic affect on the feelings, behaviors, and functioning of individual family members and the family as a whole.

When CPS has to remove children from their families to protect them, they set in motion numerous issues and problems for the child. Placement outside the family often negatively affects the child's emotional well-being. Being uprooted from the only family one has known, from one's routines and familiar surroundings, is emotionally debilitating to children. Parents who abuse or neglect their children may also demonstrate love and attention to their children. This may be the only adult to whom the child has bonded. It is important to remember that the child suffers a devastating loss—the loss of being taken away from his or her birth family.

Placement away from the birth family therefore means more than the physical loss of living with the family; it also means having to deal with the loss of relationships and the loss of control over one's life. Children coming into substitute care suffer a significant loss to their self-esteem and are under a great deal of stress. Therefore, it is important to remember that when placing children, caseworkers should always maintain a focus on reducing the uncertainty and anxiety for children. Some strategies for helping children better manage the placement include:

- Involving the family and children in the safety plan and the placement process, when appropriate;
- Providing contact with the family after placement as soon as possible—ideally, within the first week;
- Reassuring children that there is nothing wrong with them and that they are not to blame for the placement;
- Providing children with information about the reasons for the placement, where they are going, and how long they may remain there;
- Allowing children to take as many personal favorite items as possible, such as photos of the family or home, toys or stuffed animals, and clothing;
- Finding out as much about the children as possible—their likes and dislikes, routines, medical issues—and informing the substitute care provider;
- Encouraging children to express their feelings and normalize those feelings, possibly through starting a journal or notebook;
- Giving children a phone number to contact the caseworker.

Family members are also traumatized by the placement. They, too, need immediate contact with their children; concern and empathy from the caseworker; and involvement in the placement process.

Caseworker Safety

Every CPS case has the potential for unexpected confrontation due to the involuntary nature of investigations and assessments. It is important for caseworkers to acknowledge the nature of CPS intervention and the client's view of their role. While difficulties may occur at any point in the process, threats and volatile situations are more likely to occur during the initial assessment or investigation, during crisis situations, and when dramatic action is taken (e.g., removal of a child or the decision to take a case to court). The first step in ensuring caseworker safety is to assess the risk of the situation before the initial contact. Questions caseworkers should consider include the following:

- Are the subjects violent or hostile?
- Does the situation involve family violence, including partner, elder, or child abuse?
- Does the situation involve physical or sexual abuse or a fatality?
- Are the family members exhibiting behaviors that indicate mental illness?
- Are the family members presently abusing or selling substances?
- Are the parents or caregivers involved in ritualistic abuse or cult practices?
- Does the information note life-threatening or serious injuries to the children?
- Will the children be removed from the family situation on this visit?
- Is the family's geographic location potentially dangerous?
- Will the caseworker go into an area with limited available supports?

Preventive Measures for Making Home Visits

- Always be sure that the supervisor or other agency personnel are informed of the caseworker's schedule.
- Observe each person in and around the area closely and watch for signs that may indicate any potential for personal violence.
- Follow one's instincts. Anytime the caseworker feels frightened or unsafe, he or she should assess the immediate situation and take whatever action is necessary to obtain protection.
- Learn the layout of the immediate area around the home and the usual types of activities that occur there to provide a baseline from which to judge potential danger.
- Avoid dangerous or unfamiliar areas at night.
- Learn the safest route to the family's home.
- Be sure the car is in good working order, and park in a way for quick escape, if necessary.
- Carry a cell phone.
- Assess whether it is safe to accept refreshments.
- Learn how to decline offers of food or other refreshments tactfully.[75]

- Is the area known for high crime or drug activity?
- Does the housing situation or neighborhood increase concerns for staff personal safety?
- Does anyone in the home have a previous history of violence or multiple referrals? Have there been previous involuntary removals of family members?[74]

Substantiation Appeal Hearings or Reviews

Every State has a mechanism to appeal an agency's decision to substantiate abuse or neglect. Some States have a formal or administrative hearing process where the parent or caregiver substantiated as a perpetrator of child maltreatment can request a hearing to review the decision. In these hearings, the burden of proof rests with the CPS agency. If the review reverses or modifies the substantiation decision, then the CPS agency will have to revise the records.

Initial Assessment or Investigation in Institutional Settings

States differs with respect to who is responsible for initially assessing or investigating allegations of child abuse and neglect in out-of-home care. In some States, local CPS staff have responsibility for investigating certain types of allegations (e.g., in daycare settings). The investigation of alleged maltreatment in institutional settings is often handled by central or regional CPS or licensing staff rather than by local CPS agencies. Depending on the nature of the

Interviews in Institutional Settings

Investigation of alleged maltreatment in institutional settings includes interviewing:

- Alleged victim(s)
- Staff witness(es)
- Child witness(es)
- Administrator or supervisor of the alleged perpetrator
- Alleged perpetrator.

The primary questions to be asked in these cases include:

- Did the reported event occur independent of extenuating circumstances?
- Is the administrative authority culpable and, if so, in what manner?
- Is the problem, if validated, administratively redressable?
- Are personnel actions indicated and, if so, are they being initiated appropriately by the residential facility?
- What responsibility do others in the facility have for any incident of maltreatment, and is a corrective action plan needed to prevent the likelihood of future incidents?
- How can the victim be interviewed and still be protected from repercussions?

allegations, law enforcement agencies also will assume a primary role in investigating these types of cases. A coordinated approach helps minimize the trauma to children and childcare staff.

Safety in Foster Care Placements

Caseworkers should continually assess the risk to and safety of children once placed in foster or kinship care settings. Considerations include:

- What is the level of acceptance of the placed child into the family? Notice whether the placed child is included in family routines and life. Is the child appropriately physically incorporated into the home, for example, does the child have a place for his or her belongings and a seat at the table? Examine family interaction. Is the child fully or selectively involved? Is the child included appropriately in family communications? Does the family share equally with the child?
- Are the kinship or foster parents' expectations for the placement and the child being met?
- Are the kinship or foster parents satisfied with the arrangement?
- How do the kinship or foster parents explain their parenting expectations, style, and responses to the placed child?
- What specific perceptions of and attitudes toward the placed child do the kinship or foster parents hold?
- What are the kinship or foster parents' attitudes about, opinions of, and relationship to the placed child's parents and family?
- What methods of discipline does the foster or kinship family use?
- Have circumstances or composition of the family changed in any way since the placement?
- What does the child report? Listen for acceptance into and involvement with the family or exceptions or differences between how the family deals with its own children and the placed child.
- How is the child physically, emotionally, socially, and behaviorally? Is the child's condition a result of the care received in the child's own home, the adjustment to the new home or family setting, or the possible mistreatment by the kinship or foster parents?
- What are the attitudes and perceptions that the placed child has about the care situation?
- What expectations does the child have for this family situation? Are they realistic? Do they stimulate positive or negative reactions from family members (and caregivers specifically)? Do they result in the child behaving in challenging and difficult ways?
- What are the similarities and difference between the placed child and other children in the family?
- How has the family functioning been affected since the placement?[76]

CHAPTER 7
Family Assessment

During the initial assessment, the child protective services (CPS) caseworker has identified behaviors and conditions about the child, parent, and family that contribute to the risk of maltreatment. During the family assessment, the CPS caseworker engages the family in a process designed to gain a greater understanding about family strengths, needs, and resources so that children are safe and the risk of maltreatment is reduced. The family assessment is initiated immediately after the decision is made that ongoing services are needed.

This chapter explores principles for conducting family assessments, key decisions made during family assessments, the family assessment process, community collaboration, and special practice issues related to cultural sensitivity and cultural competence.

Family Assessment Principles

Family assessments, in order to be most effective, should be culturally sensitive, strength-based, and developed with the family. They should be designed to help parents or caretakers recognize and remedy conditions so children can safely remain in their own home.[77] Given the emphasis on timeliness built into the Adoption and Safe Families Act (ASFA), the assessment of the family's strengths and needs should be considered in the context of the length of time it will take for the family to provide a safe, stable home environment.

A culturally sensitive assessment recognizes that parenting practices and family structures vary as a result of ethnic, community, and familial differences, and that this wide range can result in different but safe and adequate care for children within the parameters of the law. Each family has its own structure, roles, values, beliefs, and coping styles. Respect for and acceptance of this diversity is a cornerstone of family-centered assessments. The assessment process must acknowledge, respect, and honor the diversity of families.[78]

A strength-based assessment "recognizes that people, regardless of their difficulties, can change and grow, that healing occurs when a family's strengths, not its weaknesses, are engaged, and that the family is the agent of its own change."[79] While an outline for the family assessment process increases the likelihood that all assessment areas are covered, family assessments must be individualized and tailored to the unique strengths and needs of each family.[80] An individualized assessment is undertaken in conjunction with other service providers to form a comprehensive picture of the individual, interpersonal, and societal pressures on the family members—individually and as a group. This holistic approach takes both client competencies and environment into consideration and views the environment as both a source of and solution to families' problems.[81] When possible, the assessment process also should be conducted in conjunction with the families' extended family and

support network through the use of family decision-making meetings and other formats.[82]

For both practice accountability and empirical usefulness, CPS caseworkers should consider using assessment tools and standardized clinical measures to evaluate risk and protective factors. Tools that support the assessment of specific family strengths, needs, and resources include:

- Genogram—diagram resembling a family tree completed with the family's assistance;
- Ecomap—diagram linking the family tree with outside systems and resources;
- Self-report instruments—questionnaire or survey measuring beliefs, strengths, risks, and behaviors;
- Observational tools—devices enabling professionals to examine personal and family dynamics.[83]

Using such tools, identified needs are translated into specific intervention outcomes that form the basis of time-limited, individualized case plans.

In summary, while the initial assessment identifies the risk factors of concern in the family, the family assessment considers the relationship between strengths and risks and identifies what must change in order to keep children safe, reduce the risk of future maltreatment, increase permanency, and enhance child and family well-being. Consequently, where the initial assessment identifies problems, the family assessment promotes an understanding of the problems and becomes the basis for an intervention plan.

Family Assessment Decisions

Based on the additional information gathered and analyzed, the caseworker must ask the following questions to inform the assessment:

- What are the risk factors and needs of the family that affect safety, permanency, and well-being?
- What are the effects of maltreatment that affect safety, permanency, and well-being?
- What are the individual and family strengths?
- What do the family members perceive as their problems and strengths?
- What must change in order for the effects of maltreatment to be addressed and for the risk of maltreatment to be reduced or eliminated?
- What are the parent's or caregiver's level of readiness for change and motivation and capacity to assure safety, permanency, and well-being?

To arrive at effective decisions during the family assessment process, the CPS caseworker should use competent interviewing skills to engage the family in a partnership; gather and organize information; analyze and interpret the meaning of the information; and draw accurate conclusions based on the assessment.

Family Assessment Process

To accomplish the purposes of the family assessment, caseworkers should:

- Review the initial assessment or investigation information;
- Develop a family assessment plan;
- Conduct the family assessment by interviewing all members of the household and other individuals the family identifies as having an interest in the safety and well-being of the child;
- Consult with other professionals as appropriate;
- Analyze information and make decisions.

Review the Initial Assessment or Investigation Information

To provide focus for the family assessment, the caseworker should begin by reviewing the information previously gathered and analyzed during the initial assessment or investigation. Based on an analysis of this information, the caseworker should develop a list of questions that need to be answered during the family assessment process. The following questions are examples of areas that the caseworker may want to examine:

- What was the nature of the maltreatment (type, severity, chronicity)?
- What was the family's understanding of the maltreatment?
- Which risk factors identified during the initial assessment or investigation are most concerning?
- What is the child's current living situation with regard to safety and stability?
- Was a safety plan developed? What has been the family's response to this plan?
- What is currently known about the parent or caregiver's history? Are there clues that suggest that further information about the past will help to explain the parent or caregiver's current functioning?
- What is known about the family's social support network? Who else is supporting the family and who will be available on an ongoing basis for the family to rely on?
- Are there any behavioral symptoms observed in the child? How has the child functioned in school and in social relationships? Who else may have information about any behavioral or emotional concerns?
- Have problems been identified that may need further examination or evaluation (e.g., drug or alcohol problems, psychiatric or psychological problems, and health needs)?
- What further information about the family will help provide an understanding of the risks and protective factors related to the potential of continued maltreatment?

Develop a Family Assessment Plan

Based on the areas identified through the review, the caseworker should develop a plan for how the assessment process will occur. In general, it takes an average of 4 to 6 weeks to "get to know" the family enough to draw accurate conclusions, although laws may vary from State to State regarding the time before an assessment is required. The following issues need to be considered in developing the plan for the assessment:

- When will the first meeting be held with the family?
- How often will meetings with the family occur?
- Where will meetings be held and how will the setting be controlled?
- Who will be involved in each meeting? Are there other persons (e.g., friends, extended family, other professionals) who have critical information about the needs of this family? How will they be involved in the process?
- Will the services of other professionals be needed (e.g., for psychological tests, or alcohol or other drug abuse assessments)?
- What reports may be available to provide information about a particular family member or the family as a system (e.g., from school or health care providers)?
- When will the information be analyzed and a family assessment summary completed?
- How will the caseworker share this information with the family?

Conduct the Family Assessment

Once the plan for the assessment has been established, the caseworker should conduct interviews with the child and family to determine the treatment needs of the family. Four types of meetings are held:

Meeting with the Family

If possible and if it is safe for all family members, the caseworker should meet with the entire family to begin the family assessment. This ensures that each family member knows the expectations from the beginning; everyone's participation is judged important; and communication is open and shared among family members.

During this initial contact, the caseworker should provide an opportunity for the family to discuss the initial assessment, share the plan for conducting the family assessment, and seek agreement on scheduling and participation. The caseworker should be specific with the family about the purposes of the family assessment and should avoid technical or professional terminology. It also is important to affirm that the intention of CPS is to help the family keep the child safe and address mutually identified problems to reduce the risk of child maltreatment in the future. The caseworker should attempt to gain an initial understanding of the family's perception of CPS and its current situation.

To gain a better understanding of family dynamics, at least one assessment meeting beyond the introductory session should be conducted with the entire family to observe and assess the roles and interactions. Caseworkers should consider communication patterns, alliances, roles and relationships, habitual patterns of interaction, and other family-related concepts.

Meeting with the Individual Family Members

Meetings with individual family members, including the children, should be held. At the beginning of each meeting, the caseworker should clarify the primary purpose of the interview and attempt to build rapport by identifying areas of common interest. It is important to demonstrate appreciation of the person and his or her situation and worth. This is not an interrogation; the caseworker is trying to better understand the person and the situation.

In each individual meeting, the caseworker should carefully explore the areas that have been identified previously for study. In interviews with the children, the emphasis will likely be on understanding more about any effects of maltreatment. In interviews with the parents, the emphasis is on trying to uncover the causes for the behaviors and conditions that present risk and obtain the parents' perceptions of their problems. As part of meetings with the parents, it is important that the caseworker examines the influence that family history and culture may have on current behavior and functioning. In meetings with both children and parents, the caseworker should also attempt to obtain family members' perceptions about the strengths in their family and how these strengths can be maximized to reduce the risk of maltreatment.

Meeting with the Parent or Caregiver

In families with more than one adult caregiver, the caseworker should arrange to hold at least one of the meetings with the adults together, if it is possible and safe for both adults. During this interview, the caseworker should observe and evaluate the nature of the relationship and how the two communicate and relate. The caseworker should also consider and discuss parenting issues and the health and quality of the marital relationship as well as seek the parent or caregiver's perception of problems, the current situation, and the family. The worker should be alert to signs that could indicate the possibility of partner abuse and avoid placing either adult in a situation that could increase risk, such as referring to sensitive information that may have been disclosed in individual meetings. As appropriate or if requested, the caseworker may also provide referrals for resources or services to clients experiencing difficulties that are not risk factors.

Consulting with Other Professionals

While the CPS caseworker has primary responsibility for conducting the family assessment, frequently other community providers may be called upon to assist with the assessment. Other providers should be consulted when there is a specific client condition or behavior that requires additional professional assessment. For example:

- The child or parent exhibits undiagnosed physical health concerns or the child's behaviors or emotions do not appear to be age-appropriate (e.g., hyperactivity, excessive sadness and withdrawal, chronic nightmares, bed wetting, or aggressive behavior at home or at school);
- The parent exhibits behaviors or emotions that do not appear to be controlled, such as violent outbursts, extreme lethargy, depression, or frequent mood swings;
- The child or parent has a chemical dependency.

A good way to judge whether outside referrals are needed is to review the gathered information and assess whether significant questions still exist about the risks and strengths in this family. If the caseworker is having difficulty writing the tentative assessment, he or she should consult the supervisor to determine whether consultation with an interdisciplinary team or an evaluation of presenting problems by others in the community may be appropriate.

If the assessment identifies the need for specific evaluation, the referral should specify the following:

- The reason for referral, including specific areas for assessment as they relate to the risk of maltreatment;
- The parent's knowledge regarding the referral and their response;
- The time frames for assessment, and when the agency will need a report back from the provider;
- The type of report requested regarding the results of the evaluation;
- The purpose and objectives of the evaluation (e.g., the parents' level of alcohol use and its effects on their ability to parent);
- The specific questions the caseworker wants answered to assist in decision-making;
- The need for a confidentiality release.

In addition, sometimes other providers contribute to the assessment process because of their role as advocates for the child. For example, if juvenile or family court is involved, the child may have a Guardian ad Litem (GAL) or court-appointed special advocate (CASA) who advises the court on needed services based on interviews conducted with the child and other family members.

Analyze Information and Make Decisions

Once adequate information has been gathered, the caseworker must analyze the information with regard to the key decisions. The CPS caseworker must identify which risk factors are most critical and what is causing them. This is determined by examining the information in terms of cause, nature, and extent; effects; strengths; and the family's perception of the maltreatment in order to individualize the CPS response to each child and family.

At the conclusion of the family assessment, the caseworker and family have identified changes necessary to keep children safe and reduce the risk of child maltreatment. These conclusions are then translated into desired outcomes and matched with the correct intervention response that will increase safety, well-being, and permanency for children. While the specific areas studied in the assessment are unique to each family circumstance, the following guide identifies areas for gathering essential information needed to draw necessary assessment conclusions.

Family Assessment Guide

Reasons for Referral. Briefly summarize the primary reasons this family is receiving continuing child welfare services and define the terms of any safety plan that was developed with the family.

Sources of Information. Identify all sources of information used to frame this assessment and refer to the specific dates of contact with the family and other persons or systems that relate to assessment information.

Identifying Information. Describe the family system, as defined by the family. Include members' names, ages, and relationship to the primary caregiver; sources of economic support and whether it is perceived as adequate; and current school or vocational training status. Describe the current household situation, including sleeping arrangements, and the client's perception of their neighborhood, especially as it pertains to safety.

Presenting Problems, Needs, and Strengths. Describe family members' perceptions of the presenting needs as they relate to each individual member, the family system, and its environment. As appropriate, include a history of the problem development and previous attempts to address it, as well as an explanation of family members' readiness and motivation to engage in help for the problem at this particular time. Also, identify the family's stated goals as they relate to each problem.

Family Background and History. Write a social history. Ideally, the primary caregiver(s) should be described first. Begin with his or her birth, and describe the family of origin—its members, their relationships with each other, and significant descriptive characteristics of each member. Follow that member's development into adulthood and up to but not including the present time. Genograms are particularly helpful in understanding life events over time. Identify important personal relationships, including those characterized by maltreatment, substance abuse, or violence; identify positive life events as well as stressful ones; and describe relationships with systems, including educational, vocational, legal, religious, medical, mental health, and employment. The history of other adults and children in the household should be summarized, addressing the preceding points, as appropriate and available. Complete this history in chronological order, if possible.

Present Status. Describe the present life situation of the family, particularly information about risks and strengths related to each child in the family, each caregiver's functioning, the family system, and the environment and community. Standardized assessment measures may be helpful to better understand the family and identify areas to be recorded in the casefile.

Tentative Assessment. Summarize risks and strengths related to each family member. This is the opportunity for the worker to analyze the collected information and to draw conclusions about the most important strengths and needs of individual family members and the family as a system. Knowledge of human development, personality theory and psychopathology, family systems, ecological theory, and psychosocial theory should be drawn on to form these conclusions. The worker should make informed judgments about the objective and observational information that has been collected and recorded. In this section, the caseworker specifically summarizes what must change to reduce the risk of child maltreatment.

Special Practice Issue—Cultural Sensitivity

Cultural sensitivity is a critical element in obtaining a comprehensive understanding of a family's situation. For a thorough analysis, it is also a necessary component of the family assessment process. There are three important principles to consider when working with families from different cultures:

- Believe that diversity is a good thing and that having different ideals, customs, attitudes, practices, and beliefs does not, in and of itself, constitute deviance or pathology. If a worker approaches culturally different clients from this perspective, the client is more likely to perceive that the worker has communicated respect for them as persons, and the assessment will be more accurate.
- Accept that everyone has biases and prejudices. This helps to increase objectivity and guard against judgments affected by unconscious biases.
- Understand that the nature of the CPS caseworker and client relationship represents a power imbalance. If there are cultural differences between the caseworker and the client, the client may have difficulty trusting that the caseworker truly intends to empower the client to be an equal partner in the helping relationship.[84]

For example, to develop rapport with clients during the family assessment effectively, the caseworker should be sensitive to cultural similarities and differences with the client. In order to be empathetic, the caseworker should be aware of both the individual uniqueness and the cultural or historical roots of the client.[85] In all assessments, the client is the most important source of information about the family, including providing information about cultural aspects and lifestyles unique to that family. Effective cultural competence requires that caseworkers:

- Respect how clients differ from them;
- Be open to learning about cultural differences when assessing strengths and needs of families;
- Avoid judgments and decision-making resulting from biases, myths, or stereotypes;
- Ask the client about a practice's history and meaning if unfamiliar with it;
- Explain the law that regards a particular cultural practice as abuse;
- Elicit information from the client regarding strongly held family traditions, values, and beliefs, especially child rearing practices.

Guide to Understanding Cultural Differences

With every family assessment, there are certain areas that may be affected by a person's history and culture. The following questions may be used as a guide to understand cultural difference as part of the assessment. According to the client:

- What is the purpose and function of the nuclear family?
- What roles do males and females play in the family?
- What is the role of religion for the family? How do these beliefs influence child-rearing practices?
- What is the meaning, identity, and involvement of the larger homogenous group (e.g., tribe, race, nationality)?
- What family rituals, traditions, or behaviors exist?
- What is the usual role of children in the family?
- What is the perception of the role of children in society?
- What types of discipline does the family consider to be appropriate?
- Who is usually responsible for childcare?
- What are the family's attitudes or beliefs regarding health care?
- What are the family's sexual attitudes and values?
- How are cultural beliefs incorporated into family functioning?
- How does the family maintain its cultural beliefs?
- Who is assigned authority and power for decision-making?
- What tasks are assigned based on traditional roles in the family?
- How do family members express and receive affection? How do they relate to closeness and distance?
- What are the communication styles of the family?
- How does the family solve problems?
- How do family members usually deal with conflict? Is anger an acceptable emotion? Do members yell and scream or withdraw from conflict situations?[86]

CHAPTER 8

Case Planning

Intervention with abused and neglected children and their families must be planned, purposeful, and directed toward the achievement of safety, permanency, and well-being. One of the essential elements of planned and purposeful intervention is a complete understanding of the factors contributing to maltreatment. The case plan identifies risks and problematic behaviors, as well as the strategies and interventions to facilitate the changes needed, by laying out tasks, goals, and outcomes. Safety plans and concurrent permanency plans are often incorporated into the case planning process, as needed.

Flexibility also is critical in developing and implementing case plans. The use of creativity helps in developing new approaches to tackle difficult problems. The children and family's needs and resources may change, and flexibility allows the plan to follow suit. Planning is a dynamic process; no plan should be static.

Since safety plan considerations are incorporated throughout this manual, this chapter focuses on the case plan process. This entails developing the case plan, involving the family, targeting outcomes, determining goals and tasks, and developing concurrent case plans.

Developing the Case Plan

The case plan that a child protective services (CPS) caseworker develops with a family is their road map to successful intervention. The outcomes identify the destination, the goals provide the direction, and the tasks outline the specific steps necessary to reach the final destination. The purposes of case planning are to:

- Identify strategies with the family that address the effects of maltreatment and change the behaviors or conditions contributing to its risk;
- Provide a clear and specific guide for the caseworker and the family for changing the behaviors and conditions that influence risk;
- Establish a benchmark to measure client progress for achieving outcomes;
- Develop an essential framework for case decision-making.

The primary decisions during this stage are guided by the following questions:

- What are the outcomes that, when achieved, will indicate that risk is reduced and that the effects of maltreatment have been successfully addressed?
- What goals and tasks must be accomplished to achieve these outcomes?
- What are the priorities among the outcomes, goals, and tasks?
- What interventions or services will best facilitate successful outcomes? Are the appropriate services available?
- How and when will progress be evaluated?

Involving the Family

Families who believe that their feelings and concerns are heard are more likely to engage in the case-planning process. Therefore, decisions regarding outcomes, goals, and tasks should be a collaborative process between the caseworker, family, family network, and other providers. Caseworkers should help the family maintain a realistic perspective on what can be accomplished and how long it will take to do so. Involving the family accomplishes the following:

- Enhances the essential helping relationship because the family's feelings and concerns have been heard, respected, and considered;
- Facilitates the family's investment in and commitment to the outcomes, goals, and tasks;
- Empowers parents or caregivers to take the necessary action to change the behaviors and conditions that contribute to the risk of maltreatment;
- Ensures that the agency and the family are working toward the same end.

Family Meetings

Since the early 1990s, CPS agencies have primarily been using two models—the Family Unity Model and the Family Group Conferencing Model (also known as the Family Group Decision-making Model)—to optimize family strengths in the planning process. These models bring the family, extended family, and others in the family's social support network together to make decisions regarding how to ensure safety and well-being. The demonstrated benefits of these models include:

- Increased willingness of family members to accept the services suggested in the plan because they were integrally involved in the planning process;
- Enhanced relationships between professionals and families resulting in increased job satisfaction of professionals;
- Maintained family continuity and connection through kinship rather than foster care placements.

Family meetings can be powerful events. During the meetings, families often experience caring and concern from family members, relatives, and professionals. Since meetings are based on the strengths perspective, families may develop a sense of hope and vision for the future. The meetings also can show families how they should function by modeling openness in communication and appropriate problem-solving skills.[87]

Targeting Outcomes

One of the decisions resulting from the assessment is what changes must the family make to reduce or eliminate the risk of maltreatment. Achieving positive client outcomes indicates that the specific risks of maltreatment have been adequately reduced and that the effects of maltreatment are satisfactorily addressed.

Agency Outcomes

With the passage of the Adoption and Safe Families Act (ASFA) in 1997, child welfare agencies have been directed to design their intervention systems to measure the achievement of outcomes. There has been consensus that child welfare outcomes, at the program level, can be organized around four domains: child safety, child permanence, child well-being, and family well-being (functioning). Although all four are important, Federal and State laws emphasize child safety and permanence, so these two outcomes are often used to evaluate agency performance. The agency outcomes are defined as:

- **Child safety.** The safety of children is the paramount concern that guides CPS practice. In many States, the evaluation of child safety is equivalent to the determination that the child is at imminent risk of serious harm.[88]

- **Child permanence.** Although maintaining a constant focus on child safety is critical, casework interventions also must be aimed at maintaining or creating permanent living arrangements and emotional attachments for children. This is based on the belief that stable, caring relationships in a family setting are essential for the healthy growth and development of the child. This stresses providing reasonable efforts to prevent removal and to reunify families, when safe and appropriate to do so and as specified under ASFA. This also promotes the timely adoption or other permanent placement of children who cannot return safely to their own homes.[89]

- **Child well-being.** The general well-being of children who come in contact with the CPS system also must be addressed, especially for children placed in substitute care. This requires that children's physical and mental health, educational, and other needs will be assessed, and that preventive or treatment services are provided when warranted.[90]

- **Family well-being.** Families must be able to function at a basic level in order to provide a safe and permanent environment for raising their children. Caseworkers are not expected to create optimal family functioning, but rather facilitate change so that the family can meet the basic needs of its members and assure their protection.

Child and Family-level Outcomes

Positive outcomes indicate that both the risks and the effects of maltreatment have been reduced due to changes in the behaviors or conditions that contributed to the maltreatment. The outcomes should address issues related to four domains—the child, the parents or other caregivers, the family system, and the environment—and be designed to contribute to the achievement of the CPS agency outcomes for child safety, child permanence, child well-being, and family well-being.[91]

- **Child-level outcomes.** Outcomes for children focus on changes in behavior, development, mental health, physical health, peer relationships, and education. Sample desired outcomes are improved behavior control (as evidenced by managing angry impulses) or developmental appropriateness and adjustment in all areas of functioning (as evidenced by the child's physical development within range of the chronological age).

- **Parent or caregiver outcomes.** Outcomes for parents or caregivers focus on many areas, such as mental health functioning, problem solving ability, impulse control, substance abuse treatment, and parenting skills. A sample desired outcome is improved child management skills (as evidenced by establishing and consistently following through with rules and limits for children).

- **Family outcomes.** Outcomes for the family focus on such issues as roles and boundaries, communication patterns, and social support. A sample desired outcome is enhanced family maintenance and safety (as evidenced by the ability to meet members' basic needs for food, clothing, shelter, and supervision).

- **Environmental outcomes.** Sometimes outcomes focus on the environmental factors contributing to the maltreatment, such as social isolation, housing issues, or neighborhood safety. A sample desired outcome is utilizing social support (as evidenced by a family being adopted by a church that provides child care respite, support group, and family activities).

Targeting Outcomes for a Family: Case Example

The Dawn family consists of the father, Mr. Dawn, age 34; mother, Mrs. Dawn, age 32; daughter, Tina, age 6; and son, Scott, age 3½. The family was reported to CPS by the daycare center. Scott had lateral bruises and welts on his buttocks and on the back of his thighs. The daycare center reported that Scott was an aggressive child; he throws things when he is angry, hits other children, and runs from the teacher. The center also has threatened not to readmit him.

Through investigation and family assessment, the caseworker learned that Mr. and Mrs. Dawn have been married for 10 years. Mr. Dawn completed high school and is employed as a clerk in a convenience store. He works the evening shift, 4 to 11 p.m., and was recently turned down for a promotion. Mrs. Dawn also completed high school, went on to become a paralegal, and is employed as a legal assistant. Tina was a planned child, but Scott was not. The parents described Tina as a quiet and easy child. They described Scott as a difficult child and as having a temper and not minding adults. Recently, he threw a truck at his sister, causing her to need stitches above her eye, and tore his curtains down in his bedroom. His parents described Scott as unwilling to be held and loved. Both parents are at their wits' end and do not know what to do with Scott. Mrs. Dawn reported that all of the discipline falls on her, and she cannot control Scott.

The home appeared chaotic with newspapers, toys, and magazines strewn all over the living room. There was no evidence of structure or consistent rules. Scott misbehaved during the interview. Sometimes the parents ignored his behavior, and other times they addressed his behavior only when it had escalated to the point that he was out of control. It also appeared that Tina had a lot of age-inappropriate responsibility, for example, making Scott's breakfast every morning.

Mr. Dawn said his mother used severe forms of punishment when he misbehaved. He feels it taught him right from wrong, believing that children need strong discipline to grow up into healthy, functioning adults. He said he often "sees red" when Scott misbehaves and that he yells at Scott or hits Scott with a nearby object.

The family is socially isolated. Mr. Dawn's mother is alive, but they are estranged. Mrs. Dawn's parents are deceased, and her two brothers live hundreds of miles away. Mrs. Dawn has a friend at work, but they do not communicate outside of work. The parents described being very much in love when they met. However, because of work schedules, they have very little time to spend together. Mrs. Dawn describes her husband as often yelling at her and the children rather than just talking.

Targeting Outcomes for a Family: Case Example

The behaviors and conditions contributing to the risk include:

- Father's poor impulse control
- Father's childhood history of abuse
- Father's aggressive behavior
- Lack of structure, rules, and limits
- Inconsistent and inappropriate discipline
- Family isolation
- Inappropriate role expectations
- Poor family communication
- Scott's poor impulse control
- Scott's aggressive and dangerous behavior

Sample parent outcomes may be improved impulse control, child management skills, and coping skills.

Sample family outcomes may be improved communication and family functioning.

Sample child outcomes may be improved and age-appropriate behavioral control.

Determining Goals

Caseworkers should work with families to develop goals that indicate the specific changes needed to accomplish the outcomes. The objective is not to create a perfect family or a family that matches a caseworker's own values and beliefs. Rather, the goal is to reduce or eliminate the risk of maltreatment so that children are safe and have their developmental needs met. Goals should be **SMART**; in others words, they should be:

- ***S*pecific.** The family should know exactly what has to be done and why.
- ***M*easurable.** Everyone should know when the goals have been achieved. Goals will be measurable to the extent that they are behaviorally based and written in clear and understandable language.
- ***A*chievable.** The family should be able to accomplish the goals in a designated time period, given the resources that are accessible and available to support change.
- ***R*ealistic.** The family should have input and agreement in developing feasible goals.
- ***T*ime limited.** Time frames for goal accomplishment should be determined based on an understanding of the family's risks, strengths, and ability and motivation to change. Availability and level of services also may affect time frames.

Goals should indicate the positive behaviors or conditions that will result from the change and not highlight the negative behaviors.

Determining Tasks

Goals should be broken down into small, meaningful, and incremental tasks. These tasks incorporate the specific services and interventions needed to help the family achieve the goals and outcomes. They describe what the children, family, caseworker, and other service providers will do and identify time frames for accomplishing each task. Families should understand what is expected of them, and what they can expect from the caseworker and other service providers. Matching services to client strengths and needs is discussed in Chapter 9, "Service Provision."

In developing tasks, caseworkers should also be aware of services provided by community agencies and professionals, target populations served, specializations, eligibility criteria, availability, waiting lists, and fees for services. With this knowledge, CPS caseworkers can determine the most appropriate services to help the family achieve its tasks. The following text box illustrates a sample outcome, the goals, and the tasks using the case example from earlier in this chapter.

Developing Concurrent Plans

Concurrent planning seeks to reunify children with their birth families while at the same time establishing an alternative permanency plan that can be implemented if reunification cannot take place. In cases such as these, the caseworker needs to develop two separate case plans, although it may seem confusing to work in two directions simultaneously. Concurrent permanency plans provide workers with a structured approach to move children quickly from foster care to the stability of a safe and continuous family home.[92]

Sample Outcome, Goals, and Tasks for the Dawn Family

Outcome: Effective child management skills.

Goal: Mr. and Mrs. Dawn will establish, consistently follow, and provide positive reinforcement for rules and limits.

Task: Mr. and Mrs. Dawn will set consistent mealtimes, bedtimes, and wake-up times for the children.

Task: Mr. and Mrs. Dawn will work with the caseworker to set specific, age-appropriate expectations for their children.

Goal: Mr. and Mrs. Dawn will use disciplinary techniques that are appropriate to Scott and Tina's age, development, and type of misbehavior.

Task: Mr. and Mrs. Dawn will identify those components of Scott's behavior that are most difficult for them to manage and the disciplinary techniques they can use to help him control his behavior.

CHAPTER 9
Service Provision

Once the case plan has been developed, the caseworker provides or arranges for services identified in the plan to help family members achieve tasks, desired outcomes, and case plan goals. Selecting and matching interventions is a critical step in the casework process. To the extent possible, interventions that have demonstrated success in addressing the issues that brought the family to child protective services (CPS) should be selected.

An important consideration in selecting interventions is an assessment of the readiness to change. For further information, see Chapter 3, "The Helping Relationship," Chapter 7, "Family Assessment," and Chapter 8, "Case Planning." For example, if a family member is at the precontemplation stage, it is important to select initial interventions that will increase their motivation to change, rather than selecting interventions that assume the individual is at the action stage. However, there is significant variation in readiness or eagerness to change among clients, and an individual's readiness to change may fluctuate from time to time. The role of the caseworker is to collaborate with the individual or family in developing plans and selecting services that will best facilitate change.

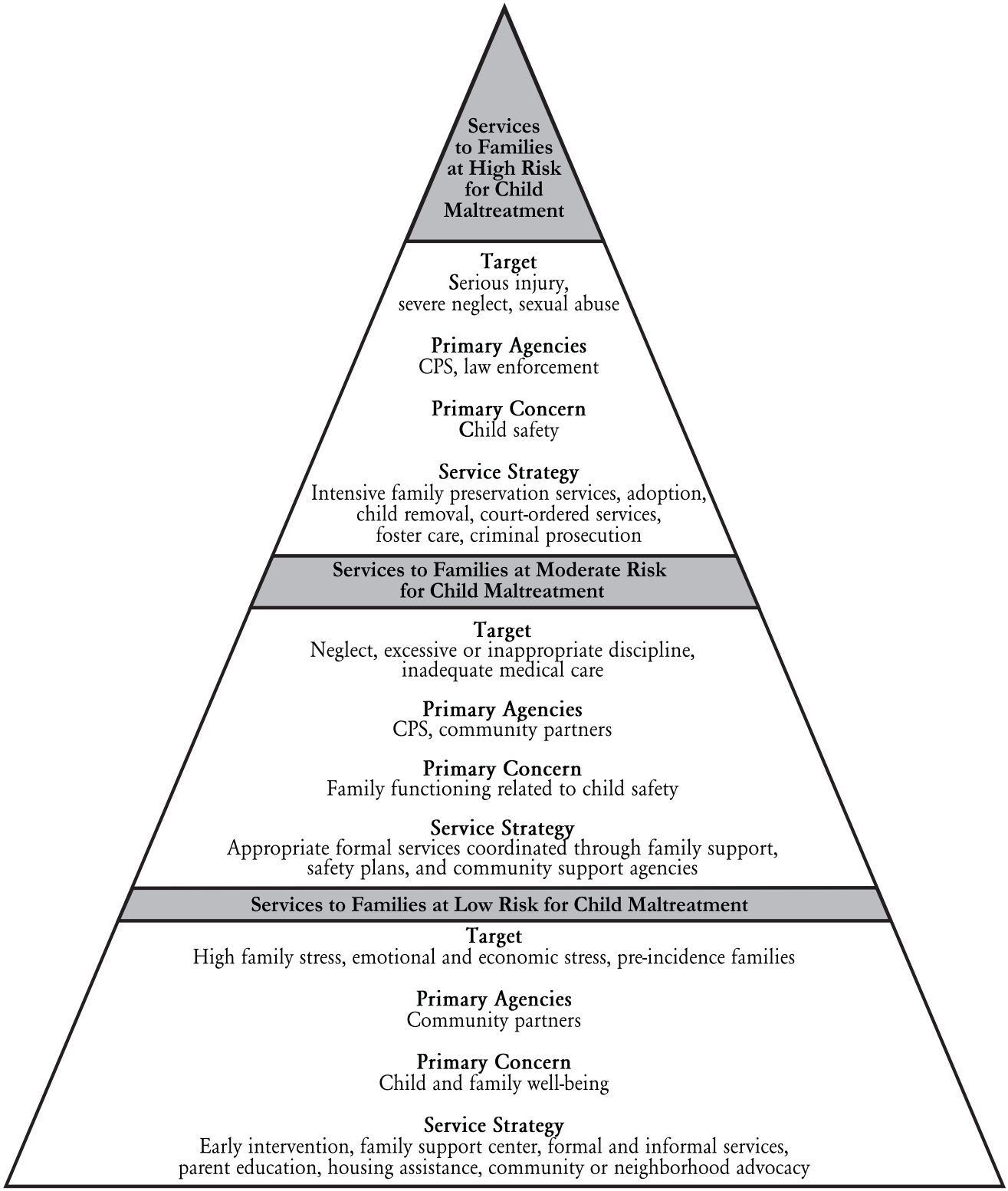
Richard Gelles, a leading researcher in the field of family violence, suggests that some families with maltreatment problems are treatment-resistant. He proposes making early decisions about permanence because the risk of maltreatment is high and the readiness for change is low.[93] Since the principles and provisions of the Adoption and Safe Families Act (ASFA) are designed to ensure child safety and decrease the time necessary to reach permanency, it is critical to evaluate a family's readiness to change and select interventions that will help families ultimately achieve child safety and permanence.

This chapter introduces a conceptual framework for services based on levels of risk in a family and discusses case management and service coordination issues. The chapter also presents an overview of the various types of treatment and intervention services available for abused and neglected children and their families.

Service Framework Based on Levels of Risk

A conceptual framework developed by the National Association of Public Child Welfare Administrators (NAPCWA), presented in Exhibit 9-1, is helpful in thinking about the levels of services appropriate to the level of risk presented by the family. The top third of the pyramid represents reports of child abuse and neglect that pose the highest risk for children, are concerned primarily with child safety, and often involve child removal and court-ordered services. The primary role for the CPS caseworker is to help families understand and acknowledge the risk factors that contributed or could lead to serious maltreatment, and to engage them in developing safety, case, and concurrent permanency plans. Since

Exhibit 9-1
Child Protection Service Pyramid[94]



services are often court-ordered, the likelihood of success will be dependent on both the caseworker's ability to communicate the potential benefits of specific intervention strategies effectively and the family's response. Family members served in this category are likely to be in the precontemplation stage of change.

The middle third of the pyramid represents family conditions that pose moderate risk to children, warrant services by CPS, focus on child safety and family well-being, and often involve collaboration with other service providers. The success of intervention is directly related to the CPS worker's ability to develop a partnership with the family. When referred, some families may be at the precontemplation stage of change, while others may be at the contemplation or determination stages of change. The role of the CPS worker is to help family members prepare for change and to collaborate on safety and case plans that will lead to improvements in family well-being and child safety.

The bottom third of the pyramid represents families that are identified as low risk for immediate maltreatment, but who experience high family stress. These families can often be served by early intervention, family support centers, and informal helping systems. The primary outcomes for these families are enhanced child and family well-being.

Case Management

Case management emphasizes decision-making, coordination, and provision of services.[95] Caseworkers collect and analyze information, arrive at decisions at all stages of the casework process, coordinate services provided by others, and directly provide supportive services. Three primary objectives for case management practice are relevant to the case management role of CPS caseworkers: (1) continuity of care, (2) accessibility and accountability of service systems, and (3) service system efficiency.[96] These objectives are best achieved when caseworkers know the resources available, have expertise in a particular area of practice, use interpersonal and group skills to interact with other professionals, and lead and coordinate the service delivery process by developing case plans that are clear to all parties. It is the caseworker's responsibility to:

- Select, provide, and arrange for the most appropriate services;
- Communicate and collaborate with identified service providers;
- Measure progress toward achievement of outcomes and goals;
- Maintain records to document client progress and ensure accountability;
- Prepare and review necessary reports.

When other service providers are used as part of the CPS caseworker's overall risk-reduction strategy, it is important to establish a contract with the referral agency or individual professional. The contract should include the following:

- Results of the family assessment, including an identification of the most critical risk factors that the service provider is to address;
- Copy of the case plan with tasks, outcomes, goals, and identification of the service provider's role;
- Specification of the purpose of the referral and the expectations regarding the type, scope, and extent of services needed;
- Specification of the number, frequency, and method of reports required, as well as reasons for reports;
- Expectations for reporting on observable changes in achievement of client tasks, outcomes, and goals;
- Measures of client progress;
- Provisions for coordinating among providers and monitoring service provision.

Treatment and Intervention

Since child maltreatment is rooted in a variety of personal and environmental factors, interventions need to address as many of these contributing issues as possible. Early evaluation research on treatment effectiveness suggests that successful intervention requires a comprehensive package addressing both the interpersonal and concrete needs of all family members. This research suggests that programs relying solely on professional therapy without other supportive or remedial services to children and families offer less opportunity for maximizing client gains. In addition, the findings suggest that during the initial months of treatment agencies should invest the most intensive resources to engage the family, then begin altering behavior as close to the point of initial referral as possible.[97]

Clearly, each community should possess a broad range of services to meet the multidimensional needs of abused and neglected children and their families, but that is not always the case due to funding or other issues. Nevertheless, CPS maintains responsibility for identifying and obtaining the most appropriate services available. Selecting services in a particular case is based on:

- Assessment of the factors contributing to the risk of maltreatment and the family's strengths;
- Outcomes targeted for change;
- Treatment approaches best suited to a particular outcome;
- Resources available in the community.

Exhibit 9-2 reflects a broad selection of treatment and other intervention services for child abuse and neglect, although it is not a comprehensive guide. These services range from support for children and families to long-term treatment interventions. Some services require extensive training before implementation. Arranged alphabetically by title within categories, the exhibit summarizes the primary focus and target population for each type of service. Information regarding evaluation and research support, and related studies is included, along with references to selected manuals, curricula, guidelines for implementation, and other background material.

For more information on these treatment and intervention services, please visit the *User Manual Series* Web site at **www.calib.com/nccanch/pubs/usermanual.cfm** or review the related literature. Inclusion in this exhibit does not reflect an endorsement of the treatment or intervention by the U.S. Department of Health and Human Services.

Exhibit 9-2 Selected Treatment and Intervention Services				
Service	**Focus**	**Population**	**Research**	**Reference Information**
Services for Children and Adolescents				
Art Therapy	To use art to help children deal with feelings of victimization, loss, and separation. Used for assessment and treatment.	Abused children	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy at time of writing.	Literature review and supporting information are available.[98]
Cognitive Processing Therapy	Through cognitive restructuring, provides relief of symptoms arising from exposure to traumatic events.	Children and adolescents with post-traumatic stress disorder (PTSD) or related depression	Research indicates positive results.[99]	Treatment manual, guidelines, and supporting information are available.[100]
Early Childhood Programs	To provide children with respite from a stressful home situation by giving them clear structure and opportunities to interact with positive adult role models in a safe childcare setting.	Abused and at-risk children	When provided in conjunction with other appropriate services, research indicates positive results.[101]	Supporting information is available.
Eye Movement Desensitization and Reprocessing	To integrate a range of therapeutic approaches in combination with eye movement stimulation to affect cognitive processes and resolve therapeutic issues at a faster rate.	Traumatized children or adolescents	When provided in conjunction with other appropriate services, research indicates positive results.[102]	Guidelines, protocols, training, and supporting information are available.[103]

Exhibit 9-2 Selected Treatment and Intervention Services				
Service	**Focus**	**Population**	**Research**	**Reference Information**
Services for Children and Adolescents (continued)				
Family Foster Care and Kinship Care	To provide a safe, supportive environment through out-of-home placement while working toward family reunification or permanent placement.	Children and adolescents who have been abused or are at high risk for further maltreatment.	Some research indicates positive results of kinship care; while others suggest concerns about the availability of fewer services to these families.[104]	Supporting information is available.[105]
Resilient Peer Training Intervention	School-based service designed to enhance the social competencies of vulnerable children through interactions with resilient peers and supportive adults.	Abused and at-risk children	Research indicates positive results.[106]	Guidelines and supporting information are available.[107]
Sex Offender Treatment for Adolescents	To change beliefs and attributions that support sex abuse, improve reactions to negative emotions, enhance behavioral risk management, and promote pro-social behaviors.	Adolescent sex offenders	Some research suggests promising results, yet there is no clear evidence.[108]	Treatment manuals and supporting information are available.[109]
Supportive Services	To provide assistance, guidance, and positive role models. May include services provided by Big Brothers/Big Sisters, YMCA, Foster Grandparents, and faith- and community-based groups.	Abused and at-risk children	Generally supported in research and practice, yet empirical evidence of efficacy has varied.[110]	Supporting information is available.[111]

Exhibit 9-2 Selected Treatment and Intervention Services				
Service	**Focus**	**Population**	**Research**	**Reference Information**
Services for Children and Adolescents (continued)				
Trauma-focused Play Therapy	To use play to enable abused children to express overwhelming emotions and thoughts. Used for both assessment and treatment.	Abused children	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy. Review of literature suggests positive results.[112]	Guidelines and supporting information are available.[113]
Treatment Foster Care	To provide therapeutic services to children within the private homes of trained families. Serves as a less restrictive, family-based alternative to residential or institutional care.	Children and adolescents with significant behavioral, emotional, and mental health problems	Research indicates positive results.[114]	Supporting information is available.[115]
Services for Parents				
Adult Child Molester Treatment	To address harmful thinking and behaviors that led offenders to sexually abuse by replacing them with appropriate thoughts and choices.	Adult sex offenders	Research indicates positive results.[116]	Supporting information is available.[117]
Focused Treatment Interventions	To increase child safety, reduce risk, identify and build family strengths, and clarify responsibility in child maltreatment cases using a multidisciplinary approach.	Families that have experienced abuse	Initial research suggests positive results.[118]	Guidelines and supporting information are available.[119]

Exhibit 9-2 Selected Treatment and Intervention Services				
Service	**Focus**	**Population**	**Research**	**Reference Information**
Services for Parents (continued)				
Focus on Families	To decrease drug use and enhance parenting skills. Sessions address relapse, family management, and promoting children's success in school.	Maltreating, substance abusing parents	Research indicates positive results.[120]	Training curriculum is available.[121]
Parent-Child Education Program for Physically Abusive Parents	To establish positive parent-child interactions and child rearing methods that are responsive to situational and developmental changes.	Physically abusive parents	Research indicates positive results.[122]	Guidelines and treatment manuals are available.[123]
Parents Anonymous, Inc.	To provide opportunities to strengthen parenting skills through mutual support, shared leadership, and personal growth in groups co-led by parents and trained facilitators.	At-risk and abusive parents	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy. Limited research supports positive results.[124]	Guidelines, facilitation manual, and supporting information are available.[125]
Services for Parents and Children				
Attachment-Trauma Therapy	To create a secure primary attachment relationship for child and caregiver by increasing communication and building trust.	Caregivers and children	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy.	Guidelines and treatment manual are available.[126]

Exhibit 9-2 Selected Treatment and Intervention Services				
Service	**Focus**	**Population**	**Research**	**Reference Information**
Services for Parents and Children (continued)				
Behavioral Parent Training Interventions for Conduct-Disordered Children	To teach parents specific skills regarding child-focused behavioral interventions to minimize coercive interactions between parent and child.	Children with conduct disorders and their families	Research indicates positive results.[127]	Guidelines and supporting information are available.[128]
Cognitive-Behavioral and Dynamic Play Therapy	To help children gain insight into their needs and behaviors, and educate parents on age-appropriate sexual behavior through behavior modification techniques.	Sexually abused children ages 6 to 12 with sexual behavior problems and their parents	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy.	Guidelines, treatment manual, and supporting information are available.[129]
Family Preservation Services	To allow children to remain safely in their own homes by building on family strengths and reducing family deficits through frequent individualized services.	Families in crisis or with chronic problems	Most evaluations of family preservation services have focused on intensive family preservation services (see below).	Supporting information is available.[130]
Family Resolution Therapy	To develop long-term resolution for family relationships, which may range from full-family reunification to termination of parent-child contacts. Concerned with the latter stages of treatment process.	Families where sexual or physical abuse has occurred, and where professional intervention with family is complete	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy.	Guidelines and supporting information are available.[131]

Exhibit 9-2 Selected Treatment and Intervention Services				
Service	**Focus**	**Population**	**Research**	**Reference Information**
Services for Parents and Children (continued)				
Intensive Family Preservation Services	To prevent out-of-home placement and reduce the risk of child maltreatment by changing behaviors and increasing skills through intensive, time-limited, and comprehensive services.	Families whose children have been identified at risk for placement	Research varies regarding the effectiveness of this intervention.[132]	Supporting information is available.[133]
Physical Abuse-focused, Cognitive-behavioral Treatment for Individual Child and Parent	To address beliefs about abuse and violence and improve skills to enhance emotional control and reduce violent behavior. Children and parents work with separate therapists for 12 to 16 sessions.	Physically abusive parents and their children	Research indicates positive results.[134]	Supporting information is available.[135]
Integrative Developmental Model for Treatment of Dissociative Symptomatology	To address dissociative behavior by teaching the child and parents alternative communication strategies and by helping the family learn new interactive patterns.	Children with dissociative symptoms and their families	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy.	Guidelines, treatment manual, and supporting information are available.[136]
Multisystemic Therapy	To assess the "fit" between identified problems and broader systemic issues, and implement a tailored, action-oriented intervention.	Maltreated children and their families	Research indicates positive results.[137]	Supporting information is available.[138]

Exhibit 9-2 Selected Treatment and Intervention Services				
Service	**Focus**	**Population**	**Research**	**Reference Information**
Services for Parents and Children (continued)				
Nurturing Parenting Programs	To teach nurturing skills and discipline while reinforcing positive family values. Programs are available for different target populations based on child's age, family's culture, and special needs.	Families at risk of physical abuse or neglect	Research indicates positive results.[139]	Training manual is available.[140]
Parent-Child Interaction Therapy	To improve the quality of the parent-child relationship by decreasing child behavior problems and increasing positive parent behaviors.	Children ages 2 to 8 years and their parents	Research indicates positive results.[141]	Treatment manual and supporting information are available.[142]
Parents United: Child Sexual Abuse Treatment Program	To offer clinical and support services to individuals affected by sexual abuse through group sessions.	Victims, offenders, adults molested as children, and their support persons	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy.	Guidelines, treatment manual, and supporting information are available.[143]
Physical Abuse-informed Family Therapy	To promote cooperation, develop shared views about the value of non-coercive interaction, and increase skills of family members.	Physically abusive parents and their children	Research indicates positive results. [144]	Guidelines and supporting information are available.[145]
Project 12-Ways	To deliver 12 services, including parent-child training, stress reduction for parents, basic skill training for children, money management training, behavior management, problem solving, and marital counseling.	Families who have experienced abuse or neglect, or are at risk	Initial research studies suggest positive results; however, potential for replication is unclear.[146]	Supporting information is available.[147]

Exhibit 9-2 Selected Treatment and Intervention Services				
Service	**Focus**	**Population**	**Research**	**Reference Information**
Services for Parents and Children (continued)				
Strengthening Families Program	To strengthen family attachment while addressing substance abuse. Interventions consist of parent training, social and life skills training for children, and family practice sessions.	Families who are at risk of substance abuse	Research indicates positive results.[148]	Supporting information is available.[149]
Strengthening Multiethnic Families and Communities	To decrease risk factors related to violence through a training program with five components: cultural or spiritual, enhancing relationships, positive discipline, rites of passage, and community involvement.	Parents of children ages 3 to 18 from diverse ethnic and cultural backgrounds	Research indicates positive results.[150]	Training manual is available.[151]
Therapeutic Child Development Program	To provide children with a consistent, safe, monitored environment, while also providing parents with educational and support services.	Abused preschool children and their parents	Research indicates positive results.[152]	Guidelines and supporting information are available.[153]
Trauma-focused, Cognitive-behavioral Therapy	To reduce children's negative emotional and behavioral responses and correct maladaptive beliefs related to abusive experiences. Used in individual, family, and group therapy, and in office-based and school-based settings.	Sexually abused children and individuals exposed to other traumatic events	Research indicates positive results.[154]	Guidelines, treatment manual, and supporting information are available.[155]
Trauma-focused, Integrative-eclectic Therapy	To increase safety in the home, enhance the quality of the parent-child relationship, and assist children and teenagers by addressing issues of shame and self-blame.	Abused children, their parents, or families	Generally supported in clinical literature and practice, yet no controlled studies of its efficacy.	Guidelines, treatment manual, and supporting information are available.[156]

CHAPTER 10
Family Progress

Determining the extent and nature of family progress is central to child protective services (CPS) intervention. Monitoring change should begin as soon as intervention is implemented, and should continue throughout the life of a case until the family- and program-level outcomes have been achieved. This chapter explores caseworker decisions based on the collection and analysis of information on family progress.

Collect and Organize Information on Family Progress

The process of evaluating family progress is a continual case management function. Once the case plan is established, each contact with the children and family should focus on assessing the progress being made to achieve established outcomes, goals, and tasks, and to reassess safety. Formal case evaluations should occur at regular intervals, however, specifically to measure progress and to redesign case plans if appropriate. Caseworkers should evaluate family progress at least every 3 to 6 months by following these steps:

- **Review the case plan.** Outcomes, goals, and tasks are written in measurable terms so that they can be used to determine progress toward reducing risk and treating the effects of maltreatment. Many agencies have a review form that should be used to document the change process.
- **Collect information from all service providers.** Intervention and service provision are typically a collaborative effort between CPS and other agencies or individual providers. Consequently, the evaluation of family progress must also be a collaborative venture. Referrals to service providers should clearly specify the number, frequency, and methods of reports expected. The caseworker must also clearly communicate expectations for reporting concerns, observable changes, and family progress. It is the caseworker's responsibility to ensure the submission of these reports and to request meetings with service providers, if indicated. In addition, when the court is involved, it is appropriate to obtain information from the parent's attorney, the child's attorney, and the court-appointed special advocate (CASA) or the Guardian ad Litem (GAL).
- **Engage the child and family in reviewing progress.** Using the case plan as a framework for communication, the caseworker should meet with the family to review progress jointly. Family members should be asked about their perceptions of task, goal, and outcome progress. If these have been established in measurable terms, there should be agreement about the level of progress. Any differences in the family's and caseworker's perceptions should be clarified in the written evaluation. The caseworker should then discuss any need to revise the case plan.

This is also the family's opportunity to identify any barriers to participation in the case plan or any new problems or concerns to be discussed.

- **Measure family progress.** Change is measured during the evaluation of family progress on two levels. The most critical risk factors (identified during family assessment) should be assessed. Specifically, what changes have been made in the conditions and behaviors causing the risk of maltreatment? The same criteria used to assess these factors during the family assessment should be used again to understand the current level of risk. The second level of measurement evaluates the extent to which specific outcomes, goals, and tasks have been accomplished by the family, caseworker, and service provider.

- **Document family progress.** Thorough documentation allows the caseworker to measure family progress between the initial assessment and current evaluation. This documentation provides the basis for many case decisions.

Analyze and Evaluate Family Progress

Once the information has been collected, the caseworker should analyze it to help determine progress and decide on further actions. The focus of the evaluation of family progress should address the following issues:

- **Is the child safe? Have the protective factors, strengths, or safety factors changed, thereby warranting the development of a safety plan or a change in an existing safety plan?** Safety should be assessed at specific times throughout the life of the case–minimally at receipt of referral, during first contact with the family, at the conclusion of the initial assessment or investigation, during establishment of the case plan, at the case review, and at case closure. Assessing safety requires caseworkers to identify and examine the risk factors affecting the child's safety. To re-evaluate safety, the caseworker examines the factors to determine whether there have been any changes in the family situation requiring the implementation of a safety plan, the change or elimination of a safety plan, or the taking of necessary action to insure the safety of the child.

- **What changes have occurred in the factors contributing to the risk of maltreatment?** Change is measured by comparing the conditions and behaviors identified during the family assessment to the current functioning of the family and individual family members.

- **What progress has been made toward achieving case goals and outcomes?** When goals and outcomes are specific, measurable, achievable, realistic, and time-limited, they can be used to determine the level of change. Goals should indicate what specifically will be different in the family when the conditions or behaviors contributing to the risk of maltreatment have been successfully addressed.

- **How effective have the services been in achieving outcomes and goals? If ineffective, what adjustments need to be made to find effective services for children and families?** The caseworker is responsible for assessing the extent to which services are being provided as planned and for determining whether services should be altered to enhance risk reduction. Specific questions that should be considered are:

  – Have the services been provided in a timely manner?

  – Has the family participated in services as scheduled?

  – Has the service provider developed rapport with the family?

  – Is there a need to alter the plan of service based on changes in the family?

- **What is the current level of risk in the family?** Based on the changes made by family members, the caseworker must determine the current level of risk of maltreatment to the children. The factors that were used to determine the level of risk of maltreatment during the initial assessment or investigation and family assessment should be applied again.

- **Have the risk factors been reduced sufficiently so that the parents or caregivers can protect their children and meet their developmental needs, allowing the case to be closed?** One of the primary purposes of CPS intervention is to help the family change the behaviors and conditions that will likely lead to maltreatment in the future. The caseworker should also be realistic about change. While it may not be possible to help a family reach optimal levels of functioning in relation to all of the conditions and behaviors contributing to the risk of maltreatment, it may be possible to help a family change the most critical issues so that the parent is able to provide sufficient care for the child. The criteria used to determine whether to close the case should be minimal, not optimal standards. If risk is reduced sufficiently and the child is safe, then the case should be closed. Ongoing support for the family and treatment for the child by other professionals may be needed, however, even after the case has been closed by CPS.

- **Is reunification likely in the required time frame or is an alternate permanency plan needed?** Assessment of the appropriateness of reunification or other permanent placement is based on whether:

  – Current level of threats to safety have been reduced to a level that ensures that the family can protect the child in the home;

  – Protective factors or strengths have been developed to respond to future threats;

  – Social supports are available to sustain the strengths and prevent the return of threats to safety.[157]

After evaluating family progress, the caseworker must discuss with the casework supervisor the decisions made and the next steps. Chapter 13, "Supervision, Consultation, and Support," provides information on supervisory consultation.

CHAPTER 11
Case Closure

Termination is the process of ending the caseworker's relationship with the family and providing the family with the opportunity to put closure on their relationship with the caseworker (and possibly with the agency). Depending on the nature of the relationship between the caseworker and the children and family, what was accomplished, and the nature of the closure, termination may generate a range of feelings.[158] Involuntary clients are less likely than voluntary clients to experience regret at closure. Since they did not seek contact, termination may be approached with relief that an unsought pressure will be removed. However, if the caseworker has been able to work through the resistance and engage the family in the intervention process, they may experience regret. This is a positive sign because family members will feel these feelings only if the relationship or the work has come to be valued.[159]

Types of Case Closure

For the most part, child protective services (CPS) case closures will be one of four types:

- **Termination.** If all of the outcomes have been achieved, or if the family feels unready or unwilling to work toward those outcomes, and there is sufficient reason to believe that the child is safe (even though there may still be some risk of maltreatment), then the caseworker may agree that ending the relationship with the family is appropriate. This also means that the family will not move on to work with other service providers.

- **Referral.** If the family is able or willing to continue to work with other service providers toward some or all of the outcomes that have not yet been accomplished, then the caseworker will work with the family to identify other strategies to support the work. This may include referral to other agencies or providers, or it may include the identification of such informal supports as family or friends who will encourage and guide them.

- **Transfer.** If the caseworker's time with the family is ending, but they will work with another caseworker in the agency, then the ending work with the family will, in part, focus on developing a relationship with the new caseworker. If the caseworker had developed a positive relationship with the family, it is desirable that both the current and new caseworker have at least one joint session to introduce the colleague to the client.

- **Discontinuation by family.** If the family is receiving voluntary services and makes a unilateral decision to end their relationship with the agency, this decision may be communicated behaviorally. For example, family members may gradually or suddenly stop keeping scheduled

appointments and not respond to outreach attempts to reconnect. The caseworker must consult with the supervisor to examine the agency's response.[160] Discontinuation by the family is the least desirable type of case closing, but likely to happen some of the time. The family, however, cannot legally discontinue services if the court mandates the services.

Process of Case Closure

Caseworkers should take the following steps in terminating services:

- **Review risk reduction.** Talk with the family about the specific accomplishments, emphasizing the positive change in behaviors and conditions.
- **Review tasks completed.** Discuss any obstacles encountered and focus on the successes and knowledge obtained.
- **Review general steps in problem solving.** Remind families of the strides made as well as the methods they can use when future problems arise.
- **Consider any remaining needs or concerns.** Help family members plan how to maintain the changes. Discuss any potential obstacles they may encounter as well as strategies for overcoming them.[161]

Community Collaboration During Case Closure

When a family has received services from CPS and other agencies or individual providers, the evaluation of family progress must be a collaborative venture. The caseworker should determine the family's progress based on information from all service providers. In some cases, it may be appropriate to convene a team meeting to review the family's progress in relation to the assessment, case plan, and service agreement(s) prior to case closure.

When the court is involved in a case that is being closed, the court must approve case closure as well as terminate any existing court orders. Depending on the jurisdiction, this may involve written notification to the court or a hearing.

Family Involvement During Case Closure

Each child and family's experience of and response to ending the relationship will be unique. Feelings can range from relief, satisfaction, and happiness to sadness, loss, anger, powerlessness, fear, rejection, denial, and ambivalence. It is important to encourage family members to discuss their feelings. Even if it has been a difficult relationship, the caseworker should provide some positive statement of closure.[162]

Some practical steps to involve the family include:

- Meeting with the family to discuss the case closure;
- Anticipating a family-created crisis that may occur as a reaction to independence resulting from the planned closure;
- Reviewing the progress made as a result of CPS involvement;
- Referring the family to any additional resources needed;
- Leaving the door open for services should they be needed in the future, including providing appropriate contact information.

CHAPTER 12
Effective Documentation

Case documentation provides accountability for both the activities and the results of the agency's work. In child protective services (CPS), case records and information systems must carefully document: (1) contact information; (2) the findings of the assessments; (3) decisions at each stage of the case process; (4) interventions provided to the family both directly and indirectly; (5) the progress toward goal achievement, including risk reduction; (6) the outcomes of intervention; and (7) the nature of partnerships with community agencies. This chapter describes the primary purposes of record-keeping, principles about the way both paper and automated records should be maintained, and content that should be documented at each step of the process. The strategies outlined here not only assure accountability to others, but also facilitate a way of thinking and a process to measure the results of the agency's work with families and children.[163]

Purposes of Child Protective Services Record-keeping

The key purposes for keeping records are to:

- **Guide the CPS process.** Case records provide an ongoing "picture" of the nature of CPS involvement with families, the progress toward achieving outcomes, and the basis of decisions that eventually lead to case closure. The process of record-keeping itself helps to clarify and focus CPS work.

- **Provide accountability for the agency and the caseworker.** Records should describe who is and is not served (including any other household members who may not be participating in services), the kinds of services provided (or not provided due to availability or level of service issues), the basis for all decisions, the degree to which policies and procedures are implemented, and other aspects of accountability and quality control. The record provides a statement about the quality of CPS work that may decrease personal liability should legal action be taken against the agency or a caseworker.

- **Serve as a therapeutic tool for the caseworker and the family.** Case records can demonstrate the way in which the caseworker and family collaborate to define the purpose of CPS work, including the goals and outcomes that will reduce the risk of maltreatment, and serve to evaluate the progress toward them. Some CPS agencies are using instruments and tools that seek input, and, therefore, the record itself provides an illustration of this collaborative process.

- **Organize the caseworker's thinking about the work.** Structured presentation of factual information leads to more in-depth assessment and treatment planning. Sloppy recording and

disorganized thinking go hand-in-hand and will likely lead to poor service delivery to clients.[164]

In addition to the primary purposes of record-keeping listed above, the case record becomes a means for supervisory review, statistical reporting and research, and interdisciplinary communication.

Content of Case Records

Case records should factually document what CPS does in terms of assessment and intervention, as well as the results of CPS-facilitated interventions and treatment, which serve the outcomes of child safety, permanence, and well-being. Family records, whether paper or automated, should include:

- Information about the nature and extent of the referral or report; identify demographic data on the child, family, and significant others; and the response of the agency to the referral.
- A record of all dates and length of contacts, including in-person and telephone interviews with all family members, collateral sources, and multidisciplinary team, as well as the location and purposes of these contacts.
- Documentation that the family has been informed of the agency's policy on the release of information from the record.
- Information about the initial assessment, including documentation of what may have already occurred (e.g., the report of alleged child maltreatment), as well as the assessment of the risk to and safety of the child.
- Information about any diagnostic procedures that may have been part of the initial assessment (e.g., medical evaluations, x-rays, or other medical tests; psychological evaluations; and alcohol or drug assessments).
- Clear documentation of initial decisions with respect to substantiation of the alleged maltreatment, risk assessment and safety evaluation, basis for any placement in out-of-home care or court referral (if necessary), and reasons for continued agency involvement or for terminating services.
- The safety plan, if one was developed, and documentation of referrals to other programs, agencies, or persons who will participate in the implementation of the safety plan.
- A record of the family assessment (including risks and strengths) and a delineation of the treatment and intervention needs of the child, caregivers, and the family.
- A description of any criminal, juvenile, or family court involvement and the status of any pending legal action in which the client may be involved.
- The case plan with specific measurable goals, as well as a description of the process used to develop the plan.
- Specification of the intervention outcomes, which, if achieved, will reduce the risks and address the effects of maltreatment. These intervention outcomes should lead to the achievement of child safety, permanency, and child and family well-being.
- Documentation of the case activities and their outcomes, including information from all community practitioners providing intervention or treatment (written reports should be requested from all providers) and information about the family's response to intervention and treatment.
- Information about the progress toward the achievement of outcomes, completion of case plans, risk reduction process, and reunification of children with their families or other permanency options.
- Information provided to the court, if court involvement was necessary.

- Inclusion of a case-closing summary that describes:
  - Outline summarizing the original reason for referral;
  - Process of closure with the family;
  - Outcomes and goals established with the family;
  - Nature of the services provided and the activities undertaken by the various practitioners and the family;
  - Description about the level of progress accomplished with respect to outcomes and goals;
  - Summary of any new reports of maltreatment that may have occurred during intervention;
  - Assessment of risk and safety as it now exists;
  - Problems or goals that remain unresolved or unaccomplished;
  - Reasons for closing the case.[165]

Principles of Record-keeping

The case record is a professional document and tool. As such, it should be completed in a timely and professional manner, and confidentiality should be respected at all times. This means that appropriate controls should be in place to ensure the security of paper and automated files.

Caseworkers should:

- Maintain only information that is relevant and necessary to the agency's purposes. Facts should be recorded and distinguished from opinions. When opinions are offered, their basis should be documented (e.g., Mr. Smith appeared to be intoxicated; his eyes were red; he had difficulty standing without losing his balance; his breath smelled of alcohol).
- Never record details of clients' intimate lives or their political, religious, or other personal views, unless this information is relevant to CPS purposes.
- Record as much information as possible based on direct communication with clients.
- Inform clients about the agency's authority to gather information, their right to participate (or not) in the process, the principal purpose for the use of the information that they provide, the nature and extent of the confidentiality of the information, and under what circumstances information in records may be shared with others.
- Never disclose any verbal or written information about clients to other practitioners without a signed "release of information" prior to disclosure. An exception usually exists in State child abuse-reporting laws to provide for the sharing of information between members of a multidisciplinary team. Specific State laws and policies should guide these actions.
- Retain and update records to assure accuracy, relevancy, timeliness, and completeness. Mark errors as such rather than erasing or deleting them.
- Use private dictation facilities when using dictation equipment to protect a client's right to confidentiality.
- Never include process recordings in case files. The primary purpose of a process recording is to build the practitioner's skills. As such, they do not belong in an agency record.
- Obtain the child and family's permission before audiotaping or videotaping any session and inform the client that refusal to allow taping will not affect services.

- Never remove case records from the agency, except in extraordinary circumstances and with special authorization (e.g., if the record was subpoenaed for the court).

- Never leave case records or printouts from the automated file on desks or in other open spaces where others might have access to them.

- Keep case records in locked files. Keys should be issued only to those requiring frequent access to files. There also should be a clear record of the date that the file was removed and by whom. Similar security procedures (e.g., password-protected) should be provided for automated case records.[166]

Quality record-keeping is an integral part of professional CPS practice. When the case record is used as an opportunity to organize the worker's thinking and to integrate an approach to measuring the results of CPS work, it becomes an important part of the CPS process rather than something that only documents the process.

CHAPTER 13

Supervision, Consultation, and Support

Child protective services (CPS) supervisors are responsible for ensuring that the agency mission and goals are accomplished, and that positive outcomes for children and families are achieved through the delivery of competent, sensitive, and timely services. The supervisor is the link between the front-line of service delivery and the upper levels of administration. It is the supervisor who brings the resources of the organization into action at the front line—the point of client contact.[167]

The supervisor has two overarching roles: building the foundation for and maintaining unit functioning, and developing and maintaining staff capacity.[168] These roles are accomplished through the following activities:

- Communicating the agency's mission, policies, and practice guidelines to casework staff;
- Setting standards of performance for staff to assure high-quality practice;
- Assuring that all laws and policies are followed, and staying current with changing policies and procedures;
- Creating a psychological and physical climate that enables staff to feel positive, satisfied, and comfortable about the job so that clients may be better served;
- Helping staff learn what they need to know to effectively perform their jobs through orientation, mentoring, on-the-job training, and coaching;
- Monitoring workloads and unit and staff performance to assure that standards and expectations are successfully achieved;
- Keeping staff apprised of their performance and providing recognition for staff efforts and accomplishments;
- Implementing safety precautions.[169]

This chapter examines the role of the CPS supervisor, including the supervisor's involvement in decision-making, clinical consultations, monitoring, and feedback. Finally, the chapter looks at the ways in which supervisors and peers provide support to caseworkers, prevent burnout, and ensure worker safety.

Supervisory Involvement in Decision-making

Supervisors must be involved in any casework decision that affects child safety and permanence. The supervisor and caseworker should collaborate to reach consensus on decisions regarding safety and achieving permanence for the child. Since the caseworker is the primary holder of the information,

the supervisor should review the caseworker's documentation and meet with the caseworker to analyze the information. The supervisor and caseworker work together to understand and arrive at the most appropriate decision.[170] This approach requires that the supervisor respects the caseworker, works with the caseworker to gather thorough and accurate information from the family and collateral sources, analyzes the information thoughtfully, and draws reasonable conclusions (inferences and deductions). Ultimately, the supervisor is responsible for directing the activities of the worker and will share in any liability that results from the caseworker's action or failure to act.

Supervisory Involvement in Clinical Consultation

Caseworkers are not expeted to have all of the answers. There are many avenues available to CPS workers for consultation on cases. Within the CPS unit, caseworkers often turn to their supervisors when they are unsure about how to handle a situation, when they need help with a particular decision, or when they need to discuss their conclusions or ideas with an objective person.

When to Consult Supervisors on Casework Decisions

Caseworkers must always consult their supervisors about the following decisions:

- Upon receipt of a report of child abuse or neglect, caseworkers must decide how soon to initiate contact. State laws typically dictate the time frame for initiating the investigation; however, the caseworker and supervisor must make a decision regarding which cases necessitate immediate contact with the child.
- During the first contact with the child and family, the caseworker must decide if the child will be safe while the initial assessment or investigation proceeds. Supervisors review the decision and approve or modify it.
- Upon conclusion of the initial assessment or investigation, and after the decisions regarding the validity of abuse or neglect and the risk assessment have been made, caseworkers and supervisors must determine whether the child will be safe in his or her home with or without continuing CPS intervention.
- If it is determined that the child is unsafe, the caseworker and supervisor must determine which interventions will assure the child's protection in the least intrusive manner possible.
- When the child has been placed in out-of-home care, the reunification recommendation must be made between the caseworker and supervisor.
- When the child has been placed in out-of-home care, the recommendation to change to another permanent goal other than reunification must be made between the caseworker and supervisor.
- At the point of case closure, the caseworker and supervisor must evaluate risk reduction and client progress toward assuring the child's protection and meeting the child's basic developmental needs.

CPS supervisors are responsible for assuring that children are safe, their families are empowered to protect them from harm and meet their basic needs, and effective interventions and services are provided to families. Key aspects of supervision through which this is accomplished are case consultation and supervision or clinical supervision. Case consultation and supervision focuses on the casework relationship including any direct interaction, intervention, or involvement between the caseworker and the children and families. It involves the supervisory practices of review, evaluation, feedback, guidance, direction, and coaching. Specifically, case consultation and supervision focuses on:

- Rapport or the helping relationship between the worker and the client;
- A caseworker's ability to engage the client;
- Risk and safety assessment and the associated decisions or plans;
- Comprehensive family assessment and development of the case plan;
- Essential casework activities to assist the family in changing;
- Client progress review and evaluation;
- Casework decision-making.[171]

In individual supervision, case consultation should occur on an ongoing basis. It may also occur when problems or needs arise. The following case consultation format gives shape to the consultation so it will be focused, goal driven, maximize the use of time, and encourage sharing of expertise:

- Describe briefly why the family came to the attention of CPS.
- Identify the safety issues that need to be immediately addressed.
- Outline what the family wants, what CPS wants, and how the differences can be reconciled.
- Determine the inner resiliencies, strengths, or resources in the family that will provide the foundation for change.
- Examine the success of previous contacts with the family. For example, what was accomplished? What still needs to be accomplished? What has the caseworker contributed to the results, and what has the family contributed to the results?
- Identify the purpose of the next contact with the family. Examine how it ties in with where the family is in the intervention process.
- Assess the caseworker's relationships with each family member. Define what family members need in order to assure that the family is willing and able to experience the process of change and achieve the necessary goals to assure greater permanence, safety, and well-being for the children.
- Describe the specific strategies that will help family members accomplish their goals.
- Discuss what services the family says have been most helpful.
- Determine the level of risk within the family. Identify the risks, the strengths, or protective factors within the family, and how the agency will know when the risk has been reduced.
- Establish what needs to happen in the family for the agency to return the child and what needs to happen in the family to close the case.
- Identify the signs of success for the family.[172]

Peer Consultation

In addition to receiving clinical consultation from their supervisors, caseworkers can also consult other caseworkers in the unit. Experienced and competent CPS caseworkers may have handled similar situations and be able to provide suggestions, guidance, and direction.

Also, group case staffings involving the whole unit are extremely beneficial sources of consultation. In group case staffings, caseworkers present a problematic case. The supervisor and other caseworkers in the unit share their expertise and suggest actions, services, resources, or decisions. Many CPS agencies use case staffings to help with such major case decisions as the return of children to the home and case closure within the entire unit.

Professionals in the community are another source of consultation. Depending on the relationship between the caseworker or the CPS unit and the professional community, informal consultation on cases may be possible. Formal consultation in the form of an evaluation may be necessary, such as in a drug screening or developmental evaluation.

The Child Abuse Prevention and Treatment Act (CAPTA) requires that every State establish a citizen review panel to evaluate State and local CPS agencies, their implementation of CAPTA, and their coordination of foster care and adoption services. The inclusion of community members can often bring a fresh perspective to the CPS case review process, as well as provide an opportunity for the community to better understand CPS. Citizen review of case plans in cases where the child has been placed in foster care can also be a source of information and assistance.

In addition, multidisciplinary case reviews are excellent resources for CPS staff. Not only do these case reviews provide consultation from other disciplines on a particular case, they also provide opportunities to address coordination and collaboration issues as well.

Supervisory Monitoring of Casework Practice

Since supervisors are ultimately responsible for assuring accomplishment of program outcomes and are accountable for what happens in each case, they must have systems in place to monitor practice. There are three methods that the supervisor can use to learn what caseworkers are doing with clients:

- Reviewing casework documentation
- Providing individual supervision
- Observing caseworkers with clients

Documentation is an essential part of casework practice. (See Chapter 12, "Effective Documentation," for a more detailed description of what and how to document case activities and what information to include.) Supervisors should review case documentation on a regular and systematic basis. Review of case documentation provides the supervisor with information about the frequency and content of caseworker-client contacts; the family's strengths, needs, and risks; the plan to assure safety; casework decisions; services or interventions to reduce risk; progress toward outcomes; and any changes in the child and family's situation.

As stated previously, supervisors should have scheduled weekly individual conferences with staff. Supervisors should have a monitoring system in place that assures that each case is discussed in depth on at least a monthly basis. This will enable supervisors to remain apprised of actions taken or needed in cases, progress toward change or risk reduction, and casework decisions. It also will enable the supervisor to provide consultation, guidance, direction, and coaching to caseworkers regarding casework practice.

Finally, supervisors do not truly know a caseworker's effectiveness in working with clients unless they observe caseworker-client interaction directly. Regular observation should be conducted with all caseworkers. There are many opportunities for observation, including:

- Home visits
- Office visits
- Court hearings

- Supervised family-child visits
- Case staffings and reviews
- Family group conferences or meetings

The observations can be structured in a number of ways, depending on what is negotiated between the caseworker, supervisor, and family. For example, the caseworker may feel "stuck" in a case and, with the family's permission, would like consultation from an objective observer.

Based on the review and evaluation of the caseworker's efforts with families, the supervisor recognizes the caseworker's efforts and accomplishments and provides positive feedback on the specific casework practices that he or she is doing well. Areas and skills needing improvement also are addressed, as well as ways to do so.

Caseworker Safety

Since any CPS case has the potential for unexpected confrontation, supervisors and caseworkers must work together to ensure worker safety. Difficulties may occur at any point in the CPS process, but threats and volatile situations are more likely to occur during the initial assessment or investigation, during crisis situations, and when major actions are taken (e.g., the removal of the child).

The first step in ensuring caseworker safety is to assess the risk of the situation before the initial contact. Before caseworkers conduct an initial assessment, they need to assess the risk to themselves. Questions caseworkers should consider include:

- Is there a history of domestic violence?
- Does the complaint indicate the possibility of a family member being mentally ill, using drugs, or being volatile?
- Are there firearms or other weapons noted in the report?
- Is the family's geographic location extremely isolated or dangerous?
- Is this a second or multiple complaint involving the family?
- Is the initial assessment scheduled after normal working hours?[173]

If the answers to the first four questions are "yes," law enforcement may need to be involved in the initial assessment. If the answers to the last two questions are "yes," two caseworkers may need to conduct the home visit.

Peer Support and Burnout Prevention

Providing child protective services is a complex, demanding, and emotionally draining job. Making decisions that affect the lives of children and families takes a toll on caseworkers. Because working with families experiencing abuse and neglect is difficult, it may elicit multifaceted feelings. In order to maximize performance and minimize burnout, support systems must be developed within the CPS unit to provide caseworkers with opportunities to discuss and deal with feelings that may range from frustration and helplessness to anger and incompetence. Opportunities to discuss these feelings openly in the unit are essential. However, it is important that when support groups are established they do not degenerate into "gripe sessions," where caseworkers leave feeling worse than when they came to the group. A certain amount of discussion of feelings is cathartic; a positive outcome, however, must result for caseworkers to benefit from the discussion. In addition, whenever crises occur in cases (e.g., a child is reinjured or a child must be removed from his or her family) the caseworker involved needs extra support and guidance.

Effective supervision is one of the key factors in staff retention. An effective supervisor demonstrates empathy toward the needs and feelings of CPS staff. In addition, the supervisor should facilitate the

Taking Care of Yourself

CPS caseworkers need support in order to find a balance between their professional and personal lives. Due to stress inherent in CPS work, it is important that workers find effective ways to unwind and relax. It is important to:

- Be aware of the potential for burnout, stress, and trauma that can occur in child welfare work;
- Identify and use social supports to prevent burnout and stress while working in the child welfare system;
- Look to supervisors, peers, and interdisciplinary teams to talk about difficult client situations, including fatalities and serious injury situations;
- Be alert to signs of vicarious trauma and take steps to seek help when these signs endure and affect the quality of practice.

development and maintenance of a cohesive work team. Group cohesion provides emotional support to staff, as well as concrete assistance in carrying out case activities.

Conclusion

Working with CPS is usually challenging for all involved–children and families, professional and citizen partners, and caseworkers. Children and families are often fearful of and upset by CPS involvement in their lives, particularly due to the uncertainty associated with the process. Professional and citizen partners sometimes struggle with initiating and identifying their roles in addressing child maltreatment issues. The CPS caseworker must walk a fine line between following the legal mandate to protect maltreated children and recognizing parents' rights to rear their children as they deem appropriate. Additionally, CPS caseworkers are consistently confronted with numerous and multifaceted problems that affect many of the families involved with CPS, such as substance abuse, mental illness, domestic violence, and poverty. This manual is intended to address the concerns of these various audiences, as well as to serve as a practical and user-friendly guide in addressing and effectively responding to the ever-changing demands in the child welfare field.

Endnotes

[1] Child Welfare League of America. (1999). *CWLA standards of excellence for services for abused and neglected children and their families* (Rev. ed.). Washington, DC: Author.

[2] Pecora, P. J., Whittaker, J. K., Maluccio, A. N., Barth, R. P., & Plotnick, R. D. (2000). *The child welfare challenge* (2nd ed.). New York, NY: Aldine de Gruyter; Zlotnick, J. (2000). What are the core competencies for practitioners in child welfare agencies? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 571-576). Thousand Oaks, CA: Sage.

[3] Rauch, J. B., North, C., Rowe, C., & Risley-Curtiss, C. (1993). *Diversity competence: A learning guide.* Baltimore, MD: University of Maryland School of Social Work.

[4] Child Welfare League of America. (1999); Holder. W., & Costello, T. (1989). *Caseworker desk guide for self assessment of child protective services practice competencies.* Charlotte, NC: ACTION for Child Protection 1989; Costello, T. (1989). *Survey results-national child protective services competency-based training project: Defining and measuring critical CPS competencies.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children, Youth and Families.

[5] Zlotnick, J. (2000).

[6] Abramczyk, L. (1994). Should child welfare workers have an M.S.W.? In E. Gambrill & T. Stein (Eds.), *Controversial issues in child welfare* (pp. 174-179). Needham, MA: Allyn & Bacon.

[7] National Association of Public Child Welfare Administrators. (1999). *Guidelines for a model system of protective services for abused and neglected children and their families.* Washington, DC: American Public Human Services Association; Child Welfare League of America. (1999); Rittner, B., & Wodarski, S. S. (1999). Differential uses for BSW and MSW educated social workers in child welfare services. *Children and Youth Services Review, 21*(3), 217-238.

[8] Russell, M. (1987). *1987 National study of public child welfare job requirements.* Portland, ME: University of Southern Maine, National Resource Center for Management and Administration.

[9] Child Welfare League of America. (1990). *Florida recruitment and retention study.* Washington, DC: Author.

[10] Hess, P. M., Folaron, G., & Jefferson, A. B. (1992). Effectiveness of family reunification services: An innovative evaluative model. *Social Work, 37*, 304-311.

[11] Booz, Allen & Hamilton. (1987). *The Maryland social services job analysis and personnel qualifications study, executive summary.* Baltimore, MD: Maryland Department of Human Resources.

[12] Dhooper, S., Royse, D., & Wolfe, L. (1990). Does social work education make a difference? *Social Work, 35*(1), 57-61.

[13] Abers, E. C., Reilly, T., & Rittner, B. (1993). Children in foster care: Possible factors affecting permanency planning. *Child and Adolescent Social Work Journal, 10*(4): 329-341.

[14] Hopkins, K., & Mudrick, N. (1999). Impact of university/ agency partnerships in child welfare on organizations, workers, and work activity. *Child Welfare, 78*(6), 749-773.

[15] Rome, S. H. (1997). The child welfare choice: An analysis of social work students' career plans. *Journal of Baccalaureate Social Work, 3*(1), 31-48.

[16] DePanfilis, D. (2000a). How do I develop a helping alliance with the family? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 36-40). Thousand Oaks, CA: Sage.

[17] DePanfilis, D. (2000a).

[18] Horejsi, C. (1996). *Assessment and case planning in child protection and foster care services.* Englewood, CO: American Humane Association, Children's Division.

[19] Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103; Truax, C., & Carkhuff, R. (1967). *Toward effective counseling and psychotherapy.* Chicago, IL: Aldine de Gruyter.

[20] DePanfilis, D. (2000a); Truax, C., & Carkhuff, R. (1967).

[21] Fong, R. (2001). Culturally competent social work practice: Past and present. In R. Fong & S. Furturo (Eds.), *Culturally competent practice: Skills, interventions, and evaluation* (pp. 1-9). Needham Heights, MA: Allyn and Bacon.

[22] Rogers, C. (1957); Truax, C., & Carkhuff, R. (1967).

[23] Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services.* New York, NY: W. W. Norton; DePanfilis, D. (2000a); Rooney, R. (2000). How can I use authority effectively and engage family members? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 44-46). Thousand Oaks, CA: Sage.

[24] Anderson, J. (1988). *Foundations of social work practice.* New York, NY: Springer.

[25] Rooney, R. (2000).

[26] Griffin, W. V., Montsinger, J. L., & Carter, N. A. (1995). *Resource guide on personal safety for administrators and other personnel.* Durham, NC: Brendan Associates and ILR.

[27] Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice, 19*, 276-288.

[28] National Association of Public Child Welfare Administrators. (1999).

[29] Child Welfare League of America. (1999).

[30] Child Welfare League of America. (1999).

[31] National Research Council. (1993). *Understanding child abuse and neglect.* Washington, DC: National Academy Press.

[32] Pecora, P. J., et al. (2000).

[33] Wells, S. (1997). Screening in child protective services: Do we accept a report? How do we respond? In T. Morton & W. Holder (Eds.), *Decision-making in children's protective services: Advancing the state of the art* (pp. 94-106). Atlanta, GA: Child Welfare Institute and Denver, CO: ACTION for Child Protection.

[34] Wells, S. (1997); Wells, S. (2000a). How do I decide whether to accept a report for a child protective services investigation? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 3-6). Thousand Oaks, CA: Sage.

[35] Wells, S. (2000a).

[36] Child Welfare League of America. (1999).

[37] Wells, S. (1997).

[38] Wells, S. (2000b). What criteria are most critical to determine the urgency of the child protective services response? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 7-9). Thousand Oaks, CA: Sage.

[39] Zuravin, S., & Shay, S. (1991, June). Preventing child neglect. In D. DePanfilis & T. Birch (Eds.), *Proceedings of the National Child Maltreatment Prevention Symposium.* Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.

[40] Farrow, F. (1997). *Child protection: Building community partnership. Getting from here to there.* Cambridge, MA: Harvard University, John F. Kennedy School of Government; Gordon, A. L. (2000). What works in child protective services reforms. In M. P. Kluger, G. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 57-66). Washington, DC: CWLA Press; Pelton, L. H. (1998). Four commentaries: How we can better protect children from abuse and neglect. *The Future of Children: Protecting Children from Abuse and Neglect, 8*(1), 120-132; Waldfogel, J. (1998). Rethinking the paradigm for child protection. *The Future of Children: Protecting Children from Abuse and Neglect, 8*(1), 104-119; Weber, M. W. (1998). Four commentaries: How we can better protect children from abuse and neglect. *The Future of Children: Protecting Children from Abuse and Neglect, 8*(1), 120-132.

[41] Turnell, A., & Edwards, S. (1999). *Signs of safety: A solution and safety oriented approach to child protection casework.* New York, NY: W. W. Norton.

[42] Turnell, A., & Edwards, S. (1999).

[43] Drake, B. (2000). How do I decide whether to substantiate a report? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 113-117). Thousand Oaks, CA: Sage.

[44] Filip, J., McDaniel, N., & Schene, P. (1992). *Helping in child protective services: A competency-based casework handbook* (p. 189). Denver, CO: American Humane Association.

[45] DePanfilis, D. (2000b). What is inadequate supervision? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 134-136). Thousand Oaks, CA: Sage.

[46] DePanfilis, D. (2000b).

[47] DePanfilis, D. (2000c). How do I determine if a child is neglected? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 134-136). Thousand Oaks, CA: Sage.

[48] Dubowitz, H. (2000). How do I determine whether a child has been physically abused? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 134-136). Thousand Oaks, CA: Sage.

[49] Adams, J. (2000). How do I determine if a child has been sexually abused? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 175-179). Thousand Oaks, CA: Sage.

[50] Hart, S., Brassard, M., & Karlson, H. (1996). Psychological maltreatment. In J. Briere, L. Berliner, J. Bulkley, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment* (pp. 72–89). Thousand Oaks, CA: Sage.

[51] Brassard, M., & Hart, S. (2000). How do I determine whether a child has been psychologically maltreated? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 215-219). Thousand Oaks, CA: Sage.

[52] Pecora, P. J. et al. (2000).

[53] Hollinshead, D., & Fluke, J. (2000) What works in safety and risk assessment for child protective services. M. Kluger, G. Alexander, & P. Curtis (Eds.), *What works in child welfare* (p. 67). Washington, DC: CWLA Press.

[54] Hollinshead, D., & Fluke, J. (2000).

[55] Holder, W., & Morton, T. (1999). *Designing a Comprehensive approach to child safety.* Atlanta, GA: Child Welfare Institute and Denver, CO: ACTION for Child Protection.

[56] Holder, W., & Morton, T. (1999).

[57] Young, N., Gardner, S., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy* (p. 126). Washington, DC: CWLA Press.

[58] Young et al. (1998).

[59] Ganley, A., & Schechter, S. (1996). *Domestic violence: A national curriculum for child protective services.* San Francisco, CA: Family Violence Prevention Fund.

[60] Ganley, A., & Schechter, S. (1996).

[61] Pecora, P. J. et al. (2000).

[62] DePanfilis, D. (1997). Is the child safe? How do we respond to safety concerns? In T. Morton & W. Holder (Eds.), *Decision making in children's protective services: Advancing the state of the art* (pp. 121-142). Atlanta, GA: Child Welfare Institute and Denver, CO: ACTION for Child Protection.

[63] DePanfilis, D. (1997).

[64] Berg, I. K., & Kelly, S. (2000).

[65] Christian, S. M. (1997). *New directions for child protective services: Supporting children, families and communities through legislative reform.* Washington, DC: National Conference of State Legislatures.

[66] Farrow, F. (1997).

[67] Waldfogel, J. (1997). *The future of child protection: How to break the cycle of abuse and neglect.* Cambridge, MA: Harvard University Press.

[68] Pintello, D. (2000). How do I interview non-maltreating parents and caregivers? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 80-84). Thousand Oaks, CA: Sage.

[69] Child Welfare League of America. (1999).

[70] Miller, W., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York, NY: The Guilford Press.

[71] Saywitz, K. J., & Goodman, G. S. (1996). Interviewing children in and out of court: Current research and practice implications. In J. Briere, L. Berliner, J. Bulkley, C. Jenny, & T. Reid (Eds.) *The APSAC handbook on child maltreatment* (pp. 297-318). Thousand Oaks, CA: Sage; Kolko, D., Brown, E., & Berliner, L. (2002). Children's perceptions of their abusive experience: Measurement and preliminary findings. *Child Maltreatment, 7*(1), 42-55.

[72] Berliner, L., & Loftus, E. (1992). Sexual abuse accusations: Desperately seeking reconcilation. *Journal of Interpersonal Violence, 7*(4), 570-578; Saywitz, K. J., & Goodman, G. S. (1996); Kolko, D., Brown, E., & Berliner, L. (2002).

[73] Boat, B., & Everson, M. (1986). *Using anatomical dolls: Guidelines for interviewing young children in sexual abuse investigations.* Chapel Hill, NC: University of North Carolina, Department of Psychiatry.

[74] American Humane Association. (1997). *Worker safety for human services organizations.* Denver, CO: Author; Griffin, W. V. et al. (1995).

[75] American Humane Association. (1997).

[76] Holder, W. (2000).

[77] National Association of Public Child Welfare Administrators. (1999).

[78] Dunst, C. J., Trivette, C. M., & Deal, A. G. (1994). *Supporting and strengthening families: Volume 1: Methods, strategies, and practices.* Cambridge, MA: Brookline Books; Horejsi, C. (1996).

[79] Child Welfare League of America. (1999). (p. 41).

[80] Kinney, J., Strand, K., Hagerup, M., & Bruner, C. (1994). *Beyond the buzzwords: Key principles in effective frontline practice.* Falls Church, VA: National Center for Service Integration and Chicago, IL: National Resource Center for Family Support Programs.

[81] Whittaker, J., Schinke, S., & Gilchrist, L. (1986). The ecological paradigm in child, youth, and family services: Implications for policy and practice. *Social Service Review, 60*, 483-503; Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press; Garbarino, J. (1982). *Children and families in the social environment.* Hawthorne, NY: Aldine de Gruyter.

[82] Hudson, J., Morris, A., Maxwell, G., & Galaway, B. (1996). *Family group conferences: Perspectives on policy and practice.* Monsey, NY: Willow Tree Press; Merkel-Holguin, L. (2000). How do I use family meetings to develop optimal service plans? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 373-378). Thousand Oaks, CA: Sage; Merkel-Holguin, L. (1998). Implementation of family group decision making in the U.S.: Policies and practices in transition. *Protecting Children, 14*(4), 4-10; Merkel-Holguin, L. (2001). Family group conferencing: An "extended family" process to safeguard children and strengthen family well-being. In E. Walton, P. Sandau-Beckler, & M. Mannes (Eds.), *Family-centered services and child well-being: Exploring issues in policy, practice, theory, and research* (pp. 197-218). New York, NY: Columbia University Press; U.S. Department of Health and Human Services, Administration on Children and Families, Children's Bureau. (2000). *Rethinking child welfare practice under the Adoption and Safe Families Act of 1997.* Washington, DC: Author.

[83] Compton, B., & Galaway, B. (1999). *Social work processes* (6th ed.). Pacific Grove, CA: Brooks/Cole Co.; Congress, E. P. (1994). The use of culturagrams to assess and empower culturally diverse families. *Families in Society, 75*, 531-539; Hartman, A. (1978). Diagrammatic assessment of family relationships. *Social Casework, 59,* 465-476; Hartman, A., & Laird, J. (1983). *Family-centered social work practice.* New York, NY: The Free Press; Dunst, C. J. et al. (1994); Children's Bureau of Southern California. (1997). *Family assessment form.* Washington, DC: CWLA Press; Magura, S., & Moses, B. S. (1986). *Outcome measures for child welfare services: Theory and applications.* Washington, DC: CWLA Press.

[84] Abney, V. (1996). Cultural competency in the field of child maltreatment. In J. Briere, L. Berliner, J. A. Bulkely, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment* (pp. 409-419). Thousand Oaks, CA: Sage.

[85] Ivey, A. E., Ivey, M. B., & Simek-Downing, L. (1987). Individual and cultural empathy. In *Counseling and psychotherapy: Integrating skills, theory, and practice* (pp. 91-118). Englewood Cliffs, NJ: Prentice-Hall.

[86] Shepard R. (1987). Cultural sensitivity. In D. DePanfilis (Ed.), *Enhancing child protection service competency: Selected readings*. Charlotte, NC: ACTION for Child Protection.

[87] Merkel-Holguin, L. (2000).

[88] DePanfilis, D. (1997).

[89] Courtney, M. (2000). What outcomes are relevant for intervention? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (p. 373). Thousand Oaks, CA: Sage; U.S. Department of Health and Human Services, Administration on Children and Families, Children's Bureau. (2000).

[90] Courtney, M. (2000).

[91] DePanfilis, D. (2000c). How do I match risks to client outcomes? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 367-372). Thousand Oaks, CA: Sage.

[92] Lutz, L. (2000). *Concurrent planning: Tool for permanency survey of selected sites*. New York, NY: City University of New York, Hunter College School of Social Work, National Resource Center for Foster Care and Permanency Planning.

[93] Gelles, R. J. (2000). Treatment-resistant families. In R. M. Reece (Ed.), *Treatment of child abuse* (pp. 304-312). Baltimore, MD: The Johns Hopkins University Press.

[94] National Association of Public Child Welfare Administrators. (1999). Reprinted with permission.

[95] LeVine, E. S., & Sallee, A. L. (1999). *Child welfare clinical theory and practice*. Dubuque, IA: Eddie Bowers.

[96] Rose, S. M. (Ed.). (1992). *Case management and social work practice*. White Plans, NY: Longman.

[97] Cohn, A., & Daro, D. (1987). Is treatment too late? What 10 years of evaluative research tell us. *Child Abuse and Neglect, 11*, 433-442; Daro, D., & Cohn, A. (1998). Child maltreatment evaluation efforts: What have we learned? In G. T. Hotaling, D. Finkelhor, J. T. Kirkpatrick, & M. A. Straus, (Eds.), *Coping with family violence: Research and policy perspectives* (pp. 275-287). Thousand Oaks, CA: Sage; Dubowitz, H. (1990). Costs and effectiveness of interventions in child maltreatment. *Child Abuse and Neglect, 14,* 177-186.

[98] Malchiodi, C. A. (1997). *Breaking the silence: Art therapy with children from violent homes*. Bristol, PA: Brunner/Mazel; Johnston, S. S. M. (1997). The use of art and play therapy with victims of sexual abuse: A review of the literature. *Family Therapy, 24*(2), 101-113; Riordan, R. J., & Verdel, A. C. (1991). Evidence of sexual abuse in children's art products. *The School Counselor, 39*, 116-121; Culbertson, R. M., & Revel, A. C. (1987). Graphic characteristics on the Draw-a-Person test for identification of physical abuse. *Art Therapy: Journal of the American Art Therapy Association, 4*(2), 78-83.

[99] Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748-756; Ellis, L. F., Black, L. D., & Resick, P. A. (1992). Cognitive-behavioral treatment approaches for victims of crime. In P. A. Keller & S. R. Heyman (Eds.), *Innovations in clinical practice: A source book* (pp. 23-38). Sarasota, FL: Professional Resource Exchange.

[100] Resick, P., & Clum, G. (2001). Cognitive processing therapy (CPT). In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 30-31). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage.

[101] Roditti, M. G. (2001a). What works in child care. In M. P. Kluger, B. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 285-292). Washington, DC: CWLA Press; Roditti, M. G. (2001b). What works in center-based child care. In M. P. Kluger, B. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 293-301). Washington, DC: CWLA Press; Roditti, M. G. (2001c). What works in child care for maltreated and at-risk children. In M. P. Kluger, B. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 311-319). Washington, DC: CWLA Press; Seitz, V., Rosenbaum, L. K., & Apfel, N. H. (1983). Effects of family support intervention: A 10-year follow-up. *Child Development, 56*, 376-391; Oats, R. K., Grey, J., Schweitzer, L., Kempe, R. S., & Harmon, R. J. (1995). A therapeutic preschool for abused children: The KEEPSAFE Project. *Child Abuse and Neglect, 19*, 1379-1386.

[102] Chemtob, C. M., Naksahima, J., Hamada, R., & Carlson, J. (in press). Brief treatment for elementary school children with disaster-related PTSD: A field study. *Journal of Clinical Psychology*; Puffer, M. K., Greenwald, R., & Elrod, D. E. (1998). A single session EMDR study with 20 traumatized children and adolescents. *Traumatology 3*, (2) [On-line serial]. Available: http://www.fsu.edu/~trauma/v3i2art6.html; Scheck, M. M., Schaeffer, J. A., & Gilette, C. S. (1998). Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. *Journal of Traumatic Stress, 11*, 25-44; Soberman, G. S., Greenwald, R., & Rule, D. L. (in press). A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment, and Trauma*.

[103] Chemtob, C. (2001). Eye movement desensitization and reprocessing (EMDR). In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 32-35). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Greenwald, R. (1993). *Using EMDR with children*. Pacific Grove, CA: EMDR Institute; Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York, NY: The Guilford Press.

[104] Berrick, J. D. (2001). What works in kinship care. In M. P. Kluger, B. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 127-133). Washington, DC: CWLA Press; Berrick, J. D., Barth, R. P., & Needell, B. (1994). A comparison of kinship foster homes and foster family homes: Implications for kinship foster care as family preservation. *Children and Youth Services Review, 16*, 13-63; LeProhn, N. S. (1994). The role of the kinship foster parent: A comparison of the role conceptions of relative and non-relative foster parents. *Children and Youth Services Review, 16*, 107-122; Berrick, J. D., Needell, B., Barth, R. P., & Johnson-Reid, M. (1998). *The tender years*. New York, NY: Columbia University Press; Courtney, M., & Needell, B. (1997). Outcomes of kinship care: Lessons from California. In J. D. Berrick, R. P. Barth, & N. Gilbert

(Eds.), *Child Welfare Research Review 2* (pp. 130-149). New York, NY: Columbia University Press; Berrick, J. D. (2001); Berrick, J. D. et al. (1994); Dubowitz, H. (1990). *The physical and mental health and educational status of children placed with relatives: Final report*. Baltimore, MD: University of Maryland School of Medicine, Department of Pediatrics; Meyer, B. S., & Link, M. K. (1990). *Kinship foster care: The double-edged dilemma*. Rochester, NY: Task Force on Permanency Planning for Foster Children, Inc.; Zwas, M. G. (1993). Kinship foster care: A relatively permanent solution. *Fordham Urban Law Journal, 20*(2), 343-373.

105 Berrick, J. D. (2001).

106 Fantuzzo, J., Sutton-Smith, B., Atkins, M., & Meyers, R. (1996). Community-based resilient peer treatment of withdrawn maltreated preschool children. *Journal of Clinical and Consulting Psychology, 64*, 1377-1368.

107 Fantuzzo, J. (2001). Resilient peer training intervention. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 38-39). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Fantuzzo, J., Weiss, A., & Coolahan, K. (1998). Community-based partnership-directed research: Actualizing community strengths to treat victims of physical abuse and neglect. In R. J. Lutzker (Ed.), *Child abuse: A handbook of theory, research, and treatment* (pp. 213-238). New York, NY: Pergamon Press.

108 Chaffin, M. (2001). Adolescent sex offender treatment. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 87-89). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology, 34*, 105-113; Alexander, M. A. (1999). Sexual offender treatment efficacy revisited. *Sexual Abuse: A Journal of Research and Treatment, 11*(2), 101-116.

109 Henggeler, S. W., Swenson, C. C., Kaufman, K., & Schoenwald, S. K. (1997). *MST supplementary treatment manual for juvenile sexual offenders and their families*. Charleston, SC: Medical University of South Carolina, Family Services Research Center; Kahn, T. J. (1996a). *Pathways: A guided workbook for youth beginning treatment*. Orwell, VT: Safer Society Press; Kahn, T. J. (1996b). *Pathways guide for parents of youth beginning treatment*. Orwell, VT: Safer Society Press; Marsh, L. F., Connell, P., & Olson, E. (1988). *Breaking the cycle: Adolescent sexual abuse treatment manual*. (Available from St. Mary's Home for Boys, 16535 SW Tualatin Valley Highway, Beaverton, OR 97006); O'Brien, M. J. (1994). *PHASE treatment manual*. (Available from Alpha PHASE, Inc., 1600 University Avenue West, Suite 305, St. Paul, MN 55104-3825); Steen, C. (1993). *The relapse prevention workbook for youth in treatment*. Orwell, VT: Safer Society Press; Way, I. F., & Balthazor, T. J. (1990). *A manual for structured group treatment with adolescent sexual offenders*. Notre Dame, IN: Jalice.

110 Tierney, J., & Grossman, J. B. (2001). What works in promoting positive youth development: Mentoring. In M. P. Kluger, B. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 323-328). Washington, DC: CWLA Press; Cave, G., & Quint, J. (1990). *Career beginning impact evaluation*. New York, NY: Manpower Demonstration and Research Corporation; Johnson, A. W. (1998). *An evaluation of the long-term impact of the Sponsor-a-Scholar (SAS) Program on student performance*. Princeton, NJ: Mathematica Policy Research; Tierney, J. P., Grossman, J., & Resch, N. L. (1995). *Making a difference: An impact study of Big Brothers/Big Sisters*. Philadelphia, PA: Public/Private Ventures.

111 Tierney, J., & Grossman, J. B. (2001).

112 Johnston, S. S. M. (1997). The use of art and play therapy with victims of sexual abuse: A review of the literature. *Family Therapy, 24*(2), 101-113.

113 Gil, E. (in press). *Moving mountains: Helping traumatized children through collaborative play*. Rockville, MD: Launch Press; Gil, E. (1991). *The healing power of play: Working with abused children*. New York, NY: The Guilford Press; Gil, E. (2001). Trauma-focused play therapy. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 47-48). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center.

114 Chamberlain, P. (2001). What works in treatment foster care? In M. P. Kluger, B. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 157-162). Washington, DC: CWLA Press; Clark, H., Boyd, L., Redditt, C., Foster-Johnson, L., Hard, D., Kuhns, J., Lee, G., & Steward, E. (1993). An individualized system of care for foster children with behavioral and emotional disturbances: Preliminary findings. In K. Kutash, C. Liberton, A. Algarin, & R. Friedman (Eds.), *Fifth Annual Research Conference Proceedings for a System of Care for Children's Mental Health* (pp. 365-370). Tampa, FL: University of South Florida, Research and Training Center for Children's Mental Health; Chamberlain, P., & Reid, J. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology, 6*, 624-633; Hawkins, R., Almeida, C., & Samet, M. (1989). Comparative evaluation of foster family-based treatment and five other placement choices: A preliminary report. In A. Algarin, R. Friedman, A. Duchnowski, K. Kutash, S. Silver, & M. Johnson (Eds.), *Children's mental health services and policy: Building a research base* (pp. 98-119). Tampa, FL: University of South Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

115 Meadowcroft, P., Thomlinson, B., & Chamberlain, P. (1994). Treatment foster care services: A research agenda for child welfare. *Child Welfare, 33*, 565-581.

116 Adkerson, D. L. (2001). Adult child molester treatment. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 90-92). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Association for the Treatment of Sexual Abusers (ATSA). (in press). The ATSA report on the effectiveness of treatment for sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*; Alexander, M. A. (1999). Sexual offender treatment efficacy revisited. *Sexual Abuse: A Journal of Research and Treatment, 11*(2), 101-116; Dwyer, S. M. (1997). Treatment outcome study: Seventeen years after sexual offender treatment. *Sexual Abuse: A Journal of Research and Treatment, 9*(2), 149-160; Hansen, R. K.,

Steffy, R. A., & Gauthier, R. (1992). *Long-term follow-up of child molesters: Risk prediction and treatment outcome*. Ottawa, Canada: Corrections Branch, Ministry of the Solicitor General of Canada.

[117] Association for the Treatment of Sexual Abusers (ATSA). (1997). *Ethical standards and principles for the management of sexual abusers.* Beaverton, OR: Author; Abel, G. G., Becker, J. V., Cunningham-Rathner, J., Rouleau, J. L., Kaplan, M., & Reich, J. (n.d.). *The treatment of child molesters*. Atlanta, GA: Authors; Bays, L., & Freeman-Longo, R. (1989). *Why did I do it again? Understanding my cycle of problem behaviors*. Holyoke, MA: NEARI Press; Bays, L., Freeman-Longo, R., & Hildebran, D. D. (1990). *How can I stop? Breaking my deviant cycle*. Holyoke, MA: NEARI Press; Barbaree, H. E., & Seto, M. C. (1997). Pedophilia: Assessment and treatment. In D. R. Laws & W. O'Donohue (Eds.), *Sexual deviance: Theory, assessment, and treatment* (pp. 175-193). New York, NY: The Guilford Press; Freeman-Longo, R., & Bays, L. (1988). *Who am I and why am I in treatment?* Holyoke, MA: NEARI Press; Salter, A. C. (1988). *Treating child sex offenders and victims*. Newbury Park, CA: Sage.

[118] Swenson, C. C., & Ralston, M. E. (1997).

[119] Lipovsky, J., Swenson, C. C., Ralston, M. E., & Saunders, V. E. (1998). The abuse clarification process in the treatment of intrafamilial child abuse. *Child Abuse and Neglect, 22*, 729-741; Ralston, M. E. (1982). *Intrafamilial sexual abuse: A community system response to a family system problem*. Charleston, SC: Author; Ralston, M. E. (1998). A community system of care for abused children and their families. *Family Futures, 2*(4), 11-15; Ralston, M. E., & Swenson, C. C. (1996). *The Charleston collaborative project intervention manual*. Charleston, SC: Authors; Swenson, C. C., & Ralston, M. E. (1997). *The Charleston collaborative project implementation manual*.

[120] Kumpfer, K. L. (1999). *Strengthening America's families: Exemplary parenting and family strategies for delinquency prevention*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention; Catalano, R., Haggerty, K., Flemming, C., & Brewer, D. (1996). *Focus on families: Scientific findings from family prevention intervention research*. Paper presented at National Institute of Drug Abuse conference: Drug Abuse Prevention Through Family Intervention, Gaithersburg, MD.

[121] Haggerty, K. P., Mills, E., & Catalano, R. F. (1991). *Focus on Families: Parent training curriculum*. Seattle, WA: Social Development Research Group.

[122] Wolfe, D. A., Sandler, J., & Kaufman, K. (1981). A competency-based parent training program for child abusers. *Journal of Consulting and Clinical Psychology, 49*, 633-640; Wolfe, D. A., St. Lawrence, J., Brehony, K., Bradlyn, A., & Kelly, J. A. (1982). Intensive behavioral parent training for a child abusive mother. *Behavior Therapy, 13*, 438-451; Wolfe, D. A., Edwards, B., Manion, I., & Koverola, C. (1988). Early intervention for parents at risk for child abuse and neglect: A preliminary investigation. *Journal of Consulting and Clinical Psychology, 56*, 40-47.

[123] Wolfe, D. (2001). Parent-child education program for physically abusive parents. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 71-73). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Wolfe, D. A. (1991). *Preventing physical and emotional abuse of children: Treatment manuals for practitioners series.* New York, NY: The Guilford Press.

[124] Kumpfer, K. L. (1999); Behavior Associates. (1976). *Parents Anonymous self-help for child abusing parenting project: Evaluation report*. Tuscon, AZ: Behavior Associates; Cohn, A. H. (1979). Essential elements of successful child abuse and neglect treatment. In *Child Abuse and Neglect, 3*, 491-496.

[125] Hanson, R., & Rosen, S. (2001). Parents Anonymous. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 84-85). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Lieber, L., & Baker, J. M. (1977). Parents Anonymous—Self-help treatment for child abusing parents: A review and evaluation. *Child Abuse and Neglect, 1*, 133-148; Rafael, T., & Pion-Berlin, L. (1996). *Parents Anonymous program bulletin*. Claremont, CA: Authors; Rafael, T., & Pion-Berlin, L. (1999). *Parents Anonymous: Strengthening families*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention; Hermann, E. (1993). *Manual for group facilitators.* Los Angeles, CA: Parents Anonymous.

[126] James, B. (2001). Attachment-trauma therapy. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 36-37). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; James, B. (1994). *Handbook for treating attachment-trauma problems in children*. New York, NY: Free Press/Simon & Schuster.

[127] Breston, E., & Payne, H. (2001). Behavioral parent training intervention for conduct-disordered children. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 52-56). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Alexander, J. R., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*, 219-225; Barkely, R. A., Guevremont, A. D., Anastopoulos, A. D., & Fletcher, K. E. (1992). A comparison of three family programs for treating family conflicts in adolescents with attention-deficit hyperactivity disorder. *Journal of Consulting and Clinical Psychology*, *60*, 450-462; Bernel, M. E., Klinnert, M. D., & Schultz, L. A. (1980). Outcome evaluation of behavioral parent training and client centered parent counseling for children with conduct problems. *Journal of Applied Behavior Analysis, 13*, 677-691; Hughes, R. C., & Wilson, P. H. (1989). Behavioral parent training: Contingency management versus communication skills training with or without the participation of the child. *Child and Family Behavior Therapy, 10*, 11-23; Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S. (1987). Effects of parent management training and problem-solving skills training combined in the treatment of antisocial child behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 26*, 416-424; Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology, 60*, 733-747.

[128] Breston, E., & Payne, H. (2001). Forehand, R. L., & McMahon, R. J. (1981). Helping the noncompliant child: A clinician's guide to parent training. New York, NY: The Guilford Press; Patterson, G. R. (1976). *Living with children: New methods for parents and teachers*. Champaign, IL: Research Press; Patterson, G. R., & Gillion, M. E. (1968). *Living with children: New methods for parents and teachers*. Champaign, IL: Research Press.

[129] Bonner, B. (2001). Cognitive-behavioral and dynamic play therapy for children with sexual behavior problems and their caregivers. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 27-29). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Bonner, B., Walker, C. E., & Berliner, L. (1999a). *Treatment manual for cognitive-behavioral group therapy for children with sexual behavior problems*. Norman, OK: Oklahoma University Health Sciences Center, Center on Child Abuse and Neglect; Bonner, B., Walker, C. E., & Berliner, L. (1999b). *Treatment manual for cognitive-behavioral group treatment for parents/caregivers of children with sexual behavior problems*. Norman, OK: Oklahoma University Health Sciences Center, Center on Child Abuse and Neglect; Bonner, B., Walker, C. E., & Berliner, L. (1999c). Treatment manual for dynamic group play therapy for children with sexual behavior problems and their parents/caregivers. Norman, OK: Oklahoma University Health Sciences Center, Center on Child Abuse and Neglect.

[130] Nelson, K. (2000). When do family preservation services make sense, and when should other permanency plans be explored? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 257-266). Thousand Oaks, CA: Sage; Walton, E., & Denby, R. (1997). Targeting families to receive intensive family preservation services: Assessing the use of imminent risks of placement as a service criterion. *Family Preservation Journal, 2*, 53-70; Barth, R. (1988). Theories guiding home-based intensive family preservation services. In J. Whittaker, J. Kinney, E. Tracey, & C. Booth (Eds.), *Improving practice technology for work with high risk families: Lessons from the Homebuilders Social Work Education Project* (pp. 91-113). Seattle, WA: Center for Social Welfare Research; Barth, R. (1990). Theories guiding home-based intensive family preservation services. In J. K. Whittaker, J. Kinney, E. M. Tracey, & C. Booth (Eds.), *Reaching high-risk families: Intensive family preservation in human services* (pp. 89-112). Hawthorne, NY: Aldine de Gruyter; Bronfenbrenner, U. (1979); Berry, M. (1991). The assessment of imminence of risk of placement: Lessons from a family preservation program. *Children and Youth Services Review, 13*, 239-256; Berry, M. (1992). An evaluation of family preservation services: Fitting agency services to family needs. *Social Work, 37*, 314-321; Grigsby, R. K. (1993). Theories that guide intensive family preservation services: A second look. In E. S. Morton & R. K. Grigsby (Eds.), *Advancing family preservation practice* (pp. 16-27). Newbury Park, CA: Sage; Schuerman, J. R., Rzepnicki, T., & Littell, J. (1994*). Putting families first: An experiment in family preservation*. New York, NY: Aldine de Gruyter.

[131] Lipovsky, J. et al. (1998); Saunders, B. E., & Meinig, M. (2000). Immediate issues affecting long-term family resolution in cases of parent-child sexual abuse. In R. M. Reece (Ed.), *Treatment of child abuse: Common ground for mental health, medical, and legal practitioners* (pp. 36-53). Baltimore, MD: The Johns Hopkins University Press; Saunders, B. E., & Meinig, M. (2001). Family resolution therapy (FRT). In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 62-63). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center.

[132] Schuerman, J. R., Rzepnicki, T., & Littell, J. (1994); Jordan, K., Alvarado, J., Braley, R., & Williams, L. (2001). Family preservation through home-based family therapy: An overview. *Journal of Family Psychotherapy, 12*(3), 31-44.

[133] Booth, C. (2001). Intensive family preservation services. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 66-67). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Kinney, J. M., Haapala, D., & Booth, C. L. (1991). *Keeping families together: The Homebuilders model*. New York, NY: Aldine de Gruyter; Nelson, K. (2000).

[134] Kolko, D. (2001). Individual child and parent physical abuse-focused cognitive-behavioral treatment. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 36-37). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Swenson, C. C., & Kolko, D. J. (2000). Long-term management of the developmental consequences of child physical abuse. In R. M. Reese (Ed.), *Treatment of child abuse: Common ground for mental health, medical, and legal practitioners* (pp. 135-154). Baltimore, MD: The Johns Hopkins University Press.

[135] Kolko, D. (1996). Individual cognitive behavioral therapy and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1*, 322-342.

[136] International Society for the Study of Dissociation. (2000). Guidelines for the evaluation and treatment of dissociative symptoms in children and adolescents. *Journal of Trauma and Dissociation, 1*, 105-154; Owaga, J. R., Sroufe, L. A., Weinfield, N. S., Carlson, E. A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology, 9*, 855-879; Putnam, F. W. (1997). *Dissociation in children and adolescents*. New York, NY: The Guilford Press; Silberg, J. (2000). Fifteen years of dissociation in maltreatment children: Where do we go from here? *Child Maltreatment, 5*, 199-136; Silberg, J. (2001). Integrative developmental model for treatment of dissociative symptomatology. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 64-65). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Silberg, J. (in press). Treating maladaptive dissociation in a young teenage girl. In H. Orvaschel, J. Faust, & M. Hersen (Eds.), *Handbook of conceptualization and treatment of child psychopathology*. Oxford, UK: Elsevier Science LTD; Wieland, S. (1998). *Techniques and issues in abuse-focused therapy.* Thousand Oaks, CA: Sage.

[137] Swenson, C. C., & Henggeler, S. (2001). Multisystem therapy (MST) for maltreated children and their families. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 68-70). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Brunk, M.,

Henggeler, S. W., & Whelan, J. P. (1987). A comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology, 55*, 311-318; Kumpfer, K. L. (1999).

[138] Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York, NY: The Guilford Press.

[139] Bavolek, S. J., Comstock, C. M., & McLaughlin, J. A. (1983). *The Nurturing Program: A validated approach to reducing functional family interactions.* Rockville, MD: National Institute of Mental Health; Kumpfer, K. L. (1999).

[140] Bavoleck, S. (1983). *The Nurturing Parenting Program: Parent trainer's manual*. Eau Claire, WI: Family Development Associates, Inc.

[141] Urquiza, A. (2001). Parent-child interaction therapy (PCIT). In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 74-76). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Borrego, J., & Urquiza, A. J. (1998). Importance of therapist use of social reinforcement with parents as a model for parent-child relationships: An example with parent-child interaction therapy. *Child and Family Behavior Therapy, 20* (4), 27-54; Borrego, J., Urquiza, A. J., Rasmussen, R. A., & Zebell, N. (1999). Parent-child interaction therapy with a family at high-risk for physical abuse. *Child Maltreatment, 4*, 331-342; Eyberg, S. M. (1998). Parent-child interaction therapy: Integration of traditional and behavioral concerns. *Child and Family Behavior Therapy, 10*, 33-46; Eyberg, S., & Robinson, E. A. (1982). Parent-child interaction training: Effects on family functioning. *Journal of Clinical Child Psychology, 11*, 130-137.

[142] Hembree-Kigin, T., & McNeil, C. B. (1995). *Parent-child interaction therapy.* New York, NY: Plenum; Urquiza, A. J., Zebell, N., McGrath, J., & Vargas, E. (1999). *Parent-child interaction therapy: Application to high-risk and maltreating families*. Sacramento, CA: University of California Davis Medical Center, Department of Pediatrics, Child Protection Center; Urquiza, A. J., Zebell, N., McGrath, J., & Vargas, E. (1999). *Parent-child interaction therapy: Application to high-risk and maltreating families*. Videotape series. Sacramento, CA: University of California-Davis Medical Center, Department of Pediatrics, Child Protection Center; Urquiza, A. J., & McNeil, C. B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment, 1*, 132-141.

[143] Johnson, D. A. (2001). Parents United (child sexual abuse treatment program). In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 79-84). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Child Sexual Abuse Treatment Services. (1994). *Treatment manual for child sexual abuse treatment services.* Modesto, CA: Author.

[144] Kolko, D. (1996).

[145] Kolko, D. (2001); Swenson, C. C., & Kolko, D. (2000).

[146] Lutzker, J. R., & Rice, J. M. (1984). Project 12-Ways: Measuring outcome of a large-scale in-home service for the treatment and prevention of child abuse and neglect. *Child Abuse and Neglect, 8*, 519-524; Lutzker, J. R., & Rice, J. M. (1987). Using recidivism data to evaluate Project 12-Ways: An ecobehavioral approach to the treatment and prevention of child abuse and neglect. *Journal of Family Violence, 2*, 283-290; Dachman, R. S., Halasz, M. M., Bickett, A. D., & Lutzker, J. R. (1984). A home-based ecobehavioral parent-training and generalization package with a neglectful mother. *Education and Treatment of Children, 7*, 183-202; Campbell, R. V., O'Brien, S., Bickett, A., & Lutzker, J. R. (1983). In-home parent-training, treatment of migraine headaches, and marital counseling as an ecobehavioral approach to prevent child abuse. *Journal of Behavior Therapy and Experimental Psychiatry, 14*, 147-154; Tertinger, D. A., Greene, B. F., & Lutzker, J. R. (1984). Home safety: Development and validation of one component of an ecobehavioral treatment program for abused and neglected children. *Journal of Applied Behavior Analysis, 17*, 159-174; Lutzker, S. Z., Lutzker, J. R., Braunling-McMorrow, D., & Eddleman, J. (1987). Prompting to increase mother-baby stimulation with single mothers. *Journal of Child and Adolescent Psychotherapy, 4*, 3-12; Lutzker, J. R., Bigelow, K. M., Doctor, R. M., Gershater, R. M., & Greene, B. F. (1998). An ecobehavioral model for the prevention and treatment of child abuse and neglect. In J. R. Lutzker (Ed.), *Handbook of child abuse research and treatment* (pp. 239-266). New York, NY: Plenum.

[147] Lutzker, J. R., & Rice, J. M. (1984); Lutzker, J. R. et al. (1998).

[148] Kumpfer, K. L. (1998). Selective prevention interventions: The Strengthening Families program. In R. S. Ashery, E. B. Robertson, & K. L. Kumpfer (Eds.), *Drug abuse prevention through family interventions* (pp. 160-207). Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse; Kumpfer, K. L. (1999).

[149] Kumpfer, K. L. (1998); Kumpfer, K. L. (1999).

[150] Steele, M. L. (2001). *Beech Acres Family Center evaluation analyses*. Los Angeles, CA: Author; Kumpfer, K. L. (1999).

[151] Steele, M., & Marigna, M. (1999). *Workshop manual program components: Strengthening multiethnic families and communities: A violence prevention parent training program*. Los Angeles, CA: Authors.

[152] Moore, E., Armsden, G., & Gogerty, P. L. (1998). A 12-year follow-up study of maltreated and at-risk children who received early therapeutic care. *Child Maltreatment, 3*, 3-16.

[153] Sheehan, L. (2001). Therapeutic child development program. In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 40-41). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Childhaven. (n.d.). *Childhaven therapeutic child development manual*. Seattle, WA: Author.

[154] Berliner, L., & Saunders, B. E. (1996). Treating fear and anxiety in sexually abused children: Results of a controlled 2-year follow-up study. *Child Maltreatment, 1*(4), 294-309; Celano, M., Hazzard, A., Webb, C., & McCall, C. (1996). Treatment of traumagenic beliefs among sexually abused girls and their mothers: An evaluation study. *Journal of Abnormal Child Psychology, 24*, 1-16; Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study

for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 42-50; Cohen, J. A., & Mannarino, A. P. (1997). A treatment study of sexually abused preschool children: Outcome during a 1-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 1228-1235; Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment findings. *Child Maltreatment, 3*, 17-26; Deblinger, E., McLeer, S. V., & Henry, D. (1990). Cognitive behavioral treatment for sexually abused children suffering post-traumatic stress: Preliminary findings. *Journal of the American Academy of Children and Adolescent Psychiatry, 19*, 747-752; Deblinger, E., Lippman, J., & Steer, R. (1996). Sexually abused children suffering traumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*, 310-321; Deblinger, E., Steer, R. A., & Lippmann, J. (1999). Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. *Child Abuse and Neglect, 23*, 1371-1378; Stauffer, L., & Deblinger, E. (1996). Cognitive behavioral groups for nonoffending mothers and their young sexually abused children: A preliminary treatment outcome study. *Child Maltreatment, 1*, 65-67.

155 Cohen, J., & Deblinger, E. (2001). In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 42-44). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Cohen, J., & Mannarino, A. P. (1993). A treatment model for sexually abused preschoolers. *Journal of Interpersonal Violence, 8*, 115-131; Deblinger, E., & Heflin, A. H. (1996). *Treatment for sexually abused children and their nonoffending parents: A cognitive-behavioral approach*. Thousand Oaks, CA: Sage.

156 Friedrich, W. N. (2001). Trauma-focused integrative-eclectic therapy (IET). In B. E. Saunders, L. Berliner, & R. F. Hanson (Eds.), *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse* (pp. 38-39). Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center; Friedrich, W. N. (1998). Treating sexual behavior problems in children: A treatment manual. (Available from the author at the Mayo Clinic, Department of Psychiatry and Psychology, Rochester, MN 55905); Friedrich, W. N. (1995). *Psychotherapy with sexually abused boys*. Thousand Oaks, CA: Sage; Friedrich, W. N., Luecke, W. J., Beilke, R. L., & Place, V. (1991). Group treatment of sexually abused boys: An agency study. *Journal of Interpersonal Violence, 7*, 396-409.

157 Morton, T. (2000). When can a child be safely reunited with his or her family? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 522-525). Thousand Oaks, CA: Sage.

158 Glazer-Semmel, E. (2000). How do I prepare families for case closure? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 531-534). Thousand Oaks, CA: Sage.

159 Rooney, R. (1992). *Strategies for working with involuntary clients*. New York, NY: Columbia University Press.

160 Cournoyer, B. (2000). *The social work skills workbook* (3rd ed.). Belmont, CA: Brooks/Cole.

161 Rooney, R. (1992).

162 Glazer-Semmel, E. (2000).

163 DePanfilis, D. (2000d). How do I use the case record to guide intervention and provide accountability? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 598-603). Thousand Oaks, CA: Sage; Child Welfare League of America. (1999); Hepworth, D. H., Rooney, R. H., & Larsen, J. (2002). *Direct social work practice* (6th ed.). Pacific Grove, CA: Brooks/Cole.

164 DePanfilis, D. et al. (2000d).

165 DePanfilis, D. et al. (2000d).

166 DePanfilis, D. et al. (2000d).

167 Morton, T., & Salus, M. (1994). Supervising child protective services caseworkers. Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.

168 Morton, T., & Salus, M. (1994).

169 Colorado Department of Human Services, & National Child Welfare Resource Center for Management and Administration. (1994). *Standards for supervision in child welfare*. Portland, ME: University of Southern Maine, National Child Welfare Resource Center for Management and Administration.

170 Holder, W., & Morton, T. (1999).

171 Salus, M. (1996). *Case consultation and supervision*. Denver, CO: University of Denver, School of Social Work.

172 Salus, M. (1999). *The educational role of the supervisor*. Baton Rouge, LA: Louisiana Department of Social Services, Office of Community Services; Berg, I. K., & Kelly, S. (2000).

173 Griffin, W., & Bandas, J. (1985). *Risk assessment–early warning program*. Helena, MT: Montana Department of Social and Rehabilitative Services, Community Services Division.

APPENDIX A
Glossary of Terms

Adjudicatory Hearings — held by the juvenile and family court to determine whether a child has been maltreated or whether another legal basis exists for the State to intervene to protect the child.

Adoption and Safe Families Act (ASFA) — signed into law November 1997 and designed to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. The law requires CPS agencies to provide more timely and focused assessment and intervention services to the children and families that are served within the CPS system.

CASA — court-appointed special advocates (usually volunteers) who serve to ensure that the needs and interests of a child in child protection judicial proceedings are fully protected.

Case Closure — the process of ending the relationship between the CPS worker and the family that often involves a mutual assessment of progress. Optimally, cases are closed when families have achieved their goals and the risk of maltreatment has been reduced or eliminated.

Case Plan — the casework document that outlines the outcomes, goals, and tasks necessary to be achieved in order to reduce the risk of maltreatment.

Case Planning — the stage of the CPS case process where the CPS caseworker develops a case plan with the family members.

Caseworker Competency — demonstrated professional behaviors based on the knowledge, skills, personal qualities, and values a person holds.

Central Registry — a centralized database containing information on all substantiated/founded reports of child maltreatment in a selected area (typically a State).

Child Abuse Prevention and Treatment Act (CAPTA) — the law (P.L. 93-247) that provides a foundation for a national definition of child abuse and neglect. Reauthorized in October 1996 (P.L. 104-235), it was up for reauthorization at the time of publication. CAPTA defines child abuse and neglect as "at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

Child Protective Services (CPS) — the designated social services agency (in most States) to receive reports, investigate, and provide intervention and treatment services to children and families in which child maltreatment has occurred. Frequently, this agency is located within larger public social service agencies, such as Departments of Social Services.

Concurrent Planning — identifies alternative forms of permanency by addressing both reunification or legal permanency with a new parent or caregiver if reunification efforts fail.

Cultural Competence — a set of attitudes, behaviors, and policies that integrates knowledge about groups of people into practices and standards to enhance the quality of services to all cultural groups being served.

Differential Response — an area of CPS reform that offers greater flexibility in responding to allegations of abuse and neglect. Also referred to as "dual track" or "multi-track" response, it permits CPS agencies to respond differentially to children's needs for safety, the degree of risk present, and the family's needs for services and support. See "dual track."

Dispositional Hearings — held by the juvenile and family court to determine the legal resolution of cases after adjudication, such as whether placement of the child in out-of-home care is necessary, and what services the children and family will need to reduce the risk of maltreatment and to address the effects of maltreatment.

Dual Track — term reflecting new CPS response systems that typically combine a nonadversarial service-based assessment track for cases where children are not at immediate risk with a traditional CPS investigative track for cases where children are unsafe or at greater risk for maltreatment. See "differential response."

Evaluation of Family Progress — the stage of the CPS case process where the CPS caseworker measures changes in family behaviors and conditions (risk factors), monitors risk elimination or reduction, assesses strengths, and determines case closure.

Family Assessment — the stage of the child protection process when the CPS caseworker, community treatment provider, and the family reach a mutual understanding regarding the behaviors and conditions that must change to reduce or eliminate the risk of maltreatment, the most critical treatment needs that must be addressed, and the strengths on which to build.

Family Group Conferencing — a family meeting model used by CPS agencies to optimize family strengths in the planning process. This model brings the family, extended family, and others important in the family's life (e.g., friends, clergy, neighbors) together to make decisions regarding how best to ensure safety of the family members.

Family Unity Model — a family meeting model used by CPS agencies to optimize family strengths in the planning process. This model is similar to the Family Group Conferencing model.

Full Disclosure — CPS information to the family regarding the steps in the intervention process, the requirements of CPS, the expectations of the family, the consequences if the family does not fulfill the expectations, and the rights of the parents to ensure that the family completely understands the process.

Guardian ad Litem — a lawyer or lay person who represents a child in juvenile or family court. Usually this person considers the "best interest" of the child and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian for the child. A lay person who serves in this role is sometimes known as a court-appointed special advocate or CASA.

Home Visitation Programs — prevention programs that offer a variety of family-focused services to pregnant mothers and families with new babies. Activities frequently encompass structured visits to the family's home and may address positive parenting practices, nonviolent discipline techniques, child development, maternal and child health, available services, and advocacy.

Immunity — established in all child abuse laws to protect reporters from civil law suits and criminal prosecution resulting from filing a report of child abuse and neglect.

Initial Assessment or Investigation — the stage of the CPS case process where the CPS caseworker determines the validity of the child maltreatment report, assesses the risk of maltreatment, determines if the child is safe, develops a safety plan if needed to assure the child's protection, and determines services needed.

Intake — the stage of the CPS case process where the CPS caseworker screens and accepts reports of child maltreatment.

Interview Protocol — a structured format to ensure that all family members are seen in a planned strategy, that community providers collaborate, and that information gathering is thorough.

Juvenile and Family Courts — established in most States to resolve conflict and to otherwise intervene in the lives of families in a manner that promotes the best interest of children. These courts specialize in areas such as child maltreatment, domestic violence, juvenile delinquency, divorce, child custody, and child support.

Kinship Care — formal child placement by the juvenile court and child welfare agency in the home of a child's relative.

Liaison — the designation of a person within an organization who has responsibility for facilitating communication, collaboration, and coordination between agencies involved in the child protection system.

Mandated Reporter — people required by State statutes to report suspected child abuse and neglect to the proper authorities (usually CPS or law enforcement agencies). Mandated reporters typically include professionals such as educators and other school personnel, health care and mental health professionals, social workers, childcare providers, and law enforcement officers, but some States require all citizens to be mandated reporters.

Multidisciplinary Team — established between agencies and professionals within the child protection system to discuss cases of child abuse and neglect and to aid in decisions at various stages of the CPS case process. These terms may also be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams.

Neglect — the failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. *Physical neglect* can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or coats). *Educational neglect* includes failure to provide appropriate schooling, special educational needs, or allowing excessive truancies. *Psychological neglect* includes the lack of any emotional support and love, chronic inattention to the child, exposure to spouse abuse, or drug and alcohol abuse.

Out-of-Home Care — child care, foster care, or residential care provided by persons, organizations, and institutions to children who are placed outside their families, usually under the jurisdiction of juvenile or family court.

Parent or caretaker — person responsible for the care of the child.

***Parens Patriae* Doctrine** — originating in feudal England, a doctrine that vests in the State a right of guardianship of minors. This concept has gradually evolved into the principle that the community, in addition to the parent, has a strong interest in the care and nurturing of children. Schools, juvenile courts, and social service agencies all derive their authority from the State's power to ensure the protection and rights of children as a unique class.

Physical Abuse — the inflicting of a nonaccidental physical injury upon a child. This may include, burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. It may, however, have been the result of over-discipline or physical punishment that is inappropriate to the child's age.

Primary Prevention — activities geared to a sample of the general population to prevent child abuse and neglect from occurring. Also referred to as "universal prevention."

Protocol — an interagency agreement that delineates joint roles and responsibilities by establishing criteria and procedures for working together on cases of child abuse and neglect.

Protective Factors — strengths and resources that appear to mediate or serve as a "buffer" against risk factors that contribute to vulnerability to maltreatment or against the negative effects of maltreatment experiences.

Psychological Maltreatment — a pattern of caregiver behavior or extreme incidents that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value to meeting another's needs. This can include parents or caretakers using extreme or bizarre forms of punishment or threatening or terrorizing a child. The term "psychological maltreatment" is also known as emotional abuse or neglect, verbal abuse, or mental abuse.

Response Time — a determination made by CPS and law enforcement regarding the immediacy of the response needed to a report of child abuse or neglect.

Review Hearings — held by the juvenile and family court to review dispositions (usually every 6 months) and to determine the need to maintain placement in out-of-home care or court jurisdiction of a child.

Risk — the likelihood that a child will be maltreated in the future.

Risk Assessment — to assess and measure the likelihood that a child will be maltreated in the future, frequently through the use of checklists, matrices, scales, and other methods of measurement.

Risk Factors — behaviors and conditions present in the child, parent, or family that will likely contribute to child maltreatment occurring in the future.

Safety — absence of an imminent or immediate threat of moderate-to-serious harm to the child.

Safety Assessment — a part of the CPS case process in which available information is analyzed to identify whether a child is in immediate danger of moderate or serious harm.

Safety Plan — a casework document developed when it is determined that the child is in imminent risk of serious harm. In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of imminent serious harm to the child, and identifies, along with the family, the interventions that will control the safety factors and assure the child's protection.

Secondary Prevention — activities targeted to prevent breakdowns and dysfunctions among families who have been identified as at risk for abuse and neglect.

Service Agreement — the casework document developed between the CPS caseworker and the family that outlines the tasks necessary to achieve goals and outcomes necessary for risk reduction.

Service Provision — the stage of the CPS casework process when CPS and other service providers provide specific services geared toward the reduction of risk of maltreatment.

Sexual Abuse — inappropriate adolescent or adult sexual behavior with a child. It includes fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography. To be considered child abuse, these acts have to be committed by a person responsible for the care of a child (for example a baby-sitter, a parent, or a daycare provider) or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely be the police and criminal courts.

Substantiated — an investigation disposition concluding that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or State policy. A CPS determination means that

credible evidence exists that child abuse or neglect has occurred.

Tertiary Prevention — treatment efforts geared to address situations where child maltreatment has already occurred with the goals of preventing child maltreatment from occurring in the future and of avoiding the harmful effects of child maltreatment.

Treatment — the stage of the child protection case process when specific services are provided by CPS and other providers to reduce the risk of maltreatment, support families in meeting case goals, and address the effects of maltreatment.

Universal Prevention — activities and services directed at the general public with the goal of stopping the occurrence of maltreatment before it starts. Also referred to as "primary prevention."

Unsubstantiated (not substantiated) — an investigation disposition that determines that there is not sufficient evidence under State law or policy to conclude that the child has been maltreated or at risk of maltreatment. A CPS determination means that credible evidence does not exist that child abuse or neglect has occurred.

APPENDIX B

Resource Listings of Selected National Organizations Concerned with Child Maltreatment

Listed below are several representatives of the many national organizations and groups that deal with various aspects of child maltreatment. Please visit **www.calib.com/nccanch** to view a more comprehensive list of resources and visit **www.calib.com/nccanch/database/index.cfm** to view an organization database. Inclusion on this list is for information purposes and does not constitute an endorsement by the Office on Child Abuse and Neglect or the Children's Bureau.

Child Welfare Organizations

American Humane Association Children's Division

address: 63 Inverness Dr., East
Englewood, CO 80112-5117

phone: (800) 227-4645
(303) 792-9900

fax: (303) 792-5333

e-mail: children@americanhumane.org

Web site: www.americanhumane.org

Conducts research, analysis, and training to help public and private agencies respond to child maltreatment.

American Public Human Services Association

address: 810 First St., NE, Suite 500
Washington, DC 20002-4267

phone: (202) 682-0100

fax: (202) 289-6555

Web site: www.aphsa.org

Addresses program and policy issues related to the administration and delivery of publicly funded human services. Professional membership organization.

American Professional Society on the Abuse of Children

address: 940 N.E. 13th St.
CHO 3B-3406
Oklahoma City, OK 73104

phone: (405) 271-8202

fax: (405) 271-2931

e-mail: tricia-williams@ouhsc.edu

Web site: www.apsac.org

Provides professional education, promotes research to inform effective practice, and addresses public policy issues. Professional membership organization.

AVANCE Family Support and Education Program

address: 301 South Frio, Suite 380
San Antonio, TX 78207

phone: (210) 270-4630

fax: (210) 270-4612

Web site: www.avance.org

Operates a national training center to share and disseminate information, material, and curricula to service providers and policy-makers interested in supporting high-risk Hispanic families.

Child Welfare League of America

address: 440 First St., NW, Third Floor
Washington, DC 20001-2085

phone: (202) 638-2952

fax: (202) 638-4004

Web site: www.cwla.org

Provides training, consultation, and technical assistance to child welfare professionals and agencies while also educating the public about emerging issues affecting children.

National Black Child Development Institute

address: 1023 15th St., NW, Suite 600
Washington, DC 20005

phone: (202) 387-1281

fax: (202) 234-1738

e-mail: moreinfo@nbcdi.org

Web site: www.nbcdi.org

Operates programs and sponsors a national training conference through Howard University to improve and protect the well-being of African-American children.

National Children's Advocacy Center

address: 200 Westside Sq., Suite 700
Huntsville AL 35801

phone: (256) 533-0531

fax: (256) 534-6883

e-mail: webmaster@ncac-hsv.org

Web site: www.ncac-hsv.org

Provides prevention, intervention, and treatment services to physically and sexually abused children and their families within a child-focused team approach.

National Indian Child Welfare Association

address: 5100 SW Macadam Ave., Suite 300
Portland, OR 97201

phone: (503) 222-4044

fax: (503) 222-4007

e-mail: info@nicwa.org

Web site: www.nicwa.org

Disseminates information and provides technical assistance on Indian child welfare issues. Supports community development and advocacy efforts to facilitate tribal responses to the needs of families and children.

National Resource Centers

National Resource Center on Child Maltreatment

address: Child Welfare Institute
3950 Shackleford Rd., Suite 175
Duluth, GA 30096

phone: (770) 935-8484

fax: (770) 935-0344

e-mail: tsmith@gocwi.org

Web site: www.gocwi.org/nrccm

Helps States, local agencies, and Tribes develop effective and efficient child protective services systems. Jointly operated by the Child Welfare Institute and ACTION for Child Protection, it responds to needs related to prevention, identification, intervention, and treatment of child abuse and neglect.

National Resource Center on Domestic Violence: Child Protection and Custody

address: Family Violence Department
National Council of Juvenile and Family Court Judges
P.O. Box 8970
Reno, NV 89507

phone: (800) 527-3223

fax: (775) 784-6160

e-mail: info@dvlawsearch.com

Web site: www.nationalcouncilfvd.org/res_center

Promotes improved court responses to family violence through demonstration programs, professional training, technical assistance, national conferences, and publications.

National Child Welfare Resource Center for Family-Centered Practice

address: Learning Systems Group
1150 Connecticut Ave., NW, Suite 1100
Washington, DC 20036

phone: (800) 628-8442

fax: (202) 628-3812

e-mail: info@cwresource.org

Web site: www.cwresource.org

Helps child welfare agencies and Tribes use family-centered practice to implement the tenets of the Adoption and Safe Families Act to ensure the safety and well-being of children while meeting the needs of families.

National Child Welfare Resource Center on Legal and Judicial Issues

address: ABA Center on Children and the Law
740 15th St., NW
Washington, DC 20005-1019

phone: (800) 285-2221 (Service Center)
(202) 662-1720

fax: (202) 662-1755

e-mail: ctrchildlaw@abanet.org

Web site: www.abanet.org/child

Promotes improvement of laws and policies affecting children and provides education in child-related law.

Prevention Organizations

National Alliance of Children's Trust and Prevention Funds

address: Michigan State University
Department of Psychology
East Lansing, MI 48824-1117

phone: (517) 432-5096

fax: (517) 432-2476

e-mail: millsda@msu.edu

Web site: www.ctfalliance.org

Assists State children's trust and prevention funds to strengthen families and protect children from harm.

Prevent Child Abuse America

address: 200 South Michigan Ave., 17th Floor
Chicago, IL 60604-2404

phone: (800) 835-2671 (orders)
(312) 663-3520

fax: (312) 939-8962

e-mail: mailbox@preventchildabuse.org

Web site: www.preventchildabuse.org

Conducts prevention activities such as public awareness campaigns, advocacy, networking, research, and publishing, and provides information and statistics on child abuse.

Shaken Baby Syndrome Prevention Plus

address: 649 Main St., Suite B
Groveport, OH 43125

phone: (800) 858-5222
(614) 836-8360

fax: (614) 836-8359

e-mail: sbspp@aol.com

Web site: www.sbsplus.com

Develops, studies, and disseminates information and materials designed to prevent shaken baby syndrome and other forms of child abuse and to increase positive parenting and child care.

Community Partners

The Center for Faith-Based and Community Initiatives

e-mail: CFBCI@hhs.gov

Web site: www.hhs.gov/faith/

Welcomes the participation of faith-based and community-based organizations as valued and essential partners with the U.S. Department of Health and Human Services. Funding goes to faith-based organizations through Head Start, programs for refugee resettlement, runaway and homeless youth, independent living, childcare, child support enforcement, and child welfare.

Family Support America
(formerly Family Resource Coalition of America)

address: 20 N. Wacker Dr., Suite 1100
Chicago, IL 60606

phone: (312) 338-0900

fax: (312) 338-1522

e-mail: info@familysupportamerica.org

Web site: www.familysupportamerica.org

Works to strengthen and empower families and communities so that they can foster the optimal development of children, youth, and adult family members.

National Exchange Club Foundation for the Prevention of Child Abuse

address: 3050 Central Ave.
Toledo, OH 43606-1700

phone: (800) 924-2643
(419) 535-3232

fax: (419) 535-1989

e-mail: info@preventchildabuse.com

Web site: www.nationalexchangeclub.com

Conducts local campaigns in the fight against child abuse by providing education, intervention, and support to families affected by child maltreatment.

National Fatherhood Initiative

address: 101 Lake Forest Blvd., Suite 360
Gaithersburg, MD 20877

phone: (301) 948-0599

fax: (301) 948-4325

Web site: www.fatherhood.org

Works to improve the well-being of children by increasing the proportion of children growing up with involved, responsible, and committed fathers.

For the General Public

Childhelp USA

address: 15757 North 78th St.
Scottsdale, AZ 85260

phone: (800) 4-A-CHILD
(800) 2-A-CHILD (TDD line)
(480) 922-8212

fax: (480) 922-7061

e-mail: help@childhelpusa.org

Web site: www.childhelpusa.org

Provides crisis counseling to adult survivors and child victims of child abuse, offenders, and parents, and operates a national hotline.

National Center for Missing and Exploited Children

address: Charles B. Wang International
Children's Building
699 Prince St.
Alexandria, VA 22314-3175

phone: (800) 843-5678
(703) 274-3900

fax: (703) 274-2220

Web site: www.missingkids.com

Provides assistance to parents, children, law enforcement, schools, and the community in recovering missing children and raising public awareness about ways to help prevent child abduction, molestation, and sexual exploitation.

Parents Anonymous

address: 675 West Foothill Blvd., Suite 220
Claremont, CA 91711

phone: (909) 621-6184

fax: (909) 625-6304

e-mail: parentsanon@msn.com

Web site: www.parentsanonymous.org

Leads mutual support groups to help parents provide nurturing environments for their families.

For More Information

National Clearinghouse on Child Abuse and Neglect Information

address: 330 C St., SW
Washington, DC 20447

phone: (800) 394-3366
(703) 385-7565

fax: (703) 385-3206

e-mail: nccanch@calib.com

Web site: www.calib.com/nccanch

Collects, stores, catalogs, and disseminates information on all aspects of child maltreatment and child welfare to help build the capacity of professionals in the field. A service of the Children's Bureau.

APPENDIX C

State Toll-free Telephone Numbers for Reporting Child Abuse

Each State designates specific agencies to receive and investigate reports of suspected child abuse and neglect. Typically, this responsibility is carried out by child protective services (CPS) within a Department of Social Services, Department of Human Resources, or Division of Family and Children Services. In some States, police departments also may receive reports of child abuse or neglect.

Many States have an in-State toll-free telephone number, listed below, for reporting suspected abuse. **The reporting party must be calling from the same State where the child is allegedly being abused for most of the following numbers to be valid.**

For States not listed or when the reporting party resides in a different State than the child, please call **Childhelp, 800-4-A-Child** (800-422-4453), or your local CPS agency.

Alaska (AK)
800-478-4444

Arizona (AZ)
888-SOS-CHILD
(888-767-2445)

Arkansas (AR)
800-482-5964

Connecticut (CT)
800-842-2288
800-624-5518 (TDD)

Delaware (DE)
800-292-9582

Florida (FL)
800-96-ABUSE
(800-962-2873)

Illinois (IL)
800-252-2873

Indiana (IN)
800-800-5556

Iowa (IA)
800-362-2178

Kansas (KS)
800-922-5330

Kentucky (KY)
800-752-6200

Maine (ME)
800-452-1999

Maryland (MD)
800-332-6347

Massachusetts (MA)
800-792-5200

Michigan (MI)
800-942-4357

Mississippi (MS)
800-222-8000

Missouri (MO)
800-392-3738

Montana (MT)
800-332-6100

Nebraska (NE)
800-652-1999

Nevada (NV)
800-992-5757

New Hampshire (NH)
800-894-5533
800-852-3388 (after hours)

New Jersey (NJ)
800-792-8610
800-835-5510 (TDD)

New Mexico (NM)
800-797-3260

New York (NY)
800-342-3720

North Dakota (ND)
800-245-3736

Oklahoma (OK)
800-522-3511

Oregon (OR)
800-854-3508, ext. 2402

Pennsylvania (PA)
800-932-0313

Rhode Island (RI)
800-RI-CHILD
(800-742-4453)

Texas (TX)
800-252-5400

Utah (UT)
800-678-9399

Vermont (VT)
800-649-5285

Virginia (VA)
800-552-7096

Washington (WA)
866-END-HARM
(866-363-4276)

West Virginia (WV)
800-352-6513

Wyoming (WY)
800-457-3659

APPENDIX D
National Association of Social Workers Code of Ethics

The National Association of Social Workers Code of Ethics provides guidance regarding the everyday professional conduct of all social workers, including child protective services (CPS) caseworkers. The following standards are based on guidelines for professional conduct with clients:

Commitment to clients. A CPS caseworker's primary responsibility is to assure child safety, child permanence, child well-being, and family well-being.

Self-determination. CPS caseworkers respect and promote the right of clients to self-determination and help clients identify and clarify their goals. The right to self-determination may be limited when the caseworker, in their professional judgment, determines that the clients' actions or potential actions pose a serious and foreseeable, imminent risk to their children.

Informed consent. CPS caseworkers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. In instances where clients are receiving services involuntarily, CPS caseworkers should provide information about the nature and extent of services and about the extent of clients' right to refuse the services.

Competence. CPS caseworkers should provide services and represent themselves as competent only within the boundaries of their education, preservice and inservice training, license, and certification.

Cultural competence and social diversity. CPS caseworkers should understand culture and its function in human behavior, recognizing the strengths in all cultures. Caseworkers should be knowledgeable about their clients' cultures and demonstrate competence in providing services that are sensitive to the cultures and to differences among people and cultural groups.

Conflicts of interest. CPS caseworkers should be alert to and avoid any conflict of interest that may interfere with the exercise of professional discretion and impartial judgment. Caseworkers should not take any unfair advantage of a professional relationship or exploit others for personal gain.

Privacy and confidentiality. CPS caseworkers should respect the child and family's right to privacy. They should not solicit private information from clients unless it is essential to assuring safety, providing services, or achieving permanence for children. Caseworkers can disclose information with consent from the client or person legally responsible for the client's behalf. Caseworkers should discuss with clients and other interested parties the nature of the confidentiality and the limitations and rights of confidentiality. Caseworkers should protect the confidentiality of all information, except when disclosure is necessary to prevent serious, foreseeable, and imminent harm to the child.

Access to records. Caseworkers should provide clients with reasonable access to the records about them. Caseworkers should limit client access to records when there is compelling evidence that such access could cause serious harm to the child or family. When providing access to records, caseworkers must protect the confidentiality of other individuals identified in the record, such as the name of the reporter.

Sexual relationships. Caseworkers should not, under any circumstances, engage in sexual activities or sexual contact with current or former clients, client's relatives, or others with whom the client maintains a close personal relationship when there is a risk of exploitation or potential harm to the client. Caseworkers should not provide clinical services to individuals with whom they have had a prior sexual relationship.

Sexual harassment. Caseworkers should not make sexual advances or sexual solicitation, request sexual favors, or engage in other verbal or physical conduct of a sexual nature with clients.

Physical contact. Caseworkers should not engage in physical contact with children and parents when there is a possibility of psychological harm.

Derogatory language. Caseworkers should never use derogatory language in their verbal or written communication about clients. Caseworkers should use behavioral, respectful, and sensitive language in their communications to and about clients.

Clients who lack decision making capacity. When acting on behalf of clients who lack the capacity to make informed decisions, caseworkers should take reasonable steps to safeguard the interests and rights of those clients.

Termination of services. CPS caseworkers should terminate services to clients when child safety is assured or permanence has been achieved.

Source: National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers.* Washington, DC: Author.

To view or obtain copies of other manuals in this series, contact the National Clearinghouse on Child Abuse and Neglect Information at:

800-FYI-3366
nccanch@calib.com
www.calib.com/nccanch/pubs/usermanual.cfm