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

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

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

Targeting Outcomes for a Family: Case Example

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

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

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

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

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

Targeting Outcomes for a Family: Case Example

The behaviors and conditions contributing to the risk include:

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

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

Sample family outcomes may be improved communication and family functioning.

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

Determining Goals

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

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

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

Determining Tasks

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

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

Developing Concurrent Plans

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

Sample Outcome, Goals, and Tasks for the Dawn Family

Outcome: Effective child management skills.

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

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

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

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

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

CHAPTER 9
Service Provision

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

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

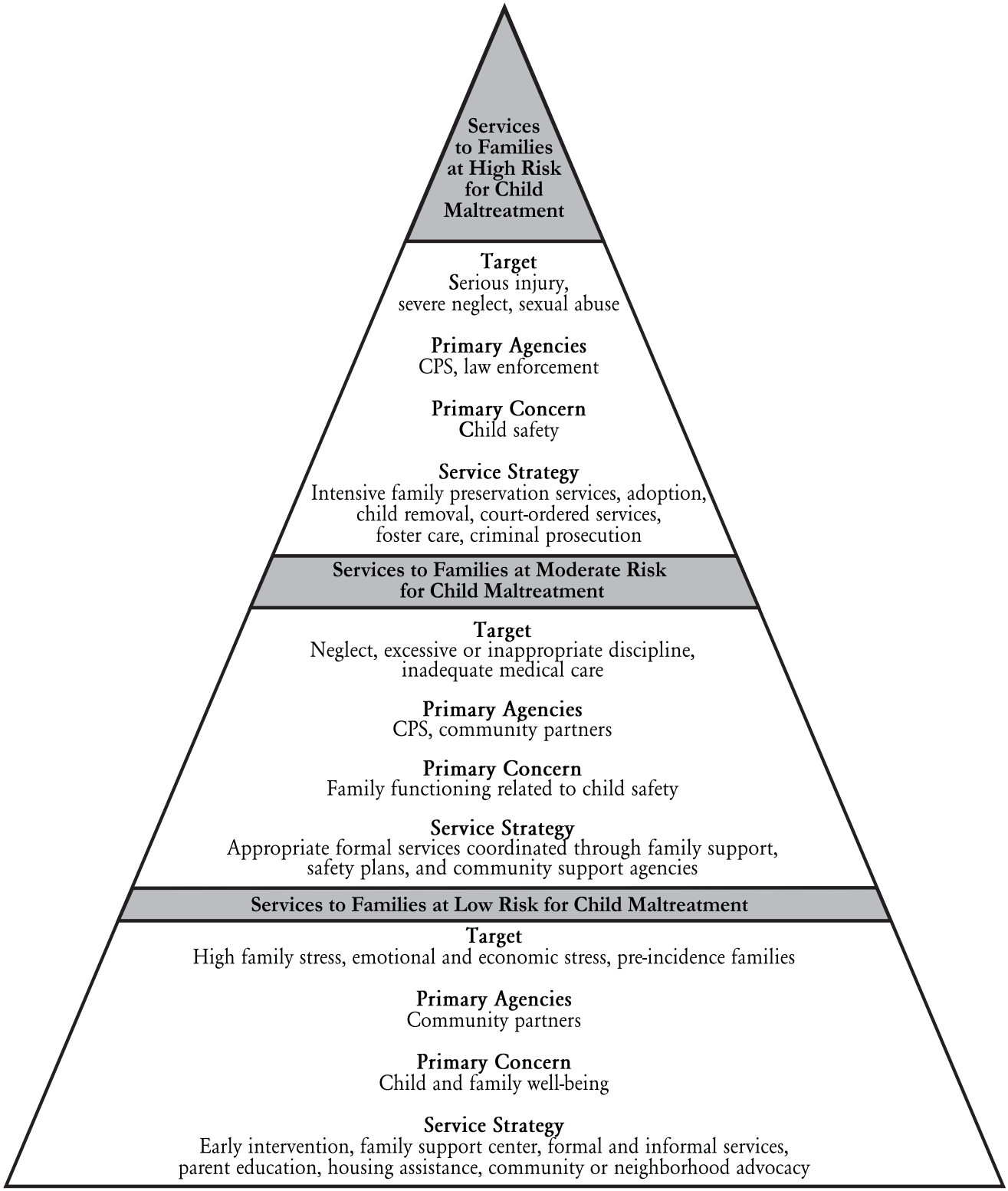
Richard Gelles, a leading researcher in the field of family violence, suggests that some families with maltreatment problems are treatment-resistant. He proposes making early decisions about permanence because the risk of maltreatment is high and the readiness for change is low.[93] Since the principles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

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

Service Framework Based on Levels of Risk

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

Exhibit 9-1
Child Protection Service Pyramid[94]



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

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

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

Case Management

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

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

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

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

Treatment and Intervention

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 10
Family Progress

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

Collect and Organize Information on Family Progress

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

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

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

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

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

Analyze and Evaluate Family Progress

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

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

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

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

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

  – Have the services been provided in a timely manner?

  – Has the family participated in services as scheduled?

  – Has the service provider developed rapport with the family?

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

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

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

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

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

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

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

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

CHAPTER 11
Case Closure

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

Types of Case Closure

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

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

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

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

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

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

Process of Case Closure

Caseworkers should take the following steps in terminating services:

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

Community Collaboration During Case Closure

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

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

Family Involvement During Case Closure

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

Some practical steps to involve the family include:

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

CHAPTER 12
Effective Documentation

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

Purposes of Child Protective Services Record-keeping

The key purposes for keeping records are to:

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

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

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

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

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

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

Content of Case Records

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

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

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

Principles of Record-keeping

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

Caseworkers should:

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

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

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

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

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

CHAPTER 13

Supervision, Consultation, and Support

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

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

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

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

Supervisory Involvement in Decision-making

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

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

Supervisory Involvement in Clinical Consultation

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

When to Consult Supervisors on Casework Decisions

Caseworkers must always consult their supervisors about the following decisions:

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

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

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

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

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

Peer Consultation

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

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

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

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

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

Supervisory Monitoring of Casework Practice

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

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

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

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

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

- Home visits
- Office visits
- Court hearings

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

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

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

Caseworker Safety

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

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

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

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

Peer Support and Burnout Prevention

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

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

Taking Care of Yourself

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

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

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

Conclusion

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

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APPENDIX A
Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

credible evidence exists that child abuse or neglect has occurred.

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

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

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

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

APPENDIX B

Resource Listings of Selected National Organizations Concerned with Child Maltreatment

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

Child Welfare Organizations

American Humane Association Children's Division

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

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

fax: (303) 792-5333

e-mail: children@americanhumane.org

Web site: www.americanhumane.org

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

American Public Human Services Association

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

phone: (202) 682-0100

fax: (202) 289-6555

Web site: www.aphsa.org

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

American Professional Society on the Abuse of Children

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

phone: (405) 271-8202

fax: (405) 271-2931

e-mail: tricia-williams@ouhsc.edu

Web site: www.apsac.org

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

AVANCE Family Support and Education Program

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

phone: (210) 270-4630

fax: (210) 270-4612

Web site: www.avance.org

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

Child Welfare League of America

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

phone: (202) 638-2952

fax: (202) 638-4004

Web site: www.cwla.org

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

National Black Child Development Institute

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

phone: (202) 387-1281

fax: (202) 234-1738

e-mail: moreinfo@nbcdi.org

Web site: www.nbcdi.org

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

National Children's Advocacy Center

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

phone: (256) 533-0531

fax: (256) 534-6883

e-mail: webmaster@ncac-hsv.org

Web site: www.ncac-hsv.org

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

National Indian Child Welfare Association

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

phone: (503) 222-4044

fax: (503) 222-4007

e-mail: info@nicwa.org

Web site: www.nicwa.org

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

National Resource Centers

National Resource Center on Child Maltreatment

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

phone: (770) 935-8484

fax: (770) 935-0344

e-mail: tsmith@gocwi.org

Web site: www.gocwi.org/nrccm

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

National Resource Center on Domestic Violence: Child Protection and Custody

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

phone: (800) 527-3223

fax: (775) 784-6160

e-mail: info@dvlawsearch.com

Web site: www.nationalcouncilfvd.org/res_center

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

National Child Welfare Resource Center for Family-Centered Practice

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

phone: (800) 628-8442

fax: (202) 628-3812

e-mail: info@cwresource.org

Web site: www.cwresource.org

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

National Child Welfare Resource Center on Legal and Judicial Issues

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

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

fax: (202) 662-1755

e-mail: ctrchildlaw@abanet.org

Web site: www.abanet.org/child

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

Prevention Organizations

National Alliance of Children's Trust and Prevention Funds

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

phone: (517) 432-5096

fax: (517) 432-2476

e-mail: millsda@msu.edu

Web site: www.ctfalliance.org

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

Prevent Child Abuse America

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

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

fax: (312) 939-8962

e-mail: mailbox@preventchildabuse.org

Web site: www.preventchildabuse.org

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

Shaken Baby Syndrome Prevention Plus

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

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

fax: (614) 836-8359

e-mail: sbspp@aol.com

Web site: www.sbsplus.com

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

Community Partners

The Center for Faith-Based and Community Initiatives

e-mail: CFBCI@hhs.gov

Web site: www.hhs.gov/faith/

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

Family Support America
(formerly Family Resource Coalition of America)

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

phone: (312) 338-0900

fax: (312) 338-1522

e-mail: info@familysupportamerica.org

Web site: www.familysupportamerica.org

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

National Exchange Club Foundation for the Prevention of Child Abuse

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

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

fax: (419) 535-1989

e-mail: info@preventchildabuse.com

Web site: www.nationalexchangeclub.com

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

National Fatherhood Initiative

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

phone: (301) 948-0599

fax: (301) 948-4325

Web site: www.fatherhood.org

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

For the General Public

Childhelp USA

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

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

fax: (480) 922-7061

e-mail: help@childhelpusa.org

Web site: www.childhelpusa.org

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

National Center for Missing and Exploited Children

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

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

fax: (703) 274-2220

Web site: www.missingkids.com

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

Parents Anonymous

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

phone: (909) 621-6184

fax: (909) 625-6304

e-mail: parentsanon@msn.com

Web site: www.parentsanonymous.org

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

For More Information

National Clearinghouse on Child Abuse and Neglect Information

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

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

fax: (703) 385-3206

e-mail: nccanch@calib.com

Web site: www.calib.com/nccanch

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

APPENDIX C

State Toll-free Telephone Numbers for Reporting Child Abuse

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

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

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

Alaska (AK)
800-478-4444

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

Arkansas (AR)
800-482-5964

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

Delaware (DE)
800-292-9582

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

Illinois (IL)
800-252-2873

Indiana (IN)
800-800-5556

Iowa (IA)
800-362-2178

Kansas (KS)
800-922-5330

Kentucky (KY)
800-752-6200

Maine (ME)
800-452-1999

Maryland (MD)
800-332-6347

Massachusetts (MA)
800-792-5200

Michigan (MI)
800-942-4357

Mississippi (MS)
800-222-8000

Missouri (MO)
800-392-3738

Montana (MT)
800-332-6100

Nebraska (NE)
800-652-1999

Nevada (NV)
800-992-5757

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

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

New Mexico (NM)
800-797-3260

New York (NY)
800-342-3720

North Dakota (ND)
800-245-3736

Oklahoma (OK)
800-522-3511

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

Pennsylvania (PA)
800-932-0313

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

Texas (TX)
800-252-5400

Utah (UT)
800-678-9399

Vermont (VT)
800-649-5285

Virginia (VA)
800-552-7096

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

West Virginia (WV)
800-352-6513

Wyoming (WY)
800-457-3659

APPENDIX D
National Association of Social Workers Code of Ethics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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