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Child Protective Services: A Guide for Caseworkers

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Child Protective Services: A Guide for Caseworkers

Diane DePanfilis, Ph.D., M.S.W.

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Table of Contents

PREFACE **6**

ACKNOWLEDGMENTS **8**

Acknowledgments 8

Principal Reviewers 8

Reviewers 9

Other Acknowledgments 9

CHAPTER 1: PURPOSE AND OVERVIEW **10**

1.1 Background 10

1.2 Terms and Definitions 11

1.3 Topics Addressed in This Manual 12

CHAPTER 2: CHILD PROTECTIVE SERVICES PRACTICE **13**

2.1 National Goals for Child Protection 15

2.2 Philosophical Tenets of Child Protective Services 15

2.3 Framework for Practice 17

2.4 Caseworker Competence 19

2.5 Stages of CPS 19

CHAPTER 3: LEGAL CONTEXT OF CPS INTERVENTION **24**

3.1 Federal Role 24

3.2 Basis for State and Tribal Intervention 30

3.3 Child Maltreatment Definitions 31

CHAPTER 4: ENGAGING AND WORKING WITH CHILDREN AND FAMILIES **35**

4.1 Engaging Diversity and Difference With Cultural Sensitivity 35

4.2 Core Conditions of Helping Relationships 37

4.3 Building Rapport and Engaging Families 40

4.4 Use of Authority in Child Protective Services 43

4.5 Culturally Competent CPS Intervention 45

CHAPTER 5: REPORTING AND INTAKE **48**

5.1 Community Outreach and Education 48

5.2 Reporting Child Abuse and Neglect 49

5.3 CPS Intake 54

CHAPTER 6: INITIAL ASSESSMENT OR INVESTIGATION **64**

6.1 Initial Assessment Process 65

6.2 Analysis of Information at Decision Points 79

CHAPTER 7: COMPREHENSIVE FAMILY ASSESSMENT **99**

7.1 Principles for Conducting Family Assessments 99

7.2 Family Assessment Process 101

CHAPTER 8: DEVELOPMENT OF THE FAMILY PLAN 112
8.1 Family Plan Decisions 113
8.2 Involving the Family in the Planning Process 113
8.3 Targeting Outcomes in the Family Plan 115
8.4 Determining Goals to Accomplish Outcomes 118
8.5 Determining Action Steps to Achieve Goals 120
CHAPTER 9: CHANGE STRATEGIES AND INTERVENTIONS 123
9.1 Defining Terms to Guide the Selection of Change Strategies 124
9.2 Matching Change Strategies and Interventions to Outcomes 126
9.3 Collaborating With Community Partners 128
CHAPTER 10: EVALUATION OF CHANGE 130
10.1 Evaluating Change on a Regular Basis 130
10.2 Evaluating the Change Process 132
10.3 Considering Areas of Assessment and Key Decisions 132
10.4 Linking the Evaluation of Change to Other Reviews 135
CHAPTER 11: CLOSURE AND ENDING CPS INVOLVEMENT 136
11.1 Types of CPS Closure 136
11.2 The Process of Ending CPS Involvement 137
11.3 Community Collaboration During Closure 139
CHAPTER 12: EFFECTIVE DOCUMENTATION 140
12.1 Purposes of Child Protective Services Recordkeeping 140
12.2 Principles of Effective Documentation 141
12.3 Using Behavioral Descriptors 142
12.4 Content of Child Protective Services Records 143
CHAPTER 13: SUPERVISION 145
13.1 Consultative Supervisory Practices 146
13.2 Coaching Supervisory Practices 148
13.3 Supervisory Consultation and Coaching on Key CPS Decisions 156
CHAPTER 14: CASEWORKER WELLNESS AND SAFETY 162
14.1 Caseworker Wellness 162
14.2 Caseworker Safety 166
REFERENCES 169
APPENDIX A: GLOSSARY 191
APPENDIX B: RESOURCE LISTINGS OF SELECTED ORGANIZATIONS CONCERNED WITH CHILD MALTREATMENT 199
APPENDIX C: STATE DIRECTORY OF WHERE TO REPORT SUSPECTED CHILD MALTREATMENT 200
APPENDIX D: EXAMPLES OF CPS CORE COMPETENCIES 204
APPENDIX E: MAJOR PROVISIONS OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA) REAUTHORIZATION ACT OF 2010 207

APPENDIX F: CONTENT OF AN INTAKE REPORT 212
APPENDIX G: ASSESSMENT INSTRUMENTS 214
APPENDIX H: EXAMPLES OF CHANGE STRATEGIES AND OUTCOMES 230
APPENDIX I: CHAPTER 10 – ALTERNATIVE CASE SCENARIOS FOR THE SMITH FAMILY 247S

Preface

Each day, the safety and well-being of children across the nation are threatened by child abuse and neglect. Intervening effectively in the lives of these children and their families does not rest with any single agency or professional group but rather is a shared community concern.

The *Child Abuse and Neglect User Manual Series* has provided guidance on child protection to hundreds of thousands of multidisciplinary professionals and concerned community members since the late 1970s. The series provides a foundation for understanding child maltreatment and the roles and responsibilities of various practitioners in its prevention, identification, investigation, assessment, and treatment. Through the years, the manuals have served as valuable resources for building knowledge, promoting effective practices, and enhancing community collaboration. It is the hope that these updated manuals continue that tradition.

Since the last update of the *User Manual Series* in the early 2000s, the changing landscape reflects increased recognition of the complexity of issues facing parents and their children, new legislation, practice innovations, and system reform efforts. Advances in research and evidence-based practice have helped shape new directions for interventions. The Office on Child Abuse and Neglect, within the Children's Bureau of the Administration for Children and Families, U.S. Department of Health and Human Services, has developed the fourth edition of this manual in the *User Manual Series* to reflect the increased knowledge base and the evolving state of practice. *Child Protective Services: A Guide for Caseworkers* provides a comprehensive view of the child welfare process. This manual examines the roles and responsibilities of child protective services (CPS) workers, who are at the center of every community's child protection efforts. It describes the laws and policies that govern child protection, the basic stages of the CPS process and the steps necessary to accomplish each stage, and the importance of supervision and worker safety and wellness.

Best practices and critical issues in casework practice are underscored throughout. The primary audience includes CPS caseworkers, supervisors, and administrators. State, tribal, and local CPS agency trainers may use the manual for pre- or inservice training of CPS caseworkers, while schools of social work may add it to class reading lists to orient students to the field of child protection. In addition, other professionals and concerned community members may consult the manual for a greater understanding of the child protection process. Another manual, *Child Protection in Families Experiencing Domestic Violence*, serves as a companion piece by looking at the CPS process through a domestic-violence lens.

Child Protective Services: A Guide for Caseworkers, *Child Protection in Families Experiencing Domestic Violence*, and prior versions of the entire User Manual Series, are available at https://www.childwelfare.gov/pubs/usermanuals/.

Acknowledgments

Author

Diane DePanfilis, Ph.D., M.S.W., is Professor of Social Work at the Silberman School of Social Work, Hunter College, City University of New York. She has over 40 years of experience in the child welfare field as a caseworker, supervisor, director, trainer, evaluator, educator, and researcher and has published extensively on child maltreatment and child protection issues. She has led the design, testing, and implementation of federally funded, community-based interventions focused on preventing child maltreatment and on supporting systems to use evidence and data to inform decision-making related to policy, program, and practice reforms. Dr. DePanfilis is a former Vice President of the Society for Social Work and Research and former President of the American Professional Society on the Abuse of Children. She has received numerous awards and honors including appointment as a fellow of the American Academy of Social Work and Social Welfare and the Society for Social Work and Research; a University of Maryland-Baltimore Champion of Excellence and Founders Research Lecturer of the Year; and the Aaron Rosen Lecturer by the Brown School of Social Work and the Society for Social Work and Research.

Acknowledgment of Prior Editions

This manual is an update of two prior versions of this manual, written by Diane DePanfilis and Marsha K. Salus in 1992 and 2003. The first edition of the manual was published in 1980 as Child Protection: Providing Ongoing Services by Cynthia K. Ragan, Marsha K. Salus, and Gretchen L. Schultze.

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Principal Reviewers

These individuals provided extensive review and feedback:

Debra Gilmore, M.P.A., J.D.
Research Strategist
Capacity Building Center for States

Kathy Simms, M.S.W.
Program Area Advisor,
Protective Services & In-Home Services
Capacity Building Center for States

Quincy Wilkins, M.S., L.M.F.T., L.P.C.C.
Program Area Manager, Child Protection Services
Capacity Building Center for States

Reviewers

The following individuals also reviewed drafts and provided valuable feedback:

Gloria Carroll, M.S.W., L.C.S.W.
Program Area Manager, In-Home/Family Preservation Services
Capacity Building Center for States

Suzan Cohen
Staff Paralegal
Child Welfare Information Gateway

Theresa Costello
Executive Director
Action for Child Protection

Mark Ells, J.D., L.L.M.
Research Assistant Professor
Center on Children, Families and the Law, University of Nebraska-Lincoln

John D. Fluke, Ph.D.
Associate Director for Systems Research and Evaluation, Research Professor
Department of Pediatrics, Kempe Center for the Prevention and Treatment of Child Abuse & Neglect, University of Colorado School of Medicine
Research Professor
Department of Epidemiology, Colorado School of Public Health, University of Colorado-Denver

Matthew Shuman, M.S.W.
Senior Writer/Editor
Child Welfare Information Gateway

Eileen West
Senior Program Specialist
Administration for Children and Families, Children's Bureau

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Chapter 1: Purpose and Overview

This manual, *Child Protective Services: A Guide for Caseworkers*, provides the fundamental information that child protective services (CPS) professionals need to know to perform essential casework functions. This first chapter:

- Provides the context for the manual
- Defines basic terms, used in general and throughout the manual, for describing the CPS process and activities
- Lays out the sequencing of the chapters, each of which builds upon previous chapters, for ease of reference

1.1 Background

For federal fiscal year 2016, the Children's Bureau (2018) found that the United States had approximately 676,000 reported victims of child abuse and neglect, or 9.1 victims per 1,000 children in the population. To protect children from harm, CPS relies on community members to identify and report suspected cases of child maltreatment, including physical abuse, sexual abuse, neglect, and psychological maltreatment. Many professionals (including health care providers, mental health professionals, educators, and legal and court system personnel) are involved in responding to cases of child maltreatment and in providing needed services.

Because child abuse and neglect is a community concern, each community has a legal and moral obligation to promote the safety, permanency, and well-being[1] of children, which includes responding effectively to reports of child maltreatment. At the federal level, the Child and Family Services Reviews (CFSRs) monitor states to measure their effectiveness at achieving these goals. At the state, tribal, and local levels, professionals assume numerous roles and responsibilities (ranging from prevention, identification and reporting of child maltreatment to assessment, intervention, and treatment) to achieve those goals.

CPS, a division within state, tribal, and local social services, is at the center of every community's child protection efforts. CPS agencies, along with law enforcement, play a central role in receiving and investigating reports of child maltreatment. The focus of CPS agencies is to determine if a child is safe and whether there is risk of future maltreatment. They also offer services to families and children where maltreatment has occurred or is likely to occur.

[1] The focus of the CPS process is on safety. Permanency and well-being are the purview of other areas of the child welfare system and are beyond the scope of this manual.

Child and Family Services Reviews

The CFSRs enable the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, to (1) ensure conformity with federal child welfare requirements; (2) determine what is actually happening to children and families engaged in child welfare services; and (3) assist states in enhancing their capacity to help children and families achieve positive outcomes. The Children's Bureau completed the first round of the CFSRs in 2004 (after the publication of the third edition of this manual) and currently is conducting the third round. The CFSRs evaluate public child welfare systems to determine how well they achieve safety, permanency, and well-being in difficult situations of child maltreatment (U.S. Department of Health and Human Services, Children's Bureau, n.d.). They also help states develop effective Program Improvement Plans to improve child and family outcomes and to enhance collaboration with service providers. For more information on the CFSRs, visit https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews (para.1).

1.2 Terms and Definitions

Terminology not only varies throughout the field and from system to system, it also evolves as practice and protocols change. Appendix A provides a glossary of terms used throughout this and other manuals. For example, prior manuals referred to the "case plan" or "service plan." This manual uses the term "family plan." This change is to emphasize that to truly support change, the family must own the plan, not just be directed what to do by the caseworker, agency, and/or court. Another change from prior editions is referring to "service provision" now as "change strategies and interventions." This phrase more accurately captures a paradigm shift. Now the caseworker's goal focuses more on matching change strategies and interventions to family strengths and needs to achieve specific outcomes, rather than merely providing services or requiring attendance in programs that may or may not be beneficial to achieving those outcomes. The *Overview of Child Protection Process* in chapter 2, **exhibit 2.1**, also incorporates these terms. The stages of the CPS process illustrated by this flowchart also track to chapters 5–11 in this manual.

While the manual's title refers to "caseworkers," the term is used generally to refer to the various workers that provide CPS services. Therefore, at various times and during different stages of the CPS process, this manual also uses other terms, including "worker," "CPS worker," "intake worker," and "practitioner."

"Parent" in this manual most often refers to birth parents, as well as other parental-role caregivers. Other examples of caregivers who may be involved with CPS include guardians, emotional or psychological parents (e.g., fictive kin who often assume a parental role without any legal or biological relationship or responsibility to the children), foster and adoptive parents, and stepparents. The parent who is not the subject of a report of alleged maltreatment is referred to as the "nonmaltreating" or "nonoffending" parent.

The reader should note two other items:

1. The author and reviewers made every effort to use the most up-to-date research and materials. However, in some cases, the material referenced is older because the field recognizes it as the gold standard of certain definitions, terminology, or concepts and/or it is a primary source cited in a secondary source.

2. While the manual attempts to cover the various forms of child maltreatment covered by the Child Abuse Prevention and Treatment Act (described in detail in chapter 3), the trafficking of children is considered beyond its scope. For more information on that important topic, see https://www.childwelfare.gov/topics/systemwide/trafficking/pir/.

1.3 Topics Addressed in This Manual

Child Protective Services: A Guide for Caseworkers covers numerous topics essential to good CPS casework practice, including:

- Philosophical tenets, legal context, and national goals of child protection
- Core components of the helping relationship, including cultural sensitivity and competency and family engagement
- Purposes, key decisions, and practice issues for the stages of the CPS process:
    - Reporting and intake
    - Initial assessment/investigation
    - Comprehensive family assessment
    - Development of the family plan
    - Change strategies and interventions
    - Evaluation of change and family progress
    - Closure and ending of CPS involvement
- Effective documentation of actions in case records and information systems
- Strategies for casework supervision, training, consultation, and support
- Caseworker wellness and safety

Each chapter concludes with highlights of its key points for a quick summary. Appendices include a glossary, resources of information on child protection, and various casework tools.

Child abuse and neglect is a complex problem, and child protection is a challenging responsibility. While no single publication can provide all the information needed to promote effective CPS practice, explore all of the relevant issues, or reflect the multitude of policy and practice variations in place across the country, this manual provides a starting point. Its solid foundation for casework practice should be augmented through training, other professional development activities, and experience.

Please note that any programs, models, instruments, surveys, or websites discussed in this manual do not connote an endorsement by the Children's Bureau.

Targeted audiences are encouraged to read *Child Protection in Families Experiencing Domestic Violence*, a companion manual in the *User Manual Series* that builds upon the concepts discussed in this manual through a domestic violence lens. It also includes the *Overview of Child Protection Process* graphic, with the relevant chapters tracking to the flowchart.

Chapter 2: Child Protective Services Practice

Child protective services (CPS) is the central agency in each community that receives reports of suspected child maltreatment (sometimes in tandem with law enforcement). It assesses the risk to and safety of children and provides or arranges for services to achieve safe, permanent families for children who have been abused or neglected, or who are at risk of abuse or neglect. CPS also facilitates community collaborations and engages formal and informal community partners to support families and to protect children from maltreatment.

The basis for CPS stems from a concern for the care of children, which is expressed through laws established at the federal, state, and tribal levels (chapter 3). This chapter introduces CPS practice and covers the:

- National child protection goals of safety, permanency, and well-being
- Culturally competent, developmental, ecological, evidence-informed, strengths-based, and permanency-driven perspectives guiding this practice
- Child-centered, family-focused, and culturally responsive framework for practice
- Core competencies necessary for caseworkers
- Stages of CPS practice: planning, service provision, evaluation of family progress, and case closure

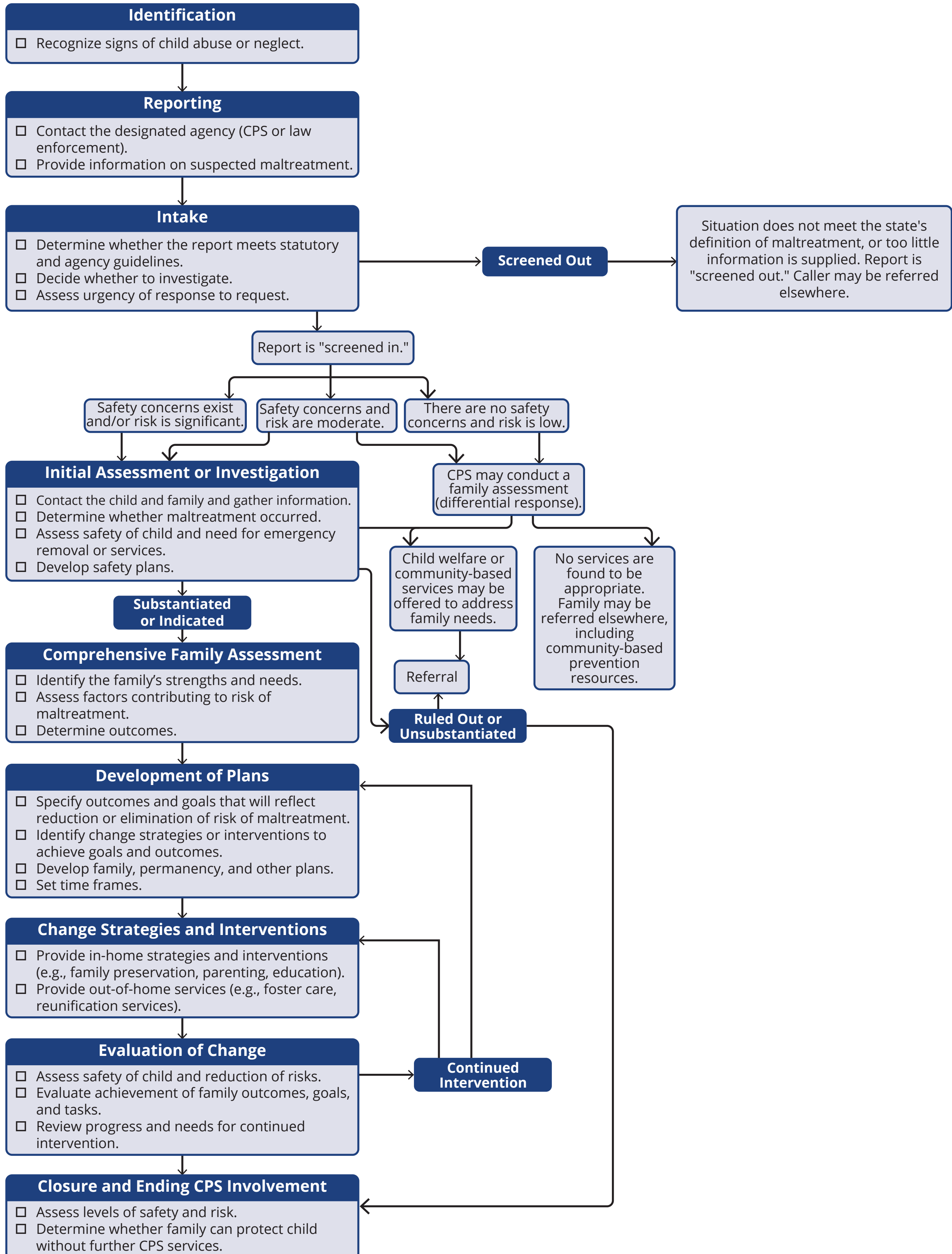


Exhibit 2.1
Overview of Child Protection Process
Identification
Recognize signs of child abuse or neglect.
Reporting
Contact the designated agency (CPS or law enforcement).
Provide information on suspected maltreatment.
Intake
Determine whether the report meets statutory and agency guidelines.
Decide whether to investigate.
Assess urgency of response to request.
Screened Out
Situation does not meet the state's definition of maltreatment, or too little information is supplied. Report is "screened out." Caller may be referred elsewhere.
Report is "screened in."
Safety concerns exist and/or risk is significant.
Safety concerns and risk are moderate.
There are no safety concerns and risk is low.
Initial Assessment or Investigation
Contact the child and family and gather information.
Determine whether maltreatment occurred.
Assess safety of child and need for emergency removal or services.
Develop safety plans.
CPS may conduct a family assessment (differential response).
Child welfare or community-based services may be offered to address family needs.
No services are found to be appropriate. Family may be referred elsewhere, including community-based prevention resources.
Substantiated or Indicated
Referral
Ruled Out or Unsubstantiated
Comprehensive Family Assessment
Identify the family's strengths and needs.
Assess factors contributing to risk of maltreatment.
Determine outcomes.
Development of Plans
Specify outcomes and goals that will reflect reduction or elimination of risk of maltreatment.
Identify change strategies or interventions to achieve goals and outcomes.
Develop family, permanency, and other plans.
Set time frames.
Change Strategies and Interventions
Provide in-home strategies and interventions (e.g., family preservation, parenting, education).
Provide out-of-home services (e.g., foster care, reunification services).
Evaluation of Change
Assess safety of child and reduction of risks.
Evaluate achievement of family outcomes, goals, and tasks.
Review progress and needs for continued intervention.
Continued Intervention
Closure and Ending CPS Involvement
Assess levels of safety and risk.
Determine whether family can protect child without further CPS services.

2.1 National Goals for Child Protection

The Adoption and Safe Families Act of 1997 (ASFA, P.L. 105–89) establishes three national goals for child protection:

- **Safety.** All children have the right to live in an environment free from abuse and neglect. The safety of children is the paramount concern that guides child protection efforts.
- **Permanency.** Children need a family and a permanent place to call home. A sense of continuity and connection is central to a child's healthy development. Therefore, child protection efforts focus on keeping children with their families as long as their safety can be maintained.
- **Child well-being.** Children deserve nurturing environments that promote their cognitive, psychological, and behavioral development, as well as social and emotional competence and physical health. When children are considered to be unsafe, child protection practices must consider methods for supporting families so that the well-being of children is achieved.[1]

CPS agencies are accountable for achieving outcomes of child safety, permanency, and well-being for children who come to their attention. At the federal level, the Children's Bureau, through the Child and Family Services Reviews (CFSRs) monitors states to measure their effectiveness at achieving these goals. To achieve these outcomes, caseworkers must engage families in identifying and then achieving family-level outcomes that reduce the risk of further maltreatment and ameliorate the effects of maltreatment that have occurred.[2]

1 For more on ASFA, visit https://training.cfsrportal.org/section-2-understanding-child-welfare-system/2999 or read the law at https://www.gpo.gov/fdsys/pkg/PLAW-105publ89/pdf/PLAW-105publ89.pdf.

2 For more on the CFSRs, go to https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews.

2.2 Philosophical Tenets of Child Protective Services

When selecting staff to work in CPS, child welfare agencies need to align their programs and policies with, and select staff who embrace, the following philosophical tenets, which are based on the values that underlie sound child protection and community responses to child maltreatment:

A safe and permanent family is the best place for children to grow up. Every child has a right to adequate care and supervision and to be free from abuse, neglect, and exploitation. It is the responsibility of parents to see that the physical, mental, emotional, educational, and medical needs of their children are met. CPS should intervene only when parents request assistance or fail, by their acts or omissions, to meet their children's basic needs adequately, cause physical or emotional harm, or fail to keep them safe. Two frameworks for strength-based assessments of families are protective capacities and protective factors (Capacity Building Center for States (n.d.-b):

- **Protective capacities.** Caregiver characteristics directly related to child safety that help ensure the safety of the child by the caregiver responding to threats in ways that keep the child safe from harm. Building protective capacities also helps reduce the risk of maltreatment.
- **Protective factors.** Conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families, today and in the future

Most parents want to be good parents and have the strength and capacity, when **adequately supported by family or other social supports, to care for their children and to keep them safe.** Most children are best cared for by their own family. Therefore, CPS and the community can provide essential supports to families who have maltreated their children, or who are at risk or otherwise need support, to help them develop the strengths and to build protective capacities to keep their children safe so the family may stay together.

Families who need assistance from CPS agencies are diverse in family structure, culture, race, ethnicity, religion, economic status, beliefs, values, and lifestyles. Agencies and caseworkers need to be responsive to, and demonstrably respectful of, these differences. Furthermore, caseworkers, along with their partners in other public and community-based agencies, can and should (1) build on the strengths and on the protective capacities and factors within families and communities, and (2) advocate for the families they serve to gain access to needed services. Often securing access to services and resources means helping families overcome barriers rooted in poverty or discrimination.

CPS practice should be implemented through a trauma-informed lens. When children have been victims of child maltreatment, they likely have been exposed to multiple forms of trauma. It is, therefore, essential for caseworkers to (National Child Traumatic Stress Network, 2008):

- Maximize the sense of safety for children
- Assist children in reducing overwhelming emotion and building healthy coping skills
- Conduct a comprehensive assessment of the child and family's trauma experience and impact and to coordinate services with other agencies[3]
- Help parents and children make meaning of their trauma history
- Understand and address the impact of trauma on child development and subsequent changes in the child's behavior, development, and relationships
- Support and promote positive and stable relationships
- Provide support and guidance to the child's family
- Manage professional stress

CPS efforts are most likely to succeed when families are ready and actively participate in the process. Whatever a caseworker's role, he or she should have the ability to elicit motivation for change and to develop helping alliances with family members (see chapter 4). Caseworkers need to work in ways that encourage families to participate fully in the assessment, safety planning, and development of the family plan, as well as other critical decisions in CPS intervention.

The goal is to keep children in the home when safe to do so, and the parents' participation is key. When parents cannot or will not fulfill their responsibilities to protect their children, however, CPS has the right and obligation to intervene directly on the children's behalf. Both laws and good practice maintain that interventions should be designed to help parents protect their children and should implement strategies using the least-intrusive approach possible. Caseworkers are legally required to make reasonable efforts to develop safety plans that keep children with their families, whenever possible, and to refer for court intervention and placement of children in out-of-home care only when children cannot be kept safely within their own homes.

3 Chapter 9 provides more on trauma-focused practice. Other practice guidelines can be found through the National Child Traumatic Stress Network at http://www.nctsn.org/.

When children are placed in out-of-home care because their safety cannot be assured, the agency should select a home that best meets the child's needs and develop a case plan as soon as possible. A properly chosen placement will:

- Meet children's physical, emotional, and social needs
- Strengthen and preserve children's relationships with their families
- Reflect and/or actively value a child's culture
- Minimize separation trauma

To the degree possible, children should be placed with members of their own extended families or in their home communities to maintain continuity, preserve important relationships, and support their cultural identity. In most cases, the preferred permanency goal is to reunify children with their families. All children need continuity in their lives, so if the goal is family reunification, the plan should include frequent contact and quality interactions between the child and family and other efforts to sustain the parent-child relationship while the child is in out-of-home care. Also, the agency must begin immediately (in the case of emergency placements) or continue to work with the family to mitigate the behaviors and conditions that led to the maltreatment and necessitated placement in out-of-home care in order to start working toward reunification.

To best protect a child's overall well-being, agencies must take actions to ensure that children move to permanency as quickly as possible; doing so requires thorough planning early in the life of the case. Along with developing plans to support reunification, agencies should develop concurrent plans for permanence from the time a child enters care. This early planning will prove beneficial, as caseworkers will be able to implement alternative permanency plans expeditiously, such as adoption and guardianship, if it is determined that a child cannot be safely reunited with his or her family.

The next section explains how CPS professionals put these philosophical tenets into practice by working in ways that are child centered, family focused, and culturally responsive.

2.3 Framework for Practice

Building on these philosophical tenets, child welfare professionals generally agree that a *child-centered, family-focused,* and *culturally responsive* framework for child welfare practice will promote the best outcomes for children (Child Welfare League of America, 1999). This integrative framework builds on six main perspectives, described below.

Cultural competence perspective. As the National Association of Social Workers (2015) states, practitioners should strive to consider the values, worldview, or perspectives of families and peers who may come from culturally diverse backgrounds. They can both build cross-cultural knowledge and skills and demonstrate a respect for their own cultural identities and those of others. Given the complexity of multiculturalism, it is beneficial to understand cultural competency (also known as cultural responsiveness) as a process rather than as an end product.

Cultural competence comes from developing a set of attitudes, behaviors, and policies that integrates knowledge about diverse groups of people into practices and standards to enhance the quality of services to all cultural groups being served. Basic cultural competency is achieved when organizations and practitioners:

- Accept and respect differences
- Recognize, affirm, and value the worth of individuals and communities

- Protect and preserve the dignity of each person and respond respectfully and effectively to people of all:
    - Cultures, languages, socioeconomic status, races, ethnic backgrounds, and immigration and refugee status
    - Religions and spiritual practices
    - Sexual orientation, gender, gender expression, and gender identity
    - Family status
    - Physical and mental abilities

Cultural competence should be a key component of any caseworker training. Caseworkers should then continue to engage in ongoing cultural self-assessment, expand their diversity knowledge and skills, and adapt service models to fit the unique needs and strengths of the families they serve. More information on culture and culture-related terminology (e.g., cultural sensitivity and humility) is provided in chapter 4.

Developmental perspective. Caseworkers need working knowledge of human growth and development and of family development, including the effects of trauma on development, from a life-span perspective. Planning with families and children takes into account which interventions are effective with which specific child/family problems, in which environmental settings, and at what particular developmental stages.

Ecological perspective. Child welfare professionals also need to recognize human behavior and social functioning within an environmental context. Personal, family, and environmental factors interact to influence the family. Child maltreatment is viewed as the consequence of the interplay of a complex set of risk and protective factors at the individual, family, community, and societal levels.

Evidence-informed practice perspective. Policies and practices should be based on the best available research, practice applications, and resources. An important perspective is that each family is unique. Therefore, each deserves an individualized, tailored response that considers the best options for responding based on the family and community characteristics combined with the best available evidence.

Strengths perspective. Child welfare professionals need to draw upon the strengths of children, families, and communities/environment to promote their effective functioning. Strengths-based practice involves a paradigmatic shift from a deficit approach, which emphasizes problems and pathology, to an approach that focuses on identifying and building upon family and community assets to develop a positive partnership with the family. In addition to building on the families' strengths, assessments examine the complex interplay of risks and strengths related to: (1) individual family members, (2) the family as a unit, and (3) the broader neighborhood and environment. With a clearer understanding of the multiple factors leading to child maltreatment, rather than a problem-focused approach, caseworkers also foster support and build on the resilience and potential for growth inherent in each family. Chapters 6 and 7 discuss strengths-based assessment in more detail.

Relational perspective. This embodies the tenet that all children need a family and a permanent place to call home in order to build on the sense of identity, continuity, and connectedness that is central to a child's healthy development. Child welfare service delivery should focus on safely maintaining children in their own homes and communities or, if necessary, placing them temporarily or, in some cases, permanently with other families. When approaching planning with this perspective, caseworkers incorporate goal-directed activities designed to help children

maintain or strengthen existing positive relationships and to live in safe families that offer them a sense of belonging and legal, lifetime, family ties.

2.4 Caseworker Competence

The U.S. Office of Personnel Management (OPM) defines competency as "a measurable pattern of knowledge, skill, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully" (n.d.-a, para.1). Developing CPS caseworker competence is an ongoing process. Child welfare agencies should begin this process with an analysis of job functions and then define competencies to guide worker selection and training.

OPM suggests developing competencies so that readers are able to identify easily what the competency is. Each competency should focus on one single, readily identifiable characteristic and should avoid unnecessary qualifiers. For example, instead of describing "considerable skill" to draw conclusions, a competency for reasoning would be described as "identifies rules, principles, or relationships that explain facts, data, or other information; analyzes information and makes correct inferences or draws accurate conclusions (OPM, n.d.-b)." Most state child welfare agencies use a competency-based framework. Rather than proposing that only one approach "fits all," **appendix D** compiles examples of CPS competencies from a number of sources.

2.5 Stages of CPS

As previously discussed, to fulfill its mission CPS, either directly or through other agencies, must provide services that are child centered, family focused, and culturally responsive to achieve safety, well-being, and permanency for children. Each child welfare agency may be organized differently based on state and tribal laws, policies, departmental structures, and geography. All programs, however, essentially implement their CPS mandates through seven stages. These stages are briefly reviewed here and then addressed in separate chapters in the manual, which correspond to the flowchart shown in **exhibit 2.1.**

2.5.1 Reporting and Intake

The Child Abuse Prevention and Treatment Act (detailed in chapter 3) specifies that CPS should develop, facilitate, and implement research-based strategies and training protocols for individuals who are mandated to report child abuse and neglect.[4] This includes educating any reporters (mandated or not) of suspected child abuse or neglect about state statutes, tribal and agency guidelines, and the roles and responsibilities of CPS. CPS is responsible for receiving and assessing those reports of suspected child maltreatment, which many jurisdictions refer to as "intake." Intake's purpose is to determine: (1) if a child is in imminent danger; (2) if the reported information meets the statutory definitions and agency guidelines for child maltreatment; and (3) the urgency with which the agency must respond to the report.

4 For the specific language of Sec. 106(a)(8) of the Act, go to https://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf, p. 18

After CPS receives a report of suspected child abuse or neglect, a worker evaluates its information (known as "screening") to determine if the alleged child victim is in imminent danger. The screener next determines if the report meets the statutory definition of and agency guidelines for child maltreatment in that jurisdiction. Sometimes the person taking the report screens it, while some agencies have others who screen the report. The decisions the screener makes determines the next steps:

- The report does not meet statutory definitions and agency guidelines and is screened out with no further action.
- The report does not meet statutory definitions and agency guidelines, but the information in the report indicates that a referral to community services may be helpful. If information reveals criminal activity that does not indicate child maltreatment, a referral to law enforcement may be appropriate.
- The report meets the statutory definitions and agency guidelines, and the information contained in the report indicates that it is appropriate for differential response ([DR], also known as alternative or multiple response and dual- or multi-track) as an alternative to a formal investigation. In states offering DR, the child welfare agency provides the response or refers the family to another agency. Chapter 6 explains DR in more detail.
- The report meets the statutory definitions and agency guidelines and is appropriate for an assessment or investigation.
- The report meets the statutory definitions and agency guidelines but a joint investigation with and/or referral to law enforcement is more appropriate due to the nature of the alleged abuse.

2.5.2 Initial Assessment/Investigation

After a report is "screened in," CPS conducts an initial assessment/investigation to determine whether:

- Child maltreatment occurred (for investigations)
- The child is in immediate or imminent danger (that is, not safe) and, if so, giving the supports or interventions that will immediately provide for the child's protection while minimizing further harm by: (1) keeping the child within the family home or with family members (e.g., kinship care or guardianship), if safe and possible, or (2) otherwise placing the child in nonfamily, out-of-home care
- The behaviors and circumstances that led to the alleged maltreatment are present
- There is a risk of future maltreatment and the level of that risk
- The family is in need of services, supports, and/or resources to address the behaviors that led to the safety threats and risk factors (for most assessments/investigations)
- Continuing services are needed to address any effects of child maltreatment and to reduce the risk of maltreatment occurring
- There are protective factors and capacities that will need development or enhancement to reduce the likelihood of future maltreatment

The terms *assessment* and investigation are used interchangeably in many states and territories, but they are not synonymous. *Investigation* encompasses the efforts of the CPS agency to determine if abuse or neglect has occurred. *Assessment* goes beyond this concept to evaluate a child's safety and risk and to determine whether and what strategies or interventions are needed to ameliorate or prevent child abuse and neglect (Child Welfare League of America, 1999). Initial assessment and investigation purposes and protocols, along with variations if a jurisdiction uses DR or alternative response, are described in chapter 6.

Referred to above and described in more detail in both chapters 5 and 6, DR is an increasingly common model for how CPS agencies address reports of child maltreatment. Agencies that use DR seek to be less adversarial than traditional CPS by separating incoming referrals into two (or more) tracks (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2016).

2.5.3 Family Assessment

If a report has been "screened in" after a child's immediate safety has been secured, and it has been determined that there is risk of harm, the next step is to conduct a more comprehensive family assessment, which varies by state, tribe, and agency. During this step, the caseworker and/or community-based, preventive-services provider engage family members in a process to understand their strengths and needs. In particular, they work with the family to:

- Identify family strengths and caregiver protective capacities that can provide a foundation for change
- Recognize and begin to plan to address factors placing the children at risk
- Determine action steps toward targeted outcomes (e.g., building or strengthening a family's support network) to strengthen the family's capacity to protect their children
- Help children cope with the effects of maltreatment

Because child maltreatment is the result of interacting risk and protective factors, using an ecological developmental framework for this assessment is appropriate. Some CPS and community providers use a protective factor framework to guide understanding of families and to target outcomes for intervention (Center for the Study of Social Policy, n.d.). Chapter 7 explains the process, protocols, instruments, and decisions pertinent to family assessment.

2.5.4 Planning

To achieve the programmatic outcomes of child welfare (safety, permanency, and well-being), intervention should be planned and purposeful. These outcomes are achieved through three main types of plans:

Safety plan, which is developed whenever it is determined that there are threats to a child's safety in order to identify and manage those threats.

Family plan (also called a family service or case plan), which is developed for all cases (both out-of-home and in-home) to set forth goals and targeted outcomes. It describes how the agency (which may entail different caseworkers throughout the life of the case), family, and community partners (if applicable) will work toward these outcomes and goals.

Permanency plan, which identifies primary and concurrent forms of permanency, addressing both how reunification can be achieved (primary) and how legal permanency with a specific, alternate caregiver will be achieved if reunification efforts fail (concurrent). Both goals are pursued "concurrently." with full knowledge of all case participants.

All three plans should be developed collaboratively among the caseworker, family, community professionals, and families' informal supports who will provide services to the family. Approaches for fully engaging families in planning and examples of each type of plan are described in chapter 8.

2.5.5 Change Strategies and Interventions[5]

After a child's immediate safety has been secured and a more comprehensive family assessment reveals a need for ongoing services, the caseworker develops and implements the family plan to tie change

5 Also referred to as service provision in prior manuals and in numerous jurisdictions

strategies and interventions to outcomes. It is the agency and/or community partner's role (depending on whether or how ongoing

services may be privatized) to arrange for, provide, and/or coordinate the delivery of these change strategies and interventions to families involved with child welfare. Both chapter 9 and **appendix H** describe an array of strategies and interventions that have been shown to be effective or promising in addressing different needs of families.

2.5.6 Evaluating Change

Assessment is an ongoing process that begins at the first contact with the family and continues throughout the life of the case. It should incorporate reports from and communication with other service providers. When evaluating family progress, caseworkers focus on:

- Level of child maltreatment risk and whether safety of the child has been achieved.
- Changes in the behaviors and conditions that led to the need for intervention (i.e., reduction of risk factors and promotion of protective factors and caregiver protective capacities)
- Level of achievement:
    - Of family-level outcomes
    - Of goals and tasks in the family plan
    - To reduce the effects of maltreatment on the child and other family members

Methods for measuring change over time and evaluating progress are outlined in chapter 10.

2.5.7 Closure and Ending CPS Involvement

The process of closing a case, which entails ending the relationship between the CPS agency and the family, involves a mutual review of the level of risk and of progress made in the beginning, middle, and end of the helping relationship. Optimally, change strategies and interventions end when families have achieved their goals and the risk of maltreatment has been sufficiently reduced or mitigated.

Some cases are closed because the family discontinues services and the agency does not have a sufficient basis to determine that the risk of future maltreatment warrants intervention. When this happens, the caseworker should carefully document what risks may still be present or likely to reoccur so that this information is available should the family be referred again to the agency.

At the time of closure, workers should involve families in a discussion about what has changed over time and what goals they may still want or need to address on their own. When needs are still apparent that extend beyond the scope of the CPS system, every effort should be made to help families identify and receive services tailored to address their specific needs through community resources, supports, and programs. The process of ending a family's involvement with CPS is described in chapter 11.

This chapter provided the context and overview of CPS practice. The next chapter describes the laws and policies that guide it.

Chapter Highlights

- The national goals for child protection include child safety, permanency, and well-being.
- Philosophical tenets are based on the values that underlie sound child protection and community responses to child abuse and neglect. When selecting staff to work in this field, it is essential that caseworkers embrace these important philosophical principles.

- A *child-centered*, *family-focused*, and *culturally responsive* framework for child protective practice will promote the best outcomes for children.
- Six important perspectives guide the CPS practice framework: (1) cultural competence, (2) developmental, (3) ecological, (4) evidence informed, (5) strengths based, and (6) permanency driven.
- Core CPS competencies are measurable patterns of knowledge, skills, abilities, behaviors, and other characteristics that a caseworker needs to successfully implement CPS roles.
- The seven stages of the CPS process are: reporting and intake; initial assessment/ investigation; family assessment; planning; change strategies and interventions; evaluation of change; and case closure.

Chapter 3: Legal Context of CPS Intervention

Child welfare policy and practice are grounded in the premise that parents are in the best position to nurture, protect, and care for the needs of their children. Although most parents are capable of meeting these needs, the states and tribes have the authority to intervene in the parent-child relationship if parents are unable or fail to protect their children from preventable and significant harm. The basis for government's intervention in child maltreatment is grounded in the concept of *parens patriae*, a legal term that asserts that government has a role in protecting the interests of children and in intervening when parents fail to provide proper care to and keep their children safe. The purpose of this chapter is to:

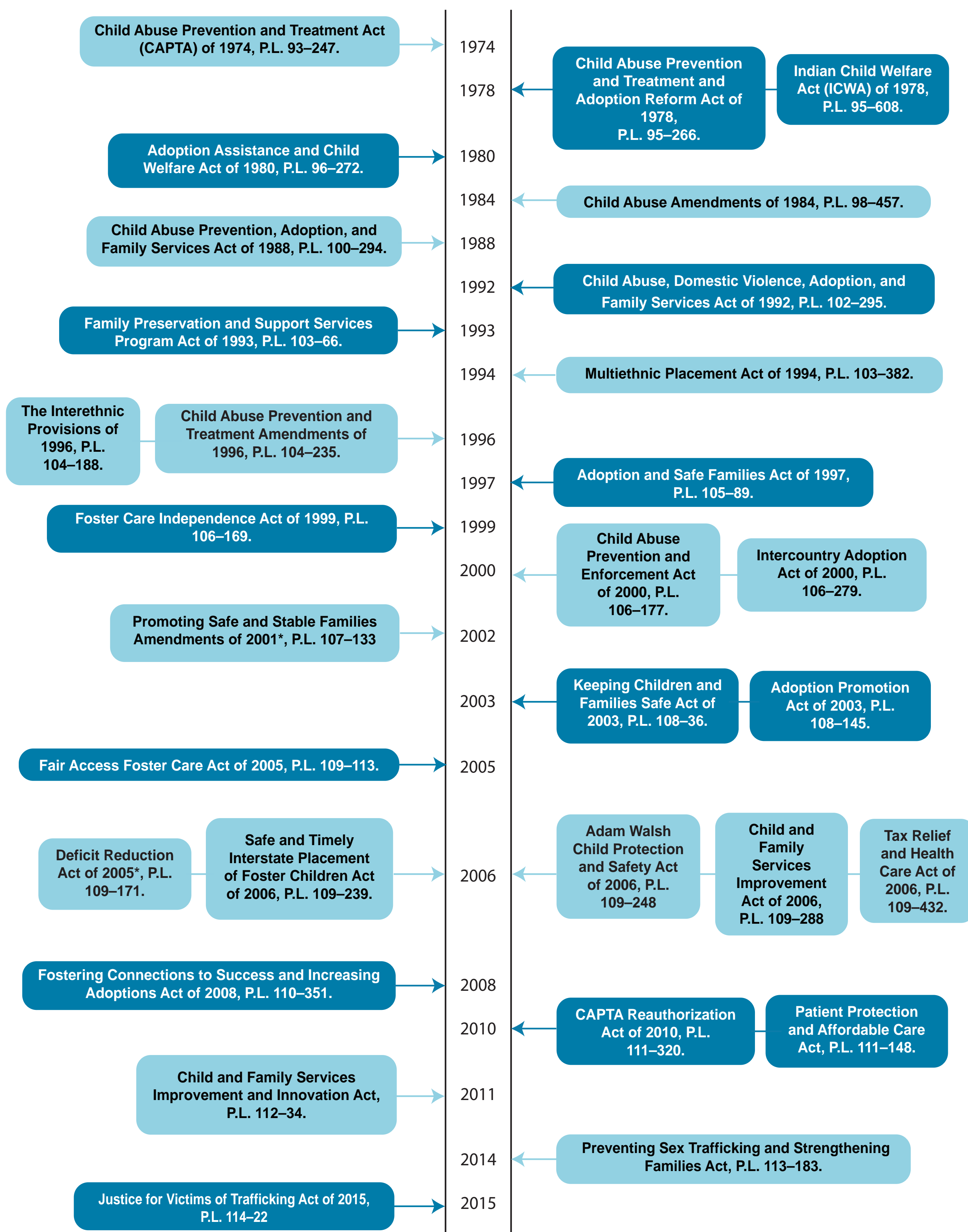
- Review the federal role in addressing child maltreatment,
- Discuss the basis for state and tribal intervention in family lives, highlighting state child maltreatment reporting statutes and describing the functions of the courts
- Explain the circumstances under which the government has the legal authority to intervene at the federal, state, and tribal levels
- Define child abuse and neglect

3.1 Federal Role[1]

The primary responsibility for child welfare services rests with the states, each of which has its own legal and administrative structures and programs that address the needs of children and families. However, states must comply with specific federal requirements and guidelines in order to be eligible for federal funding under certain programs (Child Welfare Information Gateway, 2016a). **Exhibit 3.1** provides an overview and timeline for federal child welfare legislation. A synopsis of the legislation relevant for caseworkers follows and is highlighted in **exhibit 3.2.**

[1] Portions of this chapter were adapted from Child Welfare Information Gateway. (2016). *Major federal legislation concerned with child protection, child welfare, and adoption*. Retrieved from https://www.childwelfare.gov/pubPDFs/majorfedlegis.pdf#page=2&view=

Exhibit 3.1 Major Federal Legislation Timeline



3.1.1 The Children's Bureau

The First White House Conference on Children in 1909 marked the first, formal federal statement on the rights of children. Federal programs designed to support child welfare services and to direct federal aid to families date from 1935, with the passage of the Social Security Act (SSA). Because state-supervised and -administered programs were already in place, the child welfare policy of the SSA layered federal funds over existing state-level foundations. These child welfare programs, therefore, were new only to the extent that they established a uniform framework for administration (Dobelstein, 1996; Goldman & Salus, 2003).

However, a landmark historical event was the creation of the U.S. Children's Bureau in 1912.[2] The role of the Children's Bureau has evolved over the years from its founding emphasis on infant mortality, dependent children, and child labor to today's focus on child abuse and neglect prevention, along with outcomes of safety, permanency and well-being of children. Housed in the U.S. Department of Health and Human Services, Administration for Children and Families, the Children's Bureau leads the Child and Family Services Reviews (CFSRs).[3] The CFSRs enable the Children's Bureau to (U.S. Department of Health and Human Services [HHS], Administration for Children and Families [ACF], Children's Bureau, n.d.-a):

- Ensure conformity with federal child welfare requirements
- Determine what actually is happening to children and families as they are engaged in child welfare services
- Assist states and tribes in enhancing their capacity to help children and families achieve positive outcomes in safety, permanency, and well-being

2 For a comprehensive story of the Children's Bureau over its first 100 years, visit https://cb100.acf.hhs.gov/Cb_ebrochure

3 To learn more about the CFSRs, go to https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews

The first round of the CFSRs was completed in 2004 (after the first edition of this manual), and the third round is in progress at the time this manual is being written.

3.1.2 Child Abuse Prevention and Treatment Act (P.L. 93–247)

Despite the long-standing interest of the federal government on the welfare of children, it was not until 1974, when the Child Abuse Prevention and Treatment Act (CAPTA) was signed into law, that a specific federal leadership role related to the protection of children began. CAPTA was established to ensure that victimized children are identified and reported to appropriate authorities. The law (Myers, 2011b):

- Provides minimum standards for definitions and reports of child maltreatment
- Authorizes federal funds to improve the state response to physical abuse, neglect, and sexual abuse
- Focuses attention on improved investigation and reporting
- Provides funds for training, regional multidisciplinary centers focused on child abuse and neglect, demonstration projects, and research

The scope of CAPTA has been expanded and reauthorized numerous times since it was enacted. Certain provisions of the act were amended recently by the Justice for Victims of Trafficking Act of 2015 (P.L. 114–22) and the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114–198).[4]

Appendix E details the provisions of CAPTA. Additionally, a copy of CAPTA, as amended, can be retrieved from the Children's Bureau web site at https://www.acf.hhs.gov/sites/default/files/cb/capta2016.pdf

4 See https://www.childwelfare.gov/pubPDFs/about.pdf.

3.1.3 Indian Child Welfare Act of 1978 (P.L. 95–608)

The Indian Child Welfare Act (ICWA) governs intervention by non-Indian authorities in the custody of Indian children. Its purpose is "... to protect the best interest of Indian children and to promote the stability and security of Indian tribes and families by the establishment of minimum federal standards for the removal of Indian children and placement of such children in homes which will reflect the unique values of Indian culture ... ." (25 U.S.C. §1902). ICWA provides guidance to states regarding the handling of child maltreatment and adoption cases involving American Indian and Alaska Native (AI/AN) children and sets minimum standards for the handling of these cases (U.S. Department of the Interior, Bureau of Indian Affairs, n.d.).

When a child is brought into custody, or when a case is assigned, the caseworker must determine in each case if the child is or may be a member of a tribe. If there may be AI/AN heritage but the tribal affiliation is not known, a Notice of Involuntary Child Custody Proceeding Involving and Indian Child should be sent to the Bureau of Indian Affairs (BIA). This alone does not fulfill ICWA notice requirements. Once the tribal affiliation is known, notification to the tribe should be sent whenever a dependency proceeding commences.

It is important to understand that improper, inadequate, or poorly documented ICWA inquiry and notice can lead to reversals in cases and/or undermine the permanency needs of children. The BIA provides guidelines for implementing ICWA at https://www.bia.gov/sites/bia.gov/files/assets/bia/ois/pdf/idc2-056831.pdf.

3.1.4 Additional Recent and Selected Federal Legislation Relevant to Child Protection

Besides CAPTA, other federal legislation serves to provide guidance to state, tribal, and local authorities related to the prevention and treatment of child abuse and neglect. A snapshot of key federal legislation is provided in **exhibit 3.2.** The Children's Bureau also issues program and policy guidance on legislation at https://www.acf.hhs.gov/cb/laws-policies/policy-program-issuances.

Exhibit 3.2 Additional Recent and Selected Federal Legislation Relevant to Child Protection
(Child Welfare Information Gateway, 2016a)

Legislation	Brief Summary of Purpose
P.L. 96–272 Adoption Assistance and Child Welfare Act of 1980	Establishes a program of adoption assistance; strengthens the program of foster care assistance for needy and dependent children; and improve the child welfare, social services, and Aid to Families With Dependent Children programs (now called Temporary Assistance for Needy Families).
P.L. 103–382 Multi-Ethnic Placement Act of 1994	Prohibits states from delaying or denying adoption and foster care placements on the basis of race or ethnicity.
P.L. 105–89 Adoption and Safe Families Act of 1997	Promotes the adoption of children in foster care; reauthorizes the Family Preservation and Support Services Program and renames it the Safe and Stable Families Program; extends categories of services to include time-limited reunification services and adoption promotion and support services; and ensures safety for abused and neglected children by requiring a new emphasis on the safety of the child at the federal and state levels.
P.L. 106–177 Child Abuse Prevention and Enforcement Act of 2000	Reduces the incidence of child abuse and neglect; authorizes states' use of federal law enforcement funds to improve the criminal justice system in order to provide timely, accurate, and complete criminal history record information to child welfare agencies, organizations, and programs engaged in the assessment of activities related to the protection of children, including protection against child sexual abuse, and the placement of children in foster care.
P.L. 107–133 Promoting Safe and Stable Families (PSSF) Amendments of 2001	Extends and amends the PSSF program, provides new authority to support programs for mentoring children of incarcerated parents, and amends the Foster Care Independent Living program under Title IV-E to provide for education and training vouchers for youth aging out of foster care.
P.L. 109–288 Child and Family Services Improvement Act of 2006	Amends part B of Title IV to reauthorize the PSSF program and for other purposes; authorizes grants for regional partnership/substance use disorder grants; specifies funds for states to support caseworker visits with children in foster care.

Legislation	Brief Summary of Purpose
P.L. 109–248 Adam Walsh Child Protection and Safety Act of 2006	Protects children from sexual exploitation and violent crime; prevents child abuse and child pornography, with an emphasis on comprehensive strategies across federal, state, tribal, and local communities to prevent sex offenders' access to children and to promote internet safety; and honors the memory of Adam Walsh and other child crime victims.
P.L. 110–351 Fostering Connections to Success and Increasing Adoptions Act of 2008	Amends parts B and E of Title IV to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access to title IV-E funds, improve incentives for adoption, and for other purposes.
P.L. 112–34 Child and Family Services Improvement and Innovation Act of 2011	Amends part B of Title IV of the SSA to extend the Child and Family Services Program and for other purposes, including requiring that each state plan for oversight and coordination of health care services for any child in foster care (to include monitoring and treatment of emotional trauma associated with a child's maltreatment).
P.L. 113–183 Preventing Sex Trafficking and Strengthening Families Act of 2014	Amends the SSA with provisions to prevent and address sex trafficking of children in foster care, develop a reasonable and prudent parent standard to allow a child in foster care to participate in age-appropriate activities, extend and improve adoption incentives, and for other purposes.
P.L. 114–22 Justice for Victims of Trafficking Act of 2015	Provides justice for the victims of trafficking through grants to states for child abuse investigation and prosecution programs, services for victims of child pornography, and domestic child human trafficking deterrence programs; authorizes specialized training programs for law enforcement officers, first responders, health care and child welfare officials, juvenile justice personnel, prosecutors, and judicial personnel to identify victims and acts of child human trafficking and to facilitate the rescue of victims.
P. L. 114–198 Comprehensive Addiction and Recovery Act of 2016 (CARA)	Helps states address the effects of substance use disorders on infants, children, and families; requires the HHS Secretary to maintain and disseminate information about the CAPTA state plan and the best practices related to safe-care plans for infants born and identified as being affected by substance use disorder, withdrawal symptoms, or fetal alcohol spectrum disorder.

3.2 Basis for State and Tribal Intervention

To receive CAPTA funds, states must comply with CAPTA's minimum definitions of child abuse and neglect. However, in general states have flexibility in how to respond and what services to provide. All states have enacted child maltreatment laws, which play a significant role in reporting and intervening in cases of child abuse and neglect. To enforce these laws, civil courts sometimes must intervene in the lives of families when parents are unable or unwilling to provide for the safety and well-being of their children. Additionally, the criminal justice system may be involved when parents commit acts or egregious omissions that constitute crimes.

3.2.1 State Reporting Statutes

The parent-child legal relationship is defined in state statutes. These statutes (1) define who is considered a "parent" (birth or adoptive parent) or other caregiver, and (2) indicate that the law imposes rights, privileges, duties, and obligations on this relationship. The states' intervention into family life is often triggered by a report of child maltreatment by a voluntary or mandated reporter, as defined by state law under the CAPTA requirements.

Through mandated reporting statutes, the state requires certain individuals to make a report of suspected child abuse or neglect when they suspect child maltreatment. Termed "mandated reporters," individuals are often defined by profession (e.g., health care and education), and laws usually carry penalties for these professionals if they suspect child abuse or neglect but fail to make a report. State reporting statutes also define the acts or omissions considered abuse or neglect in each state. Reports of suspected maltreatment, as required under such laws, activate the child protection process. While they may differ from jurisdiction to jurisdiction, all states, tribes, and U.S. territories have enacted statues requiring that the maltreatment of children be reported to a designated agency or official. The statutes provide the definitions and state/tribal policies and procedures that guide the conditions for intervention.

Many states and territories also have enacted Infant Safe Haven laws to provide safe places for parents to relinquish newborn infants. Typically, these laws address authorization for certain entities (e.g., hospitals, fire stations, law enforcement) to receive the infant, immunity for those designated providers, legal protection from prosecution for the parents, and the impact on parental rights. The provider is then required to notify the local child welfare department that an infant has been relinquished. Summaries of laws in each state and territory related to these issues can be found at https://www.childwelfare.gov/pubPDFs/safehaven.pdf.

The Child Welfare Information Gateway, supported by the Children's Bureau, maintains information about all state laws in its *State Statutes Series* at https://www.childwelfare.gov/topics/systemwide/laws-policies/permanency/ and https://www.childwelfare.gov/topics/systemwide/laws-policies/state/.

For those specifically on mandatory reporting, see https://www.childwelfare.gov/topics/systemwide/laws-policies/can/reporting/.

3.2.2 Civil Court Intervention

Family, juvenile, and tribal courts have the authority to make decisions about what happens to a child after he or she has been identified as needing the court's protection. CPS initiates the courts' involvement by the filing of a petition containing the allegations of abuse or neglect. The primary purpose of these courts is to protect the child and to otherwise intervene in the lives of families in a manner that promotes the best interest of the child and his or her safety. The court is responsible for making the final determination about whether a child should to be removed from the home, where a child is to be placed, or if parental rights are to be terminated.

Most families involved with CPS do not need to be referred to court. However, court intervention is needed when maltreatment is serious, it is unsafe to leave the maltreated child in the home, or when children are at risk because their parents are unable or unwilling to cooperate with voluntary intervention (Myers, 2011a). Judges and attorneys must fully understand how to arrive at appropriate child safety decisions and to recognize the importance of targeting and tailoring safety services to the unique circumstances of each child and family (Roe Lund & Renne, 2009).

> Juvenile and family court judges receive specialized training and technical assistance through the National Council of Juvenile and Family Court Judges (http://www.ncjfcj.org/our-work). Judges and other legal staff also receive specialized training from the American Bar Association's Center on Children and the Law (https://www.americanbar.org/groups/child_law.html). The user manual, *Working With the Courts in Child Protection*, is available at https://www.childwelfare.gov/pubs/usermanuals/courts/.

3.3 Child Maltreatment Definitions

To prevent or respond to child abuse and neglect effectively, there needs to be a common understanding of the definitions of those actions and omissions that constitute child maltreatment. CAPTA (described earlier) provides minimum standards for defining maltreatment that states must incorporate in statutory definitions to receive federal CAPTA funds. Under CAPTA, child abuse and neglect means, 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 (HHS, ACF, Children's Bureau, n.d.-b).

State and tribal child abuse reporting laws identify the types of behaviors or omissions and their consequences that are reportable in each jurisdiction. There are four common types of maltreatment:

- Physical abuse
- Sexual abuse
- Psychological or emotional maltreatment
- Neglect

While CAPTA provides definitions for sexual abuse and the special cases related to withholding or failing to provide medically indicated treatment, it does not provide specific definitions for the other types of maltreatment. The next sections provide general definitions, and **exhibit 5.2** in chapter 5 details numerous possible signs of child abuse and neglect.

3.3.1 Child Physical Abuse

Physical abuse is usually defined as an inflicted (versus accidental) act that results in a significant physical injury or the risk of such injury. It can include striking, kicking, burning, or biting the child, or any action that results in a physical impairment of the child (Child Welfare Information Gateway, 2016b).

3.3.2 Child Sexual Abuse

Sexual abuse involves any sexual activity with a child below the legal age of consent, which varies by state, but typically ranges from 14 to 18 years of age (Berliner, 2011). CAPTA defines sexual abuse as (HHS, ACF, Children's Bureau, n.d.-b):

- [T]he employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct
- [T]he rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children

In response to increased awareness of the sex trafficking of minors in the United States, the Justice for Victims of Trafficking Act of 2015 amended the federal definition of child abuse by adding the following special rule (Child Welfare Information Gateway, 2016b; HHS, ACF, Children's Bureau, n.d.-b):

- A child shall be considered a victim of "child abuse and neglect" and of "sexual abuse" if the child is identified, by a state or local agency employee of the state or locality involved, as being a victim of sex trafficking (as defined in §103(10) of the Trafficking Victims Protection Act of 2000 [22 U.S.C. §7102]) or a victim of severe forms of trafficking in persons (described in §103(9)(A)).

3.3.3 Psychological or Emotional Maltreatment

Psychological or emotional maltreatment consists of psychological abuse or neglect, which can occur by itself or in association with physical abuse, sexual abuse, or neglect (Hart et al., 2011). Specific types of this type of maltreatment include (Hart & Brassard, 1991, 2001):

- **Spurning:** verbal and nonverbal caregiver acts that reject and degrade a child
- **Terrorizing:** caregiver behavior that threatens or is likely to physically hurt, kill, abandon, or place the child or child's loved ones/objects in recognizably dangerous situations
- **Isolating:** caregiver acts that consistently deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home
- **Exploiting/corrupting:** caregiver acts that encourage the child to develop inappropriate behaviors (e.g., self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors)
- **Denying emotional responsiveness:** caregiver acts that ignore the child's attempts and needs to interact (e.g., failing to express affection, caring, and love for the child) and showing no emotion in interactions with the child

3.3.4 Neglect

Child neglect, the most common form of child maltreatment (HHS, ACF, Children's Bureau, 2017), is frequently defined as the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child's health, safety, and well-being are threatened with harm (Child Welfare Information Gateway, 2016b). Some of these needs have also been classified under the definition of psychological maltreatment (above).

In addition to physical neglect, there is mental health, medical, and educational neglect. These are caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical, and educational problems or needs for the child (Hart & Brassard, 1991, 2001).

CAPTA defines medical neglect as the "withholding of medically indicated treatment" as (U.S. HHS, ACF, Children's Bureau, n.d.-b):

> "[T]he failure to respond to the infant's life-threatening conditions by providing treatment…which, in the treating physician's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions."

The term "withholding of medically indicated treatment" does not include the failure to provide treatment (other than appropriate nutrition, hydration, and medication) to an infant when, in the treating physician's reasonable medical judgment:

> A. The infant is chronically and irreversibly comatose;
> B. The provision of such treatment would:
> > i. merely prolong dying;
> > ii. not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or
> > iii. otherwise be futile in terms of the survival of the infant;
>
> C. The provision of such treatment would be virtually futile in terms of the survival of the infant, and the treatment itself under such circumstances would be inhumane.

This chapter provided the legal context and policies that guide the CPS process and definitions of child abuse and neglect. Before examining the first stage in the CPS process (chapter 5), the next chapter discusses how to navigate all the stages successfully through engaging and working with families and children.

Chapter Highlights

- The basis for the government's intervention in child maltreatment is grounded in the concept of parens patriae, a legal term that asserts that government has a role in protecting the interests of children and intervening when parents fail to provide prober care.
- The Children's Bureau was established in 1912, and the Office on Child Abuse and Neglect within the Children's Bureau is charged with leading the federal role related to preventing and responding to child maltreatment.
- The intent of the Child Abuse Prevention and Treatment Act (CAPTA), enacted in 1974, was to improve the state response to child maltreatment and to improve reporting and investigation of child maltreatment.
- CAPTA has been reauthorized and amended on numerous occasions, with the most recent reauthorization occurring in 2010 and amendment in 2016.
- Numerous other federal laws focus on child abuse and neglect and address how state and tribal child welfare systems should intervene to prevent and respond to child maltreatment.
- When a child is brought into custody or when a case is assigned, the caseworker must determine in each case if the child is or may be a member of a tribe. Once the tribal affiliation is known, the tribe must be notified.

- The primary basis for state intervention stems from state reporting statutes, which issue mandates to report based on definitions of child abuse and neglect that are partially developed by standards set forth in CAPTA.
- CPS agencies rely on courts to protect children when voluntary intervention is insufficient to keep children safe.
- There are four types of child maltreatment: physical abuse, sexual abuse, neglect, and psychological or emotional maltreatment.

Chapter 4: Engaging and Working With Children and Families

The prior chapters provided the context for the CPS process, the definitions of child abuse and neglect, and CPS's legal authority. The next chapters lay out the stages of the CPS process. This chapter discusses how engaging families and children is integral to that process. To engage families effectively and to complete each stage successfully, interpersonal helping skills are key. Recognizing the diversity and differences of each family, and doing so with cultural sensitivity, is a key component of those skills. This chapter:

- Begins with a discussion of culture, disproportionality, and disparity in child welfare
- Emphasizes the importance of striving to implement culturally competent practice
- Describes the core conditions of helping relationships: respect, empathy, genuineness, self-responsibility, and bias toward action as a solution-focused activity
- Reviews skills for building rapport and engaging all family members
- Discusses the use of authority in CPS

4.1 Engaging Diversity and Difference With Cultural Sensitivity

While the skills in this chapter focus on engaging and working with all children and families involved in child welfare, additional attention has been placed on recognizing the culture of each family because many are of various racial, religious, sexual orientation, and ethnic backgrounds. Listed below are several important definitions for guiding this discussion:

- **Culture** "is a learned worldview or paradigm shared by a population or group and transmitted socially that influences values, beliefs, customs, and behaviors and is reflected in the language, dress, food, materials, and social institutions of a group" (Burchum, 2012, p. 7).
- **Cultural sensitivity** is "the ability to recognize, understand, and react appropriately to behaviors of persons who belong to a cultural or ethnic group that differs substantially from one's own" (Cournoyer, 2017, p. 214).
- **Cultural competence** (also known as cultural responsiveness) "is the awareness, knowledge, understanding, sensitivity, and skill needed to conduct and complete professional activities effectively with people of diverse cultural backgrounds and ethnic affiliations" (Cournoyer, 2017, p.214).

However, cultural competence is "never ending and ever expanding" (Burchum, 2012, p.14) and is a journey that develops with each new person one meets.

- **Cultural humility** is the humble and respectful attitude toward those of other cultures, which pushes one to challenge his or her own cultural biases, realize that he or she cannot possibly know everything about other cultures, and approach learning about other cultures as a goal and a process. This enables a system, agency, or provider to work effectively in cross-cultural situations with awareness of and respect for the diverse experiences, customs, and preferences of individuals and groups (Gonzalez, 2018, para.4, California Department of Social Services & California Department of Health Care Services, n.d., p. 2).
- **Disproportionality** refers to the under- or overrepresentation of families of color out of proportion to their representation in the general population of the United States. Its causes are complex and may reflect bias or other conditions beyond the stated facts or circumstances (California Department of Social Services & California Department of Health Care Services, n.d., p. 2).
- **Inclusive cultural empathy** involves accepting and valuing those who belong to different cultural groups, learning about others' cultures, and engaging others in ways that convey respect for their cultural affiliations (Pedersen, Crethar, & Carlson, 2008).

With increasing racial and ethnic diversity in our nation (Jones & Bullock, 2012), it is important to approach all families that come to the attention of child welfare with openness and cultural humility. Research has established that children and families of color are disproportionally represented in the child welfare system, starting with referrals alleging child maltreatment. In some jurisdictions, data indicate continued disproportionality in other parts of the CPS process as well (e.g., investigations, placement decisions) (McCarthy, 2011). Research has further confirmed that children of color have experienced disparity in the child welfare system, i.e., they have experienced unequal treatment and outcomes compared to their white counterparts (Hill, 2006). The research of over more than 10 years highlights the complexity of this situation (Fluke, Jones Harden, Jenkins, & Ruehrdanz, 2010) and why caseworkers need to develop the skills to engage diversity and differences with cultural sensitivity.[1]

Working with American Indian/ Alaska Native (AI/AN) Families (U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Tribal Youth Training and Technical Assistance Center, 2017, para.5).

When working with AI/AN families, it is important for caseworkers to be aware of the various kinds of trauma that have affected Indian Country and to be culturally sensitive to their impact:

- **Cultural trauma** is an attack on the fabric of a society that affects the essence of the community and its members.
- **Historical trauma** is a cumulative exposure of traumatic events that affect an individual and continues to affect subsequent generations.
- **Intergenerational trauma** occurs when trauma is not resolved, subsequently is internalized, and is passed from one generation to the next.

Chapter 9 addresses trauma in more detail.

1 For resources on the complexity of this issue and how child welfare systems are addressing it, go to The Alliance for Racial Equity in Child Welfare web site at: https://www.cssp.org/reform/child-welfare/alliance-for-race-equity

The diversity of children and families illustrates the cultural richness of the world. Caseworkers have a responsibility to recognize and value the diversity of the families they serve and to understand cultural competency as a process rather than an end product (Walters & Asbill, 2013). This chapter examines how these concepts specifically apply to casework. The next section reviews some of the other essential ingredients for all helping relationships.

4.2 Core Conditions of Helping Relationships

Developing a "helping relationship" with the family is critical to facilitating change in the conditions or patterns of behavior that contribute to the risk of maltreatment and of lack of safety of the child. Experience demonstrates that successful intervention and treatment depend heavily on the quality of the caseworker's relationship with the family (van Zyl, Barbee, Cunningham, Antle, Christensen, & Boamah, 2014).

Developing helping alliances with families experiencing or at risk for child maltreatment is challenging. Families may have a history of difficulties in forming and sustaining mutually supportive, interpersonal relationships and may not have had positive relationships with formal systems (DePanfilis, 2000a). They may initially distrust CPS based on negative community perceptions of CPS involvement. Whether one's role is interviewing family members as part of the initial assessment/investigation (chapter 6) or determining what must change to reduce the risk of maltreatment and to determine outcomes for risk reduction (chapter 7), the quality of the caseworker's work is directly dependent on his or her ability to develop a collaborative relationship with the family (DePanfilis, 2000a).

This relationship begins with the very first contact with the family and continues to develop with ongoing caseworker and family interaction. By definition, relationships have a strong emotional component. Good relationships do not just happen; they must be built. The caseworker-family relationship does not result from a caseworker's charismatic personality or a mystical connection between people. Instead, it is a product of (1) the caseworker's commitment to helping the child and family, (2) his or her ability to relate effectively to them on an interpersonal level, and (3) the family's willingness to be open and risk "relating" to the caseworker. Obviously, caseworkers cannot control the family's behavior, but they can control their own. Caseworkers' behavior toward families can significantly increase the chances that a positive relationship will develop. The following classic quotation illustrates the importance of the relationship with families involuntarily involved with child welfare:

> *The relationship between the caseworker and client provides the foundation for all interactions and intervention. The more positive the relationship between the caseworker and the client, the more likely the client is to disclose and explore difficult and personal problems, as well as listen to and act on change efforts or advice offered by the caseworker* (Ivanoff, Blythe, & Tripodi, 1994, p. 19).

Rogers (1957) initially introduced three core conditions, which are essential to the helping relationship: empathy, respect, and genuineness. Numerous others have integrated these conditions with other key features of effective, helping alliances. For example, Egan (2006) suggests that:

- Respect is the foundation value
- Empathy is the value that orients helpers in their dialogues with families

- Genuineness is the “what you see is what you get” professional value
- Self-responsibility is at the heart of family empowerment and energizes the entire helping process
- A bias toward action is the value that underscores the centrality of constructive change in lives of clients

Other qualities demonstrated to influence the effectiveness of helpers are personal warmth, acceptance, affirmation, sincerity, and encouragement (Duncan, Miller, Wampold, & Hubble, 2010). A caseworker’s ability to communicate and model core conditions and values opens the door to building a relationship with children and families that is characterized by cooperation. The goal is to develop cooperative working relationships in which the family’s increased sense of trust, security, and safety (along with decreased tension, threat, and anxiety) leads to honest conversations about its life and circumstances, and, eventually, to acceptance of the need to change those circumstances that threaten the safety of the children. In a sense, this is going back to the basics of good social work practice. Brief summaries about how these qualities influence the helping relationship and the process of working with children and families follow.

4.2.1 Respect

Respect refers to the caseworker’s communication of acceptance, caring, and concern for the child and family. It involves valuing the individual family members as people, separate from any evaluation of their behavior or thoughts. All human beings need to feel accepted and respected; it is especially important for abused and neglected children and their families to feel accepted and respected by their caseworker. This helps lead to a balanced assessment, which views families beyond the reasons they enter the child welfare system and focuses also on their demonstrated strengths and protective capacities. If respect is to make a difference, it cannot remain just an attitude—it must be communicated by approaching family members with a true interest in getting to know them and their circumstances.

4.2.2 Empathy

Empathy is the ability to perceive and communicate with sensitivity the feelings and experiences of another person by being an active responder rather than a passive listener. It is a process of attempting to experience another person’s world and then communicating an understanding of, and compassion for, the other’s experience. Accurate empathy involves skillful, reflective listening, which amplifies the family’s own experience and meaning without imposing one’s own interpretation of a client’s situation (Miller & Rollnick, 2012). As described earlier, cultural empathy involves accepting and valuing those who belong to different cultural groups.

Empathy builds trust and openness and helps to establish rapport between the children and family and the caseworker. Caseworkers can demonstrate empathy by:

- Paying attention to verbal and nonverbal cues
- Using reflective listening (i.e., listening and then summarizing what is heard) to communicate an understanding of the children and family’s message and feelings
- Showing a desire to understand from the client’s point of view
- Listening more than talking

4.2.3 Genuineness

Genuineness refers to caseworkers being themselves. This means simply that caseworkers are congruent in what they say and do, nondefensive, and spontaneous. They must have a clear knowledge and acceptance of the agency's authority, procedures, and policies and of the professional role both in its meaning to the caseworker and its meaning to clients. Genuineness means integrating who one is and one's role in the agency with acceptance of families and commitment to their welfare. When this occurs, what caseworkers say is then congruent with their agency's values and principles.

Genuineness does not mean articulating all of one's thoughts with families. In fact, this could be harmful both to the families and to the caseworker-family relationship. For example, if a caseworker is feeling shock, horror, or anger over what a parent "did to the child," expressing these feelings to the parent would not be a productive exchange. This would likely alienate parents or cause them to be angry, defensive, or resistant. Rather, caseworkers need to be aware of their feelings and, at the same time, respond to the family in a professional, respectful manner that opens, rather than closes, communication. However, even in the respectful sharing of information, the caseworker is responsible for sharing the agency's concerns related to child maltreatment.

Genuineness contributes to the helping relationship by reducing the emotional distance between the caseworker and family and by helping the family to identify with the caseworker as fellow human being. Caseworkers can demonstrate genuineness by:

- Being aware of diversity "blind spots" and taking special care to be sensitive to differences, as well as asking questions rather than making assumptions
- Being themselves and not taking on a role or acting contrary to how they believe or feel
- Making sure that their nonverbal and verbal responses match
- Demonstrating being "present" by using nonverbal behaviors, such as eye contact (though this may be a sign of disrespect in some cultures), smiles, sitting forward in the chair, and turning cell phones to mute
- Avoiding defensiveness
- Providing a transparent overview about the CPS process, which includes a clear explanation of the allegations that resulted in the family's involvement with child welfare

4.2.4 Self-Responsibility

This value conveys the attitude that family members own the responsibility and have the potential for change. Therefore, the caseworker's role is to empower individuals to identify, develop, and use resources that will support strengthening factors that will increase safety of the children (Egan, 2006). It also is the caseworker's responsibility to identify and leverage resources to support the family.

To fully embrace this approach, caseworkers need to begin with the premise that families can change if they choose. This also requires avoiding seeing families as victims and, instead, to help them discover the strengths, protective capacities, formal and informal supports, and resources that can be used to resolve the child protection concerns.

For families to own the change process, caseworkers must engage them in order to help them understand the choices they have and to help them interpret, on their own, the consequences if they choose not to change.

Another way to shift the ownership of the change process is to support family members by breaking actions into small steps to increase the likelihood that change will be possible. Another important ingredient, discussed in more detail in chapter 8, is to promote willingness, confidence, and capacity. Child protection casework should "generate plans on which families can act" (Turnell & Edwards, 1999, p.79).

4.2.5 A Bias Toward Action as a Solution-Focused Value

This core condition relates to an empowerment-based perspective: When families are supported to become effective agents in both the helping process and their daily lives, they build the capacity to manage future problems even when caseworkers are no longer in their lives. The caseworker's job is to help families see the difference between discretionary and nondiscretionary change (Egan, 2006), especially when the court is involved. While they may not have a choice to work with caseworkers, families do, however, have a choice in how they work with them.

4.3 Building Rapport and Engaging Families

The core conditions discussed earlier are prerequisites before attempting to engage families as partners. Engaging families at all stages of the CPS process begins with first developing rapport or connections with family members in a way that helps them focus on the changes needed to help keep their children safe. **Exhibit 4.1** provides examples of techniques for developing rapport.

Exhibit 4.1 Techniques for Building Rapport
(Berg & Kelly, 2000)

- Approach the family with an open mind.
- Find out what is important to the family. For example, do not press the issue of staying sober as the priority if that is not important to the family, but do explain that staying sober will speed up a court's decision to return their children to them if the children are placed out of the home.
- Use mirroring. Take note of words the family uses and try to incorporate them when talking.
- Listen to the family's explanation of the situation without correcting or arguing (i.e., elicit its point of view of concerns and desire for assistance and convey an understanding of that view).
- Ask what the family's goals are.
- Ask open-ended (i.e., not answered by yes or no) questions rather than issuing threats or commands.
- Clarify expectations and purposes. Clearly explain the CPS process and the caseworker's role in working with the family toward solutions.
- Give the family a sense of control (e.g., involve the family in scheduling appointments, ask families how they would like to be addressed, include them in planning, etc.).
- Clarify commitment and obligations. When families and caseworkers agree on the time, place, and purpose of contacts, each person is able depend on the predictability of the other's behavior, attitude, and involvement.
- Acknowledge difficult feelings and encourage open and honest discussion of feelings.
- Be consistent and persistent, and follow through.
- Promote participatory decision-making for meeting needs and solving problems.

It should be noted that these are only some key techniques for building rapport. There are many other methods that will help build rapport with family members and lead to family engagement. Strategies that work with one family may not work with another. The caseworker should consult with his or her supervisor when experiencing challenges in engaging a family and should explore training opportunities offered by the agency.

4.3.1 Meaningful Family Engagement

"Family engagement is a family-centered, strength-based approach to establishing and maintaining relationships with families and accomplishing change together" (Child Welfare Information Gateway, 2017, p. 3; McCarthy, 2012). Meaningful family engagement means seeing families as essential resources and partners, not only in their case but also throughout the child welfare system (Bossard, Braxton, & Conway, 2014). Although there have been marked improvements, engaging families remains a challenge in public child welfare agencies, particularly with certain groups who are likely to be experiencing additional adversities (e.g., fathers, incarcerated parents, substance-affected families). The complexity of family circumstances, in particular the emotions of anger, guilt, shame, and trauma that often accompany a family's experience and perceptions of child welfare involvement, can greatly impede efforts toward engagement (Gopalan et al., 2011).

Much of what has been written in this chapter sets the stage for successful family engagement. Remembering the importance of culture, particularly considering how accepting professional help might be perceived, is important. The core conditions for helping relationships and the strategies for building rapport all lead to opportunities for truly empowering families to consider the possibility that a partnership with the caseworker will be possible. **Exhibit 4.2** lists practice strategies adapted from a synthesis of family engagement literature.

Exhibit 4.2 Practice Strategies for Family Engagement (Child Welfare Information Gateway, 2017)

- "Tune-in" to the likely experiences, emotions, and circumstances of family members, even before meeting them. Using preparatory empathy goes a long way in approaching the first contact.
- Honor the cultural, racial, ethnic, religious, and spiritual backgrounds of children, youth, and families and respect differences in sexual orientation.
- Support family members to understand the reasons for agency involvement, incorporating their view into all assessments.
- Be consistent, reliable, respectful, and honest with families.
- Support and value families.
- Ensure constant two-way communication and collaboration with family members.
- Value and validate the participatory role of families in planning and making decisions for themselves and their children.
- Provide timely resources, services, and interventions that are relevant and helpful.
- Invite and encourage families to participate in meetings and conferences where planning for their children's needs takes place.
- Consider the benefit of parent-partners to support the engagement process.

4.3.2 Engaging Fathers

Traditionally, caseworkers have focused on working with mothers and children, whether fathers are present in the household or living in a different home (sometimes referred to as "nonresident" fathers). However, successful family engagement, and the strategies outlined in this chapter, apply to all parental figures.

Children with absent or uninvolved fathers are at higher risk for a number of adverse outcomes, including substance use disorder and failure to complete high school (Coakley, 2013). Conversely, although the reasons are unclear, more than one study has found that fathers' involvement positively affects child outcomes for children in foster care, including a higher likelihood of children being reunified with their mother (D'Andrade, 2017; Malm & Zielewski, 2009; Coakley, 2008).

These findings demonstrate the value of investing time in early outreach and ongoing engagement of fathers. In working with families caseworkers should remember that, like mothers, fathers, whether resident or nonresident:

- May be experiencing challenges that affect their parenting and could improve with supportive services; this may include issues that present safety concerns to the mother, child, or both, that must be factored into planning for safety
- May have had negative experiences with government systems that make them wary of caseworkers
- Are important sources of financial, moral, emotional, and behavioral support for their children
- Have extended family members who often are another source of support for children

Resources on the Role of and Engaging Fathers

National Responsible Fatherhood Clearinghouse at www.fatherhood.gov

National Fatherhood Initiative at www.fatherhood.org

National Institute on Fatherhood and Domestic Violence (an initiative of Futures Without Violence) at https://www.futureswithoutviolence.org/organizational-leadership-training/national-institute-on-fatherhood-domestic-violence/

Child Welfare Information Gateway at https://www.childwelfare.gov/topics/preventing/promoting/fatherhood/ and https://www.childwelfare.gov/topics/famcentered/engaging/fathers/

National Center for Child Welfare Excellence – Fatherhood [hyperlinked resources] http://www.nccwe.org/BPR/hot-topics/Fatherhood.html

What About the Dads? Child Welfare Agencies' Efforts to Identify, Locate, and Involve Nonresident Fathers - Research Summary at https://aspe.hhs.gov/what-about-dads-child-welfare-agencies%E2%80%99-efforts-identify-locate-and-involve-nonresident-fathers-research-summary

4.4 Use of Authority in Child Protective Services

CPS is an expression of a community's concern for the welfare of a segment of its citizens. CPS services are provided because the community recognizes that children have rights and that parents have obligations and responsibilities. The authority to provide these services is vested in the CPS agency and staff through laws and policies, and competent CPS practice involves using this authority effectively and judiciously. The use of CPS authority has special relevance at the initial assessment/investigation stage of the casework process (chapter 6) but is applicable at all other stages as well. In fact, effective use of authority is an essential ingredient in establishing helping relationships with all involuntary clients.

Authority, whatever its source, can impede or enable the development of a trusting relationship between the caseworker and the family. The constructive and positive use of authority provides the child and family with a feeling of confidence that the caseworker not only knows what he or she is doing and is secure in that position but also intends the best for the child, parents, family and society (Anderson, 1988).

4.4.1 Managing Ambivalence and Resistance

A family's involvement with child welfare is often involuntarily, i.e., they receive services but do not actively seek them. Typically, they may be thought to be resistant, but often it is their ambivalence. (Resistance refers to behaviors that interfere with making progress toward desired changes, and ambivalence is a subset of resistance where there are movements both toward and away from change [Engle & Arkowitz, 2006].) **Exhibit 4.3** provides some general guidelines for engaging involuntary families.

Exhibit 4.3 Guidelines for Engaging Involuntary Families (Ivanoff, Blythe, & Tripodi, 1994; Rooney, 2000)

- Be clear, honest, and direct while maintaining a nondefensive stance.
- Acknowledge the involuntary nature of the arrangement and explain the CPS process, i.e., what the caseworker does, what the family does, timeframes, etc.
- Contact families in a manner that is courteous and respectful, and assess strengths as well as risks.
- Elicit the parents' and children's concerns and wishes for assistance and convey understanding of their viewpoints, including reservations about the CPS involvement.
- Reduce the children and family's opposition to being contacted by clarifying available choices, even when those are constrained, by emphasizing freedoms still available and by avoiding labeling.
- Earn the respect of the children and families (and gain psychological influence) by being a good listener who strives to understand their point of view.
- Establish feasible, small steps to help build in early success in order to recognize family efforts and progress.
- Acknowledge difficult feelings, and encourage open and honest discussion of feelings.
- Reframe the family's situation, with consideration to how certain behaviors impact the safety and well-being of the children. This is particularly useful when the children and family are making arguments that deny a problem or risk; it acknowledges their statements but offers new meaning or interpretation for them.

4.4.2 Using Core Strategies to Explore Ambivalence

Strengths-based engagement is successful when a caseworker strategically approaches family members to listen actively to their view of the reason why CPS is involved. One approach, motivational interviewing, a method to support families that may be ambivalent or hesitant about support from the child welfare system, has been shown to help engage clients and to enhance their motivation to use and complete services (Child Welfare Information Gateway, 2017c; Sterrett, Jones, Zalot & Shook, 2010; Damashek, Doughty, Ware, & Silovsky, 2011). Based on the principles of motivational interviewing (Miller & Rollnick, 2012), there are four core strategies to help guide families to explore their ambivalence and to express reasons for change, particularly in the early stages of meeting family members. An abbreviation for these techniques is OARS (**O**pen-ended questions, **A**ffirmations, **R**eflections, **S**ummary), described below.

Open-ended questions. As described earlier, the primary, initial goal is to develop a connection with family members and to establish an atmosphere of acceptance and trust. This means that children and their parents should do most of the talking, with the caseworker listening carefully and encouraging expression while also providing enough information about CPS and the process. A key technique is to ask good, open-ended questions, such as:

- *What do you know about the reason why I'm here today?*
- *What would you like me to tell you about working with CPS?*
- *What is a typical day like in your family?*
- *What worries you the most about this situation?*
- *What are some ways that you take time out for yourself?*
- *What do you love most about being a parent?*
- *What are some of the challenges you have with being a parent?*

Affirmations. The authentic acknowledgment of strengths goes a long way toward family members hearing that they are cared about as human beings. All families have strengths and recognizing them helps to build confidence and reduce defensiveness. Strengths should be offered naturally and in context, e.g., from a lead-in that connects to something the family member discussed. Once those strengths have been emphasized, they also become a tool in developing the helping relationship, for example:

- *I appreciate how hard it must have been for you to open the door today. You took a big step!*
- *In spite of all of the stresses and strains you have experienced, it's amazing that you have been able to keep the family together through thick and thin! [Followed by an open-ended question, for example: How have you done that?]*
- *I've noticed how your eyes light up when you talk about little Sam. He obviously brings you a lot of joy.*
- *The twins seem like quite a handful; I'm impressed at how patient you are in your response to them.*
- *It's not easy being a parent, but the way you describe how you organize each day is remarkable! [Followed by an open-ended question, for example: How did you come up with this system of yours? Followed by another affirmation: It seems like it really works for your family!]*

Reflections. Actively listening is clearly not a passive action. The crucial element in this process is reflective listening, i.e., how the caseworker responds to what the family says. The hardest part is stopping the temptation to give advice and, instead, to listen to family members consider options for solving the problem themselves. To do this well, it takes practice and should not be artificial. Each caseworker can develop his or her technique

True reflections should use the family's own words. It is also important to think about the tone of the reflections, so they do not become questions. The voice tone of a question goes up at the end, while the tone of reflective-listening statements should usually turn down at the end. For example, instead of "You are angry with your boyfriend for leaving the children alone?", a reflective statement would be "You are angry with your boyfriend for leaving the children alone."

To offer reflective listening, caseworkers need to first train themselves to think reflectively. There is usually more than one possibility of meaning when listening to what others say. In particular, emotion words, such as sad or stressed, have different meanings to different people. To think reflectively means that one hears a statement, one considers what it could mean and then chooses the most likely meaning. It may not be correct, but by offering the reflection, it helps "check out" that the family member's perspective has been understood accurately. Reflections sometimes include the word "you" in them but not always, for example:

- *It sounds like …*
- *So, you feel …*
- *You're wondering …*
- *You're feeling uncomfortable …*
- *You are worried that …*
- *You are afraid the court won't ever return your children.*

Summary. This technique is used throughout a conversation but is often especially used at the end when summarizing what was discussed as a lead-in to what will come next. Summarizing periodically throughout a conversation also helps to show that one has been listening carefully, to confirm meaning, and to open the door to moving on to discuss another issue. Linking summaries can also be helpful to express a family's ambivalence. This could be the beginning of helping family members see possible discrepancies in how they have described certain situations. Examples include:

- *Here's what I've heard so far …*
- *We have covered a lot of ground today. First you said …. And then we talked about how complicated things are with …*
- *Let me see if I understand. From the way you described your day to day, parenting gives you a lot of joy but is also stressful.*

4.5 Culturally Competent CPS Intervention

As suggested at the beginning of this chapter, cultural competency is a process rather than an end product. As Rivera-Rodriguez (2014) writes, "The development of a culturally competent practice in the child welfare system needs to be a proactive decision supported by management and staff at all levels. This is not a skill that will be acquired in a series of monthly workshops but rather an ongoing effort that requires the intentional, continuous expansion of cultural knowledge, skills, and resources" (p.89).

The culturally competent practice model, developed by Lum (1999) and updated by Fong (2001), fits well with the CPS role. It includes four components for the caseworker:

1. **Cultural awareness:** understanding and identification of critical cultural values important to the family members' system and to themselves.
2. **Knowledge acquisition:** understanding of how these cultural values function as strengths in the family's system.

3. **Skill development:** ability to match services that support the identified cultural values and then incorporate them in the appropriate intervention.
4. **Inductive learning:** continued quest to seek solutions, which includes finding culturally relevant interventions instead of forcing a match to intervention frameworks developed for other ethnic groups.

In considering the best process to build cultural competence, it is important to return to the research about racial disproportionality and disparity in the child welfare system cited at the beginning of this chapter. One of the propositions about the factors that contribute to this picture posits that the disproportionate representation of minority children in the child welfare system is a result of differential treatment by race (Fluke et al., 2010). This view suggests that there is racial bias and discrimination both outside the child welfare system (e.g., by those who choose to report or not report suspected instances of the child maltreatment) and within the child welfare system (e.g., CPS staff unconsciously view families and make decisions differently for minority children and families).

With the myriad factors that determine how CPS caseworkers and supervisors make decisions, it would be inappropriate to suggest that bias alone has resulted in disproportionality and disparity in child welfare systems. On the other hand, most CPS staff recognize that there is wide variation in how individuals within systems view the same situations. For example, when referrals come back on the same families a second or third time, one may wonder what went wrong with a previous caseworker's decision-making. Everyone is human and, therefore, should attempt to avoid cognitive bias (i.e., "a systematic error in thinking that affects the decisions and judgments that people make" [Cherry, 2017, p.1]).

Sometimes how an event is remembered may be biased. It is easy to see how when assessing or working with multiple families at a time, a caseworker's memory of what was said or not said during a specific encounter is flawed, especially if documenting the information after numerous other contacts. The following include some tendencies of cognitive bias (to be avoided through the help of peers and supervisors):

- **Ambiguity effect:** to avoid options for which missing information makes the probability seem unknown (Baron, 2007).
- **Anchoring:** to rely too heavily (or anchor) on one piece of information when making decisions. Typically, this is a piece of information gathered very early in the analysis process (Zhang, Lewis, Pellon, & Coleman, 2007).
- **Availability:** to overestimate the likelihood of events with greater "availability" in memory. For example, if one experienced, investigated, or heard about a similar event recently, one is likely to assign similar causes to the current case. This is particularly true for unusual or emotionally charged situations (Schwarz et al., 1991).
- **Bandwagon effect:** to believe things because others believe them (Coleman, 2003).
- **Confirmation bias:** to search for, interpret, focus on, and remember information in a way that confirms one's preconceptions. People are put off by information that makes them feel uncomfortable or insecure about their views and like to categorize (Oswald & Grosjean, 2004).
- **Hindsight bias:** to see past events as predictable at the time the events happened (Pohl, 2004).
- **Outcome bias:** to judge a decision by its eventual outcome instead of based on the quality of the decision at the time it was made (Gino, Moore, & Bazerman, 2009).

The prior chapters provided the legal and definitional context for the CPS process, and this chapter discussed how engaging the families and children is integral to that process. The next chapters now lay out the various stages of the CPS process.

Chapter Highlights

- With increasing racial and ethnic diversity in the United States, caseworkers should continue to strive to approach our culturally diverse clients with openness.
- Cultural competency is a process rather than an end product. Caseworkers should actively work toward building their competency to work with people of diverse cultural backgrounds and ethnic affiliations.
- The primary core conditions for building helping relationships are respect, empathy, and genuineness. Other core conditions include: self-responsibility, a bias toward action, personal warmth, acceptance, affirmation, sincerity, and encouragement.
- Building rapport and making connections with family members is the first step to working toward a helping alliance with family members.
- Meaningful family engagement is a family-centered, strength-based approach to establishing and maintaining relationships with families and accomplishing change together.
- In CPS, the constructive and positive use of authority involves stating one's purpose and function clearly at all times, supporting and challenging clients, and expressing feelings.
- Core strategies for exploring ambivalence include the use of OARS: **O**pen-ended questions, **A**ffirmations, **R**eflections, and **S**ummarizing.
- In the complex, busy practice of CPS, it is very important to avoid cognitive biases, i.e., the systematic errors in thinking that affects the decisions and judgments that people make.

Chapter 5: Reporting and Intake

As detailed in earlier chapters, the Child Abuse Prevention and Treatment Act (CAPTA) is the foundation for much of child welfare. It requires states to develop and to deliver information to improve public awareness and knowledge about the roles and responsibilities of the child protection system, as well as about the nature and basis for reporting suspected incidents of child abuse and neglect. To ensure that community professionals and others working with children and families recognize possible indicators of child maltreatment and the process to report such concerns, CPS agencies provide education on signs of possible child maltreatment, its effects, and legal reporting mandates. In addition, states and tribes implement public awareness campaigns to promote understanding of child maltreatment in the community. This chapter:

- Provides an overview of CPS' role in educating the community about the child protection system and the process of reporting
- Explains mandated reporting
- Outlines the process that states and tribes use to implement the intake process, which is the first stage of the CPS process

Exhibit 2.1 (chapter 2) provides a graphic representation of the stages of the CPS process.

5.1 Community Outreach and Education

To ensure that the public and those working with children and families recognize possible indicators of child maltreatment, CPS agencies routinely provide education on the legal mandates of reporting child abuse and neglect. Many states and tribes also implement public awareness campaigns and conduct other community events to increase understanding of child maltreatment and the role of CPS. **Exhibit 5.2** illustrates topics often included in community education campaigns and web-based resources.

Exhibit 5.2 Community Education

The CPS agency can educate the public and provide information and resources on:

- State definitions of child abuse and neglect
- Recognizing and reporting child abuse and neglect
- Guidance for parents and professionals on the child abuse investigation process
- Health and safety tips for children
- Parenting tips for promoting child well-being
- Community-based support services to reduce parenting stress and to enhance protective factors
- Caring for infants and children (e.g., information about safe sleep for babies, selecting child care providers, how to access housing and other resources)
- Commercial sexual exploitation of children
- Abusive head trauma (i.e., shaken baby syndrome)
- Safe haven/surrender baby sites
- Immigrant/refugee resources
- Impact of child maltreatment and other forms of childhood trauma on well-being
- Programs on mental health, substance use disorder, and domestic violence
- Resources on and for runaway and missing children and on human trafficking
- Programs that serve children and families with diverse cultures and ethnicities, such as those who are Spanish-speaking, American Indian and Alaska Native, LGBTQ,[1] or others

5.2 Reporting Child Abuse and Neglect

As described in chapter 3, all states, tribes, and U.S. territories have child abuse and neglect reporting laws that define child maltreatment and specify who must report a suspicion of it. However, professionals in fields outside of child welfare do not automatically know about these laws, nor do they typically receive extensive training on recognizing signs of child maltreatment.

5.2.1 Recognizing Signs of Abuse or Neglect

It takes professionals and citizens alike to recognize, identify, and report suspected incidents of child maltreatment to CPS. Medical personnel, educators, child care providers, mental health professionals, law enforcement, clergy, and other professionals often are in a position to observe families and children and to identify possible signs of abuse or neglect. Private citizens such as family members, friends, and neighbors also may identify suspected incidents or patterns of child maltreatment.

Because specific definitions of child abuse and neglect vary somewhat state to state, child welfare agencies and workers play a critical role in educating other professionals and the public about their particular state's laws and agency responses. **Exhibit 5.3** outlines the general signs of possible child abuse and neglect. However, it is important to note that not all of these signs necessarily indicate that the child is being maltreated.

1 Lesbian, Gay, Bisexual, Transgender, or Questioning

Exhibit 5.3 Recognizing Signs of Abuse and Neglect (Child Welfare Information Gateway, 2013)

Category	Potential Signs of Abuse or Neglect
Any Form of Abuse Consider the possibility of abuse when the *child*:	• Shows sudden changes in behavior or school performance • Has not received help for physical or medical problems brought to the parents' attention • Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes • Is always watchful, as though preparing for something bad to happen • Lacks adult supervision • Is overly compliant, passive, or withdrawn • Comes to school or other activities early, stays late, and does not want to go home • Is reluctant to be around a particular person • Discloses maltreatment
Consider the possibility of abuse when the *parent* or *other adult caregiver*:	• Denies the existence of or blames the child for the child's problems in school or at home • Asks teachers or other caregivers to use harsh physical discipline if the child misbehavers • Sees the child as entirely bad, worthless, or burdensome • Demands a level of physical or academic performance the child cannot achieve or that is developmentally inappropriate • Looks primarily to the child for care, attention, and satisfaction of the parent's emotional needs (parentification) • Shows little concern for the child
Consider the possibility of abuse when the *parent* or *other adult caregiver and child*:	• Rarely touch or look at each other • Consider their relationship entirely negative • State that they do not like each other • Child is extremely withdrawn or fearful in the parent's presence

Category	Potential Signs of Abuse or Neglect
Physical Abuse Consider the possibility of **physical** abuse when the *child*:	• Has unexplained burns, bites, bruises, broken bones, or black eyes • Has fading bruises or other marks noticeable after an absence from school • Has difficulty walking or sitting • Suddenly refuses to change for gym or wears too much clothing for the weather (e.g., may be hiding bruises) • Seems frightened of the parents and protests or cries when it is time to go home • Shrinks at the approach of adults • Reports injury by a parent or other adult caregiver • Abuses animals or pets
Consider the possibility of **physical** abuse when the *parent or other adult caregiver*:	• Offers conflicting, unconvincing, or no explanation for the child's injury or provides an explanation that inconsistent with the injury • Describes the child as "evil" or in some other very negative way • Uses harsh physical discipline with the child
Neglect Consider the possibility of **neglect** when the *child*:	• Is frequently absent from school • Begs or steals food or money • Lacks needed medical or dental care, immunizations, or glasses • Consistently wears dirty clothing and has poor hygiene (e.g. severe body odor) • Lacks weather-appropriate clothing • Abuses alcohol or other drugs • Is left alone or states there is no one at home to provide care
Consider the possibility of **neglect** when the *parent or other adult caregiver*:	• Appears to be indifferent to the child • Seems apathetic or depressed • Behaves irrationally or in a bizarre manner • Is abusing alcohol or other drugs • Presents with suspicious injuries and avoids providing an explanation • Fails to respond to invitations for school conferences • Leaves the child alone without provision for care

Category	Potential Signs of Abuse or Neglect
Sexual Abuse Consider the possibility of **sexual abuse** when the *child*:	• Has difficulty walking or sitting • Suddenly refuses to change for gym or to participate in physical activities • Reports nightmares or bedwetting • Experiences a sudden change in appetite • Demonstrates bizarre, sophisticated, unusual, or developmentally inappropriate sexual knowledge or behavior • Becomes pregnant or contracts a venereal disease • Runs away • Reports sexual abuse by a parent or another adult • Attaches very quickly to strangers or new adults in their environment • Abuses drugs or alcohol • Starts injuring his or herself, e.g., cutting, eating disorders • Has attempted suicide
Consider the possibility of **sexual abuse** when the *parent or other adult caregiver*:	• Is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex • Is secretive and isolated • Is jealous or controlling with family members
Emotional Abuse Consider the possibility of **psychological or emotional maltreatment** when the *child*:	• Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression • Exhibits either inappropriate, adult-like (e.g., parenting other children) or infantile (e.g., frequently rocking or head-banging) behaviors • Is delayed in physical or emotional development • Has attempted suicide
Consider the possibility of **psychological or emotional maltreatment** when the *parent or other adult caregiver*:	• Constantly blames, belittles, or berates the child • Is unconcerned about the child and refuses to consider offers of help for the child's problems • Overtly rejects the child

5.2.2 Reporting Child Abuse or Neglect[2]

While state reporting laws vary, they may:

- Specify selected individuals mandated to report suspected child maltreatment
- Define child abuse and neglect
- Explain how, when, and to whom reports are to be filed and the information to be contained in the report
- Describe the agencies designated to receive and investigate reports
- Explain when certain privileged communication rights (e.g., doctor-patient) can be abrogated or revoked
- Provide immunity from legal liability for good faith reporting
- Stipulate penalties for failure to report and false reporting

How and When Reporters Must Report

The majority of states and tribes require that reports of child maltreatment be made orally, i.e., by telephone or in person, to the specified authorities. Most states employ a statewide, toll-free (at least for in-state callers) hotline number for reporting child abuse or neglect, with only 10 states instructing reporters to call their local (county, district, or tribal) office. Several states employ an online portal to receive reports but may have requirements about when this method can be used (Capacity Building Center for States, n.d.). This helps the agency's staff gather any relevant details and family connections about which the reporter may know. Some states may require that a written report follow the oral report. In other states written reports are filed only upon request, and still others require written reports only from mandated reporters.[3]

2 This section is adapted and updated from the foundation manual in the last version of the *Child Abuse and Neglect User Manual Series*: Goldman, J., & Salus, M. K. (2003). *A coordinated response to child abuse and neglect: The foundation for practice.* Retrieved from https://www.childwelfare.gov/pubs/usermanuals/foundation/.

3 See **appendix C** for a list of state toll-free telephone numbers for reporting suspected child abuse or neglect 24 hours a day, 7 days a week.

Reports of suspected maltreatment must be made immediately to protect children from potentially serious consequences that may be caused by a delay in reporting. As part of community education, CPS should remind potential reporters not only to report any concern that a child may have been maltreated, but also that it is not the responsibility of reporters to determine or be certain whether maltreatment has actually occurred; that is the job of the professional CPS staff.

For more on mandatory reporting, see the *State Statute Series: Mandatory Reporters of Child Abuse and Neglect* at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/.

Who Receives the Reports?

Each state and tribe designates specific agencies to receive reports of child abuse and neglect. In most states, CPS has the primary responsibility for receiving reports. Reports may also go to the tribe, if the child is eligible under the Indian Child Welfare Act (ICWA), and the state and tribe may conduct a joint investigation. Other states allow reports to be made to either CPS or law enforcement. Some state laws require that certain types of maltreatment, such as sexual abuse, be reported to law enforcement in addition to CPS.

The nature of the relationship of the alleged maltreating parent may also affect where reports are made. Most alleged cases of child maltreatment within the family are reportable to CPS. Depending on the state, reports of alleged abuse or neglect by other caregivers (e.g., foster parents, day care providers, teachers, or residential care providers) may need to be filed with law enforcement. Additionally, in some states, allegations of abuse in out-of-home care are reported to

a centralized investigative body within CPS at the state or regional level. Because these agencies typically have an obligation to cross-report cases that fall within each other's mandates, community outreach efforts should emphasize that there is no "wrong door," i.e., a reporter may begin by calling either CPS or law enforcement when unsure of what to do.

Appendix E describes the contents of a report of alleged maltreatment, which may be helpful for CPS to provide to the public and mandated reporters.

5.3 CPS Intake[4]

The following sections lay out the intake process, the first stage of the agency's CPS process and one of many critical decision-making points in the child protection system. CPS hotline staff (also sometimes known as intake workers or screeners or, in some states, may be caseworkers who serve the family from intake to case closure) may be located either at a central intake center or in local offices. They interview all persons who call with concerns about suspected child abuse or neglect and follow protocols. Hotline staff may also call other sources of information to determine if the reported information meets the statutory definition and agency guidelines for child maltreatment. The decision to screen in or out a report can be made by a variety of CPS intake staff, ranging from the hotline worker to a supervisor, depending on the jurisdiction. If the report is screened in, the decision is made as to the urgency with which the agency must respond, and then assignment of a CPS caseworker is made for a face-to-face contact with the child and family.

For those jurisdictions implementing differential response (DR, also known as alternative or multiple response and dual- or multi-track), reports are assigned to either an investigative or family assessment track, depending on the safety and risk information identified at intake and on the agency's guidelines. This decision is typically made prior to making face-to-face contact with the family.

There also are a small number of jurisdictions that accept reports that do not meet the criteria for abuse and neglect or for an investigation/assessment but are accepted as prevention cases and assigned to community agencies for a voluntary, preventive response (Merkel-Holguin, Kaplan, & Kwak, 2006). In these circumstances, families who would otherwise be screened out from services are connected to voluntary, community-based services and resources. These families often have resource needs (e.g. unstable housing, lack of consistent child care, inadequate food, or others) that could result in additional, future reports for maltreatment if they are not linked to programs that address the needs. Jurisdictions typically do not implement a three-track (assessment, investigation, or DR) system simultaneously but phase in these preventive elements over time, building them as state and federal funding and other resources become available (Casey Family Programs, 2012).

4 Portions of this section were adapted from DePanfilis, D., & Costello, T. (2014). Child protective services. In G. P. Mallon & P. M. Hess (Eds.). *Child welfare for the 21st century: A handbook of practices, polices, and programs* (2nd ed). (pp. 236–252). New York, NY: Columbia University Press.

5.3.1 Intake Process

Specific guidelines for conducting the intake process vary by state, tribe, and jurisdiction. In general, to accomplish the purposes of intake, intake workers should:

- Gather sufficient information from the reporter and agency records to be able to:
  - Identify and locate the children, parents, or primary caregiver
  - Determine if the report meets the statutory definition and agency guidelines for child maltreatment
  - Assess the need for an immediate response
- Provide support and encouragement to the reporter by:
  - Explaining that the purpose of CPS is to protect children and to strengthen families
  - Emphasizing the importance of reporting and explaining the process to track the report
  - Describing the types of cases accepted by CPS, as well as the types of information needed from the reporter
  - Responding sensitively to the fears and concerns of the reporter
  - Discussing the states' regulations regarding confidentiality, including the circumstances under which a reporter's identity may be revealed (e.g., if required by court action in a particular case)
- Handle crisis situations, such as:
  - Calming the caller
  - Determining how to meet the immediate needs of the child and family being reported
- Check agency records and state central registry (if appropriate and available) to determine if the family or child has been reported and/or was known to the agency previously

5.3.2 Gathering Information From the Reporter

An important purpose of the intake process is to help reporters provide behaviorally specific, detailed information. When caseworkers comprehensively gather information from reporters, it improves the decision-making process for determining if the child is safe at the time of the report and in the near future, the urgency of the response needed, and if the report should be investigated/assessed. It also helps to clarify if the concerns must also be reported to law enforcement. In addition, information from the reporter may identify other possible sources of information about the family, which will help to evaluate the possibility of past, current, or future abuse or neglect. Finally, it will assist the caseworker responsible for the initial assessment/investigation to plan the approach to the investigation in an accurate and effective manner.

State, tribal, and local child protection agencies have guidelines for information gathering at intake. To provide context for the reporter's information, caseworkers should ask (1) how long he or she has known the child and family and had concerns, (2) the source of these concerns (e.g., directly observed the behavior or conditions or heard about them from someone else), and (3) an understanding about why he or she is calling. **Exhibit 5.4** details more information that should be collected from the reporter about the child, family, and alleged maltreatment. Although every reporter may not have all the information described, it is important to attempt to gather as much information as possible, as this helps guide the investigation/assessment and make the necessary decisions at intake. Additionally, this may be the only opportunity to talk with the reporter.

Exhibit 5.4 Sample Information to Obtain from Reporter During Intake

Demographic Information			

Child:
• Name
• Age (date of birth)
• Sex
• Race/Ethnicity
• Tribal affiliation (if applicable)
• Permanent address
• Current location
• School or day care attendingof prior CPS reports or placement (e.g., foster care, adoption) (for reporters who would have this knowledge)
	Parents/Caregivers:[5]
	• Name
	• Age (date of birth)
	• Race/Ethnicity
	• Relationship to the child
	• Permanent address
	• Current location (i.e., is the alleged abuser currently with the child or will be soon?)
	• Place of employment
	• Telephone number(s)
	• Email address
	
	*If the person alleged to have maltreated the child is a caregiver other than the child's parents, the above information should be gathered about both the parents and caregiver.
		Family Composition:
		• Names and demographics of all children and adults in the household including:
		  ○ Ages (dates of birth)
		  ○ Gender
		  ○ Race/Ethnicity
		• Current location of all children in the household
		• Names, ages, and location(s) of other children in the alleged maltreater's care outside of the household
		• Names, addresses, and telephone numbers of other relatives and their relationship to the child
		• Names, addresses, and telephone numbers of other sources of information about the family
			Reporter:
			• Name
			• Address
			• Telephone number
			• Email address
			• Relationship to the child/family
			• How he or she learned of the alleged maltreatment

5 As stated in chapter 1, the terms "parent(s)" and "caregiver(s)" are used interchangeably except where both need to be used.

Information About the Alleged Maltreatment			
Type(s): • Physical abuse • Sexual abuse • Neglect • Emotional or psychological maltreatment	**Nature of Maltreatment:** (Behaviorally-specific characteristics and parental acts or omissions) • Physical abuse: burning, beating, kicking, biting, and other physical abuse • Neglect: abandonment, withholding of needed medical care, lack of supervision, lack of adequate food or shelter, emotional deprivation, failure to register or send to school, failure of child to thrive, and exposure to domestic violence • Sexual abuse/ exploitation: fondling, masturbation, oral or anal sex, sexual intercourse, viewing or involved in pornography, and prostitution/ trafficking • Emotional/ psychological maltreatment: constantly berating and rejecting child, scapegoating a particular child, and bizarre/cruel/ ritualistic forms of punishment	**Severity:** • Extent of the physical injury (e.g., second and third degree burns on half of the child's body) • Location and size of the injury on the child's body • Extent of the emotional injury to the child (e.g., suicidal behavior, excessive fear of the parents/ caregivers) **Chronicity:** • Prior incidents of abuse or neglect • How long the abuse or neglect has been occurring • Whether abuse or neglect has increased in frequency or remained relatively constant	**Surrounding Circumstances:** • Situation leading up to the incident of alleged abuse • Setting where abuse or neglect occurred (e.g., home, school, community) • Alcohol/drug use • Number of alleged victims • Number of alleged maltreaters • Use of threat or intimidation • Interpersonal violence • Intentional/ unintentional • Use of an object, e.g., extension cord, knife, gun • Parent's explanation or lack thereof Ex

Information About the Parents/Caregivers			
Emotional and Physical Condition: • Expresses feelings in positive and healthy ways • Misuses drugs/ alcohol • Suffers from physical or mental illness • Affect regarding or following the alleged abuse **Parents/Caregivers' Functioning/ Behavior:** • Employment status • Impulse control • Awareness of triggers that cause anger • Engagement in violent outbursts or bizarre irrational behavior • Possession of weapons in the home • Abuse of pet	**View of the Child:** • Empathizes with the child • Views the child as bad or evil • Blames the child for the child's condition or maltreatment • Has incongruent perceptions about children and child conditions	**Child Rearing Practices:** • Realistic and age-appropriate expectations of the child • Extent to which use of verbal or physical punishment is the first response to misbehavior • Knowledge of different disciplinary techniques appropriate for the child's age and developmental level • Aversion to parenting responsibilities • Parenting stress or frustrations	**Relationships Outside the Home:** • Friends and quality of those friendships • Social and emotional isolation • Conflicts with neighbors/others

Information About the Child	
Child's Condition: • Physical condition • Emotional condition • Trauma symptoms • Disabilities/impairments • Strengths	**Child's Emotion/Behavior:** • Extremes in behavior • Appropriateness of behavior given child's age and developmental level • Tense or anxious • Appropriate communication or noncommunication

Information About the Family		
Family Characteristics: • Family configuration, e.g., single parent, two parents, blended family • Family income • Parent's employment • Flow of strangers in and out of home • Evidence of drug activity (e.g. use, selling, etc.) in the home	**Family Dynamics:** • Serious marital conflict • Interpersonal violence • Disorganization and chaos	**Family Supports:** • Extended family members that are accessible and available • Relationships with others outside the family • Connections in the community, e.g., houses of worship

5.3.3 Providing Support to Reporters

Reports of child abuse and neglect are most often initiated by telephone and may come from any number of sources. The intake worker should give each reporter support and encouragement for making the decision to report, as well as elicit and address his or her fears and concerns. These can range from fear that the family will retaliate to fear of having to testify in court. It is often very difficult for reporters to make the call, which can come after much thought has been given to the possible consequences to the child and family. More than likely, the reporter considered that it would be easier to do nothing or that the CPS system may not be able to help the family. It may be difficult for a reporter to think that this call will actually help the family. Simple verbal reassurance or a follow-up letter that expresses the agency's gratitude to the reporter for taking the initiative to call can make the difference in the reporter's future willingness to report similar concerns. It is also important to let the reporter know that, due to confidentiality rules, the agency will not be able to inform the reporter of the outcome of the report.

5.3.4 Analyzing Intake Information

Once the initial intake information is collected, the caseworker conducts a check of agency records or, in some states, a central registry to determine if there have been any past reports or CPS contact with the family. Then the caseworker and his or her supervisor analyze the information to determine its credibility based on the consistency and accuracy of the information being reported. A number of questions will help caseworkers evaluate the report:

- Is the reporter willing to give his or her name, address, telephone number, and email address?
- What is the reporter's relationship to the alleged victim and family?
- How well does the reporter know the family?
- Does the reporter know of previous abuse or neglect?
- What led the reporter to call now?
- How does the reporter know about the concerns (e.g., direct observation, hearsay)?
- Does the reporter stand to gain anything from reporting?
- What level of specificity is the reporter able to provide regarding the alleged maltreatment (e.g., vague information or details of observed physical injuries)?
- Has the reporter made previous unfounded reports on this or another family?
- Does the reporter appear to be intoxicated, extremely bitter, or angry, so to raise questions about the validity of the information?
- What does the reporter hope will happen as a result of the report?
- Does the reporter fear reprisal from the family?
- Does the reporter fear self-incrimination (e.g., due to his or her own substance-abusing behavior or participation in maltreating behavior)?

5.3.5 Making Intake Decisions

The first decision at this stage is to determine if the reported information meets the statutory definition of child maltreatment and, therefore, results in assignment for a face-to-face investigation or assessment. If the report is accepted or "screened in," the worker's supervisor then determines the urgency of the response.

Determining Whether to Accept (Screen in) the Report

One of the primary decisions at the intake stage is whether or not to screen in (accept) a report for assignment for investigation or assessment. This decision is based on the law; agency policy; and information about the characteristics of cases that are likely to indicate, or result in, harm to the child. The appropriateness of this decision depends on the ability of the caseworker to gather critical and accurate information about the family and the maltreatment and to apply law and policy to the information gathered.

States have different criteria and tools for acceptance of the report. Some of the actions caseworkers and/or supervisors should take to make this decision include (Wells, 2000):

- **Referring to state law.** State statutes define what is considered child maltreatment. These definitions are the caseworkers' legal source of guidance. (For more on individual state statutes defining child abuse and neglect, visit https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/define/
- **Reviewing agency policies.** Agency policies include state, tribal, and local guidelines and screening tools. They may have additional information regarding definitions and indicators of maltreatment and how to respond to different types of reports.
- **Determining through discussions with the supervisor how these guidelines apply to this situation.** Supervisors can support the caseworker to critically evaluate the details of this report based on agency policies and procedures.

Reports that might typically be screened out include:

- The reporter's information and any additional facts gathered do not meet the legal definition of child maltreatment, and there are no reported threats or safety factors that, if true, would indicate the child is unsafe.
- The child and family cannot be located despite diligent efforts to determine location.
- The alleged victim is age 18 or over (may need to refer to law enforcement or adult protective services).
- The child was assaulted by a stranger or nonfamily member (and the concerns are referred to law enforcement).

Determining the Urgency of the Response

Jurisdictions differ in determining the priority level for the timing of the response by CPS. CPS agencies, however, generally use the following factors to distinguish between reports that require an *immediate* response, reports requiring a response within *24 hours*, or reports that permit a longer period of time before face-to-face contact is required.

Examples of situations that would require an immediate response include:

- Severe injury and/or sexual abuse, such as any sexual abuse, multiple injuries, injury of the face or head, or life-threatening living conditions; the alleged maltreatment could have resulted in serious harm (e.g., shooting a gun); and/or the alleged maltreatment is occurring right now and is uncontrolled.
- Child characteristics that suggest the child is particularly vulnerable because of age, illness, disability, or need for medical attention and/or is extremely fearful.

- The parent or caregiver is acting out of control or is dangerous, violent, irrational, unpredictable, under the influence of substances, and/or incapacitated due to mental illness, and the child is completely dependent on the parent for care due to age or disability.
- The family has no fixed address, and there are indications that the family will hide the child or flee the area.

Exhibit 5.5 provides several examples of cases requiring different response times.

Exhibit 5.5 Examples of CPS Reports and Response Times

The following are examples of various types of responses to reports.

Report Requiring an Immediate Response

A single mother, who has been diagnosed as having paranoid schizophrenia, is having delusions of killing her 6-month-old infant. The mother stopped taking her medication (which is often required when pregnant) and has been drinking heavily. The community psychiatric nurse, who has been visiting the home weekly, was just told by the mother never to come back. [*Immediate response by CPS; could also indicate it would be appropriate to be accompanied by law enforcement.*]

Report Requiring a Response Within 24 Hours

At 9:00 a.m., a child care provider calls in a report concerning a 5-year-old child because he has bruises and welts on his buttocks. The child provides three different stories of how they occurred, none of which seem plausible. There are no previous reports of maltreatment, and the child care provider, who has been caring for this child for 18 months, has never seen bruises previously on the child. The provider reports that the mother brings the son at 8:30 a.m. and picks up the son at 4:30 p.m. The child is very active and difficult to manage and has attempted to hurt other children. [*There should be contact with the child before the mother arrives to pick him up from day care at 4:30 p.m.*]

Report Requiring a Response, but Not Within 24 Hours:

During the first 3 months of school, the children of a single mother were absent over half the days. When the 7-year-old girl and 10-year-old boy go to school, they have severe body odor and dirty clothes. The girl has been observed falling asleep in class on multiple occasions. The school nurse recently treated the children for lice and scabies. Yesterday, the school sent a note home and attempted to call the mother, asking that she call to schedule an appointment to go over the necessary at-home treatment. The mother failed to call the school today, and there is no answer on her cell phone.

Once the intake process has been completed, the next stage of the CPS process is to assess the family, as discussed in the next chapter.

Chapter Highlights

- CPS agencies provide education for community professionals on the mandates of reporting child abuse and neglect and implement public awareness campaigns to promote understanding about child maltreatment in the community.
- State and tribal reporting laws specify selected individuals who are mandated to report suspected child maltreatment, define reportable conditions, and explain how to make reports.
- Medical personnel, educators, child care providers, mental health professionals, law enforcement personnel, clergy and other professionals are often in a position to observe families and children and are usually, but not always, mandated to make reports when they suspect that abuse or neglect has occurred.
- Individuals (both professionals and community members) concerned about the possible maltreatment of a child should call either a state or local child protection hotline or law enforcement to make a report.
- In most states, CPS has the primary responsibility for receiving reports while some states allow reports to be made to either CPS or law enforcement. Some state laws require that certain types of maltreatment, such as child sexual abuse, be reported to law enforcement in addition to CPS.
- The intake process is the agency's first stage of the CPS process and is one of the critical decision-making points in the child protection system.
- The first decision is if the report indicates immediate child safety threats, which require an emergency response.
- If the child is not in imminent danger, then the next step is to determine if the reported information meets the statutory definition of child maltreatment and therefore results in assignment for a face-to-face investigation or assessment.
- The next decision is to determine the prioritization of the agency's response.
- Intake workers interview reporters to explore the nature of the concerns related to possible child maltreatment and to gather information about the child, parent, and family that will help them assess the current safety of the child.
- CPS workers consult with their supervisors prior to determining whether the report is screened in, and if so, to determine the priority for responding.

Chapter 6: Initial Assessment or Investigation

After a report of alleged maltreatment is received and screened in (as described in chapter 5), the next stage in the CPS process is the initial assessment or investigation.[1] Its primary purpose is to assess the safety of the child and the risk of future maltreatment. Child Welfare Information Gateway (n.d.-2) describes these assessments as:

- Safety – the collection and analysis of available information to identify whether there are current, significant, and clearly observable threats to the safety of the child
- Risk – the collection and analysis of information to determine the likelihood of future maltreatment

It is important to note that while this chapter discusses safety and risk assessment within the context of the initial assessment/investigation stage, safety and risk assessments are conducted *throughout* the life of a case, including when in-home services are provided, a child is in out-of-home care, preceding and during family visitation, and throughout the process of achieving permanency for the child.

There are many steps in the initial assessment stage of the CPS process, including preparing for and interviewing: the child; family members; others who may be able to provide relevant information (sometimes called collateral contacts), such as neighbors, other adults in the home, teachers, etc.; and professionals who may offer needed expertise. The purpose of these interviews is to gather information that will inform caseworkers' assessments, which, in turn, will guide their decision-making in order to:

- Assess for safety and risk
- Make a determination about whether the alleged maltreatment occurred (also known as a "disposition")
- Determine whether ongoing services, either through the agency or in the community, are necessary to enhance the protective capacities of the parents or caregivers to provide for the child's safety and well-being in the future

CPS workers also explain the agency's role to the children and families and serve as advocates to help them receive the best possible services from the agency and/or community. State reporting laws or policies dictate the length of time available to conduct an initial assessment; most timeframes range from 30 to 60 days.[2]

1 Note: In this chapter, the terms "initial assessment" and "investigation" are used interchangeably. Because the purpose of this stage goes beyond investigation of the report to also include assessment of safety and risk, the primary term used in this chapter is initial assessment.

2 To determine the length of time available to conduct the initial assessment, individuals may search https://www.childwelfare.gov/pubPDFs/repproc.pdf#page=6&view=Timeframes for Completing Investigations.

This chapter:

- Reviews the process for interviewing and gathering information
- Examines methods for assessing and analyzing information to inform decisions
- Considers the need to connect the family with formal or voluntary services based on the identified needs of the family
- Provides information about differential approaches that are offered in some jurisdictions

As can be seen, this stage of the CPS process has many components. To be more reader friendly, this chapter is divided into two parts. The first section comprises the actual elements of the initial assessment/investigation, such as interviewing to gather information. The second section describes how to analyze this information at various decision points to consider the next steps, such as determining the disposition and whether services and/or a differential response are needed.

6.1 Initial Assessment Process

The initial assessment process involves: (1) preparing for and implementing interview protocols, including ways to engage the children and family, as discussed in chapter 5; (2) gathering information from relevant sources; (3) collaborating with law enforcement or multidisciplinary teams in some situations; and (4) consulting with other professionals to assist with specific assessments (e.g., alcohol or other drug use, domestic violence, medical, and mental health). To make well-informed decisions during the initial assessment/investigation, CPS workers should:

- Use a trauma-informed approach[3] to minimize the potentially adverse impact of the initial assessment process and to improve the accuracy of the information collected while enhancing engagement of all parties. Actions that make both the child and adult caregiver(s) feel as safe as possible can improve fact finding and enhance engagement, while limiting the addition of new, system-oriented traumas (Kelly, 2013).
- Employ a protocol for interviewing the identified child, siblings (and any other children living in the home), all of the adults in the home, nonresident parents (if applicable), and the alleged maltreating parent(s)/caregiver(s).
- Observe the interactions among the child, siblings, and parents/caregivers.
- Observe the home, neighborhood, and general climate of the family's environment.
- Gather information from any other sources who may have information about the alleged maltreatment, family dynamics, or the risk and safety of the children.
- Analyze the information gathered in order to assess the family's strengths and needs and to make necessary decisions.

6.1.1 Using a Trauma-Informed Lens

There are actions the caseworker and agency can take to minimize the trauma of the initial assessment process. Recommendations from the field include trauma-informed actions as follows (adapted from Kelly, 2013):

Reduce Stress for Children

- Keep the process calm, including minimizing children witnessing any conflicts between the parent/caregiver and caseworker, if possible.

3 A trauma-informed approach or practice is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers.

- Interview the child in a safe and secure setting, avoiding sites within the location where the maltreatment may have occurred and where memories could be strong, such as a bedroom in a sexual abuse case.
- Explain, in age-appropriate ways, what is going on, answer the child's questions, and ask what makes him or her feel safe.
- Shield the child immediately from any crime scene where a body, seriously injured person or pet, or overt signs of violent death or injury are present.
- Focus the child on familiar people or situations, (e.g., school, pets, friends, safe relatives).
- Ask the parent to reassure the child that he or she is safe and that the CPS worker is here to help the child.
- Allow the child access to items, such as a stuffed animal, blanket, or other comfort, that may help him or her to feel at ease while talking with the CPS worker.

Reduce Stress for Parents or Other Caregivers

- Treat the parent with respect and use a calm tone and manner of communication, even when confronted with aggression and hostility.
- Be transparent and demonstrate the core conditions of helping relationships, as discussed in chapter 4.
- Seek opportunities to give the parent or caregiver a choice in how or where to proceed, within the limits of a good initial assessment.
- Incorporate the use of peer mentors to engage parents during the initial assessment process.
- Avoid threatening an adult domestic violence survivor with the child's removal in an effort to force protective action.
- Identify, with the parent's input, his or her informal and formal supports and how such supports may help during this process.

6.1.2 Planning the Interview Process

Based on the information gathered during the intake process, the CPS worker should consult with his or her supervisor to develop a plan for the initial interview, considering:

- Whether other agencies should be notified to participate or take the lead in conducting the interviews, e.g., tribal social services, Child Advocacy Centers (CACs)[4]
- 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

6.1.3 Using Interviewing Protocols

Interviews differ from ordinary conversations in that they have two definite purposes: (1) to understand the circumstances related to the alleged maltreatment, and (2) to gather information related to the safety and risk of the child,[5] existing services being received, and protective factors, strengths, and capacities. Most protocols use a phased approach that involves an initial preparatory stage (e.g., introductions, rapport development), a more-focused second phase (e.g., using open-ended questions, followed by more probing and reflecting to understand specific details), and a third phase of closure (e.g., explaining next steps) (Saywitz, Lyon, & Goodman, 2011).

The initial assessment of alleged maltreatment of children requires that CPS respond in an orderly, structured manner when interviewing to gather sufficient information to determine if maltreatment took place and to assess the risk and safety of the child.

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4 For example, many communities have a CAC where children are interviewed by highly trained forensic interviewers. In cases of sexual abuse or serious physical abuse, CPS workers and law enforcement officers are trained to minimize questioning of the child and to leave formal forensic interviewing to the CAC. This approach reduces the stress on children by avoiding the need for multiple interviews. A brief description about CACs is provided in a later section of this chapter.

5 See later sections related to substantiation decision-making and conclusions regarding safety and risk.

Employing a structured interview protocol:

- Ensures the involvement of all family members (interviewed separately whenever possible) and thorough information gathering
- Increases staff control over the process
- Increases consistency and quality of interviews across staff
- Improves the capacity of CPS staff to collaborate with other disciplines
- Increases staff confidence in the initial assessment conclusions

6.1.4 Implementing the Interview Protocol

The first step of the initial assessment is to try and meet with the child, if possible and if safe for him or her. Depending on the circumstances, the worker must determine whether it is in the child's best interest to initiate an unannounced visit to interview the parent or to contact the parent to schedule an interview (Pintello, 2000). As long as there is not a concern for the safety of the child, scheduling the visit communicates respect and is especially encouraged when a differential response (DR) is implemented. If the child is out of the home at the time the caseworker makes the initial contact with the family (e.g., the child is at school or child care), the process usually should begin with an introduction to the parent(s) to explain the purposes of the initial assessment/investigation and, if required by law, to request permission to interview family members individually.

All family members should be interviewed alone to establish rapport and a climate of trust and openness with the CPS worker. Individual interviews increase the accuracy of the information gathered and also enable the CPS worker to use information from one interview to assist in the next interview. If at all possible, family members should be interviewed separately in the order laid out in this section.

A brief summary of the purpose of each interview and the preferred order follows below:

- **The alleged child victim(s)**, to gather information regarding the alleged maltreatment and any risk of maltreatment and to assess the child's immediate safety. Because CPS's purpose goes beyond just finding out what happened, the interview with the child also addresses the strengths, risks, and needs of the child, his or her parents, and his or her family.
- **Siblings (and other children in the home)**, to determine if they have experienced maltreatment, assess their level of vulnerability, gather corroborating information about the nature and extent of any maltreatment of the identified child or to them, and collect further information about the family that may assist in the assessment of risk of maltreatment and safety of the identified child and any siblings or other children in the home.
- **All adults in the home**, to find out what adults know about the alleged maltreatment; gather information regarding the risk of maltreatment and safety of the child; family strengths or protective factors; and the adults' capacity to protect the child, if indicated. The CPS worker asks questions concerning the child, e.g., his or her normal behaviors and activities, medical history, social history, and events going on in the child's life. It is also important to ask other adults about both parents and any other caregivers' roles in the family, patterns of behavior, and circumstances surrounding the alleged maltreatment (Pence, 2011).

- **Alleged maltreating parent/caregiver**, to evaluate the alleged maltreating parent/caregiver's reaction to allegations of maltreatment, knowledge of the child's developmental needs and/or condition, and ability to meet the child's needs, as well as to gather further information about this person and the family in relation to the risk and safety of the child.
- **Nonresident parents**, to find out what they may know about the alleged maltreatment, understand the parents' level of involvement in the life of the child, gather information related to the risk of maltreatment and safety of the child and the potential capacity of this parent to offer supports or to serve as a safety service resource if needed.
- **Collateral sources**, including other community or family members who may have information to contribute to an understanding about the alleged maltreatment and/or the safety and risk of the child. Interviews with other sources (e.g., neighbors, health care providers, teachers, extended family, tribe) focus on gathering information that can contribute to a more complete understanding of the alleged maltreatment and of risk factors and strengths based on the role these other persons have in the life of the child and family.

At the completion of the interviews and analysis of the gathered information, the CPS worker should reconvene the child and family members as appropriate to:

- Share a summary of the findings and impressions
- Seek individual responses concerning perceptions and feelings
- Indicate interest in them and their responses
- Provide information about next steps, including whether ongoing services will be offered and/or court intervention will occur; if a case is opened, the information gathered and the family members' responses will help guide the more comprehensive family assessment,[6] as described in the next chapter
- Demonstrate appreciation for their participating in the process

Examples of information that a CPS worker should gather from each of these sources are presented in **exhibit 6.1.**

6 The next stage in the CPS process is to conduct the comprehensive family assessment. Its primary purpose is to gather and analyze information that will guide the intervention change process with families and children. Chapter 7 describes the comprehensive family assessment process in detail.

Exhibit 6.1 Examples of Information to Obtain During Initial Interviews

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Maltreatment	• Description of what happened (or is happening) with respect to the alleged maltreatment, when and where it occurred, and who was present • The child's current condition • The type, severity, and chronicity of the maltreatment • Contributing factors that may be associated with the circumstances (e.g., substance use disorder, mental health issues, domestic violence) • The effects of maltreatment (e.g., extreme withdrawal, fear of parents, fear of recurrence) • The identity of others who have information about the child's condition and the family situation	• Information about the alleged maltreatment • Maltreatment they may have experienced and, if so, how, when, where, how often, and for how long • The sibling's current condition • The alleged child victim(s), type, severity, and chronicity of maltreatment they have observed and/ or experienced • Knowledge of contributing factors • The effects they have observed or experienced • The identity of others who may have information	• What the adult knows about the alleged maltreatment • The adult's role in the household • Perceptions about the maltreatment and about CPS • Acceptance of the child's version of what might have happened and who the adult deems is responsible • Attitudes toward and relationship with the alleged maltreating parent/ caregiver • Description of contributing factors • Capacity to protect the child and his/her awareness about the vulnerability of the child	• Explanation of what happened or is happening that relates to alleged maltreatment, including how injuries or other consequences occurred; follow-up questions concerning any inconsistencies in the alleged maltreating caregiver's explanation • Response to the alleged maltreatment and to CPS' involvement • What is the current access or level of involvement in parenting the child?	• What is their role or level of involvement with the child? • What do they know about the circumstances related to the alleged maltreatment (e.g., observations, history)? • For medical personnel, what is the medical opinion about the parent or caregiver's explanation and any conflicting explanations of injuries?

7 As discussed in Chapter 1, to prevent repetition, the terms "parent" and "caregiver" are used interchangeably throughout the manual. This also applies to this exhibit.

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Alleged Child Victim	• The child's characteristics (e.g., age, developmental level, physical or mental handicaps, health, mental health status) • The child's behavior and feelings • The child's relationship with peers, extended family, and/or other significant persons • The child's daily routine (e.g., school, child care, clubs, home life, other)	• Information that could not be obtained from the alleged child victim or confirmation of information gathered during the initial interview • Similar demographic information about all other children in the family	• Feelings, expectations, and perspective about the alleged child victim and siblings • Empathy to the child's condition and experience • Description of the characteristics, feelings, and behaviors of the child(ren)	• View of the child's characteristics, developmental needs, strengths, and condition • Relationship with the children and others in the family	• For nonresident parents, what role does this person play in the life of the alleged child victim? How do they describe the child, including emotions and behaviors? What knowledge do they have of the child's developmental needs or current condition? • For all collaterals, what do they know about the child's physical appearance and affect on a daily basis? How does the child get along with peers? How is the child's school attendance and performance? Any concerns about the behavior or emotions of the child?

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Family	• Others who reside in or frequent the home • The child's relationship with and feelings toward the parents/caregivers and siblings • The child's perception of the relationships among others in the household • The child's perception of how family problems are addressed and how the family communicates • A description of who's involved in child care responsibilities (e.g., extended family, informal kin) • The child's perception of the child's own and the family's identification with a tribe, race, or larger cultural group	• Others who reside in or frequent the home • The siblings' characteristics, behaviors, and feelings • Further information about the parents (e.g., feelings and behaviors frequently exhibited, problems, child rearing measures, discipline, and parents' relationships outside the home) • Further information about the family's functioning, dynamics, demographics, and characteristics	• Relationship to the children 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 in the family • The types of discipline the family considers to be appropriate • Who is involved in child care responsibilities in the family • How cultural beliefs are incorporated in the family functioning • The role religion plays in the family, and how it affects child rearing practices • The family's rituals, traditions, and behaviors • Roles in the family and overall family functioning • Communication and expressions of affection	• Approach to parenting, expectations, and sensitivity to children • Description of the roles and functioning in the family • Methods of communication and level of affection • Who usually makes decisions about the children in the family • Types of discipline the family considers to be appropriate • Who is involved in child care responsibilities in the family • How cultural beliefs are incorporated in the family functioning • The role religion plays in the family and how it affects child rearing • The family's rituals, traditions, and behaviors	• For nonresident parents, how well do the adults in the child's life get along? How often does the nonresident parent visit the child? Does the nonresident parent share parenting responsibilities? • How well do the caregivers get along with each other? • For professionals, what have they observed of the interactions between the child and parents or other involved adults in the child's life? • For all, how do they describe the interaction between family members?

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/ Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Family	• The child's perception of the family rituals, traditions, and behaviors • The child's perception about a typical evening at home • The child's description of what happens when parents (the adults) fight • The child's perception of and reaction to parents/ caregivers fighting		• Demographics about the family, including financial status and other factors that may be stress producing • The presence of domestic violence/ partner abuse • How do the adults solve problems together? • Do any adults have a history of problems with the law?	• Description of demographics about the family, including financial status and other factors that may be stress producing • The presence of domestic violence/ partner abuse • How do the adults solve problems together? • Does this person have a criminal history?	• For nonresident parents, how well do the adults in the child's life get along? How often does the nonresident parent visit the child? Does the nonresident parent share parenting responsibilities? • How well do the caregivers get along with each other? • For professionals, what have they observed of the interactions between the child and parents or other involved adults in the child's life? • For all, how do they describe the interaction between family members?

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/ Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Adult Caregiver Functioning	• Description of the emotional and behavioral functioning of adults in the household, e.g., angry, sad, response to stress, use/ misuse of alcohol or drugs, etc.	• Description of the emotional and behavioral functioning of adults in the household, e.g., angry, sad, response to stress, use/ misuse of alcohol or drugs, etc. • Sample questions: What do your parents do when you (or your sister/ brother) do something good? Something bad? What is an example of something that is "bad"?	• Approach to solving problems, ability to deal with stress, use of drugs/ alcohol • History as a child (positive and negative memories), educational and employment history, any criminal activity, or history of physical or mental health problems • Relationships outside the home, supports, memberships, and affiliations • Willingness to accept help (if needed)	• Present emotional state particularly in terms of the possibility of further harm to the child • Approach to solving problems, dealing with stress, using drugs/alcohol, coping • View of himself/ herself • 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)	• For current treatment providers of the adults, a description of the history and reasons for treatment; view of the adult's overall functioning and treatment progress • For nonresident parents, determine their adult functioning and whether he or she can be a support or viable option to care for the child if needed

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/ Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Environment (family, social, and physical)	• Who are their closest relatives/friends • Where they spend their time when not at home; other positive relationships with adults/ mentors • The child's description of where they go during their parents/ caregivers physical or verbal fights, whether they have tried to stop a fight, and whom they would call for help • A description of the neighborhood, available resources, and the degree of crime or violence	• Who are their closest relatives/ friends • The child's description of where they go during their parents/ caregivers fights, whether they have tried to stop a fight, and who they would call for help • A description of the neighborhood, available resources, and the degree of crime or violence	• View of supports in his/her life, relationships with extended family, and the climate of the neighborhood and community • Description of the neighborhood, available resources, and the degree of crime or violence • Role of extended family or kin	• View of supports in his/her life, relationships with extended family or kin, and the climate of the neighborhood and community • Description of the neighborhood, available resources, and the degree of crime or violence • Role of extended family/kin	• For nonresident parents, the role of the nonresident parent's extended family (e.g., child's grandparents) in the lives of the children

6.1.5 Interviewing Adult Family Members

Chapter 4 referenced techniques for engaging children and families, including approaching individuals with cultural sensitivity, motivational interviewing,[8] and the use of OARS[9] (Miller & Rollnick, 2012). These are key techniques for helping family members talk about the alleged maltreatment and about other aspects of their family. When confronting potential maltreatment situations, five motivational interviewing principles are important to incorporate, particularly when interviewing adult family members, as follows:

Expressing empathy involves communicating warmth and using reflective listening to understand the family member's feelings and perspectives without judging, criticizing, or blaming. Acceptance is not the same as approval of abusive or neglectful behavior. It instead promotes the importance of practicing respectful listening with the family member while exhibiting a true desire to understand.

Developing discrepancy is creating and amplifying, in the family member's mind, a discrepancy between present behavior and broader goals. This means helping him or her to see the discrepancy between where he or she is and where he or she says he or she wants to be. This can be triggered by the family member's awareness of the impact of the present behavior. When a person sees that a behavior conflicts with important personal goals (e.g., like keeping the family together), he or she may be readier to consider change. During initial assessments, this principle is particularly relevant to interviews with nonmaltreating parents and the alleged maltreating parent when trying to assess whether an in-home safety plan is feasible.

8 As described in Chapter 4, motivational interviewing is a method to support families who may be ambivalent or hesitant about support from the child welfare system. For more on motivational interviewing, go to https://www.childwelfare.gov/pubs/motivational-interviewing/.

9 **O**pen-ended questions, **A**ffirmations, **R**eflections, **S**ummary.

Avoiding arguments is an important strategy to use to reduce resistance. When there are differences in perspectives, actively confronting those differences decreases the likelihood that the other individual will consider alternatives. The goal is to help the adults in the household to consider the possibility of the need to change, and they will be much more likely to be open to another way of thinking if they come up with this idea on their own. If the CPS worker tries to argue about or demand the need to change, this comes off as labeling the person, which will likely cause him or her to become more resistant. The ideal approach focuses on the behavior and its impact on the families' broader goals and separates the maltreating or nonprotective behavior from the person.

Rolling with resistance requires the caseworker to acknowledge that reluctance and ambivalence are both natural and understandable. Workers need to help adult family members consider new information and new perspectives. To do this, the worker turns a question or problem back to them to discover their own solutions. By "rolling with the resistance" and recognizing that resistance is a natural response in these situations, it is easier for family members to consider the consequences of their choices.

Supporting self-efficacy means supporting the adults' belief in their ability to consider the current situation and to come up with possible solutions. An example of this would be where the parents left a child alone after school for several hours and initially did not understand or fully acknowledge the potential harm that could arise when young children are left alone. They later acknowledged how their actions put the child's safety at risk and identified potential resources, who could care for the child in the future. There is an advantage for the parents to come up with their own alternatives and solutions, rather than for the worker "telling them" that something has to change. It is much more likely that the parents will be open to alternatives and identify workable solutions if they come up with solutions on their own.

6.1.6 Interviewing Children

In addition to gathering information for the assessment, the primary goals when interviewing children are to build trust, increase the accuracy and reliability of information, decrease potential suggestibility, and minimize trauma. It is also extremely important to consider the child's developmental level, or interviews can result in misinterpretation of a child's statements (Saywitz & Camparo, 2014). Following are some principles about the setting, structure, and approach:

- Carefully choose the setting so that it is age appropriate, private, and child friendly, with minimal distractions.
- Give children permission to say, "I don't know," or, "I don't understand," and possibly use a little exercise in the rapport-building phase to illustrate this, such as asking if they have pets, what they like to do after school, or what their favorite food or song is.
- Use a phased approach for developing rapport (e.g. starting with simple questions about the child's likes or interests per above and build up to questions that are more focused on the alleged abuse and family situation), followed by inviting the child to tell his or her story (without interruptions). It is important not to make promises but to describe next steps in the closing part of the interview.
- Consider the age and development of the child when deciding the length of the interview and communication methods (e.g., eliciting drawing vs. words), as well as issues related to his or her potential reluctance and suggestibility. It is important to remember that the worker does not know ahead of time if, in fact, a child has been maltreated and so should be careful not to lead the child to say things that may not be true.
- Focus on creating a neutral, supportive atmosphere.
- Encourage the child to use his or her own words with minimal prompting.
- Pay attention to nonverbal cues, using reflections of content and feeling to support the child to tell his or her story.
- Avoid concepts that are difficult for the child to understand. For example, it may be impossible for young children to accurately report how many times something has happened, the timing of when it occurred, or for how long.
- Use elaboration prompts in the child's own words to further explore something that has previously been stated or to move forward; a common and useful open-ended question is, "And then what happened?"

6.1.7 Observing the Child and Family Members

In addition to information gathering through interviews, part of the process of gathering adequate information includes the responsibility to observe the alleged child victim, family members, and the environment. Specific areas for observation include:

- Physical condition of the child, including any observable effects of maltreatment[10]
- Emotional status of the child, including mannerisms, signs of fear or vulnerability, and developmental status, which informs how the worker approaches the interview
- Whether the child and/or caregivers requires additional supports within the interview process, such as interpreters or translators
- Physical condition of the parents, including any observable disabilities or impairments
- Reactions of the parents or caregivers to the agency's concerns
- Emotional and behavioral status of the parents and other adults during the interviewing process

10 Depending on the jurisdiction, CPS workers may be required to take pictures of specific child injuries. When this is part of the mandate, workers should be provided specific training about the process for collecting this evidence.

- 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 or misuse of legal medications
- Climate of the neighborhood, including level of violence or support, and accessibility of transportation, telephones, or other methods of communication

Children and Youth Who Cannot Be Interviewed Verbally.

Sometimes, it is not possible to interview some children and youth because of their age, developmental level, disabilities, or other reasons. However, according to research, infants and toddlers can recall experiences, as demonstrated through behavioral reactions to people, objects, and environments (e.g., twitching or cringing when a certain person approaches). With training, investigators can use play and drawings to gather some information from toddlers, such as observing how they act during play or what they draw. For example: Are they physically abusive of dolls or materials? Do dolls hurt each other or play sexually? Because this type of observation is not always possible, the caseworker's own observations, as well as the interviews of others who may have observed the alleged maltreatment (e.g., other family members, collateral contacts) are key (U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2015; Stanford Medicine, 2018).

6.1.8 Involving Other Professionals

The previous section identified specific information that may be sought through interviews from collateral professionals who may have important information about the maltreatment, or about risk and protective factors about the child, parent, family, and environment. In addition to interviews, it is sometimes appropriate to involve other professionals in the initial assessment process. Some professionals may require the consent of the parent or caregiver to provide verbal information and/or records. Professionals can be helpful in the assessment process, as follows:

- **Alcohol and other drug specialists** may be involved in evaluating parental or other adult caregiver substance use disorder and its impact on the safety of the child. These specialists may also be involved in collaboration with pediatricians when infants are identified with prenatal alcohol and other drug exposures.
- **Educators** may be involved in providing direct information about maltreatment, particularly educational neglect or when a child has reported information to a teacher or school counselor about other types of maltreatment. They may also have information about effects of maltreatment on the child's academic achievement and/or on the child's mental, behavioral, or social well-being.

- **CACs** are multidisciplinary centers that are structured to assure safety and to minimize trauma to children, particularly when more than one professional needs to be involved in the assessment. Typically, a CAC is contacted in reports of serious physical abuse or sexual abuse. Medical exams and forensic interviewing are provided in a child-friendly setting. A forensic interview[11] is a single-session, recorded interview designed to elicit a child's unique information through a supportive and nonleading manner. Interviews are remotely observed by representatives from CPS and law enforcement (and sometimes other involved professionals, such as prosecutors, agency attorneys, victim advocates, and others) to minimize the need for multiple child interviews.[12]
- **Domestic violence** specialists and shelters may be involved in the collaboration of initial assessments and as a safety resource when there is a need for one parent and the children to leave the household or to have dedicated support (e.g., to seek medical attention, request a protective order). There is evidence that when these systems formally collaborate effectively, safety is enhanced for adult and child survivors (Banks, Duth, & Wang, 2008; Greenbook National Evaluation Team, 2008).
- **Emergency or concrete service providers** could be called on to respond to emergency concrete needs that are discovered during the initial assessment. Examples are food, furniture, clothing, and household chore services to address unsanitary or hazardous household conditions.
- **Law enforcement** and CPS work collaboratively either by jointly conducting initial assessments/investigations or by sharing information when both are involved in response to a report of alleged child maltreatment. Law enforcement is also called upon when there are concerns for a CPS worker's safety and/or when there is a need to remove an alleged offender from the home. State laws provide guidance on the particular types of cases where both professionals are involved.[4] In some communities, there are Memoranda of Understanding (MOUs) that define the ways these systems collaborate (Cross, Chuang, Helton, & Lux, 2015).
- **Medical personnel** may be involved in assessing and responding to the medical needs of a child or parent, documenting the nature and extent of maltreatment, and may also serve as a safety resource for children when the nature of the maltreatment leads to hospitalization. Medical personnel are often requested to provide opinions on whether explanations of the parent or caregiver are consistent with assessed injuries. Multidisciplinary teams (discussed later) are sometimes based in hospitals.
- **Mental health personnel** may be involved in evaluating the parent or caregiver's mental health status and its effect on the safety to the child. They could also have a role later in the CPS process to assess the effects of any alleged maltreatment on the child.

11 For more on forensic interviewing, go to https://www.childwelfare.gov/pubs/factsheets/forensicinterviewing/.

12 Further information about services provided by local Child Advocacy Centers can be found at http://www.nationalcac.org/forensic-interview-services/ and http://www.nationalchildrensalliance.org/ (the accrediting organization).

4 See chapter 2 for further guidance on roles of CPS and law enforcement. Specific state laws may also be searched via the Child Welfare Information Gateway State Statutes database at https://www.childwelfare.gov/topics/systemwide/laws-policies/state/

- **Safety service providers** could be called on during the initial assessment stage to provide in-home safety services (described later in this chapter). Examples are child care and after-school care providers; parent aides; intensive, home-based services workers; and relatives to provide supervision or other support (e.g., transportation assistance).
- **Tribal social services** should be contacted as soon as it is determined that a child is/may be eligible for ICWA.

After the caseworker has completed the interviews/observations with the family and collateral contacts and has consulted/contacted others (if necessary), the next step in the initial assessment process is to analyze the information to inform and prioritize various decision points. The next section describes this second phase.

6.2 Analysis of Information at Decision Points

Following the gathering of information through interviews and other sources, this section discusses how the caseworker analyzes it to determine whether or not the allegations have been substantiated, the safety and risk level of the child, and whether emergency, basic needs, safety, and/or ongoing services are needed. While the various steps taken during the initial assessment and analysis may appear "siloed," as this section lays out, they all work together in a comprehensive process that results in an assessment that informs the caseworker and family at various decision points This assessment, in turn, will guide the next stages of the CPS process, as the next several chapters and the flowchart (**exhibit 2.1**) illustrate.

The order when decisions are made varies, especially if a worker determines a child is unsafe at the first contact with the family. This could result in the immediate need for an in-home or out-of-home safety plan while also continuing the information gathering for the full initial assessment. And while these decisions are related, they are determined based on different sets of facts. For example, a determination could be made that the maltreatment alleged in the report is unfounded or unsubstantiated, yet the child could be determined to be unsafe or at risk of future maltreatment. Or, the allegation(s) could be substantiated because a child experienced one or more types of maltreatment, but the child could be determined to be safe if the caregiver responsible for the maltreatment is no longer present in the household. Each of the decision points and the analysis that contributes to them are described below.

It should be noted that CPS deals with the determination of whether a child is safe and can remain in the home and receive or be referred for services, or whether the case can be closed (and still be referred for services). If the child is determined not to be safe and is removed, another part of the child welfare system—one that deals with foster and kinship care and achieving permanency—comes into play and is beyond the scope of this manual.

6.2.1 Decision Point: Substantiating Maltreatment

Upon completion of the initial assessment, the CPS worker must determine the case disposition based on state laws/Tribal Code, agency guidelines, and the information gathered. CPS agencies use different terms for this decision. For example, an occurrence of maltreatment may be labeled as substantiated, confirmed, or founded, while a determination that maltreatment did not occur may be labeled as unsubstantiated or unfounded (or the particular term used).

States, tribes, and jurisdictions may use different terminology with similar meanings for the findings of maltreatment, such as substantiated/unsubstantiated or founded/unfounded.[14] If a CPS investigation determines that the allegation of child maltreatment is *unsubstantiated* or *unfounded*, in those jurisdictions that use this terminology, this may mean that there is insufficient evidence for the caseworker to conclude that a child was abused or neglected or that what happened does not meet the legal definition of child abuse or neglect. A finding of unsubstantiated or unfounded, however, does not always mean that maltreatment did not occur. Instead, it may mean that there is not enough evidence to support a finding of substantiated/founded.

If the case is determined to be unsubstantiated, the CPS agency may still provide services or refer the family to a community provider for voluntary services to address needs or risk factors that were identified during the initial assessment process, and the family agrees to the referral. In some circumstances, the case may be closed with no further contact between the family and the CPS agency.

Some states have a classification system that has three findings: substantiated, indicated/inconclusive, and unsubstantiated. The middle classification means that the caseworker has some evidence that maltreatment has occurred but not enough to substantiate the case.

14 Adapted from the Child and Family Services Review information portal at https://training.cfsrportal.org/section-2-understanding-child-welfare-system/3014 and California Legislative Information at http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN§ionNum=11165.12, para. C.

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. The primary question that needs to be answered is: Did neglect, physical abuse, sexual abuse, or psychological maltreatment occur as defined by state law?[15] Guidance for making these decisions for each of these types of maltreatment is included below.

Determining Child Neglect

During the child abuse and neglect assessment process, it is important to consider the following two questions, especially when trying to determine neglect. As always, this determination will depend on state and jurisdictional statutes (DePanfilis, 2000b), but this is especially the case when trying to determine neglect and specific state and jurisdiction definitions of neglect:

1. *Do the conditions or circumstances indicate that a child's basic needs for healthy development are unmet (e.g., failure to thrive)?*
2. *What harm has already resulted or serious threat of harm exists if the situation continues (e.g., not taking needed medications)?*

Answers require sufficient information to assess the degree to which omissions in care have resulted in significant harm or risk of harm. Unlike the other forms of maltreatment, the CPS worker may not be able to make this determination by looking at one incident; the decision often requires looking at patterns of care over time. The analysis should focus on the child's age and vulnerabilities, examine how the child's basic needs are met, and identify situations that may indicate specific omissions in care that have resulted in harm or the serious risk of harm to the child (DePanfilis, 2000b).

15 Refer to Chapter 3 for definitions and descriptions of state child abuse and neglect reporting laws.

Affirmative answers to any of the following questions may indicate that a child's physical, emotional, or medical needs are unmet due to neglect.

- Have the parents failed to:
  - Take the child for needed health care related to a physical injury, acute illness, physical disability, or chronic condition?
  - Provide the child with regular and ample meals that meet basic nutritional requirements or the necessary rehabilitative diet to the child with special nutritional needs for reasons other than poverty alone (e.g., parent receives and spends public assistance but fails to make meals consistently due to effects of drug abuse or other issues)?
  - 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. CPS workers should consider the chronicity, extent, and nature of the condition, as well as the impact on the child and appropriate professional opinions, such as a dental care provider.
  - Arrange for a safe substitute caregiver for the child, e.g., they choose someone whom they do not know well, such as an adult that they only know by a street name or first name or left the child alone for an extended period without arranging for reasonable care and supervision or without providing information regarding their whereabouts or when they will return.
- Does the child regularly or intermittently have inappropriate clothing for the weather and conditions? Has the parent been made aware of resources where they could access free or reduced-cost clothing but failed to take advantage of them? CPS workers must consider the nature and extent of the conditions and the potential consequences to the child.
- Does the home have obvious hazardous physical conditions, e.g., homes with exposed wiring or drug paraphernalia or toxic substances easily accessible to young children, and the family has failed to address?
- Does the child experience unstable living conditions, e.g., frequent changes of residence or places the child sleeps or evictions due to the parent's mental illness, substance use disorder, and/or extreme poverty?

Not all state statutes or policies provide specific ages about when children may be left alone for short periods of time. In determining whether neglect has occurred, the following issues should be considered, along with the caseworker's jurisdictional laws and agency policies, practices, and protocols:

- The child's age, physical condition, development, 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 or access that other adults have to the home, e.g., is there an adult who is checking in on the child? Do other adults come in and out of the home for reasons other than 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, e.g., the safety of the neighborhood or apartment building, access to a telephone, and physical safety within the home.

Determining Physical Abuse

As described in the first section of this chapter, the worker must gather information about how the injury occurred from interviews with and observations of the child and the parents (separately), as well as other possible witnesses or caretakers. In determining whether physical abuse occurred, the key questions to answer are:

- *Does the explanation fit the injury?* For example, the explanation of a toddler falling out of bed 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 the abuse. This could also indicate inadequate supervision (neglect) by a parent or caregiver.
- *Is there a delay in obtaining medical care?* Abusive parents may not immediately seek medical care for the child, possibly to deny the seriousness of the child's condition, to try to cover up the abuse, or in hope the injury will heal on its own.

Caseworkers must also examine the nature of the injury, e.g., bruises or burns in the shape of an implement (a welt in the shape of a belt buckle) or a cigarette burn. Agencies will provide guidance and/or have a protocol for detailing observations of any injuries, including photographing them.

Determining Sexual Abuse

In addition to the factors mentioned in determining physical abuse, there are questions that may help determine whether sexual abuse has occurred (Adams, 2000):

- Who has reported that the child alleges sexual abuse? For example, CPS workers should be aware if there are custodial issues between the parents, which, depending on other factors, may affect the credibility of the report.
- What are the qualifications of the professional reporting the physical findings? For example, some health care providers are specially trained to conduct sexual assault physical exams and to administer rape kits. If the health care provider does not routinely examine the genitalia of young children, he or she may mistake normal conditions for abuse or vice versa.
- What is the child's description of what occurred or is occurring? Did the child describe the sexual abuse in terms that are consistent with his or her developmental level? Can the child give details, such as the frequency, time and place of the incident(s), or circumstances under which the abuse occurs (e.g., after it has turned dark on nights when the mother is at work, when stepdad comes home really late reeking of alcohol)? If a child cannot provide detailed information, it does not necessarily mean the alleged abuse did not occur. It is important to have someone knowledgeable about child sexual abuse gathering this information and/or guiding the caseworker.

- 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, including seeing pornography?
- Where does the child say the abuse took place? Is it plausible that the child described genital touching that is not sexual in nature, for example, when a parent or caregiver was bathing the child?
- What is the alleged perpetrator's relationship to the child and what is the primary caregiver's reaction? For example, is the alleged perpetrator a paramour of whom the parent is very protective in words and actions?

Determining Psychological Maltreatment

Psychological maltreatment consists of a pattern of caregiver behaviors that negatively affect the child's cognitive, social, emotional, and/or physical development and can occur by itself or in association with physical abuse, sexual abuse, or neglect (Hart et al., 2011). In order to determine if psychological maltreatment exists, CPS workers must have information on the caregiver's behavior over time and the child's behavior/condition. Workers must determine whether there is a chronic or recurring behavioral pattern of psychological maltreatment, such as parents who place expectations on their child that are unrealistic for the child's developmental level, threaten to abandon the child, or make frequent, critical and derogatory statements toward the child. There also may be indicators in the child's behavior suggestive of psychological maltreatment; however, the child's behavior alone often is insufficient to substantiate a case. The following questions may help determine if psychological maltreatment has occurred (Brassard & Hart, 2000):

- 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?

Use of Multidisciplinary Teams to Determine Whether to Substantiate a Report

Determining whether a child has been maltreated can be complicated. When a child is suspected to be physically or sexually abused or medically neglected, health care professionals may already be involved. Many hospitals and communities have developed teams of professionals from different disciplines, such as pediatricians, forensic interviewers, and other professionals, who specialize in the assessment and/or treatment of suspected maltreatment (National Association of Children's Hospitals and Related Institutions, 2011) to conduct shared decision-making with regard to concerns of child maltreatment. Involving such teams early in the process can improve accurate and comprehensive assessments, information sharing between CPS and other disciplines, and analysis of gathered information to support an accurate substantiation decision (Anderst, Kellogg, & Jung, 2009).

CPS agencies usually have protocols for how to access these teams. It can improve the determination of an (un)substantiation finding in complex situations and minimize trauma to the child and family when teams come together to assess and analyze information. In addition, collaborating with pediatricians trained in how to evaluate suspected child maltreatment will improve decision-making (Christian & Committee on Child Abuse and Neglect, 2015). The American Academy of Pediatrics has a section on child abuse and neglect that is dedicated to improving the care of infants, children, and adolescents who are abused and neglected, and the group works to develop policy statements and provides links to research papers related to practice issues in this area.[16]

6.2.2 Decision Point: Determining Whether the Family Has Concrete, Emergency Needs

Child maltreatment often is 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/investigation, the caseworker is in the position of determining whether a family has concrete, emergency needs that must be addressed immediately to address present danger threats and of arranging for emergency services or referrals to community resources or other agencies. The worker should assess for and respond to concrete needs starting at the first contact and throughout the initial assessment period. When appropriate, CPS may provide these emergency services directly or refer to community resources. Examples of services and resources to address concrete, emergency needs may include:

- Medical attention or supplies
- Food, clothing, or furniture (e.g. crib or pack and play)
- Utility assistance (e.g., when utilities have been shut off)
- Housing chore services to remove hazards
- Sanitation services to remove rodents, roaches, bed bugs
- Temporary housing or shelter services

6.2.3 Decision Point: Determining Whether a Child is Safe

As stated in the prior section and throughout the manual, safety is the paramount issue throughout the life of a case. The Adoption and Safe Families Act (ASFA) requires that states assess and assure a safe environment

16 Recent policy statements related to child abuse and neglect may be retrieved here http://pediatrics.aappublications.org/collection/committee-child-abuse-and-neglect.

for children in birth families, out-of-home placements, and adoptive homes. As reiterated earlier, determining the risk of maltreatment and of the child's safety are two separate decisions. Children may be at risk of harm sometime in the future (as determined by the risk assessment), and they may currently be safe (as determined by the safety assessment, i.e., no threat of immediate danger or imminent serious harm). Arguably, safety is on a continuum, rather than a concept that can be answered as yes or no (Pecora, Chahine, & Graham, 2013). In assessing for safety, the caseworker must consider factors that may need external intervention. The following sections describe key safety decision points during the assessment, steps for arriving at the safety decision, and development of a safety plan.

"A child is safe when there is an absence of safety threats or caregiver protective capacities are sufficient to assure protection. A child is considered unsafe when he or she is in immediate danger or at imminent risk of serious harm" (National Resource Center for Child Protective Services, n.d., p. 1).

Safety Decision Points

There are two key decision points during the initial assessment in which the child's safety is evaluated. During the first contact with the child and family,, as discussed throughout the first section of this chapter, the caseworker must decide whether the child will be safe during the initial assessment, i.e., "*Is the child in danger right now?*"[17] CPS workers assess current danger by evaluating circumstances in the family situation and/or caregiver behavior or condition, emotions, physical circumstances, and social contexts. Examples of these circumstances include young children with serious injuries that are inconsistent with the caregiver's explanation, children in the care of caregivers who are out of control or violent, and intentional maltreatment or bizarre cruelty.

Although safety must be assessed continuously because new information or circumstantial changes can affect the initial decision, a 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 risk assessment and a more complete picture of the family's dynamics and circumstances. *At both decision points,* caseworkers must determine whether:

- There are protective factors and or the parent has the capacity to protect the child
- The child will be safe in his or her home with community services or no additional services
- An in-home safety plan and continued CPS intervention is needed to control for the child's safety
- Safety services are needed and at what level of intensity if an in-home service plan is feasible
- The child needs to be placed in out-of-home care because an in-home safety plan is not feasible

To determine safety at this point, as mandated by CAPTA (Sec. §106(a)(4)),[18] the CPS worker uses tools and protocols for assessing safety and risk. The caseworker identifies the factors: that directly affect the safety of the child; are operating at a more intense, explosive, immediate, and dangerous level; or, in combination, present a more dangerous mix. The caseworker then weighs or balances the factors directly affecting the child's safety against the family or caregiver protective factors (strengths/resiliencies/resources) to determine if the child is safe (Holder, 2000). **Exhibit 6.3** lists the steps for arriving at the decision.

17 It should be noted that there are different points of view about whether determining if a child is safe is a definitive, yes-or-no decision.

18 See https://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf, p. 17.

Exhibit 6.3: Steps for Arriving at the Safety Decision (DePanfilis, 1996).

1. Identify the behaviors and conditions that increase concern for the child's safety, and consider how they affect each child in the family. Sometimes these characteristics are called safety threats or safety factors.
2. Identify the behaviors and conditions that may protect the child. In some safety models, these characteristics are called protective capacities.
3. Examine the relationship among the safety threats. When combined, do they increase concern for safety?
4. Determine whether family members and/or other community partners are able to address safety concerns without CPS intervention.
5. For each factor directly affecting the child's safety, consider what in-home services are needed to address the specific behaviors and conditions.
6. Identify who is available (CPS or other community partners) to provide the needed service/intervention in the frequency, time frame, and duration the family needs to protect the child.
7. Evaluate the family's willingness to accept and ability to use the safety intervention/service at the level needed to protect the child.

If the safety services or interventions are not available or accessible at the level the family needs to protect the child, or if the caregivers are unable or unwilling to accept and use the services, caseworkers should consider whether the abusive caregiver will leave home and the nonmaltreating caregiver can protect the child or whether out-of-home care and/or law enforcement or court intervention are needed to assure the child's safety.

Safety Assessment in Families With Co-Occurrence of Domestic Violence and Child Maltreatment

Children who live with and are aware of violence in the home face many challenges and risks that can last throughout their lives (UNICEF, 2006). When CPS workers are assessing child safety in families where domestic violence occurs, the worker should be aware of the following short-term effects that children may present: generalized anxiety, sleeplessness, nightmares, difficulty concentrating, high activity levels, increased aggression, increased anxiety about being separated from a parent, and intense worry about their safety or the safety of a parent. Exposure to domestic violence (also known as witnessing) has also been linked to poor school performance, and children may have impaired ability to concentrate; difficulty in completing school work; and lower scores on measures of verbal, motor, and social skills (National Child Traumatic Stress Network, n.d.-b). Furthermore, adolescents who have exposure to both child abuse and domestic violence experience greater internalizing and externalizing behavior problems than those with a single exposure (i.e., abuse only or exposure to domestic violence only) (Moylan et al., 2010).

There are numerous forms of domestic violence, including physical violence; sexual violence; threats of physical or sexual violence; psychological/emotional violence; and economic violence (Children's Hospital of Philadelphia Research Institute, n.d.). The most commonly considered type of domestic violence centers on a pattern of coercively controlling behaviors perpetrated by one intimate partner against another (Stark, 2002). These controlling behaviors do not always involve physical violence, but physical violence can escalate in coercively controlling situations. Some CPS offices have domestic violence specialists on site to assist with evaluations of safety when both child maltreatment and domestic violence are alleged. When assessing safety in cases where domestic violence and child abuse and neglect overlap, the caseworker should consider the factors detailed in **exhibit 6.4**.

Exhibit 6.4 Factors to Consider With Families Experiencing Domestic Violence (Child Welfare Information Gateway, 2003; Ganley & Schecter, 1996; King County, 2015)

- Circumstances of the alleged child maltreatment:
  - Child was assaulted, injured, or threatened during a domestic violence incident.
  - Child was in danger of physical harm during the incident
- Perpetrator's access to the child or adult survivor(s)
- Diminished protective capacity of the adult survivor because the parent was harmed or incapacitated by the perpetrator to such an extent that he or she is unable to meet the needs of the children
- Pattern of the abuse:
  - Frequency/severity of the abuse in the current and past relationships
  - Use and presence of weapons
  - Threats to kill the survivor or other family members
  - Hostage taking, stalking
  - Past criminal record
  - Abuse of pets
  - Child's exposure to violence
- Perpetrator's state of mind:
  - Obsession with the adult survivor
  - Jealousy
  - Ignoring the negative consequences of the violence
  - Depression or desperation.
  - Threats or attempts to kill adults or children
  - Display, threat, or use of firearms or other deadly weapons
- Individual factors that reduce the behavioral controls of either the survivor or perpetrator:
  - Abuse of alcohol or other substances
  - Suffers from untreated psychosis, other major mental health disorder, or brain damage
- An adult survivor, child, or perpetrator thinking about or planning suicide
- An adult survivor's use of physical force or emotional abuse to the child
- A child's use of violence
- Situational factors:
  - Presence of other major stresses, e.g., poverty, loss of a job, or chronic illness
  - Increased threat of violence when the survivor leaves or attempts to leave the perpetrator
  - Increased risk when the perpetrator has ongoing or easy access to survivors
  - Physical inability of nonmaltreating parent to protect child due to assault
  - Nonmaltreating parent's fear of leaving or inability to leave due to economic status or lack of safe alternative place

The companion to this manual, Child Protection in Families Experiencing Domestic Violence, provides an indepth look at the overlap of domestic violence and child abuse and neglect, including the causes and types of domestic violence, barriers to leaving, the impact of domestic violence on survivors and their children, levels of dangerousness, understanding perpetrators, and how to assess families and to develop safety plans.

https://www.childwelfare.gov/pubs/usermanuals/

Safety Assessment in Cases of Families Affected by Substance Use Disorders

CPS workers should be aware of the relationship between parental alcohol or drug use, abuse, and dependency and child maltreatment. Safety and risk assessment instruments examine its specific influence among families referred for initial assessment. While the prevalence of alcohol and drug problems among parents served by CPS agencies is considered to be under-reported, some national data do draw the connections.

- In 2015, 25 percent of child maltreatment victims were reported with a drug abuse caregiver risk and 10 percent with an alcohol abuse caregiver risk (U.S. Department of Health and Human Services (HHS), Administration on Children and Families (ACF), Children's Bureau, 2017, p. 21).
- 8.7 million children live with at least 1 parent who abused or was dependent on alcohol or an illicit drug (Lipari & Van Horn, 2017, para.7).
- Each year, an estimated 15 percent of infants are affected by prenatal alcohol or illicit drug exposure (National Center on Substance Abuse and Child Welfare, 2015, para.1).

There are many children and families who come in contact with CPS agencies with drug or alcohol problems that may affect children in numerous ways. To assess whether a child is unsafe due to a parent's alcohol or drug use disorder or misuse, the worker should analyze information related to the type and frequency of use and understand how this affects a parent's capacity to adequately care for children and keep them safe. Many CPS programs use substance abuse treatment consultants to help with assessing parents whose use, abuse, or dependency appears to be jeopardizing their children's safety.

As a first step to knowing whether a substance use disorder consult is needed to evaluate safety, a CPS worker may want to implement a basic screening. The Substance Abuse and Mental Health Services Administration (SAMHSA) publishes resources for screening for alcohol and other drugs.[19] A helpful screening tool useful to understanding whether a more comprehensive assessment is needed is the CAGE-AID questionnaire (Brown & Rounds, 1995). Two or more affirmative responses indicate, with high likelihood, that the person is a problem drinker and/or drug abuser and requires further assessment. The CAGE-AID is available publicly and comprises only four questions:

1. Have you ever felt that you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you ever felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

19 Screening tools published by SAMHSA available at http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs and https://www.ncsacw.samhsa.gov/resources/daily-practice-client.aspx.

Responding to Child Fatality Cases

While not a frequent occurrence, a caseworker might have some involvement or need to address a child fatality. Whether or not there is an active child welfare case, a report of a child's death made to a state, tribe, or jurisdiction is considered a critical incident and requires that certain steps be taken. Every state has protocols for addressing child fatalities and the person who has responsibility for carrying out those steps.

The protocol may direct that there is a joint response between CPS and law enforcement, or it might entirely rest on law enforcement. However, it is usually the caseworker's responsibility to assess the safety of any other children in the home. It is best practice to provide the family with community resources, specifically for grief and loss, which may be supportive to them. For more on the response to child fatalities, see https://www.childwelfare.gov/topics/responding/fatalities/.

Child Fatality Review Teams

All CPS agencies use child fatality review teams to look at system breakdowns that may have either contributed to a child maltreatment fatality or could possibly prevent similar circumstances in the future by changing policies or practices that would target similar, high-risk situations differentially.[20] The focus of the reviews should be on learning and supporting workers and supervisors who may have been involved with the child and family. Chapter 14 discusses ways to support caseworkers dealing with critical incidents.

Using Teams to Inform Safety Decision-Making[21]

When workers and supervisors have concluded that a child is unsafe, some CPS programs implement child safety team meetings to assist in making the decisions about where a child can safely live. Parents and other family and community members whom they wish to invite join with the representatives of the CPS agency, including the caseworker, supervisor, and other current or past service providers, such as substance use disorder counselors or domestic violence specialists. Caseworkers should work with the families to help identify relatives or close friends to be a part of the safety planning (and, if needed, for relative placement/kinship care). A facilitator runs a child safety team meeting with the goal of coming to agreement about how to manage the safety of the child either through the receipt of in-home services or through out-of-home placement. Initial safety meetings are held within 24 to 48 hours of when a CPS worker makes the referral so that timely decisions may be made. Research on the benefit of child safety team meetings such as Team Decision Making, or similar types of meetings is equivocal with respect to specific child welfare outcomes; however, one potential benefit appears to be an increase in kinship care placements versus formal foster care (LaBrenz& Fong, 2016).

20 Resources including links to Child Death Reports for each state are available from the National Center for the Review and Prevention of Child Deaths at http://www.childdeathreview.org.

21 The Annie E. Casey Foundation has supported the development of team decision-making meetings for nearly 20 years. To read more about this initiative and download an infographic on team decision making, go to http://www.aecf.org/blog/team-decision-making-a-better-way-to-assess-child-safety/.

Development of a Safety Plan

The safety plan and the family plan have two different purposes. As chapter 8 lays out, the family plan (also known as the case plan) outlines the outcomes, goals, timelines, tasks, change strategies and interventions, and supports necessary to reduce the risk of maltreatment, assist in achieving those outcomes and goals, or facilitate adoption or other permanent placement when a child cannot safely return home. The interventions in the safety plan are designed to control the safety threats to the child. To control the factors directly affecting child safety, the identified safety interventions must:

- Have a direct and immediate impact on one or more of the safety factors
- Be accessible and available in time and place
- Match the duration of the threat of harm
- Fill the gaps in caregiver protective capacities with safety services to control for the specific threats to safety
- Include realistic timeframes and expectations for both immediate services and for how long to maintain the safety plan

In identifying safety interventions and developing a safety plan, ASFA requires workers to make reasonable efforts to preserve or to reunify families, and those efforts may include developing a safety plan and connecting a family with services, resources, and supports that are tailored to address the specific factors that impede the child's safety. Child safety is the most important consideration in these efforts. ASFA also states that when certain factors—considered "aggravated circumstances"—are present (such as, but not limited to, abandonment, torture, chronic abuse, some forms of sexual abuse, killing of another person or the child's sibling, or termination of parental rights to 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 services provided outside of the home, which address the needs (e.g., child care services)
- A maltreating parent or perpetrator temporarily or permanently leaves the home
- Relative or kinship care
- Out-of-home-placement

The safety assessment should be conducted jointly with the family, when possible; it may not be safe to include the maltreating parent, and the safety assessment may need to be done with him or her separately. The safety plan also should be developed with the family. This accomplishes the following (Berg & Kelly, 2000):

- The worker and the caregivers assess the feasibility of the caregivers following the safety plan
- The worker can be assured that the caregivers understand the consequences of their choices
- The caregivers are provided with a sense of control over what happens and are able to salvage a sense of dignity

An important component of all safety plans includes identifying who is responsible to manage the identified interventions in the plan. This ensures not only that all safety services are implemented as intended at the level of intensity specified in the plan but also that the behaviors that need to be addressed are monitored. Initially, this usually is a CPS worker. Later, the responsibility may be transferred to the worker assigned to provide and monitor ongoing services (e.g., family preservation worker, community prevention worker). It is important that whenever a case is transferred, all key concerns are flagged and documented so that the plan and identified interventions can be monitored effectively. Chapter 12 discusses how to document this information to help ensure that this happens. Safety plans should have regular and frequent reviews built in to assure that the safety threats are controlled.

An example of a safety plan is presented in **exhibit 6.5**. Given that most states have developed their own list of safety threats, general safety threats are used. Of greater importance is the family-specific information to justify the conclusion for each threat identified. In this example, 3-year-old Dante is in the care of his single mother, Amber. The agency determined Dante has typical child functioning for a child his age: he is talkative, persistently demands attention, and will whine and complain when he wants something. The actions and time frames of the safety plan directly relate to when and how the danger is understood to occur. In addition, even if the safety threat becomes active, there is someone present to ensure no severe effect or harm to the child.

Exhibit 6.5 Sample Safety Plan[22]

Safety Threats Identified	Information From Investigation to Describe Threats	When, How, and Triggers to the Safety Threats	Safety Services/ Actions to Control Threats	Who, Where, and When of the Safety Plan
1. Lack of supervision. 2. Amber cannot control her feelings and resulting impulses/ behaviors. 3. Amber has extremely negative and unrealistic perceptions of Dante.	• When Dante demands attention or is defiant or challenging, Amber quickly becomes frustrated with his behavior. She does not know how to handle these situations or her own negative feelings, which results in the lack of supervision: Amber locks Dante in his room. When Dante is locked in his room, Amber ignores his cries or will leave the home as a means of coping with her frustration. • Amber does not understand that Dante's behaviors are typical for a child his age, and she expects him to not whine or repeatedly ask for attention after she says "no." When Dante begins to whine, cry, or otherwise act out, Amber feels these behaviors are a personal attack. She has expressed that she feels Dante is attempting to make her "miserable," and she calls him derogatory names.	• The agency's investigation revealed that Dante is in preschool/child care Monday—Friday while Amber is at work. As long as he gets to bed on time, weekday mornings are not a concern. Saturday and Sunday mornings also are not a concern, as Amber is not trying to get things done and is more relaxed. • The times Amber is trying to cook, clean, or run errands are when she is most frustrated. These are the times when Dante demands attention or acts out, and Amber is prone to locking him in his room. The safety threats are likely to become active weekday evenings and during the late afternoon of the weekends. The agency determined that prior to the safety plan, Amber was locking Dante in his room two to three times per week, up to a few hours each time.	• Supervise and monitor, crisis management to deescalate Amber if she is getting frustrated and assume parenting of Dante if Amber is not supervising or responding to him. Ensure Dante is not locked in his room. • Separation of Dante from the safety threats via child care/care by a licensed childcare provider. • Identification of supports for the mother when she is having negative and unrealistic perceptions, and clarification of age-appropriate behaviors.	• Amber's cousin, Anthony Ruiz, Thursday–Sunday, from 6 p.m. until Dante is asleep (between 8 and 9 p.m.). • Amber's mother's best friend, Shelly Lindberger, Monday–Wednesday, from 6 p.m. until Dante is asleep (between 8 and 9 p.m.). • Dante will continue to go to his child care provider, Tiffani Magee, Monday–Friday, 9 a.m.–5:30 p.m. Additionally, he will go from 2–4 p.m. both Saturday and Sunday. This separation while Amber is not at work will give her time to run errands and complete chores without Dante present, lowering her stress, and making the safety threat less likely to occur.

22 Developed by Action for Child Protection, January 2018.

The Capacity Building Center for States provides information on models and approaches for targeting safety outcomes in its publication, *Showcase: Safety Outcomes and Decision-Making Approaches*. It includes how to use decision-making and practice models, teaming during different decision-making points, and existing data to engage in predictive analytics: https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Record?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27safety+outcomes%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=2&.

The Center for States also reviews current research around decision science and safety decision-making practices in child in *Decision-Making in Child Welfare for Improved Safety Outcomes* at: https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Record?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27risk+assessment%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=1&.

6.2.4 Decision: Determining Whether the Child is at Risk of Future Maltreatment

As discussed earlier, "the concepts of safety and risk are different but related" (Keating, Buckless, & Ahonen, 2016, p. 2). Safety refers to immediate and/or imminent harm, while risk of maltreatment is a broader concept sometimes simply defined as the likelihood of future maltreatment. Risk assessment is designed to predict whether a child might be maltreated sometime in the future. 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's and family's situation to identify and weigh the risk factors, as well as how family strengths and resources and agency and community services may mitigate or contribute to risk (Pecora, Barth, Maluccio, Whittaker, & DePanfilis, 2009).

The next sections describe risk assessment models, key elements, and analysis of risk assessment information.

Risk Assessment Models

Risk assessment protocols were established prior to the more recent focus on child safety. If a state uses both a safety assessment and a risk assessment model, they are designed to work together to establish the best way to respond to children and families. The majority of states use risk assessment models or systems, which are designed to (Hollinshead & Fluke, 2000):

- 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 other community stakeholders

There are three main types of risk assessment models used in the child protection field (Hollinshead & Fluke, 2000):

- ***Actuarial models*** ask caseworkers to rate risk factors identified through research as reliable and valid factors associated with the risk of future harm to the child. They rate the risk factors using numerical, scaled values. In some states, the ratings automatically generate an overall risk rating in the case.
- ***Consensus models*** ask caseworkers to score risk factors that have been identified by experienced, child protection professionals as being most closely linked to the risk of future harm to the child. They score the factors based on descriptions, which are based on examples of behaviors or conditions that characterize a certain risk rating.
- ***Composite actuarial-consensus models*** combine risk factors supported by empirical research and include factors identified by professionals as important and relevant to the risk of future harm.

Even though risk assessment approaches have been around for some time, how well they will guide decision-making is dependent both on the reliability and validity of the model (Shlonsky & Gambrill, 2014), as well as how well they are implemented as intended (DePanfilis, 1996). New ways of thinking suggest that jurisdictions should integrate risk assessment with clinical judgment in an evidence-based practice framework, optimizing the use of data in the real context of the family and its situation (Shlonsky & Gambrill, 2014, Shlonsky & Wagner, 2005).

Regardless of the model, risk assessment usually considers factors related to the following areas: child maltreatment, the child, the caregivers, parenting, and family functioning. **Exhibit 6.6** presents examples in each area.

Exhibit 6.6 Examples of Risk Assessment Information

Maltreatment

- Parent actions and behaviors responsible for the maltreatment
- Duration and frequency of the maltreatment
- Physical and emotional effects on the child
- Parent's attitude toward the child's condition and the initial assessment
- Parent'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
- Supportive relationships outside of the home
- Financial situation

Parenting

- Nature and quality of the caregiver-child relationship (e.g., attachment, empathy toward child)
- Attitudes toward and expectations of the children
- Understanding and use of disciplinary methods
- Understanding of child development
- Ability to provide attention, affection, and nurturing to the children

Family Functioning

- Power and boundaries in the family
- Interactions and communications among family members
- Interactions and connections with others outside the family
- Quality of relationships (awareness of, and ability to respond appropriately to, each other's needs)

Analysis of Risk Assessment Information

CPS workers analyze the information collected to determine what information is significant in terms of its contribution to the risk of maltreatment. The following are suggested steps for assessing risk:

- Organize the information by defined categories
- 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
- Group the significant information into an overall picture of the family to produce a meaningful conclusion regarding the risk of maltreatment.

6.2.5 Decision Point: Determining if Ongoing Services Will Be Offered

The final decision that a caseworker makes during the initial assessment is whether to offer a family ongoing CPS or other agency services or to end agency involvement with the family. (Chapter 11 describes the process of ending CPS involvement in more detail.) Who is offered services and on what basis that decision is made depends on guidelines and availability of services, which can vary by state, tribe, and jurisdiction. (Working with the family and determining change strategies and interventions are discussed in the next two chapters.) In some cases, the decision is made on the basis of whether a report is substantiated; in others, it is based on the level of perceived risk of maltreatment in the future, as substantiation alone is not the best predictor of future maltreatment. More recently, some states have offered continuing services when the safety assessment has determined that a child is unsafe. Sometimes the continuing services are offered by the CPS agency, but, often, ongoing services, whether voluntary or court ordered, are provided by community-based service agencies either alone or in collaboration with CPS. In either case, as discussed earlier and in chapter 12, documentation is key if the case is transferred to another worker or agency.

The two primary reasons to offer services and change strategies are to (1) prevent future instances of child maltreatment, and (2) remedy the conditions that brought the children and their families to the attention of the agency, as well as other issues that may have been raised by the parent or identified subsequently by the caseworker during the assessment. In 2015, 47 states reported that 2.3 million children received services with the goal of preventing recurrence of maltreatment. Approximately 1.3 million children received postresponse services from a CPS agency, and two-thirds of victims and one-third of nonvictims received postresponse services (HHS, ACF, Children's Bureau, 2017, p. xi). In cases where both a tribe and state are involved, the state may conduct the CPS investigation while the tribe provides the in-home services. There are a number of variations of how cases with tribal children are managed, e.g., tribal culture typically specifies who is expected to care for a child if a parent is not available.

6.2.6 Decision Point: Differential Response

As noted in chapter 5, many states have implemented differential response (DR) organized CPS systems. These systems have two pathways for serving accepted child maltreatment reports: an investigation response (IR) for high-risk or egregious maltreatment reports and an alternative response (AR), which some states refer to as the family assessment response (FAR), for moderate- and low-risk maltreatment reports.

States implementing DR have different criteria and processes for determining the assignment to either the AR or IR pathway. For example, some states implement DR at intake, i.e., after meeting certain criteria, the report is referred to that track. Other states wait until after the initial assessment to determine if the case should be referred to DR or if a more traditional investigation should continue. Some of those criteria include age of the child, number of previous reports, and source of the report. There are some states that have an additional pathway to serve families whose reports are screened out with the purpose of connecting families with voluntary services and resources to meet their needs. Typically, community-based organizations serve families whose reports are screened out from receiving a formal CPS response. In general, core elements of a DR system include (Child Welfare Information Gateway, 2014; National Quality Improvement Center on Differential Response in Child Protective Services, 2010):

- Two or more discrete responses (pathways or tracks) for cases that are screened in and accepted for response by CPS
- Use of protocols and criteria to determine the response pathway, based on factors that might present imminent danger or other risks
- Formalization of DR in statute, policy, or protocols
- Ability to change tracks, based on new information that alters risk level or safety concerns
- For families receiving AR: (1) voluntary participation as long as there are no safety concerns; (2) no formal determination of whether child maltreatment has occurred, meaning there is no substantiation decision; and (3) no listing of parents' names in a central registry

CPS delivers both the IR and AR response. Because DR-organized systems respond to screened-in reports on both the IR and AR pathway, all reports, independent of the pathway, receive a safety or risk assessment per the state or jurisdiction's standard protocols. In some states, the AR worker also conducts an assessment of service needs with the intent of linking families with needed resources. Families receiving AR may be closed at intake, or, in some communities, may be transferred to an ongoing services unit.

A key issue in the evaluations of DR is that jurisdictions implement DR inconsistently (Casey Family Programs, 2012; Fluke et al., 2016), making comparison of its impact challenging. Nevertheless, in two studies examining the potential impact of DR on child safety, findings suggest that higher rates of DR implementation were associated with both lower re-reports and re-reports with substantiation (Casey Family Programs, 2012; Fluke et al., 2016).

As discussed in chapter 2, the reauthorization of CAPTA in 2010 specifies that DR is an eligible use of basic, state-grant funds for improving CPS. As of 2017, the California Evidence-Based Clearinghouse rates Minnesota's FAR as a promising practice for Child Welfare.[23] The specific classification identifies the FAR with a scientific rating of "promising research evidence" and "high child welfare system relevance" in the area of reducing racial disparity and disproportionality in child welfare.

The process for assessing families in jurisdictions that implement DR varies but is likely to be consistent with the comprehensive family assessment process presented in the next chapter of this manual. However, that assessment is the next stage in the CPS process; it is also applicable for families that are not eligible for DR but are now involved with CPS.

23 http://www.cebc4cw.org/program/family-assessment-response/

Chapter Highlights

- After accepting a report of child maltreatment, CPS workers conduct an initial assessment to determine whether child maltreatment occurred; assess children and families related to emergency needs, risk, and safety; and determine whether continuing services should be provided to prevent future maltreatment and to address the consequences of maltreatment.
- Assessing for safety of the child at this point and throughout the life of the case is paramount.
- For child fatality cases, when a caseworker is assessing the safety of any other children in the home, it is best practice to provide the family with community resources, specifically for grief and loss, which may be supportive to them.
- CPS workers use a trauma-informed approach to minimize the potentially adverse impact of the initial assessment process and to improve the completeness of the information collected.
- The initial assessment process includes implementing interviewing protocols with the identified child, siblings, adults in the home, nonresident parents, and the alleged maltreating parent or caregiver.
- The CPS worker also observes the child, siblings, family interaction, and home and neighborhood and collects information from others about the alleged maltreatment and risk and safety of the children.
- Other professionals, most notably law enforcement and medical personnel, may contribute to the assessment of alleged maltreatment, safety, and risk.
- In certain types of alleged maltreatment, Child Advocacy Centers may be employed to minimize the trauma of the assessment process by reducing the number of child interviews and by facilitating interagency collaboration.
- Multidisciplinary teams may convene to help analyze the information collected and to inform decision-making about the alleged maltreatment and safety and risk.
- Child safety team meetings that include engagement of family members may be employed to support developing safety plans, preferably in home when possible.
- Many states use a differential response for lower-risk situations so that assessments of families occur without a determination of child maltreatment. Some recent evaluations suggest that in jurisdictions that use a DR system, there are lower re-report and substantiated re-report rates than jurisdictions that do not use alternative responses.

Chapter 7: Comprehensive Family Assessment

As discussed in chapter 6, if a report of alleged maltreatment is substantiated or founded, the next step in the CPS process is the comprehensive family assessment. The primary purpose of conducting a comprehensive family assessment is to gather and analyze information that will guide the intervention change process with families and children. Through Child and Family Services Review (CFSR) findings, the Children's Bureau identified a connection between comprehensive family assessments and good outcomes for children and families: positive ratings on comprehensive family assessments were associated with positive ratings on permanency and safety outcomes (Child Welfare Information Gateway, 2014). Thus, targeting change strategies to the unique risk and protective factors present in families (as identified through the assessment process) will likely lead to increased safety, permanency, and well-being of children and families. There is widespread agreement across the field that effective intervention to reduce the risk of child maltreatment should be based on a comprehensive, individualized assessment of the family.

As discussed in the previous chapter, who conducts the comprehensive family assessment depends on the state, tribe, or jurisdiction. In some cases, it may be the same person who conducted the initial assessment; in others, it may be transferred to a worker who provides ongoing services. During this stage, the practitioner responsible for providing or arranging change strategies (i.e., CPS worker or community practitioner) engages the family in a process designed to gain a greater understanding about the strengths, needs, and resources of the family so that change strategies will be tailored to achieve relevant outcomes. The family assessment also focuses on understanding any effects of child maltreatment, including trauma symptoms, that may need change strategies or intervention. This chapter explores:

- Principles for conducting family assessments
- The process of planning and implementing the family assessment
- Key decisions made during family assessments
- Special practice issues that may warrant collaboration with community providers

7.1 Principles for Conducting Family Assessments

Family assessments should be strengths-based, culturally sensitive, and developed in collaboration with the family. They should be designed to help parents recognize and remedy conditions, so children can safely remain in their own home to the maximum extent feasible (National Association of Public Child Welfare Administrators, 1999). Given the

emphasis on timeliness built into the Adoption and Safe Families Act (ASFA),[1] 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 (HHS, ACF, Children's Bureau, 2013). Principles of the comprehensive family assessment process are outlined in **exhibit 7.1**.

Exhibit 7.1	Principles of the Comprehensive Family Assessment
Consider unique needs	Children and families who come to the attention of child welfare agencies and their community partners have unique strengths and needs. Therefore, assessments must be individualized and tailored to the individual strengths and needs of each family (Chadwick Center for Children and Families, 2009; Schene, 2005).
Respect cultural differences	Culturally sensitive assessment recognizes that parenting practic-es and family structures vary as a result of religious, ethnic, cultur-al, community, and familial differences, and that this wide range can result in different but safe and adequate care for children. Each family has its own structure, roles, values, beliefs, and coping styles. Respect for and acceptance of this diversity is a corner-stone of comprehensive family assessments. The assessment pro-cess must acknowledge, respect, and honor the racial, ethnic, cul-tural, religious, and socioeconomic diversity of families while ad-hering to laws and keeping the child safe (Constable & Lee, 2015; Fong & Furuto, 2001).
Emphasize strengths	Assessments should be strengths-based (Browne, 2014), devel-oped with the family, and should be designed to help parents or other caregivers recognize and remedy conditions so children can safely remain in their own homes.
Conduct assessments in a timely manner	Given the emphasis on timeliness built into ASFA, the assessment of the family's strengths and needs should be comprehensive but considered in the context of the length of time it will take for the family to provide a safe, stable home environment (HHS, ACF, Children's Bureau, 2013).
Collaborate across systems	When possible, the assessment process should be undertaken in conjunction with other service providers to form a comprehensive picture of the individual, interpersonal, and societal pressures on individual family members and the family as a system (Taylor, Schultz, & Noel, 2007). 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. This also improves assessments of parents and children related to exposure to complex trauma (Chadwick Center for Children and Families, 2009).
Involve both parents and extended family	The assessment should be undertaken in conjunction with nonres-ident parents (Coakley, 2014) and with extended family members and those in the support network who can be included in family decision-making meetings or other processes to increase under-standing and to co-construct relevant solutions (American Humane Association & FGDM Guidelines Committee, 2010; Merkel-Holguin, 2000; Merkel-Holguin, 1998; Merkel-Holguin, 2001).
Use assessment tools	For both practice accountability and empirical usefulness, practi-tioners should consider incorporating the use of assessment tools and standardized clinical instruments in their assessment of specif-ic risk and protective factors. Assessing change over time is more easily accomplished when standardized tools are incorporated in the comprehensive assessment. Selected examples are provided in **exhibit 7.2**.

1 ASFA requires that a child welfare agency file a petition for termination of parental rights if a child has been in foster care for 15 of the past 22 months, unless it is not in the best interest of the child. See https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf.

7.2 Family Assessment Process

In contrast to the initial assessment, which focused on immediate danger to the child and the risk of future threats to safety in the family, the comprehensive family assessment considers the relationship between protective and risk factors (see box below) and identifies what must change in order to (1) keep children safe, (2) reduce the risk of future maltreatment, and (3) address any effects of past or ongoing child maltreatment. Consequently, where the initial assessment may have focused on the most serious problems, the comprehensive family assessment promotes an understanding of the enabling or maintaining behaviors that contribute to the problems (Schene, 2005), and more fully develops and plans around an understanding of the family's natural supports and strengths.

Protective and Risk Factors

Protective factors are conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families and appear to mitigate vulnerability to or negative effects from maltreatment.

Protective capacities are caregiver characteristics that help ensure the safety of his or her child; building protective capacities contributes to a reduction in risk and an increase in safety.

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

A webinar developed and hosted by the Child Welfare Capacity Building Collaborative, *Protective Capacities and Protective Factors: Common Ground for Protecting Children and Strengthening Families*, examines protective capacities and protective factors frameworks and explores how to use them together to create stronger safety assessments. It is available at: https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Record?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27risk+assessment%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=3&.

To accomplish the purpose and objectives of the family assessment, CPS workers should:

- Review the initial assessment summary, including decisions and conclusions
- Arrange a transfer staffing if case is transferring to a new worker, i.e., meet with the initial worker so the initial worker can offer perspective, answer questions, and share nuances not captured in the assessment summary
- Develop a plan for conducting the comprehensive family assessment
- Employ a protocol for meeting with all members of the household as well as other persons the family identifies as having an interest in the safety and well-being of the child
- Consult with other professionals particularly when parents or children may have specialized needs (e.g., physical disabilities, mental health, alcohol or other drug, trauma symptoms) that need to be understood before developing a family plan for change focused intervention
- Analyze information and make necessary case and safety planning decisions
- Produce a comprehensive family assessment summary that synthesizes key information about the children, parents, family, culture, and environment, and targets child and family level outcomes

7.2.1 Review the Initial Assessment Decisions and Conclusions

To provide focus for the family assessment, the worker begins by reviewing the information previously gathered and analyzed during the initial assessment. Based on an analysis of this information, the worker develops a list of questions that need to be answered during the family assessment process, such as:

- What was the nature of the maltreatment (type, severity, chronicity)?
- What was the family's understanding of and response to the maltreatment?
- Which risk factors, identified during the initial assessment, are most concerning?
- What is the child's current living situation? Is the child safe there? Is it a stable situation?
- Was a safety plan developed, and how has the family managed to maintain this plan? Who is currently responsible for managing the safety plan?
- What is currently known about the parents' history? Are there clues that suggest that further information about the past will help to explain the parents' current functioning, e.g., trauma?
- Was the family previously involved with the child welfare system, and is there information available? What was the family's understanding of the child welfare involvement?
- Does the family have any criminal background information? If so, what was the family's explanation for it?
- Is the family currently receiving any services or accessing resources? Has the family sought out services in the past, and what was the outcome?
- What is known about the family's social support network, i.e., who is supporting the family, in what ways, and are they reliable and available on an ongoing basis?

- 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?
- What individual strengths do each of the family members have?
- Have problems been identified that may need further examination or evaluation of the children or parents (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?
- What is the readiness, willingness, and ability of family members to work toward behavioral change?

7.2.2 Develop a Plan for the Comprehensive Family Assessment

Based on the areas identified through the review, the worker should develop a plan for how the assessment process will occur. In general, it takes several hours of face-to-face time 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. It is important to ensure that there is no significant lapse in time between contacts so that safety continues to be managed. The following issues need to be considered when developing the plan for the comprehensive family assessment:

- When will the first meeting with the family be held to review the information gathered in the initial assessment?
- 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 (friends, nonresident parents, extended family, professionals) who have critical information about the needs of this family? How will they be involved in the process, e.g., will the agency incorporate a team or family group decision-making model? (For more on this model, see chapters 6 and 8.)
- Will the assistance of other professionals be needed (e.g., for psychological tests or substance use disorder assessments)?
- What reports may be available to provide information about a particular family member or the family as a system (e.g., from school, health care providers)? Will releases need to be signed by the family to obtain those reports?
- Will assessment instruments be employed to better understand risk and protective factors and needs of family members?
- When will the information be analyzed and a comprehensive family assessment summary completed?
- How will the worker discuss this information with the family?

7.2.3 Implement an Interviewing Strategy With Family Members

To conduct the comprehensive family assessment, the worker implements a series of meetings with the family as a whole, i.e., with individual family members and with others who can contribute to the best understanding of risk factors (which may become the focus of change-focused intervention) and strengths, supports, and other protective factors that will help the family make the needed changes. If self-report instruments will be employed, they should be implemented early in the assessment process so that results can be discussed and potentially become the focus of future conversations.

Family meeting. Because the worker conducting the comprehensive family assessment may not always be the same person who conducted the initial assessment (though it may be helpful for that worker who conducted the initial assessment to also be present), it is important to begin with all immediate family members, if possible and safe. This ensures that each immediate family member who has a role in the life of the child knows the expectations from the beginning, that everyone's participation is judged important, and that communication is open and shared among family members. The primary parent(s)/caregiver(s) should make the decision about whom to include in this meeting.

During this first family meeting to begin the comprehensive family assessment process, the worker should provide an opportunity for the family to discuss the initial assessment and then share the plan for conducting the family assessment and seek acceptance concerning scheduling and participation. The worker should be specific with the family about the purpose of the family assessment and should avoid technical or professional terminology. It is also important to affirm that the intention of CPS is to help the family:

- Keep the child safe
- Recognize current safety threats
- Mutually address identified problems to reduce the risk of child maltreatment in the future

In general, the worker should attempt to gain an initial understanding of the family's perception of CPS, their family culture, their strengths, their problems, their current situation (e.g., in crisis, stable, or experiencing chronic issues), and their openness to working with CPS. If instruments (e.g., assessment tools) will be used, it is helpful to review how and when this will occur and how they will aid understanding the views of individual family members about their strengths and needs.

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 roles and interactions. The timing of this next meeting will vary based on state and jurisdictional protocols for the assessment timeframe. Workers should consider communication patterns, alliances, roles, and relationships.

Meetings with individual family members. At the beginning of each initial and ongoing meeting, the caseworker should clarify the primary purpose of the meeting (e.g., changes to the safety plan or permanency goals, or if more or different services or interventions are needed) 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, as well as to ask the parent what he or she wishes to discuss. This is not an interrogation; the caseworker is trying to get to know the family member to understand him or her and his or her situation better. In each individual meeting, the worker should carefully explore the areas that have been identified previously for assessment.

- In interviews with the children, the emphasis likely will be on understanding more about any effects of maltreatment or trauma resulting from CPS intervention.
- In the interviews with the parents, the emphasis is on uncovering the underlying contributors to the risk-influencing behaviors and conditions and obtaining the parents' perceptions of their problems. It is important to examine the influence that history and culture may have on current behavior and functioning.

- In meetings with both children and the parents, the worker should 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. The worker may consider using motivational interviewing techniques to help the family members self-assess readiness to change (Miller & Rollnick, 2012), identify discrepancies, and engage family members in conversations about the prospect of change.

Meetings with parents and other caregivers. 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 worker should:

- Observe and evaluate the nature of the relationship of the parents and how they communicate and relate with each other
- Consider and discuss parenting issues and partner satisfaction
- Seek the parents' perceptions of the problems, current situation, and family
- Be alert to signs that could indicate the possibility of domestic violence
- Avoid placing either adult in a situation that could increase risk, such as referring to information that may have been disclosed in individual meetings

7.2.4 Identify and Assess Protective and Risk Factors

The *Comprehensive Family Assessments Guidelines for Child Welfare*,[2] developed for the Children's Bureau, identified four domains (Schene, 2005):

- Patterns of social interaction, including the nature of contact and involvement with others, and the presence or absence of social networks and relationships.
- Parenting practices, including methods of discipline, patterns of supervision, understanding of child development and/or of the emotional needs of children.
- Background and history of the parents or caregivers, including the history of abuse and neglect.
- Problems in access to basic necessities such as income, employment, adequate housing, child care, transportation, and other needed services and supports.

The focus is on understanding better what continuing characteristics or behaviors may increase the likelihood of child maltreatment (risks) as well as the strengths or protective factors that may support risk reduction and child safety. Thus, a prevention science framework is useful because the goals are to decrease risk factors (precursors to child maltreatment) and increase protective factors (moderators of risk and the effects of risk exposure) (DePanfilis, 2009; Hawkins, Horn, & Arthur, 2004). The goal is to understand how the characteristics, behaviors, and conditions related to the parent or other caregiver, children, family system, and environment support or challenge the adequacy of care and protection of children in order to develop a holistic plan of reducing risk.

A recent review of research on protective factors for children and youth identified the top 10 protective factors that explain how many children and youth, even those who have experienced trauma or other adversity, are able to avoid or mitigate negative outcomes more readily than others. (Development Services Group, Inc., Brodowski, & Fischman, 2013). Understanding these 10 protective factors, listed in **exhibit 7.2**, could be useful for targeting outcomes.

2 Found at https://www.acf.hhs.gov/sites/default/files/cb/family_assessment.pdf

Exhibit 7.2 Top 10 Protective Factors Across Administration on Children, Youth and Families Populations

INDIVIDUAL LEVEL	
Relational skills:	Two main components: (1) a youth's ability to form positive bonds and connections, and (2) interpersonal skills, such as communication skills, conflict resolution skills, and self-efficacy in conflict situations.
Self-regulation skills:	Ability to manage or control emotions and behaviors. This includes self-mastery, anger management, character, long-term self-control, and emotional intelligence.
Problem-solving skills:	General problem-solving skills, self-efficacy in conflict situations, higher daily living scores, decision-making skills, planning skills, adaptive functioning skills, and task-oriented coping skills.
Involvement in positive activities:	Engagement in and/or achievement in school, extracurricular activities, employment, training, apprenticeships, or military.
RELATIONSHIP LEVEL	
Parenting competencies:	Two broad categories of parenting: (1) parenting skills (e.g., parental monitoring and discipline, prenatal care, setting clear standards, and developmentally appropriate limits), and (2) positive parent-child interactions (e.g., close relationship between parent and child, sensitive parenting, support, caring).
Positive peers:	Friendships with peers, support from friends, or positive peer norms.
Caring adult(s) outside the family:	Including individuals such as mentors, home visitors (especially for pregnant and parenting teens), older extended family members, or individuals in the community.
COMMUNITY LEVEL	
Positive community environment:	Neighborhood advantage or quality, religious service attendance, living in a safe and higher quality environment, a caring community, social cohesion, and positive community norms.
Positive school environment:	Supportive programming in schools.
Economic opportunities:	Household income and socioeconomic status; a youth's self-perceived resources; employment, apprenticeship, coursework and/or military involvement; and placement in a foster care setting (from a poor setting).

In addition to the factors listed in **exhibit 7.2**, the Center for the Study of Social Policy lists five protective factors, with the Children's Bureau adding the sixth, nurturing and attachment (Center for the Study of Social Policy, n.d.):

- **Parental resilience** occurs when parents are able to effectively manage stressors.
- **Social connections** occur when families have healthy, sustained relationships with people, institutions, and the community.
- **Knowledge of parenting and child development** involves understanding the unique aspects of child development in order to provide parenting that is attuned to children's needs and development.
- **Concrete support in time of need** involves identifying and obtaining resources to meet the concrete and basic needs of children and families and empowering families so they may eventually access these resources on their own.
- **Social and emotional competence of children** is achieved by providing an environment and experiences that enable children to form close and secure adult and peer relationships and to experience, regulate, and express emotions.
- **Nurturing and attachment** includes the emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

Many CPS-related assessment systems consider the notion of caregiver protective capacities as crucial for ensuring child safety. While different than protective factors described above, emotional, behavioral, and cognitive caregiver protective capacities are extremely important for parenting. These caregiver protective capacities are consistent with protective factor dimensions related to knowledge of parenting and child development, nurturing and attachment, and parenting competencies. For example (ACTION for Child Protection, 2010):

- **Cognitive protective capacities** are observed when parents have accurate perceptions of their children; recognize the needs of their children; have realistic expectations for their children; and possess adequate knowledge about child development, parenting, and protection.
- **Emotional protective capacities** are observed when parents are sensitive toward their children, have empathy, demonstrate love, and have secure attachments with their children.
- **Behavioral protective capacities** are observed when parents control their impulses in parenting situations and set aside their own needs to care for their children.

The Capacity Building Center for States provides an infographic, *Protective Capacities and Protective Factors: Common Ground for Protecting Children and Strengthening Families*,[3] which illustrates three frameworks, all of which are strength-based approaches to assess, intervene, and serve families. By assessing for and promoting both protective capacities at the individual level and protective factors at the individual, family, and community levels, interventions will have a solid foundation from research about the strengths in families and the resilience of children and youth.

3 See https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Blob/107035.pdf?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27Protective+Factors+and+Protective+Capacities%3A+Common+Ground+for+Protecting+Children+and+Strengthening+Families+%5BInfographic%5D%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=1

To explore risk and protective factors and caregiver protective capacities, some jurisdictions have implemented the use of assessment tools to guide conversations with families and to depict agreed-upon areas for change. They also can be used as a method of engaging families in conversations about difficult areas of assessment (Zaid, Eames, Driver, & LeGendre, 2009) and to measure change over time (Chadwick Center for Children & Families, 2009). For maximum clinical relevance, instruments should be reliable and valid[4] and should be culturally congruent with target families (Bridge, Massie, & Mills, 2008). This is especially important if instruments are used to assess risk and protective factors and the intention is to measure change in these indicators over time. **Appendix F** provides examples of instruments that could be useful to inform comprehensive family assessments.

7.2.5 Consulting With Other Professionals

Caseworkers should seek the expertise of other providers if (1) a provider has delivered prior services to the family and/or is continuing to do so, or (2) there is a specific client condition or behavior that requires additional professional assessment. These consultations can help caseworkers learn more about how the family is progressing and/or how to help the family manage an issue or condition that is outside the caseworker's expertise. Some examples include:

- The child or parent exhibits undiagnosed physical health symptoms
- The child's behaviors or emotions do not appear to be age appropriate (e.g., chronic nightmares, bedwetting, aggressive behavior at home or at school)
- The child or parent may have a substance use disorder
- The parent exhibits behaviors or emotions that do not appear to be controlled, such as violent outbursts, extreme lethargy, depressive symptoms, or frequent mood swings
- The child is presenting with potential developmental delays
- The family may need support from other departments comprising the larger agency, including income support, Medicaid, or public health

A good way to judge whether outside referrals are needed is to review the gathered information and to assess whether significant questions still exist about the risk and protective factors in the family. If the worker is having difficulty writing the assessment summary, he or she should consult the supervisor to determine whether consultation with a multidisciplinary team or an evaluation of presenting problems by others in the community may be appropriate. If an 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 safety of the child and 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 specific purpose of the evaluation (e.g., the parent's level of alcohol use and its effects on protective capacity)
- The specific questions the worker wants answered to assist in decision-making

Appropriate releases (including court orders, if necessary) of information should be obtained so that parents have provided permission for the family to be referred for services and for collaborative exchanges of results.

4 Reliability refers to the consistency in use of a measure. Inter-rater reliability is particularly important for observational measures. Validity refers to the whether a measure actually measures what it was designed to measure.

7.2.6 Analyze Information and Make Decisions

The comprehensive family assessment summary analyzes and summarizes all the information gathered. Key decisions include:

- What are the most important risk and protective factors related to the children, parents, family, and environment that affect safety, permanency, and well-being?
- How does the maltreatment affect safety, permanency, and well-being?
- What do family members perceive as their problems and strengths?
- What must change or occur in order for the effects of maltreatment to be treated and mitigated?
- What must change for the risk of maltreatment to be sufficiently reduced?
- How ready are family members to change the behaviors and conditions that create the most concern for safety, permanency, and well-being?

To arrive at effective decisions during the assessment process, the worker should fully engage family members in a partnership, gather and organize information, analyze and interpret meaning of the information, and draw accurate conclusions. At the conclusion of the family assessment (timeframes for completion vary by jurisdiction), the worker and family arrive at agreement on the changes necessary to keep children safe and to reduce the risk of maltreatment.

These conclusions are then translated into desired child-, parent-, and family-level outcomes. The desired outcomes should be tailored to each family and should be measurable. Outcomes should match the most important risk and protective factors that were identified during the assessment process (e.g., enhance protective capacity, increase social support, improve family communication, reduce parenting stress). A sample comprehensive family assessment summary outline is depicted in **exhibit 7.3**. Once the family and caseworker have determined the outcomes, the next step is to choose the change strategies and interventions to help achieve them. Chapter 9 discusses that next stage in the CPS process.

Exhibit 7.3 Sample Comprehensive Family Assessment Summary Outline

Reasons for referral. Briefly summarize the primary reasons this family is receiving continuing 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 specific dates of contact with the family and other sources. Identify other sources of information that may have been obtained (e.g., school records, health records, psychological assessment report, etc.) and any instruments used to inform the under-standing of risk and protective factors.

Brief description of family history, including traumatic events that affect current functioning. Provide a summary of life events (positive and negative) and cultural tradi-tions, including the role that extended family members may still have with the family. Consider how family rituals, traditions, types of discipline, methods of problem solving, and familial roles in the history of the parents may affect how adults currently function in the role of parent. Genograms or culturagrams could be useful.[5]

Summarize risk and protective factors. Synthesize information about risk and protective factors related to the children, parents, absent parents (if applicable), family, extended family, home, neighborhood, and environment.

- For the *child*, address physical health and disabilities, mental health status and adjustment, school adjustment and cognitive abilities, behavior, and social and peer relationships.
- For the *parent*, address extent of alcohol and/or drug use or use disorder; physical health; abilities to achieve self-sufficiency, cope with daily stresses, manage emotions, and control impulses; employment status or involvement in educational or training programs; recreation and hobbies; religion/spiritual issues; abilities and motivation to identify and solve problems; and parenting attitudes, knowledge, and skill.
- For the *family system*, consider functioning of the family (e.g. commitment to each other, spending time with each other, communication, role expectations, coping strategies, problem solving, flexibility, and balance); methods for solving conflict; and stability of family composition/members, including describing nonrelated household members.
- For the *environment*, consider the physical household (e.g., household furnishings, overcrowding, household sanitation, security of residence, availably of utilities, physical safety); neighborhood, environment, and community; family's access to and use of extended family, friends, and systems to meet social support needs; family's cultural identity (e.g., world view, beliefs, values), and participation in celebrations of its culture.
- If instruments were used, refer to the discussions that followed the use of instruments with family members. Consider how these factors relate to one another both positively and negatively.

Tentative conclusions and selection of outcomes. Critically analyze the most important risk and protective factors that emerged through the assessment. Identify which of these factors may be translated into key child-, parent-, or family-level outcomes. Describe the child and parent level of readiness to address these outcomes. Further discussion of outcomes and how they are translated into SMART (**S**pecific, **M**easurable, **R**ealistic, **A**chievable, and **T**ime-limited) goals and the selection of interventions during the family plan stage of the process will be discussed in chapter 8.

5 For examples of genograms and culturagrams, see http://msass.case.edu/downloads/vgroza/placementgenogram.pdf and http://socialworkpodcast.blogspot.com/2008/12/visual-assessment-tools-culturagram.html.

Chapter Highlights

- In contrast to the initial assessment, which identified risk factors and safety threats, the comprehensive family assessment considers the relationship between protective and risk factors, identifies what must change in order to keep children safe and to reduce the risk of future maltreatment, and addresses any effects of child maltreatment.
- During the family assessment stage, the practitioner responsible for providing or arranging change strategies (e.g., CPS worker or community practitioner) engages the family in a process designed to gain a greater understanding about the strengths, needs, and resources of the family so that change-oriented strategies will be tailored to achieve relevant outcomes. The family assessment also focuses on understanding any effects of maltreatment, including trauma symptoms, that may need change-oriented treatment or intervention.
- Principles to guide comprehensive family assessments include the need to consider the unique needs of families, respect cultural differences, emphasize strengths, conduct assessments in a timely manner, collaborate across systems, involve the extended family, and use assessment tools.
- The comprehensive family assessment process involves considering the results of the initial assessment, implementing interviews with all members of the family, gathering information from other sources, considering the need for specific assessments to understand specific needs better, and analyzing information to make key decisions.
- Assessment instruments and tools may help to engage family members about key risk and protective factors and to inform the analysis of information and identification of the most important needs for change.
- Understanding the difference between caregiver protective capacities and protective factors is important to guide a comprehensive understanding of the family. It is also important to understand how caregiver protective capacities and protective factors are complimentary and strengthen assessments when used together. Both types of frameworks are strength-based approaches for assessing and intervening with families.
- Comprehensive family assessment summaries help to analyze all gathered information and to prioritize child-, parent-, and family-level outcomes.

Chapter 8:
Development of the Family Plan

Intervention with abused and neglected children and their families must be planned, purposeful, and ultimately directed toward the achievement of programmatic outcomes—safety, permanency, and well-being. One of the decisions resulting from the comprehensive family assessment is selecting the core outcomes that will drive the change process to reduce the risk of maltreatment and to mitigate the effects of maltreatment. All child welfare services target one or more program-level outcomes. However, true change occurs when child- and family-level outcomes are targeted to drive the selection of goals, action steps, and interventions.

The family plan[1] focuses on behavioral change, reducing both risk and the effects of trauma and maltreatment, promoting strengths, and identifying social and other supports. In the family plan, the worker and family identify and agree on what needs to change, using it as a mechanism to finalize targeted outcomes; SMART goals (discussed in more detail later); and action steps. It also spells out the change strategies and interventions that will support family members to achieve the outcomes and goals. This chapter:

- Considers the decisions associated with the family plan
- Emphasizes the importance of fully engaging all family members in the planning process
- Examines how to select and target child-, parent-, and family-level outcomes
- Identifies how to develop SMART goals
- Outlines processes for developing action steps and selecting facilitative strategies planned for the worker and others
- Targets methods and time for evaluating plan achievement

1 Note: This plan is sometimes called a case plan or service plan. However, to emphasize that to truly support change, the family must own the plan, the term used throughout is family plan.

8.1 Family Plan Decisions

The family plan developed is the road map for successful intervention:

While that final destination will be different for each family, it will always encompass the programmatic goals of safety, permanency, and well-being. For a family plan to be effective, key decisions should be created in partnership with the family and guided by the following questions:

- What are the family outcomes that will indicate risk is sufficiently reduced and the effects of maltreatment mitigated?
- What goals must be accomplished to achieve the outcomes?
- What are the priorities among the outcomes and goals?
- What interventions have the best evidence that they will facilitate successful outcome and goal achievement based on the family's unique needs?
- What strengths and natural supports does the family have that can be used or enhanced to help achieve goals & outcomes?
- How and when will progress toward outcome and goal achievement be evaluated?

8.2 Involving the Family in the Planning Process

Family members who are treated as full partners are more likely to engage in the planning process. The strategies employed during the engagement and family assessment processes continue in the planning stage, allowing the agency and family to co-construct a plan that is co-owned and, therefore, has the greatest likelihood to succeed. Workers 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 in planning accomplishes the following:

- Enhances the essential helping relationship because it increases the likelihood that the family feels its concerns have been heard, respected, and considered
- Honors the family's cultural beliefs and practices to the greatest extent possible
- Facilitates the family's investment and commitment in the outcomes, goals, and action steps
- Empowers parents to take the necessary action to change behaviors and conditions that contribute to the risk of maltreatment
- Ensures that the agency and the family are working toward the same end

Family Group Decision-Making Practice

Family group decision-making (FGDM) has promising evidence as a practice that may help to support robust family involvement in the planning process. FGDM practice emphasizes the importance of meetings in a process, based on family-centered, strength-based, culturally relevant principles (HHS, ACF, 2015).

The intent of FGDM is to address potential disproportionate agency responses that have affected poor and socially disadvantaged families who have felt powerless to have a voice in the child welfare system response to their situations (Fluke, Harden, Jenkins, & Ruehrdanz, 2010). The key to successful FGDM practice is engaging and calling together a family group, which includes parents/caregivers, children, maternal and paternal kin, others with like-family relationships, community members, or others with connections to the children or family (American Humane Association & FGDM Guidelines Committee, 2010).

While there are various models of FGDM, based on review of research the Children's Bureau has suggested a set of components that are key to its effective practice:[2]

- An independent coordinator/convener that is culturally respectful and responsible for facilitating the family group meeting. The coordinator should recognize that all families are unique and experts in themselves and demonstrate commitment to understanding the families' cultural values, assumptions, worldviews, and decision-making models.
- Recognition and acknowledgement by the child welfare agency that the family group represents key decision-making partners in the child welfare case process, including the commitment of time and resources to convene the family group meeting.
- Inclusion of private family time so that the family group members have the opportunity to meet on their own to process information and to develop a plan to address identified concerns without the presence of child welfare authorities or service providers.
- Preference afforded to the plan developed by the family over other plans as long as it maintains child safety and addresses other agency concerns. However, court-ordered plans always take precedence over any plan.
- Timely provision of the services, resources, and supports necessary to implement the plan agreed upon by the family and the agency or as ordered by the court.

2 Adapted from the funding announcement, *Building the Evidence for Family Group Decision-Making in Child Welfare* (HHS-2015-ACF-ACYF-CF-1008), retrieved from https://ami.grantsolutions.gov/files/HHS-2015-ACF-ACYF-CF-1008_0.pdf

8.3 Targeting Outcomes in the Family Plan

As discussed in the introduction, child welfare services target one or more of the programmatic outcomes of safety, permanency, and well-being. When child- and family-level outcomes are targeted to drive the selection of goals, action steps, and interventions, true change occurs.

8.3.1 Programmatic Outcomes

The Adoption and Safe Families Act (ASFA) directed child welfare agencies to design their intervention systems to measure the achievement of outcomes. At the program level, these organize around four domains: child safety, child permanence, child well-being, and family well-being. Although all four are important, federal and state laws emphasize child safety and permanence to evaluate agency or system performance. At the individual case level, caseworkers usually attempt to achieve child safety and permanence through efforts to ensure child well-being and family well-being (Courtney, 2000). **Exhibit 8.1** provides definitions of the four programmatic outcomes.

Exhibit 8.1 Programmatic Outcome Domains

- **Child safety:** Public child welfare agencies work to ensure that children who have been found to be victims of abuse or neglect are, first and foremost, protected from immediate or imminent danger. Whether the child is placed in out-of-home care or maintained in the home, an agency's first concern must be to ensure the safety of the child. States are measured on two child safety indicators: (1) the percentage of child victims who experience a recurrence of maltreatment within a 6-month period, and (2) the percentage of all children in foster care who were maltreated by a foster parent or facility staff member (HHS, ACF, Children's Bureau, 2014).
- **Child permanence:** For children who receive in-home services, permanence refers to family preservation and the family's demonstrated ability to sustain a safe, stable environment for the child. When foster care is necessary to ensure a child's safety and well-being, agencies work with the families and courts to return children to their homes or to find other permanent homes in a timely manner. To measure how well states achieve this outcome, a child achieves permanency when he or she is reunified with parents or primary caregivers, living with other relatives or legal guardian, or legally adopted (HHS, ACF, Children's Bureau, 2014). Although maintaining a constant focus on child safety is key, interventions must also maintain or create permanent living arrangements and emotional attachments for children. This is based on the assumption that stable, caring relationships in a family setting are essential for the healthy growth and development of the child. This emphasizes the provision of reasonable efforts to prevent removal and to reunify families, except under specified circumstances, and promotes the timely adoption or other permanent placement of children who cannot safely return to their own homes (Courtney, 2000).
- **Child well-being:** In guidance to the states in 2012, the Administration on Children, Youth and Families emphasized that agencies must promote the well-being of children and youth in four domains: (1) cognitive functioning, (2) physical health and development, (3) behavioral/emotional functioning, and (4) social functioning (HHS, ACF, Children's Bureau, 2012). Findings from the comprehensive family assessment determine whether well-being should be a target of child- and family-level goals, action steps, and interventions.
- **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. Focusing on strengthening protective factors, such as parental resilience, social connections, concrete support and resources, knowledge of parenting and child development, and nurturing and attachment will promote family well-being. Findings from comprehensive family assessment could help determine if family well-being is an appropriate program-level outcome.

8.3.2 Child-, Parent-, Family-, and Environmental-Level Outcomes

The comprehensive family assessment also helps determine what changes the family must make to reduce or eliminate the risk of maltreatment. Achieving positive outcomes indicates that the specific risks of maltreatment have been adequately reduced and the effects of maltreatment satisfactorily addressed. These intermediate-level outcomes should also be designed to contribute to the achievement of the programmatic outcomes (DePanfilis, 2000b).

The actual approach to achieve specific outcomes might not be a direct path. For example, changes in family-specific outcomes may affect child-specific outcomes. To serve as an appropriate outcome, it must be positively framed, modifiable by the child, youth, parent, or family system, and matched to available interventions to support outcome achievement. For example, one cannot change trauma exposure but can assist an individual to adjust to its consequences. Below are some examples of these various outcomes, followed by a case example.

- **Child outcomes** usually target the child's safety and functioning. Examples include relational skills, self-regulation skills, problem-solving skills, positive school environment, or developmental appropriateness.
- **Parent or caregiver outcomes** usually target developing the family's ability to provide safety for the child. Examples include resilience, stress management, problem-solving skills, parenting attitudes, parenting skills, emotional control, or communication skills.
- **Family outcomes** often address strengthening the family's ability to provide safety for the child. Examples include roles and relationships, communication patterns, collaborative problem solving, commitment to family members, stability, or flexibility.
- **Environmental outcomes** could target all of the child welfare program-level outcomes. Sometimes these outcomes focus on the environmental factors contributing to the maltreatment, e.g., social isolation, housing issues, or neighborhood safety. Examples include social support, household physical safety or sanitation, or economic resources.

Case Example
Part I: Targeting Outcomes With a Family

The family composition is father, Mr. Smith, age 34; mother, Mrs. Smith, age 32; daughter, Tina, age 6; and son, Scott, age 3½. The family was reported to CPS by the child care center. The child care center reported that Scott is an aggressive child; he throws things when he is angry, hits other children, and runs from the teacher. The call came in to CPS because he came to child care with lateral bruises and welts on his buttocks and back of his thighs.

Through the initial assessment, the parents admitted that Mr. Smith hit Scott with a belt after one of Scott's temper tantrums. They presented as completely overwhelmed and motivated to have someone work with their family. During the family assessment, the worker learned that Mr. and Mrs. Smith have been married for 10 years. Mr. Smith completed high school and is employed as a clerk in a convenience store. He works the evening shift, 4 to 11 p.m. He had recently been turned down for a promotion. Mrs. Smith 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. He threw a truck at his sister, causing her to need stitches above her eye. When he was put in his room for misbehaving, he tore his curtains down and set his wastebasket on fire. His parents described Scott as unwilling to be held and loved. Both parents do not know what to do with Scott. Mrs. Smith 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 appeared to be no structure or consistent rules. When Scott misbehaved during the family meetings, sometimes the parents ignored his behavior until it had escalated to a point that he was out of control. They did not have rules about bedtime, for example. It appeared that Tina had a lot of responsibilities, for example, making Scott's breakfast every morning.

Mr. Smith described his mother using severe forms of punishment when he misbehaved and feels it taught him right from wrong. He believes that children need strong discipline to grow up into healthy, functioning adults. He describes feeling out of control when Scott misbehaves. He said he often sees red when Scott misbehaves and can't help but "lose his cool."

The family is socially isolated. Mr. Smith's mother is alive, but they are estranged. Mrs. Smith's parents are deceased, and her two brothers live hundreds of miles away. Mrs. Smith 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. Smith describes her husband as often yelling at her and the children.

To understand the potential cause of Scott's behavior, the worker requested a complete medical and psychological workup. The final diagnosis was fetal alcohol syndrome, but it had gone undetected until this assessment because there were no specific symptoms at birth, and Scott has not seen a regular pediatrician. Mrs. Smith drank alcohol (whiskey sours) through most of her pregnancy, as she did not realize she was pregnant until about 6 months.

Through multiple conversations with the family, both parents identified the following behaviors and conditions that they think contributed to the reported incident and could contribute to things getting out of control in the future:

- Life stress brought on by different work schedules
- Scott's uncontrolled behavior
- Stress associated with parenting Scott, both parents feel overwhelmed
- Isolation from family and friends or others to turn to in times of stress
- Lack of knowledge and skill about how to manage Scott's behavior
- Inappropriate parenting responsibilities managed by Tina, making it difficult for her to have friends
- Lack of a routine to manage the household tasks
- Lack of time for the parents or family to spend any quality time together

Through discussions with the parents, and with Tina and Scott, the family identified the following outcomes in their family plan:

Parent outcomes: improved child management skills, stress management
Family outcomes: improved communication, spending quality time together
Child outcomes: behavioral control (Scott); social skills for making friends (Tina)
Environmental outcomes: household routine; social connections for each family member and the family system

outcomes down into specific positive goals that represent measurable accomplishments for the family. There is an "art" to developing goals in the words of family members but to still have them formatted as goals. The idea that goals are changes in behavior, skill, attitudes, functioning, etc., may be different from what workers and families are used to, e.g., defining a goal as a service. But if families are unable to articulate what will be different in their family first, they could complete specific services without making the necessary changes to reduce risk or deal with effects of maltreatment.

The caseworker's role is to help the family consider options that they believe match the identified target for change. Walking the family through a scenario that asks open-ended questions about what they would be saying or doing differently if they are successful sometimes helps everyone articulate how the end accomplishments will look. When helping families consider options for developing goals, it is important that the goals are congruent with the family's value and cultural systems. In co-constructing goals with families, as referenced earlier, the goals should be SMART[3]:

- ***Specific.*** The family should identify exactly what they will do. This usually means that the goal has to state a desired result that identifies who, what, when, and why. The agency should also identify exactly what actions it will take and services it will provide.
- ***Measurable.*** 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. Asking the question, "How will we know when a goal is achieved?" may help to fine tune the goal so it can be measured.
- ***Achievable.*** The family should be able to achieve goals in a designated time period given the resources that are accessible and available to support change. Is it realistic that the family has the capacity to achieve the goals as stated? If not, then it may mean helping the family to break the goal down into smaller actions that can be built on each other over time.
- ***Relevant.*** Goals need to be in alignment with the selected outcome(s). If the goal is accomplished, will it represent changes in the behaviors and conditions that led to the need for CPS involvement?
- ***Time limited.*** Time frames for goal accomplishment should be determined based on a thorough understanding of the risks and on the family's strengths, ability, and motivation to change, and input regarding the length of time it would take to accomplish the goal. Availability and/or level of services may also affect time frames.

Goals are not services. They represent accomplishments and changes in behaviors, conditions, skills, functioning, status, and attitudes. To be most effective, goals should meet SMART criteria and be broken down into small, meaningful, and incremental action steps. These steps incorporate the change strategies and interventions that will be implemented to help the family achieve goals and outcomes.

3 There are slight variations for how to define SMART criteria. This manual adopts one option that is thought best to match child welfare.

Case Example
Part 2: Working With Families to Set Their Own Goals

Some parents, children, and youth are better able to verbalize their wants and desires than others. Using open-ended questions to help family members develop SMART goals can prompt them to articulate goals that will be congruent with their view of their situation and capacities. For example, once the planning process identifies the key problems and outcomes, the worker could say to Mr. and Mrs. Smith:

Worker: Now that Scott is seeing a specialist, and the medication he is taking seems to help him control his impulses, how important is working on the outcome you previously identified—child management skills? Is this still something that is important to you?

Mrs. Smith: Yes, because the medication only goes so far. We have learned that we have to be consistent with him and stick to the same schedule every day or else he tends to get worked up.

Worker: Okay. In specific terms, how will you know when what you are doing to manage Scott's behavior is successful, that it is working? What will show you that this problem is truly a thing of the past?

Mrs. Smith: I think when I can say that my husband and I are on the same page and working together to keep to the routine that seems to calm him. And we follow the directions to look for the signals that he may not be listening and could be getting frustrated with something.

Worker: Let's see if I understand. Both of you have to be consistent every day in how you look at Scott's behavioral cues so that you can help him avoid getting upset. How long do you think it will take you both to feel confident that you are successfully doing that to help him avoid losing control?

Mr. Smith: Well, we don't expect him to be a perfect child overnight, and we also realize he is only 3½ years old. So,
I think it would take several months for us to practice the techniques the clinic gave us to see results.

Worker: Let's try to develop a goal that is realistic but makes it very clear what you both will do so you can successfully manage Scott's behavior. How about this?

Goal: For the next 90 days, we (Mr. and Mrs. Smith) will use the skills we learned to manage the effects of Scott's fetal alcohol syndrome by addressing Scott's need for a calm, consistent routine and by looking for any cues when he begins to lose control of his emotions. We will be consistent with these actions on a daily basis starting immediately.

Mrs. Smith: Wow! That would be amazing and would give me some immediate relief from the daily stress I feel. I know I will need a lot of support to keep up with this.

Worker: That's why I'm here. I know our time is almost up today, so between now and next week, how about if you review the outcomes you came up with. Then we can think about how we can break up each of them that still feels important to you into realistic, manageable goals. I will do the same, and, when we meet again, we will try to put the rest of the plan together. Before I leave today, do you want to practice one of the techniques you learned about at the clinic?

Mr. Smith: I think that would be helpful. I know I'm only around in the morning because of working the night shift, but I want to practice the morning routine, so I know for sure what I agreed to do.

Flexibility and creativity are critical to developing and implementing family plans to allow for changing circumstances and to try new approaches when the existing or old goals are not working. It is also important to follow the pace set by the family (within the agency's required timeframes) and to encourage the family members to be in the driver's seat when developing goals, as this makes it much more likely that they will be successful in achieving the goals of the plan. Planning is a dynamic process; no plan should be static. The text box below provides some tips for setting priorities among outcomes and goals. To be realistic, it is often appropriate to start with just one or two goals and then incrementally to move on to other goals as family members are successful.

Setting Priorities Among Outcomes and Goals

As discussed throughout this manual, families referred to CPS often experience multiple problems (e.g., substance use disorder, domestic violence, mental illness). Consequently, many behaviors and conditions must change to reduce the risk of maltreatment and the effects of maltreatment and trauma. These circumstances can feel overwhelming to families, particularly when figuring out where and how to start to change. Workers should facilitate a process so that family members can set priorities among possible outcomes and goals and experience success. Using the interviewing techniques described in Chapter 4 such as OARS (Open-ended questions, Affirmations, Reflective listening, Summary) is a good approach that empowers family members to identify and then consider options for change. Factors to consider when setting priorities include identifying:

- Goals that are determined to be the most important to achieve the safety of the child and to address the issues that brought the family to the attention of CPS
- Goals in which the greatest client motivation lies
- Goals that have the greatest likelihood of achievement
- Goals that are dependent upon accomplishment of other goals
- The time needed to accomplish a goal

8.5 Determining Action Steps to Achieve Goals

Goals must be broken down into small, meaningful, and incremental action steps. These steps incorporate the specific services and interventions that the agency will implement to help the family achieve their goals and outcomes. Action steps describe what the family, worker, and other service providers will do and identify time frames for accomplishing each outcome, goal, and action step. Sometimes, the action steps are the methods that families and workers use to measure goal achievement, so they also need to meet SMART criteria. Families must understand both what is expected of them and what they can expect from the worker, agency, court (if applicable), and other service providers.

In developing action steps, workers should be aware of the specific services and interventions provided by community agencies and professionals, target populations served, specializations, eligibility criteria, availability, waiting lists, and fees. (Examples are provided in chapter 9.) Caseworkers can help families select the most appropriate change strategies and interventions to help them achieve their goals. And, if family meetings are used as a strategy to use in developing family plans, other community members (including supports identified by the family) and service providers should be invited to these meetings as well. Guidelines for matching change strategies and interventions to family strengths and needs are discussed in the next chapter.

Case Example
Part 3: Developing the Family Plan With the Smith Family

Plan	Accomplishment	Persons	Due Date
Outcome(s)	Household routine; child management skills	-Smith family -Worker -Child guidance clinic	90 day
SMART goal	For the next 90 days, we (Mr. and Mrs. Smith) will use skills we learn about managing the effects of Scott's fetal alcohol syndrome by attending to Scott's need for a calm, consistent routine and by looking for cues when he begins to lose control of his emotions. We will be consistent with these actions every day, starting immediately.	Mr. & Mrs. Smith	90 days
Action step	I will give Scott his medication daily, as directed by the clinic.	Mrs. Smith	Immediately, continue as directed
Action step	Within the next week, we will develop and use a daily schedule that results in a calm and consistent routine. Responsibilities of all family members will be outlined, along with rewards, for keeping to the schedule. The schedule will be reviewed each week at a family meeting, adjusting details for specific events for the following week.	Smith family, caseworker will bring supplies and facilitate a family activity to develop the schedule	Start date – next Wednesday, continue over 90 days
Action step	Starting in 2 weeks, we (Mr. and Mrs. Smith) will attend and participate in a parenting class on Saturday mornings held at the clinic, Parenting a Child with Fetal Alcohol Syndrome. Tina and Scott will also go to the clinic and participate in age-appropriate, child activity groups. Tina will attend a computer class. Scott will be in art class. The family will discuss what it learns in weekly sessions with the worker. The worker will facilitate practice sessions as needed.	Smith family; clinic programs; caseworker	Start in 2 weeks and continue for 12 weeks
Action step	Starting in 2 weeks, we (parents) will do the weekly homework from the parenting class. Together, we will record in the journal what we did and when and how well it worked. We will share the journal with our worker and the class facilitators.	Parents, clinic parenting group, caseworker	Start in 2 weeks and continue for 12 weeks
Action step	Starting today, I will share materials about fetal alcohol syndrome with the child care staff, so they can follow the same directions I will use at home to pay attention to cues when Scott is losing patience. As I receive materials that could be useful for the child care staff, I will share them and ask the staff about Scott's behavior each day when I pick him up.	Mrs. Smith, child care	Starting today, continue for 90 days

Case Example
Part 3: Developing the Family Plan With the Smith Family Continued

We make this plan and commit to implementing it together. We will review progress each week and formally review the plan in 90 days, when we may develop additional goals to address other outcomes.

Mother signature Date

Father signature Date

Worker signature Date

Chapter Highlights

- Intervention with abused and neglected children and their families must be planned, purposeful, and ultimately directed toward the achievement of safety, permanency, and well-being outcomes. However, programmatic child welfare program outcomes are only achieved when families are successful at achieving child- and family-level outcomes that represent changes in the behaviors and conditions that led to the need for CPS intervention in the first place.
- During the planning stage of the CPS process, the worker and family develop a family plan that is the road map for successful intervention. The outcomes identify the destination, goals provide the direction, and action steps outlining the specific actions necessary to reach the final destination.
- Family group decision-making (FGDM) practice and other family meetings may be useful to facilitate a process where the families co-create plans with the agency. Even if official team meetings are not held, workers should engage families in assessment and decision-making.
- It is important that families confirm the ultimate direction they want to take by reaching agreement on the core outcomes that will drive the selection of goals.
- There is an "art" to helping families construct goals that are congruent with their values, beliefs, and capacity. This process should not be rushed and could take more than one session for family members to be 100 percent in agreement with their initial family plan.
- Goals are not services. They represent accomplishments and changes in behaviors, conditions, skills, functioning, status, and attitudes. To be most effective, goals should meet SMART criteria: **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime limited.
- Goals must be broken down into small, meaningful, and incremental action steps. These steps incorporate the specific services and interventions that will be implemented to help the family achieve goals and outcomes.
- The role of the worker is to facilitate change; thus, the worker implements actions that serve to guide and support family members to achieve goals and action steps. This could mean bringing resources for family activities, role playing when family members struggle to practice a new skill on their own and coordinating the actions of other service providers.

Chapter 9: Change Strategies and Interventions

During the development of the family plan, family members and the worker collaborate to identify core outcomes, goals, and action steps. Embedded within the action steps are change strategies and interventions that may be facilitated by the worker, by another service provider, or through a combination of providers and/or family members. One size does not and should not fit all. The factors that contribute to child maltreatment are complex; therefore, the solutions are not always simple. Selecting and matching change strategies[1] and interventions to outcomes and goals is a critical step in the CPS process and represents a paradigm shift from focusing on compliance and attendance at generic service. To that end,this chapter concentrates on the general tenets of change strategies and interventions. **Appendix H** provides examples of specific models.

As emphasized throughout this manual, it is crucial that agencies support families to receive tailored interventions or change strategies based on the families' unique strengths and needs, best available research, practice expertise, and available resources. An important principle of the strategies suggested in this chapter is that the CPS worker or community practitioner is the facilitator of the change process.

Results from the CFSRs suggest the importance of quality casework contacts for agencies to achieve positive child welfare outcomes. To support workers and supervisors in implementing quality contacts and interactions with families, there are resources available to support the preparation of staff to implement purposeful, meaningful contacts with family members.[2] For example, within the Capacity Building Center for States' *Quality Matters Improving Caseworker Contacts With Children, Youth and Families* product suite, some of the resources include: Defining Quality Contacts (https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Blob/113403.pdf?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27Defining+Quality+Contacts%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=1) and the *Quality Contact Casework Activities Worksheet* (https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Blob/114636.pdf?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27Quality+Contact+Casework+Activities+Worksheet%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=1)

1 This used to be called services or service provision. However, that does not look at the holistic picture and can engender families being referred to a list of services (that are not focused on what needs to change) rather than on developing strategies that address the needed changes and incorporate services.

2 For further information about the print and video resources focused on quality casework contacts, go to: https://capacity.childwelfare.gov/states/focus-areas/foster-care-permanency/quality-matters/

The American Professional Society on the Abuse of Children (APSAC) suggests that these children and families deserve an approach that is collaborative, respectful, and includes interventions that are most likely to lead to outcomes on family-identified and programmatic goals. This individualized approach is a focused, assessment-driven, and science-informed approach that both favors plans that sufficiently address the identified needs and avoid overburdening families with compulsory services that address problems not directly needed to change to prevent future maltreatment and/or address the effects of maltreatment (Berliner et al., 2015).

The approach used throughout this user manual is consistent with the APSAC guidelines. The purpose of this chapter is to:

- Provide key definitions to serve as a context for the process of selecting change strategies and interventions that match specific outcomes
- Support an understanding of evidence-informed change strategies and interventions
- Describe different types of change strategies and interventions
- Discuss important procedures when collaborating with other professionals

9.1 Defining Terms to Guide the Selection of Change Strategies

The following terms help to provide context for matching outcomes and goals to the appropriate strategies and interventions.

Change strategies are the actions taken by children, youth, parents, and families toward the achievement of outcomes that will strengthen protective factors and reduce risk factors associated with child maltreatment. Family members may implement change strategies alone or through support from friends or family members, and/or the CPS or other child welfare worker, a community provider, or a combination of professional and informal supports.

Interventions are a specific practice, service, strategy, program, practice model, or combination that is clearly defined, operationalized, and distinguishable from one or more alternatives (Framework Workgroup, 2014). This manual views interventions as implemented by a community provider to supplement the worker and family-led change strategies.

Evidence-based practice is *generally* meant when the caseworker considers the current best evidence about a particular problem or need, family preferences, the specific family circumstances, and the practitioner's clinical expertise (Gibbs, 2003; Shlonsky & Benbenishty, 2014). Based on that approach, the caseworker implements:

Evidence-based practices (EPBs) or evidence-supported interventions (ESIs) are *the actual, well-defined policies*, programs, and services that have shown through rigorous evaluation the potential to improve outcomes for children and families (Framework Workgroup, 2014).

While it is important that families are provided interventions supported by the best available evidence, many evidence-based interventions or practices may not be accessible to the average CPS worker looking to match strategies and interventions on an individual family basis. Evidence-based practices and interventions often are thought to be more expensive to implement on a wide scale and, if available at all in a jurisdiction, may be available only in limited areas. As a result, the change strategies and interventions included in this chapter and **appendix H** are categories and examples of interventions that may be more accessible or have had wider implementation. Additionally, the California Evidence Based Clearinghouse for Child Welfare provides detailed information about programs that have met criteria for research

evidence of effectiveness and in what capacity the program has been determined to be effective.[3] Some child welfare systems are beginning to implement ESIs through private providers under contract; if those sources are available, agencies will have information available about appropriate target populations and how to make referrals. **Exhibit 9.1** provides an example of ESIs to work with American Indian/Alaska Native (AI/AN) children.

Exhibit 9.1 Evidence-Based Interventions for Culturally Appropriate Treatment for American Indian/Alaska Native (AI/AN) Children

The Indian Country Child Trauma Center (ICCTC) offers a training program to provide specialized training to mental health and behavioral health professionals working in Indian Country, which is specific to Native populations and the unique characteristics of tribal people. The program includes the following models[4]:

Honoring Children, Making Relatives – Cultural Adaptation of Parent Child Interaction Therapy
Incorporates AI/AN philosophies into the basic concepts of Parent-Child Interaction Therapy. Included in the curriculum are the issues of implementation and dissemination of evidence-based interventions in rural and/or isolated tribal communities with limited licensed professionals. Procedures are in place for assisting, measuring and monitoring the skills acquisition and treatment fidelity for rural/isolated or reservation-based therapist-trainees. Online video consultation is used in live, remote, real time coaching sessions to overcome the issue of distance and time constraints. This treatment is appropriate for children between the ages of 3 to 7 years of age.

Honoring Children, Mending the Circle – Cultural adaptation of Trauma-Focused Cognitive Behavior Therapy
Combines trauma-sensitive interventions with elements of cognitive behavioral therapy into a treatment designed to address the unique needs of children with post-traumatic stress disorder and other problems related to traumatic life experiences. It is appropriate for most types of trauma and for children up to the age of 18.

Honoring Children, Respectful Ways – Cultural adaptation of Treatment for Children with Sexual Behavior Problems
Appropriate for children between the ages of 3 to 12 years of age who have experienced traumas of sexual abuse, physical abuse, and violence in the family. Inappropriate sexual behaviors of AI/AN children and youth can have wide ranging impact on not only the children but also can significantly affect the family, the extended family, and the community, and can result in serious negative social consequences.

Honoring Children, Honoring the Future – American Indian Life Skills Development Curriculum
A suicide prevention curriculum for middle and high school students. It was the only evidence-based suicide prevention program in Indian Country that has been recognized by the Department of Health and Human Services in 2005 as a SAMHSA program of excellence. ICCTC has assisted the author to modify the curriculum for middle schools students and Boys and Girls Clubs in Indian Country.

3 To search for ESIs with relevance to child welfare, go to the CEBC website at: http://www.cebc4cw.org/.

4 Adapted from http://www.icctc.org/treatmentmodels-1.asp.

9.2 Matching Change Strategies and Interventions to Outcomes

This section identifies categories of change strategies and interventions that match needs, problems, and outcomes of children, youth, parents, and family systems and discusses principles for how to do so.

9.2.1 Categories of Interventions

Strategies and interventions are identified with the family through the development of the family-worker relationship and throughout the comprehensive family assessment. Some child welfare staff may have the education and training to facilitate some family interventions. Otherwise the family will need to matched, based on the resources available within the jurisdiction, to the most appropriate services and interventions offered by other service providers. Whichever source of the intervention, the decision for what intervention to select should be determined in consultation with the caseworker's supervisor and driven by the policies of the state, tribe, or jurisdiction. **Appendix H** provides examples of strategies and interventions that best match the categories of specific needs and outcomes, such as outlined below.

Children and Youth: Strategies addressing the needs of children and youth are often in combination with family interventions. Some interventions address the trauma associated with maltreatment, and others target behaviors or emotions that may challenge parenting and increase risk of future maltreatment.

Children and Youth: Healthy Behavioral and Emotional Functioning

Some maltreated children and youth have been exposed to life events that have resulted in serious negative consequences on their behavioral and emotional health. It is important to note, however, that only a minority of child welfare-involved children develop clinically significant levels of self-reported, post-traumatic stress symptoms, so assessment is essential (Kolko et al., 2010). When the comprehensive family assessment concludes that children are exhibiting behavioral and/or emotional symptoms that affect their overall well-being, the CPS worker should consider interventions provided through mental health or family service programs.[5] Examples of these interventions are included in **table 9.1** in **appendix M**. In addition, some interventions focus on parent child interaction and family functioning in addition to targeting problem behavior. Examples are provided in **table 9.2**.

Children and Youth: Healthy Social Functioning

Children and youth who have positive social skills and social connections to peers and adults are more successful "beating the odds" and adjusting to negative life events. Maltreated children sometimes have trouble forming and sustaining healthy relationships due to fear and lack of trust based on their past experiences. When assessments conclude that children are isolated, lack appropriate peer socialization experiences, or need respite from stressful home environments, having others to whom they can turn is crucial for their healthy development. Examples of strategies or interventions designed to help youth build healthy social supports are outlined in **table 9.3** in **appendix M**.

5 Note: Some community mental health systems now require that funded mental health agencies use ESIs. Check the local mental health system for further information.

Parents: Parent-focused interventions often help to build protective capacities to enhance the safety and well-being of children, as well as addressing the parents' experiences of trauma and emotional well-being. These may be associated with adult functioning or specific to parents' caregiving roles.

Parents: Healthy Behavioral and Emotional Functioning
Two of the main adult functioning issues that contribute to risk and safety concerns for children are substance use disorder and mental health problems. There are numerous effective treatments for both, and matching depends on strong assessments. Ideally, the intervention setting will have expertise in considering the impact of alcohol or other drug problems and/or mental health problems on parental protective capacity. If equally effective treatments are available, choices can be offered to parents. To compare evidence among efficacious interventions, see **table 9.4** in **appendix H**, which lists sources of ESIs.

Parents: Parenting Competence
Some child maltreatment occurs because of a lack of knowledge about child development, unrealistic expectations of children, lack of empathy, or lack of understanding about the special needs of children. When assessments conclude that parents need to increase parenting competence, change strategies facilitated by the worker in the home or group-based parenting programs could be an appropriate fit. Examples of parenting strategies or interventions that are focused on building or strengthening parenting competence that are readily available in many communities are described in **table 9.5** of **appendix H**.

Family System: Parent-Child Interaction and Family Functioning
When results of the comprehensive family assessment conclude that strengthening family functioning and parent-child interaction will promote protective factors and reduce risk factors for child maltreatment, multidimensional, family-based strategies and interventions often are the best option. Interventions range from change strategies delivered by family preservation programs, which may be delivered by the worker or a private provider to target specific parent-child interaction or relationships. Examples of both types are included in **table 9.6** of **appendix H**.

9.2.2 Principles for Matching Change Strategies and/or Interventions to Key Desired Outcomes

The categories of change strategies and interventions in this chapter were selected based on relevance to children and families involved with CPS because of child maltreatment and associated problems. Key principles for selecting from among the array of options follow.

- Individualized family assessment is essential so that strategies and interventions match the specific outcomes that families hope to achieve as a result of ongoing CPS- and community-based intervention.
- Families must be provided options that they believe will work for them.
- Strategies and interventions should be selected based on the needs of the family and the availability of strategies and interventions with the highest level of evidence.
- Not all examples provided in this chapter and **appendix H** are accessible in all communities; however, there should be logic to why specific strategies or interventions are selected. One size does not fit all.

- Less is more. Caseworkers should be strategic and select the fewest number of strategies to be implemented at the same time.
- Assessment of progress should be ongoing and formally implemented at least every 90 days or as prescribed by agency protocol. (See chapter 10.)
- The CPS worker or community provider who has primary responsibility for delivering ongoing intervention should build frequent communication mechanisms across all providers and the family to make sure everyone is on the same page.

9.3 Collaborating With Community Partners

The caseworker is responsible for assuring that family members are engaged and involved in the selection of change strategies and interventions, and that all strategies and interventions are implemented to support the achievement of outcomes and SMART goals in the family plan. To ensure that all strategies and interventions are implemented as intended, the caseworker should bring people to the table whenever adjustments need to be made and make this process transparent for everyone, especially the family. The family should be involved in meetings to finalize these arrangements. Examples of items that should be clearly understood by everyone include:

- Results of the family assessment, including the selection of core outcomes
- A copy of the family plan that has identified outcomes and SMART goals
- Specification of the purpose of the referral and the expectations regarding the type, scope, and extent of change strategies or interventions that are requested by the family
- Specification of the number, frequency, and method of reports required, as well as reasons for reports (e.g., family progress)
- Expectations for reporting about critical incidents or barriers in the work associated with the family plan
- Provisions for coordinating among providers and the family, and the timing of these meetings

The agency management or supervisors should establish a written contract with other organizational or individual providers, depending on the jurisdiction. Chapter 9 in the companion manual, *Child Protection in Families Experiencing Domestic Violence*, addresses issues that often arise when collaborating with other providers, such as confidentiality, different missions and legal mandates, and use of memoranda of understanding. In addition, the Administration for Children and Families (ACF) developed the *Confidentiality Toolkit* to help jurisdictions successfully navigate the balance of confidentiality with the delivery of efficient and effective services. See https://www.acf.hhs.gov/sites/default/files/assets/acf_confidentiality_toolkit_final_08_12_2014.pdf. The Child Welfare Information Gateway also provides numerous resources on topics affecting inter- and interagency collaboration at: https://www.childwelfare.gov/topics/management/practice-improvement/collaboration/.

Chapter Highlights

- Each family is unique; therefore, tailored intervention is crucial to match to family outcomes and SMART goals.
- Caseworkers should select change strategies and intervention based on the families' unique strengths and needs, the best available research, practice expertise, and available resources.
- Children and families who need an intervention response because of child maltreatment deserve an approach that is collaborative and respectful and includes interventions most likely to lead to outcomes based on family-identified and programmatic goals.
- Ongoing strategies and interventions need to avoid overburdening families with compulsory services that address problems not directly related to issues that need to change to prevent future maltreatment and/or to address the effects of child maltreatment.
- Change strategies are the actions taken by children, youth, parents, and families toward the achievement of outcomes that will strengthen protective factors and reduce risk factors associated with child maltreatment. Family members may implement change strategies alone or through support from friends or family members, and/or the CPS or other child welfare worker, community provider, or a combination of professional and informal supports.
- Change strategies should be supplemented with interventions when family members have specific needs that may require the involvement of specialists with expertise in the presenting issue or challenge (e.g., substance use disorder, trauma).
- Evidence-supported interventions are well-defined policies, programs, and services that have shown, through rigorous evaluation, the potential to improve outcomes for children and families.
- The role of the worker is to facilitate change; thus, the worker implements actions that serve to guide and support family members to achieve goals and action steps. The worker also serves as the coordinator of interventions or strategies facilitated by others. Community collaboration is essential.
- When selecting interventions, caseworkers must also consider state, tribe, and jurisdiction practices and policies.

Chapter 10: Evaluation of Change

Throughout the delivery of change strategies and interventions, caseworkers should constantly evaluate the change achieved by families. By focusing on outcomes and SMART goals, it is possible for families to see their progress. This ongoing assessment of change reinforces the steps that families make to change the behaviors and conditions that led to them to being involved with CPS. By routinely discussing progress with families, it is possible to adjust goals, action steps, change strategies, and interventions if needed. Flexibility is key for reinforcing the continuous change process.

Chapter 9 discussed focusing on outcome-driven change strategies and interventions. This chapter discusses the shift from "monitoring" progress by measuring attendance at services to measuring changes in behaviors and conditions. The purpose of this chapter is to:

- Review the process of evaluating change, both on an ongoing basis and formally, i.e., at least every 90 days
- Consider important areas for assessment and key decisions
- Identify how this stage of the CPS process links to other reviews, particularly for families who have conditions of participation through court orders

10.1 Evaluating Change on a Regular Basis

Most CPS jurisdictions call for using safety evaluation and risk assessment instruments at multiple times throughout the life of the case. Additionally, reviewing the SMART goals allows caseworkers to assess and discuss progress at each family contact. During the development of the family plan (See chapter 8), family members co-develop goals and action steps with the caseworker, who then both facilitates implementation of action steps and supports family members to self-evaluate their progress. Using the initial "Smith Family Plan" outlined in chapter 8, the following scenario is an example of how a worker checks in on progress toward accomplishing a SMART goal and action step that targeted two outcomes: household routine and child management skills.

Case Example
Part IV: Evaluating Change

Sample SMART goal: For the next 90 days, we (Mr. and Mrs. Smith) will use the skills we learn about managing the effects of Scott's fetal alcohol syndrome by attending to Scott's need for a calm and consistent routine and by looking at behavioral when he begins to lose control of his emotions. We will be consistent with these actions every day, starting immediately.

Sample action step: Within the next week, we will sit down together to talk through a typical week and make a daily schedule to help the family have a calm and consistent routine. Responsibility of all family members will be outlined, along with rewards, for keeping to the schedule. We will review each week at a family meeting and make any adjustments for specific events for the following week.

Worker and family conversation after three visits:

Worker: How is everyone doing this week?

Mrs. Smith: It has been a pretty good week. We sort of got jumbled up on Thursday because we didn't know that it was back-to-school night at Tina's school, but we managed to attend, even though we were about 5 minutes late.

Worker: For the last several weeks, you have been using the schedule for everyone. (*Pausing, looking at the refrigerator.*) I see that someone has been getting a lot of stickers! How about if you walk me through it day by day to let me know what worked well this week, and if there were any challenges, we can talk about those, too.

Mr. Smith: I was on breakfast duty every day, and both kids said they loved our morning quiet time. I make sure we have plenty of time to get up and get ready and that we have 30 minutes at the breakfast table together. That way, we not only enjoy breakfast together but also check in about what each of us has planned for the day. This is a very special time for me, since I work nights and usually don't see them after school.

Mrs. Smith: I can't tell you how much I appreciate starting our days this way. It was always so hectic when I was trying to get ready for work and get the kids something to eat at the same time. And, most of the time, we left the house screaming at each other, because we were late.

Worker: Wonderful! It sounds like this was a perfect way to do your action step, because it gave everyone relief right away. How are other parts of the schedule working for everyone?

Mrs. Smith: Well, as you can see, both Tina and Scott have been getting lots of stickers for doing their chores and getting ready to leave the house on time. I appreciate you helping us come up with rewards that seem to work for both kids. Tina is counting her stickers, so she will have enough money to go to the skating rink with a girl in her class, and Scott wants to go to Toys "R" Us® to pick out a new truck. Having them pick out their own rewards really seems to be working.

Worker: It sounds like you have really gotten good at using the schedule. Is there anything you want to change about this action step?

Mr. Smith: No, it's working fine. Let's not change anything about it.

Worker: Okay. Let's go on and talk about ….

As the case example illustrates, facilitating the process of change reinforces the process of continually evaluating the progress family members make. Even when families are unable to implement action steps as successfully as the scenario above, there is an opportunity to adjust action steps and goals, so they are more realistic. **Appendix I** provides two additional scenarios of the Smith family for readers to review.

In addition to evaluating progress on goals and action steps, it is critical that the caseworker assess child safety and risk at every contact with the child and family, even if a formal safety plan has not been developed. If a safety plan is in place, the caseworker and family evaluate whether the safety and other services outlined in the plan are working, and whether the plan should be adjusted based on changing circumstances.

10.2 Evaluating the Change Process

The caseworker should conduct a formal evaluation of change (i.e., that which is required by the agency, jurisdiction, tribe, or state) at least every 90 days in consultation with the supervisor. Using SMART goals and realistic action steps means that families will make incremental change but often will need to build on these successes by adding goals and action steps as they become more able to implement them. The process includes the following steps:

- Review the comprehensive family assessment including the identification of risk and protective factors and outcomes. If assessment instruments were used, consider whether they should be used again as part of the evaluation of change.
- Review the family plan considering the progress that has been observed, or not, during the regular home visits.
- Review the safety plan, if one has been implemented.
- Review the progress notes, making note of observations and verbal reports from family members in relation to implementation of action steps and goals.
- Collect information from other providers who have been facilitating change strategies or interventions targeting SMART goals. Ask that providers submit written reports on observed changes in behaviors or conditions and on progress toward achieving SMART goals.
- If extended family members or friends have been part of the family plan or safety plan, determine the level of their continued interest or involvement through direct contact with them and the parent(s).
- Make plans for convening a family meeting that includes the family, outside providers, and extended family and friends (if applicable), providing at least two weeks' notice (or in accordance with the state, tribe, or jurisdiction's practice) to encourage maximum participation.
- Convene the family meeting to (1) review progress and any assessments of the areas identified in the next section (e.g., reports, documentation of services provided and results), and (2) determine the need for continuing any goals and action steps or revising or creating new ones.
- Develop a summary of the formal evaluation of change process, precisely noting areas of change (both successes and challenges), and amend the family plan if needed.

10.3 Considering Areas of Assessment and Key Decisions

The evaluation of change considers progress by examining the status of safety and current levels of risk, comparing the current situation to initially identified risk and protective factors, evaluating the degree of goal achievement, and considering outcomes that may still need to be achieved in order to reduce the risk of maltreatment and address any effects of maltreatment.

10.3.1 Consideration of the Status of Safety and Current Level of Risk

While the caseworker continually assesses safety and risk throughout the case, during the formal evaluation of change, it is important to develop a formal assessment of the current safety and level of risk. Specific questions that need to be explored may include the following:

- Based on a new safety assessment, are there any current safety factors or threats that need to be controlled through updates to an existing or the development of a new safety plan?
- If there is a current safety plan, does the safety plan need to continue or be modified based on the current assessment of safety?
- What is the current level of risk of maltreatment? How is that the same or different from the initial assessment of risk?
- Based on the current assessments of safety and risk, if this family was referred to CPS today, would this family need CPS intervention?
- Since the development of the family plan, have there been any new incidents of child maltreatment? If there are, should a new referral be made (based on the agency's protocols)?
- Have there been any significant changes to the family situation (e.g., enhanced protective factors) that increase or decrease risk of maltreatment?

10.3.2 Comparing Risk and Protective Factors

This component of the evaluation of change considers changes in risk or protective factors from the time the comprehensive family assessment was conducted to the time change is formally evaluated (usually within 90 days of the development of the family plan). Specific questions that need to be explored include:

- What were the most important risk and protective factors related to the child, parent(s), family, and environment identified during the process of the comprehensive family assessment?
- Based on the current assessment of the family, what has changed, and what has remained the same?
- What changes have occurred in the protective capacities of the parent(s)?
- If risk factors continue, what specific impact do they have on the current safety of the children?
- For areas that have not changed, what efforts have been made to address them in the family plan via the selection of outcomes, goals, and action steps?
- What specific improvement has been noted in protective factors? Will these protective factors help to offset the influence of any remaining risk factors?
- If assessment instruments were used at various decision points, how well does any change over time match the views of the family and the worker about the current family situation?

10.3.3 Assessing Outcomes and SMART Goal Achievement

The family plan identifies outcomes and SMART goals as the initial target for change, based on prioritizing the most important needs of the family and the readiness of family members to work toward specific outcomes. Specific questions that need to be explored include:

- What specific accomplishments were made by the family to implement action steps toward goals?
- Have accomplishments been equal across all goals or have some areas changed more than other areas?
- In addition to the outcomes and goals targeted through the initial family plan, what other outcomes identified during the comprehensive family assessment still need to be addressed through a new family plan?
- To ultimately achieve all outcomes, what other SMART goals should be considered?
- How well have change strategies and/or interventions supported goal achievement? If goals have yet to be achieved, what other strategies or interventions should be offered to the family?
- What, if any, barriers have affected the success of family members to achieve goals? What strategies can be employed to address these barriers?
- How well has the agency followed through on its commitments?
- What have the supervisor and worker determined about the readiness of the family to continue to work toward change?

10.3.4 Making an Evaluation of Change Key Decision

In addition to the areas of assessment and specific decisions above, the key decision at this stage of the CPS process is whether to continue change strategies and interventions or whether sufficient change has occurred so that the family is ready for case closure. The closing decision is made when the caseworker and supervisor feel and can document that:

- All children are assessed as safe in the home because the parents have gained protective capacities to keep their children safe on their own.[1]
- The risk of future maltreatment has been reduced sufficiently as laid out in the family plan.
- Positive changes over time reducing risk and increasing protective factors have been noted.
- The family has achieved the majority of its outcomes and goals.
- Children, parents, and/or the family have successfully dealt with any trauma or other effects of maltreatment or could continue to do so without the need for CPS oversight, i.e., they can be referred to a community services provider.

1 As stated earlier, this manual discusses the role of the CPS caseworker in determining safety for the child and developing a family plan. If a child is removed from the home, the case is transferred to another part of the child welfare system that deals with out-of-home care and permanency, which is not addressed in this manual.

10.4 Linking the Evaluation of Change to Other Reviews

This manual suggests that change directed through the family plan be evaluated at least every 90 days to support families to make incremental changes so that CPS no longer needs to be involved. This timeframe, however, may differ from other case reviews required by state or tribal laws and/or policies. For example, CPS agencies may implement administrative or citizen reviews at 6-month intervals to assure that families are receiving the best possible CPS response. In addition, some children and families are under court jurisdiction. Court orders often mandate services, rather than focus on the behaviors and conditions that need to change to keep children safe and reduce the risk of maltreatment. Caseworkers can employ specific strategies to help families reconcile the differences in these review processes. For example:

- At a systems level, the CPS program can educate the courts and other systems to understand the rationale for focusing on change, rather than attendance at services.
- Court reports prepared by the worker can identify the targeted outcomes and SMART goals, in addition to specifying the change strategies and interventions recommended to support families to achieve outcomes and goals.
- If the court mandates a family to attend or receive specific services, the worker and family can discuss how they can use this mandated service to support goals and actions steps. The worker could also help the family bridge what the service is targeting to how the family can apply what they may have learned from a mandated service.
- When families have demonstrated significant changes in risk and protective factors over time, the CPS agency can recommend (to the court, if applicable) discontinuance of a mandated service.

Chapter Highlights

- Evaluating change requires shifting to measuring success by actual changes in behaviors and conditions rather than measuring attendance at services.
- Through the use of SMART goals in the family plan, workers review progress with families at each contact.
- Best practice suggests that a formal evaluation of change should occur, at a minimum, every 90 days or as directed by agency or jurisdictional policy or by court order.
- The steps for evaluating change include reviewing progress with benchmarks set during the comprehensive family assessment and specified in the family plan.
- Other providers and family members should be included, when available, in a process that reviews progress with the family.
- Key areas for evaluation relate to the current levels of safety and risk, the comparison between risk and protective factors initially and at this 90-day evaluation, and the degree of outcome and goal achievement.
- The key decision that is made during this stage of the CPS process is whether continuing change strategies and interventions are needed or whether sufficient change has occurred that the family is ready for case closure.
- The worker should minimize confusion for families when other review systems are mandated. In particular, if families are mandated by the court to attend specific services, the worker should work with the family so that the mandated service can be used to support SMART goal achievement.

Chapter 11: Closure and Ending CPS Involvement

CPS involvement is time limited and focuses on the safety of the child. After that, other areas of the child welfare agency expand the focus to permanency and well-being. Ideally, CPS involvement ends when sufficient change has occurred through family engagement with the agency and/or when families have achieved desired outcomes and SMART goals. Throughout collaborative work with families, the CPS or community worker details the progress made in maintaining or increasing safety, reducing risk, and ameliorating the effects of child maltreatment. The caseworker supports family members to complete goals and action steps toward the "goal" of ending CPS involvement. Naturally occurring markers such as holidays or school vacations, can be used as opportunities to talk with families about how much time has passed and remains to achieve goals in the plan and as milestones to support families to transition to the end of CPS involvement. This chapter reviews the:

- Types of CPS closure
- Skills used in the process of ending CPS involvement with families
- Process of collaborating with other systems either related to approving closure (e.g., the court) or to pursuing continued involvement with the family to further reinforce change

11.1 Types of CPS Closure

There are various types of CPS closure. These include:

- **Outcomes and goals achieved, no further support needed.** This closure type is desirable when families are successfully implementing action steps, achieving goals, and accomplishing outcomes. Successful closure of CPS involvement is based on actual change in the behaviors and conditions that led to the need for continued CPS involvement, and the families' ongoing demonstration that they can maintain child safety.
- **Outcomes and goals achieved or partially achieved, further support is voluntarily requested or needed.** In some situations, families achieve outcomes and goals and there are no present safety concerns, but ongoing needs beyond the scope of CPS remain. Examples include ongoing mental health needs for the parent or child, or parental medical conditions that require ongoing in-home services. In other situations, the family may have partially achieved outcomes and goals but needs ongoing support to sustain the changes initiated through CPS involvement. In both of these situations, the CPS worker is responsible for connecting the family to the appropriate community resources (e.g., mental health agency, afterschool programs, faith-based organizations) to fulfill the ongoing need.

- **Family moves out of the jurisdiction, referral to another CPS program.** When families move outside the jurisdiction, and there are ongoing concerns for safety, if the CPS worker knows to where the family moved, he or she initiates a referral to the appropriate CPS jurisdiction. Families should be informed that this referral will be made. While attending to the safety concerns of the child, the CPS worker is involved in the logistics of making the connection to providers in the new jurisdiction.
- **Family moves without any ability to locate.** If a family moves without providing a location or a new address, and the CPS worker is unable to locate the family through available search mechanisms, he or she should thoroughly document the status of safety at the time the family moved so that information will be available should a new report of child maltreatment be made.
- **Parental rights are terminated.** In rare situations, if children have been in out-of-home care and there is no possibility of reunification due to the inability of the family to actively change the circumstances that led to the need for placement, parental rights are terminated so that children may achieve permanency through adoption.
- **Family refuses voluntary CPS involvement, insufficient reasons to refer to court.** In some situations in which there are no active safety concerns, families may continue to express ambivalence about the need to change, may not receive the services or supports they need, and/or may be difficult to engage in a helping relationship. For these cases, there is no legal basis to compel the family to work with CPS through court intervention. In these situations, the CPS worker should provide information to the family about community resources that could be helpful based on the referring circumstances.

11.2 The Process of Ending CPS Involvement

Workers should prepare families for a formal closing process. Depending on the CPS agency and court protocols, there may be mandated family meetings or court hearings that are required as part of this process. It is also very important that the worker and the family implement a closing meeting to review the process (asking for the families' perceptions and input of the process) and evaluate success, address feelings about saying goodbye, and mark the ending with some type of recognition. If other providers have been involved with the family, families may choose to invite them to this closing meeting. As described in this section, the caseworker uses a specific set of skills to support families when CPS involvement is ending.

11.2.1 Reviewing the Process

Families that have been involved with CPS may have experienced past endings that have been challenging, both in their life histories as well as their experience with community agencies. Therefore, it is important to help shift their perspective by making this a positive process. This not only helps families sustain important changes they have made through CPS involvement but also recognizes their success. Convening one or more meetings to mutually recollect the process of working with CPS reminds families of how far they have come. This provides the worker opportunities to encourage family members individually and as a whole, as well as to identify accomplishments, strengths, and remaining unmet needs. It is also helpful to ask what could have been done to improve the experience and to discuss what was most helpful about the work as a collective.

Reviewing the goals and action steps achieved is an appropriate way to begin the closing conversation. The worker encourages family members to own successes and to celebrate them. It is also a time to specifically "call out" new skills the family uses to solve problems, manage conflict, and address challenges and to openly discuss how the family will use those skills in the future once CPS involvement ends. For example:

Worker: I've been thinking about the changes you each have made since we started working together. I've noticed changes in feelings and emotions, the way you think about things, and how you approach each other during good and challenging times. As you think back over our work together, what strikes you as especially significant or meaningful?

11.2.2 Saying Goodbye and Sharing Ending Feelings

Saying goodbye may be the most challenging dimension to the closing process. Family members may experience a wide variety of feelings that can include, but are not limited to: sadness and loss, anger, betrayal, powerlessness, fear, rejection, ambivalence, or relief. Whether their participation was involuntary or voluntary, the caseworker should not assume that families will be pleased for CPS involvement to end, particularly if the process opened the door for them to make substantial, positive changes. If appropriate, based on the relationship and work done together, the worker should attempt to have some alone time with the children to discuss their feelings about the experience and to make sure they know how to contact the agency should there be a time in the future when they are in the same, or a similar, situation as when CPS first became involved (refer to the initial reasons for involvement).

Endings are a type of loss. Depending on the life experiences of family members and workers, ending CPS involvement could trigger unexpected and strong feelings. It may be helpful to encourage family members to recall past endings, with both friends and helping professionals, and to explore the feelings experienced, as well as the coping strategies, and support systems they have previously used in those situations. It is important to remember that each family will experience the ending of the CPS involvement in a unique way. Not all family members will want to discuss their feelings. In some situations, it may not be part of the culture of the family to discuss feelings and in other situations, there could still be distrust of the system. Rather than predetermine what is important for each family, it is important to provide an opportunity to express feelings as part of the closing process. For example, a worker might use an open-ended question, like: "This is our last session together. How are you feeling about this?"

11.2.3 Acknowledging the End

Especially when the reason for ending CPS involvement is because families have successfully achieved outcomes and goals, holding the last family meeting in a setting other than the CPS office can be a powerful way to say good-bye and recognize success. Rituals are important in cultures and families. They serve to assist in normalizing and understanding experiences. An ending is a time to "mark" a significant life experience.

Some workers like to use closing exercises that include all family members in deciding how to "celebrate." Similar to a graduation, this could be a small party, making gifts for each other or creating a story together that is written down along with art work provided by each of the children. Or the worker could ask everyone to work together to draw a picture of the family today. Another example is to have the children work together to make a frame for a family portrait and the worker can provide the picture (taken the week before).

Some CPS programs have collections of donated tickets to community or sporting events, and the last family meeting might involve providing the family with tickets so that they can do something together as a family to celebrate their accomplishments.

11.3 Community Collaboration During Closure

In certain situations, even though CPS involvement is ending families may still have unmet or ongoing needs. As discussed in chapter 10, when families need continuing intervention (e.g., mental health or substance use disorder treatment), it is important that other providers are aware that CPS involvement is ending. At a minimum, the worker should send a formal letter notifying other current providers of the end of CPS involvement.

There could also be situations that suggest the need for a new connection in the community to further support and sustain change. When workers review the progress made by families, ongoing or new needs may be identified. Many communities have family support centers or family resource centers, which could prove to be helpful supports to families should they experience challenges in the future. Caseworkers can also review with the family those parties they have identified as their personal, ongoing support (e.g., other family or fictive kin, religious affiliations, etc.) and can talk about how to reach out for help and support. Workers should provide information about community resources as part of the closing process, including ensuring that families receive any public benefits for which they qualify.

When the court is involved, the CPS worker is required to request approval for court and agency involvement to end. Depending on the jurisdiction, this request may be through a final court report, a legal motion, or a review hearing. Ideally, the worker will incorporate this requirement in planning the closure process.

Chapter Highlights

- Ideally, ending CPS involvement happens when sufficient change has occurred through the delivery of change strategies and interventions, and when families have achieved outcomes and SMART goals.
- There are at least four reasons for CPS closure: outcomes and goals have been achieved; outcomes and goals have been partially achieved and further community support is needed; the family moves out of the jurisdiction, resulting in referral to another CPS program; or the family refuses voluntary CPS involvement, but there are insufficient reasons to refer the family to court.
- The process of ending CPS involvement should include a formal closing meeting with the family.
- Specific skills used in the closing process include reviewing the process and final evaluation, saying good bye and sharing ending feelings, and marking the end.
- Community collaboration is an important part of the closing process. Some families need ongoing intervention and/or support from community agencies even after CPS involvement ends.
- When families are under court order to participate with CPS, court approval is required prior to ending CPS involvement.

Chapter 12: Effective Documentation

Effective CPS documentation provides accountability for both what the agency does and the *results* of what the agency does. CPS recordkeeping is structured via electronic information systems that vary across jurisdictions. However, regardless of the structural differences of information systems, effective documentation not only assures accountability to others, but also facilitates a way of thinking and a process to measure the results of the agency's work with families and children (DePanfilis, 2000c).

Many CPS workers would say that documentation is the least favorite part of the job, often because the approach to keeping records isn't seen as useful. This chapter is intended to reframe documentation as a tool to guide critical thinking rather than a mere requirement. This chapter:

- Identifies the principles of recordkeeping
- Emphasizes the importance of using behavioral descriptors in records
- Describes the purposes of documentation
- Outlines the content of effective documentation.

12.1 Purposes of Child Protective Services Recordkeeping

The key purposes of keeping records and providing accurate documentation are to:

Guide the CPS process. Each stage of CPS builds on the stage before it; therefore, the record provides a cumulative summary of the CPS process from intake to closure. The purposes, process, and decisions of each stage should be clearly documented, particularly because different parts of the CPS system (e.g., investigation, in-home services, foster care) usually mean differences in caseworkers and/or community providers over time. Clear documentation also helps prevent duplication of effort, and the record itself helps to clarify and focus each stage of the process.

Provide accountability for the agency and the caseworker. Records should describe which family and/or other household members are (and are not) participating in CPS intervention and provide a complete and factual account of how the caseworker and agency fulfill the mandates specified in law and policy related to each stage of the CPS process. This should include documentation of services needed and referrals made by the worker to demonstrate that the agency is making reasonable efforts to ensure child safety in the parents' care. The content of records, described in the next section of this chapter, provide accountability and may decrease or negate personal liability should legal action be taken against the agency and/or a caseworker.

Serve as a therapeutic tool for the caseworker and the family. Records should demonstrate the way in which the caseworker and family collaborate to help family members improve the safety of their children, reduce the likelihood of child maltreatment, and participate in any needed interventions to address the consequences of maltreatment. When CPS programs use collaboration mechanisms such as self-report instruments and family team meetings, the record itself provides an illustration of this collaborative process.

Organize the caseworker's thinking about the work. Structured and timely presentation of factual information leads to more indepth assessment and planning. Particularly in the ongoing phases of CPS, reflecting on progress from each casework contact facilitates thinking about and planning the next home visit. This process can then be used to summarize progress with family members over time so that the purpose of each home visit is focused and directed toward goals in the safety and family plans.

12.2 Principles of Effective Documentation

The records about families are professional tools. As such, caseworkers should complete documentation in a timely and professional manner and respect confidentiality at all times. This means that the following appropriate controls should be in place to ensure the security of paper and electronic files:

- Paper and electronic records should only contain information that is relevant and necessary to the CPS program's purposes.
- Facts should be recorded using behavioral descriptors (see next section).
- Conclusions should be based on specific observed facts.
- Documentation should be accurate, relevant, timely, and complete.
- Once recorded, information should not be erased or deleted. Errors can be noted as an addendum to a specific note.
- If there is a reason to audio- or videotape a session with a child or family, it is necessary to explain the purpose and obtain written permission from the child and parent. Family members need to be informed that refusal to allow taping is permitted without consequence.
- If CPS caseworkers dictate their notes, they need to do so in a way that protects a client's right to privacy and confidentiality.
- Written documents, reports, records, or printouts should never be left out on desks or in other open spaces where others might have access to them. If a worker needs to take written information to court, the worker should ask the agency attorney before bringing any documentation other than copies of the most recent court report and return the materials immediately to the office after use.

- Families have a right to anything documented about them, including all parts of the case record, reports, and logs. It is important to remember this access before documenting any parts of the case record. Caseworkers should only record what they are willing to share directly with family members.
- The CPS record includes professional documents that may be discoverable by the court and legal parties in related legal proceedings; as such it is important that other principles (e.g., factual, specific, professional language) apply to everything that is documented.
- If caseworkers choose to include copies of emails or text messages between themselves and their clients as a record of efforts to schedule with or follow up with family members, it is important to remember how these contacts will be used before sending written messages, so they will be understandable to others who have access to records.
- Records should never be a place for caseworkers, supervisors, and/or other providers to air differences of opinions or perceptions about families and children. Results of team meetings that are recorded for the electronic record should follow the same principles for describing facts, observations, summaries of discussions, and decisions.

12.3 Using Behavioral Descriptors

As indicated in the principles of effective documentation, it is important to record factual information and to avoid opinions or jargon in the language used in records. Caseworkers should avoid subjective language with negative connotations used to describe an action, a person, or a behavior. The language chosen should be based on observations of specific behaviors and conditions or obtained by asking open ended questions to clarify opinions offered by others. This approach increases the likelihood that conclusions and decisions are based on facts, not baseless judgments. When conclusions are drawn, the basis for them should be well established by facts and observed behaviors. For example, "Mr. Smith appeared to be intoxicated, his eyes were red, he had difficulty standing without losing his balance, and his breath smelled of alcohol at 10 a.m."

Examples of how buzzwords can lead to faulty decision-making and negative child and family outcomes are illustrated in a short, animated video developed by the Capacity Building Center for States at https://www.youtube.com/watch?v=ipCgPXp_Vmc#action=share

Subjective language creates stereotypes and negative characterizations and leads to challenges with engaging families as partners, assessments that are biased, faulty decisions, eroded credibility, and family plans that are not individualized and tailored. Labels attached to specific family members early in the CPS process can follow the children and parents into later stages, possibly leading to missteps by others who have roles with the family.

When reviewing one's own language and the choices of words used by others, the caseworker should ask the following questions:

- Does this word explain a behavior clearly?
- Could this description create unintended bias or negative connotations?
- Is there sufficient information about how often the description occurs and how it specifically affects the child?
- Are conclusions backed up with facts and behavioral descriptors?

12.4 Content of Child Protective Services Records

Records should factually document what CPS does in terms of assessment and intervention, as well as the results of CPS-facilitated safety or change focused strategies and interventions. Child and family records, whether paper or electronic, should include:

- Information about the nature and extent of the referral or intake report; the demographics of children, families, and significant others; and the response of the agency to the referral, including if the family was referred to a DR program or track.
- A record of all dates and length of contacts, including in-person, mail, telephone, text, email, and other attempted contacts with all family members, collateral sources, teams, and other service providers as well as the location and purpose of these contacts.
- Documentation that the family has been informed of the agency's policies on the confidentiality and release of information from the child's and family's record.
- Documentation of efforts to identify family members, including fathers and the paternal side of the family, as well as other important people in the child's life. They may be able to provide emotional connections or kinship care (or other permanency options), if needed.
- Documentation that the caseworkers asked if the child is eligible under the Indian Child Welfare Act (ICWA).
- Information about the initial assessment, including factual accounts of all interviews, and facts and behaviors relating to assessments of risk and safety of the children. All completed forms and checklists should have narrative information that justifies selection of specific risk or safety criteria.
- Copies (if available) or summaries of 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, timely documentation of initial decisions with respect to substantiation of the alleged maltreatment, risk and safety assessments, and basis for any placements in out-of-home care or court referral if necessary (including of approval of any placement decisions involving relatives). Periodic (at least every 90 days) documentation of reasons for continued CPS agency or community-based agency ongoing involvement.
- The safety plan, if one was developed, and the documentation of referrals to other programs, agencies, or persons who have roles to implement strategies for keeping children safe. The worker should also document if and why a safety plan was not needed.
- A description of any criminal, juvenile, or family court involvement and the status of any pending legal action that may involve specific family members, including copies of reports provided to the court by CPS and any court orders, motions, or affidavits.
- A record of the family assessment (including identification of risk and protective factors) and a delineation of the primary outcomes that are targeted for change strategies and interventions.
- Specification of the family plan with target outcomes, SMART goals, planned change strategies and interventions, as well as the process used to collaboratively develop the plan with family members.
- Progress notes that identify actions taken by family members in collaboration with CPS and community providers to address the behaviors and conditions that led them to need CPS intervention, as well as strategies and interventions facilitated by CPS and/or community providers.

- Supervisory notes that document their role in key CPS assessments, decisions, and reports and provide accountability for guidance to workers related to their work with children and families.
- Summary reports provided by community providers and results of progress assessments that occur at least every 90 days.
- Documenting supervisory review and approval of assessments, key decisions, etc., as required by policy in any given jurisdiction.
- A closing summary that describes:
  - The process of closure with the family
  - A description of the reasons for closing, including specific documentation of all progress assessments that summarizes the degree to which outcomes and goals have been achieved
  - A synthesis of the strategies and interventions provided by CPS and others
  - An identification of any new reports of maltreatment that may have occurred since the initial report/referral
  - A current assessment of risk and safety at the point of recommending closure
  - An identification of any ongoing community support requested by the family and arranged for by CPS prior to closure.

Chapter Highlights

- Effective CPS documentation provides accountability for both what the agency does and the results of what the agency does.
- Documentation also facilitates a way for the caseworker to critically think about how to facilitate purposeful and focused interactions with children and families.
- Records should only contain information that is relevant and necessary to the CPS program's purposes.
- Documentation should be accurate, relevant, timely, and complete.
- Jargon should be avoided, and the descriptions of circumstances should be written using behavioral descriptors based on observations and specific statements of involved parties.
- Conclusions or opinions must be based on facts that are clearly described.
- The content of records should provide an accurate and complete record of all stages of the CPS process.

Chapter 13: Supervision

Despite a gap in research that has explored how supervision directly affects child and family outcomes in child welfare (Carpenter, Webb, & Bostock, 2013), the consistency and quality of supervision in child welfare has been linked to intermediate outcomes, including:

- Perceived worker empowerment (i.e., the ability to make change in one's own and other's lives) (Cearly, 2004)
- Worker self-efficacy (Collins-Camargo & Royse, 2010)
- Training transfer (i.e., using skills on the job that were learned in training) (Curry, McCarragher, & Dellmann-Jenkins, 2005)
- Increased job satisfaction and reduced burnout (Marin & Schinke, 1998)
- Retention of frontline staff (DePanfilis & Zlotnik, 2008; Yankeelov, Barbee, Sullivan, & Antle, 2009)
- Support for the implementation of child welfare practice models (Frey et al., 2012)
- Fidelity of the implementation of evidence-based interventions in child welfare (Bartley, Bright, & DePanfilis, 2017)

Most models of supervision as applied to child welfare emphasize three overarching functions that supervisors play: (1) administrative; (2) educational; and (3) supportive (Hess, Kanak, & Atkins, 2009; Kadushin & Harkness, 2014; NASW, 2011; Potter & Brittain, 2009). Addressing all of these supervisory roles goes beyond the scope of this chapter. Instead, it focuses on the supervisory practices that support CPS caseworkers to competently fulfill their responsibilities in each of the CPS stages described in this user manual. This chapter:

- Reviews two broad areas of supervisory practices, consultative and coaching, which complement each other and often may be used in tandem
- Examines individual and group supervision
- Looks at key CPS decisions when supervisors use consultative and coaching supervisory practices to support critical thinking and effective decision-making

Other supervisory practices that focus on the well-being of CPS staff are discussed in chapter 14.

The following sections discuss both practices indepth. However, brief definitions are listed here:

Consultative supervisory practices focus on supporting caseworkers to fulfill their responsibilities to interview, conduct assessments, develop plans, implement and change strategies and interventions, and evaluate changes in the risk and protective factors that brought families to need CPS intervention.

Coaching supervisory practices support caseworkers to build competency and empower them to come up with their own solutions.

13.1 Consultative Supervisory Practices

As conceptualized here, consultative supervisory practices focus on supporting workers to fulfill their responsibilities to interview, conduct assessments, develop plans, implement change strategies and interventions, and evaluate changes in the risk and protective factors that brought families to the attention of CPS. Implementing consultative supervision occurs through discussion about specific children and families assigned to staff. Thus, consultative supervision focuses on the interventions the CPS caseworker uses with specific families and children, addresses family dynamics and functioning, and identifies examples of implicit bias that may pose the need for alternate perspectives (Ferguson, 2009).

A form of consultative supervision is reflective supervision that creates an opportunity for caseworkers to consider, debate, and analyze confusing and even conflicting data regarding family situations (Lietz, 2009). Experiential learning focused on applying theoretical knowledge to actual situations is essential in CPS and caseworkers learn best through a dynamic process of reflecting on the details of specific circumstances experienced by children and families (Tourse, McInnis-Dittrich, & Platt, 1999; Zorga, 1997). Studies have suggested that decisions that are not "well thought out" evolve when there is sufficient probing or questioning of discrepancies or inconsistencies (Munro, 2005), and that in order to result in strong assessments, child welfare decision makers need to dig deeper and ask further questions (Benbenishty, Segev, Surkis, & Elizs, 2002). Thus, supervision needs to incite reflection in order to develop critical thinking skills to support CPS caseworkers to sufficiently manage the complexity of their work (Lietz, 2009). Using a reflective supervision approach, particularly during group supervision, offers the opportunity for peer support and multiple perspectives about challenging situations and enhance critical thinking about key decisions (Lietz, 2008).

13.1.1 Process of Individual Consultative Supervision

In CPS, workers and supervisors often have daily contact. A supervisor might stop by to ask about a recent field visit or a worker and supervisor might have conversations as they travel together on their way to court. Those interactions are crucial to providing support to staff as they approach their work.

In addition, to these frequent interactions, however, all CPS caseworkers need regular and routine opportunities for consultative supervision. Best practice suggests that supervisors should meet individually with their workers regularly. To be truly effective for building staff competence, consistency is key. Supervisory meetings should be private to permit indepth discussions without interruption. Ideally, the caseworker and supervisor will contract with each other to develop a mutual understanding about how they will work together. Like any other professional relationship, these opportunities are most successful when they are planned and purposeful, target specific goals, and include a process for reciprocal feedback. Examples of topics of discussions about families include:

- Child safety and risk assessment, including evaluation of protective capacities and protective factors
- Implementation and ongoing management of safety plans and outcomes
- Strengths-based engagement strategies to build partnerships with children, parents, and family systems
- Information gathering protocols to fully achieve the purposes of the initial or comprehensive family assessment
- Reflection on facts versus opinions to guide analysis of gathered information to inform key decisions
- Consideration about when to initiate multidisciplinary team meetings or when outside evaluations may be necessary to fully inform assessments
- Selection of core outcomes to guide change-focused strategies and drafting SMART goals following input from families
- Review and evaluation of progress made by family members, and consideration of the need to modify plans, change strategies, or interventions
- Review of any barriers to securing services for children and family members in order to address them

13.1.2 Process of Group Consultative Supervision

An advantage of CPS agencies is that they are organized by caseworkers in a unit with other caseworkers and their supervisor (Hanna, 2009). The unit structure provides an opportunity to develop a team identity, which promotes peer support, the ability to communicate and work together, develop a common work ethic, and establish a commitment to best practice (Hanna & Potter, 2012). Using the unit structure in CPS, best practice suggests that consultative group supervision should also occur regularly. This structure permits peer learning and support and offers the opportunity to consider different perspectives in context of discussions about families and their children.

To be most effective, each session should be guided by a protocol or specific theme. To create maximum participation, group members should periodically co-create the agenda by identifying specific aspects of CPS practice that could be enhanced by role-play activities, case staffing discussions, practice exercises, or other mechanisms appropriate for a group format. For example, if all members of the unit recently participated in a motivational interviewing learning program, during the 4 weeks following completion of the program, the supervisor could set up practice role-playing sessions based on children and families with whom unit members are currently working. The supervisor can create a safe place to practice OARS[1] to guide the role play. For training to make an impact on practice behavior, there is substantial research that suggests reinforcement and the opportunity to practice increase transfer of learning to the real world (Antle, Barbee, Sullivan, & Christensen, 2010).

1 **O**pen ended questions, **A**ffirmations, **R**eflections, and **S**ummarization.

13.2 Coaching Supervisory Practices[2]

Child welfare agencies are increasingly using coaching as a core strategy for providing supportive supervision (Northern California Training Academy, 2012; Watson, 2012). Coaching is a process for supporting caseworkers to build competency and to empower them to come up with their own solutions (Atlantic Coast Child Welfare Implementation Center, 2013), which parallels the helping process between the CPS worker and families. The process and skills of coaching work well with supporting CPS workers to build critical thinking skills and develop and implement plans for strengthening their practice skills. The coaching process and skills may be used in individual and group supervision. An advantage of integrating coaching within the supervisory process is that supervisors often already have these skills, and just need to practice employing the coaching approach in their supervisory processes with staff.

13.2.1 Coaching Skills

This section summarizes information about core coaching skills. Each of these skills may be used in both formal and informal coaching sessions. **Exhibit 13.1** then provides a scenario incorporating these skills.

Presence. The nature of CPS work does not automatically lend itself to both parties being "present" during supervision. To be effective, both the supervisor and the CPS worker have to be 100 percent attentive to each other and the process. While this seems very basic, it often is hard to do. To fully support a respectful and collaborative process, there must be a commitment to putting phones on silent, staying in the moment without distraction, and avoiding attending to other things. Supervisors who use the coach approach close their doors, avoid responding to phone calls or emails, put up a "do not disturb" sign, and prepare others to respect privacy during supervision. If a supervisor does not have a private office, this may mean finding other ways to hold supervision, such as reserving the use of a conference or interview room, or if necessary, by hanging a sign in front of the cubicle to try to prevent interruptions. Also, supervisors can begin supervision by asking the CPS worker to join in taking a moment to focus on being present or even simply taking a deep breath together before beginning.

Listening. A key skill for interpersonal helping, active listening skills are essential in a coaching model of supervision. The supervisor must avoid trying to fix or solve the problem, but instead should listen while the caseworker presents the issue(s) she/he wants to address in supervision. The "art" of listening can't be accomplished if presence has not first been established. Making eye contact, facing each other, and being attentive to both verbal and nonverbal cues are essential parts of listening

> **Example:** Verbal encouragers, like "hmm," "go on," and nodding your head to acknowledge you heard what is being said are examples of demonstrating listening.

2 Information in this section based on the Atlantic Coast Child Welfare Implementation Center (2012), *Coaching in child welfare curriculum*. Baltimore, MD: University of Maryland School of Social Work, Ruth Young Center for Families and Children. Funded by the HHS/ACY/ACYF-Children's Bureau (90CO1042), Diane DePanfilis, Principal Investigator. Available from: http://socialwork.umaryland.edu/cwa/RYC/assets/ACCWIC-Coaching_Training_PPT_Curriculum_Companion.pdf

Reflecting and clarifying. Similar to how CPS workers use these skills in sessions with families, supervisors use reflection and ask open-ended clarifying questions to explore the issue(s) the caseworker has brought to supervision. This means reflecting back the content of the caseworker's words to affirm that the supervisor understands. Or, it could also mean identifying with the emotion the caseworker may be evoking when presenting a particularly troubling situation. It also involves using summarization to check in that the supervisor and caseworker are on the same page with respect to the focus of the supervisory session that day.

> **Example:** It sounds like this is a particularly complex situation for this family. They received their eviction notice on Friday and only have two weeks to find another apartment, and the mother seems unable to cope, as this is one more thing on top of a series of crises this family has experienced. You are feeling somewhat overwhelmed because you can't imagine finding a livable apartment for a mother and three children in only two weeks within the family's income. You really want to help this family avoid having to move into a shelter. What have I missed with how you see the problem?

Questioning. The supervisor asks questions intended to move the caseworker into reflection and discovery. Open-ended questions that begin with "what" or "how" keep the conversation focused and empower the caseworker to consider options for problem solving. To coach the caseworker, the supervisor must focus on supporting the caseworker to consider options or solutions.

> **Example:** What options have you considered so far? What are your thoughts about the way to handle this situation? What have you tried so far? In similar situations, what has worked in the past? Based on your experience, what do you think the next step should be? How do you think the mother would respond to your idea?

Feedback. Giving strengths-based feedback is essential to the coaching process. This means that even if the supervisor is in a position to offer constructive feedback, it should be balanced with feedback on strengths as well. The supervisor should also use this skill by asking the caseworker for feedback on the supervisory process. Feedback should be:

- **Frequent** enough to sustain expected practice
- **Direct** and related to a performance issue
- **Behavioral** in that it is focused on changes and is not personal
- **Well-timed** in relation to the emotional readiness of receiver and giver
- **Helpful** in that the receiver perceives the motives of the giver as constructive
- **Clear** so that the feedback and intention is understood

Accountability. This involves the supervisor and caseworker setting clear action items together and implementing plans for following up. It also involves discussing barriers and constructing strategies to address breakdowns with initial plans.

> **Example:** Now that you have set a goal to bring your overdue documentation up to date, when would you like to check in on your progress? Last week we talked about how you were going to have a courageous conversation with Ms. Brown by exploring whether she has initiated contact with her boyfriend again even though she has said there was no way she was going back to him after what he did to her and her 9-year-old son. How helpful was the role-play we did last week to prepare you for this conversation? What worked? And what might you try differently next time you have a similar situation?

Exhibit 13.1 Example Of Giving Feedback[3]

Supervisor: I just wanted to check in with you about your engagement with the Gordon family. From my review of your progress notes, it seemed like you were using your new motivational interviewing skills. I noticed that you were using many open-ended questions, affirmations, and successfully engaged the family in conversation, even though they had been ambivalent about working with CPS when they were initially referred. I also noticed that your use of summarization is helping the family to remain focused during your visits. How did it feel to put your motivational interviewing skills into practice?

Caseworker: It feels a little awkward to me since it is still new, but I am determined to continue to try it out. So far, so good.

Supervisor: So even though it can be challenging, it sounds like you are taking advantage of this learning opportunity and also recognizing how these skills can benefit your work. Caseworker: Yeah, I am surprised it is working so well. I am going to keep practicing with the Gordon family and emphasize ways to recognize their change talk.

Supervisor: You should be proud of your willingness to practice motivational interviewing skills while they are still fresh in your mind. It shows that you are serious about your skills development and helping your families.

Caseworker: Thank you. I am proud of myself. I am trying very hard to emphasize partnership, respect, and compassion in my work with families.

Supervisor: I know from past conversations that you were experiencing a breakdown with the Andrews family. How could you use what you learned from the motivational interviewing training and your experience with the Gordon family to increase their readiness to change?

Caseworker: I am so frustrated with the Andrews family and my frustration is growing by the minute. They don't return my calls. They pretend they are not home for our scheduled appointments. And as far as I can tell, they haven't made any progress to implement their family plan.

Supervisor: I know that you are trying very hard to engage this family. You are a dedicated caseworker who always keeps appointments with your families, you have conversations with each of the family members at your visits, and your families report that you are a great support. And, I noticed that you recently used motivational interviewing and strengths-based engagement skills to include all members of the Gordon family in developing their family plan. I also noticed that the Andrews family didn't have much input into the creation of their plan.

Caseworker: Yes, due to time constraints, I was unable to get them involved in the development of their plan.

Supervisor: How does the approach you used with the Andrews family demonstrate partnership, respect, and compassion?

Caseworker: Wow! I think I can do better at that! Thank you for pointing that out, I have been so frustrated with this family that I failed to realize that I didn't even try to include them in the planning. Maybe I need to be more empathic by tuning into the family's needs and reengage the family by asking them what their priorities are. This will help us have more of a partnership in revising their family plan.

3 Excerpt adapted from NYC Administration for Children's Services. (2017). *Building coaching competency; Script for advanced coaching videos.* New York, NY: Author.

13.2.2 Coaching Process. The supervisor uses the coaching approach and coaching skills any time that listening and asking questions will empower caseworkers to reflect on their practice. During weekly supervisory sessions, the full coaching process may be used as reflected in **exhibit 13.2**. This involves:

- Beginning the session to center together, making sure both are 100% present
- Clarifying the focus for the supervisory coaching session; if the caseworker had developed goals and an action plan during the previous session, this session might begin by understanding what did and did not work to determine if further strategies are needed on the issue discussed previously to explore other issues that the caseworker and supervisor believe could benefit from a deeper discussion
- Selecting a priority issue for focus; the next step is for the caseworker to develop a SMART goal about something he or she may want to work on
- Developing an action plan that details the specific strategies he or she will employ, with whom, and by when
- Finalizing the action plan, the supervisor works with the caseworker to gain commitment to the specific details of the plan
- Concluding with a plan for how and when they will assess progress

Exhibit 13.2 The Coaching Process[4]

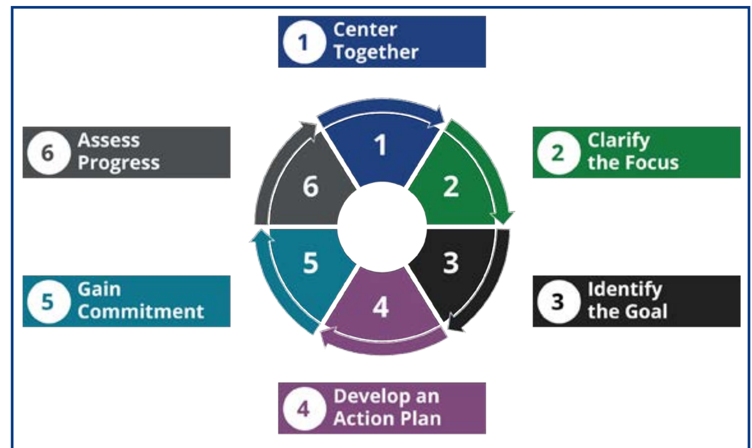

Exhibit 13.3 provides a sample script from a full coaching session.[5]

4 Exhibit used with permission from Administration for Children's Services. (2017). *Building coaching competency*. New York, NY: Author.

5 Script originally written by Carolyn Rohe and Doodmattie Ramiakan from NYC Administration for Children's Services. (2017).

Exhibit 13.3 Example of a Full Coaching Session

Carolyn is the supervisor, Mattie is the worker. The two are meeting in Carolyn's office after Mattie requested via email for Carolyn to meet with her. Mattie is feeling overwhelmed and unfocused at work.

Carolyn: Hello Mattie, how are you feeling today?
Mattie: I'm good. Well, I'm trying to be good. I'm trying to feel good!
Carolyn: I got your email and I know there is a lot that you wanted to talk about today. But, before we get started, I just want to take a minute to clear our thoughts so that we can be present ere today. I will make sure that my phone is off, so that we won't be disturbed. I let everyone know that I'm here with you in supervision, so we shouldn't have any interruptions. How does that sound?
Mattie: Great! I'll also put my phone away.
Carolyn: Let's take a few deep breaths together to clear our minds. Let the stress of the day go away so that we can have a productive conversation.
Mattie: Sure. I need that.
Carolyn: Breathe in … let it out … breathe in again ….
Mattie: (Doing the breathing exercise)
Carolyn: Are you feeling ready to start?
Mattie: Yes, sure.
Carolyn: When you are ready, you can tell me what's going on.
Mattie: I am not able to keep up with the daily tasks and to do's for each of my cases. Especially with my case documentation! Contacting collaterals and doing interviews require me to document progress notes each time. Because of my heavy workload, I'm now behind on my paperwork! I also struggle with finding time to invest in my professional development.
Carolyn: Thank you for being so honest with where you are in your documentation. You are thinking ahead and being proactive. I also do appreciate your commitment to continue to grow as a worker. These are two very important areas of your work. Which would you like to focus on today?
Mattie: I feel that the most pressing issue for me today is to catch up with my documentation.
Carolyn: Sounds like for today's conversation you would like to focus on how to get up-to-date with your progress notes?
Mattie: Yes. I am one month behind on progress notes in our computer system. I think finding the time is an issue … maybe having a plan … maybe figuring out what is priority? Then working on those first. However, because I believe everything is important, I can't figure out what should be done first!
Carolyn: What I hear you say is figuring out how to best prioritize may help you in getting caught up on your documentation, and is something you want to work on today?
Mattie: Yes, it is a struggle keeping up with the case notes, making the home visits … and recently going to the field is a challenge because I don't feel comfortable going out when I need to catch up on the documentation. It's like I'm being tugged back to my desk. I have so many things to do, and it is a struggle to balance my responsibilities … and this includes my professional development … they are all important. Especially with my caseload being higher than usual, I'm challenged. I have to find a way to strike a balance!

Exhibit 13.3 Example of a Full Coaching Session

Carolyn: I agree. All the work you do is very important and finding that balance especially during difficult times can be overwhelming. How have you managed high caseloads in the past?
Mattie: (pause) Hmm … Let me think back. Last time my caseload spiked, I was able to work on time management by having a daily work schedule.
Carolyn: It sounds like having a schedule to better manage your time throughout the day worked for you in the past. Please tell me more about what that schedule looks like.
Mattie: From what I recall, the daily schedule did help me to manage my cases and documentation better, however I can't remember the details of what it looked like. To be honest, the thought of finding time to create a schedule now seems unrealistic since I am already behind on my paperwork.
Carolyn: I sense that you feeling overwhelmed, and that there is not enough time in the day to get everything done. What is contributing most to you feeling this way?
Mattie: The paperwork!!! What seems to be most pressing is getting caught up with the progress notes. I think the cases are going to keep coming in … and each requires its own documentation. If I'm able to work on updating my notes and keeping up with my daily documentation, then perhaps managing that one thing, can lend to managing all the others.
Carolyn: What I hear you saying is, figuring out a way for you to catch up with your documentation and remain caught up is the first step … am I hearing you correctly?
Mattie: Yes! I need to catch up with my notes ASAP so that I can move my cases along.
Carolyn: Let's brainstorm …. What ideas do you have that will help you catch up on your notes?
Mattie: I think I can start by reviewing my cases and making a note of which need to be worked on first. To come up with sort of a timeline of which cases are most behind versus least behind. This will help me structure myself and organize how I will begin to get the documentation in.
Carolyn: That's a great idea. What other ideas do you have?
Mattie: Let me think … another option could be …work on a creating a schedule for the day. Maybe I need to come up with an agenda, a plan of my own, with a daily plan of my daily work. For example, I come in at 9 a.m. and the first thing I do is to check my emails and that takes me 15 minutes. And then the next thing I do, should be to look at my to do's, on the computer system, to see what's priority and that should take me 5 mins. Something like that.
Carolyn: So wonderful, it sounds like you have already come up with two possible solutions. The first is for you to sit down and prioritize your cases, the second is to develop a daily work schedule.
Mattie: Maybe finding a way to ground myself in the work or, or to focus. That's my problem. I am not focused!
Carolyn: Tell me a little bit more about that?
Mattie: I'm the social person at work … you know that, I talk a lot. I have all these friends and people in my area who want to chitchat. It's like they, they think that I come to work every day to be their chat buddy. And maybe I'm the one who started that trend. This has been an ongoing struggle for me but it's one of my time wasters, the chitchatting.
Carolyn: Okay ….
Mattie: I like to be friendly, however lately the conversations are less about work and more about current events and reality TV! I find that because of our work environment, how our cubicles are situated, plus the idea of everyone thinking that I have feedback/comments to share about everything. Too many distractions for me!
Carolyn: That's some great insight into who you are as a person, and a worker. You also came up with two possible ways to help you with documentation, and now that we are brainstorming a third, you had this great realization that you need some help in staying focused. What ideas do you have in mind to help you with being focused?

Exhibit 13.3 Example of a Full Coaching Session

Mattie: Oh my God!! Can I just move my cubicle off of the floor? I know we don't have a lot of space, but somewhere secluded. That would be great. Because I think, in isolation I work better. Being a part of the mix of conversations that's happening on the floor is not helpful to me being focused. I have this new colleague who is sitting next to me and she has all these questions because I'm the seasoned worker. Every two minutes, she interrupts me and I feel bad and don't want to say anything to shut her down or hurt her feelings. However, I think I'm encouraging a habit. I think I need to put a sign up on my desk stating that I am working on something or that, "I'm busy, progress notes in session," or something like that.
Carolyn: That sounds great. Definitely putting up a sign could work. What other ideas do you have for getting focused?
Mattie: I can put my headphones on.
Carolyn: Another great idea. There are lot of people around in the office to distract you.
Mattie: I'm sure it will help to tune things out.
Carolyn: Any other ideas?
Mattie: Just to be able to message to people that I'm currently unavailable and have work to do!
Carolyn: It sounds a little bit like you're talking about setting boundaries.
Mattie: Yes!
Carolyn: So that you can get your work done.
Mattie: Exactly! I need to clip my social-butterfly wings.
Carolyn: I think those are great ideas to begin to help you to get caught up on your documentation. Your first idea was for you to go through all of your cases, sort and prioritize them. The second was for you to develop a daily schedule with time frames and the third was this sort of realization that you need to become more focused. You also said that by getting more focused, which looks like maybe putting a sign up, maybe putting your headphones on, and setting some boundaries with your peers and colleagues. Of those three ideas, which do you feel will be most helpful in your goal of trying to get all caught up on your documentation?
Mattie: I feel that what would be most helpful is if I sit down, look at my cases and prioritize them.
Carolyn: It sounds like the thing that's going to help you most immediately then is really to prioritize your cases? To look at what needs to be addressed and completed first and work your way back from that. Am I right?
Mattie: Yes.
Carolyn: So, tell me a little bit more about this idea and what would be most helpful to you to start?
Mattie: To start, I need to put aside some time so that I can sit down and look at my cases and come up with something concrete.
Carolyn: So having a concrete plan of action is something that may help you at this time?
Mattie: Yes. Creating a chart with the cases listed and identify which cases are ready or almost ready to be transferred, closed etc. Ranking what is most important to least important. To create sort of a roadmap or vision board to help guide me.
Carolyn: What does that look like for you?
Mattie: It looks like a chart that I can put on my wall and next to my computer. That at-a-glance it can guide and help me keep track of my progress. I can picture it to be a landscape sheet of paper with all the details.
Carolyn: I imagine that maybe that's the first step …. Developing a chart?
Mattie: Yes! Yes! That is it!
Carolyn: How can I support you in that?
Mattie: I can work on getting the chart made, and perhaps you can help me to fill in the details?

Exhibit 13.3 Example of a Full Coaching Session

Carolyn: That sounds doable … it does sound like a doable plan. When do you believe you can have the chart made so that we can start to fill it out?
Mattie: Wow! Now I have to make time to do this. Maybe sometime next week? I'll work on notes on Monday, so maybe next Tuesday?
Carolyn: So you would have the chart ready by Tuesday?
Mattie: Yes.
Carolyn: And when would you like for us to sit down again to fill it out?
Mattie: On Wednesday, maybe?
Carolyn: Looking at my calendar, does Wednesday at 11 a.m. work for you?
Mattie: Yes, that works. Now that we have talked about this, I am thinking that I should start to work on documenting as soon possible. That documentation is the priority it seems. The sooner my notes are in, the faster I can do all the other things.
Carolyn: Sounds like you are prioritizing already as we are having this conversation! You seem very committed to actualizing the plan you came up with, to ensure that you get caught up with your documentation.
Mattie: Yes, this is helping me to organize my thoughts and how to get this done.
Carolyn: And you are coming up with a bit of an action plan.
Mattie: Yes, I think so. Work in progress.
Carolyn: Let me recap. You are going to create the chart and decide what items take priority and we will meet back here together on Wednesday to review your progress … and continue to prioritize the cases. What if something gets in the way of you carrying out this plan?
Mattie: I am going to go back to my desk and write some bullet points to remind myself of what we came up with as a plan. And so if something gets in the way, a barrier or a crisis comes up, I'll still have this plan to go back to. That this will remain the plan on how to move forward regardless of if anything comes up.
Carolyn: What support or resources do you need you to help achieve this goal?
Mattie: As a check-in, an email reminder maybe?
Carolyn: When would you like me to check in with you?
Mattie: At the end of the week.
Carolyn: Okay, I will check in with you at the end of the week to see how you are progressing with creating the chart and we will meet next Wednesday to review it.
Mattie: Sounds like a plan! Can you also please send me a meeting invite?
Carolyn: Sure, I can certainly send you a meeting invite as well to help get back on track. Sounds like we have a plan. How are you feeling about the plan?
Mattie: It feels good to have a plan to start to address the issue of being behind on my documentation. And it seems tangible.
Carolyn: When you came in today, you were feeling a little stressed out ….
Mattie: Very stressed out! I'm glad that we had an opportunity to sit down and discuss this.
Carolyn: How are you feeling now?
Mattie: Much better!
Carolyn: Tell me, how helpful was this meeting? On a scale from 1 to 10, 1 being not so helpful , 10 being very helpful?
Mattie: Up there … hmm, an 8!!! I now have some concrete things to go back and work on.
Carolyn: I'm very glad that you found this conversation helpful. I am looking forward to further support you through this. And I am also looking forward to Wednesday to review your chart. Thank you!
Mattie: Thank you Carolyn.

13.3 Supervisory Consultation and Coaching on Key CPS Decisions

The supervisor has a critical role to support effective decision-making during each of the stages of the CPS process, as **exhibit 13.3** illustrates.

Exhibit 13.4 Supervisory Consultation and Coaching on Key CPS Decisions

Stage	Supervisory Consultation
Intake Supervisors (or, in some cases, teams) use consultative and coaching skills to support CPS caseworkers to make the following intake decisions:	**Determine:** • **Whether to accept the report.** Whether the report originates from a state child abuse and neglect hotline or local CPS agency, the supervisor of the caseworker supports this decision, referring to state law and agency policies to make this decision. • **Urgency of the response.** Even though most CPS agencies have guidelines to prioritize when a CPS caseworker needs to go out to see the child and begin the initial assessment/investigation, supervisors explore the nature and extent of the report, in discussions with the intake worker, to arrive at a timeline for immediate response, response within 24 hours, and a response that can be initiated longer than 24 hours after acceptance of the report. • **If there are any worker safety issues in the report.** The supervisor and caseworker discuss if there may be any potential caseworker safety threats in the report and should consider if law enforcement or additional CPS supportive assistance is needed for a response. (Chapter 14 addresses this issue in more detail.) • **Whether the report will have a traditional assessment/investigation or DR.** In CPS systems that implement alternative or DR systems, the screener with supervisory coaching support or a screening team uses policies and assignment criteria to make this decision.

Stage	Supervisory Consultation
Initial Investigation/ Assessment Supervisors (or teams) use consultative and coaching skills to support CPS caseworkers to make the following initial assessment decisions:	Supervisors guide caseworkers to analyze the information gathered to: • **Determine whether:** ○ **The child is safe.** The supervisory role is to coach CPS or alternative response workers to consider whether safety threats exist and to assure that safety evaluation tools are used appropriately. ○ **Substantiation is warranted.** If a traditional CPS initial assessment is implemented, a key determination is whether abuse or neglect has occurred as defined by law and policy. Supervisors also guide whether the report should be referred for DR instead. ○ Engagement of the family is sufficient. The supervisor actively explores if all members of the family, including fathers, have been engaged and involved in the assessment process. ○ **The family's protective capacities and protective factors are sufficient or need additional support.** The supervisor is responsible for discussing the protective capacities and factors identified during the initial investigation/assessment and any supports that may be needed. ○ **The family has concrete needs.** A responsibility of the worker is to assess the children and family to determine if there are concrete needs related to safety: medical attention or supplies; food, clothing, furniture; utility assistance; housing chore services to remove hazards; sanitation services to remove rodents, roaches, bedbugs; temporary housing or shelter services; or others. The supervisor is responsible to assure that an adequate assessment of concrete needs has been conducted and to approve the use of emergency funds to address. • **Develop appropriate safety plans.** If a child is determined to be unsafe, the supervisor coaches the CPS caseworker to consider options of in-home safety plans that will control the influence of safety threats if the child is to remain at home. The supervisor also consults with the caseworker to determine whether out-of-home placement is needed to keep a child safe when in-home safety plans are not possible. This decision may also be guided by a safety team meeting in jurisdictions that use teams to support this decision. • **Determine whether:** ○ **A child is at risk of future maltreatment.** The supervisor assures that caseworkers use facts to support how they use any required risk assessment tools to determine the likelihood that future maltreatment may occur. Coaching questions may pursue the rationale for checking certain risk factors so that conclusions are drawn based on factual child and family circumstances. ○ **Ongoing change strategies will be offered.** In most jurisdictions, this decision is based on the result of the safety evaluation and risk assessment. However, the supervisor supports the caseworker to analyze the information so that appropriate decisions are made about whether to offer ongoing safety services or change focused strategies, and to determine the best match of providers if the ongoing work is not fully implemented by the CPS agency. As discussed earlier, once a disposition has been made the case often is transferred to another worker or possibly to another provider (e.g., with DR), so it is important to document everything in the safety plan and information gathered below and to make sure this information is transferred as well.

Stage	Supervisory Consultation
Comprehensive Family Assessment Supervisors use consultative and coaching skills to support caseworkers to make the following comprehensive family assessment decisions:	**Determine:** • **Most important risk and protective factors.** Supervisors support caseworkers to consider and prioritize the most important risk and protective factors that should be the focus of change focused strategies and interventions. • **Effects of maltreatment.** The supervisor consults with the caseworker to assure that appropriate assessments have been implemented to identify trauma effects and other physical or mental health needs of children and parents. The supervisor coaches the caseworker to consider the specific treatment needs of family members based on these assessments. • **What must change to address the effects of maltreatment and/or to reduce the risk of future maltreatment.** The conclusion of the comprehensive family assessment should isolate the primary behaviors, conditions, skills, attitudes, etc. that must change as a target of change-focused intervention. • **Readiness of family members to fully participate in the development of a family plan.** The supervisor coaches the caseworker about how to assess the acceptance or ambivalence of family members about the need to change specific behaviors and conditions. The supervisor may coach the caseworker on the strategies used to increase readiness to change. • **Primary child, parent, and family outcomes as a target of change.** Since the circumstances that bring children and families to the attention of CPS are complex, prioritizing the key outcomes as the target of family plans and change strategies requires critical thinking. The supervisor uses coaching to support the caseworker to consider the pros and cons of selecting specific outcomes.

<table>
<tr><th>Stage</th><th>Supervisory Consultation</th></tr>
<tr><td>Family Plan
Supervisors use consultative and coaching skills to support caseworkers to make the following family plan decisions:</td><td>
Finalize the selection of family-level outcomes. Based on the conclusions of the comprehensive family assessment, the worker must engage the family to reach agreement on the final selection of family-level outcomes. Supervisors coach caseworkers on strategies for having these conversations with family members.
Develop SMART goals. Supervisors coach caseworkers on crafting draft SMART goals that match each of the selected outcomes for discussion and finalization with family members. Goals and outcomes should address the behaviors that led to the family's involvement with CPS and that must change in order to keep the child safe. Input by family members would have come before these discussions and has an important role in supporting caseworkers to develop goals that are positively stated and meet SMART criteria.
Identify:
Action steps. Supervisors consult with the caseworker on potential action steps to be accomplished by family members and facilitative action steps planned for the worker and other providers.
Change strategies and interventions with the best evidence. Supervisors are a resource for helping caseworkers consider options of strategies and interventions that are tailored to address the families' individual needs and have the best available evidence. During the planning process, there should be congruence between outcomes, goals, and strategies and interventions. The supervisor supports the caseworker to make logical links and to practice how to empower family members to select among these options.

Develop a timeline for formal review, including in-court reviews. While certain timelines of family plans may be set in policy, the supervisor helps the caseworker to consider the best timeline for formally evaluating progress. Goals are more easily accomplished when they are time limited.
</td></tr>
<tr><td>Change Strategies and Interventions
Supervisors use consultative and coaching skills to support CPS caseworkers to make key decisions related to change strategies and interventions. The decisions have been made about the specific strategies and interventions that are planned to support the family plan. At this stage, supervisors support caseworkers to make the following additional decisions:</td><td>Determine:
Whether interventions are implemented as intended to support goal achievement. CPS has a responsibility to assure that interventions are implemented as specified in the family plan. Supervisors ask caseworkers coaching questions to explore the methods used by caseworkers to evaluate the implementation of interventions to assess delays, family member participation, and progress.
How well family members and caseworkers are implementing action steps to support goal achievement. The supervisor coaches the caseworker to assure that change strategies are implemented as intended.
</td></tr>
</table>

Stage	Supervisory Consultation
Evaluating Change Supervisors use consultative and coaching skills to support CPS caseworkers to make the following evaluating change decisions:	**Determine:** • **Current status of safety and level of risk.** The supervisor coaches the caseworker to compare the current status of safety and level of risk compared to safety and risk at the beginning of change strategies and interventions. Coaching questions explore the specific observed behaviors and conditions that are occurring now, compared to when the family was initially referred to CPS. • **Degree to which outcomes and goals have been achieved.** Based on the action steps, outcomes and SMART goals in family plans, the supervisor asks coaching questions to support the caseworker to consider the degree of achievement of outcomes and goals. Even though this has been the focus of change strategies, the formal evaluation of change considers the cumulative indicators of outcome and goal achievement. • **How family members have successfully coped with trauma or other effects of maltreatment.** The supervisor consults with the caseworker to review reports from other providers (if used) to assess the degree to which ongoing interventions are needed to address the effects of maltreatment and/or if those interventions can continue without agency involvement. • **Whether continued strategies or agency oversight is needed.** Based on the overall evaluation of change, the caseworker decides whether additional strategies or ongoing interventions are needed. The supervisor coaches the caseworker to determine whether moving toward closure is appropriate or whether a new or updated family plan should be developed with the family. The determination, if this was based on a court-ordered plan, will need input from the court
Closure and Ending CPS Involvement Supervisors use consultative and coaching skills to prepare the caseworker for the various ways families may react to closure and to acknowledge the ending. They also support CPS caseworkers to make the following decisions when ending CPS involvement is planned:	**Determine whether:** • **Additional interventions or support services are needed.** When families have made sufficient progress to achieve outcomes and goals, a key decision is whether the family has continued needs from the agency. The supervisor coaches the caseworker to consider the need for ongoing agency intervention either to support the family to sustain change or to continue to address the effects of maltreatment. • **All court mandates have been fulfilled.** Prior to officially ending CPS intervention, the CPS caseworker and supervisor must assure that all court mandates have been fulfilled. The court will make the final decision, with input from the agency.

Chapter Highlights

- The quality of child welfare supervision has been linked to perceived worker empowerment, worker self-efficacy, transfer of learning, job satisfaction and reduced burnout, retention of staff, support for implementation of child welfare practice models, and the fidelity of the implementation of evidence-based interventions in child welfare.
- Most models of supervision emphasize three overarching functions that supervisors play: (1) administrative, (2) educational, and (3) supportive.
- Consultative supervisory practices focus on supporting caseworkers to fulfill their responsibilities to interview, conduct assessments, develop plans, implement change strategies and interventions, and evaluate changes in the risk and protective factors that brought families to need CPS interventions.
- To be most effective, best practice suggests that consultative individual and group supervision should be provided on a regular basis.
- Coaching supervisory practices support caseworkers to build competency and empower them to come up with their own solutions.
- Key supervisory coaching skills include presence, listening, reflecting/clarifying, questioning, feedback, and accountability.
- The process of a coaching session includes the following steps: centering, clarifying the focus, identifying the goal, developing an action plan, gaining commitment, and assessing progress.
- Supervisors use consultative and coaching practices to support critical thinking and core CPS decisions at each stage of the CPS process.

Chapter 14: Caseworker Wellness and Safety

CPS staff, like other "first responders," must react to crisis situations, sometimes without complete information about what they might find when knocking on a door. Caseworkers also face stress when having to make immediate decisions in complex situations, managing large caseloads, and dealing with continuous media scrutiny (Martinez, 2004), particularly when children die due to child maltreatment (Child Welfare Information Gateway, 2017). In addition to the very real, personal, and physical risks associated with these situations, there are risks of secondary traumatic stress (STS), also referred to as vicarious trauma or compassion fatigue. Effects of working in stressful work situations include "empathic stress responses" (Buchanan, Bagley, Stansfield, & Preston, 2012; Wieingarten, 2003) such as burnout, compassion fatigue, and vicarious trauma (Conrad & Kellar-Guenther, 2006; Middleton & Potter, 2015).

It is crucial that human service agencies implement systematic approaches to prevent or reduce the effects of STS in CPS to increase the retention of experienced CPS workers (DePanfilis, 2006). This chapter examines:

- How caseworkers take care of themselves in the context of the daily stress of CPS work
- The role of organizations and supervisors to support staff and prevent burnout
- How to minimize situations that may threaten the physical safety of caseworkers in the office, home, and community

14.1 Caseworker Wellness

When considering strategies to address the continued exposure to stressful situations that comes with CPS work, it is important to recognize the necessity of both organizational strategies (e.g., supervisory practices, unit based support) and individual strategies (i.e., self-care). Definitions of key concepts provide a context for the consideration of strategies to promote wellness of CPS staff.

- **Burnout** – overwhelming emotional exhaustion, depersonalization, and feelings of professional inefficacy. It results from cumulative stress in a work environment (Boyas, Wind, & Kang, 2012).
- **Compassion fatigue** – a state of deep physical and emotional exhaustion experienced by helping professionals, including CPS caseworkers (Conrad & Kellar-Guenther, 2006).
- **Compassion satisfaction** – the fulfillment from helping others; higher compassion satisfaction may mitigate compassion fatigue and burnout (Conrad & Kellar-Guenther, 2006).

- **Empathic stress responses** – the effects of stress experienced by helping professionals because of their empathy with families. Truly putting oneself in a family's shoes can result in stress responses in the helper (Buchanon, Bagley, Stansfield, & Preston, 2012).
- **Secondary traumatic stress (STS)** – work-related stress arising from secondary exposure to extremely or traumatically stressful events (Mathieu, 2011, p. 27).
- **Vicarious trauma** – the profound shift that helpers experience in their worldview when working with families who experience trauma. Fundamental beliefs about the world are altered and possibly damaged due to repeated exposure to traumatic material (Mathieu, 2011, p. 14; Pearlman & Saakvitne, 1995).
- **Vicarious resilience** – the positive effects on helping professionals from supporting trauma victims to survive and grow as a result of traumatic experiences (Edelkott, Engstrom, Herandez-Wolfe, & Gangsei, 2016).

14.1.1 Organizational Strategies to Promote Wellness

Increasing numbers of CPS agencies are developing strategies to support CPS staff to prevent and/or address the effects of workplace related stress. Some of the strategies included in this chapter have more evidence than others; however, all seem promising for attempting to more strategically support CPS staff toward greater work and personal balance.

Implementing trauma-informed guidelines. Based on research about the effects of STS, some agencies are implementing guidelines (Chadwick Trauma-Informed Systems Dissemination and Implementation Project, 2016) to incrementally prepare staff for preventing and addressing the effects of STS. Strategies range from recruitment efforts and preparing new staff members to orientation of all employees to the effects of a trauma-exposed work environment. A range of additional strategies (some of them described below), include assessment of STS, building resiliency, managing coverage and caseloads, focusing on empowerment and advocacy, building support systems, and emphasizing the importance of recognition, team building, and peer support.

Building resilience. To build resilience, organizations focus on promoting optimism and compassion satisfaction and create opportunities for staff to engage in active coping with each other (Chadwick Trauma Informed Systems Dissemination and Implementation, 2016). One particularly promising organizational intervention, called the Resilience Alliance intervention, has been implemented with newly hired child protective specialists and their supervisors in New York City (ACS-NYU Children's Trauma Institute, 2012). It focuses on three core concepts: optimism, mastery, and collaboration. The intervention first teaches and then helps staff apply emotion regulation and other resilience-rated skills. Participants are grouped in same-peer sessions and work unit-based sessions and are provided safe spaces for staff to discuss challenges and concerns with their peers while maintaining a focus on the team. The intervention fosters mutual social support and helps to improve the functioning and culture of the workplace. For more on the Resilience Alliance, go to http://www.nctsn.org/products/nctsn-affiliated-resources/resilience-alliance-promoting-resilience-and-reducing-secondary-trauma.

Critical incident debriefing. CPS programs need to plan for strategically addressing critical incidents so that staff members are supported through the opportunity to reflect on the experience. Examples of critical incidents include: incidents of violence against staff, unsafe visits between children and parents, world events, homicide due to domestic violence, bereavement due to death (of a staff member or of a child receiving services). Ideally, critical incident debriefings are facilitated by a neutral party and held within 24 to 48 hours after the incident. Debriefing should focus on the current stress reactions experienced by staff, not on the details of the case (Chadwick Trauma-Informed Systems Dissemination and Implementation Project, 2016).

Data-driven analytics to prevent future child maltreatment incidents that result in severe harm or child fatality situations. An increasing number of jurisdictions are employing predictive analytics to target situations that could lead to recurrence of child maltreatment that may result in severe harm or a child maltreatment related fatality (e.g., Putnam-Hornstein, Wood, Fluke, Yoshioka-Maxwell, & Berger, 2013). In Florida, for example, high probability cases are reviewed with the Eckerd Rapid Safety Feedback system within 1 business day of being targeted so that the caseworker and supervisor are promptly made aware of safety concerns identified through the review.[1] Predictive analytics is also used to support the development of system responses to help inform future decisions related to (Clapier, DePanfilis, & Weiner, 2016):

- Avoiding re-entry into foster care following reunification
- Preventing recurrences of child maltreatment
- Preventing the need for out-of-home placement
- Supporting transition-age youth to avoid coming back to the system as parents
- Helping youth avoid crossing over to the juvenile justice system

Encouraging time off. CPS employee benefit programs often include fringe benefits, such as vacation and personal leave. Managers and supervisors should emphasize the importance of routinely scheduling time off to recharge. This involves planning for caseload coverage when CPS caseworkers are on leave, so they can fully disconnect from a stressful work environment. Some agencies hire a pool of caseworkers whose job is to cover for those who are out of the office, thus when caseworkers return to work, there is less "catch-up" required.

Professional development. Creating opportunities to participate in learning programs not only helps to strengthen practice skills but also serves to increase confidence and competence. This is particularly true when supervisors and caseworkers work together to develop a coverage plan so that they will not be interrupted when away from the office.

Recognition, team building, and peer support. When organizations recognize positive contributions of staff and build support systems, this helps to decrease stress associated with the job (Maslach, Schaufeli & Letiter, 2001). As discussed in chapter 13, supervisors can build effective support systems by employing group and individual consultative support, recognizing small successes regularly, and by emphasizing the strengths that each team member brings to the unit. For example, a monthly potluck or team gathering can celebrate the work of the entire team and also be combined with a team skill-building and discussion opportunity.

1 Further information about the Eckerd Rapid Safety Feedback System is available at http://www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/

Reflective supervisory practices. Also consistent with consultative supervisory practices, reflective supervision involves regular collaborative reflection between a caseworker and supervisor, as noted in chapter 13, about complex child and family situations. Use of reflective supervisory practices not only improves the quality of CPS practice but also supports the caseworker to build skills to prevent or respond to secondary trauma (Berckelaer, n.d.).

Work-related stress seminars. These training and peer-support avenues focus both on preparing staff to understand the effects of STS and on practicing strategies in the context of an environment of safety and trust. Resources for designing seminars can be downloaded from the National Child Traumatic Stress Network.[2]

Use of safety science in child maltreatment-related fatalities. Similar to strategies employed by high-profile industries such as aviation and health care, some CPS agencies are successfully experimenting with how to use safety science to constructively learn from child maltreatment related fatalities (Cull, Rzepnicki, O-Day, & Epstein, 2013). The strategies focus on building a safety culture that strives to balance individual accountability with system accountability by valuing open communication, feedback, and continuous learning and improvement. The focus is on learning how the system can prevent similar incidents in the future.

Some states and agencies proactively champion the positive impact that child welfare professionals have on children and families by structuring internal systems to support job satisfaction and commitment, and by working to engage the public in a deeper and more positive understanding of the child welfare system. For more information, go to *Championing the Role of Child Welfare Professionals*, at https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Blob/115504.pdf?w=NATIVE(%27SIMPLE_SRCH+ph+is+%27%27Championing+the+Role+of+Child+Welfare+Professionals%27%27%27)&upp=0&order=native(%27year/Descend%27)&rpp=25&r=1&m=1.

2 Resources may be accessed at https://learn.nctsn.org/course/index.php?categoryid=41

14.1.2 Individual Strategies to Promote Wellness

Although everyone can benefit from adopting a work-life balance, one-time trainings or events that focus exclusively on self-care activities (e.g., taking lunch, getting adequate sleep, not taking work home, etc.) may be perceived as putting the onus for change on individuals, thus "blaming the victim." The self-care strategies summarized in this section should be promoted in combination with organizational strategies, such as those outlined in the previous section.

Focus on mindfulness. Mindfulness has been found to reduce emotional distress and, when studied in the context of compassion fatigue, to significantly reduce symptoms (Mathieu, 2009). Examples include mediation, breathing exercises, yoga, and Tai Chi. To be most effective, these strategies need to be integrated daily or several times a week routinely. In the coaching supervisory practices discussed in chapter 13, the supervisor starts each coaching session with a centering activity, like breathing exercises. Most communities have mindfulness continuing education courses, and various apps can send notification reminders to pause for 1-minute, deep-breathing intervals throughout the day.

Increase self-awareness. This involves knowing what has (not) helped during stressful times in the past and applying that knowledge to current situations. Taking a moment to periodically reflect on what he or she has learned from past situations, the caseworker can use that information to address issues that are causing feelings that affect overall well-being. Supervisory coaching practices can also be used to support self-reflection and the development of action plans to address work related stress.

Weave self-care into the workday. To increase the likelihood that self-care is prioritized and activities sustained, self-care strategies need to be incorporated as a part of the job and fit into the everyday life (Su, 2017). A few examples are to:

- Set aside 15 minutes at the beginning of each day to jot down the 3 things you hope to accomplish that day; this can help with prioritization when competing demands begin to interfere with the plan
- Take time to reflect on what has worked well, potentially in relation to the CPS unit, as this helps to support a different outlook even if much of the job is stressful
- Take the time to clean off your desk from time to time; because environment and workspace can have a significant impact on productivity, put up pictures, artwork, or images that inspire or remind you of the people and things that matter
- Even if getting a full-night's sleep every night is impossible, select a day of the week to get in some extra sleep
- Try scheduling walking meetings with your supervisor or a co-worker just to have some time away from the office
- Block your calendar a few times a week for "catch up" time; this prevents you and others from overbooking your day with meetings

14.2 Caseworker Safety

Many CPS training programs emphasize that, compared to the volume of CPS reports and home visits conducted, the incidence of threats or actual violence while on the job is low. However, based on a study by the American Federation of State, County, and Municipal Employees (2011), about 70 percent of survey respondents reported that they knew of frontline child welfare workers in their agencies that had been victims of violence or threats in their work. So while actual incidence in relation to the number of contacts in the home or community may be low, the fear of the possibility of threats to personal safety is present every day for many CPS caseworkers. This fear may lead to mental and emotional harm (Kim & Hopkins, 2015).

Many associate the safety risk of child welfare workers only with the threat of physical violence (Capacity Building Center for States, 2017). However, child welfare worker safety encompasses all aspects of worker well-being while on the job—physical, mental, and emotional. In addition, caseworker safety includes safety from legal risk and prosecution for decisions made in good faith. The Capacity Building Center for States issued *The Child Welfare Worker Safety Guide*, which offers more information on the topics this chapter discusses. It can be accessed at: https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Blob/115592.pdf?w=NATIVE(%27SIMPLE_SRCH+ph+is+%27%27The+Child+Welfare+Worker+Safety+Guide%27%27%27)&upp=0&order=native(%27year/Descend%27)&rpp=25&r=1&m=1.

The National Association of Social Workers (2013) also has established guidelines for worker safety. These standards outline the responsibility of the work place for creating an organizational culture of safety and security, strategies to prevent violence, and methods for securing safety in the office. Further guidance focuses on the use of safety technology and mobile phones, as well as risk assessment for field visits and transporting clients. The standards further delineate the recommended procedures for reporting and responding to incidents and the provision of safety and student training. Highlights from the standards related to office safety, field visits, transporting clients, and safety training are outlined below.

Standard 3. Office safety. Social workers' office environments should promote safety for social workers and their clients. Examples of practices include work spaces that allow for social workers to exit easily in potentially violent situations, access to visually open meeting spaces or presence of another staff team member when meeting with a client who may be verbally abusive or aggressive. The office should have security that monitors entries by all visitors, meeting spaces that are free of objects that may be used as weapons, well-lit hallways that lead to employees' workspaces, and secure entrances to employee's workspaces that are separate from public spaces.

Standard 6. Risk assessment for field visits. Social workers should assess and take steps to reduce their risk for violence prior to each field visit. Examples of recommended practices fit well with the preparation that CPS workers do before going out on home visits. Especially prior to the first visit to a family home, information from the report or history with this family should be reviewed, including consideration of whether the family is known to have weapons; has a history of substance use disorder, mental illness, or domestic violence; or is known for criminal activity. The CPS worker should also consider the level of violence in the neighborhood, as well as the time of day for the planned visit, and consult with the supervisor to determine whether law enforcement should be contacted instead of going alone. The guidelines also address the experience, confidence, and competence of the worker and the importance of considering attire that may add to potential vulnerability.

Standard 7. Transporting clients. Social workers should acknowledge particular safety concerns about transporting clients. When transporting clients is an expectation of the job (and this could vary by CPS agency), employers should ensure that policies and practices are in place to protect both social workers and clients. At the time of pickup, the social worker should assess: the client's level of agitation (if any), use of intoxicants, and the meaning of the appointment to the client; the possibility that the client has a weapon; and their own perception of a safety risk.

Standard 10. Safety training. Social workers should participate in annual training (or case supervision as needed) that develops and maintains their ability to practice safely. CPS workers need ongoing refresher training to assure that they do not under or overestimate safety concerns associated with CPS work. Some states have legislated mandates for CPS agencies to provide safety training for their staff.[3]

Providing further examples of how CPS organizations can increase safety for caseworkers goes beyond the scope of this chapter. Additional resources that may be useful for programs considering updates to their worker-safety training or policies are in the text box below (full citations provided in the list of references).

- Annie E. Casey Foundation. (2002). *Family to family: Tools for rebuilding foster care. Safety first: Dealing with the daily challenges of child welfare. Part one: Building support for child welfare's frontline workers.*
- OSHA. (2016). *Guidelines for preventing workplace violence for healthcare and social services workers.*
- Sulpizio, E. (2016). *Literature review: worker safety.*

3 For an example of legislation related to worker safety, see Michigan's "Lisa's Law," which can be retrieved from: http://www.michigan.gov/mdhhs/0,5885,7-339-73970_7701_7869-15406--,00.html.

Chapter Highlights

- The nature of CPS work may lead CPS staff to experience secondary traumatic stress, vicarious trauma, and compassion fatigue. If these issues are not addressed, CPS staff may experience burnout.
- CPS agencies are responsible for implementing organizational strategies to prevent and/or address the effects of workplace-related stress.
- Implementing trauma-informed guidelines that help staff build resilience and promote optimism and compassion satisfaction are important organizational strategies to address the occupational stress of CPS work.
- Other organizational strategies that may be useful include child fatality review teams, critical incident debriefing, data-driven analytics, encouraging time off, professional development, team-building, reflective supervision, and the use of safety science in child maltreatment related fatalities.
- Individual strategies to promote wellness include a focus on mindfulness, increasing self-awareness, and weaving self-care into the average workday.
- The threat of workplace violence for CPS workers results in mental and emotional harm.
- CPS agencies must establish worker safety policies and provide comprehensive training for preventing workplace violence in the office, home, and community.
- CPS staff should participate in annual worker safety training and supports.

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Appendix A: Glossary

Adjudicatory Hearings – held by the juvenile and family courts 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) – passed in 1997, this act (P.L. 105–89) emphasized the safety of children as the paramount concern in child welfare and promoted timely adoption and other permanent placements for children in foster care.

Burnout – overwhelming emotional exhaustion, depersonalization, and feelings of professional inefficacy; results from cumulative stress in a work environment.

Court Appointed Special Advocates (CASA) – people appointed by the court (usually volunteers) who serve to ensure that the needs and bests interests of a child are fully presented to the court in child protection judicial proceeding. See also Guardian ad Litem.

Case Closure – the process of ending the involvement between the CPS worker and the family, which often involves a mutual assessment of progress and outcome achievement. Optimally, cases are closed when families have achieved their goals, and the risk of maltreatment has been sufficiently reduced or mitigated.

Case Plan – See Family Plan.

Case Planning – (also known as developing the family plan) the process where the CPS caseworker works with the family and other professionals comprising the family team to develop the family plan.

Caseworker Competency – professional behaviors based on the knowledge, skills, personal qualities, and values a person demonstrates and/or are required.

Central Registry – a centralized database containing information on all substantiated/founded reports of child maltreatment in a selected area (typically a state or tribe).

Change Strategies – actions taken by children, youth, parents, and families toward the achievement of outcomes that will strengthen protective factors and reduce risk factors associated with child maltreatment. Family members may implement change strategies alone or through support from friends or family members, and/or the CPS or other child welfare worker, a community provider, or a combination of professional and informal supports.

Child Abuse Prevention and Treatment Act (CAPTA) – Federal law (P.L. 93–247, enacted in 1974; last amended in 2016 as P.L. 114–198) establishing a federal definition of maltreatment 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 and Family Services Review (CFSR) – periodic reviews of state child welfare systems conducted by the Children's Bureau to ensure conformity with federal child welfare requirements; determine what is actually happening to children and families as they are engaged in child welfare services; and assist states and territories in helping children and families achieve positive outcomes of safety, permanency, and well-being.

Child Protective Services (CPS) – the designated social services agency (in most states, tribes, and territories) to usually receive, investigate, or assess report of alleged maltreatment and to provide intervention and treatment services to children and families in which child maltreatment has occurred; frequently located within larger public social service agencies, such as Departments of Social Services.

Coaching Supervisory Practice – a practice which supports caseworkers to build competency and empower them to come up with their own solutions.

Coercive Control – a domestic violence perpetrator's pattern of behavior that seeks to take away the survivor's liberty or freedom and to strip away the survivor's sense of self.

Compassion Fatigue – a state of deep physical and emotional exhaustion experienced by helping professionals, including caseworkers.

Compassion Satisfaction – the fulfillment from helping others; higher compassion satisfaction may mitigate compassion fatigue and burnout.

Comprehensive Family Assessment – following the initial assessment/investigation, its purpose is to gather and analyze information that will guide the intervention change process with families and children.

Concurrent Planning – simultaneously identifies alternative permanency goals while making efforts to achieve reunification of the child with his or her parents. The process allows the child to realize other legal permanency more quickly if reunification efforts fail.

Consultative Supervisory Practice – a practice which focuses on supporting caseworkers to fulfill their responsibilities to interview, conduct assessments, develop plans, implement and change strategies and interventions, and evaluate changes in the risk and protective factors that brought families to need CPS interventions.

Cultural Competence (also known as Cultural Responsiveness) – "the awareness, knowledge, understanding, sensitivity, and skill needed to conduct and complete professional activities effectively with people of diverse cultural backgrounds and ethnic affiliations."[1]

Cultural Humility – "the humble and respectful attitude toward those of other cultures, which pushes one to challenge his or her own cultural biases, realize he or she cannot possibly know everything about other cultures, and approach learning about other cultures as a goal and process."[2] This enables a system, agency, or providers to work effectively in cross-cultural situations with awareness of and respect for the diverse experiences, customs, and preferences of individuals and groups.

Cultural Sensitivity – "the ability to recognize, understand, and react appropriately to behaviors of persons who belong to a cultural or ethnic group that differs substantially from one's own."[3]

Differential Response – also referred to as "dual track," "alternative," or "multi-track" response, it permits CPS agencies greater flexibility to respond with either a traditional investigation or a family assessment approach to children's needs for safety based on the degree of risk present and the family's needs for services and support. See Dual Track.

Dispositional Hearings – held by the court to determine the disposition of children, such as whether placement of the child in out-of-home care is necessary and/or should continue and what services and support the children and family will need to reduce the risk of maltreatment and to address the effects of maltreatment.

Disproportionality – the under- or overrepresentation of families of color out of proportion to their representation in the general population of the United States. Its causes are complex and may reflect bias or other conditions beyond the stated facts or circumstances.[4]

Domestic Violence – a pattern of coercively controlling behaviors perpetrated by one intimate partner against another.

Domestic Violence Perpetrator Intervention Program – typically court-ordered programs for domestic violence perpetrators, which both hold them accountable for their actions and identify alternate appropriate and nonviolent behaviors; usually held in a group format where participants learn about the dynamics of domestic violence, its effects on both the adult and child survivors, and issues of power and control. Also known as Batterer Intervention Programs.

Domestic Violence Advocates or Specialists – individuals, both professional and volunteer, who work to empower child and adult survivors of domestic violence by advocating for the rights of survivors within multiple systems, identifying resources and supports, and aiding them in developing plans for their safety. An advocate usually works for a domestic violence service provider and advocates for the survivors, while a specialist generally works within the child welfare (or agency other than the domestic violence service provider) and, as the name implies, specializes in addressing domestic violence issues for that particular agency.

1 Cournoyer, 2017, p. 214.
2 Gonzalez, 2018, para. 4; California Department of Social Services, & California Department of Health Care Services, n.d., p. 2.
3 Cournoyer, 2017, p. 214.
4 California Department of Social Services, & California Department of Health Care Services, n.d., p. 2.

Dual Track (also known as alternative response) – a term reflecting 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.

Emotional Abuse – See Psychological Maltreatment.

Empathic Stress Responses – the effects of stress experienced by helping professionals because of their empathy with the families they are working with; truly putting oneself in the family's shoes can result in stress responses in the helper.

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

Exposure to Violence – environments in which children live where they are exposed to domestic violence perpetrators' abusive behaviors; applies to children who witness physical violence, as well as to those who do not (i.e., hearing violence, being exposed to threats or verbal abuse, intervening, having awareness of its aftermath).

Family Assessment – the stage of the child protection process when the CPS caseworker or ongoing worker, community treatment provider, and the family develop 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 Decision-Making – a generic term that includes a number of approaches in which family members are brought together and empowered to work with CPS and other service providers to make decisions about how to care for their children and to develop a plan for services. Different terms used for this type of intervention include family group conferencing, family team conferencing, family team decision making, family team meetings, and family unity meetings.

Family Preservation Services – short-term, family-focused, and community-based services designed to help families cope with significant stresses or problems that interfere with their ability to nurture their children; goal is to maintain children with their families or to reunify the family, when it can be done safely.

Family Plan (also known as Case Plan) – the casework document that outlines the outcomes, goals, timelines, tasks, and services and supports necessary to reduce the risk of maltreatment, assist in achieving those outcomes and goals, or facilitate adoption or other permanent placement when a child cannot safely return home.

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 (GAL) – a lawyer or lay person who represents a child in court proceedings in CPS cases. Usually this person considers the "best interests" of the child and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian for the child. See also CASA.

Historical Trauma—a form of trauma often associated with racial and ethnic population groups who have suffered major intergenerational losses and assaults on their culture and well-being; refers to the cumulative emotional and psychological wounding, as a result of group traumatic experiences, that is transmitted across generations within a community

Home Visitation Programs – prevention programs (often voluntary) 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.

Inclusive Cultural Empathy – involves accepting and valuing those who belong to different cultural groups, learning about others' cultures, and engaging others in ways that convey respect for their cultural affiliations.[5]

Indian Child Welfare Act (ICWA) – enacted in 1978 (P.L. 95–608), establishes standards for the placement of American Indian/Alaska Native children in foster and adoptive homes and enables tribes and families to be involved in child welfare cases.

In-Home Services – services provided to families involved with the child welfare agency whose children remain at home or have returned home from out-of-home care.

Initial Assessment or Investigation – the stage of the CPS case process where the CPS caseworker determines whether a child is unsafe and assesses current safety threats and risk of future maltreatment; the worker also develops a safety plan, if needed to assure the child's protection, and determines if services are warranted.

Intake – the stage of the CPS case process (or on a child abuse hotline) where a worker (also known as the screener or intake specialist) screens alleged child maltreatment calls, reports, and referrals and makes collateral calls, as needed, to determine if the information meets the jurisdiction's criteria to assign for initial assessment or investigation.

Interventions – a specific practice, service, strategy, program, practice model, or combination that is clearly defined, operationalized, and distinguishable from one or more alternatives. For the purposes of CPS, the goal of the intervention is likely to address the reasons the family became involved with the agency.

Memorandum of Understanding (MOU) – a written agreement that serves to clarify relationships and responsibilities between two or more organizations that share services, clients, or resources.

Motivational Interviewing – a method to support +families that may be ambivalent or hesitant about support from the child welfare system.

5 Pedersen et al., 2008.

Multidisciplinary Team – established between agencies and professionals to confidentially share information related to families involved with CPS and to aid in decisions at various stages of the CPS case process; also known as child protection teams, interdisciplinary teams, or case consultation teams.

Multiethnic Placement Act of 1994 (MEPA) – as amended in 1996 by the Interethnic Placement provisions (MEPA-IEP), prohibits state agencies and other entities receiving federal funding and are involved in foster care or adoption placements from delaying, denying, or otherwise discriminating when making a foster care or adoption placement decision on the basis of the parent or child's race, color, or national origin.

Neglect – the failure to provide for the child's basic needs. Physical neglect can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection. 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. Medical neglect includes the failure to (1) provide or to allow needed care as recommended by a competent health care professional, and/or (2) seek timely and appropriate medical care for a serious health problem that any reasonable person would have recognized as needing professional medical attention.

Out-of-Home Care – placement by the CPS agency in the care of a licensed foster parent, relative, or fictive kin or in a group home or residential facility.

Parens Patriae – 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.

Permanency – as defined in the Child and Family Services Reviews, a child in foster care is determined to have achieved permanency when any of the following occurs when the child is discharged from foster care to: (1) reunification with his or her family or either a parent or other relative, (2) a legally finalized adoption, or (3) the care of a legal guardian.

Perpetrator – the person who commits a pattern of domestic violence and coercive control; also referred to as offender, batterer, abuser, etc.

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 overdiscipline or physical punishment that is inappropriate to the child's age.

Protective Factors – conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families and appear to mitigate vulnerability to or negative effects from maltreatment.

Protective Capacities – caregiver characteristics that help ensure the safety of his or her child; building protective capacities contributes to a reduction in risk.

Protective Order – order a criminal court issues that prohibits persons arrested for domestic violence from abusing their alleged victim(s); may include requirements that the perpetrator leave the home and/or refrain from contacting the victim(s); typically expires when the case is adjudicated.

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; can include parents or caregivers using extreme or bizarre forms of punishment or threatening or terrorizing a child; also known as emotional abuse or neglect, verbal abuse, or mental abuse.

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

Restraining Order – a legal intervention where a survivor petitions a civil or family court for temporary protection. If granted by a judge, it typically orders that a perpetrator not commit acts of violence or threaten the adult or child survivors; some orders will not allow the perpetrator to enter the home of the survivor or may order no contact by the perpetrator with the survivor or children for a period of time guided by state law.

Review Hearings – held by the court to review dispositions (usually every 6 months) and the progress being made in meeting family plan goals and outcomes and to determine the need to maintain placement in out-of-home care or court jurisdiction over a child.

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

Risk Assessment – assesses and measures 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 – the absence of an imminent or immediate threat of moderate-to-serious harm to the child.

Safety Assessment – an ongoing CPS process in which available information is analyzed to identify whether a child is in immediate or imminent danger of moderate-to-serious harm.

Safety Plan – a casework document developed when it is determined that a child is in imminent or potential risk of serious harm; it 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.

Safety Plan (when domestic violence is involved) – a casework document developed when it is determined that the adult or child survivor is in imminent or potential risk of serious harm. In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of serious harm and identifies, in concert with the adult survivor, the interventions that will control the safety factors and enhance the child and adult survivors' safety.

Secondary Traumatic Stress (STS) – work-related stress arising from secondary exposure to extremely or traumatically stressful events.

Service Provision – the ongoing process when CPS and other providers deliver specific services geared toward the reduction of risk of maltreatment and/or meeting outcomes.

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 babysitter, parent, or daycare provider) or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Shelter – a temporary, short-term home, which typically has an undisclosed location, where survivors of domestic violence and their children can reside safely. Shelter staff provide advocacy and access to resources and counseling for residents.

Substantiated/Founded – an investigation disposition concluding that the allegation of child maltreatment or risk of maltreatment was supported by state law or policy, i.e., that credible evidence exists that child abuse or neglect has occurred.

Survivor – the perpetrator's target (adult or child) of domestic violence, including emotional, physical, verbal, sexual, and coercive control; includes children who witness domestic violence.

Trauma-Informed – a trauma-informed system or practice is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers.

Treatment – the provision of specific, formal services by CPS and other providers to reduce the risk of maltreatment, support families in meeting case goals, and address the effects of maltreatment.

Unsubstantiated/Unfounded (not substantiated) – an investigation disposition that determines that there is not sufficient or credible evidence under state law or policy to conclude that the child has been maltreated or is at serious risk of maltreatment.

Vicarious Trauma – the profound shift that helpers experience in their worldview when working with clients who experience trauma; fundamental beliefs about the world are altered and possibly damaged due to repeated exposure to traumatic material.

Vicarious Resilience – the positive effects on helping professionals from supporting trauma victims to survive and grow as a result of traumatic experiences.

Well-Being – when the educational, emotional, physical, and mental health needs of children and their families are being met.

Appendix B: Resource Listings of Selected Organizations Concerned With Child Maltreatment

The Child Welfare Information Gateway provides an extensive database of national and state organizations dealing with child maltreatment at https://www.childwelfare.gov/organizations/

The Child Welfare Capacity Building Collaborative (https://capacity.childwelfare.gov/about/) is a partnership designed to help public child welfare agencies, tribes, and courts enhance and mobilize the human and organizational assets necessary to meet federal standards and requirements, improve child welfare practice and administration, and achieve safety, permanency, and well-being outcomes for children, youth, and families. A service of the Children's Bureau, it comprises:

Capacity Building Center for States:
Phone: 844.222.0272
Email: capacityinfo@icfi.com
Website: https://capacity.childwelfare.gov/states/

Capacity Building Center for Tribes:
Phone: 800.871.8702
Email: info@cbc4tribes.org
Website: https://capacity.childwelfare.gov/tribes/

Capacity Building Center for Courts
Phone: 202.662.1731
Email: Jennifer.Renne@americanbar.org
Website: https://capacity.childwelfare.gov/courts/

FRIENDS, the National Resource Center for Community-Based Child Abuse Prevention (CBCAP), provides training and technical assistance to federally funded CBCAP programs.
Website: https://friendsnrc.org/

The National Center on Substance Abuse and Child Welfare (NCSACW) is a national resource center providing information, expert consultation, training, and technical assistance to child welfare, dependency court, and substance abuse treatment professionals to improve safety, permanency, well-being, and recovery outcomes for children, parents, and families.
Phone: 866.493.2758
Email: ncsacw@cffutures.org
Website: https://ncsacw.samhsa.gov/

Note: 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.

Appendix C: State Directory of Where to Report Suspected Child Maltreatment

For updated contact information, please visit https://www.childwelfare.gov/organizations/?CWIG-Functionsaction=rols:main.dspList&rolType=custom&rs_id=5.

If you are unable to contact someone in your state, contact the National Child Abuse Hotline at 1-800-4-A-Child (1-800-422-4453). For more information, go to https://www.childhelp.org/.

State	Phone	Website
Alabama	Childhelp® (800) 422-4453	http://dhr.alabama.gov/services/Child_Protective_Services/Abuse_Neglect_Reporting.aspx
Alaska	Toll-free: (800) 478-4444	http://dhss.alaska.gov/ocs/Pages/default.aspx
Arizona	Toll-free: (888) SOS-CHILD (888-767-2445)	https://dcs.az.gov/report-child-abuse
Arkansas	Toll-free: (800) 482-5964 TDD: (800) 843-6349	http://humanservices.arkansas.gov/hotlines
California	Childhelp (800) 422-4453	http://www.cdss.ca.gov/Reporting/Report-Abuse/Child-Protective-Services/Report-Child-Abuse
Colorado	(844) 264-5437	http://co4kids.org/
Connecticut	Toll-free: (800) 842-2288 TDD: (800) 624-5518	http://www.ct.gov/dcf/cwp/view.asp?a=2556&Q=314388
Delaware	Toll-free: (800) 292-9582	http://kids.delaware.gov/services/crisis.shtml
District of Columbia	Local (toll): (202) 671-SAFE (202-671-7233)	http://cfsa.dc.gov/service/report-child-abuse-and-neglect
Florida	Toll-free: (800) 96-ABUSE (800-962-2873)	http://www.dcf.state.fl.us/abuse/

State	Phone	Website
Georgia	Childhelp (800) 422-4453	http://dfcs.dhs.georgia.gov/child-abuse-neglect
Hawaii	Local (toll): (808) 832-5300	http://humanservices.hawaii.gov/ssd/home/child-welfare-services/
Idaho	Toll-free: (800) 926-2588 TDD: (208) 332-7205	http://healthandwelfare.idaho.gov/Children/AbuseNeglect/ChildProtectionContactPhoneNumbers/tabid/475/Default.aspx
Illinois	Toll-free: (800) 252-2873 Local (toll): (217) 524-2606	http://www.state.il.us/dcfs/child/index.shtml
Indiana	Toll-free: (800) 800-5556	http://www.in.gov/dcs/2398.htm
Iowa	Toll-free: (800) 362-2178	http://dhs.iowa.gov/report-abuse-and-fraud
Kansas	Toll-free: (800) 922-5330	http://www.dcf.ks.gov/Pages/Report-Abuse-or-Neglect.aspx
Kentucky	Toll-free: (877) 597-2331	http://chfs.ky.gov/dcbs/dpp/childsafety.htm
Louisiana	Toll-free: (855) 452-5437	http://dss.louisiana.gov/index.cfm?md=pagebuilder&tmp=home&pid=109
Maine	Toll-free: (800) 452-1999 TTY: (800) 963-9490	http://www.maine.gov/dhhs/ocfs/hotlines.htm
Maryland	Childhelp (800) 422-4453	http://dhr.maryland.gov/child-protective-services/reporting-suspected-child-abuse-or-neglect/local-offices/
Massachusetts	Toll-free: (800) 792-5200	http://www.mass.gov/eohhs/gov/departments/dcf/child-abuse-neglect/
Michigan	Toll-free: (855) 444-3911 Fax: (616) 977-1154	http://www.michigan.gov/dhs/0,1607,7-124-5452_7119---,00.html
Minnesota	Childhelp (800) 422-4453	http://mn.gov/dhs/people-we-serve/children-and-families/services/child-protection/contact-us/index.jsp
Mississippi	Toll-free: (800) 222-8000 Local (toll): (601) 359-4991	https://www.mdcps.ms.gov/
Missouri	Toll-free: (800) 392-3738	http://dss.mo.gov/cd/can.htm
Montana	Toll-free: (866) 820-5437	http://www.dphhs.mt.gov/cfsd/index.shtml
Nebraska	Toll-free: (800) 652-1999	http://dhhs.ne.gov/children_family_services/Pages/children_family_services.aspx
Nevada	Childhelp (800) 422-4453	http://dcfs.nv.gov/Programs/CWS/CPS/CPS/

State	Phone	Website
New Hampshire	Toll-free: (800) 894-5533 Local (toll): (603) 271-6556	http://www.dhhs.state.nh.us/dcyf/cps/contact.htm
New Mexico	Toll-free: (855) 333-7233	http://cyfd.org/child-abuse-neglect
New York	Toll-free: (800) 342-3720 TDD: (800) 369-2437 Local (toll): (518) 474-8740	http://www.ocfs.state.ny.us/main/cps/
North Carolina	Childhelp (800) 422-4453	http://www2.ncdhhs.gov/dss/local/index.htm
North Dakota	Childhelp (800) 422-4453	https://www.nd.gov/dhs/services/childfamily/cps/#reporting
Ohio	Toll-free: (855) 642-4453	http://jfs.ohio.gov/ocf/reportchildabuseandneglect.stm
Oklahoma	Toll-free: (800) 522-3511	http://www.okdhs.org/contactus/pages/default.aspx
Oregon	Toll-free: (855) 503-SAFE (7233)	http://www.oregon.gov/dhs/children/child-abuse/Pages/Reporting-Numbers.aspx
Pennsylvania	Toll-free: (800) 932-0313 TDD: (866) 872-1677	http://www.dhs.pa.gov/citizens/reportabuse/
Puerto Rico	Toll-free: (800) 981-8333 Local (toll): (787) 749-1333	https://www.adfanpr.com/ (in Spanish)
Rhode Island	Toll-free: (800) RI-CHILD (800-742-4453)	http://www.dcyf.ri.gov/child_welfare/index.php
South Carolina	Local (toll): (803) 898-7318	https://dss.sc.gov/abuseneglect/report-child-abuse-and-neglect/
South Dakota	Childhelp (800) 422-4453	https://dss.sd.gov/childprotection/reporting.aspx
Tennessee	Toll-free: (877) 237-0004	https://www.tn.gov/content/tn/dcs/program-areas/child-safety/reporting/child-abuse.html
Texas	Toll-free: (800) 252-5400	https://www.dfps.state.tx.us/Contact_Us/report_abuse.asp
U.S. Virgin Islands	(340) 774-0930 St. Thomas (340) 773-2323 St. Croix (340) 776-6334 St. John	http://www.dhs.gov.vi/contact/index.html
Utah	(855) -323-3237	https://dcfs.utah.gov/
Vermont	After hours: (800) 649-5285	http://dcf.vermont.gov/protection/reporting

State	Phone	Website
Virginia	Toll-free: (800) 552-7096 Local (toll): (804) 786-8536	http://www.dss.virginia.gov/family/cps/index.cgi
Washington	Toll-free: (866) END-HARM (866-363-4276) Toll-free: (800) 562-5624 TTY: (800) 624-6186	http://www1.dshs.wa.gov/ca/safety/abuseReport.asp?2
West Virginia	Toll-free: (800) 352-6513	http://www.dhhr.wv.gov/bcf/
Wisconsin	Childhelp (800) 422-4453	https://dcf.wisconsin.gov/reportabuse
Wyoming	Childhelp (800) 422-4453	https://sites.google.com/a/wyo.gov/dfsweb/social-services/child-protective-services

Appendix D:
Examples of CPS Core Competencies

CPS Values, Philosophy, and Professionalism

- Approaches children, youth, and families consistent with the philosophical tenets of CPS and through the lens of the CPS practice framework
- Demonstrates agency values, including respect for each person's dignity, individuality, and right to self-determination
- Collaborates with internal and external partners and communicates respect for the roles partners play in promoting safety, permanency, and well-being of children and families
- Acts professionally in the CPS role, including protecting the privacy of individuals and families and keeping all information about children and families confidential
- Considers evidence of effectiveness with similar individual children and families in selecting services as part of a tailored plan
- Plans, organizes, and manages the workload and uses technologies, e.g., data dashboards to track case data, email or other e-communication tools allowed by policy, and calendar functions, to enhance personal and unit efficiency, productivity, and accountability

Strengths-Based Engagement Skills

- Uses interpersonal helping skills of empathy, genuineness, and respect throughout CPS involvement
- Shows understanding, friendliness, courtesy, tact, concern, and politeness in all interactions with others
- Uses assessment, investigatory, and social work skills to partner with families, exercising protective authority when necessary to ensure children's safety
- Considers all family members' perceptions of their strengths and of the issues or problems they are facing, even if they are unable to recognize how the issues create risk or safety concerns for children
- Uses engagement strategies (e.g., motivational interviewing, safety team/family group decision-making meetings) that encourage family participation/involvement in safety decisions
- Educates family members about the CPS process, including sharing complete assessment information for transparent decision making

Legal Aspects of Child Protection

- Applies federal, state, tribal, and local policies and procedures that affect the CPS roles and responsibilities
- Recognizes and responds to the potential tension between parent's and children's rights during CPS investigations/assessments
- Uses court systems appropriately (depending on state laws) to protect children from maltreatment and to assure permanency within legally established timeframes
- Works with legal systems to ensure safety of children (e.g., collaborates with law enforcement, explains the court process to family members)
- Gathers, prepares, and thoroughly documents case information
- Prepares for and testifies in court, delineating between fact and opinion

Assessment/Investigation
• Uses open-ended questions to interview children, parents, and others to gather factual information about the reported circumstances • Considers the dynamics of neglect and of physical, sexual, and emotional abuse and their traumatic impact on children and families throughout the assessment process • Uses knowledge of child development, including the impact of child maltreatment on brain development, throughout the assessment process • Employs techniques to minimize system-induced trauma on family members • Synthesizes information, assesses the validity of information gathered, addresses gaps and inconsistencies, and suspends judgment until complete information has been gathered • Differentiates between risk and safety and the complex sets of factors that contribute to child maltreatment • Balances information about protective capacities and factors in the context of risk and safety assessments
Critical Thinking and Decision-Making
• Screens referrals according to laws and policy to determine the level of priority for agency response • Determines the level of risk and safety based on a thorough analysis of information • Works with supervisor and peers to help weigh information and arrive at balanced conclusions based on factual information • Looks beyond superficial or simplistic explanations and searches for underlying causes of situations, behavior, or conditions prior to arriving at key decisions • Continually gathers and reevaluates available information and adjusts decisions as needed • Thinks through the implications of situations or events and potential unintended consequences of all decisions • Uses teams and consultants to advise when complex circumstances need to be considered from multiple perspectives
Planning and Intervention
• Develops and implements safety plans to protect children in immediate or impending danger of serious harm • Accesses safety services to prevent removal of children and/or to reunify families when emergency placement may have been necessary, if possible • Collaborates with family members and other formal and informal resources to target outcomes and SMART (**S**pecific, **M**easurable, **A**chievable, **R**esults-focused, and **T**ime-limited) goals (discussed in detail in Chapter 8) • Engages family members as partners to plan appropriate service strategies, which are individualized and tailored to the unique needs of each family • Selects available interventions and promising practices that have evidence of their effectiveness in similar situations to address the risks associated with child maltreatment and to ameliorate its effects • Collaborates with community partners to secure needed, change-focused intervention
Cultural Responsiveness
• Conducts safety assessments in a manner which demonstrates sensitivity to differences in culture, ethnicity, sexual orientation, gender identity, physical and mental ability, language, religious beliefs, and other forms of human diversity • Employs active listening skills to communicate with diverse families throughout all stages of the CPS process, e.g., using a bilingual/bicultural colleague when needed • Seeks consultation from a supervisor to work through personal biases that may affect CPS assessment and decisions • Avoids stereotyping when analyzing gathered information in order to make objective CPS decisions

Communication
• Presents ideas orally in a professional and respectful manner by organizing thoughts and feelings and avoiding premature judgment and opinions, and is aware of nonverbal communication, i.e., "body language" • Writes clearly and understandably, laying out information in a logical manner to aid understanding; uses appropriate grammar and punctuation; avoids jargon; and uses tone and format suggested by the topic and audience • Follows protocols to document the facts, factual observations, and results of CPS assessments accurately and thoroughly • Submits documentation for case records, court reports, and case summaries on time • Enters complete and accurate information in electronic case records for all case contacts
Wellness
• Recognizes the personal and psychological stresses associated with CPS and uses strategies to prevent emotional distress and burnout • Employs strategies to promote personal safety at all times • Regularly assesses and prioritizes work in order to meet deadlines, while focusing attention on the most critical tasks • Seeks consultation and coaching from supervisor to support thorough assessments, analysis, and decisions • Places a high priority on organizational goals and helps co-workers when necessary

(Administration for Children's Services Child Welfare Workforce Institute, 2015; California Social Work Education Center [CalSWEC], 2011; Florida Center for Child Welfare, 2012; Institute for Human Services for the Ohio Child Welfare Training Program, 2010; Child Welfare Training Institute, n.d.; National Child Welfare Workforce Institute, 2015; New Jersey Child Welfare Training Partnership Curriculum Workgroup, 2010; Rycus & Hughes, 2000.)

Appendix E: Major Provisions of the Child Abuse Prevention and Treatment Act (CAPTA) Reauthorization Act of 2010

Provision Category	Requirements
State plan eligibility:	• Submit a plan for the duration of the state's participation in the program • Periodically review the plan to reflect any changes in state programs • Provide notice to the U.S. Department of Health and Human Services (HHS) of any changes related to child abuse prevention • Prepare and submit to HHS an annual report describing how CAPTA funds were used
Mandate studies and reports to Congress on:	• Shaken baby syndrome/abusive head trauma • Efforts to coordinate agencies responsible for programs and activities related to child abuse and neglect • Effectiveness of citizen review panels • How provisions for immunity from prosecution under state and local laws facilitate and inhibit individuals cooperating, consulting, or assisting in making good faith reports of child abuse or neglect
Authorized grants to organizations to develop or expand effective collaborations between CPS and domestic violence entities to improve:	• Collaborative investigation and intervention procedures • Provision for the safety of the nonabusing parent and children • Provision of services to children exposed to domestic violence that also support the caregiving role of the nonabusing parent

Provision Category	Requirements
Amended requirements for state plan and assurances to include laws, policies, or programs for:	• Identifying categories of mandated reporters • Including fetal alcohol spectrum disorders in procedures for referral and development of a plan of safe care for substance-exposed newborns • Including differential response in screening and assessment procedures • Requiring that guardians ad litem be trained in early childhood, child, and adolescent development • Providing that reunification not be required when a parent has committed intrafamilial sexual abuse or must register with a sex offender registry • Ensuring the provision of technology to track CPS reports from intake through final disposition • Encouraging the appropriate involvement of families in decision-making • Promoting and enhancing collaboration among child protective, substance abuse, and domestic violence agencies • Requiring training and programs that address the needs of unaccompanied homeless youth • Ensuring collaboration with community-based prevention programs and families affected by child abuse and neglect in the development of the state plan • Ensuring that the state has coordinated its CAPTA state plan with its title IV-B state plan
Requiring additional data in the annual state data reports, including:	• The number of families that received differential response as a preventive service • Caseload requirements and the average caseload for CPS workers • The education, qualifications, and training requirements for CPS personnel • The number of children referred to CPS under policies established to address the needs of infants born affected by illegal substance abuse or fetal alcohol spectrum disorder • The number of children under age 3 involved in a substantiated case of child abuse or neglect who were eligible for referral to agencies providing early intervention services, and the number of those children who actually were referred

Recent authorization included and expanded to:

Establish the Office on Child Abuse and Neglect to execute and coordinate the functions and activities of CAPTA.

Appoint an advisory board on child abuse and neglect to make recommendations to the Secretary and to the appropriate committees of Congress concerning specific issues relating to child abuse and neglect.

Establish a national clearinghouse for information relating to child abuse and neglect including mandates to:

1. Maintain, coordinate, and disseminate information on effective programs … that have demonstrated success with respect to the prevention, assessment, identification, and treatment of child abuse or neglect and hold the potential for broad scale implementation and replication
2. Maintain, coordinate, and disseminate information on the medical diagnosis and treatment of child abuse and neglect
3. Maintain and disseminate information on best practices related to differential response
4. Maintain and disseminate information about best practices used for achieving improvements in child protective systems
5. Maintain and disseminate information about best practices relating to the development of plans of safe care as described in such section for infants born and identified as being affected by substance abuse or withdrawal symptoms, or a fetal alcohol spectrum disorder
6. Maintain and disseminate information relating to the incidence of cases of child abuse and neglect in the United States, the incidence of such cases in populations determined by the Secretary, and the incidence of any such cases related to substance abuse
7. Provide technical assistance upon request that may include an evaluation or identification of various methods and procedures for the investigation, assessment, and prosecution of child physical and sexual abuse cases, ways to mitigate psychological trauma to the child victim, and effective programs carried out by the states under this Act
8. Collect and disseminate information relating to various training resources available at the state and local level
9. Collect and disseminate information on effective programs and best practices for developing and carrying out collaboration between entities providing child protective services and entities providing domestic violence services
10. Coordinate with other federal agencies and develop a federal data system including compiling summaries of state data and best practices

Implement an interdisciplinary program of research, including longitudinal research, designed to provide information needed to better protect children from child abuse or neglect and to improve the well-being of victims of child abuse or neglect, with at least a portion of such research being field initiated.

Conduct research on the national incidence of child abuse and neglect and produce a report no later than 4 years after the date of enactment of CAPTA.

Conduct a study on shaken baby syndrome that identifies data collected on shaken baby syndrome and determines the feasibility of collecting uniform, accurate data from all states.

Provide technical assistance to state and local public and private agencies and community-based organizations to assist such agencies in planning, improving, developing, and carrying out programs and activities, including replicating successful program models relating to the prevention, assessment, identification, and treatment of child abuse and neglect.

Implement demonstration programs and projects for innovations including: the promotion of safe, family-friendly, physical environments for visitation; education, identification, prevention, and treatment; risk and safety assessment tools; and training.

Award grants to states, tribes or tribal organizations, or public or private agencies for:

1. Training programs
2. Triage procedures
3. Mutual support programs
4. Kinship care
5. Linkages among CPS and public health, mental health, substance abuse, developmental disabilities, and domestic violence service agencies
6. Collaborations between CPS and domestic violence service entities

Provide grants to states for child abuse or neglect prevention and treatment programs for the purposes of assisting states in improving the CPS system of each state including:

1. The intake, assessment, screening, and investigation of reports of child abuse or neglect
2. Creating and improving the use of multidisciplinary teams and improving legal preparation and representation
3. Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families
4. Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols, including the use of differential response
5. Developing and updating systems of technology that support the program and track reports of child abuse and neglect form intake through final disposition and allow interstate and intrastate information exchange
6. Developing, strengthening, and facilitating training
7. Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers
8. Developing, facilitating the use of, and implementing research-based strategies and training protocols for individuals mandated to report child abuse and neglect
9. Developing, implementing or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions
10. Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect, including the use of differential response
11. Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level

12. Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems
13. Supporting and enhancing interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs
14. Developing and implementing procedures for collaboration among CPS, domestic violence services, and other agencies

Establish citizen review panels to examine the policies, procedures, and practices of state and local agencies and where appropriate, specific cases, to evaluate the extent to which state and local child protection system agencies are effectively discharging their child protection responsibilities.

Mandate state data reports from all states receiving CAPTA state grants that report on the number of children reported, the disposition of reports, as well as a description of the services received or not received, and other mandated data elements.

Award grants to states for programs relating to investigation and prosecution of child abuse and neglect cases designed to assist states in developing, establish, and operating programs designed to improve assessment and investigation of suspected child abuse and neglect cases.

Mandate the coordination of child abuse and neglect programs, including providing periodic reports to Congress.

Provide for community-based grants for the prevention of child abuse and neglect to support community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to prevent child abuse and neglect and to support the coordination of resources and activities to better strengthen and support families to reduce the likelihood of child abuse and neglect; and to foster an understanding, appreciation, and knowledge of diverse populations in order to be effective in preventing and treating child abuse and neglect.

Appendix F: Content of an Intake Report

Specific requirements may vary slightly, depending on state, tribal, or jurisdictional laws. Although it is not necessary to have all this information to make a report, reporters should generally be prepared to describe the following:

- The name, age, sex, and address of the alleged child victim(s) as well as siblings and/or any other minor children living in the same residence
- The name and address of the parent(s) or other person(s) responsible for the child's care
- The basis for making the report, i.e., what are the circumstances that have been observed that makes the reporter suspect that child maltreatment may have occurred
- The nature and extent of the alleged maltreatment and surrounding circumstances. Information should include:
  - Type and severity of maltreatment
  - History of the maltreatment (if known) and duration, and whether the maltreatment has increased in severity or frequency
  - Description of specific events and whether objects or weapons were used
  - Description of any injuries observed (if applicable), including size, shape, color, etc.
  - Description of emotional and physical symptoms
  - Identification of the alleged maltreating caregiver and anything known about the intent of the caregiver about the incident or circumstances
  - Response of the alleged maltreating caregiver or other caregivers in the home (if known)
- The child the child's condition and the child's whereabouts (at the time of the report)
- The parents and their whereabouts (at the time of the report)
- Concerns about the current safety of this child or other children in the home
- Safety concerns for CPS staff such as possession of weapons, manufacture of drugs, or other concerns

Reporters should be aware that the person taking the referral (the intake worker) will ask questions to determine whether the report will be "screened in" (accepted) for an investigation/initial assessment. If it will, the intake worker may ask questions to be able to prioritize the response time indicated by the alleged circumstances. There will be a check of agency records and state central registries to determine if the family is currently involved in an open case or has a history of involvement in a previous maltreatment case.

Reporters should describe circumstances by specifically noting the reporter's observations and should avoid passing on judgments or opinions about what should happen. Regarding the details of the abuse/neglect situation, the intake worker should specifically use the reporter's words to describe their observations. If the state has a differential response system, meaning it diverts some referrals to community agencies for assessment (prevention) instead of investigation, there could be questions about whether the family is aware that the reporter is making a referral.

Appendix G: Assessment Instruments

Selected examples of instruments that could be useful to inform comprehensive family assessments with children and families referred due to child maltreatment are summarized in the table below. Instruments are categorized by the targeted domains they purport to assess and classified by type of instrument (e.g., self-report, observation, or spatial). Families complete self-report instruments. The worker who conducted the comprehensive family assessment usually completes observational assessments based on a series of interviews and other collected data. Spatial instruments, like genograms or ecomaps, are usually completed collaboratively between the worker and family members.

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Multiple dimensions	The Child and Adolescent Needs & Strengths for Children and Youth in Child Welfare (CANS-CW) is a descriptive tool for rating strengths and needs of youth in nine domains: Functional Status, Child Safety, Mental Health, Child Risk Behaviors, Substance Abuse, Criminal and Delinquent Behavior, Care Management, Caregiver Needs and Strengths, and Strengths.	The manual for the CANS-CW may be downloaded from http://rbsreform.org/materials/CANS-CW%20Manual.pdf The Praed Foundation provides information about the reliability and validity of the instrument as well as links to different versions of the instrument for different target populations and for different states. http://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/ Reference: Lyons, J. S., Weiner, D. A., & Lyons, M. B. (2004). Measurement as communication. The Child and Adolescent Needs and Strengths tool. In M. Mariush (Ed.), The use of psychological testing for treatment planning and outcome assessment (3rd ed., pp. 461–476). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.	Worker observation
Multiple dimensions	The Family Assessment Form (FAF) assesses family functioning via 58 scales organized into 8 categories: Living Conditions, Financial Conditions, Supports to Caregivers, Caregiver/Child Interactions, Developmental Stimulation, Interactions Between Caregivers, Caregiver History, and Caregiver Personal Characteristics. The first six categories may be used at multiple points in time to assess change following intervention. There also is an optional check list that identifies behaviors concerns regarding children via 31 scales organized into five factors: Acting Out Behaviors, Inner-Directed Behaviors, School Behavior Problems, Health and Development Problems, and Temperament.	The FAF booklet may be ordered from the Child Welfare League of America's bookstore at https://net-forum.avectra.com/eweb/shopping/shopping.aspx?site=cwla&webcode=shopping&shopsearch=family+assessment+form&prd_key=4f8f8aca-4a42-419c-80b4-86b31fa8032f FAF software may be obtained from the FAF website at: http://myfaf.org/ Reference: Children's Bureau of Southern California. (1997). *Family assessment form: A practice based approach to assessing family functioning.* Washington, DC: Child Welfare League of America.	Worker observation

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Multiple dimensions	The Home Observation for the Measurement of Environment (HOME) measures the family's capacity to fulfill basic needs, patterns of social interaction, and parenting practices. Versions of the HOME are tailored to families with age-specific children (e.g., infants and toddlers, early childhood, middle childhood, and early adolescence).	Information about the HOME inventory is available online at: https://thesanfordschool.asu.edu/home-inventory Reference: Caldwell, B. M., & Bradley, R. H. (2003). *HOME inventory administration manual.* Tempe: Family & Human Dynamics Research Institute, Arizona State University.	Worker observation after implementing a structured interview/observation protocol.
Multiple dimensions	North Carolina Family Assessment Scale (NCFAS) is an assessment tool designed to examine family functioning in the domains of Environment, Parental Capabilities, Family Interactions, Family Safety, and Child Well-being. The NCFAS has 36 subscales in 5 domains.	Information about the NCFAS can be obtained from the National Family Preservation Network at http://www.nfpn.org/assessment-tools Further information about CANS and various versions for target populations and specific states can be located at the Praed Foundation at https://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/	Worker observation
Multiple dimensions	The Protective Factor Survey (PFS) is a 20-item pencil and paper survey that is divided into two sections. The first demographic section is to be completed by program staff and program participants complete the second section. Protective factors included in the survey include: Family Functioning/Resiliency (5 items); Social Support (3 items); Concrete Support (3 items); Knowledge of Parenting and Child Development (5 items); and Nurturing and Attachment (4 items). The instrument is in English and Spanish.	The instrument and user manual may be downloaded for free at the FRIENDS National Resource Center at https://friendsnrc.org/protective-factors-survey Reference: Institute for Educational Research & Public Service, University of Kansas. (n.d.). *The development and validation of the protective factors survey: A self-report measure of protective factors against child maltreatment phase IV report.* Chapel Hill, NC: FRIENDS National Resource Center for Community-Based Child Abuse Prevention. Retrieved from https://friendsnrc.org/jdownloads/attachments/phase4summary.pdf	Parent self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Adult Mental Health	The Brief Symptom Inventory (BSI) measures specific mental health symptoms and provides a global severity index. Symptom scales include: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism. The BSI may be used in individuals age 13 to adult.	Information about ordering the BSI is located at: http://www.pearsonclinical.com/psychology/products/100000450/brief-symptom-inventory-bsi.html Reference: Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine, 13*(3), 595–605.	Adult self-report
Adult Mental Health	Center for Epidemiologic Studies – Depression (CESD) Scale and the Center for Epidemiologic Studies-Depression Scale Revised (CESD-R) 20-item self-report scales designed to measure depressive symptomatology. Items on the scale range from 0 (rarely or none of the time, less than 1 day) to 3 all of the time, 4–7 days). Symptoms represent nine dimensions: sadness, loss of interest, appetite, sleep, thinking/concentration, guilt, tired, movement, and suicidal ideation. Scores 16 or higher is indicative of depressive symptoms and suggest the need for further evaluation.	The CESD and the CESD-R are in the public domain available from multiple sources on the internet. Information from the American Psychological Association about the CESD can be located here: http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/depression-scale.aspx An online version of the CESD-R can be obtained here: http://cesd-r.com/cesdr/ References: Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. Applied Psychological Measurement, 1, 385–401; Rinehart, D., Becker, M., Buckley, P., Dailey, K., Reichardt, C., Graeber, C., VanDeMark, N., & Brown, E. (2005). The relationship between mothers' child abuse potential and current mental health symptoms. Implications for screening and referral. *Journal of Behavioral Health Sciences and Research, 32*(2), 155–166.	Adult self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Adult Mental Health	The PTSD Checklist for DSM-5 (PCL-5) assesses 20 DSM-5 symptoms of PTSD in the past month of the adult's life. It can be used to monitor symptom change before, during, and after intervention. It can also be used to provide a provisional diagnosis of PTSD.	Information about the PCL-5 is available at the National Center for PTSD at: https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp Reference: Steinberg, A. M., Brymer, M. J., Kim, S., Briggs, E. C., Ippen, C. G., Ostrowski, S. A., Gully, A., & Pynoos, R. S. (2013). Psychometric properties of the UCLA PTSD reaction index: Part I. Journal of *Traumatic Stress, 26* (1), 1–9.	Adult self-report
Alcohol and Drug Problems	CAGE-AID is a brief screening instrument to measure an individual's potential problems with alcohol and/or drugs. One or more affirmative answers should be considered a positive screen indicating the need for a more comprehensive assessment of use, abuse, or addiction.	The CAGE-AID and other resources for screening for alcohol and other drugs are available through SAMHSA at https://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs Reference: Brown, R. L., & Rounds, L. A. (1995). Conjoint screening questionnaire for alcohol and other drug abuse: Criterion validity in a primary care practice. *Wisconsin Medical Journal, 94*(3), 135–140.	Adult self-report
Child Mental Health	The Child Behavior Checklist (CBCL) measures behavioral, emotional, and social problems in children. There are two versions, one for children ages 1.5 to 5 years and one for children 6 and older. There syndrome scales and a total problem score. The instrument is sensitive to change over time.	The CBCL web site provides information about how to order as well as descriptions of research at http://childbehaviorchecklist.com/ Reference: Achenbach, T. M. (1991). *Manual for child behavior checklist/4-18 and 1991 profile.* Burlington: University of Vermont, Department of Psychiatry.	Parent or teacher self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Child Mental Health	Strengths and Difficulties Questionnaire (SDQ) assesses mental health of children ages 2–17 years (in different versions by age). The SDQ asks about 25 attributes, some positive and others negative. Five subscales include: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, pro-social behavior. The SDQ is available in numerous languages.	Information about the SDQ is available at: http://www.sdqinfo.org/ Reference: Goodman, R., & Scott, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful? *Journal of Abnormal Child Psychology, 27*(1), 17–24.	Parent or teacher self-report about the child
Family Functioning/ Family Strengths	Assessment of Strategies in Families-Effectiveness (ASF-E) is a brief 20 item instrument that measures congruence and family health on four dimensions of family behavior patterns and strategies: stability; growth; control; and connectedness/spirituality.	A copy of the ASF-E is available at: http://store.ets.org/store/ets/en_US/pd/ThemeID.12805600/productID.39398900 Reference: Friedemann, M., Astedt-Kurki, P., & Paavilainen, E. (2003). Development of a family assessment instrument for transcultural use. *Journal of Transcultural Nursing, 14*(2), 90–99.	Parent self-report
Family Functioning/ Family Strengths	FACES IV was developed to tap the full continuum of the cohesion and flexibility dimensions from the Circumplex Model of Marital and Family Systems. Six scales were developed to measure low and high cohesion (disengaged and enmeshed) and flexibility (rigid and chaotic).	Information from a validation study of FACES IV is available at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.582.1200&rep=rep1&type=pdf Information about the development of the PHASES IV over time is available at: http://www.societyofpediatricpsychology.org/sites/default/files/files/3_innovations.pdf Reference: Olson, D. H., & Gorall, D. M. (2003). Circumplex model of marital and family systems. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (3rd ed., pp. 514–548). New York, NY: Guilford Press.	Parent self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Family Functioning/ Family Strengths	Family Assessment Device (FAD) is based on the McMaster Model of Family Functioning (MMFF) and measures structural, organizational, and transactional characteristics of families. It assesses six dimensions: affective involvement; affective responsiveness, behavioral control, communication, problem solving, and roles. A 7th scale measures general family functioning. The instrument can be used to guide intervention as well as to measure change over time. There are versions in multiple languages.	For more information about the FAD visit: https://www.nctsn.org/measures/family-assessment-device Scoring information is available online at: http://www.apexwesternwayne.com/family-evaluation-form/ Reference: Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy*, *9*(2), 171–180. Available from: http://onlinelibrary.wiley.com/doi/10.1111/j.1752-0606.1983.tb01497.x/abstract	Parent self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Family Functioning/ Family Strengths	Family Functioning Style Scale (FFSS) is an instrument for measuring two aspects of family strengths: (1) the extent to which ta family is characteristics by different qualities; and (2) the manner in which different combinations of strengths define a family's unique functioning style. The instrument consists of 26-items that are ranked on a scale from 0 "not at all like my family" to 4 "almost like my family." The FFSS assesses five factors: Interactional Patterns, Family Values; Coping Strategies; Family Commitment, and Resource Mobilization. The FFSS can be used to promote discussions about ways in which family functioning and strengths serve as resources in meeting familial needs. Higher scores indicate higher strengths.	Information about reliability and validity and how to order copies of the FFSS may be obtained from Winterberry Press at https://www.wbpress.com/shop/family-functioning-style-scale-a-research-instrument-for-measuring-strengths-and-resources Reference: Dunst, C. J., Trivette, C. M., & Deal, A. G. (1988). E*nabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books.	Parent self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Family History	Adverse Childhood Experiences (ACE) Questionnaire assesses associations between childhood maltreatment and later life health and well-being. There are seven categories of adverse childhood experiences: psychological, physical or sexual abuse, violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or imprisoned. The ACE score is used to assess the total amount of stress during childhood and as the ACE score increases, the risk for specific health problems such as drug or alcohol abuse increases.	To obtain a copy of the ACE questionnaire and obtain links to other resources including research, go to the Centers for Disease Control and Prevention website at: https://www.cdc.gov/violenceprevention/acestudy/index.html Reference: Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading cause of death in adults. The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.	Adult self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Family History	A Culturagram is a family assessment tool to understand the unique culture of a family. The diagram includes elements such as: reason for relocation, legal status, time in community, language spoken at home and in the community, health beliefs, impact of trauma and crisis events, contact with cultural and religious institutions; holidays, food, clothing; oppression, discrimination, bias and racism; values about education and work; values about family structure, power, myths, and rules.	Further information including podcast and an example is located at: http://socialworkculturagram.weebly.com/culturagrams.html Reference: Congress, E. P. (1994). The use of culturagrams to assess and empower culturally diverse families. *Families in Society, 75*, 531–539.	Spatial assessment developed collaboratively between the family and worker
Family History	Genogram Assessment is a generational family map that allows a person to see a family system historically. The genogram usually includes at least three generations of family members, as well as critical events. The genogram provides a framework for reconstructing what may be currently influencing a crisis in a particular family. Circles denote females; squares, males. An X in the figure denotes a deceased family member. It is also possible to denote relationships by different types of lines, e.g. a straight bold line would indicate a positive connection, a dotted line – a distant relationship.	Numerous text books that provide details about how to construct a genogram and there are numerous sites online with toolkits for depicting different types of genograms. Reference: Hartman, A., & Laird, J. (1983). *Family-centered social work practice.* New York, NY: Free Press.	Spatial assessment developed collaboratively between the family and worker

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Family History	Life Events Checklist (LEC-5) assesses the history of an individual's exposure to difficult or stressful events. Individuals should respond related to their entire life including their childhood to adulthood. For each event the person is asked to note if "it happened to me," "witnessed it," "learned about it." The type of traumatic experience is then scored consistent with the DSM-5 PTSD Criteria A. This instrument is usually used in combination with other measures.	Available from the National Center for Posttraumatic Stress Disorder (PTSD) at: https://www.ptsd.va.gov/professional/assessment/documents/LEC-5_Standard_Self-report.pdf Reference: Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment, 11*(4), 330–341.	Adult self-report
Helping Relationship	Helping Alliance Questionnaire (HAq) measures the quality of the worker and client alliance. There are two components from the client's perspective: Type I – perceived helpfulness defined as the client's experience of the worker as providing or being capable of providing the help that is needed and Type II – collaboration or bonding defined as the client's experience of intervention as a process of working together with the worker towards the goals of intervention. The version for the worker is the same but the focus is reversed as the worker about perceptions of the client's involvement in the relationship.	Information about the HAq along with links to how to download both versions of the instrument can be found at: http://www.med.upenn.edu/cpr/instruments.html Reference: Alexander, L. B. & Luborsky, L. (1986). Research on the helping alliance. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook.* New York, NY: Guilford Press.	Worker self report; Parent self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Helping Relationship	The Helping Relationship Inventory (HRI) measures the strength of the helping relationship from the perspective of the client and the worker. The structural component measures tasks of the professional relationship. The interpersonal component reflects the client's and worker's experience of each other.	A version of the HRI can be obtained in the paper cited below at: http://journals.sagepub.com/doi/abs/10.1177/104973159700700403 Reference: Poulin, J., & Young, T. (1997). Development of a helping relationship inventory for social work practice. *Research on Social Work Practice, 7*, 463–489.	Worker self-report; Parent self-report
Life Stress	Everyday Stressors Index (ESI) assesses problems faced by families on a daily basis and the perceptions of parents on how much these problems bother them as a measure of chronic daily stressors. This is a 20 item index covering five problem areas: role overload, financial concerns, parenting worries, employment problems, and interpersonal conflict. A higher score indicates a higher level of daily stress.	A copy of the ESI is available online at: http://www.healthandwelfare.idaho.gov/Portals/0/Children/HomeVisiting/Everyday%20Stressors%20Index.pdf Reference: Hall, L. (1983). Social supports, everyday stressors, and maternal mental health (Unpublished doctoral dissertation). University of North Carolina at Chapel Hill; Hall, L., Williams, C. A., & Greenberg, R. S. (1985). Supports, stressors, and depressive symptoms in mothers of young children. *American Journal of Public Health, 75*, 518–521.	Parent self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Parenting	Adult Adolescent Parenting Inventory (AAPI-2) is an inventory designed to assess the parenting and child rearing attitudes of adult and adolescent parent and preparent populations. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for practicing behaviors known to be attributable to child abuse and neglect. There are five subscales: Expectations of Children, Empathy Towards Children's Needs; Use of Corporal Punishment as a Means of Discipline; Parent-Child Role Responsibilities; and Children's Power and Independence.	Information about versions and research about the APPI-2 along with ordering information can be found on the Nurturing Parenting website at: http://www.nurturingparenting.com/ValidationStudiesAAPIDescription.html Reference: Connors, N., Whiteside-Mansell, L., Deere, D., Ledet, T., & Edwards, M. C. (2006). Measuring the potential for child maltreatment: The reliability and validity of the Adult Adolescent Parenting Inventory-2. *Child Abuse & Neglect, 30*, 39–53.	Parent self-report
Parenting	Keys to Interactive Parenting Scale (KIPS) assesses 12 parenting behaviors related to effective parenting that research has shown to promote children's development. The 12 key parenting behaviors assessed include: Sensitivity of Responses; Supports Emotions; Physical Interaction; Involvement in Child's Activities; Open to Child's Agenda; Engagement in Language Experiences; Reasonable Expectations; Adapts Strategies to Child; Limits & Consequences; Supportive Directions; Encouragement; Promotes Exploration & Curiosity.	Information about KIPS is located at the following website: http://www.comfortconsults.com/ Reference: Comfort, M., & Gordon, P. R. (2006). The keys to interactive parenting scale (KIPS): A practical observational assessment of parenting behavior. *NHSA Dialog: A Research-to-Practice Journal for the Early Intervention Field 9*(1), 22–48.	Worker observation of parent-child interaction using a controlled protocol

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Parenting	Parenting Stress Index-Short Form (PSI-SF) is designed to measure stress with the parent-child system and document sources of stress and how it affects parental child interaction. There are 3 sub-scales for the Short form: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child and a Total Score. A total score of 90 or higher indicates high levels of stress associated with parenting. The 4th edition version was revised to improve cultural sensitivity of language and to include fathers in the standardization sample. Available in English and Spanish.	Information about the PSI are available at the American Psychological Association Website at: https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/parenting-stress.aspx To order from the Psychological Assessment Resources (PAR), contact by phone at (800) 331-8378 or order online using PAR's contact form: https://www4.parinc.com/Support/ContactForm.aspx Reference: Abidin, R. R. (2012). *Parenting stress index (PSI).* (4th ed.). Lutz, FL: Psychological Assessment Resources, Inc.	Parent self-report
Readiness for Change	The Readiness, Efficacy, Attributions, Defensiveness & Importance Scale (READI) was develop to assess parents' motivation to change via behavioral parent training.	Available at: http://www.auburn.edu/~brestev/Measures.htm Reference: Brestan, E. V., Ondersma, S. J., Simpson, S. M., & Gurwitch, R. (1999, April). *Applications of stage of change theory to parenting behavior: Validating the parent readiness to change scale.* Poster presentation at the Florida Conference on Child Health Psychology, Gainesville, Florida. A Reference for a version of this instrument for women with substance abuse problems who were involved in child welfare is: Mullins, S. M., Suarez, M., Ondersma, S. J., & Page, M. C. (2004). The impact of motivational interviewing on substance abuse treatment retention: A randomized control trial of women involved with child welfare. *Journal of Substance Abuse Treatment, 27*, 51–58.	Parent self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Readiness for Change	Readiness for Change (REDI) measures a parent's motivation to change including recognition of the need to change parenting attitudes and behaviors and the belief that change is possible. The REDI was adapted from the READI (see above) to be a better match to parents in child welfare.	Refer to the published papers below to access a version of the REDI. References: Chaffin, M., Funderburk, B., Bard, D., Valle, L. A., & Gurwitch, R. (2010). A combined motivation and parent-child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology, 79*(1), 84–95; Chaffin, M., Valle, L. A., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., McCoy, C., & Kees, M. (2009). A motivational intervention can improve retention in PCIT for low-motivation child welfare clients. *Child Maltreatment, 14*, 356–368.	Parent self-report
Resources	Family Resource Scale (FRS) is a 30-item self-report instrument that measures the adequacy of different resources in households. It is designed to assess the adequacy of resources to meet the needs of the family as a whole as well as the needs of individual family members. There are six subscales: Growth and Support; Necessities and Health; Physical Necessities and Shelter; Intra-family Support; Child Care; and Personal Resources.	Information about reliability and validity and how to order copies of the FRS may be obtained from Winterberry Press at https://www.wbpress.com/?s=Family+Resource+Scale&post_type=product Reference: Dunst, C. J., & Leet, H. E. (1987). Measuring the adequacy of resources in households with young children. *Child Care, Health and Development, 13*, 111–125.	Parent self-report
Social Support	The Support Functions Scale (SFS) measures the need for different types of help or assistance. The scale items were identified through extensive interviews of parents raising preschool aged children. The need for types of support includes: Emotional; Instrumental; Child; Financial; and Agency.	Information about reliability and validity and how to order copies of the SFS may be obtained form Winterberry Press at https://www.wbpress.com/shop/support-functions-scale-reliability-and-validity/ Reference: Dunst, C. J., Trivette, C. M., & Deal, A. G. (1988). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books.	Parent self-report

Domain	Instrument Name & Brief Description	Reference/How to Locate	Type of Instrument
Social Support	Ecomap Assessment is a widely used tool to assess the level of social support inherent in family member's transactions with possible environment resources and connections. Both formal and informal resources should be explored. A bold straight line indicates positive connections. Tenuous connections are indicated by dotted lines. Stressful connections are indicated by a line with cross hatches or wiggly (/\/\/\/\/\/\/\/\/\/\) line.	Numerous text books that provide details about how to construct an ecomap and there are numerous sites online with toolkits for depicting different types of ecomaps. Reference: Hartman, A., & Laird, J. (1983). *Family-centered social work practice.* New York, NY: Free Press.	Spatial assessment developed collaboratively between the family and worker

Appendix H: Examples of Change Strategies and Outcomes

While this list is by no means exhaustive, it provides examples that correspond with the needs categories delineated in Chapter 9.

Table 9.1 Selected Strategies or Interventions to Promote Healthy Behavioral and Emotional Functioning for Children & Adolescents

Strategy/ Intervention	Focus	Population	Research	Reference Information
Art Therapy	Use of 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; may be combined with other treatment types to reduce symptoms from abuse (Pifalo, 2006; Slayton, Archer, & Kaplan, 2010; Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2001).	Guidelines & supporting information are available. (See American Art Therapy Association at https://arttherapy.org)
Eye Movement Desensitization and Reprocessing (EMDR)	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 in lowering post-traumatic stress symptoms and mitigating related behavior issues (Shapiro, Solomon, & Gold,(Eds.), 2017; Adler-Tapia, & Settle, 2009; Soberman, Greenwald, & Rule, 2002).	Materials available in English and Danish, Dutch, Flemish, French, German, Haitian Creole, Hebrew, Italian, Japanese, Mandarin, Spanish, Swedish. Training & implementation manual available. http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/ www.emdr.com

Strategy/ Intervention	Focus	Population	Research	Reference Information
Kid's Club[1]	Targets children's knowledge about family violence; their attitudes and beliefs about families and family violence; their emotional adjustment; and their social behavior in the small group.	Children ages 6–12 who have been exposed to intimate partner violence in the last year	Promising research evidence indicating significant change from baseline in knowledge about violence, safety planning, social skills, emotion regulation, and emotional// behavioral domains (internalizing and externalizing behaviors) (Graham-Bermann, 2000; Graham-Bermann, & Halabu, 2004).	There is a manual that describes how to implement the program and training is available. http://www.cebc4cw.org/program/kids-club-moms-empowerment/
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Structured, short-term treatment to address affective, cognitive & behavioral problems in children related to trauma and improve parental distress and skills and supportive parent-child interactions.	Children & youth with trauma history experiencing significant emotional or behavioral difficulties	Well-supported by research evidence for trauma and anxiety treatments (Cohen, Mannarino, & Deblinger, 2006).	Materials available in English, Mandarin Chinese, German, Dutch, Polish, Japanese & Korean. Training & implementation manual available. http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/ https://tfcbt.org/
Trauma-Focused Play Therapy	Systematic use of play to enable abused children to express overwhelming emotions and thoughts. Used for both assessment and treatment.	Abused & traumatized children	Meta-analyses and empirical studies have demonstrated statistically significant improvements (e.g., trauma, anxiety, disruptive behaviors, internalizing problems) for children participating in play therapy (Association for Play Therapy, 2015).	Guidelines and supporting information are available at www.a4pt.org

1 Designed to be delivered in combination with Mom's Empowerment parenting program – see section of this chapter about parenting competence.

Strategy/ Intervention	Focus	Population	Research	Reference Information
Therapeutic Foster Care	Provide therapeutic services to children within the private homes of trained foster parents. Serves as a less restrictive, family-based alternative to residential or institutional care.	Children and adolescents with significant behavioral, emotional, and mental health problems; medically fragile infants & children	Research indicates positive results (Chamberlain et al., 2008; Chamberlain, 2001).	Guidelines and supporting information are available. See Family Focused Treatment Association at www.ffta.org Treatment Foster Care Oregon at http://www.tfcoregon.com/) (Meadowcroft, Thomlinson, & Chamberlain, 1994)

Table 9.2 Selected Strategies or Interventions to Promote Healthy Behavioral and Emotional Functioning for Children & Youth and Positive Parent Child Interaction

Strategy/ Intervention	Focus	Population	Research	Reference Information
Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	Outpatient treatment therapies that include communication skills training, job-getting skills training, a self-control intervention, a stimulus control intervention & tele-therapy.	Youth ages 11–17 with drug abuse & dependence as well as co-existing problems	Supported by research evidence showing significant improvement in conduct & reduced use of illicit drugs, maintained at 6-months post-intervention (Azrin et al., 2001).	Training and implementation manuals available. Materials available in English and Spanish. http://www.cebc4cw.org/program/adolescent-focused-family-behavior-therapy/
The Incredible Years	The program is delivered in three separate, developmentally based curricula for parents, teachers, and children. Goals are improved parent-child interactions, building positive relationships and attachment, improved parental functioning, less harsh and more nurturing parenting, and increased parental social support and problem solving. The program also targets prevention, reduction, and treatment of early onset conduct behaviors and emotional problems and promotes child social competence, emotional regulation, positive attributions, academic readiness, and problem solving.	For children ages 4–8 and their parents. May be used to prevent or treat behavioral and emotional problems in young children	The intervention is well supported by research evidence and is widely available in many communities (Reid, & Webster-Stratton, 2001; Webster-Stratton, & Reid, 2004; Webster-Stratton, & Reid, 2003).	http://www.cebc4cw.org/program/the-incredible-years/

Strategy/ Intervention	Focus	Population	Research	Reference Information
Multisystemic Therapy (MST)	MST is an intensive family treatment for serious juvenile offenders with possible substance abuse issues and their families. Goals are to empower parents with skills needed to eliminate or significantly reduce the frequency and severity of the youth's behavior problems and to empower youth to cope with family, peer, school, and neighborhood problems.	Children and adolescents ages 12–17 and their parents	There is substantial research evidence for this version of MST (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009).	There is a manual and training available. Programs implementing must consult with an expert weekly, participate in quarterly booster training, and collaborate to monitor fidelity. Summary description: http://www.cebc4cw.org/program/multisystemic-therapy/detailed More information available at www.mstservices.com

Table 9.3 Selected Strategies or Interventions to Promote Healthy Social Functioning for Children & Adolescents[2]

Strategy/ Intervention	Focus	Population	Research	Reference Information
Early Childhood Programs	Provide children with respite from a stressful home situation by giving them clear structure & opportunities to interact with peers and positive adult role models in a safe childcare setting.	Maltreated and at risk children	Providing quality early childhood education is considered primary prevention and, when provided in conjunction with parenting education/other services, is also associated with positive outcomes for at-risk families (Ellenbogen, Klein, & Wekerle, 2014; Roditti, 2001a; Roditti, 2001b; Roditti, 2001c).	Early childhood programs should be licensed and meet standards of quality. Examples of standards and research about Head Start for example, is available at: https://www.acf.hhs.gov/opre/research/topic/overview/head-start Studies on the benefits of child care can be retrieved here: http://www.researchconnections.org/childcare/resources?q=child+maltreatment+prevention+AND+early+education
Mentoring	Structured relationship between a child or adolescent and an older individual (the mentor), with the goal of developing the competence and potential of the child or adolescent. A mentor may serve as a stable adult in a person's life throughout transitions.	At risk or maltreated youth ages 6–18	Promising research with respect to youth avoiding risky behaviors, achieving educational success, having higher aspirations and greater confidence (Tierney, Grossman, & Resch, 1995; Herrera, Grossman, Kauh, Feldman, & McMaken, 2007; Herrera, DuBois, & Grossman, 2013).	Center for Evidence-Based Mentoring: http://www.mentoring.org/program-resources/the-center-for-evidence-based-mentoring/ Program Example: Big Brothers Big Sisters (BBBS) Material available in English and Spanish. Training & implementation manual available. http://www.cebc4cw.org/program/big-brothers-big-sisters/ www.bbbsa.org

2 Note: The specific programs or models that are used will depend on the state, tribe, and jurisdiction. Some models will not be available to all agencies, or the agencies may have contracted with specific programs.

Table 9.4 Links to Compare Interventions to Promote Healthy Behavioral and Emotional Functioning for Parents

Source	Link to Source
American Psychological Association Publications and Databases	http://www.apa.org/pubs/index.aspx
Mental Health Practices in Child Welfare Guidelines Toolkit developed by Casey Family Programs, The Reach Institute, and Annie E. Casey Foundation	http://www.centerforchildwelfare.org/kb/mentalhealth/MentalHealthPractices%5b1%5d.pdf
National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices	http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices	http://nrepp.samhsa.gov/landing.aspx

Table 9.5 Selected Strategies or Interventions to Promote Parenting Competence[3]

Strategy/ Intervention	Focus	Population	Research	Reference Information
Moms' Empowerment Program (MEP)[4]	A group parenting program that provides support to mothers by empowering them to discuss the impact of the violence on their child's development; to build parenting competence; to provide a safe place to discuss parenting fears and worries; and to build connections for the mother in the context of a supportive group.	Mothers who have been exposed to interpersonal violence	Promising research evidence related to improvement in positive parenting, reduction of depressive symptoms and reduction of traumatic stress (Graham-Bermann, & Miller-Graff, 2015; Graham-Bermann, & Miller, 2013).	Summary description at: http://www.cebc4cw.org/program/kids-club-moms-empowerment/ There is a manual that describes how to implement the program, and training is available through the developer. Send an email to sandragb@umich.edu

3 Note: Interventions that target both children and parents are described in the section about family interventions.

4 Note: to be delivered in combination with Kid's Club, see section on Children and Youth: Emotional and Behavioral Functioning.

Strategy/ Intervention	Focus	Population	Research	Reference Information
Nurturing Parenting Programs	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 promising results (Maher, Marcynyszyn, Corwin, & Hodnett, 2011); Devall, 2004).	Materials available in English and Arabic, Chinese, Haitian Creole, Hmong, Spanish. Training & implementation manual available. Description for school age program at http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/ Other versions of the program are described here: http://nurturingparenting.com/ecommerce/category/1:3:2/
Parents Anonymous	Provide opportunities to strengthen parenting skills through mutual support, shared leadership, and personal growth in groups co-led by parents and trained facilitators.	Parents and caregivers of at-risk or maltreated children	Promising research evidence (Polinsky, Pion-Berlin, Long, & Wolf, 2011; Polinsky, Pion-Berlin, Williams, & Wolf, 2010).	Materials available in English and Spanish. Training & implementation manual available. http://www.cebc4cw.org/program/parents-anonymous/ http://parentsanonymous.org/programs/parents-anonymous-groups/adult-group/

Strategy/ Intervention	Focus	Population	Research	Reference Information
Parent-Child Education Programs for Physically Abusive Parents	Establish positive parent-child interactions and child rearing methods that are responsive to situational and developmental changes.	Verbally and physically abusive parents	Research indicates positive results, with some programs more supported by empirical evidence than others (Lundahl, Nimer, & Parsons, 2006; Wolfe, 2004).	Guidelines and treatment manuals are available. (Lundahl, Nimer, & Parsons, 2006; Wolfe, 2004).
Parent Management Training (PMTO)	Parent training interventions that may be implemented in a group, individual parent treatment in the home or via telephone/ video conference delivery. Goals include improving parenting practices, reducing and preventing behavioral problems, substance use, delinquency, negative peer associations of youth.	Parents of children ages 2–18 with disruptive behaviors such as conduct disorder, oppositional defiant disorder, and anti-social behaviors	Substantial evidence that this is an efficacious treatment.	Materials available in English and Spanish. http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/ www.isii.net
SafeCare	In-home training to provide parents with concrete skills in health, home safety, and parent-child interaction.	Families who have experienced or are at risk of abuse or neglect	Supported by research evidence for prevention & abusive behavior intervention; promising research evidence for child well-being.	Materials available in English and French, Hebrew, Spanish. Training & implementation manual available. http://www.cebc4cw.org/program/safecare/ www.safecare.org

Table 9.6 Selected Strategies or Interventions to Promote Positive Parent-Child Interactions and Family Functioning

Strategy/ Intervention	Focus	Population	Research	Reference Information
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)	Psycho-education & training in specific intrapersonal and interpersonal skills for caregivers who are emotionally or physically aggressive with their children.	Physically abused children ages 5–17 & their families	Considered an evidence-based treatment for child physical abuse by the National Child Traumatic Stress Network (NCTSN) (Forgatch, Bullock, & Patterson, 2004; Forgatch, & Patterson, 2005a; Forgatch, & Patterson, 2005b). Significant decreases in caregivers' use of physical punishment and abuse, and high consumer satisfaction. NCTSN notes that this intervention has been used extensively with urban African-American families and reviewed.	Materials are available in English, Japanese & Spanish. Training & implementation manual available. http://www.cebc4cw.org/program/alternatives-for-families-a-cognitive-behavioral-therapy/ http://www.afcbt.org/ http://www.nctsn.org/sites/default/files/assets/pdfs/afcbt_general.pdf

Strategy/ Intervention	Focus	Population	Research	Reference Information
Attachment and Bio-behavioral Catch-Up (ABC)	ABC program goals are: increase caregiver nurturance, sensitivity, and delight; decrease caregiver frightening behaviors; increase child attachment security and decrease disorganized attachment, and increase child behavioral and biological regulation. Intervention is delivered in the home with the child for one hour weekly over ten sessions.	Caregivers of infants 6 months to 2 years old who have experienced early adversity	High level of research evidence supporting the achievement of program goals.	Training and implementation manual available. http://www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up/ http://www.infantcaregiverproject.com/
C.A.R.E.S. (Coordination, Advocacy, Resources, Education & Support)	Strengths-based wraparound early intervention combined with Family Team Conferencing under a care coordination model with goal of reducing child maltreatment risk.	Families at high risk due to family stress or crisis	Promising research evidence showed that those who completed the program had less verified maltreatment than similar families who had not been in the program (Munoz, Renteria, Gelwicks, & Fasano, 2015).	Materials available in English and Spanish. Training & implementation manual available. http://www.cebc4cw.org/program/c-a-r-e-s-coordination-advocacy-resources-education-and-support/ http://ncfie.net/cares-replication/

Strategy/ Intervention	Focus	Population	Research	Reference Information
Child and Family Traumatic Stress Intervention (CFTSI)	Brief early intervention model to improve the parent's communication with & ability to support child.	Children ages 7–18 who have experienced or witnessed trauma (e.g., physical or sexual abuse, domestic violence, community violence)	Promising research evidence shows significantly lower PTSD diagnoses and anxiety scores in treatment group (Berkowitz, Stover, & Marans, 2010).	Materials available in English and Spanish. Training & implementation manual available. http://www.cebc4cw.org/program/child-and-family-traumatic-stress-intervention-cftsi/ https://medicine.yale.edu/childstudy/communitypartnerships/cvtc/cftsi/ http://www.nctsn.org/sites/default/files/assets/pdfs/CFTSI_General_Information_Fact_Sheet.pdf
Child-Parent Psychotherapy (CPP).	The Parent-Child Dyad is usually the unit of treatment. The primary goal is to strengthen the parent-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the parent-child relationship.	Children ages 0–5 who have experienced a trauma, and their parents	The program is supported by research evidence (Lieberman & Van Horn, 2008).	A manual and training are available to support implementation of this program. http://www.cebc4cw.org/program/child-parent-psychotherapy/ http://childtrauma.ucsf.edu/ http://www.nctsn.org/sites/default/files/assets/pdfs/cpp_general.pdf

Strategy/ Intervention	Focus	Population	Research	Reference Information
Cognitive-Behavioral Treatment Program: School-Age Group	Short-term psychotherapy designed to reduce or eliminate incidents of child sexual behavior problems.	Children ages 6–12 with sexual behavior problems & their parents	Supported by research evidence showing long-term reduction in sex offenses for children in treatment group; there were no significant differences in nonsexual offenses (Carpentier, Silovsky, & Chaffin, 2006).	Training & implementation manual are available. http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-school-age-group-2/ www.oumedicine.com/pediatrics/department-sections/developmental-behavioral-pediatrics/center-on-child-abuse-and-neglect/programs-and-clinical-services/children-with-sexual-behavior-problems
Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)	Short-term, strengths-based therapy program grounded in cognitive behavioral therapy.	Children ages 3–17, exposed to coercive parenting or physically abused, and their parents/caregivers	Promising research evidence showed significantly reduced symptoms of parental depression, less use of violent parenting strategies & less inconsistent parenting as well as reductions in children's trauma symptoms & depression (Kjellgren, Svedin, & Nilsson, 2013).	Materials available in English & Swedish, some handouts available in Spanish. Training & implementation manual available. http://www.cebc4cw.org/program/combined-parent-child-cognitive-behavioral-therapy-cpc-cbt/ http://www.caresinstitute.org/services_parent-child.php

Strategy/ Intervention	Focus	Population	Research	Reference Information
Families Facing the Future (formerly Focus on Families)	Preventive intervention to reduce substance use disorders among children in families with a parent in methadone treatment. Method: Group parent-training workshops at the methadone clinics and through home-based services to teach parenting skills & skills for avoiding relapse to drug abuse. Children attend some sessions with their parents. To allow children to remain safely in their own homes by building on family strengths and reducing family deficits through frequent individualized services.	Substance abusing/ dependent parents using methadone treatment and their children ages 5–14	Intended outcomes are supported by research evidence. Long-term results are somewhat mixed based on a random-control study 12–15 years post-intervention indicating reduction of substance use disorders among the treatment parents' sons, but not their daughters (Gainey, Haggerty, Fleming, & Catalano, 2007; Haggerty, Skinner, Fleming, Gainey, & Catalano, 2008).	Training curriculum & implementation manual are available. Curriculum is only available in English http://www.cebc4cw.org/program/families-facing-the-future/ http://www.sdrg.org/fffsummary.asp

Strategy/ Intervention	Focus	Population	Research	Reference Information
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	Results of evaluations are mixed partially due to wide variability in models and poor implementation fidelity. However some components have demonstrated positive outcomes, e.g., addressing concrete needs (Berry & McLean, 2014). Multi-service programs that are variable based on lack of clarity on the specific components and varying expertise of staff are very difficult to evaluate. Most evaluations of family preservation services have focused on intensive family preservation services (see below).	Supporting information is available (Berry, 1991; Berry & McLean, 2014; Nelson, 2000)
Intensive Family Preservation Services	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 as at risk for placement	Those that follow the Homebuilders model (see Reference Information) are supported by research evidence showing they significantly reduce out-of-home placement, but more research on different demographic populations is needed (Nelson, Walters, Schweitzer, Blythe, & Pecora, 2009).	Program Example: Homebuilders Training & Implementation manual are available. http://www.cebc4cw.org/program/homebuilders/ http://www.institutefamily.org/

Strategy/ Intervention	Focus	Population	Research	Reference Information
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	Assess the "fit" between identified problems and broader systemic issues, and implement a tailored, action-oriented intervention.	Maltreated children and their families	Supported by research evidence showing reductions in out-of-home placements, youth & mental health symptoms, parent distress & negative parent behaviors (Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010).	Materials are available in English, Dutch, and Swiss German. Training & implementation manual are available. http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/ http://www.mstcan.com/
Parent-Child Interaction Therapy (PCIT)	Improve the quality of the parent-child relationship by decreasing child behavior problems and increasing positive parenting behaviors.	Young children with emotional & behavioral disorders and their parents	Well-supported by research evidence. The National Child Traumatic Stress Network considers PCIT to be an evidence-based treatment (National Child Traumatic Stress Network, n.d.).	Materials are available in English and Spanish. Training & implementation manual are available. http://www.cebc4cw.org/program/parent-child-interaction-therapy/ www.pcit.org
Solution-Based Casework (SBC)	SBC is an evidence-informed casework practice model that prioritizes working in partnership with families, focuses on pragmatic solutions to difficult situations, and notices and celebrates change.	Families who have an open case with child welfare services due to allegations of abuse and neglect	Promising research evidence relevant to safety, permanency, and well-being and preventing child maltreatment recurrences (Antle, Barbee, Christensen, & Martin, 2008; Antle, Barbee, Christensen, & Sullivan, 2010; Antle, Christensen, van Zyl, & Barbee, 2012; van Zyl, Barbee, Cunningham, Antle, Christensen, & Boamah, 2014).	http://www.cebc4cw.org/program/solution-based-casework/ http://www.solutionbasedcasework.com/

Strategy/ Intervention	Focus	Population	Research	Reference Information
Strengthening Families Program: For Parents and Youth 10–14	Enhance positive parenting skills, build decision-making and life skills for youth, and strengthen family attachment, problem-solving, and healthy communication.	Youth ages 10–14 and their parents	Research indicates positive results in preventing risky adolescent behaviors. (Spoth, Redmond, Mason, Schainker, Borduin, 2015; Spoth et al., 2013; Spoth, Clair, & Trudeau, 2013; Kumpfer, Whiteside, Greene, & Allen, 2010; Brook, Akin, Lloyd, Bhattarai, & McDonald, 2016; Brook, McDonald, & Yan, 2012).	Materials available in English and Spanish. Training & implementation manual available. See Iowa State University Extension and Outreach's Strengthening Families Program: For Parents and Youth 10-14 website at http://www.extension.iastate.edu/sfp10-14/
Therapeutic Child Development Program	Provide children with a consistent, safe, monitored environment, while also providing parents with educational and support services.	Preschool children who are maltreated, at-risk, and/or drug-affected and their parents	Supported by research evidence for improved child and family well-being (Sheehan, 2004).	Program Example: Childhaven Childhood Trauma Treatment Materials available in English and Spanish. Treatment and implementation manual available. http://www.cebc4cw.org/program/childhaven-childhood-trauma-treatment/ www.childhaven.org

Appendix I: Chapter 10 – Alternative Case Scenarios for the Smith Family

Alternative scenario 1: Worker and family conversation after three visits:

Worker: How is everyone feeling this week?

Mrs. Smith: It has been a pretty good week. We sort of got jumbled up on Thursday because we didn't know that it was back-to-school night at Tina's school, but we managed to attend, even though we were about 5 minutes late.

Worker: For the last several weeks, you have been using the weekly schedule you made. (*Pausing, looking at the refrigerator.*) I see that someone has been getting a lot of stickers. How about if you walk me through day by day to let me know what worked well this week, and if there were any challenges, we can talk about those, too.

Mr. Smith: I was on breakfast duty every day, and both kids said they loved our morning time together. Tina likes telling me what Scott will and won't eat. I make sure we have plenty of time to get up and get ready and that we have 15 minutes at the breakfast table together. That way, we not only enjoy breakfast together, but we talk about what each of us has planned for the day. I thought this was more for our son, but I really like having this routine, too. Since I work nights, I usually don't see them after they came home from school and daycare.

I need to get better at planning what to have, though. And I'm so tired. I'm not ready to go to bed right after I come home from work. It's messing with the routine I had. I like to come home, have some leftover dinner, and watch Netflix for a couple hours. I'm only getting 4 or 5 hours of sleep instead of my usual 6 or 7.

Mrs. Smith: I can't tell you how much I appreciate starting our days this way. It was always so hectic when I was trying to get ready for work and get the kids something to eat at the same time. And, most of the time, we left the house screaming at each other, because we were late. But I feel guilty about getting a break when he (*nodding at Mr. Smith*) is not. And getting the kids to bed is awful. They're used to just falling asleep whenever they're ready, which I know wasn't working either. But … it's … it's still a struggle.

Worker: Okay, it sounds like this was a great way to *start* getting that calmness and consistency, because it gave everyone immediate relief in the mornings. Mr. Smith, I like that you've already identified one next step: planning out your weekly breakfasts. I want to explore other next steps, but, first, can you say more about these stickers?

Mrs. Smith: Well, as you can see, both Tina and Scott have been getting lots of stickers for getting up on time and leaving the house on time. I appreciate you helping us come up with rewards that seem to work for both kids. Tina is counting her stickers, so she will have enough money to go to the skating rink with a girl in her class, and Scott wants to go to Toys "R" Us® to pick out a new truck. Having them choose their own rewards really seems to be working.

Worker: Wonderful! It sounds like you have taken a great first step by putting together your first family schedule and working on it as a family. You have some really good things happening in the mornings. You also named some nighttime issues, like not getting enough sleep, and not having a smooth bedtime routine.

Mr. Smith: Yeah, I need more sleep.

Mrs. Smith: And I need the kids to just get in bed when it's time.

Worker: Okay. Let's talk about that ….

Alternative scenario 2: Worker and family conversation after three visits:

Worker: How is everyone feeling this week?

Mrs. Smith: It has been a pretty good week. We sort of got jumbled up on Thursday because we didn't know that it was back-to-school night at Tina's school, but we managed to attend, even though we were about 5 minutes late.

Worker: For the last several weeks, you have been using the weekly schedule you made. (*Pausing, looking at the refrigerator.*) I see that someone has been getting a lot of stickers. How about if you walk me through day by day to let me know what worked well this week, and if there were any challenges, we can talk about those, too.

Mr. Smith: I've been on breakfast duty every day, and it's not working. I'm so tired. It's messing with the routine I already had. I'm not ready to go to bed right after I come home from work. I like to come home, have some leftover dinner, and watch Netflix for a couple hours. But now I'm only getting 4 or 5 hours of sleep instead of my usual 6 or 7.

Worker: Okay, it sounds like you've been sticking to the morning schedule every day even though it's making you exhausted. I hear you saying that it's not working, and I want to recognize that you stuck to it and gave it a try. Has there been anything positive that came out of having the schedule?

Mr. Smith: Well, both kids said they love our morning time together. Tina likes telling me what Scott will and won't eat (*chuckles*). Since we're all at the breakfast table together, we get to check in about what each of us has planned for the day. I thought this schedule idea was more for our son, but I do really like having time together in the morning. Since I work nights, I usually don't see the kids after they came home from school and daycare.

Mrs. Smith: I can't tell you how much I appreciate starting our days this way. It was always so hectic when I was trying to get ready for work and get the kids something to eat at the same time. And most of the time we left the house screaming at each other, because we were late.

Mr. Smith: But I can't keep this up.

Mrs. Smith: I know. And getting the kids to bed is awful. They're used to just falling asleep whenever they want to, which I know wasn't working either. But … it's … it's still a struggle.

Worker: Okay, it sounds like this was a great way to start getting that calmness and consistency, because it gave everyone predictable time together in the mornings. I want to explore some changes, so you're not so exhausted, and look at their bedtime routine. But first, can you say more about these stickers?

Mrs. Smith: Well, as you can see, both Tina and Scott have been getting lots of stickers for getting up on time and leaving the house on time. I appreciate you helping us come up with rewards that seem to work for both kids. Tina is counting her stickers, so she will have enough money to go to the skating rink with a girl in her class, and Scott wants to go to Toys "R" Us® to pick out a new truck. Having them choose their own rewards really seems to be working.

Worker: Wonderful! It sounds like you have taken a great first step by putting together your first family schedule and trying it out as a family. You have some really good things happening in the mornings. You also named some nighttime issues, like not getting enough sleep and not having a smooth bedtime routine.

Mr. Smith: Yeah, like I said, I can't keep doing this.