

## CHAPTER

## 1

# Introduction

## *Overview of Child Welfare Services and Empirical Support*

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### Introduction

Despite historical progress in protecting the rights of children and the evolution of various public and private agencies dedicated to protecting children from child abuse and neglect, child maltreatment remains a daunting and heartbreaking social problem in even the most advanced societies today (Crosson-Tower, 2010; McGowan, 2005). Recent governmental data, for example, indicate that in the United States in just one year (2008) as many as 772,000 children—about 1.3% of the population of children—were substantiated victims of child maltreatment. Approximately 72% of them experienced neglect, 16% were physically abused, 9% were sexually abused, and 7% were abused psychologically/emotionally. Nearly 56% of them were younger than 8 years old. During that year about 1,740 child fatalities were connected to abuse (U.S. Department of Health and Human Services, 2010).

Of course, not all incidents of child maltreatment are reported or substantiated. The Fourth National Incidence Study of Child Abuse and Neglect (NIS-4), for example, suggested that the actual prevalence rate of child maltreatment is much higher than the substantiated rate and that one in seven youths probably experience maltreatment at some point during childhood or adolescence (Finkelhor, Ormrod, Turner, & Hamby, 2005). Although the rates of child physical abuse and sexual abuse have decreased since the 1990s, the rate of neglect has remained about the same, accounting for 71% of the substantiated child maltreatment cases in 2008 (U.S. Department of Health and Human Services, 2010).

The act of child maltreatment is appalling in itself, but what makes matters worse is its probable long-term consequences, which can include various psychological disorders and cognitive limitations (Springer, Sheridan, Kuo, & Carnes, 2003); physical injuries, including impaired brain development (Glaser, 2000); and an increased likelihood of

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such difficulties as delinquency, academic problems, substance abuse, teen pregnancy, and so on (Silverman, Reinherz, & Giaconia, 1996). For example, more than 40% of children in the child welfare system have been diagnosed with oppositional defiant disorder, conduct disorder, developmental delays, or attention-deficit/hyperactivity disorder (Garland et al., 2001; National Survey of Child and Adolescent Well-Being [NSCAW] Research Group, 2002).

Child maltreatment not only takes a toll on emotional, psychological, physical, and psychosocial functioning; it also takes a toll financially. When combining the direct and indirect costs of child maltreatment, child abuse and neglect costs an estimated \$103.8 billion annually. Hospitalization, mental health care for the victims, child welfare services, and law enforcement constitute the direct costs and account for approximately \$33.1 billion. Special education, juvenile delinquency, mental health and health care, adult criminal justice system, and lost productivity to society constitute indirect costs comprising of approximately \$70.65 billion (Wang & Holton, 2007).

In light of the serious ways that maltreatment can harm the child's psychosocial well-being, effective interventions for abused or neglected children are needed to ameliorate that damage. At the same time, effective interventions are needed for parents—not only in an effort to prevent child maltreatment, but also in recognition that approximately 90% of children remain living at home after investigations of abuse or neglect and that about half of those who are transferred from their biological home to foster care will be returned to their biological home within 18 months after removal (Wulczyn, Barth, Yuan, Jones Harden, & Landsverk, 2005). Parents with substantiated cases of abuse or neglect are much more likely than parents in the general population to have problematic parenting skills, expectations that are unrealistic in light of their child's developmental stage, domestic violence, substance abuse, depression, family instability, and serious mental illness (Crosson-Tower, 2010). In addition to direct service provision, effective public health interventions are needed to disseminate information on positive parenting and to normalize and destigmatize the process of seeking or receiving support for parenting (as discussed by Sanders, Prinz, and Shapiro in Chapter 20 of this volume).

#### Child Welfare Services

Child welfare programs and interventions are diverse in terms of purpose, aims, philosophy, and setting. The first step in the process of intervening with families reported for child maltreatment is to investigate the degree of harm experienced by the child and determine whether the report is substantiated.

**Child Protective Services (CPS)** Reports of child maltreatment are investigated by state or county agencies that, although they have varied bureaucratic labels, are generally referred to by the child protective services (CPS) rubric. As discussed by Mallon and Hess (2005), the investigation phase is crucial. It can have life-and-death consequences for the child. It thus must be immediate and thorough and must determine whether the child will be safe if he or she remains living at home. If the abuse is substantiated, the investigation might recommend keeping the child at home, but with the provision of supportive services

to the family. Alternatively, it might recommend out-of-home placement of the child. In either case, the CPS agency is responsible for ensuring that the children and families involved in substantiated cases receive a sufficient array of services.

In recent decades, the role of CPS has expanded to provide or contract for services for families and children and to make “reasonable efforts” to prevent out-of-home placements and keep families together or reunite them (Crosson-Tower, 2010). However, due in large part to insufficient funding, practitioners in CPS agencies typically have high levels of caseloads and experience role-conflict and other stresses related to bureaucratic rules and regulations and to discrepancies between those regulations and the practitioner’s concern with the needs of clients. Consequently, burnout among these practitioners is common, and they therefore tend to have high turnover rates and limited ability to be effective in providing services for children and their families (Crosson-Tower, 2010; DePanfilis & Zlotnik, 2008; A. Ellett, C. Ellett, & Rugutt, 2003).

The number of in-home and out-of-home programs and interventions to which CPS can refer children and their families is extensive. Some have had their effectiveness supported by multiple replications of well-controlled, rigorous outcome studies and are therefore referred to by some as *evidence-based*. Others have had enough empirical support to be considered promising, but not enough yet to earn the label of *evidence-based* by groups that bestow such a “seal-of-approval.” Still others have not yet had any scientifically credible degree of empirical support.

Although this book does not include chapters on the CPS investigation process, readers are reminded that that process is crucial and can have life-and-death consequences. To learn more about assessing risk in the investigation process, readers are referred to books by Crosson-Tower (2010) and Mallon and Hess (2005).

**In-Home Services** In-home services are provided when the child can remain safely at home provided that the family receives needed assistance to prevent further abuse or neglect and thus prevent the need for an out-of-home placement. These services might be voluntary, but in some cases they are legally mandated. They might include helping the family obtain resources needed to meet the child’s (and family’s) basic needs for food, clothing, adequate shelter, health care, and so on. Parents might additionally need employment training and help with child care. A critical component of in-home services involves training parents in the skills they will need to adequately care for and protect their children. Not all in-home services are geared to parents who already are involved with the child welfare system. Some are provided to prevent maltreatment among parents who are at high-risk for maltreatment but who have not yet had a substantiated incident of neglect or abuse. Until recently, few of the parent-training programs have had empirical support (Schoenwald & Hoagwood, 2001). Various chapters in this volume describe parent-training programs that have at least some promising empirical support.

**Out-of-Home Services** When it is legally decided that the child’s safety requires removing the child from their home, out-of-home services provide 24-hour care of the child. As required by law, the out-of-home placement should be in the least restrictive

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setting possible—settings that most resemble the original family setting—such as with relatives. Other out-of-home placements include licensed family foster homes in which the family is not related to the child, therapeutic or medical foster homes in which the licensed foster parent has been trained to meet the child's special needs, short-term emergency shelters while awaiting an appropriate longer-term setting, licensed group homes housing 8 to 12 children, supervised independent living facilities for older adolescents who are near adulthood, and licensed residential treatment centers that provide on-site education as well as health, mental health, and social services (Mallon & Hess, 2005). For most children residing in out-of-home placements an important aspect is *family reunification as a permanency goal* (Mallon & Hess, 2005). This book's Chapter 14 describes the Homebuilders program, which has been empirically supported as effectively speeding the process of reunification. Some families, however, are so severely abusive or neglectful, or unable or unwilling to make the necessary changes to ensure the child's safety, that it is determined that family reunification cannot be achieved. In these cases, the permanency plan involves permanent placement, such as adoption by foster parents. This book's Chapter 3 describes an empirically supported program for treating children in foster care with behavior problems and for training and supporting their foster parents. Other empirically supported programs and interventions for treating maltreated children are described in Parts III and IV of this book.

### Empirical Support

The chapters of this book describe programs and interventions that have had enough empirical support to be considered either promising or more conclusively evidence-based. The main distinction between these two categories of empirical support is that the more conclusively evidence-based programs or interventions have been supported by experimental evaluations that randomly assign clients to different treatment conditions, also known as randomized clinical trials (RCTs). The promising programs lack such support, but have been empirically supported by pretest/posttest studies that lack control groups or by quasi-experimental designs that did not employ random assignment to the treatment versus comparison group condition. The research supporting each chapter is summarized in this book's Appendix A.

Some may wonder why I say *more conclusively evidence-based* instead of more simply just saying *evidence-based*. The reason has to do with the scientific method and with the elusiveness of the term *evidence-based*. In science, all knowledge is provisional and subject to refutation. What we all might today deem to be the best evidence for intervening in child welfare might be refuted by new evidence that emerges tomorrow. Calling something *evidence-based* has a ring of finality to it. All of the programs and interventions described in this volume have a reasonable degree of empirical support. We could call them all *evidence-based*, and that would not be entirely incorrect since they all are based on some degree of scientific evidence, but I want to avoid connoting that sense of finality and instead prefer to connote a range of empirical support.

Likewise, readers might also wonder why the programs or interventions with only "promising" empirical support are included in this book. The rationale for their inclusion

is based on the meaning of the term *evidence-based practice*. As that term has been defined in the previous volumes in this series, it refers to a *process* in which practitioners choose courses of action based not only on the best evidence, but also by integrating all of the evidence with their practice expertise and knowledge of the idiosyncratic circumstances and attributes of their clientele and practice setting. Sometimes the intervention with the best evidence is not a good fit for a particular client or group of clients. Sometimes a program is just not feasible to implement in a particular setting, perhaps due to costs. Sometimes a practitioner is more skillful providing an intervention with promising empirical support than providing one with a stronger evidence base, and therefore might be more effective when providing the former intervention. Consequently, the best fit might be a program or intervention that has promising evidence, only.

As you read the chapters in this book, it is important to keep in mind the lessons of implementation science. In particular, you should realize the importance of implementation fidelity. No matter how much research evidence might support the effectiveness of a program or intervention, its effectiveness when others implement it depends on the degree of implementation fidelity; that is, the extent to which they implement it in a way that matches the way it was implemented in the research on it. Thus, if you try to implement one of the programs or techniques described in the following chapters without understanding it completely, or without first obtaining the necessary training or developing the requisite skills in it, it will probably be less effective (and perhaps entirely ineffective) than it has been found to be in the existing research on it. This caveat applies not only to those programs or interventions with promising evidence, but also to those supported by the most conclusive evidence. As I alluded to above, you probably will have more success implementing with a high degree of fidelity an intervention or program with promising empirical support than you will have implementing with inadequate fidelity an intervention or program with more conclusive empirical support.

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