

NATIONAL RESOURCE CENTER
NRCCM
ON CHILD MALTREATMENT

**Issues and Strategies for
Assessment Approaches
to Child Maltreatment**

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Acknowledgments

Over the past decade we have witnessed an increasing focus on decision-making in children's protective services. Much of this focus has been directed toward "front end" decisions regarding investigations, safety assessment and risk assessment. Comparatively less attention has been directed to decisions that guide intervention.

The assessment of families to direct change interventions when child maltreatment has occurred contributes greatly to the success or failure of subsequent intervention. In this monograph, we have attempted to raise issues and provide direction as child protection system managers work to improve the effectiveness of child protection interventions.

We express our appreciation to the Children's Bureau, Office of Child Abuse and Neglect for its financial and intellectual support of this task. As well, we thank members of the executive committee of the National Association of Public Child Welfare Administrators who shared questions that needed answers. Together, we hope for a day when the least of a child's worries is parental harm. Toward this end, we dedicate this monograph to those who have suffered and those who have sought to relieve that suffering.

Thomas D. Morton
Wayne Holder

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I. CHILD PROTECTIVE SERVICES STRATEGY

Thomas D. Morton, MSW

Introduction

Few child welfare staff and administrators would disagree that the quality of assessments conducted with families directly affects the quality and effectiveness of subsequent service interventions. Yet, some states are finding that when reviewing case records as many as 50 percent of cases appear to have no assessment recorded although a service plan is in place. In some cases, the service plan appears to be driven directly off the investigation. Problems like substance abuse or poor parenting, once noticed during the investigation, are simply paired with drug treatment and parenting skills classes as part of the ongoing CPS involvement. Some long-term child welfare practitioners observe that this has become more prevalent since public child welfare systems adopted case management strategies to replace more traditional casework strategies in child maltreatment cases (Morton 1999).

The primary goals of this monograph are to link assessment to treatment interventions and to improve treatment outcomes through more targeted assessments of the causes of child maltreatment. This monograph presents a way of defining assessment; reviews the current state of the art of CPS assessment; reviews findings from current etiological research; considers the role of the assessor and examines issues pertaining to how assessment informs treatment.

What strategy for CPS?

Current public agency CPS practice primarily relies on post-incident intervention, control and deterrence. Direct CPS interventions reflect strategies to counter or eliminate assumed causal variables, stabilize current crises and related effects and, when necessary, separate the child from a dangerous family system. The public child protection system was designed to respond to situations where caretakers have placed a child at risk of harm. The system depends on identification of incidents resulting in harm or risk of harm as its starting point. Current public policy for deploying resources emphasizes a residual approach to addressing child maltreatment. Since known instances of child maltreatment are targeted for intervention, public funds are directed at cases where some evidence of

risk has clearly been determined. Usually this involves at least one confirmed incident of child maltreatment. Constitutional protections against unjustified government intervention in family life limit involuntary interventions. By establishing that the family has violated state statutes concerning child maltreatment, the state has a legal basis for intervening in family life without the family's prior consent. These factors and others mean that the current strategy is largely concerned with correcting a situation that is known to exist rather than preventing maltreatment before it occurs.

Post-incident intervention strategies frequently combine a number of tactical elements. Current CPS agency practice relies on control (safety interventions or permanently separating the child from the maltreater), compensation, deterrence and post intervention treatment targeted at causal influences for the maltreatment or the impact of maltreatment on the child. Several child welfare systems are also pairing early intervention efforts with those of the formal CPS agency. These efforts largely target communities and involve collaboration among voluntary service agencies and primary community institutions such as schools.

Which strategy options best fit the primary mission of CPS? If certain options are more aligned with the purpose of CPS, then tactical elements that support these purposes are critical to effective CPS intervention. The answer to this question depends partially on how child maltreatment is defined.

What is Child Maltreatment?

Public strategy toward child maltreatment depends partially on how one perceives maltreatment. For many, child maltreatment constitutes anti-social adult behavior toward children. The fact that parents, rather than strangers, harm children furthers public outrage. Similarly, neglect is viewed by some as the ultimate in irresponsible parental behavior and an indication that another more caring family should raise the children involved. Such perceptions support a criminal view of child maltreatment and suggest relying on methods used by the criminal justice system to address child maltreatment.

Alternatively, child maltreatment might be viewed as a symptom of underlying family conditions that when expressed place a child at risk of harm. These conditions do not strictly suggest parental intent to harm the child, but rather are a sign of parental

dysfunction in the child-rearing role. This perception suggests that, like mental illness or substance abuse, treatment rather than punishment is the preferred strategy.

In reality, both types of child maltreatment exist. Some parental actions are deemed criminal maltreatment. Others aren't. Is child maltreatment a continuum from less to more criminal behavior or is it a dichotomous condition consisting of both criminal and non-criminal maltreatment? If certain forms of child maltreatment are non-criminal, should they be treated with a strategy that has a strong criminal justice overlay? Increasingly, some states are saying no. North Dakota changed entirely from investigations to assessments in non-criminal allegations of abuse or neglect. Missouri and other states are experimenting with dual track systems, eliminating investigations for some reports and replacing them with assessments.

Such policy decisions have significant implications for assessment strategies. Risk assessment in the criminal justice arena is primarily used to determine the restrictiveness of the control intervention. Risk assessment in social treatment settings is primarily used to determine the need for earlier intervention or for more intensive treatment. Where influencing causal conditions is not a primary part of intervention, assessment for change is not needed. Deterrence strategies that rely on the punishing effects of incarceration or probation only need to consider issues of restrictiveness as a community safeguard and means of early detection of the need for a higher level of restriction.

In contrast, where influencing causal variables is a primary element of the intervention, assessment strategies necessarily must focus on conditions for change. These conditions are derived from research and theory about the etiology of child maltreatment and knowledge and theory about effecting change in human systems.

This leads to a fundamental question. Does the public expect CPS agencies to effect change in family conditions or simply to monitor the family's efforts to change and provide needed services? The latter implies a dominant role of observation and decision-making leading to progressively restrictive interventions where the family fails to comply. It suggests that there are expected rates of failure and that the CPS agency is not responsible for the actual rate of failure it experiences. The experienced rate of failure is primarily a function of family motivation and ability to change.

In contrast, if CPS agencies are expected to effect change then they are accountable for outcome levels. Like teaching, where school systems are held accountable for whether students learn, CPS agencies are accountable for whether families change. The preferred strategy would be gauged by its effectiveness in creating change weighed against the negative effects of its use.

This reverts to the treatment versus punishment question. There is little evidence that punishment offers a significant deterrent effect against public behavior, even with severe punitive consequences. Incarceration safeguards the community but does little to assure no future criminal behavior and may well accelerate it due to the culture of prisons and jails. Criminal child maltreatment generally involves severe and egregious harm to a child. In these cases, there is generally little or no consideration of rehabilitating the birth family as a permanency option for the child unless the non-offending parent has displayed signs of acting to protect the child and had no involvement in harm occurring to the child.

Non-criminal maltreatment agency options range from a type of probationary monitoring supplemented by services to directed treatment attempts targeting identified or assumed causal conditions within the family. It is difficult to say that CPS agencies have officially declared a model or even an orientation. Some states such as Illinois openly declare that the caseworker is expected to influence change in the family. Others employ a case management strategy without clearly declaring an expectation that caseworkers influence change. In 1999 the National Resource Center on Child Maltreatment (NRCCM) conducted a survey of state approaches to assessment and service planning. Thirty-five states responded. Fifteen states indicated they rely primarily on an assessment approach that identifies problems for the purpose of identifying services. Fifteen indicated an assessment approach that identified underlying conditions (causes). Five indicated a primary focus on strengths and needs in assessment. However, many of the assessment elements identified by states using the underlying conditions orientation were identical to those identified by the problem-oriented states.

Aside from suggesting some confusion in the terminology of assessment, the information gathered tentatively suggests a predominant focus on problem identification and matching problems with community services. Few states indicated any significant casework time devoted to direct treatment intervention as most staff time was devoted to case management and administrative activities. Overall, this might suggest two

conclusions. One is that most states rely on a strategy of service provision and monitoring. Second, services are linked to identified problems and caseworkers are not expected to assess problems below this level. Further assessment presumably would be the responsibility of service providers.

This raises another acute question. Does child maltreatment occur as a byproduct of the interaction of several other concurrent social problems in a family (e.g., unemployment, substance abuse, etc.) or do concurrent social problems simply exacerbate separate and distinct maltreatment dynamics within the family? Current research focus and prevailing ecological theories lean more toward the latter conclusion. If true, this would mean that child maltreatment interventions could not rely solely on treating related social problems in the family without also directly treating the resident maltreatment dynamics.

Getting to Strategy

Strategy defines a specific way of pursuing an objective. In CPS the objective is to assure the future safety of a child where the child is at risk of serious harm due to maltreatment by an adult caretaker. Most commonly, the caretaker is a parent or someone acting in the parental role. However, in addition to physical safety, CPS also recognizes the need to consider the child's emotional security and well being. This second objective creates and maintains a set of competing tensions with the objective of physical safety.

Were physical safety the only objective, future risk of harm to the child might be managed by simply removing the child from the unsafe family and placing the child in another family where there were no threats of harm to the child. However, evidence suggests that this strategy can cause the child to sacrifice identity and the sense of emotional security derived from living in a family permanently committed to the child's well-being and care through adulthood. For this reason, efforts are made to assure future safety in the birth family, and if this is not possible, to assure this safety in an adoptive or guardianship relationship with another family.

This tension plays out every day in national policy and at the case level. In 1980, Congress passed PL 96-272, the Adoption and Child Welfare Reform Act. Its provisions included requiring reasonable efforts to prevent removal of children from their birth families and reasonable efforts to reunify these children before seeking other permanency alternatives. Over the next two decades, a debate ensued as to whether efforts to preserve

families actually sacrificed children. Nearly two decades later, Congress passed the Adoption and Safe Families Act, limiting the instances in which reasonable efforts were required and emphasizing that safety took precedence over other considerations of emotional security.

At the case level, CPS caseworkers and judges still must determine which children are safe or unsafe, and which children will be safe if reunited with their birth families. Although states have moved to implement various safety decision protocols, safety decision-making remains an inexact science. As well, CPS strategy remains confused and divided as to whether it is primarily focused on rehabilitation of family conditions presenting threats of harm or on exercising social control over maltreating families. Both strategies are needed and used daily in practice. The question is not which applies but where each applies and when the use of one sacrifices the goals of the other.

What strategic options are available and how do they relate to the strategic objectives of CPS? Secondly, how are states currently choosing among these options? Third, which strategy best suits the mission of CPS?

Strategic Options

Public social intervention strategies vary. The American criminal justice system seeks to protect the community primarily by restricting the liberty of persons who have committed criminal acts and are deemed to be a threat to community safety. Secondly, it presumes a deterrent effect of punishment and incarceration will influence others not to commit crimes and those who have committed crimes not to commit subsequent crimes. In contrast, the mental health system seeks to treat underlying causes and control the effects (symptoms) of mental illness, considering the condition a kind of disease. Restriction of liberty for an individual generally occurs when the person is considered to be a threat to self or others. The public health system seeks to prevent illness through education, inoculation and early diagnosis.

Social intervention strategies rely on three primary options.

1. Eliminate or repair the cause in order to restore normal functioning.
2. Manage or control the cause so as to limit the effects or consequences.

3. Manage or limit the consequences through direct management of the consequences or by restricting access.

The first strategy involves detecting a problem or condition that is of concern, isolating the causes and intervening to eliminate the cause by changing the dynamics that create and sustain the condition. The second strategy focuses on managing dynamics rather than eliminating them. Presumably, causal dynamics can be maintained at threshold level below that at which undesirable consequences are likely to occur. The third strategy ignores causation and simply tries to limit the undesirable effects and manage resulting disabilities. Sometimes this involves treating the symptoms.

These strategies rely on several tactical approaches. Often several approaches may be combined in an intervention and an agency's overall strategy.

Detection Approach

Detection involves case finding. Intervention cannot occur without identifying those who need it. CPS relies on community members to report suspected maltreatment for preliminary detection and on investigation, safety assessment and risk assessment to determine those situations that require intervention.

Triage Approach

Triage involves differential decisions around goals and selected courses of action to achieve those goals. Classifying cases as intact family services, family preservation, and out-of-home care and by permanency goals is a form of triage. Triage is not so much an intervention as a decision about the type or circumstances of the ensuing intervention. However, because it predetermines a number of aspects of the family system's current state, it influences the course of further assessment.

Social Control Approach

One option for social intervention is social control. Control strategies generally attempt to limit the possibility of a future event by creating a social or physical barrier between causes and persons likely to be affected. Placement in out-of-home care is the most visible control strategy used by CPS. By separating the child from the family member

who constitutes a threat of harm, future harm is prevented. In-home control strategies are used as well. Adoption or guardianship by another family represents a permanent long-term control strategy by eliminating potentially harmful contact between a caretaker and child until the child becomes an adult. Such control strategies are a type of prevention, but are only used after a first exposure to serious maltreatment. Control strategies can appear to change behavior, but only do so by removing the opportunity for the behavior to occur rather than by changing any of the conditions that cause the behavior.

Deterrence (Enforcement) Approach

Deterrence represents a less direct control strategy and relies on imposing social consequences on behavior. Deterrent efforts are designed to influence conscious choices by individuals and generally rely on the loss of liberty or property as a punishment for anti-social acts. If one assumes that child maltreatment is a conscious and chosen anti-social adult act toward a child, then the threat of losing one's child or of being incarcerated might be a deterrent to such choices. As mentioned earlier, the criminal justice system is predicated on the assumption that the threat of prosecution and punishment serves as a deterrent to citizens who have yet to commit a crime and as a deterrent to similar subsequent acts by those who have done so already. Therefore, threat of prosecution and the use of criminal justice-like procedures in CPS investigation and decision-making, including maintaining state central registries, might be considered strategies of social control through deterrence by example and experience.

Compensation Approach

Compensation is used to supplement or replace necessary capacities. In CPS, foster families provide the nurture needed for child development as well as isolate the child from the consequences of the parent's maltreatment. Parent aides and homemakers perform childcare tasks the parent is unable to perform or does not perform consistently.

Prevention Approach

Primary prevention generally requires isolation and elimination of causal variables from the ecology. Alternatively, education has been used as a preventive intervention under the assumption that behavior comes from a process of social learning. If this learning can be influenced early, then certain patterns of behavior may not be adopted later.

Preventive strategies attempt to neutralize the effect of causal variables before they can become active. Currently, CPS faces several problems in employing a primary prevention strategy. After an extensive review of the research on the etiology of child maltreatment, the National Research Council observed, “We currently know very little about the significant causes and pathways that influence risk factors in the etiology of child maltreatment.” (p. 107) The imprecise understanding of the etiology of child maltreatment makes it difficult to target prevention. Secondly, prevention is most cost effective when a large population can receive preventive care at a low unit cost. Fluoridation of water to reduce tooth decay or inoculation against polio are examples of this. Even where individual variables are strongly supported as causally linked, universal applications of preventive treatments need to be inexpensive and easily able to reach the at-risk population.

Even less is known about how to isolate potential child maltreating persons from the future effects of current social conditions that might heighten the probability of their later maltreatment of children. Such strategies would suggest, for example, isolating the differences between low-income families with no maltreatment and those with it. Presumably, preventive application of resistance building qualities could be introduced into at-risk families. Even if such qualities and treatments could be isolated, they would likely require early intervention into identified at-risk families rather than a general population application of a preventive measure.

Early Intervention Approach

Early intervention targets populations who are at risk but before the actual incidence of maltreatment. Early intervention presupposes that one can recognize the presence of causal conditions or dynamics before maltreatment occurs or while they are in a relatively mild stage and then intervene to impact the conditions and dynamics before they worsen. This may be more feasible for risk of harm from maltreatment than it is for risk of first incidence of maltreatment. Some evidence exists of success for certain high risk populations, such as young, socially isolated single parents. Part of the problem stems from the ability to develop a profile that has strong predictive power relative to eventual maltreatment. Early efforts to profile eventual child maltreatment resulted in huge proportions of false positives. Using such selection criteria would mean providing early intervention services to large numbers of families who would never eventually maltreat their children. This would again raise issues of overall cost effectiveness. Still,

were research to permit better profiling of such families, early intervention would result in lower eventual intervention costs.

Post-Incident Intervention Approach

Post-incident intervention generally requires detection of a condition and then targeting interventions toward assuring no recurrence of the condition. When dealing with physical health, options include:

- ◆ Treatment to eliminate the causes of the condition (e.g., taking antibiotics to kill bacteria);
- ◆ Stabilization and maintenance of the causal conditions and/or their effects to prevent worsening of the effects or consequences (e.g., taking medication to control depression, diabetes or high cholesterol);
- ◆ Treatment or control of the symptomatic effects while natural healing processes take their course (e.g., taking nasal decongestants while suffering from a cold), or
- ◆ Permanent separation of healthy parts of a system from infected parts (e.g., removal of a cancerous tumor).

Unlike physical health, child maltreatment presents some different conditions that preclude the full use of the same strategies. Maltreatment is not necessarily self-correcting in the same way the body's natural immune defenses organize to fight a disease. While families experiencing child maltreatment have psychological strengths, these strengths do not mobilize in quite the same way as the body's biological defense mechanisms. Even where maturation might be a corrective force, non-intervention is a usually not a viable option. As children age, their vulnerability to some forms of maltreatment will decline, however, the cumulative effects of prolonged exposure are damaging and cannot be tolerated while other factors lower the children's eventual risk. For such reasons, options within the medical model do not match well with child maltreatment intervention.

Choosing a Strategy

Ultimately, states and agencies either choose a strategy consciously or by default. If one is not expressly chosen and a culture and infrastructure created to support it, one will evolve from the resident culture of the agency and the individual choices of its members. For purposes of the discussions that follow in subsequent chapters in this monograph, the NRCCM has begun with the assumption that child maltreatment evolves from underlying conditions within the family and is exacerbated by other social problems. These co-existing social problems can intensify the underlying conditions and lead to targeting a specific child or all children in a family.

This position seems to be most strongly supported by available current research and theory. Even though there are not clear implications from research about how variables interact to influence the occurrence of maltreatment, child protection agencies must respond and therefore must create their own models and assumptions and choose practice methods to implement them.

Some forms of child maltreatment do represent parental or caretaker acts commensurate with criminally defined behavior. However, the majority of child maltreatment is defined primarily as a social problem of family functioning that can be successfully treated without permanently separating children from their families or subjecting children to unwarranted risk of severe harm. When the maltreatment is not commensurate with criminal behavior, a treatment intervention is warranted. Treatment interventions require differential assessments of the conditions within each family that create and sustain the maltreatment dynamic. No one condition causes maltreatment and no single intervention will prevent its recurrence in every family.

Implications for Practice

Without a clear operational definition of child maltreatment, there is neither a foundation upon which to form agency definitions of the variables that need to be considered in assessment nor a basis for understanding the relationship between interventions and those variables. If the child welfare system were only responsible for classifying maltreatment cases, operational definitions might be less important. However, the public seems to expect child maltreatment interventions to change family circumstances, and not just be a probationary monitoring system and triage. As this is the case, how a child welfare

agency defines child welfare (in practice as well as theory), becomes the fundamental first step in addressing causes of and interventions for child maltreatment. Without this step, assessments and interventions will follow a path that began with no particular direction in mind. (Morton 2000)

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II. THE BASIS FOR ONGOING CPS INTERVENTION: CPS STAFF FOCUSED SURVEY SUMMARY OF FINDINGS

Todd Holder, MSW

Introduction

“Emphasis has always been placed on investigation and services are secondary. Policy reflects this priority with over 140 pages devoted to investigation and 3 pages for ongoing.”

-Ongoing CPS worker, Staff Focused Survey, 1999

This chapter summarizes information gathered in a national survey conducted by the National Resource Center on Child Maltreatment (NRCCM). The NRCCM surveyed ongoing CPS staff to identify their perspectives about the nature of current ongoing CPS intervention. Additionally, the survey emphasized the role of *assessment* in ongoing CPS intervention.

The current child protective services system appears predominantly as an investigation and safety response intervention. Public opinion which influences federal, state and local policy and ultimately caseworker practice places a priority on investigating referrals, deciding to substantiate, evaluating safety, deciding to place and working toward child permanency. Examination of current practice from the caseworkers’ perspectives seems to indicate that the stereotypical image of the stoic CPS worker confronting parents and removing children may be closer to fact than fiction.

The significance of child protection and child permanency as fundamental responsibilities within CPS is generally accepted. The emphasis on these issues over the past two decades within the development of CPS decision making is well documented. Yet, while needed attention has routinely occurred with respect to the “front end” of CPS, less concentrated development has occurred relative to the “deep end” of CPS involving assessment, planning, evaluation and change.

This apparent lesser attention to the ongoing CPS intervention may be partially a result of national initiatives designed to improve CPS. National training programs, policy and procedural development, decision making and intervention methodology are typically intended to improve early CPS intervention, case determination and safety management. National conferences, roundtables and symposia are more focused on such subjects as risk assessment, safety evaluation, collaboration with law enforcement, child permanency, foster care, kinship care, investigating child sexual abuse and forensic investigations, all of which are essentially “front end” CPS concerns.

Assessment in Ongoing CPS Intervention

An area of critical concern in ongoing CPS practice is the assessment that influences the case plan. While it seems that minimal conceptualization of the case plan assessment has occurred, current pre-dispositions may be confusing this issue. An example of this can be found in the field's use of the term "family assessment." For many, the term has referred to a family centered evaluation for the purpose of understanding and individualizing family treatment needs. As the term "family assessment" has become more widely used, the specific meaning and intent have become confused. The term "family assessment" as commonly used has various meanings across jurisdictions. The variation in concept and application, the differences or lack of clarity regarding purpose and the contrasting ways of conducting family assessments raise questions regarding effectiveness.

The results of this survey provide strong indication of the need for serious development of the assessment strategy in ongoing CPS intervention and particularly with respect to family assessments that influence case planning. Perhaps the findings can stimulate an interest in serious consideration and discussion regarding the delivery of ongoing CPS.

Background of Study

The impetus for this study was to clarify what CPS does once a case is opened for ongoing services. To draw conclusions about the current status of ongoing CPS intervention effectiveness, the study sought to identify the perceptions and opinions of CPS staff who are directly responsible for ongoing CPS service delivery. The analysis of survey data focused on three evaluation questions:

- ◆ What is the fundamental objective of ongoing CPS?
- ◆ Once a decision has been made to open a case for ongoing services, what is the basis for the case plans/treatment plans?
- ◆ What is the effectiveness of ongoing CPS treatment interventions?

Methodology

A survey was mailed to 400 ongoing CPS workers. The survey sample was purposive and selected based on the expectation that respondents would provide a unique and perhaps more realistic perspective regarding the actual nature and character of ongoing CPS. The survey of ongoing CPS staff was designed to elicit candid observations based on personal perceptions and experiences of what actually occurs in the field. It was expected that worker responses might vary from agency policies, procedures and administrative positions. Fundamentally, the study's questions concerned the extent to which ongoing CPS practice as described by workers is consistent or inconsistent with ministerial guidance as expressed through the more formal and institutional parts of CPS organizations (e.g., law, policy, procedures, belief systems, intervention methods, etc.)

The survey instrument contained 11 multiple choice questions related to the three evaluation questions identified earlier. Caseworkers were encouraged to select one answer that best described or fit their experience of how ongoing CPS is approached in their agency. In addition to the 11 multiple choice questions, additional space was provided for worker comments, clarifications and individual answers that went beyond options provided within the 11 multiple choice questions.

Surveys were sent to at least one county in every state. Counties with populations below 30,000 were not included in the survey. In order to enhance data collection, surveys were sent directly to county supervisors responsible for ongoing CPS.

Who Responded

Of the 400 surveys mailed, 142 individuals from 31 states responded. This represents a response rate of 35.5%. The average number of years of CPS experience for respondents was 9.7 years with a range of 2 months to 37 years. Although the vast majority of respondents were CPS ongoing staff, some CPS supervisors and administrators returned surveys as well (which accounts for the broad range in CPS tenure). Responses were received from the following states:

Alabama	Idaho	New Mexico	Texas
Alaska	Kentucky	New York	Utah
Arkansas	Louisiana	North Carolina	Vermont
California	Massachusetts	North Dakota	Virginia
Colorado	Minnesota	West Virginia	Ohio
Delaware	Missouri	Pennsylvania	Wisconsin
Georgia	Montana	South Carolina	Wyoming
Hawaii	Nevada	South Dakota	

What They Said

“The fundamental objective shifted from facilitating change by addressing underlying causes...to protection and permanence during the last 2 years or since July 1997...”

-Ongoing CPS worker, Staff Focused Survey, 1999

The survey’s first question concerned the primary purpose for ongoing CPS. This question explored whether respondents viewed ongoing CPS as having an overriding objective. Additionally this question was expected to provide some basis for understanding the relationship between the presence or absence of a perceived ongoing CPS objective and apparent variation within the field with respect to service provision, methods, worker role, worker responsibility, worker expectations and practice outcome achievement. Table 1 illustrates the responses to the survey’s first question.

Table 1

The fundamental objective of ongoing child protective services is:	
Oversee compliance of case plans	9.9%
Identify and access services for families	10.6%
Facilitate change toward desired treatment outcomes by addressing the underlying “causes” of child maltreatment	40.8%
Facilitate positive change in the maladaptive “behavior” of parent(s)/ caregiver(s)	27.5%
Other	11.3%

The answers given in Table 1 illustrate three general categories with respect to how staff view the purpose of ongoing CPS. The majority of respondents viewed the primary objective of ongoing CPS as to “facilitate change.” The majority of respondents (68.3%) indicated that “addressing the underlying causes of child maltreatment” or “change in the maladaptive behavior” is the fundamental purpose of ongoing CPS. Although there is significant difference in the identified approaches to change (40.8% “underlying causes” and 27.5% “change in the maladaptive behavior”), it is noteworthy that the objective of ongoing CPS specifically involves altering an individual and/or family condition was a common theme.

A second group of respondents viewed the primary objective of ongoing CPS as managing and overseeing case activity and progress. While the majority is concerned with “people changing,” the second group is concerned with “people processing.” This second group defines the primary objective for ongoing CPS as a case management function that is more concerned with oversight and orchestration and likely less concerned with worker-caregiver engagement and interaction. In this category 10.6% of those responding indicate that the identification and “access of services” is the primary objective of ongoing CPS while 9.9% of the respondents identified oversight of case plan “compliance” as the primary objective. Although desired practice outcomes among the respondents for groups one and two may be similar, there is a significant difference in staff perception regarding the role of the ongoing CPS worker and how those outcomes are achieved.

The third group is comprised of those respondents (11.3%) who selected an alternative answer to the four standardized choices provided in the survey’s first question. Of those staff who chose “other” as their response, their comments indicate that the “protection of children” and/or “all of the above” (oversee compliance, access services, address underlying causes and change behavior) is the fundamental objective for ongoing CPS.

Basis for CPS Case Plans

“Ideally, treatment plans should be based on the outcome of the investigation assessment plan however, the reality in practice is that they (treatment plans) are based on a selection of services which are frequently used as providers and are known to be available.”

-Ongoing CPS worker, Staff Focused Survey, 1999

The three survey questions illustrated in Table 2 illustrate staff responses regarding the basis for CPS case plans/treatment plans.

Table 2

Once the decision has been made to “open” a case for ongoing CPS, is there a specific assessment process that serves as the basis for the case plan/ treatment plan?	
NO	34.5%
YES	65.4%
In the absence of an ongoing CPS assessment, what forms the basis for the case plan/treatment plan?	
Service identification and/or provider availability	16.1%
Investigation findings	16.1%
Risk assessment conclusion	30.3%
“Matching” services with categories of maltreatment	16.1%
Select from frequently utilized “standard” set of services	14.0%
Court ordered services	5.3%
Other	1.7%
If an assessment is used as the basis for a case plan/ treatment plan, what is the primary purpose for the assessment?	
To gather and document social history	10.8%
Engage the family in an interactive process toward problem understanding and acceptance	28.3%
Identify types of services needed	38.3%
Gain clearer understanding regarding the “cause(s)” for the maltreatment	15.8%
Determine what the family is willing to work on	1.6%
The purpose is not clear based on my understanding of program design	0.8%
Other	5.8%

The survey asked respondents to indicate whether their agency employed a “specific assessment process” to develop case plans/treatment plans. The intent of this question was to determine if ongoing CPS staff have an assessment process that is distinct from

the methodology (i.e., assessment) used during the investigation of referrals. The majority (65.4%) of those responding indicated that there is a “specific assessment process” used as the basis for case planning/treatment planning. A little more than a third (34%) of those responding indicated that there was not “a specific assessment process” following the decision to open a case for ongoing CPS.

Only those respondents (34.5%) who answered “No” to this question were directed to answer the next question in Table 2 concerning what forms the basis for case planning if a specific ongoing assessment is not used. (Although this instruction was given on the survey, several of those who responded “Yes” to the first question in Table 2 also chose to answer this second question.)

The highest percentage (30.3%) of those responding to the second question in Table 2 identified “risk assessment conclusion” as the basis for case plans/treatment plans. Significant (but not necessarily surprising) were the number of responses that suggest that case plans were based on external influences rather than case specific issues. This is evidenced by responses indicating that case plans are influenced by “provider availability” (16.1%), “matching services” (16.1%) and the use of “standardized” services (14.0%). That “court ordered services” is only 5.3% is interesting since agencies and staff commonly indicate that case plans and court ordered plans are often the same thing.

Question three in Table 2 was specifically designated for those respondents (65.4%) who indicated that case plans are based on distinct assessments. The greatest number (38.3%) of those responding to this question indicated that the “primary” purpose for an ongoing assessment was to “identify types of services needed.” Twenty-eight percent felt that the primary purpose for the ongoing assessment was to “engage the family in an interactive process toward problem understanding and acceptance.” Sixteen percent indicated that gaining an “understanding regarding the ‘causes for the maltreatment,’ while 10.8% of those responding indicated that the primary purpose for an ongoing assessment was ‘to gather and document social history.’ ” Of the 5.8% who answered “other” to question three in Table 2, several stated “all of the above” as the primary purposes for the assessment. Other responses included “to show what the agency needs to monitor” and “to determine the severity and risk.”

Case Plan Development

“Supposed to complete with family and empower them to come up with goals...However, most of the time because of time constraints the worker does these ahead of time and presents them to the family.”

- Ongoing CPS worker, Staff Focused Survey, 1999

The survey questions in Table 3 are closely associated with the previous finding in Table 2 with respect to the procedures for developing case plan/treatment plans. The first question in Table 3 differs slightly from previous findings (Table 2). It moves beyond specific inquiry regarding the use of a formal method and/or instrumentation (i.e., ongoing assessments, family assessments, social history, etc.) for establishing case plans to considering broader participatory expectations for supervisors, families, workers and court. The question regarding the length of time for case

Table 3

Regardless of whether an assessment is used as the basis for ongoing intervention, how are the majority of case plans/ treatment plans primarily developed?	
Through collaboration with the supervisor	6.3%
Through collaboration with the family	52.8%
Court expectations	6.3%
Individual experience and professional judgment of what the family needs	27.4%
Based on service availability	7.0%
What is the length of time (in days) that it takes to develop a case plan/treatment plan?	
1-5 Days	19.0%
5-10 Days	15.4%
11-20 Days	17.6%
21-30 Days	24.6%
30 or more days	23.2%

Almost 53 percent of those responding indicated that case plans were primarily developed “through collaboration with the family” while 27.4% indicated “individual experience and professional judgment of what the family needs.” The findings from the first question in Table 2 showing that 65.4% of the respondents have a “specific assessment process” for informing the case plan is comparable to the percentage of staff who indicated that case plans are primarily developed “through collaboration with the family.” Although analysis of the data did not include matching responses from these two questions, it is interesting to consider whether the two items are associated. That raises two questions: 1) Are case-based assessments accompanied by higher involvement of families in case planning? 2) When no specific assessment process is applied, do staff rely mostly on “individual experience and professional judgment” as the primary determinant for case plan development? Interestingly, the percentage of those responding who identified “court expectations” (6.3%) and “service availability (7.0) is relatively consistent with earlier findings (Table 2) when one adjusts for the variation in the number of respondents who were given specific instructions about ways to answer items given their responses.

Six percent indicated that case plans were primarily developed “through collaboration with the supervisor.” Although no “Other” category was included on this particular question, several of those responding indicated in the corresponding comments section that case plans were primarily developed as a result of “all of the above.”

With respect to the second question in Table 3 regarding length of time for case plan development, the fact that the response percentages are equally distributed is curious. It was assumed that most court jurisdictions allow 30 days to complete case plans and that the judicial standard typically would be shorter than a CPS agency standard. Therefore the expectation was that responses would primarily group around 30 days. That case plans may be established on a relatively equal distribution any time across a 30+ day period suggests a significant variation in practice across the country. A reasonable question that this finding explains the differences in time designation and what policies, procedures or practices support each.

Treatment Effectiveness

“Safety should be the baseline but safety is too subjective so the focus should be on positive behavioral change.” -Ongoing CPS worker, Staff Focused Survey, 1999

*“I am not aware of our agency ever looking at treatment effectiveness!”
-Ongoing CPS worker, Staff Focused Survey, 1999*

The three questions in Table 4 are associated with treatment effectiveness. The findings illustrated in this table provide insight into how ongoing CPS workers perceive the current status of ongoing intervention effectiveness. In some respects, the findings in Table 4 reflect how staff feel about their ability to effectively fulfill their job mission. The first question in Table 4 asked ongoing CPS workers how criteria they use to judge the effectiveness of ongoing CPS intervention. The second question in Table 4 related to worker perception regarding barriers to achieving successful outcomes in ongoing CPS. The third question in Table 4 asked workers to describe the overall effectiveness of ongoing CPS treatment interventions.

Table 4

What is the criterion used to judge the effectiveness of ongoing CPS intervention? What is the greatest barrier to achieving success in ongoing CPS? Overall, how effective are treatment interventions in ongoing CPS?	
Child Safety: In or Out-of-Home	45.7%
High Case Loads	47.1%
Highly effective	9.1%
Achieving positive behavioral change in the parent(s)/ care giver	16.1%
Limited supervisory consultation	1.4%
Somewhat effective	66.9%
Child permanence	13.3%
Family resistance	31.6%
Minimally effective	23.2%
Achieving treatment outcomes associated with the underlying causes for the maltreatment	14.7%
Lack of clarity regarding worker role and responsibility	3.5%
Not effective at all	.7%
Other	9.8%
Adhering to court requirements	2.1%
Other	14.0%

For the first question in Table 4 the majority (45.7%) indicated that “child safety: in or out-of-home” was the main criterion used to determine whether CPS interventions are effective. This represents a significant number of respondents given that the next most frequent answer to this question was “achieving positive behavioral change...” (16.1%). This was closely followed by addressing “...causes for the maltreatment” and “child permanence” at 14.7% and 13.3% respectively. Ten percent of those responding selected “other.” Once again, many who selected the designation “other” identified “all of the above” as the main criterion for judging CPS intervention effectiveness. These findings are of interest given data suggesting that CPS ongoing intervention is largely designed to “treat” family conditions.

Not surprisingly, “high case loads” (47.1%) and “family resistance” (31.6%) were most commonly cited as the greatest barriers to achieving success in ongoing CPS. Fourteen percent of the respondents identified “other.” Of the 14% who selected “other” there were two predominate themes that were specified in the corresponding comments section. The first of these had to do with the prevalence of drug and alcohol abuse among CPS families. The next significant theme noted by ongoing CPS workers who designated “other” for the second question in Table 4 related to issues of agency work environment and capacity. The suggestion that public CPS agencies operate as a barrier to “achieving success in ongoing CPS” has tremendous implications when considering what needs to occur in the field to improve the service delivery. Some of the comments made by

ongoing CPS workers regarding this issue were “...there is not stability in the agency. There is too much turnover...,” “...cannot keep experienced staff...,” “I used to think that it was high caseloads however, I am beginning to think it lies more with staff motivation, attitude, skill and commitment to assist families in the change process,” “...treatment success is not something that is ever emphasized...,” “...lack of direction...each unit and worker sees their role differently...,” “ ...worker burnout or becoming too callous. So, you are either inexperienced but fresh or experienced but burnt out...” and “... not highly qualified workers. A lot of staff are trained to do the JOB versus being educated in a theoretical foundation for decision-making.”

Concerning the overall effectiveness of CPS treatment interventions, 66.9% felt that intervention is “somewhat effective,” 23.2% indicated that intervention is “minimally effective,” 9.1% indicated intervention is “highly effective” and .7% stated that intervention is “not effective at all.” It is interesting that nearly one-fourth of the respondents consider ongoing CPS intervention to be ineffective. Considering that the majority of respondents (45.7%) identified child safety as the primary criterion for judging CPS effectiveness, it is disturbing that “minimal effectiveness” applies in one out of four cases.

Observations

On the national level these findings present a picture of ongoing CPS intervention as varied, inconsistent and largely lacking in standardization. While the responses from any particular jurisdiction may be logical, when one combines the data it seems that ongoing CPS can be just about anything from jurisdiction to jurisdiction and frequently appears to lack substance, form or rigor.

The differences in perceptions about the prime objective of CPS suggest that, within the context of the development of the state of the art, states do not agree about the fundamental purpose that guides ongoing CPS efforts and actions. One might speculate that achieving *change* as the prime objective for ongoing CPS intervention exists within caseworkers’ minds and values but is not reinforced in real life. If agency processes supported achieving change as a primary objective of CPS intervention, there would be more contextual evidence. This evidence would be in the form of well defined intervention systems, well prepared staff who are adequately supervised, workloads that offer opportunity to achieve the prime objective and resources that support the effort. The lack of these in most places is practical proof that while those in CPS may aspire to be “people changers” the context which supports that does not exist (at least in adequate ways).

One fifth of those responding to the question about the prime objective did so in ways that indicated limited responsibility for close involvement with families (i.e., oversee case plan, get services). Is this figure lower than what is actually occurring in the real day-to-day CPS work experience? Historically there has been a struggle about the role of CPS in terms of direct service providers versus case managers. For various reasons agencies have drifted toward the case management role. The National Resource Center on Child

Maltreatment's staff's exposure to agencies across the country reveals that the predominant approach to ongoing CPS practice is case management.

Finally, with respect to the fundamental objective of ongoing CPS, it is noteworthy that 10% of the respondents indicated that there are several fundamental objectives. In addition to avoiding the question of a fundamental objective, this leads one to wonder if among ongoing CPS staff there are many who are unclear about precisely what it is they are expected to address and achieve. The perception that "we have all kinds of objectives" doesn't give a specific focus to intervention that staff may need.

The data related to the basis for case plans are also disturbing but not surprising. Essentially, the overall results suggest an unsystematic, illogical, atheoretical and superficial approach to creating an intervention strategy. Over one-third of the respondents indicated that no assessment is used as the basis for a case plan. The two sources of influence on case plans among these respondents were 1) services that exist within the community and 2) findings from staff conducting investigations or risk assessments. Fundamentally both of these sources can be combined into a single strategy for creating ongoing CPS intervention: matching an identified service with a logically connected service. For instance, if substance abuse is identified during the front end of CPS, then ongoing CPS identifies substance abuse counseling as the intervention. It is an automatic style of doing CPS business that is confounded only by the absence of the matching service.

Two-thirds of the respondents said that they complete an assessment that provides a basis for the case plan. There are several revealing things about the responses among those doing assessments. The purposes of assessments vary sufficiently that one can question how assessments provide a basis for case plans. For instance nearly 11% of those doing assessments said the purpose was for collecting social history. It is not clear how a social history provides a basis for a case plan. Less than 16 percent of the respondents said that their assessments consider the cause of problems, yet 41% of all respondents said that the fundamental objective of ongoing CPS is to facilitate change by addressing underlying causes. It has been noted that the majority of those completing assessments have indicated that the purpose of assessment is to identify services that families need. Does this appear to be essentially the same thing that the workers who are not completing assessments for case plans are doing? In other words, what may be occurring across jurisdictions is that staff are functioning in various ways but for the most part are applying the same approach to intervention (i.e., matching services against identified problems - a problem-service paradigm).

Data related to the manner in which plans are developed seem contrary to other findings. Over half of the ongoing CPS staff said they develop plans with families. (This has, at least in words, become a politically correct value relative to ongoing CPS practice.) However, the third of the respondents who do not do case plan related assessments do not use a family involvement approach as a basis for case plans. Although it is not clear, it could be that half of those that do case plan related assessments may not involve the family in collaborative ways. Even if the data concerning how case plans are developed

correctly represent the way things are done, one must still reckon with the fact that 47% of case plans do not involve families as a major ingredient in case plan development.

As one looks at the data from this survey reflecting on case planning, a clear pattern begins to emerge. The strategy (as evidenced in a case plan) for ongoing CPS can be and likely is just about anything. Certainly, the field has not arrived at the truth about a best way to conceive of and deliver ongoing CPS. Case plans may or may not be based on assessments. Case plans may be primarily created on the basis of what's available. Ongoing staff may or may not be involved with the family when creating a case plan. In fact, as often as not choices about case plans are made separate from the family. Case plans are created equally from within a day to more than 30 days from when ongoing CPS receives the case. This seems to say that when data about timing are considered on the whole there is no rhyme or reason to the process of case planning (if in effect one could decipher a distinct process).

The responses concerning effectiveness are remarkable in light of the other data. There is cause to wonder how 78% of ongoing CPS work can be considered to be in the effective range in light of an intervention system that is so ambiguously conceived and articulated. What quality or factor about ongoing CPS intervention as represented in these findings contributes to a 78 percent success rate? Are there other factors or influences involved in success that have nothing or little to do with CPS intervention? Additionally such success rates seem curious in view of the data about barriers to achieving success. The barriers to achieving success that respondents identify exist within a huge majority of the cases served by ongoing CPS! Given the lack of clarity and definition in ongoing CPS intervention, how are the barriers that dominate the service population being effectively addressed?

Conclusion

The author's firsthand experience in county agencies verifies the presence of effective ongoing CPS intervention but at a personal level. In other words, indications of effectiveness across units of the organizations are less obvious. When considered from a national perspective, as this study has done, serious questions about the nature and quality of ongoing CPS intervention must be raised. Currently, the actual practice of ongoing CPS appears to be "people processing" while the concept of "people changing" appears to exist mainly as a state of mind. This study verifies what many people in the field believe. Ongoing CPS intervention remains in grave need of conceptualization, development, and standardization. While various regulations (e.g., ASFA, permanency, state statutes, etc.) governing ongoing CPS decisions and activity establish necessary parameters for intervention, they do not give direction and substance to the form and nature of ongoing CPS intervention. These findings are evidence of an area within child welfare services that has yet to receive the attention it needs to rise to the same level as other components of the overall CPS intervention system.

III. THE ROLE OF ASSESSMENT AND CPS STRATEGY

Thomas D. Morton, MSW

Although definitions of assessment vary, they also contain common themes. The NASW Encyclopedia of Social Work defines assessment as, “the process of determining the nature, cause, progression and prognosis of a problem and the personalities and situations involved therein.” The area for work guides the area for observation. The focus of treatment dictates the focus of assessment. Germain (1979) suggests, “The method of searching for information is intrinsic but subservient to the interventions employed to solve the problem. Every problem has its structural underpinning in the ecological context of the people presenting the problem, and this is the ecostructure. From the very first transaction between the therapist and the family members, every action of the therapist is directed toward modifying this structural underpinning.” This suggests that intervention efforts are themselves part of the assessment process and conversely, that assessment is itself an intervention that changes the family system’s understanding of itself and the problems it experiences.

Defining Assessment Within the Context of Change

Functionally, assessment serves four critical decisions. The first is whether change is necessary. In CPS practice, investigations, safety assessments and risk assessments are often used in some combination to decide if a change intervention is required. The receipt of a report of child maltreatment signals a concern. The investigation and other assessments confirm or deny the concern’s existence. Even when confirmed, the existence of an event of maltreatment may not mean that further changes in the family are necessary. If conditions and their consequences are not considered serious or likely to recur, change may not be warranted.

The second decision concerns what must change and what actions are necessary to promote change. It is here that assessment in child maltreatment directly links to interventions. In turn, interventions are linked to the agency’s assumptions about why maltreatment occurs and what actions will prevent its further occurrence.

The third decision concerns whether or not change is occurring and the intervention is working. The fourth concerns the prognosis for change.

Is Change Necessary?

In CPS, the need for change rests primarily on determining the existence of child maltreatment and assessing the seriousness of the consequences to the child of present family actions. Where a child is determined to be unsafe or at high risk, two possible changes are indicated - one more immediate and the other longer term. The more immediate change is in the protective capacities that surround the child. Immediate safety interventions control for threats of severe harm or supplement inadequate protective capacities within the family, but do not constitute fundamental change in family dynamics that cause the maltreatment or risk of harm. It is here that agencies use a combination of safety and risk indices to determine the need for public intervention.

What Must Change and What Actions are Necessary to Promote Change?

Both law and policy require that every child served by the CPS agency have a case plan. Having an ineffective plan helps little. Assuring child safety, permanency and well being requires that every child have a case plan that, if implemented well, will result in achievement of these outcomes.

Decisions about what must change come from either the family concluding that change is necessary or from those responsible for social control, in this case the protection of children, deciding that family circumstances make the child unsafe or at high risk of harm. While the latter can lead to environmental changes in the family, e.g., child placement, decisions external to the family system about the need for change do not lead to change until the family internalizes the need for change. Clearly, the threatened loss of the child presents the family with a compelling set of choices and may provide motivation for change.

Initial decisions about change are often global and more a statement that change is needed. For example, the conclusion might simply be that change is needed for a child to be safe. Achieving change generally requires a second set of decisions. In this case the question becomes what must change within the family in order for the child to be safe. The simple answer to this question is that the family must stop doing whatever it is that places the child at risk of severe harm. But changing human behavior patterns is not so simple and direct. If simple awareness or insight always led to action, people would not smoke, eat unhealthy diets, nor harm others and so on.

Once it is determined that a variable is actively contributing to child maltreatment in a particular family, the helper and family construct interventions to manage the effects of the variable and reduce its contribution to safe levels. In unraveling the source of human behavior, it is rare to find simple linear chains involving single variables and their consequences. For example, a parent's lack of supervision for a child might be partially explained by unrealistic parental expectations. The unrealistic expectations might derive from the parent's substance abuse, a need to relieve the stress of meeting the child's needs or of failing to meet the child's needs, rationalization of the consequences of no supervision and lack of information about child development, not to mention other factors. This can make assessment somewhat like tracing the roots of a tree. Each root leads to several separate but related contributing roots, which in turn lead to more contributing roots until literally thousands of pathways are identified. If in families with multiple problems, each problem were to have somewhat independent etiologies, the process of assessment could seem endless.

Where change interventions involve a mix of direct work by the caseworker with the family supported by external specialized services, the CPS agency must determine those underlying conditions or causes that will be further assessed and treated directly within the CPS agency itself.

Is Change Occurring?

CPS strategies that rely primarily on control and deterrence also rely most heavily on recidivism as the measure of progress. This is because the intervention is not designed to address specific aspects of family functioning other than the occurrence of maltreatment itself. While the absence of subsequent incidents of child maltreatment certainly is a necessary long-term outcome for CPS, there are some issues presented by relying exclusively on this indicator. First, not all incidences of maltreatment are observed. Although those instances that are observed might be valid evidence that change is not occurring, the absence of detected incidents could be misleading if numerous occurrences are going undetected. Second, since measurement rests on the occurrence of a potentially harmful event, relying exclusively on recidivism means that a child is re-exposed to maltreatment before redirection of interventions can occur.

Strategies that involve elimination or management of causal variables require both measurements of subsequent instances of maltreatment and the level of present activity

around the causal variables. Here again, absence of an instance of behavior might be a poor singular indicator. Even in neglect where the maltreatment effect is more pervasive, maltreatment still does not occur all the time. It is conceivable that a father might not have lost control because the correct stimuli were not present rather than that he has learned to manage his impulsiveness. Ideally, Once it is determined that a variable is actively contributing to child maltreatment in a particular measurements of parental responses in highly stimulating situations would be most helpful. Given the nature of CPS interventions and their use of infrequent, time-limited contacts with the family, the ability to observe such situations is limited.

What is the Prognosis for Change?

Consideration of prognosis serves two primary decisions. The first is whether to intervene at all. This requires a judgment about the likelihood of success for a particular intervention relative to a particular condition. If the expected response to treatment is very low and the cost of treatment is very high, this decision might be made based on resource considerations. The legal construct of right to treatment clouds this issue somewhat. If right to treatment dictates that treatment should be administered regardless of cost consideration, then government child protection programs may be bound to offer treatment regardless of prognosis. This was somewhat the case before ASFA. Prior to ASFA, “reasonable efforts” were broadly considered to require attempts to support change for at least a year before termination of parental rights could proceed.

A second consideration involves whether to continue treatment. When there is no evidence that the family is responding to treatment and no other treatments are known, then ending attempts at treatment may be justified. A variation on this involves the question of whether or not change will occur in a given time frame. Current public policy places the child’s developmental time frames ahead of certain parental rights, limiting the time the parents have to demonstrate change. With the current provision that termination of parental rights procedures must begin for children who have been in care for 15 of the last 22 months, caseworkers must now determine if at 9-12 months if change thresholds will be reached in the remaining time.

The Agency's Role in Change and Implications for Assessment Practice

The role of assessment depends on how a CPS agency defines its role in change. If the agency views change as a family responsibility, then no direct agency assessment may be involved. The family is notified of the need to change and given a time frame within which to change. The agency simply monitors family behavior for a specified period of time and bases triage on the recurrence of child maltreatment.

If the agency assumes that child maltreatment is the consequence of concurrent problems within a family and responsibility for treatment belongs with other agencies and systems, its role involves identifying these problems and directing the family to specialized services. The focus of assessment in such agencies is primarily on problem identification. Once problems are identified, families are referred to services. The family's participation in services is monitored along with their completion and progress. Further triage depends on a combination of subsequent occurrences of child maltreatment, completion of service sequences and possible change in the specific problem conditions. It is worth noting that in a number of litigation cases involving class action law suits (*R.C. v Hornsby* in Alabama, for example), plaintiffs have alleged that the agency tends only to assess for problems for which it has an available service. Thus, the family gets what's available rather than what it needs.

Where the agency sees change in the family as a shared responsibility, assessment takes a different course. An assessment focuses both on identifying contributing factors (problems that exacerbate child maltreatment) and on underlying conditions within the family unique to maltreatment itself. Usually a combination of specialized services and direct interventions is used to address the contributing factors and underlying conditions. Interventions are partially seen as both treatment and further means of assessment. Through reassessment and redirection, means, time and other resources are expended until the condition changes or they are exhausted. Further triage is based on changes in contributing factors, underlying conditions and family behavior.

The distinction made between contributing factors and underlying conditions is important. Contributing factors refers to social problems or conditions as substance abuse, domestic violence, mental illness or unemployment. In a way these factors are parallel family conditions that can enhance the risk of child maltreatment or its severity, but may not be directly caused by them. Underlying conditions are the needs of

individual family members, perceptions, beliefs, values, cultural practices, previous life experiences, etc. that influence the maltreatment dynamic more directly within the family system.

Depending on the agency's assumed responsibility for change it may adopt variations on one of three action sequences. The first is "detection - notification - observation - triage." In this sequence, the CPS agency detects instances of child maltreatment and notifies the family that it must change or other actions will be taken. The family then seeks its own course of change with the agency monitoring progress or failure and exercising triage of cases based on the results. The CPS role in assessment ends with detection. Its assessment focus involves scanning the community for families in which child maltreatment is occurring and requires an intervention. The CPS agency strategy is comprised of detection, triage and enforcement.

The second sequence is "detection - problem identification - support - observation - triage." In this sequence, the CPS agency detects instances of child maltreatment, identifies family problems presumably related to maltreatment, supports the family by arranging services, observes the family's use of services and progress and exercises triage based on the use of services, progress or both. In addition to scanning for maltreatment, individual families are assessed for the presence of a selected set of problems believed to be related to child maltreatment. The CPS agency role is primarily detection, problem identification and support. In this sequence, change is primarily the responsibility of other service providers and the family although the agency does have some responsibility to direct the family to appropriate services.

The third sequence is "detection - assessment - treatment, intervention and support - observation, reassessment and redirection - triage." Following detection of child maltreatment, the agency assesses the need for change and then identifies what must change and how. Following this, a cycle of intervention, reassessment and redirection occurs until time, resources or available means are exhausted. Triage is based on the family's progress at critical points during the intervention. In this sequence treatment decisions may either be driven simply by problem identification or by further identifying underlying conditions that cause the presence of these problems or both. Assessment is also intertwined with intervention and involves gauging the response to the intervention and adjusting interventions based on reassessment. In this sequence, the CPS agency

assumes part of the responsibility for change along with the family and with the support of other services.

CPS Strategies and Assessment

The agency's use of assessment depends considerably on its strategy. Three possible strategies are:

1. Eliminate or repair the cause in order to restore normal functioning.
2. Manage or control the cause so as to limit the effects or consequences.
3. Manage or limit the consequences.

Each of these strategies involves somewhat different perspectives on assessment. In the first, assessment must determine causes and match them with effective change interventions. For example, a parent might have unrealistic expectations of a child (based on the child's current development). Even though this may be a causal variable, it is not yet defined at a level that permits directly addressing it. The unrealistic expectations might be a result of misinformation about the child's developed skills or a rationalization which allows the parent to engage in more personally satisfying actions while leaving the child to fend for him or her self. The parent may have grown up in a family where similar parental supervision were experienced. Other explanations are also plausible. Assessment must continue until a causal variable is identified for which there is a direct intervention.

In the second strategy eliminating the cause is not the focus. In some instances there may be no direct treatment for the cause, for example a developmentally disabled parent who has difficulty remembering when to give the baby its medication. The second strategy seeks to manage the level of the cause's presence, activity or effect. A similar approach can be found in medical practice. For example, it could be argued that drug and alcohol treatments are not about cure, but rather about teaching the addicted person how to manage the circumstances that stimulate use, abuse or addiction. Recovery is a state of managing the disease in the context rather than a state in which the causes have been eliminated. A case could be made that all social treatment really involves learning how to manage precipitating stimuli rather than eliminating these from a family system. The objective is not that parents eliminate all impulses, but rather that parents learn to control

and manage impulsive behavior. Assessment, therefore, focuses on which variables may have to be managed and how to manage them.

The third strategy (manage or limit the consequences) ignores cause as a focus of determining the course of intervention. Such approaches focus more on factors that influence resiliency among children who experience maltreatment; interventions that shield children from exposure to maltreatment, and on deterrence. Assessment tends to focus on risk of re-exposure and levels of restrictiveness necessary to prevent re-exposure. Assessment might also focus on what deterrent measures would discourage a future act of maltreatment by a caregiver.

Summary

The CPS agency's chosen strategy dictates several aspects of its approach to assessment. While this may produce a logical relationship between strategy and assessment, the ultimate issue is the strategy's logical relationship to the goals being sought. Critical elements of the choice involve the CPS agency's acceptance of responsibility for change within the family and its assumptions about what actions are likely to effect this change. Cause related assessments are required where the agency's strategy involves eliminating or managing causal factors. Cause related assessments are not required where the CPS agency assigns responsibility for this type of assessment to other treatment agencies or relies on control and deterrence to prevent future maltreatment. In a strategy built around problem identification and referral, the CPS agency is necessarily assuming that the maltreatment is a consequence of other concurrent problems in family functioning. Specialized service agencies will develop their own criteria for determining if change is occurring. Since they will define change relative to the specific problem they are addressing (e.g., substance abuse), future maltreatment may not be a consideration of intervention effectiveness for the specialized service providers.

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IV. ETIOLOGY OF CHILD MALTREATMENT

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Introduction

Child maltreatment continues to plague American society. The assumptions that an agency makes about the etiology of child maltreatment are critical both to assessment and intervention. Those assumptions define what variables are to be considered in assessment and how they are to be treated.

Researchers have struggled for years to define the etiology of child maltreatment. Still, students of child welfare practice today find conflicting and insufficient research. The lack of complete, coherent reports on the subject may arise from the secrecy of the abusive act; caregivers' inability, unwillingness, or fear of describing their acts of maltreatment and the factors motivating their behavior. Additionally, maltreatment's relatively low prevalence when taken in the context of society as a whole along with the changing definitions of abuse and the multiple, often unexamined, factors that must converge in order to create an abusive climate, make it challenging to determine the exact etiology of child maltreatment.

This chapter identifies the caregiver, child, family, community and societal characteristics that converge to create an atmosphere in which maltreatment often occurs. By identifying these characteristics, child protection administrators, supervisors and caseworkers can consider critical variables in assessments and effective interventions.

Current Research and Theory

According to data published by the Administration for Children and Families, nearly a million children experienced some form of maltreatment in 1998. This maltreatment ranged from threatened harm to emotional abuse, physical abuse, sexual abuse, and physical neglect. Immediate, obvious and observable results of this maltreatment include quantifiable injury and death. Long-term effects include victim aggression, antisocial behavior, depression and anxiety, and possible trans-generational transmission.

Early research attempted to link single factors in adult personality and environment to child maltreatment. These studies suggested that certain types of child abuse result from the anger and frustration arising from life in poverty (Gil 1970); lack of parental support systems; (Garbarino 1977); a parent's substance abuse, depression or other mental dysfunction (Chaffin, Kelleher & Hollenberg 1995); difficulties faced by single-parent households (Holden et al. 1992); intergenerational transmission (Steele and Pollack, 1968, Spinetta and Rigler 1972, other studies); and from the difficulties of raising a child with physical or mental challenges (Burrell Thompson and Sexton 1994).

More recent studies indicate that no single factor causes child maltreatment. Rather, “while many maltreating parents have faulty ego function, including a distorted perception of the outside world or the self, poor judgment, insufficient ability to control impulses or direct behavior, poor reality testing and inappropriate use of ego defenses,” (Holder and Corey 1986 and 1995) none of these on their own directly lead to child maltreatment. Most poor people do not abuse or neglect their children nor do most people suffering with depression or alcohol addiction, or most single parents. The aforementioned studies “focusing on the individual alone, fail to capture the interactional nature of child maltreatment” (Holder and Corey 1986 and 1995). This interactional nature requires “multiple factors (including those at the individual, family, community and societal level) converging to outweigh protective/compensatory/buffering factors” (National Research Council).

Child maltreatment most often occurs when a number of factors converge and, in their meeting, create a climate that is conducive to child maltreatment. These include the parent/caregiver’s personal characteristics; the child’s personal characteristics; family characteristics (including the interaction between parent and child, and between/among siblings); the family’s interaction with the surrounding community; and the family’s interaction with society as a whole.

Certain buffering factors, such as the child’s visibility in the community, the parent’s ability to control impulses, the presence of alternate caregivers, and a strong social-support system, may defuse situations in which maltreatment would otherwise occur. The lack of these protective/buffering factors only increases the likelihood of maltreatment.

The following describes variables identified in theory and research as characteristics of caregivers, families, communities and societies who are physically abusive, sexually abusive, emotionally abusive and neglectful caregivers, families, communities and societies, and of children who are neglected or otherwise abused.

Caregiver Characteristics

Caregivers who maltreat children, whether they physically, emotionally or sexually maltreat the children in their care, share a number of personal characteristics. For example, researchers often find some type of mental dysfunction: depression, anxiety, and substance abuse among parents who are physically and emotionally abusive; a range of psychopathologies and personality disorders among parents who sexually abuse their children; apathy-futility syndrome among parents who neglect their children; and poor impulse control across-the-board. Many parents who abuse or neglect their children also suffered maltreatment as children. However, other characteristics vary by perpetrator type.

Parents who are physically abusive

The characteristics of parents who are physically abusive are found in their external lifestyles and internal and emotional attitudes towards themselves and their children.

Parents who physically abuse their children are more likely than their non-maltreating counterparts to be young, single, poor, under-educated, and unable to obtain or maintain meaningful employment (Gelles 1992). Caseworkers often find a history of antisocial behavior, including criminal aggression, as well as instances of abuse in the perpetrator's childhood. These adults often act immaturely and espouse an authoritarian parenting style.

Emotionally, adults who physically abuse children often suffer from anxiety and/or depression, although only a very small percentage exhibits a diagnosable psychotic disorder. Substance abuse is common among their ranks. They often have problems dealing with stress and may feel no guilt for their actions. Mothers who maltreat may have experienced negative pre-natal attitudes toward their children, as in the case of unwanted pregnancies. (Altmeier et al. 1984, other studies.) Finally, these parents often feel isolated and lonely, suffer from low self-esteem, and believe themselves to be unloved and incompetent as parents.

Parents who physically abuse their children often have a limited understanding of child development and therefore view their children's behavior as stressful. They see their offspring as aggressive, intentionally disobedient, annoying, and stupid. They may consider parenting to be a burden, and tend to blame the presence of their children for unfulfilling adult relationships. Finally, they may view their children's challenging qualities as permanent personality traits, and their positive qualities as fleeting. Parents who do not maltreat their children usually espouse a directly opposite view (Larrance and Twentyman 1983).

Caregivers who sexually abuse

The mental aberrations that cause some adults to become sexually aroused by children do not fit a specific diagnostic category. Rather, these individuals appear to suffer from a broad range of psychopathologies and personality disorders. Researchers have generally found few biological links to their actions, except in scattered cases of mental retardation and psychosis, in which the perpetrator's illness seems to lower inhibitions. Adults who sexually abuse children, like those who physically abuse children, were often themselves assaulted as children.

Although they may appear more often in middle-class communities, especially where incest is a factor, socio-economic status does not seem to directly influence their actions. (This is in contrast to the generally held belief that the frustrations of life in poverty directly contribute to instances of physical abuse.) Caregivers who sexually abuse children, although they are sometimes timid, awkward and unassertive, often enjoy a degree of professional success and an overall presence in the community.

Observable, external characteristics of caregivers who sexually abuse include emotional immaturity, behavioral/perceptual disorders, lack of behavioral inhibitions, and substance abuse (as it serves to lower inhibitions). In order to complete their abusive acts, adults who sexually abuse children must have access to children. While adults who physically abuse children tend to be parents, those who engage in sexual abuses often have either no

or diluted blood relation to the child. Stepparents, parent's sexual partners, distant cousins and social contacts can all inflict sexual abuse.

Emotionally, adults who sexually abuse children appear to demonstrate a deviant psychological and sexual arousal pattern. He or she gleans pleasure and emotional gratification from the sense of power obtained during the act of sexual abuse. The assault also often appeases displaced feelings of anger.

Parents who neglect

Neglect differs from other forms of abuse in that harm caused to the child generally results from inaction, rather than action, and "is only one expression of pervasive and deeply rooted inadequacies in the life of a parent that sometimes appears in early adolescence." (National Resource Council). These feelings of inadequacy, deemed "apathy/futility syndrome" (Polansky 1972) often pervade the caregiver's life, manifesting themselves in all areas requiring decisions.

Observable characteristics of the caretaker who is neglectful include his or her inability to plan major life choices (marriage, job procurement or change, etc.), a history of unstable relationships, and an inability or unwillingness to protect the child. Their characters are impulse-driven. They often suffer from low self-esteem, and often assume a disengaged, or detached, parenting style.

Parents who are emotionally abusive

Of all abuse forms, emotional maltreatment is the least studied. But research indicates that the psychological scars suffered by its victims can prove as damaging as those suffered by the victims of neglect and physical and sexual abuse. (Garbarino and Vondra 1987, other studies).

Adults who emotionally maltreat often suffer from anxiety and depression, and feel a "floating" anger directed not just at a given person or situation, but at the world as a whole. Stressors such as poverty, unemployment, marital discord and "difficult" children exacerbate their feelings and help lead to emotional abuse.

Buffering/protective factors

As noted earlier, buffering/protective factors may help defuse situations in which maltreatment would otherwise occur. Parental buffers include a number of external techniques and internal conditions. Parents who do not maltreat their children often unconsciously take advantage of these buffers to help them remain loving, stable parents. Parents who maltreat need direct intervention to help them discover and implement these parenting techniques, and work toward creating a safe environment for their children.

External buffering factors include the willingness and ability to develop care-taking skills, act protectively, recognize and curb violent impulses, and recognize and correct hazardous and harmful conditions in the home. Parents also may need help with learning

to abstain from drug and alcohol abuse and avoiding relationships with people who abuse substances and with persons who are violent or otherwise mentally unstable.

Internally, caretakers must receive interventions that develop or strengthen:

- ◆ their attachment to the child;
- ◆ their desire to nurture the child;
- ◆ their ability to defer their own needs and gratification in favor of the child's;
- ◆ their willingness to guide the child's moral and cognitive development.
- ◆ their ability to control their impulses as they work to reach a state of emotional stability and health.

Characteristics of Children who are At-Risk

Researchers often hesitate to examine the role that children's personal characteristics play in maltreatment. As in instances of rape, many believe that examining the personality of the victim inappropriately shifts blame away from the perpetrator. However, an etiology-of-child-abuse model proves most complete, and therefore most helpful, when it examines the characteristics of children who are at risk of maltreatment. Some of these characteristics are believed to put children at risk because they interfere with parent bonding. Other characteristics are "chicken-and-the-egg" issues. Is a child who is socially inept more likely to be abused, or does the child prove socially inept because he has been abused?

One group of children at high risk for maltreatment is children who have been born prematurely, and, consequently, at a low birth weight. They may prove difficult to feed, and suffer from chronic illness, handicap, or learning disability. These children are especially at high risk prior to reaching age six – having not yet started school, they can be virtually invisible to the outside community – and have only limited communication skills. They often have difficult temperaments and act in an irritable or fussy manner. Consequently, they may lack social skills and may find it difficult to interact with their peers.

Buffering/protective factors

Certain personal characteristics can help protect a child from abuse by a caregiver. These characteristics sit largely outside the realm of the child's control, and include his age (older children are less likely to be abused than younger ones); his ability to communicate; his mobility; his general good health; attractive appearance; easygoing temperament; and his relationships outside the family.

Characteristics of Maltreating Families

Families who experience child maltreatment often engage in a series of unhealthful interactions between caregiver and child, and among siblings. Some characteristics of these families may be observed by others in the community. Others only manifest themselves within the intimacy of the home.

Characteristics of these families include: a single woman as head of the household; the presence of a stepfather or live-in boyfriend; unsatisfactory adult interpersonal relationships; and an unpredictable family structure that allows for the presence of non-family members within the household. The family often suffers from stressors such as poverty and unemployment. Several preschoolers may live in the household, and sibling relationships may prove conflicted. The family, sometimes lacking transportation or a telephone, is often detached from the community.

When visiting a family that has experienced child abuse or neglect, caseworkers may find a disorganized environment, one in which the parents seem angry at the world and conflicted in their adult relationship. The caseworker might observe a lack of warmth, and an unsatisfactory intimate relationship between adult partners. Caseworkers may also find a tolerance of sibling violence, multiple victims of maltreatment, estrangement from extended family members, unusual sleeping arrangements, and formal, impersonal relationships among family members. Parents may discourage children's relationships with persons outside the family circle.

Buffering/protective factors

Children living in families generally considered to have multiple problems may avoid abuse if the family, as a whole, enjoys relationships with other relatives (grandparents, aunts, uncles, cousins, etc.) and if family members have strong friendships and community relationships, such as those forged through churches, social organizations, and other venues. Also, a child's general visibility in the community, including his or her attendance at school, can help minimize the possibility of on-going abuse.

Characteristics of Communities in Which Maltreatment Occurs

The word "community," for purposes of this discussion, encompasses the family's accessible environment – i.e., their neighborhood, level of social interaction, and accessibility to social resources. In very general terms, poor neighborhoods (those suffering high unemployment rates or increased instances of part-time only employment, and little access to social resources) tend to suffer higher rates of physical abuse; middle-class neighborhoods, more instances of sexual abuse; and isolated neighborhoods (those in which neighbors have little interaction) higher rates of neglect.

Buffering/protective factors

Children living in at-risk communities may escape abuse via strong relationships with extended families; friendships developed via churches, social organizations, and in the neighborhood; and through attendance at school, church, or other institutions.

Characteristics of Societies in Which Maltreatment Occurs

Unfortunately, the United States as a whole allows child maltreatment to occur. The permission is evident in society's acceptance of the number of children growing up in poverty (currently 19 percent of all youngsters); the lack of universal health care that leaves roughly 14 percent of all children uninsured; and a lack of coherent family-leave policies.

Buffering/protective factors

These factors could arise only if the U.S. populace grew to deplore the number of children growing up in poverty and demanded a universal health care system.

Conclusion

In order to develop a comprehensive model for the etiology of child maltreatment, researchers must develop further studies on:

- The differential origins of types of abuse, including physical, emotional, and sexual maltreatment, and neglect.
- Parenting styles and their contributions to child maltreatment.
- Trans-generational perpetration of abuse, with an emphasis on adults who were abused as children and who in turn abuse their own children as well as adults who experienced maltreatment as children but do not maltreat their own children.
- The lack of a male presence as a buffering factor in single-parent households.
- Individual, community, and environmental factors that converge to create climates rife for child maltreatment.
- The appearance (or lack thereof) of different types of maltreatment across various social, cultural, and ethnic classes.
- The etiology of emotional abuse.

Finally, caseworkers must have use of a model that systematically examines the convergence of personal, family, community and societal characteristics that create a

climate in which child abuse most often occurs. Only by examining this convergence, will caseworkers be able to intervene with child maltreatment at its source, and develop effective strategies to maximize protective factors and minimize the dangers of certain risk factors.

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V. THE PROCESS OF ASSESSING

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Introduction

Assessment that leads to a CPS case plan involves a process. This process is key in determining the quality of information which is known about the family at the time the case plan is formalized. Rather than examining the end product, the assessment, this chapter will address the action or process involved – the assessing.

From Diagnosis to Discovery

In CPS, the term diagnosis has been used to describe the end result of the assessment process that results in the case plan. This is based on a medical model in which the worker, acting much like a doctor in terms of his or her role, looks at the symptoms and prescribes a solution which becomes the case plan. The assumption is that the case plan – like a prescription for an illness - will make clients better. This problem-solving approach is the most commonly used approach in CPS.

It may not be the most effective, however, because we are dealing with family systems. Simple cause-and-effect solutions are often not sufficient since they do not take into account the complex emotional, social, and behavioral aspects of the family system.

Peter Block, in his book Flawless Consulting (1999), offers an approach to consulting which is applicable to CPS. He suggests, “the stance we want to take is that we can be a guide through a process of discovery, engagement, and dialogue, in which our clients will find an answer to their question and launch an implementation which will be enduring and productive. It may seem like playing with words, but it makes a difference in what we do and what we leave behind.” For CPS, this means moving from a diagnosis to a discovery, which actively involves the client in the assessing process and gives us a better chance at building client capacity and solving problems so that they stay solved.

Discovery

“The purpose of discovery is to mobilize action on a problem.” (Block 1999) In CPS, this means movement toward solving the problem or changing the situation that warranted CPS involvement. The emphasis on action has strong implications for how the worker approaches discovery in the assessing process. The discovery process is not a “research” phase. Research results in understanding, but not action.

The discovery process is directed toward action and requires a focus on four key areas:

- ◆ Simplify, narrow and reduce your study so it focuses more on the next steps the client can take.
- ◆ Use everyday language. Don't use professional jargon, labels, acronyms, diagnoses, etc.
- ◆ Give a great deal of attention to your relationship with the client. Include the client at every step in deciding how to proceed. Deal with resistance as it arises.
- ◆ Take into account how the individuals and family are dealing with their current problems/situation. What is working now?

The greatest challenge for CPS workers during this process is keeping clients open to the discovery process. What is learned during discovery may not be pleasant for the client to hear or acknowledge and may trigger resistance.

Resistance

Resistance is a likely dynamic in the discovery process. Dealing with resistance may be the hardest part of the assessing process. Resistance is a predictable, natural, emotional reaction against the process of being helped and against the process of having to face up to difficult personal and familial problems.

Resistance can be presented in various forms such as silence, intellectualizing, moralizing, attacking, etc. When we encounter resistance, we are seeing the expression of underlying anxieties. Resistance is a result of the client feeling uncomfortable and expressing this discomfort indirectly. Generally speaking, most resistance results because workers get close to issues of control and vulnerability for the client.

Maintaining control is a human need. Being out of control is a very anxious state. Feeling that they have lost or may lose control of key areas in their families can make clients feel vulnerable. Vulnerability may add to their resistance as workers expose clients' weaknesses, needs and areas that need to change. Fear of the unknown is a major cause of resistance and may hit on both control and vulnerability issues for a client.

Neal Clapp suggests that people entering therapy want confirmation, not change. Clients may sincerely want to learn to solve problems, but they also want to be told that they are handling their problems well already. (Clapp 1979) Block notes, "When we help the resistance get expressed, it diminishes and we are then working with a client who is ready and willing to learn and be influenced." (Block 1999)

So what do we do with resistance? First, accept that you are not going to talk someone out of their resistance because resistance is an emotional process. Feelings are behind the resistance and you are not going to talk someone out of how they are feeling. There are specific steps you can take to help a client get past the resistance and get on with addressing the problems and issues. (Block 1999)

Identify in your mind what form the resistance is taking. Pick up cues from your interviews, observation, etc. and put into words what you see happening. Then state in a neutral, non-punishing way, the form the resistance is taking. This is called, “naming the resistance.” The skill is to find neutral language. For example, if the client is avoiding responsibility for the problem, you might say, “You don’t see yourself as part of the problem.” Be quiet. Let the client/family respond to your statement about resistance.

Ask the client to put into words what he or she is experiencing. If you are authentic, this encourages the client to be authentic. By not fighting resistance head-on and not fooling yourself into thinking you can “overcome” resistance, you will have a better chance of getting past it.

Data Collection

A crucial phase in the discovery process is getting the data. No matter what the type of maltreatment or what the specific CPS concern might be, these steps will help you work with the client to get accurate information.

- ◆ ***Identify the Presenting Problem.*** The presenting problem is perhaps the most easily identified because it is the reason the case has been opened for services in CPS. The presenting problem will be what was found in the CPS investigation, usually the maltreatment that has occurred in the family. The presenting problem is usually only a symptom of the real problem, and the purpose of data collection is to broaden understanding about the presenting problem.
- ◆ ***Decide to Proceed.*** The worker and the family make a decision to proceed with data collection. The family member’s involvement in this process is crucial, so the need to have their commitment should not be underestimated. The motivation to proceed is based on their desire to have things different for their family (safe children, control of behaviors and/or emotions, etc).
- ◆ ***Select Dimensions.*** A limited number of problem areas will be selected. These should be chosen based upon their importance to the safety or risk of the children, as identified in the investigation phase. A good risk assessment, which identifies a few key risk factors and/or a safety assessment which identifies threats of harm, will provide the focus for the areas to be selected. The dimensions should be limited. Too much data from discovery will be overwhelming for you and for the client.

- ◆ ***Decide Who Will Be Involved.*** This is a key step and should be reflective of the family configuration. Non-related adults who are involved with the family should be involved because of their role in the family from a family systems perspective.
- ◆ ***Select the Data Collection Methods.*** There are a number of ways to collect data and it may be necessary to use more than one. The family should be involved in the selection of data collection processes. Eileen Gambrill (1990) offers the following suggestions for sources of data:
 - ***Self-report or interviews.*** This is the most commonly used method. Interviews can be individual or with different combinations of family members.
 - ***Self-monitoring.*** This is a process “in which clients keep track of behaviors, thoughts, feelings, and the conditions related to them in real-life settings.” (Gambrill, 1990) For example, clients who are depressed may keep track of their negative thoughts as well as the situations in which negative thoughts occur.
- ◆ ***Monitoring the behavior of significant others.*** In this process the client observes and records the behavior of another family member. This is most often used for parents to observe and record the behaviors of children.
- ◆ ***Using analogues.*** “Analogues include those in which clients interact together but do so in an artificial setting (such as the office) as well as contexts in which clients participate in role-playing with someone other than a real-life participant (such as with a psychologist rather than a parent).” (Gambrill 1990) Worker-observed visitations between a parent and a child are examples of this method.
 - ***Observation in the natural environment.*** Observing family members in their own home is another commonly used data collection method.
 - ***Checklists and personality inventories.*** This form of self-report uses standardized inventories or tests.
 - ***Case records.*** If case records exist, they may be a valuable source of information in the data collection process. They may contain critical family history, key events, information about past intervention and services, previous evaluations, etc.
 - ***Physiological measures.*** These are often used to assess and evaluate progress, especially in behavioral medicine. Urine analysis may be the most commonly used physiological measure in CPS given the high rate of drug usage.

- ◆ **Other professional evaluations.** Although not listed by Gambrill, evaluations such as psychological evaluations and developmental evaluations are potentially valuable sources of information.
 - **Use of tools or instruments.** Also not mentioned by Gambrill, tools such as ecomaps, genograms, etc. can be used by a trained worker to aid in gathering data during the discovery process.
- ◆ **Collect Data.** Use the selected method(s) and proceed to collect the data. Conduct the interviews, do the observations, etc.
- ◆ **Funnel the Data.** Once collected, you will need to reduce the data to a manageable, actionable amount. “The purpose of your analysis is to focus energy, not describe the universe.” (Block 1999)
- ◆ **Summarize the Data.** Figure out a way to sum up the data you have collected from all the various sources you have used.
- ◆ **Analyze the Data.** What does it all mean, what is important, and why?
- ◆ **Give Feedback.** Share the information with the client/family. Don’t forget to use everyday language. Remember, this is not a diagnosis. Allow enough time in the feedback meeting to deal with resistance.
- ◆ **Offer Recommendations.** Offer ideas on ways in which you believe the treatment plan could be structured to address the issues identified in the discovery process. Use your experience with other families to add to this. Identify those things that the client has control over and can address.
- ◆ **Make a Decision.** “The process is not complete until a decision has been made to do something.” (Block 1999) This is the commitment, the agreement to take action and to work on the areas identified.
- ◆ **Implement.** Translate the data and the decision into the treatment plan, which engages the services, and begins the work process. Your role here is to offer support, provide guidance, provide counseling services, work with providers, etc. Offer encouragement throughout the process. The relationship you build will be essential to your work in helping the client carry out the plan.

Whole-System Approach to Discovery

The process of discovery may sound like a third-party approach, where the worker does the data collection, analysis and feedback and it is mostly a process that is done “to” the client. Block offers another approach which he calls the “while-system” approach, which involves the whole client or family system much more in directly redefining the problem, naming a desired future, outlining alternative actions, and deciding how to proceed. This

is a first-party strategy. The role of the worker shifts to one of convening people to collectively develop a change strategy.

In contrast to the third-party approach, the whole-system method makes the change effort more self-managing. This is consistent with family systems theory and with family-centered practice approaches.

Making a choice about an assessing strategy means deciding whether to give priority to the special expertise and neutrality of the worker, which leads to the third-party approach, or to give priority to people's commitment to action and change, which might suggest the choice of the whole-system approach.

Conclusion

Discovery involves the whole family system in collecting data, analyzing the data, deciding what it means, and committing to take action. Assessing is a process. It is a verb; it implies doing and action. It is not a product, it is a people process, and it is based on relationships with people. Assessing is not something we "do" to clients. Rather, through the discovery process, we can work with families to help them learn to do for themselves.

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VI. ASSESSMENT'S ROLE IN SETTING TREATMENT PRIORITIES

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Fasten your own mask securely before attempting to assist others.
— Airline safety instruction

Introduction

Social work literature on *assessment* describes the purpose of this effort as the provision of a blueprint for the subsequent development of a case plan. A good assessment should serve as the guideline for which objectives (i.e., outcomes) must be achieved and how those objectives should be pursued. (Gambrill: 1990)

But this linkage of “good assessment = logical and effective case plan” isn’t necessarily automatic. For instance, the following excerpt of an assessment summary is a collaborative product of a CPS worker and agency mental health team, after working with the family for three weeks.

“...Jack and Marilyn have each been continually victimized throughout their lives and have suffered significant losses....Marilyn’s losses started with her mother’s death when Marilyn was 4.....She has coped by bingeing and purging food and sometimes abusing alcohol.....She has lost most of her friends due to her lifestyle of continually choosing men who physically abuse her.....Although Marilyn denies that these issues are affecting her, she revealed that sometimes looking at her sleeping 2-year-old twin daughters makes her cry and ‘feel empty’....Jack’s adolescence involved constant juvenile justice placements, replete with abuse and trauma....which he details with little to no affect.....He has coped with his painful losses through alcohol and drugs....and venting his anger toward Marilyn and the children with increasing physical violence.”

Although the information learned during the assessment process was clearly analyzed regarding it’s meaning, this critical thinking step did not continue as the first case plan was formulated. The case plan specified that:

- 1) Marilyn will gain control over her use of food with help from the eating disorders clinic.
- 2) Marilyn will develop the necessary skills and knowledge to meet the needs of her twin daughters by attending agency parenting classes.
- 3) Marilyn will demonstrate abstinence from alcohol by completing random UA’s (urine analyses).
- 4) Jack will demonstrate control over his anger and tendency for violence through attending anger management classes.

- 5) Jack will gain control over his use of alcohol and drugs through attending substance abuse counseling.
- 6) Jack will demonstrate abstinence from alcohol and drugs by completing random UA's.
- 7) Jack and Marilyn will participate in supervised visits with the twins according to the schedule developed by the agency.

The “disconnect” between the assessment data and the chosen sequence (or priorities) for the treatment plan is common. It seems logical to assume that a thorough assessment process will lead to meaningful assessment data. But using the data in a meaningful or effective way is another step of the assessment process. This step is dependent on the CPS worker and supervisor critically thinking through what the data suggest the priorities are *for this particular family to achieve the identified outcomes*.

Permanency planning law and policy mandate that CPS demonstrates reasonable efforts to preserve and reunify families. The implementation of the Adoption and Safe Families Act (ASFA) establishes time limits for achieving these objectives when children are in out-of-home placement. While this clearly translates into a necessity for the development of timely and specific plans for intervention, a question remains. If we ignore assessment data and begin working at the wrong place, are the efforts we are demonstrating very reasonable?

This chapter will examine how CPS staff can use scarce resources efficiently; limit intrusiveness with a primarily involuntary population; take into account what is known about how people change; and achieve positive outcomes within time constraints. The process and structure of assessment can reduce the “disconnect” between what is learned about the family and where treatment is determined to begin.

What are Priorities and Whose Priorities are they?

The identification of priorities for treatment is a last step of the assessment process, usually as the first case plan is contemplated. “Priority” is defined as “the state of being earlier in time; having precedence in order, rank, etc.” The multiple meanings offered in the dictionary provide a hint of the lack of focused judgment about this issue in CPS. Does the step of setting priorities mean CPS should “rank order” the issues of severity that must change (e.g., family problems most directly associated with maltreatment or threats to safety)? Or does the step of setting priorities imply analyzing the meaning of the issues *for this family*, looking at their perceptions and readiness to change, and considering what must change/improve/develop/stop before something else can or will be affected or ready for change?

The first option likely could be accomplished after the investigation and risk assessment. A fair amount of pressure is, in fact, placed on CPS to do just that. The pressure comes from the court, the community, other providers, and sometimes from the CPS agency. Consider how often the first “necessary” step of treatment (i.e., other treatment issues are placed on hold) is getting the parent to accept responsibility for maltreating the child.

The second option can only be accomplished through the interpersonal process of the assessment for change, combined with critically analyzing what the information means for how change can happen *in this family*.

The literature on assessment and treatment planning often speaks of the setting of priorities, but seemingly with the assumption that priorities are not competing, as they usually are in CPS. Some of the literature focuses more on the order of treatment modalities (e.g., individual therapy, then marital therapy, then family therapy), and mostly in relation to one overall identified issue (e.g., sexual abuse). (Sgroi 1982) In CPS, this direction seems less than helpful when faced with families struggling with multiple issues of loss, addiction, mental illness, violence and basic resources. The ordering of treatment modalities will not be a relevant way to set priorities.

Family behavior is complex and inter-related. It follows that the change process for a family will be correspondingly complex. Setting priorities in treatment must entail applying what is learned in the assessment process by establishing what issue(s) must change first before others can be influenced.

How Priorities are Set

Agencies sometimes encourage a rote sequence of treatment priorities according to:

- ◆ The model of intervention espoused (e.g., structural family therapy).
- ◆ What is expedient (e.g., what services are available).

The first issue is based on the assumption that the agency's model for intervention will be effective in influencing *this family with this problem*, regardless of the individual needs and desires of any particular family. The second issue is far less theoretical and more pragmatic. It suggests overlooking the case data and concentrating more on what program openings exist. If the services are relevant and effective, it is due more to good fortune than to a critical analysis step of the assessment process.

Without careful examination by the worker and supervisor, both these methods can lead to treatment plans that possess amazing similarities across cases, and often with similar outcomes as well.

The likelihood of good outcomes (i.e., the effectiveness of treatment) will significantly depend on the criteria used for setting priorities. The following criteria can be considered, separately or in combination, when determining where to begin in a treatment or change-oriented plan. The more sophisticated the assessment analysis, the more likely treatment can take into account a combination of these criteria. The data from the assessment and the case circumstances should direct the decision.

- ◆ What is the family (usually the parents) wanting/ready to change?

CPS has long struggled with the theory that suggests that change will not happen if the client is unwilling to change. Facing an involuntary population with severe

problems often associated with legal mandates, some CPS staff say using this criterion for setting priorities is unrealistic. However, positive outcomes are often absent when CPS has ignored this issue. Perhaps the key is in considering the role of the worker as that of facilitating the client's movement toward a readiness to change. This does not mean getting the client to admit that maltreatment happened. It means creating opportunities for the parent to consider how the issue has affected their family, providing information to raise their awareness of the problem, etc., in hopes of helping move the client toward a readiness to make a change.

In considering how the assessment is used to inform the decision of where to begin in treatment, it is important to examine whether the agency's assessment structure drives an interpersonal process (between the worker and family) that reveals this information. This goes beyond merely asking the family what they want to work on. This is a genuine interaction that conveys interest, respect, patience, and reflects the importance of reaching an understanding about this crucial issue that predicts likelihood and readiness for change.

◆ Where is there the greatest demand?

There often are several "greatest demands" in CPS cases. This may involve what the mandates are, such as the law or a court order. It may involve safety issues for all family members.

When considering how the agency's assessment process informs the decision of where to begin in treatment, it is worth examining how or if the family data can be used in combination with this criterion. This issue of "demand" is a reality for CPS cases that must be taken into account in treatment planning. It also places CPS in the greatest jeopardy of "disconnecting" from what is learned in assessment and simply beginning treatment with the sequence of what the court has ordered. Does the assessment structure require and assist with a planning effort that combines priorities?

◆ What is a primary issue?

This criterion suggests that family issues are interdependent and some things must change before other things can change.

The question when examining the agency's assessment structure is whether it is sophisticated and reflective of an appreciation for the complexities of behavior and how people change. Does the assessment require complex and critical thinking about what this family will need in order to change?

◆ Where is there ability to negotiate?

Particularly where there is resistance, starting at a point where you can negotiate with the family can help them feel a sense of control and more likely to remain part of the

process (Rooney 1992). It may be mandated that the parent participates in therapy, but the choice of therapists, schedule, etc. can be within the control of the parent.

This criterion relates to the issue of knowing and respecting the desires of the family. Does the agency's assessment drive an interpersonal process (between the worker and the family) that reinforces the probing of where negotiation might be possible? Does the assessment framework have a foundation of assumptions about resistance and its meaning?

- ◆ Where will there be the greatest impact?

Using this criterion may involve looking for the likelihood of success to inspire hope (and enhance the readiness to make further changes). It may involve working on a set of issues that, if changed, will likely have a significant effect on the family, creating the possibility for more changes.

When considering how the agency's assessment process informs the decision of where to begin in treatment, it is crucial to examine if and how this criterion is contemplated. Opportunities for "working smarter" toward the achievement of outcomes should be a routine part of the assessment's analysis steps.

Connecting the Assessment Data to a Logical and Effective Case Plan

CPS staff, struggling with competing workload demands, are vulnerable to thinking errors, a lack of focus or analytical thought, and retreating to a more expedient practice style. Supervision is meant to help reduce these vulnerabilities.

In addition, the use and process of assessment for change should provide guidance. The assessment's conceptual framework, its structure and the interpersonal process it drives should be carefully examined. Do all of these elements support and lead to a step of critical analysis that both identifies the issues for change and reaches logical conclusions about where to start? Does or can the assessment inform the worker and supervisor of the answers to the criteria questions for priority setting?

The starting point of treatment plays a significant role in predicting positive outcomes. The assessment process should guide and help justify this decision making point in treatment planning.

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VII. PROGNOSIS AS AN ASSESSMENT CONSTRUCT DURING CPS ONGOING INTERVENTION

Wayne Holder, MSW

Introduction

CPS agencies have been reluctant to apply the concept of prognosis to their work with families; some CPS professionals don't even like using the term. There generally has been an aversion in CPS to use medical terms like prognosis. Moreover, concern for liability, interaction with attorneys, self-fulfilling failed intervention efforts and a lack of uniform methodology have been mentioned as further reasons to avoid *prognosticating*." However, ASFA's reduced time frames for permanency, coupled with its requirements to discern which families are likely to succeed and those for whom permanency alternatives are suggested, have pushed the concept of prognosis to the CPS forefront. It is time for CPS agencies to reach a consensus on how to define and apply prognosis and then imbed that approach in the larger context of their case plan assessment model.

Definition

A number of terms have been used to describe prognosis (e.g., readiness, likelihood to change, predicting, capacity, barrier to change, likelihood for success and progress). A quick trip to the dictionary shows that prognosis is defined as "a prediction of the probable course of a disease or an individual's chance of recovery." In that sense, CPS staff can think of prognosis as either related to a consideration of likely consequences of maltreatment without intervention or an individual's or family's prospects for adequately addressing whatever problems have brought them to CPS. It is the latter view that seems more useful.

An essential aspect of prognosis is the making of a judgment prior to intervention. It is this foretelling or forecasting that sets prognosis apart from other assessment judgments. Basically it boils down to making a determination that intervention will or will not be successful. This determination considers what CPS staff know about a person or family and what kind and level of intervention will be required.

A classic source (Perlman 1975) refers to the concept of prognosis as "*workability*" which describes the combination of motivation and capacity that enables a person to engage in intervention, along with that person's ability and willingness to work with helpers. Perlman places prognosis in the context of forehandedness, a practical way of thinking about making timely judgments that can forewarn and forearm CPS to intervene accordingly and be prepared to make necessary permanency decisions.

Prognosticating

Prognosticating refers to the act of indicating beforehand a likely outcome. Judging the likelihood that a person will succeed in CPS requires the same veracity that supposedly is accorded decisions associated with screening, risk assessment, safety assessment, investigation and so on. A worker must be attuned to the signs and indicators that influence the prognosis judgment. Because prognosticating is a fluid process, a worker's prognosis of a family may change during the worker's ongoing involvement with that family.

Signs and Indicators

Much has been written about the signs and indicators supporting prognosticating. The signs and indicators for judging the likelihood of a person's success in CPS intervention can be categorized in one of two ways: 1) characteristics of people not amenable to intervention and 2) characteristics of people likely to succeed in intervention.

Characteristics of People Not Amenable to Intervention

David P. H. Jones and his colleagues (1987) described the "untreatable family" as possessing various characteristics that significantly influenced the prospects for change. Notably the factors described are severe, extreme and somewhat the exception when compared to the CPS population at large. However, they serve well to distinguish a part of the service population that can be assessed to be less likely to benefit from CPS intervention. Additional low prognosis characteristics can be added to Jones' work (Holder 1999.)

Following is a listing of characteristics of people not amenable to intervention. Keep in mind that a single indicator is not necessarily a determining factor. Also, the characteristic of not being amenable to intervention does not mean that a person cannot be treated or cannot make significant change. Rather, this characteristic means that due to a specific event or condition, a person can conservatively be judged not amenable to intervention because they have current personal and/or situational barriers.

- Parental history of severe childhood abuse
- Persistent denial of abusive behavior
- Severe personality disorder (sociopath, grossly inadequate personality)
- Mental handicap associated with personality disorder
- Psychotic parents with delusions involving their own children
- Schizoid personality with respect to pervasive detachment
- Antisocial personality with respect to total disregard for others
- Criminally insane
- Persistently addicted to drugs or alcohol
- Persistent violent sexual fantasies (in sexual abuse cases)
- Pedophilia

- Lack of empathic feeling for the child
- Failure to see the child's needs as separate from own
- Child is seen as having sexual needs/desires identical to parent's
- Previous violent acts (increasing in number)
- Degree of sadism or sexual deviancy
- Drug or substance abuse at the time of the event and the present level of dependence on drugs or other substances
- Fractures, burns and scalds
- Long history prior to discovery
- Premeditated torture or infliction of severe pain
- Munchausen by Proxy
- Non accidental poisoning
- Severe failure to thrive
- Vaginal/anal intercourse or sexual sadism

Katz and Robinson (1990) provide a similar scheme for considering poor prognosis families:

Catastrophic Prior Abuse

- Parent has killed or seriously harmed another child through maltreatment and no significant change has occurred in the interim.
- Parent has repeatedly and with premeditation harmed or tortured this child.
- Parent abused child physically or sexually when child was an infant (related to length of treatment).

Dangerous Lifestyle

- Parent's only visible support system and only visible means of financial support is found in illegal drugs, prostitution and street life.
- Parent is addicted to debilitating illegal drugs or to alcohol.
- Pattern of documented domestic violence which lasts one year or longer between spouses who refuse to separate.
- Parent has a recent history of serious criminal activity or imprisonment.
- Mother abused drugs/alcohol during pregnancy, disregarding medical advice.

Significant CPS History

- Parental rights to another child have been terminated following a period of service delivery to the parent and no significant change has occurred in the interim.
- There have been three or more separate CPS interventions for serious incidents, indicating a chronic pattern of abuse and/or severe neglect.
- In addition to emotional trauma, the child has suffered more than one form of abuse or neglect (for example, a child who has been both physically and sexually abused).
- Other children have been placed in foster care or with relatives for over six months or have had repeated placements with CPS intervention.

- This child has been abandoned with friends, relatives, in a hospital or in foster care; or once the child is placed in subsequent care, the parent does not visit of his/her own accord.
- CPS preventative measures have failed to keep the child with the parent (e.g., home-based services; visiting public health nurse; Homebuilders; therapeutic day care, etc.).
- Parent is under the age of 16 with no parenting support systems and placement of the child and parent together has failed due to the parent's behavior.
- Parent is asked by the agency to relinquish the child on more than one occasion following initial intervention.

Inherent Deficits

- Parent is diagnosed with severe mental illness (psychosis, schizophrenia, borderline personality disorder, sociopathy) which has not responded to previously delivered mental health services. Parent's symptoms continue rendering the parent unable to protect and nurture the child.
- Parent has a diagnosis of chronic and debilitating mental illness (psychosis, schizophrenia, borderline personality disorder, sociopathy or other illness that responds slowly or not at all to current treatment modalities.)
- Parent is intellectually impaired, has shown significant self-care deficits and has no support system or relatives able to share parenting responsibility.
- Parent grew up in foster care or group care or in a family of intergenerational abuse.

Hepworth (1993) considers a means by which people can be considered as being amenable to intervention. He refers to the concept *meaning attribution* and describes it as the perception and meaning people ascribe to their problems. The point is that the meaning a person attributes to his or her problem can be a problem in and of itself. Hurvitz (1975) has categorized meaning attributions that pose barriers to successful participation in intervention:

- Pseudoscientific explanations of problems as in, "my horoscope was messed up."
- Psychological labeling of problems as in, "Reed does that because he is psychotic."
- Beliefs that family members lack the capacity or desire to make essential changes.
- Unchangeable external factors as in "my mother has it in for me."
- Misconceptions about innate qualities that cannot be changed as in "it's just the way I am."
- Unrealistic feelings of helplessness.
- Reference to rigid religious or philosophical principles, natural laws or social forces as in, "my children belong to me and I can do with them as I please."
- Assertion based upon presumed laws of human nature as in, "women are dependent on men."
- Allegations about limitations of significant others involved in the problem as in, "my son is stupid and stubborn."

Characteristics of People Likely to Succeed in Intervention

While studying successful CPS cases Holder (1996) identified common qualities apparent among people which were judged to contribute to successful investment in intervention and outcomes. These qualities existed among individuals who were dealing with serious and complex problems. Many of the cases were court involved and included children in placement. The success cases that yielded these factors had been among the most serious while they were being served during ongoing CPS.

- Operating sense of family identity and desire to stay together
- A sense in the family that life can be better or different; a vision of the future
- Sufficient capacity to learn, participate in problem solving, gain some insight
- Motivation to change, a sense of hope
- An openness and capacity to participate in a relationship and the need for one
- An openness to the CPS worker and capacity to trust
- An openness or readiness for change
- A common worker/family acceptance of necessary change; a commonly formed plan
- Family ownership of the case plan to address change

Hepworth (1993) identifies several strengths that are useful in achieving successful intervention that are in the same vein as the qualities listed above:

- Facing problems and seeking help
- Risk by sharing problems with others
- Persevering to keep the family together
- Openness
- Resourcefulness and creativity in surviving and in using resources
- Sacrificing for children
- Seeking knowledge, education and skills
- Expressing loving and caring feelings to family members
- Assertiveness
- Attempting to meet debts and obligations
- Seeking independence
- Seeking to understand others
- Self-awareness and openness to consider other points of view
- Owning responsibility for one's actions and showing interest in change
- self-control
- Ability to make individual judgments
- Ability to function under stress
- Ability to form close relationships
- Flexibility

Motivation

Amenability to intervention can be influenced by motivation. DiClemente (1999) conceives of motivation with respect to change by dividing it between motive and movement. With motive there is evidence of intent to do something (or not do anything) about the issues that have resulted in CPS intervention. A person's motives can be considered in light of:

- what they say;
- what they do;
- how they plan;
- their approach to problem solving;
- the extent to which they direct their intentions at the CPS issues in question;
- their follow through;
- the extent to which they remained focused; and
- how they prioritize.

Motive has to do with a choice to change and behavior that is consistent with that choice. Movement refers to client activity and behavior that provide evidence:

- of trying,
- of participating,
- of following through,
- of being dependable and
- of making progress.

Movement also takes into account the expectation of relapse, which occurs in all change efforts. DiClemente (1999) has suggested that change is more spiral than it is linear. This description captures the notion of movement as clients move forward and upward toward desired objectives.

Timing of the Prognosis Judgment

A critical issue to consider when imbedding a prognosis function into an assessment model is the timing in which prognosis is applied. There appear to be two critical points to judge the likelihood a person or family will benefit from CPS intervention. The timelines for preliminary prognosis and second prognosis judgments are consistent with ASFA permanency planning requirements.

The *preliminary prognosis* occurs at the conclusion of the investigation or initial assessment. Following what typically is a month of involvement with a case, the worker is sufficiently informed to 1) determine if the family requires continuing CPS intervention and 2) address protection and safety issues. The sufficient information gathered and analyzed as a result of this first evaluation reasonably provides a profile of the characteristics of the family's likelihood for success in ongoing CPS. Here preference

is given to facts about the family that are known, not interpreted, that fit with the *Characteristics of People Not Amenable to Treatment* (e.g., kind of injuries, facts about history, facts about mental disorders, conclusions about behavior and functioning and so on).

The purpose of the preliminary prognosis is to establish a record for future reference concerning the facts that are known about a person or family that are indicative of poorer prospects for success. This record serves as a benchmark for reflecting on as the case proceeds forward. In this sense the preliminary prognosis becomes the foundation for the two-step approach that concludes in a decision and justification supporting permanency judgments.

The preliminary prognosis can be made by the investigator or initial assessment worker and passed along to ongoing CPS with other required documentation. The ongoing worker could also complete the preliminary prognosis when preparing for ongoing intervention. The prognosis would be based on the documents provided by the investigator or the initial assessment worker.

During the preliminary prognosis process, workers should not use signs of low amenability as a reason to intervene differently with families than if the family were high prognosis. Every family should get all that CPS has to offer. The exception with respect to intervention occurs in one discretionary area – concurrent planning. The preliminary prognosis can provide a basis for determining the need to initiate concurrent planning when children are in placement as the case transitions from investigation/initial assessment to ongoing CPS.

The *second prognosis* occurs after some time in active ongoing CPS has elapsed and time has been invested in completing an assessment to establish a case plan. It is here that one sees assessment and prognosis coming together. The assessment objective is to judge what intervention is needed and the client's potential for successfully completing treatment. Workers need to understand the person or family beyond what can be ascertained at the completion of the first intervention phase. Until such time as the client is confronted with ongoing services and the expectation for change, certain characteristics may not be obvious or demonstrated. Therefore this second appraisal applies the *Characteristics of People Likely to Succeed in Intervention* which can be included as a component in the case-based assessment.

A critical aspect of this step of the prognosis process is sufficient level of CPS effort. Success in CPS intervention results from combined responses by CPS and the person or family. Whereas the preliminary prognosis took into account known facts about a person or family, the second prognosis point should address the quality, nature and adequacy of CPS effort available to that person or family. When arriving at the second prognosis, an agency must identify a standard for CPS intervention. The standard should include: 1) the length of time required before the second prognosis occurs; 2) the amount of face-to-face contact with the person or family required for CPS or a designated service provider; and 3) the quality and nature of the contact required. Consistent with generally accepted case

review standards and with ASFA time lines, this second prognosis likely should occur at the first case evaluation following the initiation of ongoing CPS services (i.e., often at 90 days).

In summary, the second prognosis:

- a) takes into account the benchmark set at the preliminary prognosis;
- b) considers the person/family response to CPS intervention in view of a criteria for likelihood for success;
- c) factors in the nature and level of CPS intervention;
- d) evaluated progress;
- e) reviews the child-parent relationship; and
- f) assesses the child's adjustment (if in placement).

This second prognosis need not result in a final judgment. It can represent an analysis that may re-occur and be built on as the case continues. Alternatively, the prognosis could very well be the justification to permanently separate a child from his or her family. So, there can be a dynamic quality to prognosticating that factors in a growing body of knowledge about a person or family toward a later final judgment. Additionally, this process of prognosticating occurs within the context of a relevant, assertive and full regimen of services.

Summary

Prognosis as applied in CPS is not hard science. It is subjective and can be influenced by many things. It is important to keep in mind that a prognosis is not meant to prove anything or to draw hard and fast decisions based on a prediction. The information that helps to evaluate the potential a person has to succeed in treatment is indicative and must be accepted as that which 1) sensitizes CPS awareness concerning possible barriers to successful change and family preservation, 2) influences ongoing intervention and 3) establishes a foundation for eventual decisions about permanency.

Characteristics of poor or good prognosis are not definitive and so CPS staff must be open to variations and exceptions. Just as it is important to acknowledge that three or more CPS interventions for serious separate incidents indicate a chronic pattern of abuse and severe neglect, it is just as critical to remain open to the possibility that the current CPS intervention may yield different results. The pattern might cease. The family or person might change. Prognosis criteria are not to be applied in a concrete or fatalistic manner. CPS staff have a duty to provide quality services regardless of the level of prognosis.

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VIII. THE ROLE OF THE CHILD PROTECTIVE SERVICES CASEWORKER: AGENTS OF CHANGE

Todd Holder, MSW

Introduction

Confusion about the assessment process and lack of clarity about the purposes of assessments leave many CPS caseworkers without the guidance they need to work with families effectively. Caseworkers are told to “assess the family” as though that phrase clearly communicated what decisions are to be made regarding the family and what information is to be considered when making these decisions (Morton 1999).

The two primary purposes for child protective services intervention are: 1) to protect or control the safety of children and 2) to change or to alter the conditions which result in children being unsafe and at risk of maltreatment (Holder and Corey 1995). With the passage of the Adoption and Safe Families Act (ASFA) in 1997, child safety has become the paramount concern in CPS (NRCCM 1999). As a result of ASFA, states have been moving swiftly to comply with the child permanency and safety requirements outlined in the federal legislation.

Although the emphasis placed on safety decision making and safety intervention is justifiable, it has unfortunately further compounded the lack of attention given to CPS responsibilities for helping to change problematic family conditions. The lack of attention paid to CPS treatment interventions is not a byproduct of ASFA. Certainly prior to ASFA, relatively little information was explicitly articulated to CPS staff regarding their role in facilitating change in families who are abusive and neglectful. If a goal of CPS is improving the quality of people’s lives, successful outcomes cannot be measured exclusively by assuring child safety. It is necessary to move beyond child protection to consider the role CPS has for fostering change. While this chapter will not deal with specific treatment strategies for families who are abusive, it will highlight the responsibilities of CPS caseworkers in affecting the conditions that result in children being unsafe. It will also consider specific caseworker characteristics that are associated with being an effective helper or agent of change.

Defining Change Within the Context of Caseworker Responsibilities

If in theory, if not design, CPS is fundamentally a *change-oriented* intervention, then a critical first step is to define change within this context. Doing so helps to articulate the scope of responsibility that CPS caseworkers have for facilitating change. On a rudimentary level Webster’s Dictionary defines change as “put in place of something else; substitute for, replace with” or “to cause to become different; alter; transform.” These two definitions represent the variation in degree of change that occurs as a result of safety intervention versus treatment intervention. Consistent with the first definition, CPS

puts safety interventions in place to “substitute” for a family’s lack of protective capacities. Although this represents a change in the family, the family system itself has not changed. The environment has changed and is being externally reinforced through the use of safety interventions. However, in the absence of CPS, risk of maltreatment still exists. This degree or type of change has been referred to as *first order change* (Watzlawick, Weakland and Fisch 1974).

For individuals and families to alter behavior or move to a different state of being requires CPS caseworkers to generate dynamic interactions and situations to achieve a higher degree of change. This type of change is referred to as *second order change*, and if achieved, it has an internalized rehabilitative quality that can move families from potentiality to actuality (Watzlawick, Weakland and Fisch 1974).

Although CPS safety interventions create a ripple effect that changes, controls or at least relieves an unsafe family environment, this type of change is more circumstantial and less contingent on the characteristics and nature of the individual CPS caseworker. Treatment interventions, coupled with a CPS caseworker’s creative use of self, promote movement from change in the interim to change that is transforming. This chapter, therefore, will focus on how CPS workers can influence second order change.

How Caseworkers Can Influence Change

When evaluating intervention success, it is critical that CPS caseworkers consider what responsibilities they have for encouraging change. Indeed parents ultimately have the choice and burden to change but CPS caseworkers have an obligation to align themselves with families during their struggle to move from abusive to protective, from ineffective to effective and from hopeless to hopeful. The responsibilities of the CPS caseworker that are being alluded to do not involve specific tasks, are not related to the timely completion of family assessments and case plans, and are often not found in policy or job descriptions. To critically analyze job performance as it relates to intervention effectiveness, it is necessary to think outside the box with respect to caseworker responsibility.

This calls for a more speculative view of how CPS staff perceive their purpose. It is the perception of purpose and function that dictates the extent of accepted responsibility. Therefore, it is essential to reaffirm the purposes of CPS as being two-fold. The primary mandate of CPS is the protection of children. The second mandate, but perhaps no less important, is the charge of CPS to help parents and families change. Whether or not a CPS caseworker provides direct or indirect services, case management or psychotherapy, is not as important as the caseworker’s mind set. Do CPS staff view themselves as therapeutic agents or agents of change? Do they view the promotion of human growth and the betterment of family lives as a primary purpose (Ragan, Salus, and Schultze 1980)? If the answer is “yes” as it should be, then there is a price to be paid which encompasses added responsibility.

The success of treatment intervention is often subject to an individual state of self-awareness. On the surface it may seem as though this is a reference to client self-awareness as an antecedent to change. However, self-awareness as it is applied here, refers to the self-awareness of the CPS practitioner. As active participants and collaborators in the change process, CPS caseworkers have a responsibility to look at themselves critically and examine their use of self in facilitating change. The utilization of self is the greatest commodity available to CPS practitioners when establishing an effective caseworker-client relationship. If being an effective helper has as much to do with the character of an individual, then self-reflection and awareness are imperative.

There is a responsibility on the part of the CPS caseworker to examine his or her values, beliefs and attitudes. It is naive to believe that an individual's thoughts and opinions do not predispose behavior. Being aware of one's strengths, deficits, frustrations, preconceptions, cultural biases, etc., helps to foster self-control and discipline when interacting with clients. For line staff this can be particularly difficult because the nature of CPS tends to provoke strong feelings and opinions. However, it is important to routinely consider that while a CPS caseworker is evaluating a family, they are also being evaluated. The ability to maintain professionalism, even in the face of resistance, hostility, and feelings of frustration or perhaps even condemnation can help to break down barriers to change by supporting mutual acceptance (Ragan, Salus and Schultze 1980). Maintaining a professional approach with families has a lot to do with how a CPS caseworker feels about their use of authority. Being uncomfortable with authority, or role insecurity, can result in a loss of objectivity and potentially lead to conflicts with clients that involve overreaction (Filip, McDaniel and Schene 1992). A CPS caseworker who feels confident in their role as a professional helper and comfortable with their use of authority is more likely to share control with families. This not only empowers parents but reinforces a working partnership that is essential to change.

The Importance of Establishing Effective Relationships

CPS caseworkers have the responsibility to attempt to form relationships with their clients in which a collaborative interaction can serve as the context for change. To literally appreciate what this responsibility demands requires a conscientious consideration of the meaning of the word relationship. Relationships by nature have a strong emotional component (DePanfilis and Salus 1992). It is a state of being connected in thought, meaning and understanding. Developing effective relationships requires a commitment of time and energy. It calls for getting to understand the world view of the family, while at the same time taking a risk at letting the family know you. For the CPS caseworker the relationship is the essential catalyst for change (DePanfilis and Salus 1992). It is therefore necessary for the CPS caseworker to devote themselves to engaging the family. Unlike contracted mental health professionals, the CPS caseworker must reveal more and risk more in an attempt to join with the family in an almost quasi-membership role (Ragan, Salus and Schultze 1980). To some, this level of investment may seem extreme, particularly given the concern regarding counter-transference, subjectivity and encouragement of dependency. However, in CPS cases there is much at stake - not only the safety and permanency of children but also the potential of improving

peoples' lives. People change through the development of relationships in which emotional needs are more adequately met so defenses accordingly need not be so rigid and constraining (Brill 1978).

An effective working relationship is not likely to develop in the absence of frequent and consistent caseworker-client interaction. However, simply maintaining contact with families may not be adequate for building relationships. It is the CPS caseworker's behavior and skill during the interaction that contributes to the status of the relationship (Shulman 1978). A four year study conducted in the mid 1970's, investigating social work skills and their effects on building positive caseworker-client relationships, found that "being personal" in a professional capacity was advantageous to developing working relationships (Shulman 1978). Based on client-focused questionnaires, the highest correlation with respect to building relationships had to do the caseworker's willingness to share personal thoughts and feelings which enabled the client to get to know the caseworker better as a person. Other skills and behaviors that contributed to the development of a working relationship included understanding client's feelings, clear delineation of roles, open exchange of feelings and general acceptance of feelings, ability to put client's feelings into words, providing information and partializing concerns (Shulman 1978). In many cases it is an unfortunate reality that a CPS caseworker's attempts at forming effective relationships with clients are frustrated.

Resistance

Given the involuntary population that CPS frequently serves, it is common place for caseworkers to meet with resistance. Although resistance tends to make it difficult to access clients emotionally and in some situations physically, it imperative to resist the natural inclination to dismiss the resistance as a character deficiency and become detached from involvement with the client. It is a fundamental responsibility of CPS caseworkers to address client resistance - not just during isolated interactions with a client but actively planning and strategizing about how to deal with resistance. The obligation to attempt to break down resistance so that clients have an opportunity for change cannot be emphasized enough. Services can be offered, appointments can be made, court orders can be issued but treatment will not be effective if clients are resistant and do not or cannot see the need to change. In keeping with a basic premise of family centered practice, when approaching a client who is resistant, it is essential to begin the intervention where the client is. Eliminating the resistance needs to be the dominant focus of intervention. Like putting the cart before the horse, people will not change if they are not ready. Resistance is a common phase in the process of changing the human condition and it must be embraced as such. If nothing else is accomplished during intervention, it is the CPS caseworker's responsibility to attempt do all that is possible to get people to a place where they are adequately prepared to change. For many clients this will never occur but for some, the patience and commitment of the CPS caseworker, coupled with a trust in the process, could be the difference.

The Helpful Relationship

CPS caseworkers have the responsibility to be helpful. Although this seems obvious, there is more to consider with respect to being helpful than might be expected. The issue of whether or not CPS is helpful is a question that perhaps calls for greater introspection within the field. To some degree this question is different than whether or not CPS is effective at keeping children safe, or whether there is a reduction in foster care placements or caseloads. The spirit of the question goes back to the issue of how CPS caseworkers perceive their purpose. Do they view themselves as fundamentally agents of change or people processors? As essayist and philosopher Ortega y Gasset puts it, "Tell me to what you pay attention and I will tell you who you are." (Waters and Lawrence 1993)

To be helpful, it is necessary to first want to be helpful. Then it is necessary that families experience CPS intervention as being helpful. With that said, there are certain beliefs that are instrumental to being an effective helper:

- ◆ The belief that people have the capacity to deal with their problems and under the right circumstances can develop their own solutions.
- ◆ That people generally have good intentions.
- ◆ That people have worth and therefore their dignity and respect must be maintained.
- ◆ Behavior can dependably be related to meaningful principles of human behavior.
- ◆ The belief that interaction with clients produces personal growth and satisfaction.
- ◆ The belief in commonality between caseworkers and clients which results in mutual identification of experiences.
- ◆ The trust one has in one's own capabilities and the ability to depend on their own perceptions and abilities.
- ◆ A caseworker's belief that they are likable and worthwhile.
- ◆ The perception that helping clients is an opportunity to facilitate the release of his/her own abilities to deal with problems.
- ◆ The ability to view problems in a broad perspective and the awareness for the implications of events.
- ◆ A willingness to commit to the helping process and assist clients in discovering their own solutions.
- ◆ The belief that altruism is an important personal value.
- ◆ A focus on people rather than on events, objects, rules, regulation, etc. (Combs, Avila, and Parkey 1971).

Rarely does help occur as a result of happenstance. Caseworker-client interactions are the predominant context in which helping occurs and therefore every interaction should be purposeful (Rycus and Hughes 1998). From the standpoint of accountability, not only to the family but also professionally, there is a responsibility to make each contact with a family as therapeutic as possible (Ragan, Salus and Schultze 1980). This means taking

the initiative to create an environment that is conducive to facilitating change (Rycus and Hughes 1998). It is important to create an environment where families feel less threatened and are included in the decision making process (Holder and Corey 1986; DePanfilis and Salus 1992; Filip, McDaniel and Schene 1992). To be helpful it is important that CPS caseworkers remain proactively involved with families. The CPS caseworker who is proactive has a practical proclivity to look ahead. They are supporting and realistic in their interactions with families. They seek to advocate for the needs of the family and continually energize the family to remain engaged in their service provision. Perhaps most importantly, the proactive CPS caseworker anticipates and plans for relapse in problematic behavior. Anticipating problems reduces a crisis oriented caseworker-client interaction. Subsequently, this will result in a working environment that is more conducive to planned change.

Conclusion

Child maltreatment is a family dynamic involving the interaction of at least two family members. Child maltreatment stems from the interplay of contributing factors like substance abuse or domestic violence with other significant family characteristics, including the family's social environment and underlying conditions such as members' own needs, perceptions, values, beliefs, and life experiences. Assessment must necessarily include these underlying conditions along with the social environment. While caseworkers may be able to deal with contributing factors through referral to specialized services, the underlying conditions and social environmental factors will usually fall to the caseworker for change interventions. Caseworkers are not service dispatchers. (Morton 1999). Rather, they are agents of change who can help promote positive outcomes for children and families. Embracing the responsibilities inherent in building helpful relationships demonstrates an energy and fervor for helping to make peoples' lives better.

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IX. KINDS OF CASE PLAN ASSESSMENTS AND THEIR RELEVANCE TO CPS CASE PLANNING

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Introduction

Child protection agencies report many forms of assessment are applied during CPS intervention. Often, neither the purpose nor the application of assessment methods is clear. In fact, the same assessment approach may be used for more than one function. Lack of a clear purpose concerning how and when to use a specific assessment approach is most confusing when assessments are used to establish case plans.

Recent national surveys found inconsistency and disparity related to the extent to which assessments influence case plans. (NRCCM 1998 and 1999) Half of the respondents from one survey indicated that assessments were not used as the basis for a case plan while such things as provider availability or what a court required were. Assessment application variance among states and agencies is apparent with policies, instrumentation and type of approach or method.

The term *assessment* is used loosely within the CPS field. Day (1998) has indicated that “the meaning of assessment has remained somewhat elusive” and has been confused by the risk assessment influence and a community-oriented programmatic reform alternative to CPS (e.g., community-based assessments, bifurcated intervention models, family assessment, needs assessment). Despite this apparent lack of precision by planners and practitioners, definitions provided within the CPS and social work literature seem to: 1) distinguish assessment from other forms of study associated with intervention (e.g., investigation) and 2) indicate an association with case plans.

Common ingredients appear in virtually any definition of assessment that one encounters. (Day 1998; Morton 1998; Hepworth and Larsen 1986; Sheafor, Horejsi and Horejsi 1988; Berg 1994; Holder 1994; Rooney 1992; Ivey, Ivey and Simek-Downing 1987; Perlman 1957) These shared features include:

- ◆ Information gathering, analysis and synthesis.
- ◆ The purpose of making decisions related to the need to change.
- ◆ A component of professional accountability.
- ◆ The process of interpreting or giving meaning and conceptual order to data.
- ◆ A conjoint effort between a worker and client (family).

- ◆ An understanding seeking process.
- ◆ A comprehensive process and formulation that encompasses a client's problems as well as functioning of clients and significant others, motivation of clients to work out problems, nature of the family network, relevant environmental factors and resources that are available or are needed in order to achieve change.
- ◆ Inform a case plan or change strategy.

Gambrill points out that an assessment “should offer guidelines for selecting plans. It should help discover leverage points for attaining valued outcomes. It should indicate 1) those objectives that must be reached to resolve the problem; 2) what must be done to achieve them; 3) how the objectives can be pursued most effectively; and 4) the probability of attaining them, given current resources and options.” (Gambrill 1997)

Definitions of assessment from literature have not been incorporated into the CPS field. This is a problem common to many CPS terms and concepts. For instance, only recently have states begun to define the terms and concepts *safe* and *unsafe*. It would be helpful for CPS practitioners and program designers if a definition for assessment were specified according to the purpose it serves – case planning. Additionally, it would be helpful for all other studies or evaluations occurring during CPS to be given their own labels, definitions and purposes. This specificity would be helpful because many practitioners now use the term assessment interchangeably for virtually any study that is completed at any point across the CPS process. The only apparent distinction that is sometimes made is between assessment and investigation.

Concerning assessment, what can be concluded with respect to the current (applied) state of the art? Assessment as the basis for case plans is not a well-developed or consistently applied intervention construct across CPS agencies.

Kinds of Assessment Models

Following is a description of several assessment models. Given the rather loose conceptualization of assessment in CPS, one might expect that the models described vary among agencies and in application. It is reasonable to expect that some agencies may employ an assessment that uses or adapts the concepts, principles and assumptions of more than one model.

Problem Identification Plan

This popular approach for forming case plans involves an identification of the predominant problems apparent in a family. Services related to the problem type are then selected and constitute the major component of the plan. Goals or objectives may also be included as part of the plan and may meet established goal-setting criteria (e.g.,

mutuality, behavioral, specificity, etc.). The simplest way to describe this model is through example:

An investigation worker identifies that the child maltreatment is influenced by the parents' substance abuse (problem). The investigator or an ongoing worker establishes a case plan that includes substance abuse detoxification and substance abuse counseling.

This example demonstrates that the “case problem(s)” is identified during the initial intervention with the family and is categorized in symptomatic ways (e.g., parents maltreat, parents abuse substances, parents are violent, children are provocative, parents are limited, etc.).

This approach to establishing a basis for the case plan seems logical. It is straightforward and easy to understand. However, it is rather elementary and lacks serious appreciation for the complexities of human functioning. Typically, investigation procedures and risk assessment are the methods that identify problems and therefore serve as the basis for case plans. The case plan is primarily arrived at by assigning a service that logically fits the category of the problem.

The use of this model in CPS remains essentially unsophisticated. However, there is some support for a problem-service model that has been successful (perhaps in more clinically oriented settings). Hepworth (1993) discusses “matching interventions to problems.” The assertion is that empirical support exists with respect to certain kinds of interventions and with respect to their success when applied to certain problems. For instance, Hepworth points out that cognitive therapy works well with depressed people and certain behavioral skills training have proven effective with people whose problems derive from deficiencies in basic interpersonal and problem solving skills. Similarly he points out that one can “match interventions with developmental phases.” Here he refers to such things as play therapy for children lacking capacity to abstract and family therapy for parent-child problems. The most prevalent form of this type of matching in CPS might be parent education for parents who maltreat their children. Hepworth concludes by identifying “matching interventions with stressful situations.” Here he recommends crisis intervention and task-centered casework.

Family Assessment Plan

Within the past decade family-based services and intensive family intervention influences have gained support in some CPS agencies. The results are varied. The issues identified earlier with clarifying assessment approaches and applications are more pronounced here (e.g., need for definitions, unclear application, mixing of concepts and ideas, etc.). It seems that the philosophy or idea of family-based services has received wide acceptance while the translation into practical and organized application remains incomplete. There are common features associated with this model, at least in principle:

- ◆ Family-centered
- ◆ Strengths-based
- ◆ Family collaboration

The family assessment plan model is expressed in many ways: strengths-based assessment, needs assessment, and family assessment. Assessments are conducted conjointly with the family to identify strengths that can be deployed to address problem behavior that needs to change. Often the model includes the use of information-collecting tools (e.g., genograms, ecomaps), however, seldom is it clear exactly how the tools and the information they provide translates into assessed data leading to a case plan, or whether, in fact, that is their purpose.

There is an overarching belief that supports this model – families know what they need. With respect to this belief, the family assessment serves as a road map for the family. While family members may have some sense of where they want to go, they may lack clarity about how to get there. The family assessment assists in identifying the direction and the steps for how to get there. Accompanying this point of view is the commitment to collaborate with caregivers in seeking to identify and understand what must change and laying out a change strategy.

This approach to assessment is generally quite broad. Practitioners are directed to consider all family members and all aspects of family life: individual, interpersonal, systemic, demographic, environmental, etc. For example, one family assessment contains 39 family functioning factors, 20 caregiver history and characteristic factors, 20 child behaviors, seven child health issues and four child temperament factors. (McCroskey 1997)

The family assessment model embraces the concept of understanding and using strengths. It has been mentioned that the specific practice associated with assessing and applying strengths in case plans needs development and clarification. Although not offering a specific method, Hepworth (1993) has identified strengths that should be considered in a strength-oriented assessment. These include:

- ◆ Facing problems and seeking help
- ◆ Risking by sharing problems with others
- ◆ Persevering to keep the family together
- ◆ Openness
- ◆ Resourcefulness and creativity in surviving and using resources
- ◆ Sacrificing for children
- ◆ Seeking knowledge, education and skills
- ◆ Expressing loving and caring feelings to family members
- ◆ Assertiveness
- ◆ Attempting to meet debts and obligations
- ◆ Seeking independence

- ◆ Seeking to understand others
- ◆ Self-awareness and openness to consider other points of view
- ◆ Owning responsibility for one's actions and showing interest in change
- ◆ Self-control
- ◆ Able to make individual judgments
- ◆ Able to function under stress
- ◆ Able to form close relationships
- ◆ Flexible

One can readily find listings of important strengths to take into account. However, these strengths typically are not embodied in an assessment scheme. Such lists of critical strengths are not accompanied by a delineation of the ways and means that a practitioner might 1) identify and assess each strength and 2) understand how strengths can be integrated into a case plan or change strategy.

Another concept that is often associated with this model is family systems theory. This is suggested by the emphasis on family-centered CPS. The assessment is directed at the family as a whole (presumably), its parts (e.g., family/household members) and the relationship and interaction among its parts. Certainly the comprehensive information commonly observed in this model suggests a consideration of the family system. However, in practice, tools and process do not appear to keep a focus on system theory concepts in any strict assessment way (e.g., mutuality, interdependence, roles, proximity, etc.). (Brown and Brown 1977)

Cause Related Assessment Plan

This model operates on the concept of cause and effect. Maltreatment is viewed as a symptom or effect of deeper issues that may be traumatic, unresolved and driving forces that explain emotion, behavior, motive, intent, etc. This concept relies on accurately identifying and understanding the cause of a problem that when treated will result in eradication of the effect. This type of approach finds its roots in early social work literature. (Perlman 1957 and others) Early child welfare practices are well-grounded in the concept of social studies and social histories taken for the purpose of tracing development and seeking causally related experiences and events. The power of the medical model, which asserts that knowledge of causation directs the clinician to the correct intervention, undoubtedly affected those social work influences. Early use of cause related assessments positioned the worker as an outside-the-family objective observer who gathered information, conversed with the family and then arrived at a conclusion about cause. Case plans then were designed for the family directed at the cause of their problems. Due to an interest in the field to see more collaborative intervention, the behavior of the practitioner in current cause related assessments is more interactive with family members and relies more on a common agreement as to what explains problems, the source, the origin, the cause.

A problem with this etiological approach to assessment in CPS is that the clarity of causes apparent in the medical and perhaps other fields is not so well developed with

respect to child maltreatment. The literature is replete with individual, family and ecological factors that can be co-associated with child maltreatment. However, nothing exists that draws exact and definitive links between child maltreatment and its cause. Therefore, a cause related assessment must be accepted as subjective. This poses no serious problem, however, because these assessments are viewed as breathing, living things. They are described as dynamic in the sense that conclusions about cause are adjustable over time given different information and insight.

The cause related assessment may take two forms: comprehensive or focused. The comprehensive approach, like the family assessment and needs assessment, considers a wide range of data about the individuals and family being studied. Here the practitioner prospects for causal explanations by examining the nature and functioning of the family through looking at all aspects of the family situation (e.g., current individual and family functioning, history, family and social relationships, social support, etc.).

The focused approach is guided by whatever problems were identified during the initial assessment or investigation. Those issues provide a specific direction for the practitioner to proceed. Rather than considering a wide range of issues, the assessment begins with a problem and seeks to trace it to its cause. A variation of the focused approach could include beginning with a set of variables judged to be causes of maltreatment. Evaluating the extent and quality of the existence of these causal variables would presumably constitute the focus of the assessment. The problem with this approach, as mentioned earlier, is that the state of the art has not arrived at a place of designating specific causal relationships.

Cause related assessments rely on cognitive and insight capacity on the part of the participating family or family member. This is particularly so if the family member is to contribute to the process and make the full connection between problem – cause – resulting case plan. Additionally, it seems likely that a certain level of client motivation and commitment to participate is required, given the abstract nature of seeking and interpreting cause. It has also been questioned whether, in fact, most people desire a deeper self-understanding in order to solve their problems, and/or whether such an understanding is necessary. (Epstein 1977)

Conducting this sort of an assessment in the context of an acceptable worker-family relationship is essential given the need to probe into what may be very sensitive, painful areas. Some have suggested that a cause related assessment requires considerable face-to-face time in order to establish sufficient trust that allows for full revelation by clients. This may be one reason that proponents emphasize the need for continuing review and updating.

It is not entirely clear how one makes the leap from problem to identified cause to established case plan other than through subjective means. No one can make a definitive case as to what precisely causes a parent to leave a child unattended or without basic care or to subject a child to violence. Therefore, the judgment about cause is left to the expertise, interpersonal skills, biases, ideology, deductive reasoning, etc. of the

practitioner. In other words, this is an assessment approach that relies heavily on the worker's clinical and analytical skills along with a full and applicable fund of knowledge (about all potential causal influences).

Needs Assessment Plan

Some states such as Alabama, South Dakota and Michigan have implemented what they refer to as a needs assessment that is used as the basis for the case plan. This approach possesses some of the features of other assessment models. The needs assessment is for the most part a simple model like the problem assessment plan model. The needs assessment is limited in analysis. Essentially it seeks from the family what it needs and bases the case plan on the family's response. The needs assessment model attempts to consider needs associated with all aspects of family life. Its comprehensive scope is similar to the family assessment plan model. In some needs assessment models, practitioners are challenged to identify underlying need. When this is expected the needs assessment plan model is similar to the cause related assessment plan model.

A needs assessment is usually organized around what are considered domains of need. These domains include such things as health, emotional, physical, housing, financial, parenting, employment, family functioning, and so on. Typically, a domain is comprised of more detailed areas of need. For instance, the housing domain may be made up of needs associated with new or alternative housing, larger housing, housing repair or renovation, healthier housing, adequate furnishings, home management, etc. The determination of need may occur through worker inquiry and the use of something that resembles a detailed questionnaire. Alternatively, the needs assessment may be the result of a collaborative process between the worker and family in which various needs are discussed and some means of prioritization is applied. It may not always be clear how needs assessments relate to: 1) previous evaluations (e.g., investigations or risk assessments); 2) identified problems which cause CPS to be involved with the family; 3) safety threats of harm; or 4) creation of a case plan.

An area that remains somewhat confused in applying needs assessments is exactly what "need" means. Needs assessment models often are sparse with definitions and appear to operate under the assumption that the meaning of need is a given that all will understand. Hepworth (1993) says, "human needs include the universal necessities (adequate nutrition, clothing, housing and health care)." Such a definition seems to reduce the scope of what must be considered if applied in a CPS related needs assessment. The business of defining need seems more complicated than what is supporting current models. The implications of failing to define and distinguish between immediate, emergency, basic, lower order, higher order, developmental or underlying needs are not fully understood. It can be assumed that a lack of clarity respective to the most essential concept driving this model is likely to lead to inconsistencies in its understanding and application.

This issue of what constitutes need (in terms of meaning) is further compounded as one considers who makes the designation and how it is reached. If a family is asked what it needs, the judgment will be predicated on how the family understands need and may have

little to do with the reason CPS is involved with the family. Hepworth (1993) says that “the problem identified by clients typically involves a deficiency of something needed (e.g., health care) or an excess in something not desired (e.g., fear).” However, the difficulty in CPS is that many, if not most, clients do not acknowledge that they have problems and therefore do not fit this premise. If a worker gives direction to identifying needs related to CPS issues, the family members may not understand or agree that problems identified by the worker have anything to do with what they need. This may suggest that a critical task in conducting a needs assessment is bringing the client around to acknowledging problems and relating them to need deficiency or reduction of undesirable influences in their lives.

Realities that Challenge Agencies

The business of selecting and implementing a successful basis for establishing case plans reasonably should take into account the realities that exist within CPS. Does it make sense to use an assessment or other process for creating case plans that are ideal concepts but are unlikely to work because of constraints and limitations that exist within the intervention context?

Before offering criteria that can be applied in judging the suitability of any particular approach to intervention, assessment or the case planning process, it may be useful to state some of the realities that agencies face.

Nationally, the CPS work force - those responsible for implementing assessments or the case planning process - has not changed much during the past 20 years. (Hornsby 1988) It is generally accepted that a large proportion of CPS staff can be described as follows:

- ◆ recent college graduates
- ◆ young
- ◆ lacking in life and job experiences
- ◆ possessing minimal professional education/preparation
- ◆ receiving limited pre-service preparation and training
- ◆ under-trained
- ◆ poorly paid
- ◆ under-supervised
- ◆ often work in undesirable physical settings
- ◆ not career oriented (i.e., to remain in CPS)

Like the limitations among the CPS workforce, demands and constraints within child welfare organizations are also well known. While caseloads continue to rise, agency funding and resources have remained static through the years. Additionally service availability within communities often is insufficient. Recruiting, hiring, training and retaining staff are incessant issues among CPS agencies. Agencies are faced with routine expectations that create serious burdens such as advancing quality practice, installing new initiatives, complying with state and federal regulations, applying the latest state of the

art and accommodating community demands and desires. However, little occurs to enhance organizations' capacity to respond to these expectations.

Beyond the realities present within the workforce and agency settings, there are other issues that have a bearing on how one might think about the best approach (e.g., an assessment model) to establish case plans. The following questions could be translated into criteria to be applied to that judgment:

1. What level of knowledge is needed by the person using the model?
2. What ability and skill are required of the person using the model?
3. Are there certain preferred or required *personal* characteristics needed by the person using a particular model?
4. Will the model work well with an involuntary population?
5. Will the model work with an adversarial population?
6. Are there certain *personal* characteristics among clients that might indicate the success or failure of a particular model, e.g., clients' cognitive, emotional capacity?
7. Given the agency's workload, is there sufficient time and opportunity to apply the model correctly?
8. Can the model be applied within required time lines associated with law or policy?
9. Is a certain caseload size necessary to apply the model effectively?
10. Are there competing influences or demands on staff that detract from the application of the model?
11. Is the model conceptually sound, clear, cohesive, flexible?
12. Does the model fit the agency's philosophy and beliefs about its CPS strategy?
13. Does the model effectively inform and lead to acceptable and sufficient case plans?
14. How much does the model add to overall required effort (e.g., information collecting, client interaction, analysis, documentation, etc.)?
15. How difficult is the model to learn and to apply?

Conclusions: Relevance of Assessment Methods to CPS

A conclusion about the best or right assessment method that an agency should apply is not possible in this article. This is a task that each agency must consider for itself. That judgment must take into account the CPS strategy the agency desires and the capacity the agency has to apply any particular assessment approach. The agency's mission and goals (both expressed and less obvious) can be better served if the agency can influence or control the assessment process. Where gaps exist in any model's framework, it is realistic to assume it will be supplemented by the CPS staff's own ideology, values, and training. As pointed out in the discussion of the realities faced by CPS, these staff "interpretations" of the model used may be inadequate, misguided, and/or inconsistent with the agency's mission.

All of the models discussed in this article presumably have some value, depending on one's perspective. While the problem plan assessment model seems the weakest of those considered, the others appear to be potentially useful methods on which to base a case plan (again, depending on one's conceptual persuasion). Also, as one explores the realities CPS agencies face, shortcomings can be found in all the models. It should be noted that each of the models reviewed could be strengthened with respect to definition, clarity, structure, connection to case planning and application of essential concepts (e.g., strengths, needs, cause, etc.).

"Relevance" with respect to assessment models then can be reduced to five critical thinking questions:

1. Is the assessment model compatible with our strategy for CPS?
2. Does the assessment model support our beliefs about CPS intervention and interaction with the client population?
3. Does the assessment model lead to establishing a case plan in accordance with our beliefs and strategy for CPS?
4. Can our staff effectively implement the assessment model?
5. Can the assessment model be implemented within the realities that we face in CPS?

If an agency or model designers can positively answer each of these questions, then it can be assumed that the model being considered is a relevant choice for the agency.

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