Strengthening Families Alaska

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Learning OCS process:

Early Learning Program
700 Katlian St. Suite B
Sitka, AK
99835

Protective Factors Survey

Name of person completing the survey:_____
Date: _____

Completing this survey is completely optional.

This survey will help us better understand the needs of the families we serve. We want to provide the best services that we can to all of our parents and families. All of the information that you share with us will be confidential.

Part I. *Please circle the number that best describes how often the statements are true for you and your family.*

Family Functioning/Resiliency	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Always**	**N/A**
1. In my family, we talk about problems.	1	2	3	4	5	[X]
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	[X]
3. In my family, we take time to listen to each other.	1	2	3	4	5	[X]
4. My family pulls together when things are stressful.	1	2	3	4	5	[X]
5. My family is able to solve our problems.	1	2	3	4	5	[X]

Part II. *Please circle the number that best describes how much you agree or disagree with the statement.*

Social Emotional Support	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**N/A**
1. I have supportive extended family members in town.	1	2	3	4	5	[X]
2. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	[X]
3. When I am lonely there are several people I can call or visit.	1	2	3	4	5	[X]
4. I am able to connect with other families with similar interests, children's ages, and circumstances (such playgroup, church or community events).	1	2	3	4	5	[X]

Concrete Support	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
1. I know who to contact in the community when I need help.	1	2	3	4	5	[X]
2. I know where to turn if my family needed food or housing.	1	2	3	4	5	[X]
3. If I know where to go if I needed help in finding a job.	1	2	3	4	5	[X]
4. I know where to go for help if I had trouble making ends meet.	1	2	3	4	5	[X]
5. If there is a crisis, I have others I can talk to.	1	2	3	4	5	[X]

Knowledge of Parenting/Child Development	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
1. There are times when I don't know what to do as a parent.	1	2	3	4	5	[X]
2. I know how to help my child learn.	1	2	3	4	5	[X]
3. My child misbehaves just to upset me.	1	2	3	4	5	[X]
4. I have confidence in my ability to parent and take care of my child.	1	2	3	4	5	[X]
5. When I am worried about my child I have someone to talk to.	1	2	3	4	5	[X]

Part III. *Please tell us how often each of the following happens in your family.*

Nurturing and Attachment	Never	Rarely	Sometimes	Frequently	Always	N/A
1. I praise my child when he/she behaves well.	1	2	3	4	5	[X]
2. When I discipline my child, I lose control.	1	2	3	4	5	[X]
3. I am happy being with my child.	1	2	3	4	5	[X]
4. My child and I are very close to each other.	1	2	3	4	5	[X]
5. I am able to soothe my child when he/she is upset.	1	2	3	4	5	[X]
6. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	[X]

Child Welfare Information Gateway

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

FACTSHEET

June 2007

Disponible en español
www.childwelfare.gov/pubs/factsheets/sp_signs.cfm

Recognizing Child Abuse and Neglect: Signs and Symptoms

The first step in helping abused or neglected children is learning to recognize the signs of child abuse and neglect. The presence of a single sign does not prove child abuse is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination.

If you do suspect a child is being harmed, reporting your suspicions may protect the child and get

What's Inside:

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

Child Welfare Information Gateway
Children's Bureau/ACYF
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
703.385.7565 or 800.394.3366
Email: info@childwelfare.gov
www.childwelfare.gov

help for the family. Any concerned person can report suspicions of child abuse and neglect. Some people (typically certain types of professionals) are required by law to make a report of child maltreatment under specific circumstances—these are called mandatory reporters. For more information, see the Child Welfare Information Gateway publication, *Mandatory Reporters of Child Abuse and Neglect:* www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm

For more information about where and how to file a report, contact your local child protective services agency or police department. An additional resource for information and referral is the Childhelp® National Child Abuse Hotline (800.4.A.CHILD).

Recognizing Child Abuse

The following signs may signal the presence of child abuse or neglect.

The Child:

- Shows sudden changes in behavior or school performance
- Has not received help for physical or medical problems brought to the parents' attention
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
- Is always watchful, as though preparing for something bad to happen
- Lacks adult supervision
- Is overly compliant, passive, or withdrawn
- Comes to school or other activities early, stays late, and does not want to go home

The Parent:

- Shows little concern for the child
- Denies the existence of—or blames the child for—the child's problems in school or at home
- Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
- Sees the child as entirely bad, worthless, or burdensome
- Demands a level of physical or academic performance the child cannot achieve
- Looks primarily to the child for care, attention, and satisfaction of emotional needs

The Parent and Child:

- Rarely touch or look at each other
- Consider their relationship entirely negative
- State that they do not like each other

Types of Abuse

The following are some signs often associated with particular types of child abuse and neglect: physical abuse, neglect, sexual abuse, and emotional abuse. It is important to note, however, that these

types of abuse are more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected.

Signs of Physical Abuse

Consider the possibility of physical abuse when the **child:**

- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Reports injury by a parent or another adult caregiver

Consider the possibility of physical abuse when the **parent or other adult caregiver:**

- Offers conflicting, unconvincing, or no explanation for the child's injury
- Describes the child as "evil," or in some other very negative way
- Uses harsh physical discipline with the child
- Has a history of abuse as a child

Signs of Neglect

Consider the possibility of neglect when the **child:**

- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs
- States that there is no one at home to provide care

Consider the possibility of neglect when the **parent or other adult caregiver:**

- Appears to be indifferent to the child
- Seems apathetic or depressed
- Behaves irrationally or in a bizarre manner
- Is abusing alcohol or other drugs

Signs of Sexual Abuse

Consider the possibility of sexual abuse when the **child:**

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting

- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a venere al disease, particularly if under age 14
- Runs away
- Reports sexual abuse by a parent or another adult caregiver

Consider the possibility of sexual abuse when the **parent or other adult caregiver:**

- Is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex
- Is secretive and isolated
- Is jealous or controlling with family members

Signs of Emotional Maltreatment

Consider the possibility of emotional maltreatment when the **child:**

- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent

Consider the possibility of emotional maltreatment when the **parent or other adult caregiver:**

- Constantly blames, belittles, or berates the child
- Is unconcerned about the child and refuses to consider offers of help for the child's problems
- Overtly rejects the child

RESOURCES ON THE CHILD WELFARE INFORMATION GATEWAY WEBSITE ¬

Child Abuse and Neglect
www.childwelfare.gov/can/index.cfm

Defining Child Abuse and Neglect
www.childwelfare.gov/can/defining/

Preventing Child Abuse and Neglect
www.childwelfare.gov/preventing/

Reporting Child Abuse and Neglect
www.childwelfare.gov/responding/reporting.cfm

This factsheet was adapted, with permission, from *Recognizing Child Abuse: What Parents Should Know.* Prevent Child Abuse America. © 2003.

Child Maltreatment – Signs and Symptoms

Physical Abuse

- *Physical Indicators*
  - *Unexplained bruises and welts (often found on face, torso, buttocks, back or thighs)*
  - *Unexplained fractures; dislocations and skeletal injuries often involve facial structure, skull and bones around joints; may include multiple or spiral fractures, shaken baby*
  - *Unexplained burns often on the palms, soles, buttocks and back*

- *Other unexplained injuries: lacerations, abrasions, human bit marks or pinch marks, loss of hair/bald patches, retinal hemorrhage, abdominal injuries*

- *Behavioral Indicators*
  - *Request or feel deserving of punishment*
  - *Be afraid to go home and/or request to stay in school or daycare, etc.*
  - *Be overly shy, tends to avoid physical contacts with adults, especially parents*
  - *Display behavioral extremes (withdrawal or aggressiveness)*

- *Indicators in Parent/Caretaker*
  - *Perceive the child as being bad or difficult*
  - *Instruct teachers or caregivers to use harsh punishment for misbehavior*
  - *Have been physically abused as a child*
  - *Demand an unrealistic level of performance from the child for his/her age and/or ability*
  - *Use extreme forms of physical punishment*

- *Effects of Physical Abuse*
  - *Low trust of others or the world*
  - *Extremely vigilant*
  - *Learning problems*

- *Psychiatric symptoms*
- *Delinquent or other oppositional behavior*
- *Lying and stealing*
- *Constant attention seeking behavior*
- *Low self-esteem*
- *Fears seems magnified given the situation; extremely fearful*
- *Verbally abusive toward other children*
- *Physically aggressive toward other children*
- *Physically aggressive toward other children*
- *Excessive temper tantrums*
- *Suicidal or other self-destructive behavior*
- *Very protective of abusing parent*
- *Exhibit guilt and take responsibility for abuse*

Neglect

- *Physical Indicators*
  - *Height and weight significantly below age level*
  - *Inappropriate clothing for weather*
  - *Poor hygiene, including lice, body odor*
  - *Child abandoned or left with inadequate or inappropriate supervision*
  - *Untreated illness or injury*
  - *Lack of safe, warm, sanitary shelter*
  - *Lack of necessary dental, and medical care*

- *Behavioral Indicators*
  - *Begging for or stealing food*
  - *Falling asleep in school*
  - *Poor school attendance, frequent tardiness*
  - *Dull apathetic appearance*
  - *Reports no caregiver in the home*
  - *Assumes adult responsibilities*
  - *Chronic hunger*

- *Indicators in Parent/Caregiver*
    - *Show no concern for the child*
    - *Express inappropriate expectations of child*
    - *Refuses to seek medical attention needed by child*
    - *Be unaware of the child's needs*
    - *Leave very young children unattended*
    - *Fall to maintain proper hygiene of child*

- *Effects in Neglected Children*
    - *Unresponsive to others*
    - *Developmental delays*
    - *Indiscriminately seeks affection*
    - *Unattended physical problems*
    - *Delay in speech*
    - *Unruly, unfocused, wandering behavior*

Sexual Abuse

- *Behavioral Indicators*
    - *Sexualized behavior in young children; promiscuity and prostitution in adolescents*
    - *Sexual knowledge and/or behavior that is beyond what is expected for the child's age*
    - *Depression, suicidal gestures, obsessions, chronic runaway*
    - *Frequent psychosomatic complaints, such as headaches, backaches, stomach aches*
    - *Antisocial behavior such as running away, drug or alcohol abuse, delinquency*
    - *Sudden avoidance of certain familiar adults or places; sudden development of phobias*
    - *Avoidance of undressing, wearing extra layers of clothing*
    - *Decline in school performance*
    - *Pregnancy in young adolescents*
    - *Sexual victimization of other children*

- *Physical Indicators*
    - *Complaints of illness which cannot be explained medically, including pain and irritation of the genitals*
    - *Genital bleeding, pain, odor; problems sitting or walking*
    - *Frequent yeast or urinary infections*
    - *Sexually transmitted disease*

- *Indicators in Parent/Caregiver*
    - *Have been sexually abused as a child*
    - *Isolate the child or prohibit the child's contact with other children*
    - *Be secretive and/or isolated*

- *Effects in Sexually Abused Children*
    - *Pseudo maturity*
    - *Interaction problems with adults*
    - *Fearfulness and anxiety*
    - *Self-blame*
    - *Flat affect*
    - *Peer interaction problems-conflict; loner*
    - *Monocommunicative*
    - *Suicidal ideation*
    - *Overly dependent, shy or aggressive*
    - *Learning difficulties*
    - *Inability to concentrate*
    - *Sudden change in school performance*
    - *Sleep disturbances*
    - *Emotional vulnerability*

Emotional Abuse/Neglect

- *Physical Indicators*
  - *Eating disorders*
  - *Sleep disturbances, nightmares*
  - *Wetting/soiling by school-age child*
  - *Speech disorders, stuttering*
  - *Failure to thrive*
  - *Developmental lags*

- *Behavioral Indicators*
  - *Habit disorders such as biting, kicking, head banging, thumb sucking in an older child*
  - *Poor peer relationships*
  - *Behavioral extremes, overly compliant, demanding withdrawn, aggressive, destructive*
  - *Complaints of illness which cannot be explained medically*
  - *Self-destructive behavior, oblivious to hazards and risks*
  - *Chronic academic under achievement*

- *Indicators in Parent/Caregiver*
  - *Withhold love and affection*
  - *Use words that hurt the child*
  - *Reject the child*
  - *Look to the child to meet their physical and emotional needs*
  - *Show very little concerns for the child*

- *Effects among Younger Children*
  - *Delayed physically, emotionally and/or intellectually*
  - *Overly complaint, passive or undemanding*
  - *Inappropriately adult in their behaviors*
  - *Inappropriately childish*

- *Indicators Unique to adolescents*
    - *Developmental lags*
    - *Often appear extremely withdrawn*
    - *May be aggressive and exhibit antisocial behavior*
    - *Often display psychosocial and cultural deficiencies while at the same time appearing emotionally well-adjusted*

alaska office of

CHILDREN'S SERVICES

safe children | strong families

Practice Model

State of Alaska • Department of Health & Social Services

Office of Children's Services

Practice Model

Sean Parnell, Governor, State of Alaska
Bill Hogan, Commissioner, Department of Health & Social Services
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http://www.hss.state.ak.us/ocs/

Introduction

The Department of Health and Social Services, Office of Children's Services (OCS) has implemented a child safety driven intervention system that defines who the agency serves and is grounded in key core principles. While safety of children has always been a focus of the Department, OCS Practice Model brings clarity and purpose to child protective services and establishes clear parameters for the safety of children and how families are treated within the system. Child safety is the determinate for each key decision point throughout involvement with the family from intake to case closure.

This document has been developed to serve as a guide and reference for helping staff, stakeholders, and those we serve better understand the role of child protective services in Alaska. This document also seeks to define, affirm, and support a strengths based, collaborative, family-centered model of practice that all families entering the system should experience.

Vision & Mission

Vision - Safe Children, Strong Families.

Mission - The Office of Children's Services works in partnership with families and communities to support the well-being of Alaska's children and youth. Services will enhance families' capacities to give their children a healthy start, to provide them with safe and permanent homes, to maintain cultural connections and to help them realize their potential.

Who We Serve

OCS serves families whose children have been determined to be unsafe or at high risk of maltreatment by their parent or caregiver. Every family served will be treated with dignity and with consideration to their cultural values. Services to families will always be done in the least restrictive, least intrusive manner possible. Decisions regarding needed interventions with families are based on thorough information collection that guides the initial and ongoing assessment of safety and risk.

Outcomes

OCS' Practice Model works in concert with the seven outcomes required by the Federal Child and Family Services Review.

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their homes whenever possible and appropriate.
- Children have permanency and stability in their living situations.
- The continuity of family relationships and cultural connections is preserved for children.
- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.
- Children receive adequate services to meet their physical and mental health needs.

Guiding Principles

OCS Practice Model is grounded in the following principles:

- A child's safety is paramount.
- A determination that safety threats are present within a family does not equate with removal of a child from their home. The assessment of safety threats directs staff to make informed decisions about safety planning that will control and manage the threats identified. These actions may be in- home, out- of- home or a combination of the two.
- Relevant services will be sought with respect for and understanding of the families' culture and specific needs.
- Collaboration with Alaska Native Tribes is fundamental to best practice.
- Families are treated respectfully, thoughtfully and as genuine partners.
- A person's right to self determination is valued and supported.
- A safety intervention system is congruent with strengths based and family centered practice. Assessing for the safety of children is what we do; family centered practice is how we do it.
- Interventions are identified using the family's perspective about what needs and strengths exist that are selected in collaboration through family engagement.
- By engaging in a collaborative problem solving process with the family, case plans will be specific to the uniqueness of each family served.
- Enhancing parent/caregiver protective capacities are essential for the ability of families to protect their children.
- OCS needs partnerships within the community and stakeholders to achieve strong outcomes for children and families.

Five Core Components

1. Intake

Intake is a critical function and provides the first assessment of child safety. Intake is the process of receiving reports of allegations of child maltreatment, called a Protective Services Report (PSR). All reports of child maltreatment will be entered into ORCA, our automated case management system of record. OCS will respond to all reporters promptly and respectfully, capturing all the necessary information known to the reporter, including the extent of the alleged maltreatment, circumstances surrounding the alleged maltreatment, family/adult functioning, child functioning, parenting practices of the parent/caregiver and disciplinary practices of parent/caregiver, to determine whether a response is required by child protective services.

This is an interactive process that involves not only gathering the above information, but also gathering other related information that could help determine the appropriate agency response. This may include, contacting collateral sources if necessary to corroborate available information and if screened in for intervention to help inform the initial assessment of safety. If the available information indicates that the child is either unsafe or at high risk of maltreatment by their parent/caregiver, the report will be screened in for initial assessment or if not, the reporter will be

referred, if appropriate, to community services. As per state law, all mandated reporters will be notified of the screening decision.

2. Initial Assessment

Formerly called investigation, initial assessment more accurately captures the essence of this decision making process once a PSR is screened in for OCS intervention. At its core, an initial assessment requires OCS to go beyond whether the reported allegations are substantiated or not substantiated, but rather to gather information to make an informed assessment about whether the child is unsafe or at high risk by the parent/caregiver. By employing family centered practices, information can more easily be gleaned to learn the extent of the alleged maltreatment, circumstances surrounding the alleged maltreatment, family/adult functioning, child functioning, parenting practices of the parent/caregiver and disciplinary practices of parent/caregiver.

The initial assessment process assists OCS in determining whether the child is unsafe or at high risk of maltreatment and the extent of the familial protective capacities. Previous practice centered on only the alleged maltreatment and was more narrowly focused on the condition of the victim at the time of the report. Practice is now geared to evaluation of the obvious present danger, but also to the entire family and their overall functioning. This helps the case worker determine whether it's likely that the child will soon be unsafe and what type of intervention is needed to alleviate the impending danger. If it is determined that the child is unsafe or at high risk, OCS will open a case for Family Services and work with the family to implement the least intrusive approach to keep children safe, first with consideration of an in-home safety plan and last, an out-of-home placement. The initial assessment serves as the foundation for building the ongoing assessment and case plan with parents being an equal partner in that process.

3. Family Services

OCS provides Family Services to families with children remaining in their home as well as to families whose children have been placed in out-of-home care. The identified safety threats and/or high risk and diminished protective capacities will be reviewed with the family, including age appropriate children and youth and tribal representation if appropriate, and will be used to help inform the case plan. OCS will further assess the needs of the child and family members assuring that all safety/risk issues are addressed in the case planning process with the family.

Family engagement is critical to laying the foundation to build trust and build mutually beneficial relationships with the family, community providers, stakeholders and OCS staff. The engagement process must take into account the culture of the family and help the family to identify all potential support systems to better assist them to be active participants in their own family's problem solving. It is imperative that parents clearly understand and be able to articulate the identified threats to child safety, such that both parent and worker have a clear understanding of what must change. The case plan must work to alleviate the underlying issues that resulted in the safety threats and to enhance diminished protective capacities. Family engagement also commits OCS

to full disclosure with the family as to OCS' decision making, and laws and policies that affect family's situation. Parent's have the right to self determination. They are the experts about their family. Within the constraints of child safety, case workers will engage families in a process whereby the parent(s) are in control, not the agency. Decisions about what they need and when they need it are theirs to make. Trust and partnership should be built so that case workers are viewed as a true "helper" thereby providing a stronger likelihood of the parental success in changing behavior.

Essential to the Family Services provision is case worker visits, with both the child and parent/caregiver. The assigned worker must meet with both the child and parents face-to-face at least once monthly, but as often as indicated to keep the child safe and consistent with the needs of the family to achieve the case plan goals.

When considering the conditions needed for the child to be returned to the parent/caregiver, the factors to be explored by those involved in the family's decision making are whether safety can be managed in the home and extent of behavioral changes made as a result of the work on case plan. Clarity in conditions for return assures that the parent/caregiver knows exactly what must be accomplished in order to be reunified with their child. Complete compliance with the case plan should not be the determining factor whether a child is returned to the parent/caregiver, but rather that safety can be achieved in the home.

From the point of intake to case closure, continuous reassessments of child safety and family functioning are being determined to ensure steady progress toward the child and family's goals. In collaboration with families, tribes and service providers, case plans are updated to address the family's changing circumstances. OCS works first to reunify children with their parents/caregivers. When that is not possible, other permanency goals, such as guardianship, adoption or other planned living arrangements are considered in an effort to meet the child's best interests.

4. Resource Families

Resource families consist of relative or kinship families, licensed foster care families, guardianship families or adoptive families. Regardless of the type, resource families play a key role in the life of a child in care.

When out-of-home placement is needed to keep the child safe, OCS will make diligent efforts to identify, evaluate and consider relatives, family friends and those culturally tied to the family as the primary placement option. When relatives cannot be a placement option for the child, OCS will make efforts to actively recruit and support resource families within the child's home community and in close proximity as possible to the child's parents, to assure that the child may continue to maintain important and lasting cultural, familial, educational and community-based connections.

Relative assessments, licensing standards, and home studies are utilized by OCS staff to ensure

that children are placed with resource families that can provide a safe environment for the child. Families and resource families, in partnership with OCS workers, will work together to ensure that the placement best meets the child's needs for safety, permanency and well-being, and will promote reunification of the family whenever possible.

While placement of the child with their siblings is always preferred, frequent visits are arranged when siblings are placed apart due to specific needs of the child or other permanency issues. Likewise, frequent visits are arranged between the parents and the child to ensure that the child remains connected to their parents and the parents remain a primary force in the child's life.

At the point of family reunification, OCS staff and resource families will actively support the child and the child's family to successfully and permanently return home. Should the child be unable to return to the parent's home, OCS staff and the resource family will actively prepare the child for adoption or guardianship with a permanent, "forever" family.

5. Service Array

The State of Alaska has in place an array of services that is aimed at meeting the needs of all children and families that come to the attention of the child protective services system. Services are provided by grantees that are funded by OCS and various divisions within the Department of Health and Social Services, including Juvenile Justice, Public Assistance and Behavioral Health. These community providers perform a critical role in their partnership with OCS to keep children safe, enhance the parent's protective capacities, achieve permanency and child well being. Strong community partnerships, especially those with Tribes and stakeholder input into the service array needs in Alaska are an important component to OCS achieving its necessary outcomes for children and families in Alaska.

Conclusion

OCS Practice Model is supported by agency staff, management and leadership; Alaska's automated child and family information system; an evaluation unit that completes quality assurance reviews and leads continuous quality improvement efforts; and a staff training unit run by the University of Alaska – Anchorage. We are pleased to present this Practice Model document, with the intent that our families, stakeholders and communities better understand the mission, vision and guiding principles of our agency. By continuing to practice these core principles and collaborating with our community partners, Alaska can keep children safe and help families become strong.

Alaska office of
CHILDREN'S
SERVICES
safe children | strong families

Sean Parnell, Governor, State of Alaska
Bill Hogan, Commissioner, Department of Health & Social Services
Tammy Sandoval, Director, Office of Children's Services

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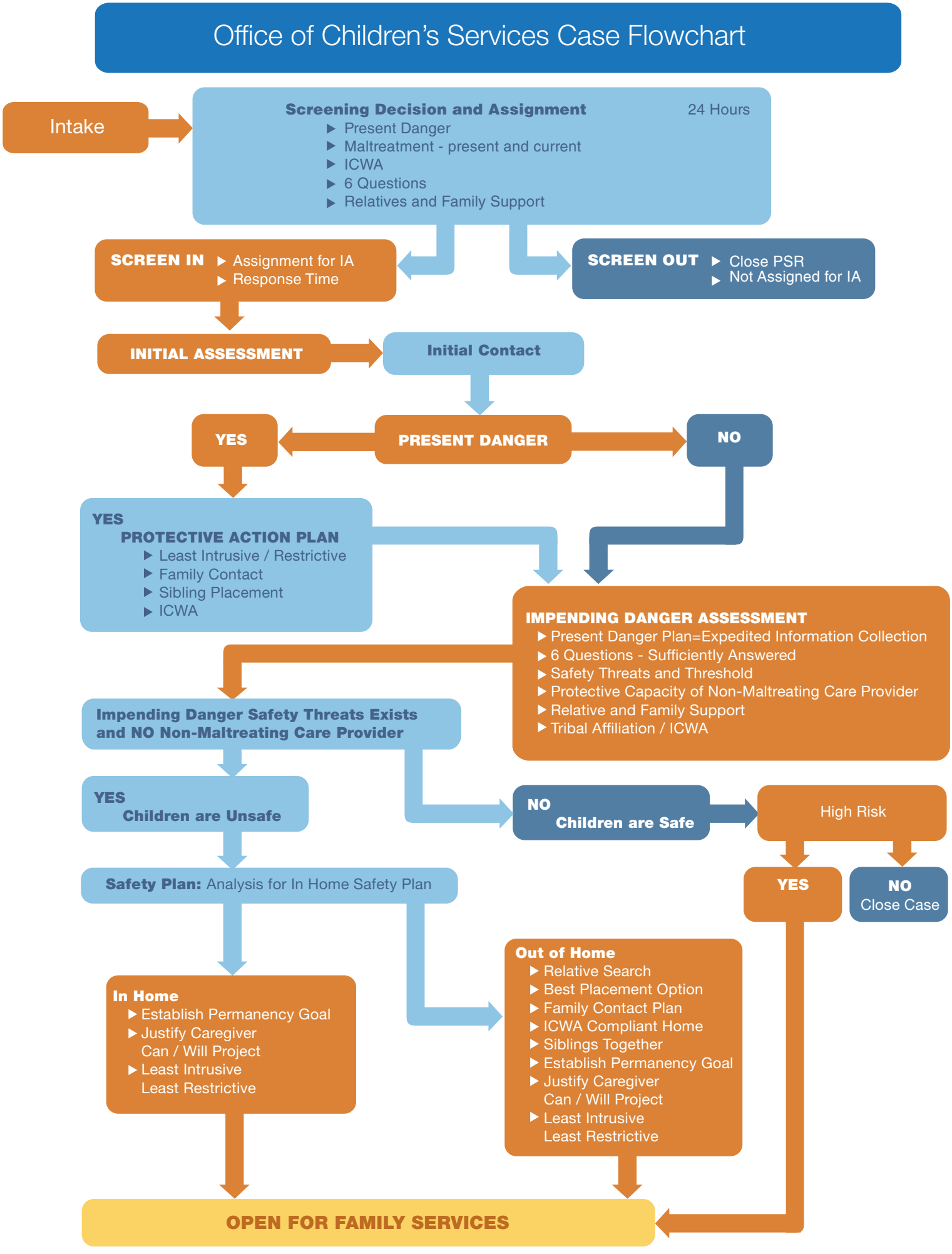
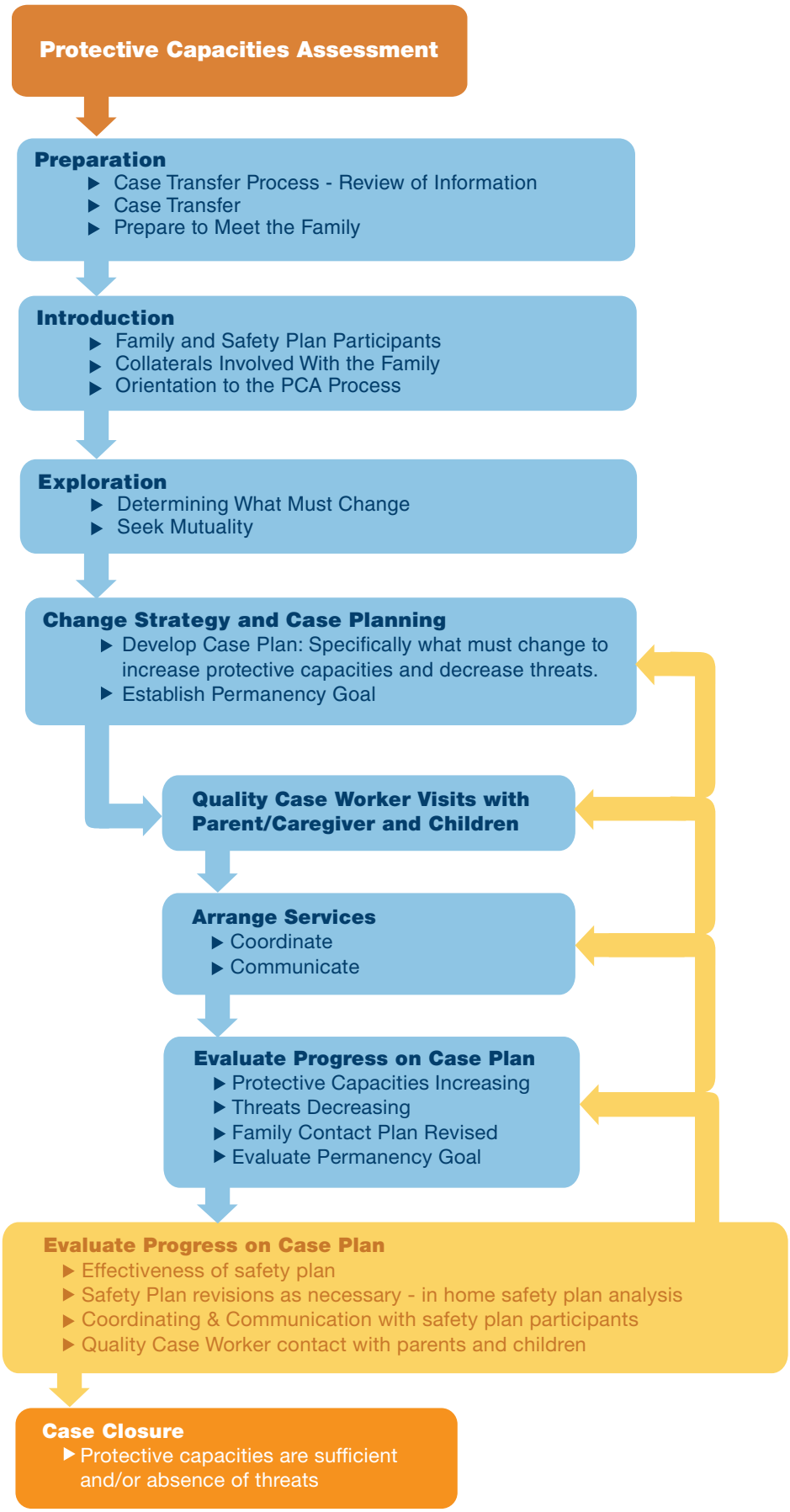
http://www.hss.state.ak.us/ocs/

Office of Children's Services Case Flowchart



Family Services



Information Collection and Documentation

Protocol for information gathering

1. Notify Tribe of PSR and encourage/invite tribal participation during investigation/assessment process
2. Interview alleged child victim(s) separately and privately
3. Interview other children in the home separately and privately
4. Interview any other caregiver in the home
5. Interview the alleged maltreating caregiver
6. Interview any other household members
7. Interview non-custodial parent
8. Interview relatives not in the house
9. Interview collaterals

1. What is the extent of child maltreatment?
(do not cut and paste the PSR; this is what you found, not what has been reported)

- Type(s) of Maltreatment
- Details about symptoms (injuries, conditions present)
- Details about severity
- Identify the maltreater and finding

2. What surrounding circumstances accompany the maltreatment?

- Circumstances and events associated with the maltreatment (where, when, who, how, who saw, what led to the event, where were other family members)
- Duration of maltreatment, patterns and length of time any type of maltreatment has been occurring (include reported and unreported CPS history)
- Explanation for maltreatment including responses of both maltreating and non-maltreating caregiver
- Attitudes of caregivers respective of maltreatment (even when no maltreatment exists)
- Other factors that may have contributed and should be considered (substance abuse, mental health, domestic violence, financial hardship)

3. How do the children function on a daily basis?
(with multiple children, identify each child and their age in your answers

- Physical, emotional and social development
- Predominant behavior
- Peer and school behavior
- Mood and temperament
- Speech and communication
- Vulnerability
- General behavior
- Daily routines and habits
- Ability to self-protect

Information Collection and Documentation

4. **How do the adults (primary caretakers) function on a daily basis?**
   (w*ith multiple adults, identify each adult in your answers)*

   - General behavior
   - Cultural identity and connectedness
   - Daily routine and habits
   - Communication
   - Emotional control and presentation
   - Social support and relationships
   - Problem solving skills
   - Abilities to manage stress
   - General issues to be considered (include medical, mental health, substance abuse, domestic violence, financial hardships and criminal activity)

5. **What are the overall typical pervasive parenting approaches used by the parent?**
   (with multiple parents, identify each parent in your answer)

   - Parenting style and approach
   - Knowledge of child development and parenting/age appropriateness
   - Parenting satisfaction, interest and motivation
   - Sensitive to child's needs and limitations
   - Realistic expectations
   - Parenting skill / creativity
   - Past parenting experiences

6. **What are the disciplinary approaches used by the parent, including the typical context?**
   (with multiple parents, identify each parent in your answers)

   - Discipline methods
   - Intent, attitudes and expectations about discipline
   - Purposes for discipline
   - Creativity and versatility
   - Age appropriateness

1. **One or both lack parenting knowledge, skills, and motivation necessary to assure a child's safety.**

This refers to basic parenting that directly affects a child's safety. It includes parents/primary caregivers lacking the basic knowledge or skills which prevent them from meeting the child's basic needs; or the lack of motivation resulting in the parents/primary caregivers abdicating their role to meet basic needs or failing to adequately perform the parental role to meet the child's basic needs. This inability and/or unwillingness to meet basic needs creates child safety concerns.

<u>Application of the Safety Threshold Criteria</u>

When is this family condition out-of-control? Caregivers who do not know and understand how to provide the most basic care such as feeding infants, hygiene care, or immediate supervision. The lack of knowledge is out-of-control since it must be consistent with capacity problems such as serious ignorance, retardation, social deprivation, and so forth. Skill, on the other hand, must be considered differently than knowledge. People can know things but not be performing or just don't perform. The lack of aptitude must be clear. The basis for ineptness may vary. Caregivers may be hampered by cognitive, social, or emotional influences. Motivation is yet another matter. People may be very capable, have plenty of pertinent knowledge, but simply don't care or can't generate sufficient energy to act. Remember, any of these are out-of-control by virtue of the behavior of the caregiver and the absence of any controls internal to the family.

This threat is illustrated in the following examples.

- Parent's/caregiver's intellectual capacities affect judgment and/or knowledge in ways that prevent the provision of adequate basic care.
- Young or intellectually limited parents/primary caregivers have little or no knowledge of a child's needs and capacity.
- Parent's/caregiver's expectations of the child far exceed the child's capacity thereby placing the child in unsafe situations.
- Parent/caregiver does not know what basic care is or how to provide it (e.g., how to feed or diaper; how to protect or supervise according to the child's age).
- Parents'/caregivers' parenting skills are exceeded by a child's special needs and demands in ways that affect safety.
- Parent's/caregiver's knowledge and skills are adequate for some children's ages and development, but not for others (e.g., able to care for an infant, but cannot control a toddler).
- Parent/caregiver does not want to be a parent and does not perform the role, particularly in terms of basic needs.
- Parent/caregiver is averse to parenting and does not provide basic needs.
- Parent/caregiver avoids parenting and basic care responsibilities.
- Parent/caregiver allows others to parent or provide care to the child without concern

for the other person's ability or capacity (whether known or unknown).

- Parent/caregiver does not know or does not apply basic safety measures (e.g., keeping medications, sharp objects, or household cleaners out of reach of small children).
- Parents/caregivers place their own needs above the children's needs thereby affecting the children's safety.
- Parents/caregivers do not believe the children's disclosure of abuse/neglect even when there is a preponderance of evidence and this affects the children's safety.

2. **A child has exceptional needs that affect his/her safety which the parents/caregivers are not meeting; cannot meet or will not meet.**

"Exceptional" refers to specific child conditions (e.g., retardation, blindness, physical disability) which are either organic or naturally induced as opposed to parentally induced. The key here is that the parents, by not addressing the child's exceptional needs, will not or cannot meet the child's basic needs.

Application of the Safety Threshold Criteria

The caregiver's ability and/or attitude are what is out-of-control. If you can't do something, you have no control over the task. If you do not want to do something and therefore do not do it but you are the principal person who must do the task, then no control exits either. If you are not doing what is required to assure the exceptional needs are being met daily then nothing within the family is assuring control.

This does not refer to caregivers who do not do very well at meeting a child's needs. This refers to specific deficiencies in parenting that must occur and are required for the "exceptional" child to be safe. The status of the child helps to clarify the potential for severe effects. Clearly, "exceptional" includes physical and mental characteristics that result in a child being highly vulnerable and unable to protect or fend for him or herself.

The needs of the child are acute, require immediate and constant attention. The attention and care is specific and can be related to severe results when left unattended. Imminence is obvious. Severe effects could be immediate to soon.

This threat is illustrated in the following examples.

- Child has a physical or mental condition that, if untreated, is a safety threat.
- Parent/caregiver does not recognize the condition.
- Parent/caregiver views the condition as less serious than it is.
- Parent/caregiver refuses to address the condition for religious or other reasons.
- Parent/caregiver lacks the capacity to fully understand the condition or the safety threat.
- Parent's/caregiver's expectations of the child are totally unrealistic in view of the child's condition.
- Parent/caregiver allows the child to live or be placed in situations in which harm is increased by virtue of the child's condition.

strengthening families program self-assessment

STRATEGY 1: FACILITATE FRIENDSHIPS AND MUTUAL SUPPORT

Facilitate Friendships and Mutual Support	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
1 A comfortable space is available for families to meet informally							
2 The program helps parents set up formal and informal support mechanisms, such as phone trees, car pools, babysitting co-ops, play groups, and other age-appropriate activities							
3 The program connects families with similar interests, children's ages, and circumstances (such as those with twins, parents of infants, parents with special-needs children, or those who speak the same language)							
4 The program provides opportunities for families to socialize and foster a sense of community through:							
a) Periodic events like coffee breaks and breakfasts							
b) Celebrations, graduations, and holidays							
c) Field trips and activities							
d) Events celebrating cultural customs, potlucks, and other opportunities for parents to share and learn about each other's home lives and cultural backgrounds							
e) Affordable family activities							
f) Special programs for dads, grandparents, teen moms, and other caregivers							
5 The program encourages and provides support for parent-organized social/educational events and activities, such as:							
a) Making information available on outside activities for parents to attend together—for example, gathering at playgrounds, fun fairs, or libraries							
b) Providing supports such as space, childcare, food, or other resources so that parents can participate in activities.							

Facilitate Friendships and Mutual Support	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
6 The program offers opportunities for parents to talk with each other about:							
a) Typical challenges of parenting							
b) Stages of child development							
c) Expectations and norms about child rearing							
d) Sibling rivalry							
e) Balancing work and family							
f) Parenting practices in and across cultural and ethnic groups							
7 Program staff reach out to isolated families by:							
a) Calling, sending notes, or making home visits							
b) Inviting them to social activities							
c) Offering support with transportation, childcare, or other barriers to participation in social activities							
d) Making special efforts to connect them with other families							
e) Connecting them with resources, such as mental health consultation, that can help them explore difficulties with forming social connections							
8 The program models positive social skills and community building by:							
a) Welcoming all families							
b) Inviting all children and families to parties or social events							
c) Helping to resolve issues among families							
d) Promoting understanding of different cultures and backgrounds							

Strengthen Parenting	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
1 Information on parenting is available through:							
a) Books and videos in a resource library							
b) Parenting classes and discussion groups							
c) Regular postings on bulletin boards in public spaces							
d) Take-home materials distributed regularly to parents							
e) Opportunities for parents with similar concerns to come together and share							
f) Specific information on such issues as Shaken Baby Syndrome, SIDS, scalding, toilet training, routine preventative health care, nutrition, and sleep patterns							
2 Parenting information is available in the language spoken by families							
3 Staff are knowledgeable about:							
a) The parenting practices of different cultural and ethnic groups							
b) The parenting styles of both mothers and fathers and the strengths of each							
c) Parent-child relationships, attachment, and bonding							
d) Promoting positive relationships between children living in the same household							
4 Opportunities are created for parents to explore:							
a) Cultural/ethnic expectations and practices about parenting							
b) How they were parented							
c) New parenting practices							
d) Their relationship with their child(ren)							

Strengthen Parenting	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
5 Staff share parenting tips and discuss parenting issues with parents when:							
a) Families are arriving and departing							
b) Staff are meeting one-on-one with parents							
c) A parent appears to be frustrated or stressed and in need of support							
d) A parent appears to be having difficulty relating to or communicating with their child(ren)							
e) Child behavior or development issues arise							
6 The program offers or connects families to resources to strengthen relationships between adults, e.g., healthy marriage, communication skills for couples, parents and grandparents, co-parenting, etc.							
7 Parents are invited to visit and observe their children participating in programming, where appropriate, and talk with staff about their observations and questions							
8 Staff reinforce parental authority by:							
a) Learning about the parent's expectations and limits for their child							
b) Supporting parents' directions and /or decisions about their child							
c) Talking with parents in a respectful manner about how best to handle differences in expectations regarding children's behavior							
d) Being careful not to contradict a parent in front of his or her child or other children							

Strengthen Parenting	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
9 Staff reinforce positive parenting by:							
a) Noticing when parents are attuned to their children's needs or communicating effectively with their children							
b) Telling parents something positive about what their child has done each day							
10 Staff guide parents' observations of their children to help them recognize:							
a) Their child's unique temperament, personality, communication styles, and cues							
b) Their children's growth and development patterns							
c) Positive social skills and developmentally appropriate emotional behavior in their children							
d) Their child's independence and abilities							
e) Activities they can use at home							
11 Information is provided on regular developmental challenges, such as bed wetting, potty training, appropriate discipline, eating, sleeping, and aggression							
12 Family activities provide opportunities to strengthen bonds between parents and their children—for example, listening to each other, playing together, and cooperative games, such as "feeling charades"							
13 Physical discipline (spanking or hitting) is not allowed in the program by staff or parents							

Strengthen Parenting	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
14 When staff talk with parents about discipline, they:							
a) Explain why physical discipline is not allowed							
b) Explain why the program uses the forms of discipline it does							
c) Provide information on age- appropriate discipline and reasonable expectations							
d) Offer ideas for alternate forms of discipline and how to recognize and reinforce desired/appropriate behavior							
e) Encourage parents to discuss discipline challenges they may have at home							
15 When staff are concerned about parenting techniques or behavior, they:							
a) Proactively and respectfully reach out to parents and share their concerns about the children or about the parents' parenting practices							
b) Acknowledge young children's frustrating behavior and recognize parents' efforts							
c) Connect parents to resources and supports that may help to address the parenting issues							
d) Connect parents to other parents who can share/model positive parenting approaches							

Strengthen Parenting	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
16 For parents of children with special needs, staff:							
a) Connect parents with parenting materials and websites, support groups and play groups, and community resources specific to their children's special needs							
b) Check regularly with parents about parenting issues							
c) Are sensitive to parents' frustration, protectiveness, guilt, loss, and other related feelings, and acknowledge challenges							
d) Support parents in understanding appropriate developmental expectations for their special-needs children							
e) Check in with parents about the impact their children's special needs are having on family dynamics and parental stress							
f) Are especially supportive at the time that special needs are initially identified							
g) Provide speakers/resources for parents on topics of interest/concern							
h) Ensure that parent-child activities are appropriate for families with children with special needs							

Respond to Family Crises	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
1 Staff develop personal relationships with parents by taking time to get to know them individually—listening and learning about their interests, families, current activities, and hopes and expectations for their children							
2 The message that parents can turn to staff in the event of a crisis is conveyed:							
a) Informally, in regular interactions that staff have with parents—by listening, showing concern, and sharing their own personal challenges or desires							
b) Formally through materials provided to participating families							
3 The program provides parents with information on the role of all staff members and which staff members can help them with particular issues							
4 Staff respond to family crises immediately by:							
a) Ensuring that a staff person is available at all times to help families needing crisis support							
b) Making space available for staff to meet with parents privately							
c) Ensuring that parents can talk with staff members with whom they are the most comfortable							
5 Resources are made available to families in crisis, such as money from a small emergency fund, access to meals, or transportation							

Respond to Family Crises	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
6 The program maintains up-to-date information about services in the communities, such as:							
a) Food pantries							
b) Domestic violence services							
c) Shelters							
d) Respite care for children							
e) Alcohol and substance abuse services							
f) Mental health services							
g) Economic supports							
h) Legal assistance							
7 Staff know how to respond appropriately to family crises. Staff receive training on:							
a) Maintaining confidentiality							
b) Resolving conflicts							
c) Talking to families about difficult issues							
d) Recognizing such issues as domestic violence, depression, developmental delays, mental illness, chronic health problems, substance abuse, and other signs of imminent crisis							
e) Helping families make immediate and long-term plans							
f) Understanding the impact of family crises and/or loss on all family members—especially children—and how to respond appropriately							
g) Talking to parents about helping children in times of crisis							

Respond to Family Crises	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
8 If appropriate, staff mobilize other parents in the program to help out families in crisis							
9 If parents bring up issues staff feel are beyond their ability, staff can refer them to a:							
a) Supervisor							
b) Specialist with knowledge in the area							
c) Cross-disciplinary staff team							
d) Community resource							
10 Staff proactively respond to signs of parent or family distress by:							
a) Expressing their concern and offering help							
b) Offering to connect families to needed resources							
c) Making themselves available to parents if they need to talk							
d) Sharing information about a parent help-line or warm-line							
e) Being sensitive and responsive to the impact of family stress on children							
11 Staff receive support when working with families under stress through:							
a) Acknowledgement of their efforts							
b) Supported opportunities to process their own emotional reactions							
c) Access to a mental health consultant							
d) Time off if needed							

Link Families to Services and Opportunities	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
1 The program develops family plans with parents that:							
a) Identify their interests, skills, needs, and goals for themselves and their children							
b) Identify services and opportunities within the program that may help them achieve their goals and use their skills and talents							
c) Identify other community resources and opportunities that may help them achieve their goals, continue their learning, and/or provide other avenues for involvement							
d) Are regularly revised and updated in conjunction with families							
e) Other:							
2 Staff and parents have access to up-to-date information about services that are available in the community that includes hours of business, fees, location, eligibility, language capacity, etc.							
3 When staff make referrals to outside services, they:							
a) Brainstorm with families about what resources would be helpful							
b) Help parents address barriers to utilizing services, such as lack of transportation or childcare, language difficulties, or fees							
c) Help them fill out paperwork that might help them access these services, for example, insurance and eligibility forms							
d) Follow up with families to see if they used the referral and ensure that they were satisfied with the services they received							
e) Try to make a personal connection between families and service providers							
f) Identify services and opportunities within the program that may help them achieve their goals and use their skills and talents							

Link Families to Services and Opportunities	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
4 The program actively builds collaborative links with other service providers in order to:							
a) Bring other services on site when possible							
b) Ease the referral process by ensuring the workers in different programs work together							
c) Share information with parents about resources							
d) Identify and fill gaps							
5 The program encourages parents to share information about community resources for families—such as toy exchanges, resale shops, play lots, family activities, and more formal services							
6 The program connects parents to opportunities that promote:							
a) Their continued growth and development							
b) Family enrichment, i.e., reading hours at the library, parent-child book groups, and cultural heritage events							
c) Healthy adult relationships and marriage							
d) Fathers' involvement with their children							
e) Enrichment activities for children							
7 The program provides information and guidance on:							
a) Transition to school for children							
b) Parents' and children's educational rights and responsibilities							
c) The importance of parents staying involved with their children's education and school							

STRATEGY 5: FACILITATE CHILDREN'S SOCIAL AND EMOTIONAL DEVELOPMENT

Facilitate Children's Social and Emotional Development	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
1 The program supports children's social and emotional development with intentional practices that:							
a) Are culturally sensitive to the families it serves							
b) Encourage children to express their feelings							
c) Encourage sharing, taking turns, and cooperative play							
2 Staff receive training on:							
a) Fostering children's social and emotional development							
b) Recognizing developmental delays							
c) Recognizing behavioral / emotional problems							
d) The impact of loss or trauma on behavior							
e) Sensory awareness and integration							
3 The program introduces parents to social and emotional development by:							
a) Informing parents of the importance of supporting children's healthy social and emotional development—and its connection to success in school							
b) Helping parents understand age-appropriate social and emotional skills and behaviors							
c) Providing opportunities to discuss social and emotional issues with parents within a cultural context							
d) Encouraging parents to be aware of their children's social and emotional development							
e) Offering parents ideas on how to foster a child's social and emotional learning at home							
f) Teaching about children's social and emotional development in parenting classes and informal discussions							

Facilitate Children's Social and Emotional Development	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
4 Parents have opportunities to observe their children interacting with other children and staff in the program							
5 Staff make sure that parents understand how their child(ren)'s positive relationships with other adults positively impact their own relationship with their child(ren)							
6 Staff coach parents about how to interact effectively with their children (listening; appreciating ideas, efforts, and feelings; creating a non-threatening environment)							
7 Staff encourage children to express their feelings through words, artwork, and expressive play							
8 Staff model behavior toward children that encourages social and emotional expressiveness							
9 Staff understand and respect the relationships and attachments that children form in the program by:							
a) Providing children the opportunity to say goodbye when they are leaving the program or when staff changes occur							
b) Helping children process class and / or staffing changes							
c) Communicating any staff changes to parents							
d) Intentionally helping children enter into new settings							

Facilitate Children's Social and Emotional Development	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
10 If staff are concerned about a child's social and emotional development, they:							
a) Discuss concerns with the child's parent(s)							
b) Connect the family to resources that can support the child's social and emotional development (such as play therapy, mental health services, or parenting classes)							
c) Help the parent(s) develop strategies for addressing the issue at home							
11 Staff have access to a mental health consultant to help them:							
a) Develop positive approaches for individual children							
b) Determine what additional resources and or training they may need							
c) Talk with parents about their child(ren)'s development, needs, or challenges							

STRATEGY 6: RECOGNIZE AND RESPOND TO EARLY WARNING SIGNS OF CHILD ABUSE OR NEGLECT

Recognize and Respond to Early Warning Signs of Child Abuse or Neglect	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
1 When parents enter the program they are informed of:							
a) Staff's status as mandatory reporters							
b) What constitutes abuse and neglect within the state							
c) The program's protocols regarding child abuse and neglect							
2 All staff are trained to recognize early signs of child abuse and neglect							
3 Staff monitor the following signs that a family may be under stress, including:							
a) Physical signs (such as bruises), acting out, distress, challenging behavior, fearful behavior, inappropriate language/behavior (such as sexual acting out), or other child symptoms							
b) Unusual parental behavior at arrival or departure times							
c) Repeated unexplained absences							
d) Repeated tardiness, late pick-ups, or missed appointments							
e) Missed payments							
f) Divorce, job loss, or other family crises							
g) Parents' acknowledgement of stress or problems							

Recognize and Respond to Early Warning Signs of Child Abuse or Neglect	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
4 When a family is experiencing extreme difficulties but there is no sign of imminent harm to the child or other family members:							
a) Staff work with the family to discuss concerns and appropriate actions							
b) At least one staff member reaches out to the family to address the issues causing concern							
c) Staff attempt to connect the family to resources that can help address the issue, including such intensive services as respite care, shelters, or emergency crisis services							
d) Staff continue to support the family and monitor the situation daily until the situation is resolved							
5 All staff are trained on the impact of loss and trauma on children and how to respond appropriately							
6 All staff are trained to follow the program's protocols for reporting child abuse and neglect							
7 Staff are oriented to the state's child welfare reporting guidelines and understand how cases are generally handled once a report is made							

Recognize and Respond to Early Warning Signs of Child Abuse or Neglect	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
8 When staff must file a child welfare report, they:							
a) Coordinate with investigative authorities to ensure that actions and interactions with the family support and do not hinder the investigation							
b) Strive to be calm, caring and supportive during the reporting process							
c) Provide fair and accurate information on the concerns that led to the child welfare report, as well as family strengths							
d) To the best of their ability, answer questions that the family may have regarding the reporting process and how the child protective services system typically responds							
e) Explain their status as mandated reporters and the goal of keeping children safe							
f) Offer to support families by answering questions, connecting them to resources they may need, and providing a listening ear and friendly advice							
9 Program staff help families find suitable respite care and/or emergency crisis services							
10 If a child is placed in custody, staff:							
a) Maintain contact with the parent							
b) Advocate for the family with the child protective services system, when possible							
c) Help the parent(s) connect with resources to help reunite them with their child							
11 The program helps families navigate the child welfare system by:							
a) Helping them get the help they need							
b) Helping maintain stability for children							
c) Collaborating with child welfare caseworkers							

Value and Support Parents	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
1 The program encourages parents to be active in making decisions about their children's education							
2 Staff recognize and affirm the central role of parents in their child's life							
3 Staff get to know parents individually and regularly inquire about what is happening in their lives							
4 Staff get to know all family members by name							
5 Parents have opportunities to volunteer and contribute to the program							
6 Parents have opportunities to share skills, talents, and cultural traditions with children and other parents							
7 Staff recognize and value parent contributions							
8 Staff are accepting and supportive of diverse family constellations, i.e. single parents, grandparents, foster parents, gay / lesbian couples, etc.							
9 Parents have regular opportunities to engage in activities in the center's physical space							
10 Parents have opportunities to participate in:							
a) Parent-only social activities							
b) Support groups							
c) Activities designed to relieve stress, such as spa days, date nights (parents' night out), or exercise classes							
d) Activities that promote healthy adult relationships, marriage, co-parenting							
e) Other:							
11 The program offers specific activities for fathers, mothers, and other family members							

Value and Support Parents	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
12 The program welcomes fathers and other male family members by:							
a) Providing information specific to fathers/male family members in a special area such as a lounge, bulletin board, or bookshelf							
b) Displaying positive portrayals of men and children in books, posters, and program materials							
c) Providing a diaper changing deck in the men's room							
d) Providing activities or services that are man-to-man, father-to-father							
e) Using intake forms, applications, and surveys that are gender-neutral							
f) Establishing working partnerships with a wide range of community resources that provide services to fathers							
13 Staff show that they value fathers and are sensitive to their unique needs by:							
a) Sharing responsibility for inviting and engaging fathers in programs and activities							
b) Taking part in periodic training on understanding and appreciating fathers' needs and parenting styles							
c) Understanding the needs of individual fathers, such as navigating the child support system or having multiple children with different mothers in the same program							
d) Being sensitive to barriers that limit father involvement, such as a difficult relationship with the child's mother, lack of information, and non-custodial relationship with child							
e) When possible and within the bounds of custody agreements, responding to non-custodial fathers' desire to participate in their children's lives by including them in mailings and updates about a child's progress, inviting them to activities, and responding to requests for information							
f) Encouraging fathers and male family members to engage in many aspects of the program, not only activities for fathers							

Value and Support Parents	check one box: 5: Strongly Agree	4: Agree	3: Neither Agree nor Disagree	2: Disagree	1. Strongly Disagree	Not Applicable	Comments
14 Parents have opportunities to discuss how they were parented and how it affects the way they parent							
15 Parents are connected to resources that help them explore different ways of parenting, including:							
a) Parent education groups							
b) Counseling							
c) Support groups							
d) Mentors/coaches							
e) Sisterhoods/brotherhoods							
f) Faith-based activities							
g) Other							
16 Staff provide emotional support and encouragement to parents							
17 Staff do not blame parents for children's challenging behaviors							
18 Staff recognize parents' growth and efforts							
19 The program provides parents opportunities for:							
a) Personal growth—such as attending conferences or special events and collecting and sharing information of interest to other parents							
b) Leadership development							
c) Input into programmatic decisions							
d) Input into staff hiring and training							

END OF SELF-ASSESSMENT

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Early Intervention and Maltreated Children

A Current Look at the Child Abuse Prevention and Treatment Act and Part C

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Current literature regarding the prevalence of child abuse and neglect, resulting developmental impacts on children, and early intervention services for children and families involved in the child welfare system is summarized. While early intervention eligibility referrals are mandated for this population under the Child Abuse Prevention and Treatment Act of 2003, Part C, maltreated children remain underrepresented and services remain underutilized. Reasons for this underutilization and weak links in service provisions for families involved in child welfare are examined. In addition, barriers for service provision of children and families involved in the welfare system and recommendations for improving outcomes, including enhanced professional development, are presented. **Key words:** *CAPTA, child welfare, early intervention, maltreatment eligibility, professional development*

MALTREATED CHILDREN AND THEIR FAMILIES

Child abuse and neglect is a complex social problem that has plagued societies, resulting in long-lasting and pervasive impacts on children and families. Educational, judicial, and health-related costs of child protective services are enormous, with estimates from $94 to $103.8 billion per year (Prinz, Sanders, Shapiro, Whitaker, & Lutzer, 2009; Wang & Holton, 2007). Moreover, children in the child welfare system tend to have diminished developmental outcomes, low educational achievement, and poor school performance, as indicated by high school dropout rates (Iverson, Hetland, Havik, & Stormak, 2010).

Family risk factors often associated with higher instances of child abuse and neglect include poverty, parental substance abuse, low maternal education, parental incarceration, parental military deployment, low maternal age, domestic violence, single-parent households, parent mental health issues, minority status, and having four or more children living at home (Brown, Cohen, Johnson, & Salzinger, 1998; Felitti et al., 1998; Hayward, Depanfillis, & Woodruff, 2010; Savitsky, Illingworth, & DuLaney, 2009; Shonk & Cicchetti, 2001; US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation

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[USDHHS-ASPE], 2008). Although maltreatment occurs in families of all economic levels, it is particularly salient in families under multiple stressors due to poverty (Slack, Holl, McDaniel, Yoo, & Bolger, 2004). Moreover, many families experience cumulative risk, exacerbating the potential for child abuse and neglect as much as 3% (for families with no risk factors) to 24% (for families with four or more risk factors) (Barth et al., 2007; Brown et al., 1998; USDHHS-ASPE, 2008). Caregiver substance abuse is also highly correlated with child abuse and neglect. For example, in Oregon, 42.1% of all substantiated abuse cases in 2008 involved parental use of drugs or alcohol (Oregon Department of Human Services, 2009). A national sample of 3529 children with mothers entering drug and alcohol treatment had an average of 6.5 of the 11 risk factors for risk of child maltreatment (Conners et al., 2004).

The Child Abuse and Prevention Treatment Act (CAPTA) of 1974 (PL 93-247) was established to provide states with support for the prevention and treatment of child abuse and neglect, with the goal of providing for the safety and well-being of children. The law has been reauthorized, amended, and expanded numerous times in response to increasing numbers of maltreated children, resulting developmental problems, and cost to society (USDHHS, 2003). Policy and lawmakers have attempted to improve outcomes for maltreated children by establishing laws that expand protection to include developmental concerns. In 2003, CAPTA was amended, reauthorized, and renamed the Keeping Children and Families Safe Act (Public Law [PL] 108-36). This amendment was in response to the increased awareness of the societal impacts of child maltreatment and further research regarding the effects of maltreatment on child development and future school readiness. The benefits of intervening early with maltreated children include the importance of protecting early brain development and the impact of positive, enriching early childhood experiences on improved outcomes for children (Ramey & Ramey, 1998; Shonk & Cicchetti, 2001; Shonkoff & Phillips, 2000; Shore, 2003), including minimizing the developmental impact for young children with delays (Grant, 2005). In addition, recognition of the impact of abuse and neglect on the development of children younger than 2 years, the highest risk by age group, necessitated mandatory referrals for evaluation to determine eligibility for early intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA) for children younger than 3 years (USDHHS, 2003). The reauthorization of the CAPTA laws also provided increased funding of demonstration projects to promote mental health and developmental needs of maltreated children and technical assistance to existing programs, including "educational identification, prevention and treatment services in cooperation with preschool, elementary, and secondary schools" (PL 108-36). The CAPTA Reauthorization Act of 2010 amended the law further in multiple areas, including advancing "effective practices and programs to improve activities that promote collaboration between the child protective service system and the medical community, including providers of mental health and developmental disability services; and providers of early childhood intervention services and special education for children who have been victims of child abuse or neglect" (PL 111-320).

Initially, states anticipated substantial increases to Part C services due to the passing of CAPTA in 2003. Derrington and Lippitt (2008) posited that the Part C system would be overburdened, estimating a 22% average statewide increase in enrollment. However, increased services resulting from the CAPTA laws have been less than dramatic, with most states serving fewer children from child welfare referrals than expected (Robinson & Rosenberg, 2004; Ward et al., 2009). In a study completed by using the National Survey of Child and Adolescent Well-Being (NSCAW) data, Ward et al. (2009) found that although the evidence is clear for the need to screen and refer maltreated children for early intervention services, many states are not,

resulting in less than expected numbers of maltreated children being served by Part C. As a nation, we have taken the steps to ensure improved outcomes for maltreated children; however, maltreated children continue to be underrepresented in Part C services.

Current status and progress toward serving maltreated children and their families since CAPTA laws were enacted are the focus of this review, and a rationale is provided for additional professional support, development, and coordination of services for Part C providers and child-protective caseworkers. First, we examine the prevalence of child abuse and neglect, and the risk factors that lead to impacts on development and future school readiness. Second, we describe the underrepresentation and underutilization of early intervention services for children and families involved in child welfare. Finally, based on our review of the literature, we describe barriers to service implementation and recommendations for future practice and research.

CHILD MALTREATMENT

Each state is responsible for defining child abuse and neglect and must meet minimum standards set by the federal government to protect children. The CAPTA (42 U.S.C.A. §5106g), as amended by the Keeping Children and Families Safe Act of 2003, defined child abuse and neglect as:

> Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act, which presents an imminent risk of serious harm (42 U.S.C.A. §5106g, Section 111).

Approximately 3.3 million abuse and neglect referrals were investigated in the United States in 2009; of those, 24% were substantiated (USDHHS, 2010). An estimated 1740 child deaths resulted from maltreatment in 2008, and 1770 in 2009, a consistently increasing trend (USDHHS, 2010; USDHHS, 2011). Infants and toddlers are at the highest risk, with infants younger than 1 year at the highest risk for fatalities from child abuse and neglect (USDHHS, 2010; Oregon Department of Human Services, 2009). Infants and young children with identified disabilities are particularly vulnerable for maltreatment (Brown & Schormans, 2003; Scarborough et al., 2004), with 6%–12% of all child-maltreatment victims reported as having a disability as compared with 2.3% of the children with disabilities younger than 5 years in the total population (Algood, Hong, Guourdine, & Williams, [in press]; Casanueva, Cross, & Ringeisen, 2008; USDHHS, 2011). In terms of ethnicity, there are no significant differences between white, African American, or Latino populations (USDHHS, 2010). Proportionately, neglect has remained the most consistent type of maltreatment, with more than 70% of investigated cases due to neglect, followed by physical (16.1%), sexual (9.1%), and psychological abuse (7.3%) (USDHHS, 2010).

The state child welfare office typically begins the process of child protection when a report of suspected abuse is received. A case is substantiated when the investigation confirms that there is reasonable cause to believe that abuse or neglect has occurred. After a case is substantiated, services begin for the child and family. Case management services include setting goals for the family, creating plans to achieve goals, providing services to obtain goals, and monitoring the outcomes. Safety (protection from abuse and neglect), permanency (a stable and permanent home), and well-being (physical, mental, educational, and developmental needs are met) are the overarching goals of child welfare (McCarthy et al., 2003). Related to child well-being, development concerns of maltreated children are well documented and can have a formidable impact on future educational and health outcomes for children.

DEVELOPMENTAL IMPACT OF CHILD ABUSE AND NEGLECT

Increases in child maltreatment and the resulting impact on young children's development indicate a pressing need for

intervention services. According to USDHHS-ASPE report (2008), "55% of children under the age of three years with substantiated cases of maltreatment are subject to at least five risk factors associated with poorer developmental outcomes" (p. 2). In a study using the NSCAW data, 47% of children with substantiated cases of child abuse or neglect had developmental problems in 1 or more domains (Ward et al., 2009). Areas of development affected by child maltreatment include social–emotional development, cognitive development, physical development, and overall health. We explore each of those areas briefly here.

Social–emotional development

Social–emotional development is the one domain of development most affected by maltreatment, leading to long-term emotional and behavioral problems (Shonk & Cicchetti, 2001; Squires & Bricker, 2007; Stormont, Lewis, & Beckner, 2005) occurring in as many as 70% of child-maltreatment cases (USDHHS-ASPE, 2008). Social competence, an important indicator for school readiness and future academic success, is often compromised for children who have been abused or neglected, which can lead to long-term behavior problems for children once they reach school age (Feil et al., 2009; Mashburn et al., 2008; Raver, 2002; Shonk & Cicchetti, 2001; Shonkoff & Phillips, 2000; Stormont et al., 2005; Webster-Stratton, Reid, & Stoolmiller, 2008). Children who have been maltreated also often have fewer skills in developing social relationships with peers, a predictor of future academic failure (Shonk & Cicchetti, 2001).

Other social–emotional problems affected by maltreatment include attachment issues, posttraumatic stress disorder, and antisocial behavior. Attachment to primary caregivers may be interrupted by abuse and neglect, which can lead to serious consequences such as a medical condition known as failure to thrive (weight for age below the fifth percentile) and mental health issues such as reactive attachment disorder (Block & Krebs, 2005; Kerr, Black, & Krishnakumar, 2000; Zero to Three, 2005). Children who have been neglected because of their parents' substance abuse have increased mental health problems, including posttraumatic stress disorder and antisocial behavior (Hayward et al., 2010). Many maltreated children also have a high incidence of traumatic experiences, leading to stress, which is indicative of increased cortisol levels that can impact brain development (Child Welfare Information Gateway, 2009; Griffin, Martinovich, Gawron, & Lyons, 2009; Johnson & Lieberman, 2007; McGowan et al., 2009). Although 85% of maltreated children are in need of mental health services, most do not receive these necessary services (National Center for Children in Poverty, 2010). While children's social emotional development is most noticeably impacted by maltreatment, brain development and cognitive functioning also are negatively affected.

Cognitive development

Abuse and neglect can also have a long-term impact on cognitive development in the growing child. Physical abuse, such as brain damage from shaken baby syndrome or traumatic brain injury, can be extremely detrimental to early brain development and ultimately can be fatal (Child Welfare Information Gateway, 2009). Neglect can have an impact on cognitive development through inadequate nutrition and lack of a stimulating environment (Child Welfare Information Gateway, 2009; Hayward et al., 2010; Iverson et al., 2010; Shonkoff & Phillips, 2000). In a recent study, Ward et al. (2009) found that almost half of the maltreated children studied had delays in the areas of cognitive, language, and behavior, evident in difficulties with reading, writing, and math, with 10% of maltreated children having general learning difficulties compared with 0.4% of their nonmaltreated peers (Iverson et al., 2010). Cognitive development is impacted by maltreatment; however, abuse and neglect also affect physical development and health.

Physical development and health

Child abuse and neglect can affect the physical development of maltreated children

by impacting growth, weight, and motor development through malnutrition, exposure to substances, stress, and lack of stimulation (Kim & Krall, 2006). Furthermore, child maltreatment is associated with health problems in childhood and later in adult life (Hagle, 2005; Wiggins, Fenichel, & Mann, 2007). Health problems related to maltreatment throughout the life span include diabetes, obesity, substance addiction, heart disease, and autoimmune deficiencies (Felitti et al., 1998). Research clearly indicates a relationship between child maltreatment and poor developmental outcomes for children, leading to the recognition for necessary changes in policy to expand the aim of child welfare beyond safety, permanency, and well-being to address the unique developmental needs of maltreated children. The CAPTA laws were enacted to address these needs; however, maltreated children remain underrepresented in Part C services (Rosenberg & Smith, 2008).

UNDERREPRESENTATION OF MALTREATED CHILDREN IN PART C

Although the CAPTA laws established a mechanism for improvement of children's developmental outcomes by mandating referrals to early intervention services for children younger than 3 years, only small percentages are actually receiving Part C services (Casanueva et al., 2008; Stahmer, Sutton, Fox, & Leslie, 2008). Maltreated infants, the largest group of children experiencing abuse and neglect, may be the least served in Part C, as infants are underrepresented in Part C overall, with the average age of identification at about 15 months of age (Rosenberg & Smith, 2008; Scarborough & McCrae, 2008; US Office of Special Education Programs, 2010). The developmental impacts of abuse and neglect can be more pervasive and devastating for younger children and can have a lasting impact, even if the child is removed from the home (Perry, 2008).

Casanueva et al. (2008) found that approximately 35% of children aged 0–3 years involved in child welfare investigations were in need of developmental services as compared with 2% in the US population receiving developmental services. Need of developmental services was defined as "2 standard deviations below the mean on at least one standardized developmental measure or 1.5 standard deviations below the mean on at last two standardized developmental measures" (Casanueva et al., 2008, p. 5). However, only 12.7% of these maltreated children were receiving early intervention services (Casanueva et al., 2008). Ward et al. (2009) found that almost half (47.3%) of a sample of maltreated children aged 0–5 years involved in child welfare services had developmental problems in one or more areas in assessments used in the NSCAW study, but only one-quarter of those children were receiving any early intervention services. These statistics point to the many barriers that young children experience related to receiving services in a timely manner. Thus, infants and toddlers experiencing abuse and neglect are underrepresented in Part C services.

Underrepresentation may be due to problems with child find, screening, and early identification procedures, as well as assessment and referral processes (Ward et al., 2009). For maltreated children with substantiated cases, there is a lack of consistency and awareness regarding screening and referral procedures (Stahmer, Leslie, Landsverk, Zhang, & Rolls, 2006; Ward et al., 2009). In some states, caseworkers use screening instruments to determine whether children need to be referred for further testing; however, there is a concern that caseworkers may lack the training needed to complete developmental screenings, thus, the potential for erroneous results (Stahmer et al., 2006). For example, child-protective caseworkers may not know how to interpret cutoff scores on developmental screening tools. Other states report that caseworkers use their informal knowledge of child development rather than validated screening or assessment measures as the basis for decision making when referring a child; therefore, many children who need an evaluation could be overlooked because of the

lack of accurate information (Ward et al., 2009). Some child-protective workers may remain confused about the referral process even after training, for example, referring children for Part C evaluations only if they are entering foster care versus children with substantiated cases who remain in the home (Ward et al., 2009). Moreover, because the referral and evaluation processes often are complicated by high caseworker turnover, multiple foster care placements, and poor coordination among agencies, there is a need to streamline the assessment and eligibility process for these children (Stahmer et al., 2008).

SERVICE BARRIERS FOR MALTREATED CHILDREN AND FAMILIES

Fragmented and poorly understood child find, screening, and assessment/eligibility procedures constitute one major barrier to entry into Part C services for maltreated children. However, many maltreated children and their families continue to experience barriers even after eligibility has been established. These barriers include (1) problems with data sharing and tracking, (2) lack of parental engagement in services, and (3) inadequate professional development for child-protective workers and early intervention specialists.

Data tracking

After eligibility for early intervention services has been established, maltreated children and their families face additional barriers to timely services. State and national data systems on children in the child welfare system receiving Part C developmental services are inadequate, which may result in fewer services or overlapping services for some families (National Center for Children in Poverty, 2010; Perlman & Fantuzzo, 2010; USDHHS-ASPE, 2008). In addition, to protect confidentiality, data systems in states often prohibit data sharing among agencies serving families with abuse and neglect issues. Improvement and refinement of data systems could assist states in tracking early intervention referrals and eligibility categories for maltreated children, providing much needed information for accountability and policy decisions.

Since early intervention services are voluntary, many families involved in child welfare choose not to engage in services (Derrington & Lippitt, 2008). Improvements in data systems could also assist in tracking how many families involved in child welfare actually engage in early intervention services, how many leave services, and why they choose to leave. Gathering information from families would help states understand barriers and assist in programming decisions to improve retention.

The lack of data-tracking systems also creates problems for the coordination of direct services to families (Robinson & Rosenberg, 2004). Child-welfare caseworkers and early intervention service providers should have access to shared information regarding children's placement, developmental progress, and family priorities to make timely programming decisions and reduce overlapping services (eg, community referrals, developmental screenings, parent-training information). Moreover, children involved in child welfare tend to move more frequently and may have multiple placements in the foster care system. When families and children move from county to county or state to state, interruptions in service may occur, delaying progress toward children's developmental goals and implementing family counseling and other services. Improvements in data tracking would assist multiple agencies to coordinate services when a child or family moves. While improvements in data tracking and sharing would assist in policy decisions and coordination of services, parents must first engage with Part C services in order for their child to benefit.

Parental engagement in services

A second barrier to receiving early intervention services for maltreated children is that parents involved in child welfare may choose not to accept or engage (eg, respond to early intervention provider's attempts to make contact and provide support and teaching strategies for their child) in voluntary Part C

services (Barth et al., 2007; Derrington & Lippitt, 2008; Shaw & Goode, 2008; USDHHS-ASPE, 2008). The impact of nonengagement may lead to increased developmental problems for children, lack of preparedness for school, and potential long-term placement in special education services once the child reaches school age (Feil et al., 2009; Mashburn et al., 2008; Raver, 2002; Shonk & Cicchetti, 2001; Shonkoff & Phillips, 2000; Stormont et al., 2005; Webster-Stratton et al., 2008). Derrington and Lippitt (2008) report that up to 37% of families with children younger than 3 years involved in child welfare did not engage in early intervention services. Also, parents who have had trauma or addiction problems may be less receptive to Part C services and may not be able to attend, comprehend, or retain information due to cognitive impairments or depression (Hayward et al., 2010). Other reasons for which parents or caregivers involved in child welfare refuse services include lack of trust, involvement with too many other mandatory services, perceptions of judgment on the part of the interventionist, lack of awareness about child development and the accumulative effects of trauma, and legal issues regarding foster parents and consent for services (Stahmer et al., 2008; USDHHS-ASPE, 2008; Ward et al., 2009). Many of these issues are related to the attitudes, training, and relationships among child protective caseworkers, early interventionists, and parents or caregivers involved in child welfare, hence, the need for comprehensive trainings and professional development for both child protective caseworkers and early interventionists.

Professional development

Child-protective caseworker training

Lack of caseworker training related to early development and early intervention constitutes a third barrier. Targeted training to enhance caseworkers' knowledge of Part C services would improve the ability of child-welfare agencies to coordinate and participate in timely and collaborative child and families services (Derrington & Lippitt, 2008; Perlman & Fantuzzo, 2010; Scarborough & McCrae, 2008, Ward et al., 2009). Caseworkers also need a thorough understanding of child development to more readily identify developmental problems, to know how and when to refer a child for services to facilitate transitions to Part C, and to know how to monitor children's development to identify problems as soon as they occur (Ward et al., 2009). Since parental engagement is a barrier for maltreated children receiving Part C services, caseworkers need to be able to communicate the benefits of early intervention services to parents and caregivers while also conveying the voluntary nature of early intervention services (Stahmer et al., 2008). In addition, child-welfare caseworkers need to understand the importance of collaboration with Part C service providers in providing a seamless process in which intervention programs are tailored to meet the needs of children and families in the child-welfare system, including incorporating progress on Individualized Family Service Plan (IFSP) goals in the family case plan (USDHHS-ASPE, 2008).

Early intervention service provider training

Just as caseworkers need more training in child development, early intervention service providers need more training in how to work with children, parents, and other care providers involved in the child-welfare system (Derrington & Lippitt, 2008; Perlman & Fantuzzo, 2010; Robinson & Rosenberg, 2004; Stahmer et al., 2008; USDHHS-ASPE, 2008; Ward et al., 2009; Wulczyn, Barth, Yuan, Harden, & Landsverk, 2006). Ward et al. (2009) suggest that early interventionists need training in how to respond to maltreated children's emotional needs and instructions on the importance of nonjudgmental and supportive attitudes toward parents involved in child welfare. Similarly, Derrington and Lippitt (2008) recommend professional training in how to effectively engage parents involved in child welfare, while Perlman and Fantuzzo (2010) suggest that cross-discipline training will help to facilitate the awareness of the multiple issues surrounding maltreated children.

Currently, professional development for early intervention preservice teachers and practitioners often includes training and coursework focused on effective partnerships with parents, interpersonal relationships with parents, and understanding the parent's perspective regarding raising a child with a disability (Bricker & Widerstrom, 1996; Turnbull, Turbiville, & Turnbull, 2000). Additional training is needed for professionals entering the field of early intervention on the effects of poverty and substance abuse due to the high frequency of these issues for families involved in child welfare; child welfare laws and policies, including the family court system to better understand how these policies and laws affect working with maltreated children and their families; how to collaborate with child welfare caseworkers and other human service agencies to prevent unnecessary barriers; and collaboration with infant mental health specialists to better serve the unique behavioral and mental health needs of maltreated children (USDHHS-ASPE, 2008).

In summary, many barriers to obtaining services exist for families involved in child welfare, even after children's eligibility is established. The prevalence of child maltreatment in our country is pervasive and steadily increasing (Child Welfare Information Gateway, 2009). The effects on society, individual children, and families are tragic, including lower educational attainment, poverty, crime, health, and the overall financial cost (Prinz et al., 2009; Shonkoff & Phillips, 2000; Wang & Holton, 2007). As a nation, we are addressing this issue through prevention programs and legislation that will provide for improved outcomes for children through early intervention. However, we have far to go in addressing these needs. The following are some recommendations based on current best practices, data, and research in child welfare and early intervention.

RECOMMENDATIONS

Part C services often uses a "linked systems" approach to intervention in which a developmental assessment is performed to assess the child's current skills, and an IFSP is written to document needed services, placement information, child's developmental goals, and family priorities and concerns (Bricker, Pretti-Frontczak, Johnson, & Straka, 2002). The provider then works with the caregiver to deliver family-focused services, with the overall goal of ameliorating developmental problems in young children and improving their independent functioning and self-sufficiency. Early intervention services provided in this linked model, if implemented effectively by Part C providers that understand the unique and multiple challenges that maltreated children face, should provide effective and family-driven services. The recommendations that follow assume that early interventionists have the skills necessary to work with these diverse families. For some interventionists, the lack of personal awareness of biases regarding families involved in child welfare may act as a barrier to Part C enrollment. Therefore, enhancement of early interventionists' skills will only increase the possibility of positive outcomes for children and families while reducing barriers that exist.

We discuss four recommendations for improving services to maltreated children and their families. They include (1) a comprehensive approach through systems coordination, (2) gaining additional knowledge of parent-training principles for early interventionists, (3) increasing the level of relationship-based services specifically targeting child welfare involved families, and (4) additional professional development strategies for early interventionists and child-protective caseworkers.

Systems coordination

Part C service coordinators are familiar with collaboration between early intervention professionals such as occupational therapists, speech and language specialists, physical therapists, and special educators. However, as previously discussed, an area of needed improvement for maltreated children and their families is increased coordination among agencies and services, specifically tailored

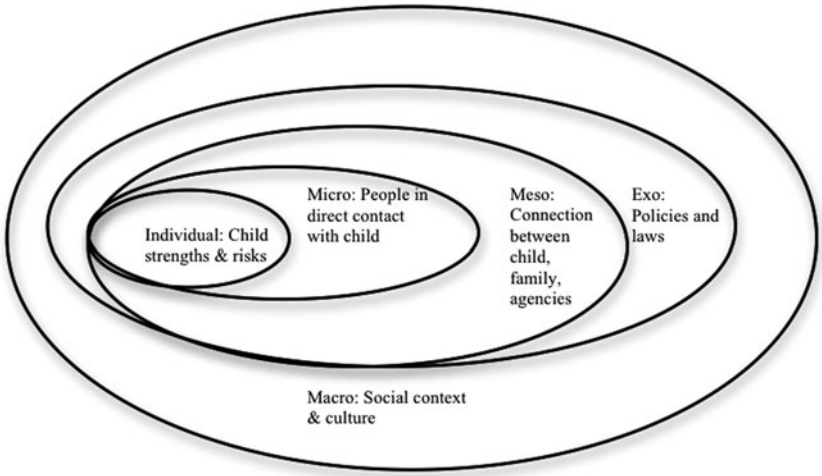

Figure 1. Bronfenbrenner's (1979) ecological model in child welfare context.

to this vulnerable population (American Academy of Child and Adolescent Psychiatry, 2002; Stahmer et al., 2008). Theoretical approaches that build on family strengths are important in serving parents and caregivers involved in child welfare.

For example, Bronfenbrenner's (1979) ecological model is particularly pertinent to families involved in the child-welfare system and early intervention. The ecological model of child development, shown in Figure 1, provides a theoretical framework for serving the individual within the context of interrelated systems (Bronfenbrenner, 1979). An ecological approach promotes the coordination and collaboration of services that attend to the multiple risk factors, numerous agencies, and resources that families involved in child welfare may need. Using an ecological approach, the central focus is the child, with family members and anyone in direct contact with the child at the micro level (ie, parents, caregivers, grandparents, and teachers). Next, the meso level contains the interconnections between the microsystems (ie, between teacher and parent or caregiver and aunt). The exosystem is composed of the policies and laws that affect the child and family (ie, special education laws, home-visiting policies, and CAPTA laws). Finally, the macrosystem refers to the culture and belief systems that affect the child and family (ie, culture of poverty, religious beliefs, and beliefs about child abuse). For example, the early intervention provider, child-protective case worker, and parent trainer will need to collaborate on developing parenting goals for families involved in child welfare. At the microlevel, the early intervention provider may work with the parents or other family caregivers to embed strategies such as positive discipline into routines while simultaneously embedding learning objectives related to the child's developmental goals. Similarly, the caseworker and caregivers may discuss the age-appropriate discipline strategies that the caregivers are learning and document progress. At the meso level, the early intervention provider and caseworker will need to work closely with the parent trainer to develop parenting goals appropriate for the developmental age of the child and monitor caregiver's and child's progress. Custody laws, IDEA laws, and child-welfare policy will determine timelines and service delivery at the exosystemic level. Finally, the macro level needs constant consideration to remain sensitive to the multiple cultural influences affecting the child and family. The ecological model is an effective framework that addresses multiple levels of a client's situation when working

with children and families involved in child welfare who are also accessing early intervention services.

Recommendations for best practice also include a social work model, a case management approach, to providing services for families involved in child welfare (American Academy of Child and Adolescent Psychiatry, 2002; Robinson & Rosenberg, 2004). Social work case management is a team approach, strength-based process with four phases: (1) assessing; (2) planning; (3) linking; and (4) monitoring with the purpose of improving the life of the client (Summers, 2009). Case management in social work is synonymous with early intervention service coordination. In early intervention procedures, the team assists in assessing the child's and family's strengths and needs, developing an IFSP for the child, developing goals for the family, providing intervention in the form of individualized services, and evaluating the intervention and child progress toward goals. Improvements can be made in early intervention practice, primarily during the linking phase, through increased awareness of community resources, networking, and building relationships with community agencies, specifically targeting issues common to maltreated children and their families. Benefits for families and children may include improved access to resources such as health care, employment services, domestic violence resources, drug and alcohol treatment, and mental health services.

Using a collaborative model is not unknown to early intervention providers. Recommended practices for Part C services suggest a transdisciplinary approach for working with the child and family (Bricker & Widerstrom, 1996). In the transdisciplinary model, early interventionists work as a team with other specialists and professionals to share knowledge and expertise regarding techniques and delivery of services to provide continuity between specialists. Similarly, collaboration between early interventionists and caseworkers may assist in enhancing service delivery through sharing of expertise, reducing redundancy of services, and increased communication regarding families' progress toward goals. Integrating ecological case management and early intervention models will provide a comprehensive method of serving multistressed families while simultaneously providing developmental interventions for maltreated children. To ensure collaboration and coordination of services between child-welfare and early intervention professionals, the partnership "must be clear, recognized, and valued by both agencies" (Stahmer et al., 2008, p. 8). The conceptual model seen in Figure 2 provides a framework for understanding the potential impact of models of delivery and collaboration between agencies for families and children in child welfare.

Knowledge of parent-training principles

Comprehensive and collaborative services are necessary to ensure the potential for positive outcomes for families involved in child welfare. However, Part C providers may need to increase their awareness and knowledge of the principles and evidence-based practices in family coaching and parent training to increase alignment with the child-welfare goals of safety, permanency, and well-being. Parent training, defined as a strength-based program that promotes skill development and knowledge of effective discipline methods, positive communication strategies, and child development, enhances the relationships between parent and child.

Parent training often is mandated for parents involved in child welfare in an effort to address safety and permanency, with up to 67% of substantiated cases receiving parent-training or family counseling services (Barth et al., 2007). Since social–emotional problems, relationship difficulties, and problem behaviors may be outcomes for children who have been abused or neglected, it is important that Part C providers have an understanding of how to work with parents to improve the parent–child relationship and understand the principles of current evidenced-based parent training programs.

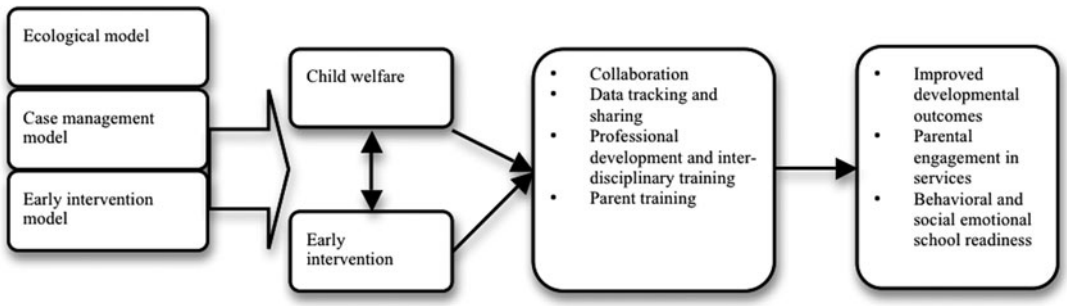

Figure 2. Conceptual model of collaborative services between early intervention and child welfare.

The most effective parent-training programs for strengthening family functioning include a combination of cognitive–behavioral parent training, modeling and coaching parenting skills, family therapy, and home visiting (Krumpfer, Alvarado, & Whiteside, 2003). For example, studies have shown the cognitive–behavioral Triple P intervention to be effective in parents' improved perceptions of child behavior, improved parenting practices, and reduction of coercive parenting (Asawa, Hansen, & Flood, 2008; Johnson et al., 2008; Petra & Kohl, 2010; Prinz et al., 2009). The Nurse Home Visitation Program has also shown statistically significant results for improved parent–child interactions, health care utilization, and reductions of child abuse reports for families at risk of child maltreatment and for families involved in child welfare, except for those experiencing severe levels of intimate partner violence (Asawa et al., 2008).

Many parents involved in the child-welfare system may have unrealistic developmental expectations of their children. Thus, there is the need for child development education for parents (Stahmer et al., 2008), with more direct instruction and coaching (Robinson & Rosenberg, 2004). Coaching models that show preliminary promise include Infant Net, an interactive video modeling maltreatment prevention program delivered through the Internet for rural at-risk mothers of infants (Feil et al., 2008) and the Play and Learning Strategies program developed for high-risk parents to increase parental responsiveness and target children's social emotional, language, and cognitive development (Dieterich, Landry, Smith, Swank, & Hebert, 2006). While it is beyond the scope of this article to provide a complete review of effective and promising parent-training programs targeting families at-risk for child maltreatment and those involved in child welfare, early intervention preservice training and on-going professional development could include becoming familiar with the current trends in parent training, providing support for families involved in child welfare who are working on parent-training goals, and integrating parenting goals within the IFSP.

Relationship-based services

Parent training as well as other services provided to families in child welfare build on the foundation of relationship-based services often offered in the mental health field (Hanson, Deere, Lee, Lewin, & Seval, 2001; Shaw & Goode, 2008). Similarly, early interventionists are trained to deliver relationship-based services to all families (Emde & Robinson, 2000; Turnbull et al., 2000). A relationship-based approach begins with building rapport by using a nonjudgmental attitude on the part of the interventionist, which is especially important with high-risk families involved in child welfare. Equally important, interventionists need to maintain a professional balance of active listening and responding appropriately, being cognizant of the power that they hold in the relationship, and avoiding dual relationships with clients (eg, friend and advisor as well as the child's

interventionist). Furthermore, to develop and maintain positive relationships, interventionists working with children and families in the child-welfare system should sustain reflective practices and supervision by experienced interventionists provided by early intervention systems and agencies (Lietz, 2010; Virmani & Ontai, 2010). While these principles should be reflected when providing early intervention services to all families, working with families involved in child welfare can be especially challenging and may require more effort, reflection, and supervision for effective delivery of services (Stahmer et al., 2008).

Likewise, when providing home-based early intervention services to children and families in the child-welfare system, it is important that interventionists are knowledgeable about the dynamics of home visiting and be aware of their own biases regarding child maltreatment (Robinson & Rosenberg, 2004). Parents involved in child welfare may be anxious and suspicious of professionals entering their home because of past experiences with professionals; therefore, extra considerations should be made to establish a trusting and respectful relationship (USDHHS-ASPE, 2008). For example, the experience of having a child removed from the home may leave parents suspicious, anxious, defensive, and angry. Those feelings may be transferred to any helping professional who enters the home. Active listening skills, a nondefensive attitude in response to parent's anger, and validation of parent's concerns to expressly address the issue of mandatory reporting may assist in relationship building. There is a need for early interventionists to be especially cognizant of their professional behavior when working with families involved in child welfare to increase the probability of continued engagement in services; therefore, increased levels of training and professional development may be necessary to meet the unique needs of families involved in child welfare.

Professional development

To address the specific issues of agency collaboration, coordination of services, parent-training knowledge, and relationship-based services, Part C providers may need additional coursework, training, or certification. In a study examining the practices of 42 state Part C programs after the CAPTA legislation was enacted, only eight provided specific training to Part C providers on working with families in child welfare and of those states, the training mainly focused on the implementation of CAPTA and administrative issues (Stahmer et al., 2008). To address these issues, early intervention professional development and training should be comprehensive and include all aspects of providing early intervention services, as well as background information in social work and family interventions. Additional courses in social work in the general early intervention program or as an elective strand to supplement professional development may enhance professionals' ability to work with child welfare-involved families. Additional recommended course work includes (a) intensive case management, (b) individual counseling skills, (c) effective communication strategies, (d) methods of evidenced-based parent training, (e) principles of infant mental health, including the effects of trauma, and collaborating with existing infant mental health systems, (f) intensive relationship-based home visiting, and (g) a concentration in social–emotional assessment, goal development, intervention, and evaluation for infants and children birth to age three years.

A thorough understanding of the child-welfare system is also needed for interventionists working with child welfare-involved families. Interventionists need internships with child-welfare caseworkers and coursework in the child-welfare system, including child-welfare laws and the court system; foster care and the effect of multiple placements; child-welfare case management and community resources; and multiple risk factors affecting child welfare-involved families, including domestic violence and drug and alcohol addiction.

In summary, to ensure that maltreated children and their families are benefiting from the CAPTA legislation, improvements are needed

in Part C and child-welfare systems coordination. In addition, awareness and integration of parent-training interventions, higher levels of relationship-based services, and focused professional development for child-protective caseworkers and early interventionists will enhance service delivery and family outcomes.

FUTURE RESEARCH AND DEVELOPMENT

The complex problems of serving children and families involved in child welfare under Part C IDEA point to a clear need for additional professional training as well as specialized research to understand the unique needs of children and families. Several model programs are demonstrating that collaborative approaches can serve maltreated children in appropriate ways. Some examples of systems approaches that include Part C are the Michigan Association for Infant Mental Health (Learning and Growing Together, 2011), Florida's Court Teams for Maltreated Infants and Toddlers Project (Court Teams for Maltreated Infants and Toddlers, 2011), Massachusetts's Connected Beginnings (Nurturing the Social Emotional Well-Being of Children Ages Birth to Five, 2011), and Hawaii's Healthy Start program (Healthy Start Program, 2011). These infant's mental health models provide innovative approaches to serving young children and families with varying degrees of targeting maltreated children and partnering with Part C early intervention service providers. We offer additional recommendations for practice and research to reduce the impact of child maltreatment on children's development, increase utilization of Part C services, and diminish referral and service barriers.

Future research should focus on evaluating the effects of comprehensive training for Part C providers and how training impacts the outcomes for children and families, including family engagement in services. Likewise, further research is needed on the effects of professional development for caseworkers in the areas of child development, developmental screening, and the components of the Part C system. Research on professional development for both early interventionists and child-protective caseworkers will help to ensure that effective training methods are used that improve the outcomes for maltreated children and their families. Finally, future research needs to explore more effective methods of tracking data for child welfare-involved families. Testing of data systems to improve the consistency of data tracking, coordination of services, and sharing of information between agencies will help to improve outcomes and supply needed information for data-based policy decisions.

It is evident that the problem of child maltreatment is pervasive and devastating to children's development and their quality of life, as well as to society in general. The 2003 Amendment of the CAPTA law was an important first step in protecting and serving young children who are abused and neglected. Yet, maltreated children continue to experience barriers to entering the Part C system. Future research could help to answer questions regarding these barriers, such as "Are states invested in serving maltreated children or do they believe maltreated children are not the intended recipients of Part C; Are states consistently providing the mechanism for the CAPTA referrals and following through with coordinated care?"

Part C services can help to ameliorate the devastating effects of child maltreatment, prepare children for future school success, and strengthen families. Child-protective service workers and early intervention service providers need improved training and also increased collaboration to effectively meet the needs of children and families in the child-welfare system. Further action is needed in the form of legislation and policy to increase awareness, funding, and services for maltreated children. Research and demonstration projects are needed to develop and test effective interventions and professional training strategies to ensure that children and families are receiving and benefiting from the services the law has mandated. Coordinated and

effective services provided by Part C and child welfare have the potential to make dramatic improvements in the lives of maltreated children and their families.

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CENTER FOR THE STUDY
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strengthening families™
A PROTECTIVE FACTORS FRAMEWORK

Strengthening Families for Practitioners

Every parent has high hopes for their children. But even great parents need help to make those hopes a reality. And sometimes, the stress of being a parent can overwhelm even the best intentions. Fortunately, most parents have a ready resource to help them: the child care and early education programs that their children are already a part of. These programs are where families already feel comfortable with the staff that care for and work with their children every day.

Strengthening Families was developed to help these local programs understand how they can be an excellent resource for the children and families they serve. It is a research-based, cost-effective approach that focuses on building five Protective Factors that promote healthy development for children, better outcomes for families and reduce the likelihood of child abuse and neglect. The Protective Factors are:

- Parental Resilience
- Social Connections
- Knowledge of Parenting and Child Development
- Concrete Support in Times of Need
- Social and Emotional Competence of Children

What are the advantages of Strengthening Families?

- It is affordable. Most public and private child care programs can adopt this approach by making small but significant changes in their everyday practice without additional cost. In many states, child abuse prevention funds, professional development opportunities and other resources may be available to help programs implement Strengthening Families.
- It has widespread support. More than 30 states and many counties and cities are using the Protective Factors Framework supported by federal, state and local funds. It helps everyone who works with children and families understand the same research and use the same language for the common work they are doing.
- Local programs are ready to go to work. A nationwide survey by the National Association for the Education of Young Children, the professional association for early childhood practitioners, showed that 97 percent of teachers and administrators wanted to do more to promote healthy families and prevent child maltreatment; and, asked for help to do it effectively.

Program Strategies that Build Protective Factors

Most people who work with children and families are already doing things to help build Protective Factors. Field research behind Strengthening Families identified seven key strategies that exemplary programs use in their work to build protective factors with families. The same strategies often help build more than one protective factor. While the strategies themselves are consistent across many different kinds of programs, the way programs implement them are adapted to the culture, concerns, values and traditions of the particular families they serve. People working in community programs, early care and education, child welfare, family support and the many other places can adapt these strategies to support the families and children they encounter.

The Seven Program Strategies are:

1. Facilitate Friendships and Mutual Support
2. Strengthen Parenting
3. Respond to Family Crises
4. Link Families to Services and Opportunities
5. Value and Support Parents
6. Facilitate Children's Social and Emotional Development
7. Observe and Respond to Early Warning Signs of Abuse and Neglect

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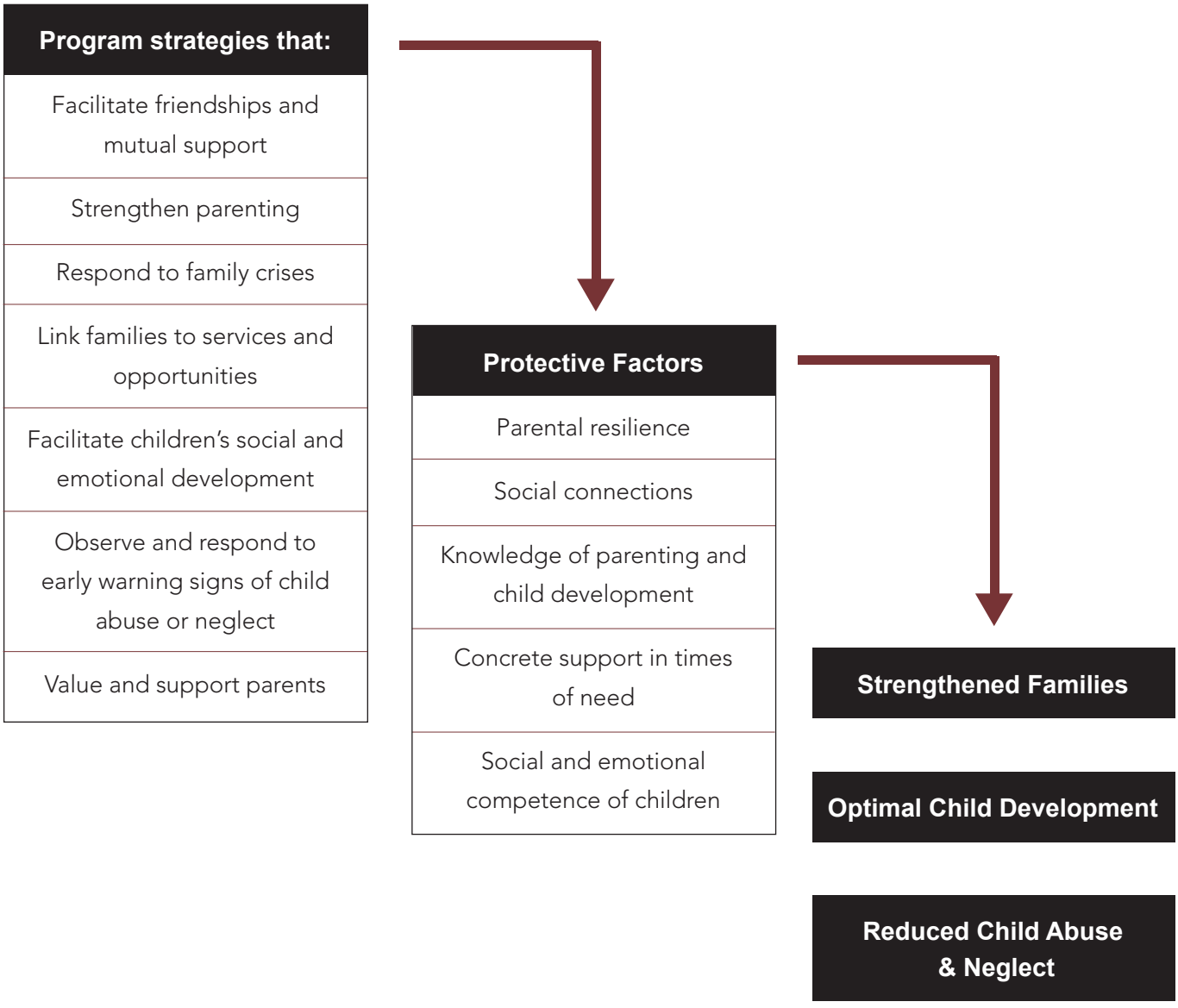
How programs help strengthen families, promote optimal child development and prevent child abuse and neglect



The Protective Families Framework and Early Care and Education Programs

Protective Factor that Helps Promote Optimal Child Development and Reduce Abuse and Neglect:

Parental Resilience

What It Means

A parent's psychological health plays an important role in their child's development. Parents who are emotionally healthy are able to maintain a positive attitude, creatively solve problems and effectively rise to the challenges that emerge in every family's life. Resilient parents form strong attachments to their children, foster the child's healthy development and are less likely to abuse or neglect their children.

Knowing when and how to seek help, and how to use it effectively, is a vital part of bouncing back from problems. Relationships with people they trust can help parents seek help for problems such as depression, feelings of frustration or assistance with a crisis.

Parents who have experienced violence, abuse and neglect or have had other adverse experiences may need extra caring relationships as adults to help them feel confident as parents and to develop and maintain positive relationships with their children.

How Programs Can Help

Train staff to develop trusting relationships with families during program time, and provide an opportunity for these relationships to flourish.

Hire or develop family support workers who build relationships with parents.

Understand that mental health consultants are an integral part of the staff team, available to staff and to parents when additional support is needed.

Train staff to observe children for early signs of child or family distress and respond to both children and their families with encouragement, support and help in solving problems.

The Protective Families Framework and Early Care and Education Programs

Protective Factor that Promotes Optimal Child Development and Reduces Child Abuse and Neglect:

Social Connections

What It Means

Everyone benefits from a strong network of extended family, friends, neighbors and others who provide healthy relationships, support and problem solving. Being new to a community, recently divorced or a first-time parent makes a support network even more important; it may require extra effort from programs to help families build the new relationships they need.

Belonging to a network builds parents' "social capital" and encourages opportunities to "give back." It helps develop a community that helps each other out, solves problems together and provides fun and companionship.

Friendships lead to mutual assistance in getting tangible resources all families need from time to time, such as transportation or occasional child care. Friendships also help lend emotional support.

Social connections help parents to develop and reinforce community norms about behavior that affects everyone. Norms against harsh discipline help reduce child abuse and neglect; norms about high expectations for children foster more achievement; norms about healthy eating and activity create a greater chance for long-term health.

Helping parents build friendships and other positive connections can reduce isolation, which is a consistent risk factor for negative outcomes like child abuse and neglect, domestic violence and depression.

How Programs Can Help

Set aside space for parents, with coffee or snacks, or other ways to offer parents a welcoming space atmosphere to mingle and talk.

Use regular potluck dinners with parents and children to make a special effort to reach out to new parents and foster new friendships.

Sponsor sports and outdoor activities for parents, including men.

Provide classes and workshops on parenting, cooking, health and other topics of interest.

Connect parents with organizations and resources outside the program such as churches or other classes that fit their interest.

Create special outreach and activities for fathers, grandparents and other extended family members.

The Protective Families Framework and Early Care and Education Programs

Protective Factors that Promotes Optimal Development for Children and Reduces Abuse and Neglect:

Knowledge of Parenting and Child Development

What It Means

Parents who understand the usual course of child development are more likely to be able to nurture their children's healthy development and less likely to be abusive or harmful to their children.

Basic information about child development and parenting comes from multiple sources, including extended families, cultural practices, books, television and other media, formal parent education classes and a parent's own experiences.

Observing other children of similar age helps parents understand their own child in relationship to other children.

All parents need just-in-time help from someone they trust in to help them manage new chapters in their children's development as well as specific behavior problems such as biting or hitting, without resorting to harsh discipline techniques.

Observing caregivers who use positive techniques for managing children's behavior, seeing men as well as women in nurturing roles, and learning from a program's efforts to teach children non-violent ways to resolve conflicts are key ways that parents may learn alternatives to their own negative experiences.

Parents of children with developmental or behavior problems or special needs need knowledgeable coaching and support in their parenting roles to reduce their frustration and help them become the parents their children need.

How Programs Can Help

Offer informal daily interactions between parents and program staff, plus coaching from staff on specific issues (for example: biting, sharing toys, bullying) when they arise.

Provide multiple parent education opportunities through classes or workshops that address topics parents initiate or that respond to current issues.

Provide observation opportunities such as video monitors or windows into classrooms and outdoor space where parents can watch their child interacting with other children and learn new techniques by observing staff.

Give parents opportunities to participate in conversations with other parents about their own experiences as children and how they want to change their parenting for their children.

The Protective Families Framework and Early Care and Education Programs

Protective Factor that Promotes Optimal Child Development and Reduces Child Abuse and Neglect:

Concrete Support in Times of Need

What It Means

Families need to have basic needs (shelter, food, clothing, health care) met to ensure a child's healthy development. Programs of all kinds need to be able to direct families to services and supports for meeting basic needs when necessary.

A family crisis such as unemployment, illness or death can create extreme stress within the family and make less attention available to support a child's developmental needs. Informal networks of support as well as tangible assistance can lessen the impact of a crisis.

Another kind of family crisis occurs when families experience domestic violence, substance abuse or mental illness. In these situations, professional services are required, along with support for family members to achieve safety and stability.

How Programs Can Help

Connect parents to economic resources such as job training and social services or serve as an access point for health care, child care subsidies and other benefits.

Provide for immediate needs through a closet with extra winter coats and a direct connection to a food pantry; facilitating help from other parents when appropriate.

Know how to help families' access crisis services such as a battered women's shelter, mental health services or substance abuse counseling by providing transportation and the name of a person instead of a phone number.

Train staff to listen for family stress and initiate positive conversations about family needs.

The Protective Families Framework and Early Care and Education Programs

Protective Factor that Promotes Optimal Development and Reduces Abuse and Neglect:

Social and Emotional Competence of Children

What It Means

A child's emerging ability to interact positively with others, self-regulate their behavior and effectively communicate their feelings has a positive impact on their relationships with their family, other adults and peers. A baby's early attachment to its parents is the first step in this process.

Parents and caregivers grow more responsive to children's needs – and less likely to feel stressed or frustrated – as children learn tell parents what they need and how parental actions make them feel rather than act them out.

Children with challenging behaviors or delays in social emotional development are at greater risk for abuse. Identifying and working with children early to keep their development on track helps keep them safe and helps their parents facilitate their child's development.

Children who have experienced or witnessed violence need special care from a program – an environment where they feel safe with trained staff experienced in dealing with experienced traumatic events.

How Programs Can Help

Use both structured curriculum and informal interaction to teach children to share, be respectful of others and express themselves through language.

Provide art programs that allow children to express themselves in ways other than words.

Have ongoing engagement and communication with parents about their child's social emotional development and the actions the program is taking to facilitate it. Children often take home what they are learning at school.

Take timely action when there is a concern – this might include asking another experienced teacher or staff member to help observe a child, talking with the parent or bringing in a consultant.

This handout and other publications and resources to help programs implement the Strengthening Families approach are available at www.strengtheningfamilies.net. The website also contains a self-assessment for programs, the research behind the Protective Factors Framework, in-depth information about the strategies that build protective factors and information about exemplary early childhood programs that informed the development of Strengthening Families.

CENTER FOR THE STUDY
OF SOCIAL POLICY'S
strengthening families™
A PROTECTIVE FACTORS FRAMEWORK

Mobilizing partners, communities and families
to build family strengths, promote optimal
development and reduce child abuse and neglect

Strengthening Families: Creating a New Normal

The Strengthening Families Approach:

- Benefits ALL families
- Builds on family strengths, buffers risk, and promotes better outcomes
- Can be implemented through small but significant changes in everyday actions
- Builds on and can become a part of existing programs, strategies, systems and community opportunities
- Is grounded in research, practice and implementation knowledge

Levers

Community and multi-system leaders act to build sustainable infrastructure through key levers for change:

- Parent Partnerships
- Policy/Systems
- Professional Development

Strategies

Community programs and worker practice consistently:

- Facilitate friendships and mutual support
- Strengthen parenting
- Respond to family crises
- Link families to services and opportunities
- Value and support parents
- Further children's social and emotional development
- Observe and respond to early warning signs of abuse and neglect

Protective Factors

Families and communities build protective factors that also promote healthy outcomes:

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete support in times of need
- Social and emotional competence of children

Results

- Strengthened families
- Optimal child development
- Reduced child abuse & neglect

A New Normal

Families and communities, service systems and organizations:

- Focus on building protective and promotive factors to reduce risk and create optimal outcomes for children, youth and families
- Recognize and support parents as decision makers and leaders
- Value the culture and unique assets of each family
- Are mutually responsible for better outcomes for children, youth and families