

**State Bar of Michigan Children's Law Section**

Jodi M. Lastuszek, Chairperson  
Robinjit Kaur Eagleson, Chairperson-elect  
Christine P. Piatkowski, Secretary  
John H. McKaig, II, Treasurer

# The Michigan Child Welfare Law Journal



## Table of Contents

Concurrent Planning: What the Evidence Shows .....	2
Family Reunification: What the Evidence Shows .....	11
Family Engagement .....	23
Highlights of Michigan's Modified Consent Decree approved on July 18, 2011 .....	35
<i>The Michigan Child Welfare Law Journal</i> Call for Papers .....	36
Enabling Mandated Reporters to Fulfill their Legal Obligations: Getting the Word Out Effectively and Affordably.....	37
by Joseph P. Kozakiewicz	

# Message from the Chair

As the new chair of the Children's Law Section, I want to express my gratitude to the outgoing chair, Jack McKaig, for working so hard last year to achieve the Section's goals. I also want to thank our membership of over 400 attorneys who work so tirelessly each day to chisel out a better path for Michigan families. Going forward, the Section will focus on outreach, policy initiatives, collaboration, and educational opportunities for our members. Each of these things promotes an increasingly knowledgeable and skilled child welfare community.

As the leader of the Section, I will be fully accessible and accountable to our membership. I encourage participation, feedback, and questions from all members or potential members to the Children's Law Section. Communication is the key to progress and positive change, and there is no better time for that change than now.

Sometimes change means simplification. In a complex child-welfare system, simplification often seems impossible. While preparing for a presentation earlier this month, I learned a valuable lesson in simplification from a three-year-old. The morning of the presentation, I sat down to breakfast with my three-year-old daughter. As we conversed over Fruit Loops, she interrogated me about the upcoming day. She quickly responded to each of my answers with, "why?" When she was worn by the "whys" she started on the "whos." She continued until she knew all the players and locations in my itinerary. The conversation became somewhat irritating until I reflected on it during my commute. When I thought about how productive the conversation had been

and its end result, my annoyance subsided. By asking all of those questions, my daughter figured out whether I would be safe, satisfied herself that I would inevitably return, and learned more about what I do for a living in the process. She fully engaged me.

How does this translate to simplifying child welfare law? Well, abuse and neglect cases span many months or years. They consist of numerous hearings – each of those hearings being an opportunity to create a record about the court, the Department of Human Services, and attorney engagement of all of the parties. During the process, we often lose the tenacity of a three-year-old and fail to create a record illustrating all of the great things we did for the families we serve. Ignoring the "whys" also decreases the likelihood that we will uncover areas in need of improvement early in the case.

Zealous advocacy is not just for the termination hearing. Whatever your role in the child welfare system involves providing services, representation, or oversight to families, you should be asking "why" early and often, until you are comfortable, satisfied, and knowledgeable about what the family needs and what they have received. Seeking answers with the tenacity of a three-year-old leads to information that will identify failures to engage any party early in the case, support well informed safety assessment and decision-making, reveal permanency options, and promote zealous advocacy. As you prepare for your next hearing, pack your legal citations, bring your DHS policy manual, and prepare your best legal arguments – but do not forget your Fruit Loops.

## Editorial and Review Board

### *Editor in Chief*

Joseph Kozakiewicz, JD, MSW, Director  
Michigan State University Chance at Childhood Program

### *Copy Editor*

Joshua Kay, JD, PhD, Clinical Assistant Professor of Law  
University of Michigan Law School  
Child Advocacy Law Clinic

Evelyn C. Calogero, JD, Associate Professor  
Thomas M. Cooley Law School

Kathryn Falk Fehrman, JD, Professor  
California Western School of Law

Jenifer Pettibone, JD  
State Court Administrative Office

Delanie Pope, JD, Staff Attorney  
Michigan State University Chance at Childhood Program

John Seita, Assistant Professor  
MSU School of Social Work

Carol A. Siemon, JD  
Department of Human Services

Kimberly Steed, LMSW, Coordinator  
Michigan State University Chance at Childhood Program

Frank E. Vandervort, JD, Clinical Assistant Professor of Law  
University of Michigan Law School

# Editor's Note

Welcome to the new CLS Chair Jody Latuszek! I am sure we will all appreciate the perspective Jody brings as chair of our section. Thanks too to Jack McKaig for his past leadership of the section and his thoughtful contributions to this journal.

Our current issue presents a number of pieces from the Child Welfare Information Gateway (CWIG). CWIG connects child welfare and related professionals to comprehensive information and resources to help protect children and strengthen families. CWIG's website, featuring the latest on topics from prevention to permanency, including child abuse and neglect, foster care, and adoption can be accessed at <http://www.childwelfare.gov/>. Take a look at the website when you get a chance. This issue includes information from CWIG regarding concurrent planning, the importance of family reunification, and ways to achieve meaningful family engagement in child welfare cases. This issue also includes highlights of the Michigan Modified Settlement Agreement and Consent Order that was approved on July 18, 2011. Thank you

to staff at the State Court Administrative Office for providing this summary. The entire MSA can be accessed on-line at [http://michigan.gov/documents/dhs/2011ConsentDecree\\_358360\\_7.pdf](http://michigan.gov/documents/dhs/2011ConsentDecree_358360_7.pdf).

Finally, this issue also includes an article regarding mandated reporting laws and the impact of the MSU Chance at Childhood Program's project to disseminate mandated reported information pamphlets throughout the state. A sample brochure follows the article. CAC still has free versions of these pamphlets geared toward physicians, nurses, clergy, and social workers. If you know of persons, agencies, or groups that might benefit from these pamphlets please let us know. The recent revelations from Penn State reveal horrific circumstances of child abuse as well as confused motivations and gross failures of action on the part of university's leaders. Whatever else we may ultimately learn from the events at Penn State, these events are a shocking reminder of the gravity of our obligation, sometimes legal but always moral, to protect our children.

—Joseph Kozakiewicz

# Concurrent Planning: What the Evidence Shows

*An April 2005 Issue Brief from the Child Welfare Information Gateway.  
Available online at [www.childwelfare.gov/pubs/issue\\_briefs/concurrent\\_evidence/index.cfm](http://www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/index.cfm).*

Concurrent planning is an approach that seeks to eliminate delays in attaining permanent family placements for children in the foster care system. Concurrent planning involves considering all reasonable options for permanency at the earliest possible point following a child's entry into foster care and concurrently pursuing those that will best serve the child's needs. Typically the primary plan is reunification with the child's family of origin. In concurrent planning, an alternative permanency goal is pursued at the *same time* (Katz, 1999; Lutz, 2000).

Evaluations of some early concurrent planning efforts suggested that they led to earlier permanence for children. The practice did not gain general acceptance, however, due primarily to opposition in the courts and among parents' attorneys, who saw the early development of an alternative permanency plan as being in conflict with agencies' genuine pursuit of family reunification (Katz, 1999; Munroe, 1997).

The Federal Adoption and Safe Families Act of 1997 paved the way for the legal sanction of concurrent planning in States and the formalization of the practice in child welfare agencies (Schene, 2001). The approach is now encouraged as a logical alternative to the sequential case planning that had become common practice following the passage of the Adoption Assistance and Child Welfare Act of 1980. That practice, which required a preferred permanent plan to be ruled out before an alternative was developed, was believed to contribute to long lengths of stay in out-of-home care (Lutz, 2000).

This issue brief examines the following questions:

- What have the Child and Family Services Reviews identified regarding concurrent planning in States?
- What does the literature say about concurrent planning?

- What are successful examples from the field?
- What are some guiding principles for implementing concurrent planning?

## Child and Family Services Reviews Findings

Final Reports from the Federal Child and Family Services Reviews (CFSRs)<sup>1</sup> present results and discussion for each State regarding its substantial conformity with child safety, permanency, and well-being outcomes. In the first full round of 52 reviews, no State was found to be in substantial conformity with the first permanency outcome, "Children have permanency and stability in their living situations" (Children's Bureau, 2004).

While concurrent planning is not directly assessed in relation to the CFSR outcomes and indicators, it is mentioned in 51 of the 52 State Final Reports. These reports serve as a useful source of information about State policies regarding concurrent planning, implementation practices, comprehensive training, and staff acceptance of the practice.

Concurrent planning is linked to positive results in at least 11 States; these include reduced time to permanency and establishing appropriate permanency goals (LA, NE, VT), enhanced reunification or adoption efforts by engaging parents (CO, ND), and reduced time to adoption finalization (CA, HI, ID, MA, ND, RI, UT, WA). In addition, the following offer positive examples of and support for concurrent planning across the United States:

- At least nine States have formal concurrent planning policies. These policies describe the circumstances under which concurrent planning must be practiced, such as mandating concurrent planning upon children's entry into foster care (AR), encouraging concurrent planning when it is in the child's best interest and

mandating the practice when the court orders it (KS), and requiring concurrent planning in cases with poor prognosis indicators (ID).

- A number of other reports indicate that concurrent planning is being implemented to varying degrees.
- Concurrent planning training has been provided to staff in at least eight States; a few other States also mention training for others involved in the work, including court staff (ID, NM) and foster/adoptive families (KY).
- Mississippi and Oklahoma indicated the support of the courts for concurrent planning. In Mississippi, the courts require concurrent plans and review the agency's progress on them.

A Federal summary and analysis of State reviews found that “concurrent planning efforts are not being implemented on a consistent basis when appropriate” in a majority of States (Children’s Bureau, 2004). The Final Reports discuss the concerns and difficulties related to concurrent planning in each State. One of the concerns was a disconnect between policy and practice. In some States with formal concurrent planning policies, little or no evidence of concurrent planning practices was found in case reviews. Similar findings occurred in some States in which stakeholders reported the use of concurrent planning, but little evidence supporting their assertions was found. In a number of States, concurrent goals were written in the case files, but case reviews showed that efforts towards the goals were sequential rather than concurrent.

A number of reports indicated that staff’s understanding of concurrent planning was unclear—concurrent planning was defined as having a “back-up” goal should the first goal prove unattainable. Some reports indicated that staff expressed concerns about concurrent planning. In some cases, the concerns focused on difficulties related to working towards two goals simultaneously. In other cases, the staff’s concerns were with the concurrent planning concept; for example, believing that it can cause anxiety for birth and/or foster/adoptive parents and impede reunification efforts.

Other difficulties reported for some States include:

- Resistance from the courts—at least two reports indicated that the courts only approve one goal at a time.
- Specialized private agency contracts—at least

two reports indicate that concurrent planning is difficult to implement when some services, such as adoption, are provided by specialized agencies; the adoption work does not begin until the case is transferred.

- Limits in data systems—at least three reports indicated that State data systems hinder concurrent planning because they only allow for one goal to be on record at a time.

In general, many States are implementing some form of concurrent planning in at least some areas of the State. Many are in the process of enhancing their concurrent planning practices by considering new policies, implementing training enhancements, and implementing new service delivery systems based on concurrent planning principles. The largest issues seem to be clear understanding of concurrent planning and consistent implementation throughout each State.

## Evaluation Findings

The recent literature on concurrent planning yields little in the way of evidence-based programs and practices. Most available studies consist of tracking permanency outcomes or gleaning qualitative information from focus groups, surveys, or interviews with caseworkers, families, foster/adoptive parents, or other stakeholders. Despite the limitations, recent evaluations do appear to offer support for the approach, especially with younger children.

The primary benefit appears to be earlier attainment of a permanent family outside of the foster care system. Anecdotal evidence within the literature also suggests that openness and direct communication between birth parents and caregivers in concurrent planning may lead to more voluntary relinquishments and open adoptions—a seemingly logical outcome of this more open relationship. Finally, the existing evaluations identify critical factors in successful concurrent planning efforts that can offer important guidance for child welfare practitioners.

### *Effective Concurrent Planning Programs Share Common Elements*

In 2000, a survey of concurrent planning programs in 12 sites was conducted for the National Resource Center for Foster Care and Permanency Planning (Lutz, 2000). Telephone interviews with staff familiar

with concurrent planning showed that, despite some variation among models, the following significant characteristics were common among the sites:

- Individualized assessment and intensive, time-limited work with birth families targeting the problems that necessitated foster care placement.
- Full, documented disclosure with birth parents of problems, changes, possible consequences, and time frames.
- Early aggressive search for birth family resources for achieving permanency.
- Early identification and consideration of all permanency options.
- Frequent and constructive use of parent-child visitation as part of reunification efforts.
- Early use of foster/adoptive or kinship placements.
- Involvement of foster/adoptive and kinship caregivers in teaching and skill-building with birth parents.

In 1997 and 1998, Potter and Klein-Rothschild (2002) conducted the only published study identifying predictors of permanency attainment in the context of concurrent planning. Their research used case reviews of 366 children served by the Colorado Department of Human Services Expedited Permanency Planning Process to determine which factors were associated with achieving permanency within 1 year. Factors predicting timely permanency included:

- *Caseworker consistency.* A single change of caseworker during the year reduced the likelihood of permanency by 52 percent.
- *Fewer placements.* Each additional placement a child experienced reduced the odds of attaining permanency within the year by 32 percent.
- *Ineligibility for Title IV-E assistance.* Children from families that were extremely poor (as indicated by Title IV-E eligibility) were 90 percent less likely to achieve permanence in 12 months.
- *Substance abuse.* When substance abuse was identified in the family, the likelihood of permanence increased by 23 percent.
- *More days of parental visitation per week.* Each

day of visitation tripled the odds of permanent placement within the 1-year time period.

Other factors found to relate to timely permanency included clear identification of the concurrent plan in the written service plan and parental signatures on the plan. This research also found agencies' terminology regarding foster/adoptive parents appeared to be related to differences in how families were viewed as part of the concurrent planning process. Agencies using the term "resource families" for foster/adoptive parents tended to involve them more fully in the planning process and make earlier foster/adoptive placements for children than did those who referred to such families as "legal risk."

#### *Younger Children May be More Likely to Benefit from Concurrent Planning*

Although many agencies use concurrent planning for children of all ages, the practice was originally developed for younger children considered at risk for delayed permanency (Katz, 1999). Some evaluation research has found that younger children are more likely than older children to benefit from concurrent planning:

- The Potter and Klein-Rothschild study mentioned above (2002) showed concurrent planning was most successful for children placed before age 3.
- Another study, examining well-being outcomes of 83 young adults adopted through the Lutheran Community Services concurrent planning program between 1981 and 1998, found that those who had been adopted at younger ages fared best (Cahn, 2003).

Neither of these studies examined or analyzed practice-related variables such as the available pool of resource families for younger children.

On the other hand, an Iowa study (Landsman, Malone, Tyler, Black, & Groza, 1999) examined the use of concurrent planning to attain permanency for teens. The Permanency for Teens Project (PTP), implemented through a public-private agency partnership, targeted youth ages 11 to 18. An initial assessment conducted with each participating youth identified persons with whom the teen had a significant connection. The program then used Family Unity Meetings, a variation of Family Group Deci-

sion Making, to bring these people together regularly with the youth to identify and concurrently explore multiple options for permanency. Findings of the program evaluation were mixed, but some youth did attain permanency, and others moved to less restrictive placements.

*More Research Is Needed Regarding the Indicators of a Poor Prognosis for Reunification*

Concurrent planning models frequently use some type of uniform assessment to identify families who have little chance for reunification. Many programs use strengths assessments and poor prognosis tools developed by Katz and her colleagues, but some have developed their own tools. The most commonly used poor prognosis indicators are the following (Lutz, 2000):

- Parent has previously killed or seriously harmed another child.
- Parent has repeatedly and with premeditation harmed a child.<sup>2</sup>
- Parent's only visible support system is a drug culture, with no significant effort to change over time.
- Parent has significant, protracted, and untreated mental health issues.
- Parent's rights to another child have been involuntarily terminated.

At least one study has found no relationship between poor prognosis indicators and the likelihood of family reunification (D'Andrade, Choice, Martin, & Berrick, 2001). Therefore, agencies should use poor prognosis indicators as only one part of a comprehensive family assessment, along with other assessment tools such as strengths, risk, and safety indicators.

A differential diagnosis that includes all these tools may be more effective in helping caseworkers gather and assess all relevant information to determine services and concurrent planning needs (National Resource Center on Foster Care and Permanency Planning, n.d.).

*Courts Play an Important Role in Concurrent Planning*

The importance of judicial involvement in concurrent planning is highlighted by a study of the Kentucky Adoption Opportunities Project (KAOP) (Martin, Barbee, Antle, & Sar, 2002). In this model,

the use of concurrent planning was combined with other permanency planning activities for achieving timely permanence: risk assessment, representation by a single attorney from initial filing to permanency, and early placement in foster/adoptive and kinship homes. These activities included changes in court procedures and roles of court personnel, as well as efforts to improve communication between the child welfare agency and the courts. The goal was to achieve permanency within 1 year of entering care for children ages 8 or younger from families with multiple risk factors.

Pilot sites included one urban and one rural court. A highly specific risk assessment tool completed by an attorney at the court was used to determine eligibility for inclusion in the project. Under the jurisdiction of the urban court, 84 children enrolled in the program; the rural court had jurisdiction over 30. While it is difficult to isolate the effect of concurrent planning on the outcomes, the KAOP children did experience stability of placement and shorter lengths of stay relative to the foster care population in their counties. In the urban county, the length of stay was 11.6 months (compared to 31.8 months for children in the State's general foster care population), and 33 percent of the KAOP urban children achieved permanency within 12 months. In the rural counties, children in the KAOP had a length of stay of 16.9 months (compared to 24.7 months for the general foster care population). Twenty-seven percent of these children were in the process of adoption by foster/adoptive homes within 1 year, although no adoptions had been completed at the time of the evaluation.

The evaluation of the KAOP's results and interviews with participants revealed several challenges of multiple systems working toward a common goal. Barriers included poor communication, lack of collaboration, lack of role clarity across systems, and lack of early and accurate assessment of child and birth parent needs, as well as the lack of involvement of service providers for mental health, substance abuse, and domestic violence issues—all essential in meeting the complex needs of high risk families.

The integral role of the court in concurrent planning is further demonstrated by the success of the Expedited Permanency Planning model in Colorado (see Examples From the Field, below). A notable component of the Colorado initiative was that State legislation mandated the courts to work with the child welfare agency to achieve more timely permanence for

children who were 6 years old or younger when they entered foster care. As a result, courts developed ways to accelerate the judicial process in child dependency cases.

### *Staff Acceptance is Critical*

A report based on interviews with staff at three public child welfare agencies found that most caseworkers believed concurrent planning is fair, necessary, and helps move children more quickly to permanency (Westat & Chapin Hall Center for Children, 2001). At the same time, staff in this study and in a 2001 study by the Urban Institute emphasized that concurrent planning is stressful and requires more information to determine various permanency options early in the case. The literature, as well as anecdotal reports, indicates that caseworkers often experience difficulty grappling with the tension inherent in attempting to reunite a child with his or her family while also working on an alternative permanent plan. For this reason, agency staffing is an important consideration in the implementation of concurrent planning, at both the caseworker and supervisor levels and in terms of agency policy.

Caseworkers must have an understanding of the dynamics underlying child maltreatment and be skilled in conducting differential assessments. They also must be competent in working with parents and other professionals to plan and deliver targeted services and assess progress toward goals (Lutz, 2000; Westat & Chapin Hall Center for Children, 2001). Both caseworkers and their supervisors must accept the philosophy of concurrent planning and believe that it is possible to work in good faith with parents while at the same time planning for an alternative permanency goal. Supervisors play a key role in promoting collaboration among service recipients, providers, and others involved in each case. Concurrent planning requires that supervisors have the time and skill necessary to involve themselves closely in timely case planning and decision-making.

Finally, the implementation of concurrent planning calls for close scrutiny of agency policies to assess their consistency with the philosophy and intent of this approach. Procedures for staff assignment, case review, documentation, and interaction with the courts and other service providers all have the potential to affect the success of efforts to achieve safe and timely

placement in a permanent family. A noteworthy example, drawn from the work of Katz and her colleagues, is the elimination of caseworker reassignment when children move from foster to adoptive status (Lutz, 2000).

### *Foster/Adoptive Families Must be Well Prepared*

Not all concurrent planning models use foster/adoptive families. When taking this approach, however, these families must be well-prepared and supported. The approach demands much of these families. They must be willing to make a permanent commitment to a child placed in their home, while at the same time working cooperatively with the agency and family of origin to effect reunification. Their work often includes teaching and modeling skills for birth parents and other family members as well as mentoring new foster/adoptive families. Not surprisingly, the literature commonly points to the recruitment, preparation, and support of foster/adoptive families as one of the most challenging aspects of concurrent planning.

### *Examples from the Field*

The following examples illustrate key elements found to be associated with the successful planning and implementation of concurrent planning in public agencies.

#### *Concurrent Planning in Colorado: Increasing Timely Permanency*

Helping foster/adoptive parents clarify and distinguish their multiple roles (providing a permanent commitment to a child while at the same time mentoring the birth family toward reunification) is a critical part of supporting them effectively.

Evaluations of most public sector concurrent planning initiatives to date have lacked rigorous research design. Most consist of tracking changes in major data indicators (such as time in foster care or type of permanent placement). One exception is Colorado, which conducted a comparison group study of its Expedited Permanency Planning (EPP) process in two pilot counties.

Colorado caseworkers trained intensively on concurrent planning from 1993 forward, particularly in counties and local jurisdictions implementing



the State's 1994 EPP legislation, which required all children ages 6 and younger and their siblings to be in a permanent placement within 12 months of entering foster care. This legislation specifically directed the courts to work with public child welfare agencies at both the State and local levels to achieve this goal. EPP combined a concurrent planning approach with an accelerated judicial process for families with young children.

The State developed procedures and resources that allowed for "front loading" of services to families. Counties were allocated up to \$5,000 per family to make specific services available to families immediately following the child's entry into foster care. Jurisdictions used the additional funding to implement Family Group Conferencing or family team meetings, or to purchase additional substance abuse or mental health evaluation and treatment services. These enhancements supported expedited permanency through earlier identification of needs and resources and reduction of waiting time to obtain clinical appointments. Some counties also adopted the practice of assigning two caseworkers to a family—one serving and advocating for the parents and the other working primarily with the child in care.

An evaluation of this approach was conducted in two pilot counties between 1995 and 1998, using a sample treatment group of 130 children and a comparison group of 105. These children were followed for 18 months following the filing of the initial dependency petition. Rates of permanency attainment within 1 year for the treatment groups in the two counties were 85 percent and 84 percent. This compared with rates of 22 percent and 32 percent in the comparison groups, a statistically significant difference.

By 2001, Colorado had expanded EPP to all counties. Outcomes of EPP continue to appear favorable despite difficulties many families have faced due to the struggling economy and budget shortfalls that have forced some changes in the model's implementation (e.g., most jurisdictions can no longer allocate two caseworkers per family). A December 2003 report to the legislature notes that, of the 1,149 children served by the program during 2003, 939 (82 percent) attained permanency within 1 year. Many of the remaining 211 children were able to leave foster care after a stay of only a few months longer than the 12-month threshold. Of the 522 children for whom post-discharge placement data were available, 77 per-

cent attained permanence within their family system. More than 41 percent returned to the parent from whom they had been removed, 9 percent were placed with another parent, and 26 percent were placed permanently with relatives (Colorado Department of Human Services, 2003).

Requests for additional information about EPP in Colorado may be addressed to:

Carol Wahlgren, MSW, LCSW Administrator of  
Ongoing Child Protective Services  
Child Welfare Division of the State  
Department of Human Services  
1575 Sherman Street, 2nd Floor  
Denver, CO 80112  
Telephone: 303.866.3278  
Carol.Wahlgren@state.co.us

*Concurrent Planning in San Mateo County,  
California: Decreasing Length of Stay*

Concurrent planning practice in San Mateo County, California, dates to 1980, having grown out of an early family preservation model implemented in the county's Department of Human Services. Although the family preservation program was largely successful, agency staff began to notice a growing population of very young children in care who appeared to have little likelihood of reunification with their families. Parents of these children presented a constellation of challenges that could not be sufficiently improved, even with the program's abundant resources and skilled staff. The agency recognized the need to place these children in homes where they could be adopted should efforts to return them to their parents fail (Brinsont-Brown, 1995).

Since establishing its foster/adoption program nearly 25 years ago, San Mateo County has developed a concurrent planning model emphasizing early identification of permanency resources, full involvement of the birth family, and a commitment to strong reunification efforts. Consensus-based indicators (such as a history of the children being placed out of the home, lack of parental visitation or involvement, and a history of parental drug use) are used to assess a family's prognosis for reunification. At one point, San Mateo tried having the same caseworkers perform both reunification and adoption functions. This practice was discontinued, however, as it was determined to be too

exhausting and not sufficiently beneficial in terms of achieving greater caseworker objectivity. Currently, the county has separate reunification and adoption units, but they are housed in close proximity to encourage communication and coordination of responsibilities.

An evaluation conducted between 1990 and 1996 showed the median length of stay for children entering foster care in the county was 5 months, compared with 17 months statewide. Rates of re-entry into foster care were also lower than in the State as a whole—12 percent in San Mateo, compared with 19 percent statewide—suggesting that children attained stability in their post-discharge placements (Schene, 2001).

Current data continue to show that children in San Mateo County attain permanency more quickly than in the State as a whole. During the period July 2003 to June 2004, 76 percent of San Mateo children were reunited within 12 months, compared with 65 percent statewide. Of adopted children, 47 percent attained permanency within 12 months in San Mateo County, compared with 27 percent for the entire State. Recent data on re-entries into care have increased slightly, however, a trend that the county is currently assessing via a citizen's review panel (C. Brinsont-Brown, personal communication, April 12, 2005).

San Mateo County stresses the importance of buy-in from administration, the courts, board members, staff, and the community. Program managers suggest that full involvement of court and agency staff in the program's design and implementation has been critical.

Direct, honest communication and clarity of roles and responsibilities also is essential. The county attributes the court's continuing support primarily to two factors: complete honesty in disclosing alternative plans and referrals for foster/adoptive placement, and training and support of casework staff in making every reasonable effort to engage and provide services to the parent.

San Mateo County is part of a six-county study of concurrent planning being conducted by the Child Welfare Research Center at the University of California at Berkeley. Preliminary findings from that research have identified a number of promising practices in concurrent planning, including preparation and support of resource families and intervention with birth parents. Details are available at

<http://cssr.berkeley.edu/childwelfare/researchdetails.asp?name=promising>.

Requests for additional information about concurrent planning in San Mateo County may be directed to:

Charlotte Brinsont-Brown  
Human Services Manager  
San Mateo County Human Services, Children and Family Services  
East Palo Alto Office  
2415 University Avenue  
East Palo Alto, CA 94303  
Telephone: 650.363.4185  
E-mail: [cbrinsont-brown@smchsa.org](mailto:cbrinsont-brown@smchsa.org)

#### *Concurrent Planning in North Dakota: Increasing Relative Placement, Reunification*

The North Dakota Department of Human Services (DHS) implemented concurrent planning statewide in 1999, following a 5-year period of development, training, and regional pilot-testing. Development of the approach involved DHS, the courts, and the mental health and juvenile justice systems. Concurrent planning also was promoted through the State's Court Improvement Project.

Comparisons of current State permanency indicators with those prior to implementation show clear differences. Average time in care decreased from 17 months in 1999 to 9.7 months in 2003. In 2003, 50 percent more children were placed with relatives than in 1999, while 92 percent of children with a goal of reunification were returned to their families (K. M. Kenna, personal communication, March 1, 2004).

North Dakota DHS staff cite early family assessment, the development of measurable case plan objectives, full exploration of family resources, and timely service provision as key elements in the success of this approach.

Requests for additional information about concurrent planning in North Dakota may be addressed to:

Kate M. Kenna  
Deputy Director/Regional Supervisor Child Welfare  
Department of Human Services  
Northeast Human Service Center  
151 South 4th Street, Suite 401  
Grand Forks, ND 58201  
Telephone: 701.795.3014  
[84kenk@state.nd.us](mailto:84kenk@state.nd.us)

## Guiding Principles for Implementation

The limited evaluations of concurrent planning conducted thus far appear to offer support for the approach in strengthening permanency outcomes for children. The evidence base in concurrent planning suggests the following guiding principles:

- To succeed, concurrent planning must be supported philosophically and with adequate resources both within the child welfare agency and among service providers and related professionals. Lack of acceptance on the part of any group can jeopardize the effectiveness of the approach; agency partners serving families should be part of the planning, training, and implementation process.
- Cooperation and preparation of the judicial system, as seen in the three initiatives featured above, is especially critical. More timely planning and casework services cannot be effective without the development and enforcement of judicial procedures that ensure smooth progress of cases through court. As these changes often have workload implications for attorneys and judges, their early involvement in planning and support of concurrent planning efforts is imperative.
- Early and aggressive efforts should be made to identify all reasonable permanency options for children entering foster care. Concurrent planning is fundamentally about focusing permanency efforts squarely on the best interests of the child.
- Families should be engaged in collaborative planning and decision-making in the permanent plan for their child. An example of a complementary approach that encourages such collaborative engagement is Family Group Decision Making, a planning and permanency strategy being adopted by many agencies.
- Interactions with families should be based on respect, honesty, and openness. Such an approach is not only essential for family engagement, but also to clarify ethical considerations for caseworkers and legal issues for the courts.

## Questions for Future Research

As concurrent planning becomes more prevalent, further questions will need to be explored. Some of these include:

- In what percentage of public agencies is concurrent planning currently being implemented?
- Is there a common definition of concurrent planning among those agencies, or do concurrent planning programs vary considerably?
- What effect do training and other factors, such as family involvement, have on the short- and long-term success of concurrent planning programs?
- What is the proportion of family reunifications to alternative placements among concurrent planning programs? How does the type of permanent placement affect child outcomes?

As more States finalize their Program Improvement Plans and more evaluations of concurrent planning programs are conducted, answers to these and other questions will guide the field in their efforts to provide children with safe and loving families in a timely and supportive manner. ©

## About the Author

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](mailto:info@childwelfare.gov)  
[www.childwelfare.gov](http://www.childwelfare.gov)

## References

- Brinsont-Brown, C. (1995). *The history of foster adoption as a factor in concurrent planning in San Mateo County*. Unpublished document. Daly City, CA: San Mateo Department of Human Services.
- Cahn, K. (2003). *Lutheran Community Services Evaluation Report*. Seattle, WA: University of Washington School of Social Work. Retrieved January 2004 from [http://depts.washington.edu/nwicf/EvalServ/LCS\\_Final\\_Report.pdf](http://depts.washington.edu/nwicf/EvalServ/LCS_Final_Report.pdf)
- Children's Bureau. (2004). *General findings from the Federal Child and Family Services Review*.

- Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Updated link retrieved May 2006 from [www.acf.dhhs.gov/programs/cb/cwmonitoring/results/genfindings04/genfindings04.pdf](http://www.acf.dhhs.gov/programs/cb/cwmonitoring/results/genfindings04/genfindings04.pdf)
- Colorado Department of Human Services (2003). *Ninth Annual Report to the Colorado Legislature on the Implementation of Expedited Permanency Planning*. Denver, CO: Author.
- D'Andrade, A. C., Choice, P., Martin, M., & Berrick, J. (2001). *Concurrent planning: The influence of new practices on permanency outcomes in child welfare*. Abstract retrieved January 2004 from <http://sswr.org/papers2001/324.htm>
- Katz, L. (1999). Concurrent planning: Benefits and pitfalls. *Child Welfare*, 78(1), 71-87. Landsman, M. J., Malone, K., Tyler, M., Black, J., & Groza, V. (1999). *Achieving permanency for teens: Lessons learned from a demonstration project*. University of Iowa, National Resource Center for Family Centered Practice. Updated link retrieved May 2006 from [www.uiowa.edu/~nrcfcp/publications/documents/Fall1999.pdf](http://www.uiowa.edu/~nrcfcp/publications/documents/Fall1999.pdf)
- Lutz, L. (2000). *Concurrent planning: Tool for permanency: Survey of selected sites*. New York: Hunter College School of Social Work, National Resource Center for Foster Care and Permanency Planning.
- Lutz, L. (2003). *Achieving permanence for children in the child welfare system: Pioneering possibilities amidst daunting challenges*. New York: Hunter College School of Social Work, National Resource Center for Foster Care and Permanency Planning.
- Malm, K., Bess, R., Leos-Urbel, J., Geen, R., & Markowitz, T. (2001). *Running to keep in place: The continuing evolution of our nation's child welfare system*. Washington, DC: The Urban Institute. Retrieved January 2004 from [www.urban.org/UploadedPDF/310358\\_occa54.pdf](http://www.urban.org/UploadedPDF/310358_occa54.pdf)
- Martin, M. H., Barbee, A. P., Antle, B. F., & Sar, B. (2002). Expedited permanency planning: Evaluation of the Kentucky Adoptions Opportunities Project. *Child Welfare*, 81(2), 203-224.
- Munroe, F. (1997). Pathways to permanent placements for young children in high-risk situations. In E. Wattenberg (Ed.), *Redrawing the family circle: Concurrent planning—Pathway to permanence for young children in high-risk situations*. University of Minnesota School of Social Work, Center for Advanced Studies in Child Welfare.
- National Resource Center on Foster Care and Permanency Planning. (n.d.). *Concurrent Planning Curriculum Module 2: Differential assessment to prevent foster care drift*. Retrieved February 2004 from [www.hunter.cuny.edu/socwork/nrcfcp/downloads/cpp/module2-diff-assess.pdf](http://www.hunter.cuny.edu/socwork/nrcfcp/downloads/cpp/module2-diff-assess.pdf)
- Northwest Resource Center for Children and Families. (2003). *Lutheran Community Services concurrent planning evaluation, Stuart Foundation final report*. Seattle, WA: Author.
- Potter, C. C., & Klein-Rothschild, S. (2002). Getting home on time: Predicting timely permanency for young children. *Child Welfare*, 81(2), 123-150.
- Schene, P. (2001). *Implementing concurrent planning: A handbook for child welfare administrators*. University of Southern Maine, National Resource Center for Organizational Improvement.
- Westat & Chapin Hall Center for Children. (2001). *Assessing the context of permanency and reunification in the foster care system*. Report submitted to the U.S. Department of Health and Human Services. Retrieved January 2004 from <http://aspe.hhs.gov/hsp/fostercare-reunif01/>

## Endnotes

- 1 The Child and Family Services Reviews are designed to enable the Children's Bureau to ensure that State child welfare agency practice is in conformity with Federal child welfare requirements, to determine what is actually happening to children and families as they are engaged in State child welfare services, and to assist States to enhance their capacity to help children and families achieve positive outcomes. For more information about the CFSR process, visit the Children's Bureau website at [www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm#cfsr](http://www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm#cfsr).
- 2 It should be noted that, with the 1997 passage of the Adoption and Safe Families Act and corresponding legislation in the States, attempts to reunite families are not typically required when a parent has killed or seriously or repeatedly harmed a child as described in the first two bulleted items.

# Family Reunification: What the Evidence Shows

*A June 2011 Issue Brief from the Child Welfare Information Gateway.  
Available online at [www.childwelfare.gov/pubs/issue\\_briefs/family\\_reunification](http://www.childwelfare.gov/pubs/issue_briefs/family_reunification)*

Family reunification in child welfare refers to the process of returning children in temporary out-of-home care to their families of origin. Reunification is both the most common goal for children in out-of-home care as well as the most common outcome. According to preliminary estimates from the Adoption and Foster Care Analysis and Reporting System (AFCARS), reunification was the case plan goal for nearly half (49 percent) of all children in foster care on September 30, 2009. More than half (51 percent) of the children who exited foster care during fiscal year 2009 returned to a parent or principal caregiver (Children's Bureau, 2010a).

Since the majority of children who leave foster care are reunified with their families, it is important to focus on practices that help achieve successful reunification. A broad review of the empirical literature in child welfare suggests common characteristics of interventions that are most helpful in reunifying families when child maltreatment has been identified.<sup>1</sup> These include:

- *Meaningful family engagement.* Engagement of families is critical to the change process (Dawson & Berry, 2002; Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Yatchmenoff, 2005).
- *Assessment and case planning.* Individualized needs assessment and clear, mutually established goals are critical to case planning (DePanfilis, 1999; Macdonald, 2001).
- *Service delivery.* Cognitive-behavioral, multi-systemic, skills-focused services have been found to be most effective (Corcoran, 2000; Macdonald, 2001).

This issue brief examines these strategies in terms of a series of questions:

- What have the Child and Family Services Reviews identified regarding family reunification in States?

- What does the literature say about family reunification?
- What are some examples of success from the field?

## The Child and Family Services Reviews and Family Reunification

Final Reports from the Federal Child and Family Services Reviews (CFSRs) present results and discussion for each State regarding its conformity with child safety, permanency, and well-being outcomes.<sup>2</sup> In the first full round of 52 reviews, 19 States met the national standard for reunification, which stated, "76.2 percent of all children who were reunified went home in less than 12 months" (Children's Bureau, 2004b). In order to reflect the ability of States to help families both achieve reunification and prevent reentry of their children into care, in the second round of reviews, which began in 2007, the data indicator for reunification was revised to include four components:

1. Percent of children who were reunified, where reunification occurred in 12 months or less from removal
2. Median length of stay from removal to reunification
3. Percent of all children who entered foster care who were reunified in 12 months or less from removal
4. Percent of children reunified who reentered foster care within 12 months

The national standard of 122.6 was then calculated using State data to establish a range.<sup>3</sup> Thirteen of the 49 States to have completed the review process received composite scores above that standard.

No State was found to be in conformity with the first permanency outcome, "Children have permanency and stability in their living situations," in either

round of reviews. However, 12 States received a rating of “Strength” on the indicator related to achievement of a child’s goal of reunification, guardianship, or placement with relatives in the first round;<sup>4</sup> three States received that rating in the second round. A Children’s Bureau (2004b) summary and analysis of the 52 Final Reports in Round One found that the following factors had a significant association with a rating of “Strength” on this indicator:

- The stability of foster care placement
- Visiting with parents and siblings in foster care
- The needs of and services for the child, parents, and foster parents
- Child and family involvement in case planning
- Worker visits with the child
- Worker visits with the parents

Items associated with stronger performance in this permanency outcome in the first 32 States reviewed in the second round were: (Children’s Bureau, 2009)

- Services to the family to protect children in the home and prevent removal or reentry into care
- Needs assessment and services to children and parents
- Worker visits with the child
- Worker visits with the parents

Further review of the States’ Final Reports in both rounds yields additional details about these and other factors’ relationships to the achievement of timely, stable family reunification. The factors related to family engagement, assessment and case planning, and service delivery, as well as a number of systemic issues, shed light on States’ successes and challenges in this area.

### Family Engagement

The CFSRs indicated that a number of family engagement activities contribute to the success of family reunification efforts. Effective family engagement activities include involving birth families in planning and decision-making, encouraging foster parent support of the birth parents, and facilitating visits between children in foster care with their parents. States’ experiences in facilitating family engagement point to the following as important practices:

- The use of some type of family team meetings (e.g., Family Group Conferencing, Family

Group Decision Making) to facilitate reunification efforts promotes active involvement of both birth parents, extended family, and others to achieve permanency for children.

- Foster parents’ support of contact between children and birth parents and the foster parents’ direct support of birth parents (e.g., mentoring) facilitates achievement of reunification goals.
- Increasing the frequency of visits leading up to reunification helps to facilitate achievement of this goal and decreases reentries to foster care.
- Early and diligent search for extended family members and use of kinship care supports maintaining parent-child connections during out-of-home care episodes contribute to reunification efforts that include return of the child to the parental home as well as permanency through guardianship and placement with relatives.

### Assessment and Case Planning

Early emphasis on reunification as the most desirable permanency goal, adequately assessing the strengths and needs of children and families, involvement of parents and children in case planning, building on family strengths and addressing specific needs, and finally, carrying out plans are all critical activities to the achievement of a family’s reunification goals. States’ experiences in assessing the strengths and needs of families indicate that initial assessments can be vital to the implementation of case plans that ultimately lead to reunification. Conversely, early assessments can also lead to the decision that reunification is not in the best interest of the child, prompting States to seek alternate routes to permanency for some children. States also report that risk or safety assessments conducted *prior to reunification* help ensure safe, timely reunification decisions and minimize both the risk of harm to children and reentries to foster care.

Many Final Reports in both rounds of reviews cite child and parent problems that impede reunification efforts and contribute to foster care reentries. Parental substance abuse is the problem most often cited; other problems include child behavior problems, child involvement with the juvenile justice system, parental mental health concerns, and parents’ lack of cooperation with service plans.

### Service Delivery

Targeted services that meet the individualized needs of children and families are key to achieving family reunification and ensuring children's safety. Issues reported by States related to the delivery of appropriate services include the following:

- Some Final Reports mention the availability and coordination of specific services as factors important to the achievement of reunification. These include in-home services, concrete services such as housing and food, mental health and substance abuse services, culturally competent services, comprehensive wrap-around services, and coordination or collocation of service providers. In the second round of reviews, many States pointed to the use of trial home visits, during which time the agency continues to provide services and supervision, as an important factor in reducing reentry to foster care.
- Many more Final Reports cite problems with service delivery, including a lack of specific services, a lack of transportation to services, long waiting lists, and inconsistent service accessibility in all jurisdictions, with rural areas having the most difficulties. Problems with housing and substance abuse, mental health, and culturally competent services were most often cited as specifically impeding efforts to reunify families.
- Many States specifically cite the provision of post-reunification services as a key to reducing the risk of harm to children, repeat maltreatment, and reentries to foster care. A number of these reports discuss the length of time post-reunification services are provided (ranging from 3 months to as long as needed). Reports indicate that continued monitoring of families supports their participation in such services.
- Specific post-reunification services that contribute to positive outcomes include in-home services, mental health or counseling services, substance abuse services, parenting support, child care, concrete services such as housing and financial assistance, and transportation.
- Many Final Reports specifically tie poor post-reunification services to an increased risk of

harm to children after reunification, repeat maltreatment, and higher numbers of reentries to foster care. Common problems include service disruptions, the lack of availability of services in all areas, services not available at the intensity or duration that families need them, and the high costs of needed services.

### Systemic Issues

The CFSR Final Reports mention a number of systemic issues that contribute both positively and negatively to the achievement of timely, stable reunifications. These include issues related to funding, courts, and staffing.

*Funding.* Positive contributions of various funding strategies cited in Final Reports as supporting reunification efforts include increased funding for reunification, dedicated reunification funds, flexibility in the use of funds, blended funding streams, and financial incentives for contractors.

*Courts.* Positive contributions related to the courts are mentioned in Final Reports and include cooperation between the courts and child welfare agencies, court tracking of permanency timeframes, and court monitoring of families after reunification. Court-related issues noted as impeding reunification efforts include continuances and crowded court dockets delaying reunification, judges extending the timeframe for reunification beyond the Adoption and Safe Families Act (ASFA) guidelines, and courts ordering reunifications in cases in which agency staff do not feel the family is ready.

*Staffing.* Staffing problems that reportedly impede reunification efforts include high rates of staff turnover, inexperienced staff, and high caseloads. These problems may result in insufficient worker visits both with foster children and birth parents, insufficient monitoring and support of parents' service participation and progress toward goal achievement, and longer timeframes to achieve reunification goals as each new worker starts over.

Finally, policies regarding timeliness to reunification are cited as a concern in many State Final Reports. A few States report that while the time taken to reunification is longer than allowed for in the national standard, this caution results in fewer reentries to foster care. Correspondingly, other States are concerned that shorter times to reunifications are result-

ing in higher reentries because families are sometimes reunited before risk and safety issues are fully resolved. Many Final Reports state that the goal of reunification is often kept too long even when it seems unlikely that it will be achieved (e.g., when the parents have made little or no progress on service plan tasks).

### Research on Family Reunification

It is clear from a review of the State CFSR Final Reports that numerous factors interact and play important roles in a State's ability to reunite children in foster care with their birth families. Meaningful family engagement, assessment, case planning, and service delivery are key. Systemic supports related to funding for services, support from the courts, and stable, competent staff also appear to impact, directly and indirectly, the achievement of reunification goals. A review of the relevant literature sheds additional light upon State CFSR findings regarding the factors in achieving timely, stable reunifications.

#### *Family Engagement Is Fundamental to Successful Reunification*

Much of the literature addresses four dimensions of family engagement:

- The relationship between the caseworker and the family
- Parent-child visitation
- The involvement of foster parents
- The involvement of a parent mentor or advocate

*The relationship between the caseworker and the family.* Both the frequency and the nature of the caseworker's contact with the family are important. Family reunification appears to be facilitated by more frequent caseworker contact (Farmer, 1996; Littell & Schuerman, 1995; Children's Bureau, 2004a).

In an analysis of 411 children who spent at least 3 years in out-of-home care, caseworker engagement with the family (measured by caseworker self-report) was positively associated with permanency outcomes of both reunification and adoption (Cheng, 2010). However, parents are sometimes mistrustful of child welfare professionals and thus unwilling to share information or establish a relationship with agency representatives (Kemp et al., 2009). Family engagement becomes meaningful when family members believe their involvement in case planning and services

is valued and respectful of their potential to keep their children safe, provides them with the information they need to successfully advocate for themselves and their children, and enables them to access the services and resources they need to achieve reunification (National Resource Center for Permanency and Family Connections, 2009). In a study examining engagement in a sample of 63 families receiving child protective services, the interpersonal relationship with the caseworker was determined to be the strongest predictor of the family's self-report of engagement (Regional Research Institute for Human Services, 1998).

The above studies, as well as engagement research in related fields, suggest that the following caseworker behaviors are important in mitigating families' fears and building the rapport necessary for effective helping:

- Establishing open, honest communication with parents (Yatchmenoff, 2005)
- Requesting family participation and feedback in the planning process (Regional Research Institute for Human Services, 1998; Rooney, 1992)
- Providing instruction and reinforcement in the performance and completion of mutually agreed-upon activities (Rooney, 1992)

*Parent-child visitation.* Research supports the significance of parent-child visitation as a predictor of family reunification (Leathers, 2002). A study of reunification in a sample of 922 children aged 12 and younger found that children who were visited by their mothers were 10 times more likely to be reunited (Davis, Landsverk, Newton, & Ganger, 1996).

Effective visitation practice goes far beyond attention to the logistics of scheduling and transportation; it provides an opportunity to build parental skills and improve parent-child interaction. Studies suggest that visitation should have a therapeutic focus. Thus, it is important that anyone supervising visits has clinical knowledge and skills (Haight, Sokolec, Budde, & Poertner, 2001).

*The involvement of foster parents.* Foster parents may facilitate family reunification through both the mentoring of the birth parents and the support of their visitation. The development of a positive relationship between the foster and birth parents may allow children to avoid the stress of divided loyalties and position foster parents to play a supportive role after reunification. However, when selecting foster parents



to work with birth parents, agencies should consider their experience, maturity, communication skills, their ability to handle these multiple roles, and the possible need for additional training (Lewis & Callaghan, 1993; Sanchirico & Jablonka, 2000).

*The involvement of a peer mentor or advocate.* When parents lose custody of their children, they must interact with an array of systems, including—at a minimum—the child welfare agency, the court, and one or more service providers. In order to negotiate their way through unfamiliar systems, they can benefit from having a designated partner who can help them understand court and agency processes, normalize their experiences, and focus on changes they need to make in order to have their children returned to them. Such partners are most often foster parents or parents who have successfully achieved reunification themselves (Marcenko, Brown, DeVoy, & Conway, 2010; Romanelli et al., 2009). Anthony, Berrick, Cohen, & Wilder (2009) found that parents participating in a program that paired them with parents who had successfully navigated the system were more than four times as likely to be reunified with their children as parents in a comparison group.

#### *Accurate, Individual Assessment and Case Planning Are Crucial for Successful Reunifications*

Child maltreatment is a complex phenomenon with a number of underlying causes. Accurate differential assessment is therefore essential. Differential assessment involves developing an individualized, family-centered understanding of a child and family's circumstances, environment, and potential in order to identify each family's unique needs, determine the extent of the risk to the child, and to construct an appropriate intervention plan (National Resource Center for Foster Care and Permanency Planning, 2003; Macdonald, 2001; National Research Council, 1993).

Research has demonstrated that adequate assessment often does not occur in child welfare, and this failing may be linked to the instability of reunification. In a review of 62 failed reunifications, Peg McCartt Hess and her colleagues found that “poor assessment or decision-making by the caseworker or service provider” was a factor in 42 cases (Hess, Folaron, & Jefferson, 1992).

The use of standardized tools to aid assessment is an emerging area of child welfare research that of-

fers some promise of improving practice in this area (Corcoran, 1997; McMurtry & Rose, 1998).

- The North Carolina Family Assessment Scales for Reunification (NCFAS-R), developed by Ray Kirk, Ph.D., at the University of North Carolina at Chapel Hill, is a validated instrument designed specifically for use in reunification. The NCFAS-R, an adaptation of the original North Carolina Family Assessment Scale used in family preservation, has proven to be an effective tool in assessing readiness for reunification and parent and child ambivalence (Kirk, 2001).
- The Structured Decision Making® Reunification Reassessment was recently validated by the California Department of Social Services (Wagner & Bogie, 2010). The instrument is designed to help workers assess caregiver case plan progress and estimate probable child safety and stability after reunification.

#### *Services Should Be Practical and Comprehensive, Addressing All Aspects of Family Life*

Services should be designed to promote an environment to which a child can be safely returned and to help maintain that environment after reunification. A number of studies have supported the use of interventions that have a behavioral, skill-building focus and that address family functioning in multiple domains, including home, school, and community (Corcoran, 2000; Macdonald, 2001). Cognitive-behavioral models have been demonstrated to reduce physical punishment and parental aggression in less time than alternative approaches (Kolko, 1996, cited in Corcoran, 2000). The most effective treatment involves all family members and addresses not only parenting skills but also parent-child interaction and a range of parental life competencies such as communication, problem solving, and anger control (Corcoran, 2000; Dore & Lee, 1999).

The literature reports on the effectiveness of several types of services:

*Concrete services.* The provision of concrete services such as food, transportation, and assistance with housing and utilities has been demonstrated to be an important aspect of family reunification services (Cheng, 2010; Choi & Ryan, 2007). A study reviewing effective family-centered service models

In 2005, the National Child Welfare Resource Center for Family-Centered Practice, a service of the Children's Bureau, published *Comprehensive Family Assessment Guidelines for Child Welfare* (available on the Children's Bureau website at [www.acf.hhs.gov/programs/cb/pubs/family\\_assessment/index.htm](http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/index.htm)).

In 2007, the Children's Bureau funded a 5-year demonstration grant cluster, Using Comprehensive Family Assessments (CFA) to Improve Child Welfare Outcomes. Grantees were:

- Alabama Department of Human Resources
- Alamance County Department of Social Services (North Carolina)
- Contra Costa County Child and Family Services Bureau (California)
- Illinois Department of Children and Family Services
- Ramsey County Community Human Services (Minnesota)

At the end of the projects, the grantees' process evaluations will assess the implementation of the eight key components of the Comprehensive Family Assessment Guidelines for Child Welfare, as well as the linkages between child-serving systems that will help ensure that identified needs of children and families are met. The practice evaluation will demonstrate how the practice of comprehensive and ongoing assessment has improved over time. The outcomes component will utilize a randomized trial, or other approach of sufficient rigor, to examine how the assessment approaches affect key outcomes of interest.

identified concrete services as critical elements of practice (Wells & Fuller, 2000). The most effective programs not only provided services to meet concrete needs, but offered families instruction in accessing community resources so that they could do so independently in the future. In a study of 1,014 families participating in a family reunification program in Illinois, the 50 percent of families who experienced reunification demonstrated high utilization of concrete services such as financial assistance and transportation (Rzepnicki, Schuerman, & Johnson, 1997).

*Substance abuse treatment.* The well-documented incidence of parental substance abuse as a factor in the placement of children into foster care (Smokowski & Wodarski, 1996) supports the critical importance of readily available resources for the assessment and treatment of addiction. In a longitudinal study of 1,911 mothers, Green, Rockhill & Furrer (2007) found that those who entered substance abuse treatment faster after their children were placed in substitute care, stayed in treatment longer, and completed at least one course of treatment were significantly more likely to be reunified with their children. A few agencies have established alliances with drug treatment centers or brought addiction professionals into the agency to ensure more effective assessment of drug-related needs, treatment planning, and monitoring of progress. Others have undertaken more intensive training of staff in addictions and the process of recovery (Maluccio & Ainsworth, 2003; Hohman & Butt, 2001). Research has shown promising results with three types of service delivery:

- *Intensive case management.* Ryan, Marsh, Testa, and Louderman (2003) reported significant results when substance-involved families received intensive case management that included "recovery coaches" to facilitate assessments, conduct service planning, and eliminate barriers to accessing substance abuse treatment. However, later follow-up with the same population indicated that likelihood of reunification is diminished when families experience co-occurring problems and are unable to make progress in those areas as well (Children and Family Research Center, 2007). Choi & Ryan (2007) found that the likelihood of both substance abuse treatment completion and family reunification was improved when mothers also received matched services that addressed co-existing problems such as mental health issues, housing, family counseling, and parenting skills.
- *Tailoring programs for women with children.* The provision of treatment services specifically developed to meet the needs of women with children appears to hold promise for retaining women in treatment and decreasing subsequent drug use (Clark, 2001). In a study of 1,115 mothers, Grella, Needell, Shi, & Hser (2009) found that the likelihood of reunification was enhanced when mothers received a broad range of employment, educational, and family and children's services in addition to substance abuse treatment.

- *Strong social support.* Because social support appears to be an important factor in the successful treatment of addiction, assessment and intervention should involve the entire family, especially spouses or partners, and include consistent, ongoing support from caseworkers and treatment providers (Gregoire & Schultz, 2001).

*Home-based services.* Many home-based service models originally developed to prevent out-of-home placement have shown some success in effecting family reunification. In one experimental study, families in the treatment group received intensive casework services, parenting and life skills education, family-focused treatment, and help in accessing community resources. The treatment group had a reunification rate three times that of the control group and remained intact at a far higher rate 7 years later (Lewis, Walton, & Fraser, 1995; Walton, 1998). It is important to note, however, that while some short-term intensive models have demonstrated success in achieving family reunification, not all such programs appear to reduce the risk of reentry into foster care substantially (Kimberlin, Anthony, & Austin, 2009; Littell & Schuerman, 1995; Wulczyn, 2004). Many families who have experienced placement of one or more children in foster care require longer term intervention and support (Gaudin, 1993).

*Post-reunification services.* Data from the Multi-state Foster Care Data Archive indicate that about 25 percent of all children who go home will return to care at some point, often within 1 year (Wulczyn, 2004). Reunification, although a positive milestone for the family, is also a time of readjustment, and a family already under stress can have difficulty maintaining safety and stability. The difficulty is compounded when children or parents have numerous or more complex personal needs or when environmental factors, such as extreme poverty and a lack of social supports, are present (Festinger, 1996; Terling, 1999). Research suggests that follow-up services that enhance parenting skills, provide social support, connect families to basic resources, and address children's behavioral and emotional needs must be provided if reentry into foster care is to be prevented. Post-reunification services are especially important when parental drug or alcohol use is a concern (Festinger, 1996; Terling, 1999).

## Examples From the Field

The following program examples illustrate key characteristics of interventions found to be associated with the achievement of timely, stable reunifications.

### *Michigan: Time-Limited, Intensive Services Promote Family Reunification*

In 1992, Michigan created and pilot tested the Family Reunification Program for families with children in out-of-home care. The program was intended to reduce the number of children in out-of-home care and to reduce the cost to the agency. The program provided several services to each family in treatment, including:

- Assessment
- Case management
- Transportation services
- 24-hour service availability
- Flexible funds
- In-home services
- Two staff (one master's level, one bachelor's level) for each family

Families were required to participate in assessment, family or individual therapy, and workshops on parenting. Services were offered for either 4 or 8 months.

An evaluation of the program showed that the families who participated in treatment programs were more likely to remain reunified than those in the control group. In addition, treatment was more cost-effective in the long run.

*Fewer children in out-of-home care.* Twelve months after exiting the program, 73 percent of the 813 children in the treatment group had been returned home and remained safely with their families; 69 percent of children in the comparison group had been returned home. No significant difference was found in reunification rates between families who participated in the 4-month (78 percent) and 8-month programs (72 percent). At 24 months following reunification, 81 percent of the treated families remained reunified, compared to only 60 percent of the comparison group families. Furthermore, the research indicated that children in the treatment group who did reenter out-of-home care tended to spend less time out of the home.

*Cost-effectiveness.* The agency calculated that it saved more than \$5,000 per family for those participating in the Family Reunification Program (more

than half of the cost for a child in the control group). The average cost per child was \$3,830 to return a child in the treatment group home, including 6 months of services and 12 months of follow-up. The cost for the same 18-month period was approximately \$9,113 per child in the comparison group, due to more frequent contacts and more reentries into care after reunification.

In follow-up interviews, families rated the following program features most strongly: the use of two-worker teams, the services offered in the family home, the 24-hour service availability, the use of a solution-focused service delivery, the skill-teaching in both individual and child management techniques, and concrete services (e.g., transportation, home repairs, etc.).

Today, the Family Reunification Program has expanded into 26 counties throughout Michigan, which serve 85 percent of all foster children in the State. The program served 730 families in fiscal year 2008. The two-worker team is made up of a team leader who provides the therapeutic intervention with family members and a family reunification worker who provides skill teaching and concrete services. Services are home-based and intensive, averaging 8-12 hours per week for the first 2 weeks after children are placed back in the home, and 4 hours per week for 4-6 months. Services are strength-based and focus on child safety. Family Reunification workers maintain small caseloads (six families), and the Team Leader provides 90 minutes of weekly family therapy and carries a larger case load (up to 12 families) during an intervention period.

For additional information, contact:

Guy Thompson, FPS Manager or Juli Gohl, FPS Specialist

Michigan Department of Human Services

Bureau of Child Welfare

235 S. Grand, Suite 510

Lansing, MI 48909

517.373.6286

ThompsonG@michigan.gov

Gohlj@michigan.gov

*Rhode Island: Project Connect Improves Reunification Rates for Substance Abuse-Affected Families*

Established in 1992 by Children's Friend & Service in Providence, RI, Project Connect is a community-based program for substance abuse-affected families

who are at imminent risk or who have already had a child removed from their care. Project Connect offers home-based substance abuse and family counseling, as well as parent education, nursing services, parenting groups, domestic violence groups, sobriety support, and links to services such as affordable housing, substance abuse treatment, and health care. Each family is assigned to a team that includes a master's level clinician, pediatric nurse, and parent educator. Staff work with parents and foster families to support relationships with children while in out-of-home care. Since 2007, the project has expanded its services statewide.

Evaluations of the program in 2003 and 2010 indicate that nearly all of the babies born to parents involved with Project Connect were born drug-free. Parents who completed the program after a high level of involvement with services showed significant progress in their parenting capabilities vis-a-vis creating a learning environment, addressing the health needs of their children, and effective use of supervision and discipline. They also were more likely to display adequate to mild strengths in family safety.

An evaluation of the 2003 program documented a number of positive outcomes. Parents showed marked improvement in meeting reunification goals and the ability to address the health needs of their children. Progress also was made in dealing with substance abuse issues, parenting behaviors, and meeting concrete needs. Researchers also noted that all but 2 of the 16 children assessed were functioning at or above the appropriate developmental stage.

Since 2007, improvements in child well-being are being assessed using the North Carolina Family Assessment Scale; while almost all children showed some improvement in the areas of child mental health, child behaviors, and parent-child relationships, those whose parents were highly involved with services displayed the greatest improvements. In the period 2007-2009, 16 of the 23 children who were removed from their families experienced reunification. Seventy-five percent of Project Connect reunifications occurred within 12 months of removal, compared to 68 percent for all reunifications in the State. Only one Project Connect child reentered foster care in that time period, 15 months after reunification.

The program attributes its success to a number of factors:

- A service coordinating committee, which developed statewide policies that are responsive

to families, reduced barriers to services, and developed opportunities for cross-training of service providers

- Increased outreach and engagement efforts by staff
- An increased focus on permanency planning for children

For more information, contact:

Valentina L.S. Laprade, LICSW  
 Director of Family Preservation  
 Children's Friend  
 153 Summer St. Providence, RI 02903  
 401.276.4352 vlaprade@cfsri.org

### Program Support for Reunification

In addition to offering insight into factors and services that are linked to reunification and stability, the literature and the program examples discussed above suggest several guiding principles for practice in this critical area of permanency planning:

- Families must be included and engaged in the planning and selection of services and the assessment of progress. Positive change is best driven by mutually established goals and open, honest communication between families and helping professionals.
- Maintaining family relationships while children are in care is a critical component of any successful reunification practice. Frequent family visitation is linked to both the likelihood of reunification and post-reunification stability.
- Successful reunification must be systematically considered and planned for from the earliest possible point. Such planning must rest on comprehensive assessment that focuses not only on the issues precipitating placement, but also on family history, relationships, the parents' health and emotional functioning, and the community environment.
- Reunification preparation and post-reunification supports must be based on the needs of the children and family rather than on arbitrary timeframes. Reunification should be viewed as a process that includes maintaining family relationships while children are in

care, careful planning, and the provision of post-reunification supports. Families are best supported when all available resources, both formal and informal, are brought to bear on their behalf (Warsh, Maluccio, & Pine, 1994).

Some of these guiding principles can be implemented by caseworkers; all of them, plus the systemic changes such as flexible funding, can be implemented at the agency level or higher. ©

### About the Author

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

*The original (2005) version of this issue brief was developed in partnership with the Child Welfare League of America, under subcontract to the National Clearinghouse on Child Abuse and Neglect. This update was developed by Child Welfare Information Gateway, in partnership with Susan Dougherty. This document is made possible by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The conclusions discussed here are solely the responsibility of the authors and do not represent the official views or policies of the funding agency.*

### References

- Adoption and Safe Families Act, 105 U.S.C. § 89 (1997). Retrieved April 2011 from [www.acf.hhs.gov/programs/cb/laws\\_policies/cblaws/public\\_law/pl105\\_89/pl105\\_89.htm](http://www.acf.hhs.gov/programs/cb/laws_policies/cblaws/public_law/pl105_89/pl105_89.htm)
- Ahart, A., Bruer, R., Rutsch, C., & Zaro, S. (1992). *Final report: intensive foster care reunification programs* (Contract No. HHS-100-91-0016). Calverton, MD: Macro International.
- Albers, E., Reilly, T., & Rittner, B. (1993). Children in foster care: Possible factors affecting permanency planning. *Child and Adolescent Social Work Journal*, 10(4), 329-341.
- Anthony, E. K., Berrick, J. D., Cohen, E., & Wilder, E. (2009). *Partnering with parents: Promising approaches to improve reunification outcomes for children in foster*

- care. Berkeley, CA: Center for Social Services Research. Retrieved February 2011 from [www.parentadvocacy.org/padocs/Final\\_Report\\_UC\\_Berkeley\\_2009\\_Evaluation\\_of\\_Contra\\_Costa\\_Parent\\_Partners.pdf](http://www.parentadvocacy.org/padocs/Final_Report_UC_Berkeley_2009_Evaluation_of_Contra_Costa_Parent_Partners.pdf)
- Cheng, T. C. (2010). Factors associated with reunification: A longitudinal analysis of long-term foster care. *Children and Youth Services Review, 32*, 1311–1316.
- Children and Family Research Center. (2007). *Illinois Alcohol & Other Drug Waiver Demonstration semi-annual progress report, June–December 2007*. Chicago, IL: Illinois Department of Children and Family Services.
- Children's Bureau. (2004a). *Findings from the initial Child and Family Services Reviews, 2001 to 2004*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved April 2011 from [www.acf.hhs.gov/programs/cb/cwmonitoring/results/sld001.htm](http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/sld001.htm)
- Children's Bureau. (2004b). *General findings from the Federal Child and Family Services Review*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved April 2011 from [www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/index.htm](http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/index.htm)
- Children's Bureau. (2007). *Corrected Federal Register announcement*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved January 2011 from [www.acf.hhs.gov/programs/cb/cwmonitoring/legislation/fed\\_reg.htm](http://www.acf.hhs.gov/programs/cb/cwmonitoring/legislation/fed_reg.htm)
- Children's Bureau. (2009). *Results of the 2007 and 2008 Child and Family Services Reviews*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved January 2011 from [www.acf.hhs.gov/programs/cb/cwmonitoring/results/agencies\\_courts.pdf](http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/agencies_courts.pdf)
- Children's Bureau. (2010a). *The AFCARS report: Preliminary FY 2009 estimates as of July 2010*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved January 2011 from [www.acf.hhs.gov/programs/cb/stats\\_research/afcars/tar/report17.htm](http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.htm)
- Children's Bureau. (2010b). *Summary of the Title IV-E child welfare waiver demonstrations*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved January 2011 from [www.acf.hhs.gov/programs/cb/programs\\_fund/cw waiver/2010/summary\\_demo2010.htm](http://www.acf.hhs.gov/programs/cb/programs_fund/cw waiver/2010/summary_demo2010.htm)
- Choi, S., & Ryan, J. P. (2007). Co-occurring problems for substance abusing mothers in child welfare: Matching services to improve family reunification. *Children and Youth Services Review, 29*(11), 1395–1410.
- Clark, H. W. (2001). Residential substance abuse treatment for pregnant and post-partum women and their children. *Child Welfare, 80*, 179–198.
- Corcoran, J. (2000). Family interventions with child physical abuse and neglect: A critical review. *Children and Youth Services Review, 22*(7): 563–591.
- Corcoran, K. (1997). Use of rapid assessment instruments as outcome measures. In E. L. Mullen & J. L. Magnabosco (Eds.), *Outcomes measurement in the human services: Cross-cutting issues and methods*. Washington, DC: NASW Press.
- Davis, I. P., Landsverk, J., Newton, R., & Ganger, W. (1996). Parental visiting and foster care reunification. *Children and Youth Services Review, 18*(4/5), 363–382.
- Dawson, K., & Berry, M. (2002). Engaging families in child welfare services: An evidence-based approach to best practice. *Child Welfare, 81*(2): 293–317.
- DePanfilis, D. (1999). Intervening with families when children are neglected. In H. Dubowitz (Ed.), *Neglected children: Research, practice, and policy* (pp. 211–236). Thousand Oaks, CA: Sage Publications, Inc.
- Dore, M. M., & Lee, J. M. (1999). The role of parent training with abusive and neglectful parents. *Family Relations, 48*, 313–325.
- Farmer, E. (1996). Family reunification with high risk children: Lessons from research. *Children and Youth Services Review, 18*(4/5), 403–424.
- Festinger, T. (1996). Going home and returning to foster care. *Children and Youth Services Review, 18*(4), 383–402.
- Gaudin, J. (1993). Effective interventions with neglectful families. *Criminal Justice and Behavior, 20*(1), 66–89.
- Green, B. L., Rockhill, A., & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review, 29*, 460–473.
- Gregoire, K. A., & Schultz, D. J. (2001). Substance abusing child welfare parents: Treatment and placement outcomes. *Child Welfare, 80*(4), 433–452.
- Grella, C. E., Needell, B., Shi, Y., & Hser, Y. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment, 36*(3), 278–293.
- Haight, W. L., Sokolec, J., Budde, S., & Poertner, J. (2001). *Conducting parent-child visits*. Urbana-Champaign, IL: University of Illinois, Children's Research Center.
- Hess, P. M., Folaron, G., & Jefferson, A. B. (1992). Effectiveness of family reunification services: An innovative evaluation model. *Social Work, 37*(4), 304–311.
- Hohman, M. M., & Butt, R. L. (2001). How soon is too soon? Addiction recovery and family reunification. *Child Welfare, 80*(1), 53–67.

- Kemp, S. P., Marcenko, M. O., Hoagwood, K., & Vesneski, W. (2009). Engaging parents in child welfare services: Bridging family needs and child welfare mandates. *Child Welfare*, 88(1), 101–126.
- Kimberlin, S. E., Anthony, E. K., & Austin, M. J. (2009). Re-entering foster care: Trends, evidence, and implications. *Children and Youth Services Review*, 31(4), 471–481.
- Kirk, R. (2001). *Tailoring intensive family preservation services for family reunification cases. Phase 2: Field testing and validation of the North Carolina Family Assessment Scale for Reunification*. Project report to the National Family Preservation Network and the David and Lucile Packard Foundation.
- Leathers, S. J. (2002). Parental visiting and family reunification: How inclusive practice makes a difference. *Child Welfare*, 81(4), 595–616.
- Lewis, R. E., & Callaghan, S. A. (1993). The peer parent project: Compensating foster parents to facilitate reunification of children with their biological parents. *Community Alternatives*, 5(1), 43–65.
- Lewis, R. E., Walton, E., & Fraser, M. W. (1995). Examining family reunification services: A process analysis of a successful experiment. *Research on Social Work Practice*, 5(3), 259–282.
- Littell, J. H., & Schuerman, J. R. (1995). *A synthesis of research on family preservation and family reunification programs*. Rockville, MD: Westat, Inc.
- Macdonald, G. (2001). *Effective interventions for child abuse and neglect: An evidence-based approach to planning and evaluating interventions* (pp. 228–284). Chichester, England: John Wiley & Sons.
- Maluccio, A. N., & Ainsworth, F. (2003). Drug use by parents: A challenge for family reunification practice. *Children & Youth Services Review*, 25(7), 511–533.
- Marcenko, M., Brown, R., DeVoy, P. R., & Conway, D. (2010). Engaging parents: Innovative approaches in child welfare. *Protecting Children*, 25(1), 23–34.
- McMurtry, S. L., & Rose, S. J. (1998). *Applying standardized assessment instruments in ongoing child welfare services*. Milwaukee, WI: University of Wisconsin.
- National Center for Youth Law. (2007). *Improving the child welfare workforce: Lessons learned from class action litigation*. Oakland, CA: Author. Retrieved January 2011 from [www.youthlaw.org/publications/yln/2007/january\\_march\\_2007/improving\\_the\\_child\\_welfare\\_workforce](http://www.youthlaw.org/publications/yln/2007/january_march_2007/improving_the_child_welfare_workforce)
- National Research Council (1993). *Understanding child abuse and neglect*. Washington, DC: National Academies Press.
- National Resource Center for Foster Care and Permanency Planning. (2003). *NRCFCPP concurrent planning curriculum: Concurrent planning for timely permanency*. New York, NY: Author.
- National Resource Center for Permanency and Family Connections. (2009). *Family engagement: A web-based practice toolkit*. New York, NY: Author. Retrieved April 2011 from [www.nrcpfc.org/fewpt](http://www.nrcpfc.org/fewpt)
- Pine, B. A., Spath, R., & Gosteli, S. (2005). Defining and achieving family reunification. In G. P. Mallon & P. Hess, (Eds.), *Child Welfare for the twenty first century: A handbook of practices, policies, and programs* (pp. 378–391). New York, NY: Columbia University Press.
- Regional Research Institute for Human Services (1998). *Strengths/needs based services evaluation*. Portland, OR: Portland State University, Graduate School of Social Work.
- Romanelli, L. H., Hoagwood, K. E., Kaplan, S. J., Kemp, S. P., Harman, R. L., Trupin, C., & the Child Welfare-Mental Health Best Practices Group. (2009). Best practices for mental health in child welfare: Parent support and youth empowerment guidelines. *Child Welfare*, 88(1), 189–218.
- Rooney, R. H. (1992). *Strategies for working with involuntary clients*. New York: Columbia University Press.
- Ryan, J., Marsh, J., Testa, M., & Louderman, R. (2003). *Integrating substance abuse treatment and child welfare services: Findings from the Illinois AODA waiver demonstration*. Urbana, IL: University of Illinois at Urbana-Champaign.
- Rzepnicki, T. L., Schuerman, J. R., & Johnson, P. (1997). Facing uncertainty: Reuniting high-risk families. In J. D. Berrick, R. P. Barth, & N. Gilbert (Eds.), *Child welfare research review, Vol. 2*. New York: Columbia University Press.
- Sanchirico, A., & Jablonka, K. (2000). Keeping foster children connected to their biological parents: The impact of foster parent training and support. *Child & Adolescent Social Work Journal* 17(3), 185–203.
- Smokowski, P. R., & Wodarski, J. S. (1996). The effectiveness of child welfare services for poor, neglected children: A review of the empirical evidence. *Research on Social Work Practice*, 6(4), 504–523.
- Terling, T. (1999). The efficacy of family reunification practices: Reentry rates and correlates of reentry for abused and neglected children reunited with their families. *Child Abuse & Neglect*, 23(12), 1359–1370.
- Wagner, D., & Bogie, A. (2010). *California Department of Social Services validation of the SDM® Reunification Reassessment*. Madison, WI: The Children's Research Center. Retrieved April 8, 2011, from [www.nccd-crc.org/crc/crc/pdf/CRR\\_Validation\\_Report.pdf](http://www.nccd-crc.org/crc/crc/pdf/CRR_Validation_Report.pdf)

- Walton, E. (1998). In-home family focused reunification: A six-year follow-up of a successful reunification experiment. *Social Work Research*, 22(4), 205–214.
- Walton, E., Fraser, M. W., Pecora, P., & Walton, W. K. (1993). In-home family-focused reunification: An experimental study. *Child Welfare*, 72(5), 473–487.
- Warsh, R., Maluccio, A. N., & Pine, B. A. (1994). *Teaching family reunification: A sourcebook*. Washington, DC: Child Welfare League of America.
- Wells, S. J., & Fuller, T. (2000). Elements of best practice in family centered services. Urbana, IL: University of Illinois at Urbana-Champaign.
- Wulczyn, F. (2004). Family reunification. *The Future of Children*, 14(1), 95–113.
- Wulczyn, F., & Martin, N. (2001). *Linking permanency and finance in child welfare: ACS Safe and Timely Adoptions and Reunifications (STAR) Program*. Paper presented at the National Association of Welfare Research and Statistics, Baltimore, MD, August, 2001.
- Yatchmenoff, D. K. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Research on Social Work Practice*, 15, 84–96.

## Endnotes

- 1 It should be noted that the literature addresses some effective reunification strategies at the agency level, rather than at the level of caseworker interventions:
  - Research suggests that caseworkers who have social work education, appropriate training, specialized competencies, and greater experience are better able to facilitate permanency (Ahart, Bruer, Rutsch, & Zaro, 1992; Albers, Reilly, & Rittner, 1993; National Center for Youth Law, 2007; Pine, Spath, & Gosteli, 2005; Walton, Fraser, Pecora, & Walton, 1993).
  - More flexible funding that allows agencies to provide better community-based services to families can also lead to greater rates of reunification (Children's Bureau, 2010b; Wulczyn & Martin, 2001; Wulczyn, Zeidman, & Svirsky, 1997). Waivers of constraints on categorical funding and collaboration with community agencies to form more efficient service networks have the potential to affect reunification efforts positively by making more formal and informal resources available to families.
- 2 The Child and Family Services Reviews are designed to enable the Children's Bureau to ensure that State child welfare agency practice is in conformity with Federal child welfare requirements, determine what is actually happening to children and families as they are engaged in State child welfare services, and assist States to enhance their capacity to help children and families achieve positive outcomes. For more information about the CFSR process, visit the Children's Bureau website at [www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm#cfcsr](http://www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm#cfcsr).
- 3 For a full explanation of data indicators and national standards in the second round of reviews, see Children's Bureau (2007).
- 4 This indicator was added in the second year of reviews and was therefore applicable for only 35 States.



# Family Engagement

*A June 2010 Issue Brief from the Child Welfare Information Gateway.  
Available online at [www.childwelfare.gov/pubs/issue\\_briefs/fam\\_engagement/](http://www.childwelfare.gov/pubs/issue_briefs/fam_engagement/)*

Family engagement is the foundation of good case-work practice that promotes the safety, permanency, and well-being of children and families in the child welfare system.

Family engagement is a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, and achieving desired outcomes. It is founded on the principle of communicating openly and honestly with families in a way that supports disclosure of culture, family dynamics, and personal experiences in order to meet the individual needs of every family and every child. Engagement goes beyond simple involvement by “motivating and empowering families to recognize their own needs, strengths, and resources and to take an active role in working toward change” (Steib, 2004).

For an indepth guide to the practice of family engagement, see *Family Engagement: A Web-Based Practice Toolkit*, developed by the National Resource Center for Permanency and Family Connections: [www.hunter.cuny.edu/socwork/nrcfcpp/fewpt/index.htm](http://www.hunter.cuny.edu/socwork/nrcfcpp/fewpt/index.htm)

Key to building a productive caseworker- family relationship, family engagement is the foundation from which change occurs. It is important throughout the life of a child welfare case—from screening and assessment; through case planning and decision-making; to service delivery, case reviews, and ultimately case closure. To build on a family’s resources and kinship connections, family engagement activities focus not only on the immediate family but also on the active involvement of both parents, extended family, and the family’s natural support systems. Beyond specific cases, engaging families as key stakeholders must extend to policy development, service design, and evaluation.

To help State child welfare managers improve family engagement across program areas, this brief offers information on:

- The benefits of family engagement

- Ways to achieve meaningful family engagement
- Specific strategies that reflect family engagement
- State and local examples of family engagement strategies
- Additional resources

## The Benefits of Family Engagement

More and more evidence suggests that family engagement has many benefits, including:

- *Enhancing the helping relationship.* A family’s belief that all its members are respected and that their feelings and concerns are heard strengthens their relationship with their caseworker. This positive relationship, in turn, can increase the chances for successful intervention.
- *Promoting family “buy-in.”* When families are part of the decision-making process and have a say in developing plans that affect them and their children, they are more likely to be invested in the plans and more likely to commit to achieving objectives and complying with treatment that meets their individual needs. A qualitative analysis of findings from the three top- performing metro sites in the 2007-2008 Child and Family Services Reviews (CFSRs) found that child and family involvement in case planning was correlated with (1) active engagement of noncustodial and incarcerated parents, (2) family-centered and strength-based approaches (e.g., team meetings, mediation) effective in building working relationships, and (3) strong rapport developed between workers and parents (U.S. Department of Health and Human Services [HHS], 2009).
- *Expanding options.* Inclusion of family members—including fathers and extended family—early in a case provides a greater opportunity

to explore the use of relatives as a placement/permanency option for children.

- *Improving the quality and focus of visits.* The partnership developed between the family and social worker through family engagement strategies strengthens the assessment process and leads to more appropriate service provision.
- *Increasing placement stability.* The CFSRs found that States with high ratings for developing case plans jointly with parents and youth also had high percentages of children with permanency and stability in their living situations (HHS, 2004). Research on family group decision-making (FGDM) also points to improvements in creating stability and maintaining family continuity (Merkel-Holguin, Nixon, & Burford, 2003).
- *Improving timeliness of permanency decisions.* Research also suggests that parental involvement is linked to quicker reunification and other forms of permanency (Tam & Ho, 1996; Merkel-Holguin, et al., 2003).
- *Building family decision-making skills.* By being involved in strength-based decision-making processes and having appropriate problem-solving approaches modeled, families are more comfortable communicating their own problem-solving strategies and exploring new strategies that may benefit themselves and their children.
- *Enhancing the fit between family needs and services.* Working collaboratively, caseworkers and families are better able to identify a family's unique needs and develop relevant and culturally appropriate service plans that address underlying needs, build on family strengths, and draw from community supports. A better fit in services often leads to a more effective use of limited resources (Doolan, 2005).

### Ways to Achieve Meaningful Family Engagement

Many child welfare agencies struggle with engaging families on a daily basis. There are challenges inherent in working with families that have experienced or are at risk of abuse and neglect, and additional challenges are posed by high caseloads, resource limitations, and

reliance on traditional practices. Changing how child welfare agencies interact with families is difficult work, but it can be done.

Agencies can minimize the challenges and prepare for effective and sustainable engagement strategies by incorporating family engagement into the agency's child welfare practice model and implementing key elements at the systems and casework practice levels.

#### *Child Welfare Practice Models*

Many child welfare agencies are encouraging practice improvement and systems change through the use of practice models that emphasize family engagement as a cornerstone of achieving positive outcomes. The practice model, which builds from a clearly defined vision and set of core values, contains definitions, explanations, and expectations of how the agency will operate and how it will partner with families and other stakeholders in child welfare services (National Child Welfare Resource Center for Organizational Improvement & National Resource Center for Family-Centered Practice and Permanency Planning, 2008).

States that have implemented a practice model over multiple years, such as Utah ([www.dcf.utah.gov/practice\\_model.htm](http://www.dcf.utah.gov/practice_model.htm)) and Alabama (<http://dhr.alabama.gov/page.asp?pageid=245>), have focused on practice as the core of their reform efforts. These States have organized their worker training to follow the process of working with families, beginning with engagement and building trusting relationships. Utah also has translated its practice framework into written staff performance expectations. One such expectation examines the worker's ability to effectively use engagement skills that include active listening (Child Welfare Policy and Practice Group, 2008). Additionally, many States are developing practice models as an overarching strategy in their Program Improvement Plans as part of the CFSR.

Family engagement strategies are a foundation of the practice model and, together with other evidence-based practices ([www.childwelfare.gov/management/service/improving\\_practices](http://www.childwelfare.gov/management/service/improving_practices)) can produce important gains for children and families.

To learn more about practice models, see *An Introduction to the Practice Model Framework: A Working Document Series* from the National Child Welfare Resource Center for Organizational Improvement and the National Resource Center for Family-Centered

Practice and Permanency Planning: <http://muskie.usm.maine.edu/helpkids/practicemodel/PracticeModelWorkingPaperIntro.pdf>

### *Key Systems Elements*

Elements relating to child welfare systems and infrastructure have been identified through research and State experiences as important to achieving meaningful family engagement. Not every element will be feasible in every instance, and many elements will evolve over time. They include the following:

- Agency leadership that demonstrates a strong commitment to family-centered practice and champions family engagement as a priority
- Organizational culture that models desired behaviors, actions, and communication among managers, supervisors, and frontline caseworkers
- Systems change initiatives and Program Improvement Plans with detailed strategies for achieving family and youth involvement
- Policies and standards that clearly define expectations, identify requirements, and reinforce family engagement in case practice
- Trained supervisors who explain agency policies that apply to family engagement, offer coaching to caseworkers, and provide support and feedback
- Manageable caseloads and workloads allowing caseworkers to attend to the time-consuming efforts of building rapport, engaging families, actively participating in team decision-making meetings, and maintaining frequent, meaningful contact with children and families
- Defined roles for planning and facilitation of team decision-making meetings to ensure that the meetings are timely (with reasonable notice to all parties), well facilitated, focused on the family and children's strengths and needs, goal directed, and inclusive of all team members
- Skillful facilitation, which in some agencies is carried out by external facilitators or coordinators who guide engagement activities such as family group conferences and make sure that all points of view are heard
- Availability and accessibility of diverse services

that can respond specifically to the family's identified needs and conditions

- Identification of service gaps and new ways to develop the community services that families need
- Training and coaching to build family engagement skills among child welfare caseworkers and supervisors, and to help birth families, foster families, caseworkers, administrators, and other helping professionals work together effectively
- Systematic documentation of caseworker/ family interaction and communication, and family involvement
- Individualized performance review systems that reward staff for family engagement efforts and provide ongoing feedback regarding performance
- Quality assurance and case review processes that monitor effective implementation of family engagement and measure its effects on safety, permanency, and well-being
- External assistance in the form of training, consultation, and technical assistance from recognized family engagement experts
- Monitoring of family engagement activities and family progress against mutually agreed-upon goals

### *Key Casework Elements*

Research underscores the crucial role caseworker interaction plays in engaging families, particularly through the development of a supportive and trusting relationship (Dawson & Berry, 2002; Yatchmenoff, 2005; Rooney, 1992; Wells & Fuller, 2000). Elements that foster such a relationship and support family engagement practices include:

- Clear, honest, and respectful communication with families, which helps set a foundation for building trust
- Commitment to family-centered practice and its underlying philosophy and values
- Sufficient frequency and length of contact with families and their identified formal and informal supports

- A strengths-based approach that recognizes and reinforces families' capabilities and not just their needs and problems
- Shared decision-making and participatory planning, which results in mutually agreed-upon goals and plans reflecting both the caseworker's professional training and the family's knowledge of their own situation
- Broad-based involvement by both parents, extended family members, informal networks, and community representatives who create a web of support that promotes safety, increases permanency options, and provides links to needed services
- Understanding of the role of confidentiality and how to involve partners in case planning in a manner which is respectful of the family, but which also enables partners to plan realistically to protect the child and work toward permanency
- Recognition of foster and adoptive parents as resources not only for the children in their care, but for the entire birth family
- Individualized service plans that go beyond traditional preset service packages (e.g., parenting classes and counseling) and respond to both parents' identified needs, specific circumstances, and available supports
- Concrete services that meet immediate needs for food, housing, child care, transportation, and other costs, and help communicate to families a sincere desire to help
- Praise and recognition of parents who are making life changes that result in safe and permanent living situations for their children (including reunification, adoption, kinship placement, or guardianship)

### Specific Strategies That Reflect Family Engagement

Family engagement strategies build on the foundation of agency commitment and caseworker skills. State agencies have adopted various strategies for engaging families at case, peer, and systems levels, frequently adapting existing models to meet their own

needs. Family engagement strategies include but are not limited to:

- *Frequent and substantive caseworker visits.* Workers must have frequent and meaningful contact with families in order to engage them in the work that needs to be done to protect children, promote permanency, and ensure child well-being. States where caseworkers have regular and well-focused visits with the child and parent have demonstrated improved permanency and well-being outcomes in the CFSRs. Frequent visits with parents also are positively associated with better client-worker relationships; better outcomes in discipline and emotional care of children; timely establishment of permanency goals; timely filing for termination of parental rights; and reunification, guardianship, or permanent placement with relatives (Lee & Ayón, 2004; HHS, 2004).
- *Family group decision-making (FGDM)* ([www.americanhumane.org/protecting-children/programs/family-group-decision-making](http://www.americanhumane.org/protecting-children/programs/family-group-decision-making)) is an effective and increasingly popular case-level strategy for engagement in the United States and around the world. FGDM is an umbrella term for various processes in which families are brought together with agency personnel and other interested parties to make decisions about and develop plans for the care of their children and needed services. FGDM strategies differ in meeting format, the stage during case meetings when they are held, the extent of family preparation, the extent of family privacy time, and other characteristics. The models are known by a variety of names and include:
  - Family group conferences
  - Family team conferences
  - Family team meetings
  - Family unity meetings
- *Motivational interviewing* (<http://motivationalinterviewing.org>) is a directive counseling method for enhancing intrinsic motivation and promoting behavior change by helping families explore and resolve ambivalence. This technique, which relies heavily on listening

reflectively and asking directive questions, has shown positive results in working with child welfare populations with substance abuse issues (California Evidence-Based Clearinghouse for Child Welfare).

- *Collaborative strategies* emphasize working in partnership with families in a strength-based way to support achievement of case goals and objectives. Examples include Collaborative Helping ([http://findarticles.com/p/articles/mi\\_m0AZV/is\\_200903/ai\\_n32319390/](http://findarticles.com/p/articles/mi_m0AZV/is_200903/ai_n32319390/)) (Madsen, 2009), the Signs of Safety approach ([www.signsofsafety.net/signsofsafety](http://www.signsofsafety.net/signsofsafety)) (Turnell & Edwards, 1999), and solution-focused practice (Berg & De Jong, 2004; Antle, Barbee, Christensen, & Martin, 2008).
- *An active and meaningful role for families* can be achieved by involving them in case planning and checking in with them during visits about their understanding of and progress toward the plan. Involvement of the family in case planning is correlated with greater engagement of noncustodial and incarcerated parents, family-centered/ strength-based approaches, and stronger rapport between workers and families (HHS, 2009).
- *Father involvement* ([www.abanet.org/child/fathers/](http://www.abanet.org/child/fathers/)) recognizes the importance of fathers to the healthy development of children. Agencies are increasingly reaching out to fathers and working to enhance their positive involvement with their children. Fatherhood programs vary greatly. Some are outreach efforts to include fathers in assessment and case planning processes; others help fathers address stressors or behaviors that affect their ability to support their children.
- *Family search and engagement* ([www.hunter.cuny.edu/socwork/nrcfcpp/info\\_services/family-search.html](http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/family-search.html)) encourages broad-based participation in family decision-making to leverage kinship connections and increase placement/ permanency options.
- *Mediation*, adopted by many agencies and courts, allows agency representatives and families to work with a neutral facilitator to arrive at a mutually acceptable plan.
- *Parent Partner Programs* engage parents who were once involved with the child welfare system to serve as mentors to currently involved parents, providing support, advocacy, and help navigating the system. Parent Partner Programs also use the birth parent experience to influence changes in policy and protocol, encourage shared decision-making, strengthen individualized plans, and educate the community.
- *Foster family-birth family meetings* encourage birth families and foster families to share information, help model parenting skills, and support participation of foster families in placement conferences that contribute to reunification efforts.
- *Parent and youth involvement in agency councils and boards* is a proactive way for State and county agencies to gather and use parent and youth input in program and policy development, service design, and program evaluation.

### State and Local Examples of Family Engagement Strategies

State and local agencies throughout the country are at various stages of implementing and strengthening family engagement efforts. Following are selected examples of family engagement initiatives. The examples are presented for information purposes only; inclusion does not indicate an endorsement by Child Welfare Information Gateway or the U.S. Department of Health and Human Services, Children's Bureau.

- California: Parent Partners Program
- Iowa: Family engagement tools and programs
- Maine: Practice model
- Massachusetts: Father engagement
- Minnesota: Court-initiated family case planning conferences
- New Mexico: Foster and birth parent icebreaker meetings
- North Carolina: Multiple response system
- Texas: Family group conferencing
- Virginia: Birth, foster, and adoptive family relationships

*Contra Costa County, California: Parent Partners Program*

In Contra Costa County, parents who have experienced child removal, child welfare services, and reunification are trained as parent advocates to mentor and support other parents new to the child welfare system. Parent Partners help other parents navigate the child welfare system and access services with the goal of moving families toward reunification.

The Parent Partners Program was implemented as part of Contra Costa County's Child Welfare Systems of Care grant ([www.childwelfare.gov/management/reform/soc/communicate/initiative](http://www.childwelfare.gov/management/reform/soc/communicate/initiative)). The County hired two full-time Parent Partners as contract staff and additional part-time Partners on an hourly contract basis. When feasible, Parent Partners were trained alongside child welfare staff.

While each partnership varies with the circumstances of the families involved, Parent Partners generally:

- Share their own stories and experiences and offer encouragement and hope
- Provide information on the child welfare system in everyday language and help parents understand their rights and responsibilities
- Coach families on how to act appropriately in court and at meetings
- Connect parents with formal and informal community resources and services
- Attend court hearings and team decision meetings, as requested by parents
- Provide ongoing emotional support, often during nights, weekends, and holidays

Research on the Parent Partners Program suggests that the parents' common experiences help inspire trust and hope, which in turn promotes engagement and may facilitate the change process (Anthony, Berrick, Cohen, & Wilder, 2008; Cohen & Canan, 2006). Findings from a process study reflected positive responses about the benefits of the program from parents, Parent Partners, and social workers. Moreover, preliminary results of an outcome study revealed that reunification may be more likely for children whose parents were served by Parent Partners (Anthony, et al.).

For more information, contact Danna Fabella at 925.335.1583, or Linda Canan at 925.335.7100.

*Iowa: Family Engagement Tools and Programs*

The State of Iowa champions engagement as the "primary door through which we help families change" (Munson & Freundlich, 2008). Iowa strives to engage the family in case planning, case management, and case closure processes. The State's commitment to family engagement efforts is reflected in and enabled by:

- The State's child welfare practice model. ([www.dhs.state.ia.us/docs/IOWA\\_CW\\_Model\\_of\\_Practice.pdf](http://www.dhs.state.ia.us/docs/IOWA_CW_Model_of_Practice.pdf)) One of its four guiding principles states: "We listen to and address the needs of our customers in a respectful and responsive manner that builds upon their strengths." Specific standards of frontline practice specify: "The child and the child's parents are actively engaged and involved in case planning activities."
- Regularly held family team meetings. These are used to assist the family network in building a common understanding of what is pertinent to the case and in developing a plan that will protect the child and help the family change.
- A published set of practice standards ([www.dhs.state.ia.us/cppc/docs/DHSfamilyteam-standards05.doc](http://www.dhs.state.ia.us/cppc/docs/DHSfamilyteam-standards05.doc)) for family team decision-making. The standards present values and beliefs that support family teams and are intended to guide daily practice; they also include indicators of effectiveness.
- An online toolkit ([www.dhs.state.ia.us/cppc/family\\_team](http://www.dhs.state.ia.us/cppc/family_team)) that offers resources, checklists, and handouts for planning, preparing for, and following up after family team meetings.
- An evaluation handbook ([www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual\\_Documents/Forms/Comm283.pdf](http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Forms/Comm283.pdf)) for family team decision-making that provides policies, guidance, and assessment support.
- A Parent Partner Program ([www.dhs.state.ia.us/cppc/Parent\\_Partner\\_Program](http://www.dhs.state.ia.us/cppc/Parent_Partner_Program)) that trains, coaches, and supports parents who have been safely reunified with their children to serve as mentors for parents currently involved with child protective services. In addition to working one-on-one with other families, Parent Partners are involved with policy, program,

and curriculum development in collaboration with child welfare staff. As a result, the experiences and insights of Parent Partners have been integrated into birth parent orientation and support groups, foster and adoptive parent recruitment and training, new child welfare worker orientation, local and statewide steering committees and conferences, and community partnership participation.

- Parent and youth involvement on advisory councils that is tracked annually ([www.dhs.state.ia.us/cppc/service\\_reviews](http://www.dhs.state.ia.us/cppc/service_reviews)). Online surveys and toolkits support the recruitment and retention of advisory council representatives ([www.dhs.state.ia.us/cppc/networking](http://www.dhs.state.ia.us/cppc/networking)).

For more information, visit the Iowa Department of Human Services website: [www.dhs.state.ia.us/cppc/family\\_team](http://www.dhs.state.ia.us/cppc/family_team)

#### *Maine: Practice Model*

Maine's Bureau of Child and Family Services (BCFS) began developing a new vision in 2001, including a detailed strategic plan for the Bureau. This ongoing reform initiative incorporates goals and strategies that address many of the findings of the State's 2003 CFSR and support greater family engagement. One of the stated goals of Maine's strategic plan was to "broaden family involvement from report to best outcome for child and family."

More recently, the BCFS expanded its initial statement of beliefs and values into a practice model. This practice model was developed with the thoughtful input of caseworkers, supervisors, and managers at all levels of Child and Family Services from every district. In addition, BCFS asked for input from approximately 20 stakeholders, most of whom had helped to develop the Program Improvement Plan after the first Federal CFSR.

The practice model is stated in plain language intended to be accessible to parents, foster parents, community providers, teachers, students, new employees, and any other members of the community. Bureau staff are responsible for giving these statements life, through practice at all levels of the organization. All policies and trainings are also under review to ensure adherence to the practice model.

The key principles of the model include:

- Child safety, first and foremost.

- Parents have the right and responsibility to raise their own children.
- Children are entitled to live in a safe and nurturing family.
- All children deserve a permanent family.
- How we do our work is as important as the work we do.

Each of these principles is supported by statements that emphasize family involvement and a strength-based approach.

The practice model philosophy and principles are provided on Maine's website at [www.maine.gov/dhhs/ocfs/cw/practicemodel.shtml](http://www.maine.gov/dhhs/ocfs/cw/practicemodel.shtml)

#### *Massachusetts: Father Engagement*

Recognizing the significance of a father's involvement to the well-being of his children, the Massachusetts Department of Children and Families is working to counteract the tendencies of social workers to overlook fathers in child protection practices. To create a culture of father engagement, the agency:

- Conducted a policy and regulation review to clarify that caseworkers are required to work with both parents, including parents out of the home, in all phases of case practice.
- Established Fatherhood Education Leadership Teams in seven area offices throughout the State. The teams meet once a month and are composed of social workers, supervisors, area directors, and representatives of community agencies that work with fathers. The teams identify gaps in practice, develop procedures for improving practice, train caseworkers in engaging fathers, and collect data on father engagement in different phases of case practice.
- Developed a systematic framework for engaging fathers. The framework calls for routine engagement of fathers in all phases of case practice, beginning with a diligent search for fathers early in the case. It also includes methods for measuring progress.
- Established a differential engagement approach that calls for working with fathers in different ways, depending on their strengths and risk profiles.
- Implemented staff training on working with

men, enhancing caseworker skills in respectful, culturally informed, and strength-based approaches to developing positive relationships with fathers, including those who are initially avoidant, angry, or hostile.

- Developed tools and resources to support implementation and help caseworkers integrate practice changes. For caseworkers, there are tip sheets on topics such as co-parenting issues when parents are not together, the basics of respectful father engagement, what to say when the father has been physically abusive to the mother, and helping fathers re-engage when they have been out of the home a long time. For fathers there are tip sheets on a variety of topics, such as being a good role model, playing with children, disciplining appropriately, and caring for crying babies.

For more information, contact Fernando Mederos at [fernando.mederos@state.ma.us](mailto:fernando.mederos@state.ma.us)

#### *Olmsted County, Minnesota: Court-Initiated Family Case Planning Conferences*

Family engagement is a key feature of Olmsted County's Parallel Protection Process (P3). Begun in 2002 as part of a Children's Justice Initiative, P3 offers an alternative justice intervention for juvenile court cases involving children at high risk of child maltreatment. P3 has been highlighted as a promising approach on the Children's Bureau website: [www.acf.hhs.gov/programs/cb/cwmonitoring/promise/states.htm#MN](http://www.acf.hhs.gov/programs/cb/cwmonitoring/promise/states.htm#MN)

For up to four cases a month in which a petition is contested, the court can order a family case planning conference (FCPC). The FCPC has two primary goals:

- Negotiate a settlement on the admission or denial of the Child in Need of Protective Services petition
- Develop the immediate next steps in the child protection or agency case plan

Judges order all parties to the case planning conference, which is a facilitated process

that includes the family, extended family, community supports, social workers, supervisors, court attorneys, family attorneys, guardians ad litem, and

other relevant parties. The conference begins with introductions and the family's presentation of their family system. Next, everyone participates in information sharing on the incidents that brought the family to the attention of social services, risk to the child or children, complicating factors (i.e., conditions or behaviors that contribute to difficulty for the family), family strengths and protective factors, and ideas to build safety. Efforts are made to develop a balanced view.

The next step is a deliberate match between the legal language in the filed petition and the information shared at the meeting. Negotiations aim to determine one or more areas of agreement among the family with their attorneys, social services, and the county attorney. Once a settlement agreement is reached, the full group then discusses the immediate next steps (i.e., case plan) to address the family's needs in the context of the identified risk.

In the first 2 years, more than 90 percent of the P3 conferences resulted in settlement agreements that were accepted by the court. Initial findings from participant surveys reported positive responses among families, social workers, and attorneys involved in the process. Early indicators suggest that the program:

- Encourages less adversarial and more meaningful involvement of families in a court-ordered process
- Reduces court processing time and hastens family access to supports through "front loading" of services
- Leads to individualized case plans for children based on family needs and risks
- Safeguards children from repeated maltreatment
- Contributes to child permanency (Lohrbach & Sawyer, 2004)

For more information:

- Read *Creating a Constructive Practice: Family and Professional Partnership in High-Risk Child Protection Case Conferences*: [www.co.olmsted.mn.us/upload\\_dir/cs/creatingaconstructive-practice.pdf](http://www.co.olmsted.mn.us/upload_dir/cs/creatingaconstructive-practice.pdf)
- Contact Rob Sawyer, Director, Olmsted County Child & Family Services, at [sawyer.orb@co.olmsted.mn.us](mailto:sawyer.orb@co.olmsted.mn.us)



### *New Mexico: Foster Parent and Birth Parent Icebreaker Meetings*

Among New Mexico's family engagement efforts is an innovative child welfare practice of using "icebreaker" meetings to bring together foster parents and birth parents. The meetings promote information sharing about a foster child and are intended to encourage easier adjustments for the children in care, as well as for the parents.

Across the State, the icebreaker meetings are held soon after a child's placement, ideally within 2 days. Discussions are focused on the child. Birth parents share information that will assist the foster parent in caring for the child, for example, their likes and dislikes, bedtime routines, and favorite pastimes. The foster parents, in turn, offer information about the child's new environment and daily activities in the foster home. The meetings are facilitated, generally by a trained former foster or adoptive parent, who ensures that the discussions remain focused on the child's needs. In some cases, there may be additional facilitated meetings and contacts.

In addition to making it easier for the child to adjust, the meetings help the foster and birth parents recognize their common concern for the child. As a result, the foundation for a respectful relationship can be formed.

For more information, contact Maryellen Bearzi at [maryellen.bearzi@state.nm.us](mailto:maryellen.bearzi@state.nm.us)

### *North Carolina: Multiple Response System*

North Carolina's Multiple Response System (MRS) is an effort to reform the entire continuum of child welfare throughout the State, from intake through placement and permanency services. The reform is based on the application of family-centered principles of partnership through seven strategies:

- Collaboration between Work First (Temporary Assistance for Needy Families) and child welfare supports can prevent the involvement of child protective services (CPS) and helps prevent recidivism by providing financial, employment, and community services to families.
- A strengths-based structured intake focuses on family strengths as well as needs.
- A choice of two responses to reports of child abuse, neglect, or dependency protects the immediate safety of children in the most severe

cases while engaging some families in services that could enable them to better parent their children.

- Coordination between law enforcement and CPS ensures that those who harm children are held accountable while minimizing the number of interviews children experience, thereby reducing retraumatization.
- A redesign of in-home family services allows caseworkers to engage families in the planning process and provide the most intensive services to families with the greatest needs.
- Child and family team meetings during in-home services acknowledge the birth family to be experts on their own situation and encourage the support and buy-in of both parents, extended family, and community in the planning and assessment process.
- Shared parenting meetings during the first 7 days of out-of-home placement keep the birth family actively involved in their role as parents and cultivate a nurturing relationship between the birth parents and foster parents.

A report to North Carolina's General Assembly in June 2006 found that families in counties implementing the MRS reform were receiving needed services more quickly. There was no evidence that children's safety was negatively affected by the reforms (Center for Child and Family Policy, 2006).

For more information, visit the North Carolina Division of Social Services website: [www.dhhs.state.nc.us/dss/mrs](http://www.dhhs.state.nc.us/dss/mrs)

### *Texas: Family Group Conferencing*

Working toward a more family-centered approach to child welfare, the Texas Department of Family and Protective Services introduced a family group decision-making (FGDM) initiative. Texas' approach, which incorporates family group conferencing, promotes group discussions among CPS, family members, relatives, friends, and others in the community and also provides private family time for case planning.

Texas' implementation of FGDM has evolved and expanded over time. Attempting to address deficiencies identified in the State's 2002 CFSR, Texas began to lay the groundwork for increased family engagement. Staff participated in information exchange

during a meeting with other States using FGDM models, received technical assistance and support from Casey Family Programs, obtained legislative permission to redirect some foster care funds into support services for kinship care, and hired five district FGDM specialists and a State liaison. In 2003, FGDM specialists began using the new approach in five cities as a pilot program targeted primarily to families experiencing the removal of a child. In later years, family conferencing services were expanded throughout the State and additional family team meetings were introduced to engage families during the investigation stage of services.

An evaluation of FGDM ([www.dfps.state.tx.us/Documents/about/pdf/2006-10-09\\_FGDM\\_Evaluation.pdf](http://www.dfps.state.tx.us/Documents/about/pdf/2006-10-09_FGDM_Evaluation.pdf)) was conducted for the period March 2004 to July 2006, reflecting a total of 3,625 conferences. Findings revealed that, compared to children receiving traditional services, children involved with FGDM:

- Were more likely to be placed with relatives immediately following a family group conference
- Experienced shorter stays in care
- Were more likely to return to their families
- Were reported to be less anxious and better adjusted, particularly when placed with relatives

In addition, parents were more satisfied with family group conferences than traditional services (Texas Department of Family and Protective Services, 2006).

For more information:

- Visit the Texas Department of Family and Protective Services website: [www.dfps.state.tx.us/child\\_protection/about\\_child\\_protective\\_services/fgdm.asp](http://www.dfps.state.tx.us/child_protection/about_child_protective_services/fgdm.asp)
- Read Casey Family Program's *Focus on Foster Care: Family Group Decision-Making: How the State of Texas Adopted a Family-Centered Approach to Child Welfare*, available through the Information Gateway library: <http://library.childwelfare.gov/cwig/ws/library/docs/gateway/SimpleSearchForm>

*Virginia: Birth, Foster, and  
Adoptive Family Relationships*

Northern Virginia's Bridging the Gap program is a self-driven collaboration of public and private child-placing agencies with a unified vision for child

welfare practice. Bridging the Gap refers to the process of building and maintaining relationships and communication between birth and foster families involved in a youth's life, with the goal of supporting family reunification or another permanency plan. The bridging process is sometimes extended to other families involved in the child's life, such as extended birth family, relative caregivers, and adoptive parents.

Facilitated icebreaker meetings held within 7 days of placement provide an opportunity for birth parents and foster parents to meet and share information about the child's needs. Plans for ongoing communication and contact between the families are individualized, and may include opportunities for the foster family to support, help, teach, and/or participate with the birth family in a variety of ways.

Although Bridging the Gap is not a new strategy, the cooperative effort in Northern Virginia seeks to standardize this process as part of foster care practice.

For more information, contact Claudia McDowell at [Claudia.McDowell@fairfaxcounty.gov](mailto:Claudia.McDowell@fairfaxcounty.gov). ©

#### Additional Resources

*National Resource Center for Permanency and Family Connections*  
(formerly, the National Resource Center for Family-Centered Practice and Permanency Planning)

Provides training and technical assistance and information services to help States, with an emphasis on family-centered principles and practices.  
[www.hunter.cuny.edu/socwork/nrcfcpp](http://www.hunter.cuny.edu/socwork/nrcfcpp)

*National Child Welfare Resource Center for Organizational Improvement*

Offers technical assistance, training, teleconferences, and publications to assist States with strategic planning, quality improvement, evaluating outcomes, facilitating stakeholder involvement, and improving training and workforce development. <http://muskie.usm.maine.edu/helpkids>

*National Center on Family Group Decision Making (FGDM)*

Helps build community capacity to implement high-quality, effective FGDM processes by sharing resources, advancing family-driven practices, creating knowledge, and building links to improve the implementation and evaluation of family group decision-making, both in the United States and abroad. [www.nccfgrm.org](http://www.nccfgrm.org)

americanhumane.org/protecting-children/programs/family-group-decision-making/national-center

The National Center on Family Group Decision Making also offers *A Compilation of State and Provincial Laws, Policies, Rules and Regulations on Family Group Decision Making and Other Family Engagement Approaches in Child Welfare Decision Making*. The paper identifies and provides brief descriptions of relevant laws and policies for 16 States, the District of Columbia, and 3 Canadian provinces: [www.americanhumane.org/assets/docs/protecting-children/PC-fgdm-leg-chart.pdf](http://www.americanhumane.org/assets/docs/protecting-children/PC-fgdm-leg-chart.pdf)

### About the Author

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](mailto:info@childwelfare.gov)  
[www.childwelfare.gov](http://www.childwelfare.gov)

### References

- Anthony, E. K., Berrick, J. D., Cohen, E., & Wilder, E. (2008). *Partnering with parents. Promising approaches to improve reunification outcomes for children in foster care. Executive summary*. Paper presented at the 17th National Conference on Child Abuse and Neglect, Atlanta, GA.
- Antle, B. F., Barbee, A. P., Christensen, D.N., & Martin, M.H. (2008). Solution-based casework in child welfare: Preliminary evaluation research. *Journal of Public Welfare* 2(2), 197-227.
- Berg, I. K., & De Jong, P. (2004). Building solution-focused partnerships in children's protective and family services. *Protecting Children* 19, 3-13.
- California Evidence-Based Clearinghouse for Child Welfare. Retrieved July 28, 2009, from [www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org)
- Center for Child and Family Policy, Terry Sanford Institute, Duke University. (2006). *Multiple Response System (MRS) evaluation report to the North Carolina Division of Social Services (NCDSS)*. Retrieved July 28, 2009, from [www.dhhs.state.nc.us/dss/mrs/docs/mrs\\_eval\\_rpt\\_6\\_30\\_06\\_all\\_combined.pdf](http://www.dhhs.state.nc.us/dss/mrs/docs/mrs_eval_rpt_6_30_06_all_combined.pdf)
- Child Welfare Policy and Practice Group. (2008). *Adopting a child welfare practice framework*. Retrieved August 4, 2009, from [www.childwelfaregroup.org/documents/CWGPracticeFramework.pdf](http://www.childwelfaregroup.org/documents/CWGPracticeFramework.pdf)
- Cohen, E., & Canan, L. (2006). Closer to home: Parent mentors in child welfare. *Child Welfare*, 85, 867-884.
- Dawson, K., & Berry, M. (2002). Engaging families in child welfare services: An evidence-based approach to best practice. *Child Welfare*, 81(2), 293-317.
- Doolan, M. (2005). *The family group conference: A mainstream approach in child welfare decision-making*. Presentation retrieved February 20, 2009, from [www.americanhumane.org/assets/docs/protecting-children/PC-fgdm-conf-fgc2004.pdf](http://www.americanhumane.org/assets/docs/protecting-children/PC-fgdm-conf-fgc2004.pdf)
- Lee, C. D., & Ayón, C. (2004). Is the client-worker relationship associated with better outcomes in mandated child abuse cases? *Research on Social Work Practice*, 14, 351-357.
- Lohrbach, S., & Sawyer, R. (2004). Creating a constructive practice: Family and professional partnership in high-risk child protection case conferences. *Protecting Children Journal*, 19(2), 26-35.
- Madsen, W. C. (2009). Collaborative helping: A practice framework for family-centered services. *Family Process* 48, 103-116.
- Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Learning with families: A synopsis of FGDM research and evaluation in child welfare. *Protecting Children*, 18(1-2), 2-11. Retrieved March 1, 2009, from [www.americanhumane.org/assets/docs/protecting-children/PC-pc-article-fgdm-research.pdf](http://www.americanhumane.org/assets/docs/protecting-children/PC-pc-article-fgdm-research.pdf)
- Munson, S., & Freundlich, M. (2008). *Families gaining their seat at the table: Family engagement strategies in the first round of Child and Family Services Reviews and Program Improvement Plans* (p.8). Retrieved February 24, 2009, from [www.americanhumane.org/assets/docs/protecting-children/PC-fgdm-CFSR-PIP-review.pdf](http://www.americanhumane.org/assets/docs/protecting-children/PC-fgdm-CFSR-PIP-review.pdf)
- National Child Welfare Resource Center for Organizational Improvement and the National Resource Center for Family-Centered Practice and Permanency Planning. (2008). *An introduction to the practice model framework: A working document series*. Retrieved February 28, 2008, from <http://muskie.usm.maine.edu/helpkids/practicemodel/PracticeModelWorkingPaperIntro.pdf>
- Rooney, R. H. (1992). *Strategies for work with involuntary clients*. NY: Columbia University Press.
- Steib, S. (2004). Engaging families in child welfare practice. *Children's Voice*. Retrieved March 5, 2009, from [www.cwla.org/programs/r2p/cvarticlesef0409.htm](http://www.cwla.org/programs/r2p/cvarticlesef0409.htm)
- Tam, T. S., & Ho, M. K. W. (1996). Factors influencing the prospect of children returning to their parents from out-of-home care. *Child Welfare*, 75(3), 253-268.

- Texas Department of Family and Protective Services (October, 2006). *Family group decision-making, final evaluation*. Retrieved March 17, 2009, from [www.dfps.state.tx.us/Documents/about/pdf/2006-10-09\\_FGDM\\_Evaluation.pdf](http://www.dfps.state.tx.us/Documents/about/pdf/2006-10-09_FGDM_Evaluation.pdf)
- Turnell, A., & Edwards, S. (1999). *Signs of safety: A solution and safety oriented approach to child protection*. New York, NY: W.W. Norton & Company.
- U.S. Department of Health and Human Services (HHS), Children's Bureau. (2009). *Results of the 2007 and 2008 Child and Family Services Reviews*. Presentation retrieved November 4, 2009, from [www.acf.hhs.gov/programs/cb/cwmonitoring/results/agencies\\_courts.pdf](http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/agencies_courts.pdf)
- U.S. Department of Health and Human Services (HHS), Children's Bureau. (2004). *Findings from the initial Child and Family Service Reviews, 2001-2004*. Presentation retrieved April 22, 2009, from [www.acf.hhs.gov/programs/cb/cwmonitoring/results/sld001.htm](http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/sld001.htm)
- Wells, S., & Fuller, T. (2000). *Elements of best practice in family centered services*. University of Illinois at Urbana-Champaign. School of Social Work. Retrieved February 28, 2008, from [www.cfr.illinois.edu/pubs/Pdf.files/fcsbest.pdf](http://www.cfr.illinois.edu/pubs/Pdf.files/fcsbest.pdf)
- Yatchmenoff, D. K. (2005). Measuring client engagement in non-voluntary child protective services. *Research on Social Work Practice, 15*(2), 84-96.

# Highlights of Michigan's Modified Consent Decree approved on July 18, 2011

- Created greater flexibility for DHS to organize the department; it is less stringent, reflects current structure, and allows flexibility for future changes.
  - Modified the method of measuring certain outcome measurements from manual spreadsheets to quality assurance case reads.
  - Modified the purchase of service (POS) monitoring caseload ratios from 45:1 to 90:1 beginning September 2011.
  - Extended implementation date of Centralized CPS Intake from October 2011 to April 2012.
  - Created greater flexibility in managing the regional Maltreatment in Care Units, allowing DHS to transfer responsibility to local offices in certain situations.
  - Created greater flexibility in the structure of Pre-Service Training Institute, allowing for progression of training caseloads and greater flexibility in delivery of training.
  - Eliminated the requirement that supervisors must have a Master's degree, affording DHS the opportunity to recognize experience and high performing staff.
  - Extended timeframes for caseloads targets out by two years.
  - Replaced "point-time" case counts for each worker with a monthly average of each worker's caseload, upon the implementation of DHS's new child welfare information system (SACWIS).
  - Replaced mandatory Team Decision Making meetings and Permanency Planning Conferences with a new case practice model that offers Family Team Meetings, enables better provision of services, and focuses on family engagement and concurrent planning.
  - Released DHS from conducting a second Needs Assessment.
  - Redirected authority for placement exceptions from the CSA director to the county directors.
  - Clarified requirements around the use of psychotropic medications.
  - Eliminated the automatic termination of a Private Agency Foster Care contract for failure to report abuse or neglect twice in a year. DHS will now investigate and determine appropriate corrective action up to and including termination or modification of the contract.
  - Redirected DHS focus from special reviews of high risk cases to a systemic approach to quality assurance.
  - Released DHS from the requirement to write an implementation plan.
  - Eliminated the requirement to create 200 Permanency Planning Specialist positions.
  - Approved DHS's use of a Permanency Resource Managers model for developing a permanency focus and for moving difficult cases to permanency.
  - Modified language regarding the provision of health services and dental services and extended timeframes to achieve compliance out two years.
  - Eliminated the limitation on placing children within the county.
- The following are new provisions to support the child welfare reform efforts commenced by Director Corrigan in January 2011.
- License 2,750 new non-relative foster homes over the next two years.
  - Establish baseline data and set targets for licensing relative foster homes through December 2012.

- Increase the annual finalization of adoptions to 77% by September 2013.
- Increase the finalization of juvenile guardianships from 150 in calendar year 2011 to 165 for each calendar year 2012-2014.
- Expand supportive services for youth aging out of foster care:
  - Require transition meetings for youth 16 years of age or older being discharged from foster care.
  - Expand Michigan Youth Opportunities Initiative (MYOI), youth boards and Individual Development Accounts (IDA) to additional counties.
- Support Michigan's implementation of extension of foster care services (SB 435-440).
- Create and expand scholarships and onsite support and mentorships for youth attending Michigan colleges and universities, including the Seita Scholars program at Western Michigan University.
- Evaluate the appropriateness of each case with an unapproved Another Planned Permanent Living Arrangement (APPLA) permanency goal.
- Reduce the number of youth with an APPLA permanency goal to 9% by 2012. ©

## *The Michigan Child Welfare Law Journal* Call for Papers

The editorial board of *The Michigan Child Welfare Law Journal* invites manuscripts regarding current issues in the field of child welfare. The *Journal* takes an interdisciplinary approach to child welfare, as broadly defined to encompass those areas of law that directly affect the interests of children. The editorial board's goal is to ensure that the *Journal* is of interest and value to all professionals working in the field of child welfare, including social workers, attorneys, psychologists, and medical professionals. The *Journal's* content focuses on practice issues and the editorial board especially encourages contributions from active practitioners in the field of child welfare. All submissions must include a discussion of practice implications for legal practitioners.

The main text of the manuscripts must not exceed 20 double-spaced pages (approximately 5000 words). The deadline for submission is December 30, 2011. Manuscripts should be submitted electronically to [kozakiew@msu.edu](mailto:kozakiew@msu.edu). Inquiries should be directed to:

Joseph Kozakiewicz, Editor  
*The Michigan Child Welfare Journal*  
School of Social Work  
238 Baker Hall  
Michigan State University  
East Lansing, MI 48823  
[kozakiew@msu.edu](mailto:kozakiew@msu.edu)  
(517) 336-8088

# Enabling Mandated Reporters to Fulfill their Legal Obligations: Getting the Word Out Effectively and Affordably

by Joseph P. Kozakiewicz, JD, LMSW

## Abstract

Child abuse and neglect remains a major problem in U.S. society. One response to this problem has been to enact laws requiring certain professionals to report suspected child abuse and neglect. Though these laws have been in effect for a number of years, they have not been successfully implemented. Many mandated reporters are unaware of their legal obligations, do not know how to satisfy those obligations, or choose to ignore their legal obligations. The author will describe a mandated reporter guide created by the Michigan State University School of Social Work to assist mandated reporters in implementing Michigan's mandated reporter law. Survey results will be described to determine the efficacy of this pamphlet in improving the knowledge and practice of mandated reporters. Recommendations will be made to build upon the survey findings regarding these materials.

## Introduction

Beginning in the early nineteenth century, many states began to enact policies designed to protect the general welfare of children (Edwards, 1996; Fox, 1996; Hurst, 1999; Ross, 1998; Rubin, 1996; Shephard, 1999; Stevenson, Larson, Cater, Gomby, Terman & Behrman, 1996). As Fox (1996) noted, in 1824 the New York Legislature opened a House of Refuge for young offenders thought capable of reform and for children deemed in need of care due to the parents' shortcomings. Other states subsequently established institutions designed to protect children from abusive parents. Over time, the definition of child maltreatment came to encompass a number of harmful behaviors toward children, including physical abuse, emotional abuse, sexual abuse, and various forms of child neglect (Haralambie, 2005).

The prevalence of child maltreatment in U.S. society first came to the attention of many professionals as well as the public at large in 1962 through the work of Denver physician C. Henry Kempe (Kempe, 1962). Through the work of Dr. Kempe and his colleagues, the etiology and treatment of child maltreatment first began to receive serious scholarly and scientific consideration (Ventrell, 2005). Though much attention has been paid to this social ill over the past fifty years, there does not today exist any consensus regarding the root causes of child maltreatment. Further, debate continues regarding the ideal balance of legal consequences and social services that might prevent child maltreatment or at least successfully intervene with those families and children involved in cases of abuse and neglect.

There is general consensus among practitioners that the child welfare system should strive to provide all children with safe, healthy, home-like environments (Hardin, 1996; Schene, 1998). Yet even with such general agreement, tension in this field of practice has revolved around the competing needs to remove children from their parent's care to prevent harm and the desire to provide necessary services to families to avoid removal of children from their parents in the first place (Cook, 2000; Kozakiewicz, 2001; Schene, 1998). Historically, the state's preference for either family preservation or the aggressive removal of children has shifted in response to public and political (and thus legislative) swings of opinion regarding the perceived efficacy and desirability of either approach (Cook, 2000; Kozakiewicz, 2001; Schene, 1998). In either case, once a child becomes a ward of the court due to maltreatment, foster care workers, counselors, therapists, adoption workers, and other child welfare workers seek to provide the necessary services and to take whatever steps thought necessary to achieve the

best possible resolution of each case from the individual child's perspective (Segal, 2010).

Despite the heightened awareness and attention devoted to issues surrounding child maltreatment, and despite the development of more and varied services and approaches to address this social ill, child maltreatment remains a grave problem in today's society. In 2008, an estimated 3.7 million U.S. children received an investigation or assessment for reported maltreatment and approximately one-fifth (758,289) of those children were found to have been maltreated (U.S. Department of Health and Human Services, 2010). While consensus regarding most aspects of child maltreatment remains elusive, it is evident that society has as of yet failed to "solve" this problem (Kenny, 2001; Segal, 2010).

### The Enactment of Mandated Reporter Laws

One social policy designed to address the problem of child maltreatment has been the adoption of laws mandating certain professionals to report suspected child maltreatment. Within three years after Dr. Kempe's seminal paper, every U.S. state passed a law requiring some form of mandated reporting (Melton, 2005; Ventrell, 2005). The federal government subsequently enacted the Child Abuse and Prevention Act of 1974 (CAPTA) which required states to establish a system of mandated reporting in order to be eligible for federal funds that were made available under the act. States were thus effectively prevented from re-considering their policies regarding mandated reporting. The impact of the mandated reporter laws has been a source of debate. Some critics have pointed out that these laws lead to many unsubstantiated reports which reduce the state's available resources that can actually serve families in need (Ainsworth, 2002). Melton (2005) went even further, writing that mandated reporting laws have "transformed public child welfare agencies into investigatory bodies with diminished involvement in the provision of social services per se" (p. 14). Melton argued that mandated reporting should be scrapped and a new model of state intervention must be developed to better serve families and children, but noted the nature of such a new system was beyond the scope of the instant article.

In contrast to Melton, other authors have noted that while much criticism of the current mandated reporting system is warranted, the policy continues to serve a crucial function (Mathews & Bross, 2008).

Mathews and Bross argued that the benefits of mandated reporting laws outweigh the costs. They stressed that the real problem in the child welfare system is the state's inability to respond to reports appropriately and to provide needed resources to families. Mathews and Bross see mandated reporters as simply the bearers of bad news in a larger system that fails to adequately protect children from harm.

Regardless of this debate, the mandated reporter laws appear here to stay. Since mandated reporting laws were first passed, states have tinkered with various aspects of their reporting laws but no state has rescinded the law as Melton (2005) advised. In fact, most laws first focused on physicians as mandated reporters, but over the years the definition of those professionals that are covered by these laws has consistently expanded (Ventrell, 2005). The Michigan Child Protection Law (1975) now defines mandated reporters to include physicians, dentists, physician's assistants, registered dental hygienists, medical examiners, nurses, persons licensed to provide emergency medical care, audiologists, psychologists, marriage and family therapists, licensed professional counselors, social workers, licensed master's social workers, licensed bachelor's social workers, registered social service technicians, social service technicians, persons employed in a professional capacity in any office of the friend of the court, school administrators, school counselors or teachers, law enforcement officers, members of the clergy, and regulated child care providers.

A crucial question remains regarding whether or not mandated reporters are adequately prepared to satisfy their legal obligations. The mandated reporter laws can be effective only if mandated reporters are willing and able to successfully carry out their responsibilities under these laws. As the following discussion will show, the performance of mandated reporters regarding the implementation of these laws leaves much room for improvement.

### The Current Performance of Mandated Reporters

While research exploring the practice of mandated reporters is fairly limited, a number of studies have been conducted to explore how these laws are implemented in a variety of settings and how implementation might be improved. Most of these studies have focused on health care providers (Botash, A. 2003; DeMattei, Sherry, Rogers & Freeman, 2009; Flaherty



& Sege, 2005; Kenny, 2001; Vulliamy & Sullivan, 2000) and school personnel (Abrahams, Casey, & Daro, 1992; Kenny, 2004; Kenny, 2007). These studies address a variety of specific research questions, but in essence they all to some extent help us understand mandated reporter's attitudes toward these laws, the extent to which the mandated reporter laws are followed, and what barriers exist toward the more effective implementation of these laws. A number of conclusions can be drawn from these studies.

First, there exist concerns regarding both the under-reporting and the over-reporting of child abuse (Delaronde, King, Bendel & Reece, 2000; Mathews & Bross, 2008; Melton, 2005). Over-reporting involves those circumstances when unnecessary reports are made, thus draining resources from where those resources are actually needed. Under-reporting of course involves one's failure to make a necessary report thus leaving a child at risk of harm. Assuming that mandated reporters have children's best interests in mind, it is unclear why underreporting should be a problem, particularly when mandated reporters may not be held liable for reports made in good faith that later prove unfounded. A number of studies address this perplexing situation.

A number of studies conclude that mandated reporters' lack of basic relevant knowledge is a fundamental barrier to the effective implementation of mandated reporter laws. A number of studies have found that many mandated reporters do not know what constitutes reportable abuse, are unclear of the legal implications of making a report, and often are not even aware of their very duty to report abuse or neglect (Abrahams, Casey, & Daro, 1992; Kenny, 2001). Reiniger, Robison, & McHugh (1995) concluded that many mandated reporters do not know what specific steps to take once they determine that a report of abuse or neglect is in fact warranted. Flaherty (2005) found that a perceived inability to assess maltreatment is a common barrier to reporting among physicians. Foreman & Bernet (2000) found that many mandated reporters are uncertain of the details of their state's reporting laws and also found that the laws themselves are often unclear or confusing. In light of these varied gaps in crucial knowledge among mandated reporters, it is no surprise that Kenny (2001) found that many mandated reporters failed to make reports due to a fear of appearing "foolish." It is unsurprising that many mandated reporters would be

reluctant to take action when they lack the confidence that their action is appropriate and will adhere to the relevant norms.

In those studies in which the authors made specific recommendations for change, the recommendations were consistently for some form of education or training of mandated reporters. Botash (2003) recommended the development and implementation of a core curriculum in child abuse for pediatric residents. Flaherty & Sege (2005) recommended continuing education programs for practitioners in the field. DeMattei, Sherry, Rogers & Freeman (2009) and King, Reece, Bendel & Patel (1998) recommended developing both academic programs for future mandated reporters and continuing education programs for mandated reporters already working in the field. Kenny (2001) too stressed that both pre-service academic training as well as some form of professional in-service education is needed to enable mandated reporters to fulfill their legal obligations. Kenny (2007) wrote that trainings need not be "in-person" trainings, which are generally time-consuming and expensive. Rather, effective training programs can be delivered through more cost-efficient on-line, web-based tutorials that provide information regarding child abuse identification and reporting.

### MSU School of Social Work's Response to these Findings

While the specific recommendations of the authors discussed above vary in some details, virtually all authors agreed that to improve the performance of mandated reporters in carrying out their charge, mandated reporters must be better educated regarding their specific responsibilities and how to effectively carry out those responsibilities. In 2005 the Michigan State University School of Social Work received a financial donation from an alumnus concerned with child maltreatment. This donor wished to improve mandated reporters' knowledge and performance and sought to have the School of Social Work develop a tool to meet this goal.

This project was assigned to staff at the Chance at Childhood Program (CAC). CAC is a collaborative program between the MSU School of Social Work and the MSU College of Law. CAC provides students with both classroom education and community-based experiential learning in child welfare and staff there were well positioned to carry out the project at hand.

Subsequent to the receipt of the alumnus' donation, the MSU College of Law received a grant from the Office of Juvenile Justice and Delinquency Prevention, US Department of Justice which was used in part to support this project.

In light of the information gathered from the literature review summarized above, CAC staff held focus groups to help narrow the focus of this project. Information obtained from focus groups supported the general conclusions reached in many of the studies cited above. In short, CAC staff learned that Michigan's mandated reporters did not have a good understanding of their legal requirements or the procedures to follow in to carry out their responsibilities under the Michigan Child Protection Law (the "Law"). Mandated reporters also lacked knowledge to recognize many common signs of abuse or neglect.

Staff sought to develop a series of pamphlets tailored to address these deficiencies among various categories of mandated reporters. The pamphlets were designed with a number of specific objectives in mind: 1) To present a clear summary (avoiding legalese) of the fundamental requirements set forth for mandated reporters in the Law; 2) To provide an overview of the common warning signs of abuse and neglect; 3) To explain in simple terms the steps one must take to report abuse or neglect to the Michigan Department of Human Services; 4) To stress the positive reasons for complying with the Law while still noting one's potential criminal liability for failing to do so, and; 5) To stress that a mandated reporter cannot be held liable to any person for a report made in good faith even if that report ultimately proves to be entirely unfounded. Staff sought to design an attractive pamphlet, in glossy color and with numerous photos to break up the often inevitably dry text.

With these goals in mind, a pamphlet was first designed for school personnel. Subsequent pamphlets were designed for physicians, nurses, social workers, and clergy. The basic outline and information presented in each version of the pamphlet is the same, with each version being tailored to account for minor variations in the Law regarding the specific profession covered by that version. Additionally, the list of warning signs of abuse and neglect in each pamphlet was modified to reflect those signs most likely to be encountered by practitioners in each professional field. Each version of these pamphlets was created with input from professionals in the field of practice to be

covered as well as feedback from recipients of earlier versions of the pamphlet.

Since mid-2007, over 10,000 pamphlets have been distributed free of charge throughout the state of Michigan. In mid-2008, a ten-question survey (attached as Appendix A) was developed and sent to organizations and individuals who received the pamphlets in the past. All subsequent mailings of pamphlets included copies of the survey. Organizations were mailed ten hard copies of the survey and were encouraged to make additional copies if needed. Recipients were asked to either return the surveys in enclosed, self-addressed return envelopes, or to return them via fax to the CAC clinic. Approximately 900 hard copies of surveys were distributed by CAC staff.

### Survey Results

As of May 2010, 312 surveys were returned to CAC. The first two questions on the survey seek identifying information. Responses to question 1 indicate that teachers returned the most surveys (141, or 45%), followed by social workers (90, or 29%), nurses (30 or 10%), clergy (28, or 9%) and physicians (23, or 7%). Survey respondents were also asked to indicate the professional setting in which they work. The most common answer to survey question 2 was schools (110, or 35%), followed by unit of government (49, or 16%), churches or private practice (both 43, or 14%), private child welfare agencies (33, or 11%), hospitals (22, or 7%), and the Michigan Department of Human Services (10, or 3%).

The remaining survey questions asked respondents to strongly agree, agree, disagree, strongly disagree, or offer no opinion to a number of statements. Questions 3 through 6 focus on how effectively the pamphlets present specific information, asking respondents to respond to the following four statements: 1) I am able to understand the information presented in the pamphlet; 2) The pamphlet helped me better understand the legal definition of abuse and neglect; 3) The pamphlet helped me better understand when I should report abuse or neglect; and, 4) The pamphlet clearly explains how to report abuse and neglect.

As tables 1 through 4 below indicate, at least 95% of all survey respondents either agreed or strongly agreed with each of these four statements. No respondents disagreed or strongly disagreed with the statements "I am able to understand the informa-

tion presented in the pamphlet” and “The pamphlet clearly explains how to report abuse and neglect.” Only 1 percent disagreed with the statement “The pamphlet helped me better understand the legal definition of abuse and neglect” and only 3 percent disagreed with the statement “The pamphlet helped me better understand when I should report abuse or neglect.” No respondents strongly disagreed with either of these statements. Both of these statements asked whether respondents *better* understood information after reading the pamphlet. It is possible these respondents disagreed with these statements because they felt their understanding was already sound. Regardless, the survey results indicate that respondents overwhelmingly believed the pamphlets effectively presented the information sought to be conveyed to mandated reporters.

**Table 1: I am able to understand the information presented in the pamphlet**

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion/ Response
Teachers (141)	115 (82%)	26 (18%)			
Social Workers (90)	55 (61%)	33 (37%)			2 (2%)
Physicians (23)	14 (61%)	9 (39%)			
Nurses (30)	19 (63%)	11 (37%)			
Clergy (28)	20 (71%)	8 (29%)			
Total (312)	223 (71%)	87 (28%)			2 (1%)

**Table 2: The pamphlet helped me better understand the legal definition of abuse and neglect**

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion/ Response
Teachers (141)	49 (35%)	88 (62%)			4 (3%)
Social Workers (90)	59 (67%)	21 (23%)	4 (4%)		6 (7%)
Physicians (23)	15 (65%)	8 (35%)			
Nurses (30)	20 (67%)	10 (33%)			
Clergy (28)	23 (82%)	5 (18%)			
Total (312)	166 (53%)	132 (42%)	4 (1%)		10 (3%)

**Table 3: The pamphlet helped me better understand when I should report abuse or neglect**

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion/ Response
Teachers (141)	53 (38%)	84 (60%)	2 (1%)		2 (1%)
Social Workers (90)	61 (68%)	21 (23%)	8 (9%)		
Physicians (23)	19 (83%)	4 (17%)			
Nurses (30)	22 (73%)	8 (27%)			
Clergy (28)	21 (75%)	7 (25%)			
Total (312)	176 (56%)	124 (40%)	10 (3%)		2 (1%)

**Table 4: The pamphlet clearly explains how to report abuse and neglect**

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion/ Response
Teachers (141)	73 (52%)	68 (48%)			
Social Workers (90)	39 (43%)	51 (57%)			
Physicians (23)	21 (91%)	2 (9%)			
Nurses (30)	27 (90%)	3 (10%)			
Clergy (28)	24 (86%)	4 (14%)			
Total (312)	184 (59%)	128 (41%)			

Survey questions 7-8 focus on the pamphlet recipients' behavior or anticipated behavior following receipt of the pamphlets, specifically asking for responses to two statements. As Table 5 indicates, 65% of respondents agreed or strongly agreed with the statement "Because I have the pamphlet as a resource, I am now more likely to report abuse or neglect than if I did not have the pamphlet." 19% of respondents disagreed, 6% strongly disagreed, and 10% of respondents offered no response to this statement. While respondents felt better informed with the information provided in the pamphlets (as is clearly indicated in the responses to survey questions 3-6 discussed above), it is possible that the 25% of respondents who disagreed with this statement felt that they already were sufficiently well informed to know when a report should be made. Still, it is important to note that 65% of the respondents indicated that they were more likely to make a report after having received and reviewed the pamphlet.

**Table 5: Because I have the pamphlet as a resource, I am now more likely to report abuse or neglect than if I did not have the pamphlet**

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion/ Response
Teachers (141)	31 (22%)	64 (45%)	22 (16%)	14 (10%)	10 (7%)
Social Workers (90)		60 (67%)	16 (18%)	4 (4%)	10 (11%)
Physicians (23)		10 (43%)	9 (39%)		4 (17%)
Nurses (30)		17 (57%)	5 (17%)		8 (27%)
Clergy (28)		20 (71%)	8 (29%)		
Total (312)	31 (10%)	171 (55%)	60 (19%)	18 (6%)	32 (10%)

Table 6 below indicates that 7% of respondents strongly agreed, 21% agreed, 23% disagreed, 7% strongly disagreed, and 42% offered no opinion or response to the statement "I have made at least one

report of abuse or neglect that I would not have made before I received the pamphlet." The number of responses expressing no opinion or disagreement could be explained by that fact that many surveys were mailed along with the actual pamphlets while other surveys were mailed approximately one year after the pamphlets themselves were mailed. As a result, many respondents completed the surveys at the same time they received and reviewed the pamphlets, thus making it highly unlikely that they would have had an opportunity to make a report of abuse or neglect since receiving the pamphlet. Future surveys will be consistently mailed to pamphlet recipients one year after mailing of the pamphlets so the author will be better able to capture this crucial piece of information.

**Table 6: Since I received the pamphlet, I have made at least one report of abuse or neglect that I would not have made before I received the pamphlet**

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion/ Response
Teachers (141)	12 (9%)	30 (21%)	34 (24%)	15 (11%)	50 (35%)
Social Workers (90)	11 (12%)	32 (36%)	12 (13%)	4 (4%)	31 (34%)
Physicians (23)			11 (48%)		12 (52%)
Nurses (30)		4 (13%)	14 (47%)		12 (40%)
Clergy (28)				3 (11%)	25 (90%)
Total (312)	23 (7%)	66 (21%)	71 (23%)	22 (7%)	130 (42%)

Survey questions 9 and 10 seek to gather whether respondents would recommend the pamphlets or additional training to other mandated reporters. Table 7 indicates that 97% of respondents either agreed or strongly agreed with the statement "I would recommend the pamphlet to other mandated reporters." Table 8 indicates 78% of respondents agreed or strongly agreed with the statement "Staff in my workplace would benefit from training on mandated reporting

**Table 7: I would recommend the pamphlet to other mandated reporters**

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion/ Response
Teachers (141)	68 (48%)	67 (48%)			6 (4%)
Social Workers (90)	55 (61%)	33 (37%)			2 (2%)
Physicians (23)	23 (100%)				
Nurses (30)	25 (83%)	5 (17%)			
Clergy (28)	24 (86%)				4 (14%)
Total (312)	195 (63%)	105 (34%)			12 (4%)

**Table 8: Staff in my workplace would benefit from training on mandated reporting of child abuse and neglect**

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion/ Response
Teachers (141)	61 (43%)	38 (27%)	20 (14%)		22 (16%)
Social Workers (90)	44 (49%)	26 (29%)			20 (22%)
Physicians (23)	11 (48%)	12 (52%)			
Nurses (30)	16 (53%)	14 (47%)			
Clergy (28)	6 (21%)	16 (57%)	6 (21%)		
Total (312)	6 (21%)	16 (57%)	6 (21%)		

of child abuse and neglect.” Eight percent disagreed with this statement and 14% offered no opinion or response. These results clearly show that respondents feel that the pamphlet is a valuable resource and that a large majority of respondents believe that more training of mandated reporters is warranted.

Finally, the survey also allowed respondents to add any qualitative feedback they felt moved to provide. Such feedback was entirely positive, including statements such as: “Great resource. Very clear and easy to use.” “I download this information and personally say I have copied it so I can use the information when I do trainings. I also share this with other social workers. Our schools use this across the state of Michigan. This is a wonderful tool.” “I would strongly recommend this to all school personnel.” “We have a refresher training for teachers each fall. Keep sending pamphlets.” “I keep this in a central location in my office.”

## Lessons

The survey results are subject to many limitations. As with all self-completed surveys, the surveys were likely completed more often by persons with strong opinions regarding the issues raised in the survey. Thus, the survey results could be skewed toward the extreme. Further, some respondents received surveys approximately one year after they received the pamphlets. Other respondents received surveys at the same time they received the pamphlets. The responses of these two groups would likely vary given the amount of time they would have had to consider the content of the pamphlet. This point is most relevant regarding survey questions 7-8 that seek to capture how the pamphlet recipients actually use the information set forth in the pamphlets in their practice.

Regardless, certain general conclusions can be drawn from the survey results. First, respondents overwhelmingly reported that the pamphlets effectively presented information regarding their legal obligations as mandated reporters, and regarding how to meet those obligations both by recognizing abuse and by following the necessary legal procedures. Given the prevalence of studies showing lack of knowledge as a major barrier to mandated reporting, this result is meaningful.

Second, a clear majority of respondents indicated that would be more likely to report suspected abuse

or neglect having received and reviewed the pamphlet. While the literature review indicates that over-reporting is a problem in this field, it remains the case that the Michigan Child Protection Law (like the laws in other states) is designed to have mandated reporters err on the side of caution. That is, failure to report is a criminal act while good faith reporting that proves unfounded cannot lead to any potential liability. Further, the problem with over-reporting is in reality a problem within the system charged with investigating and responding to reports of abuse and neglect. The failure to properly fund this system is a serious problem, but placing limits or restrictions on mandated reporting is not the solution to this problem. While mandated reporters can be trained to recognize the warnings sign of abuse and neglect, staff in the child protection system have the expertise to ultimately determine whether children brought to their attention are at risk of harm. Staff in the child protection system must be empowered to effectively respond to the cases brought to their attention by vigilant mandated reporters.

Third, virtually all respondents indicated that they would encourage further dissemination of pamphlets to other mandated reporters. This is especially meaningful because practitioners in the field are best able to determine the ultimate worth of any resource designed to improve their practices.

Finally, while a majority of respondents indicated the need for ongoing training, pamphlets such as these provide an effective, relatively inexpensive method to provide mandated reporters with the nuts and bolts information they need to carry out their responsibilities. Live trainings are costly and time consuming. Web-based trainings are far more affordable and convenient to practitioners, and may in fact provide the best way to supplement the information set forth in the pamphlets. CAC staff has prepared a training available for free viewing through the Michigan State Court Administrative Office's website. Further research is planned to determine the efficacy of this web-based training, both as a stand-alone event and in conjunction with the pamphlets. As additional pamphlets are provided to practitioners they will be advised of the availability of this web-based training as a free resource to all. ©

## About the Author

Joseph P. Kozakiewicz, JD, LMSW  
Director, Chance at Childhood Program  
MSU School of Social Work  
254 Baker Hall  
Michigan State University  
East Lansing, Michigan, 48824  
kozakiew@msu.edu  
616.638.1938

## References

- Abrahams, N. Casey, K. & Daro, D. (1992). Teachers' knowledge, attitudes and beliefs about child abuse and its prevention. *Child Abuse & Neglect*, 16, (2), 229-238.
- Ainsworth, F. (2002). *Mandatory reporting of child abuse and neglect: Does it really make a difference?* *Child and Family Social Work*, 7 (1), 57-63.
- Botash, A. (2003). From curriculum to practice: Implementation of the child abuse curriculum. *Child Maltreatment* 8, (4), 239-241.
- Child Abuse Prevention and Treatment Act, 42 USC §§5101-5106 (1974).
- Child Protection Law, MCL 722 USC §§621-638 (1975).
- Cook, K. G. (2000). When will they be safe? Children left at risk post termination of parental rights. *Michigan Child Welfare Law Journal*, IV (1), 25-31.
- Delaronde, S., King, G., Bendel, R. & Reece, R. (2000). Opinions among mandated reporters toward child maltreatment reporting policies. *Child Abuse & Neglect* 24, (7), 901-910.
- DeMattei, R., Sherry, J., Rogers, J., & Freeman, J. (2009). What future health care providers will need to know about child abuse and neglect. *The Health Care Manager*, 28 (4), 320-327.
- Edwards, L. P. (1996). The future of the juvenile court: Promising new directions. *The Future of Children*, 6 (3), 131-139.
- Flaherty, E.G. & Sege, R. (2005). Barriers to physician identification and reporting of child abuse. *Pediatric Annals*, 34 (5), 349-357.
- Foreman, T. & Bernet, W. (2000). A misunderstanding regarding the duty to report suspected child abuse. *Child Maltreatment* 5, (2), 190-196.
- Fox, S. (1996). The early history of the court. *The Future of Children*, 6 (3), 29-39.
- Haralambie, A. M. (2005). Physical, sexual, and emotional child abuse and neglect.

- In M. Ventrell & D. M. Duquette (Eds.), *Child welfare law and practice: Representing Children, Parents, and State Agencies in Abuse, Neglect and Dependency Cases*, (pp. 15-33). Denver, CO: Bradford Publishing Co.
- Hardin, M. (1996). Responsibilities and effectiveness of the juvenile court in handling dependency cases. *The Future of Children*, 6 (3), 111-125.
- Hurst, H., Jr. (1999). Family courts in the United States. *Family Court Bulletin*, 1.
- Kempe, C. H., Silverman, F., Steele, B., Droegemueller, W. & Silver, H. (1962). The battered child syndrome. *Journal of the American Medical Association*, 181, 4-11.
- Kenny, M.C. (2001). Compliance with mandated child abuse reporting: Comparing physicians and teachers. *Journal of Offender Rehabilitation*, 34 (1), 9-23.
- Kenny, M.C. (2004). Teachers attitudes towards and knowledge of child maltreatment. *Child Abuse & Neglect* 28, (12), 1311-1319.
- Kenny, M. C. (2007). Web-based training in child maltreatment for future mandated reporters. *Child Abuse & Neglect* 31, (6), 671-678.
- Kozakiewicz, J. (2001). Child Welfare Workers and Michigan's Family Court Legislation: The Relationship Between Policy and Practice. *Juvenile and Family Court Journal*, Winter, 11-23.
- Mathews, B. & Bross, D. (2008). Mandated reporting is still a policy with reason: Empirical evidence and philosophical grounds. *Child Abuse & Neglect*, 32 (1), 511-516.
- Melton, G. (2005). Mandated reporting: A policy without reason. *Child Abuse & Neglect*, 29 (1), 9-18.
- King, G., Reece, R., Bendel, R. & Patel, V. (1998). The effects of sociodemographic variables, training and attitudes on the lifetime reporting practices of mandated reporters. *Child Maltreatment* 3, (3), 267-283.
- Reiniger, A., Robison, E. & McHugh, M. (1995). Mandated training of professionals: A means for improving reporting of suspected child abuse. *Child Abuse & Neglect*, 19 (1), 63-69.
- Ross, C. J. (1998). The failure of fragmentation: The promise of a system of unified family courts. *Family Law Quarterly*, 32 (1), 3-30.
- Rubin, H. T. (1996). The nature of the court today. *The Future of Children*, 6 (3), 40-52.
- Schene, P. (1998). Past, present and future roles of child protective services. *The Future of Children*, 8 (1), 23-38.
- Segal, E. A. (2010). *Social Welfare Policy and Social Programs*. Belmont, CA.: Cengage Learning.
- Shepherd, R. (1999). The juvenile court at one hundred years: A look back. *Juvenile Justice*, VI (2), 13-21.
- Stevenson, C., Larson, C., Carter, L., Gomby, D., Terman, D. & Behrman, R. (1996). The juvenile court: Analysis and recommendations. *The Future of Children*, 6 (3), 1-28.
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2010). *Child Maltreatment 2008*.
- Ventrell, M. (2005). The history of child welfare law. In M. Ventrell & D. M. Duquette (Eds.), *Child welfare law and practice: Representing Children, Parents, and State Agencies in Abuse, Neglect and Dependency Cases*, (pp. 15-33). Denver, CO: Bradford Publishing Co.
- Vulliamy, A.P. & Sullivan, R. (2000). Reporting child abuse: Pediatrician's experiences with the child welfare system. *Child Abuse & Neglect* 24, (11), 1461-1270.

Appendix A: Mandated Reporter Pamphlet Survey

**“YOU ARE A MANDATED REPORTER” PAMPHLET SURVEY**

1) Which pamphlet version did you receive? (Please circle all that apply)

Teachers      Social workers      Clergy      Physicians      Nurses

2) In what type of professional setting do you work (e.g. school, hospital, private/public foster care agency etc.)?  
\_\_\_\_\_

*Please circle your response to each of the following statements:*

3) I am able to understand the information presented in the pamphlet.

Strongly Agree      Agree      Disagree      Strongly Disagree      No Opinion

4) The pamphlet helped me better understand the legal definition of abuse and neglect.

Strongly Agree      Agree      Disagree      Strongly Disagree      No Opinion

5) The pamphlet helped me better understand when I should report abuse or neglect.

Strongly Agree      Agree      Disagree      Strongly Disagree      No Opinion

6) The pamphlet clearly explains how to report abuse and neglect.

Strongly Agree      Agree      Disagree      Strongly Disagree      No Opinion

7) Because I have the pamphlet as a resource, I am now more likely to report abuse or and neglect than if I did not have the pamphlet.

Strongly Agree      Agree      Disagree      Strongly Disagree      No Opinion

8) Since I received the pamphlet, I have made at least one report of abuse or neglect that I likely would not have made before I received the pamphlet.

Strongly Agree      Agree      Disagree      Strongly Disagree      No Opinion

9) I would recommend the pamphlet to other mandated reporters.

Strongly Agree      Agree      Disagree      Strongly Disagree      No Opinion

10) Staff in my workplace would benefit from training on mandated reporting of child abuse and neglect.

Strongly Agree      Agree      Disagree      Strongly Disagree      No Opinion

Please provide a name and contact number if you would like to have someone contact you to discuss training in your workplace:  
\_\_\_\_\_

11) Please add any suggestions you have for improving the pamphlet or any other comments you may have: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You may fax the completed survey to (517) 432-8409 or return them by mail in the SASE that has been provided.

**THANK YOU!**



*Physicians Guide for Reporting Suspected Child Abuse and Neglect*

# ***YOU are a mandated reporter.***

The Michigan Child Protection Law requires that certain persons report any case of suspected child abuse or child neglect to the Michigan Department of Human Services (DHS). The definition of mandated reporter includes ***physicians***.



## **Why this is your responsibility**

Physicians play an important role in the lives of children. You are in a unique position to observe and interact with children. You see changes in children that may indicate abuse or neglect. Because of this special relationship, you may learn information that suggests a child is being abused or neglected.

Once you file a report, the child and family may become eligible to receive a wide variety of services that will improve the family's ability to care for the child. The family may be provided parenting classes, counseling, treatment for substance abuse, medical services, anger management education and other services designed to meet the family's specific needs.

## The legal standard for reporting

**T**he Michigan Child Protection Law requires you to file a report when you have **reasonable cause** to suspect abuse or neglect. This is an extremely low legal standard. This pamphlet describes some signs of abuse and neglect. However, you must keep in mind that you **are not** required to determine whether abuse or neglect **has actually occurred**. DHS is responsible for investigating reports of suspected abuse and neglect and for determining how each case progresses. You must make a report whenever you **suspect** that abuse or neglect **may have occurred**.

### Your liability for failure to report

If you fail to file a report of suspected abuse or neglect, you will be subject to both civil and criminal liability. In a civil action you may be held liable for **damages that any person suffers** due to your failure to file a report. In a criminal action, you may be found guilty of a **misdemeanor punishable by imprisonment for up to 93 days and a fine of \$500**.

Notifying a hospital administrator **DOES NOT** satisfy your legal obligation to file a report with DHS.

### There are NO excuses for failing to report

You may believe that filing a report will not lead to any benefit to the child involved. You may believe that filing a report may actually place the child at an increased risk of abuse or neglect. You may feel uncertain that abuse or neglect has actually occurred. Such concerns of any nature **DO NOT** discharge your legal obligation to file a report. Such concerns **WILL NOT** protect you from liability for failing to report.

### You CANNOT be “punished” for filing a report

When you file a report in good faith, you cannot be held liable to any person for any damages they may suffer. You are immune from any criminal and civil liability that could otherwise result. **When you file a report, you are PRESUMED to have acted in good faith**. A person suggesting false reporting would have the burden of proving that you made a report for some reason unrelated to the well-being of the child who was the subject of your report. This burden could not be met if you filed a report due to your concern for a child’s well-being.

Further, you cannot be penalized for making a report required by the Child Protection Law or for cooperating in an investigation.

### Your identity must be kept confidential

When you file a report with DHS, your identity may not be shared with any person unless you agree to that disclosure or a judge orders such disclosure. Your identity may be disclosed to a child protective agency, a law enforcement agency that is investigating the alleged abuse or neglect, or the Children’s Ombudsman. Any concern that a parent may discover or learn your identity **DOES NOT** discharge your obligation to file a report.



## What constitutes child abuse or neglect?

The definitions of child abuse and neglect below may be a challenge to apply to a particular circumstance. Most importantly, keep in mind that you are not required to determine whether these legal standards are met. If you suspect that circumstances in your situation may constitute abuse or neglect, then you **MUST** file a report with DHS.

The following list of common indicators of abuse and neglect **IS NOT** exhaustive. Use common sense, and always err on the side of caution by filing a report when in doubt.

**Physical abuse.** Harm or threatened harm to a child through non-accidental injury by a person responsible for the child's health or welfare. Examples of physical abuse include beating, kicking, punching, and burning.

### **Common indicators of physical abuse**

- Pattern bruises or scars
- Symmetric immersion burns
- Pattern contact burns
- Bruises or burns on a non-ambulating infant
- Multiple injuries in different stage of healing
- Bruises on earlobes
- Subdural hemorrhage
- Liver or kidney laceration
- Pancreatic injury
- Scapular fractures
- Posterior rib fractures
- Fractures of different ages
- Bite marks

**Neglect.** Harm or threatened harm to a child's health or welfare that occurs through either failure to provide adequate food, clothing, shelter, or medical care or placing a child at unreasonable risk to the child's health or welfare by failure to intervene to eliminate that risk when the person is able to do so and has or should have knowledge of the risk.

### **Common indicators of neglect**

- Persistent hunger
- Stealing or hoarding food
- Abrupt, dramatic weight change
- Persistent poor hygiene
- Recurring untreated medical issues
- Ongoing lack of supervision
- Consistently inappropriate dress
- Excessive school absences

### **Sexual abuse and sexual exploitation.**

Engaging in sexual contact or sexual penetration with a child (as defined in the criminal code) constitutes sexual abuse. Sexual exploitation is defined as allowing, permitting, or encouraging a child to engage in prostitution or to be depicted in a sexual act (as defined in the penal code).

### **Common indicators of sexual abuse and sexual exploitation**

- Age-inappropriate knowledge of sexual behavior
- Sexually explicit drawings and behavior
- Unexplained fear of a person or place
- Unexplained itching, pain, bruising or bleeding in the genital area
- Age-inappropriate seductive behavior
- Pregnancy
- Venereal disease, frequent urinary or yeast infections
- Laceration of the hymen, missing segment of hymenal tissue
- Perianal lacerations extending deep to the external sphincter
- Laceration or bruising of labia, penis, scrotum, perineal tissues or perineum

**Maltreatment.** Treatment of a child that involves cruelty or suffering that a reasonable person would recognize as excessive. Examples include forcing a child to eat dog food as punishment, locking a child in a closet, or teaching a child to assist in criminal activities.





## How to make a report

Upon suspecting child abuse/neglect, you must **both** report to DHS and to the person in charge of the facility in which you work. DHS may be prohibited from discussing the details of any investigation stemming from your report. You should receive a very general letter, stating whether or not the case was assigned for investigation or the results of an investigation. You should have at least one contact with the assigned Children's Protective Services worker. Do not assume a lack of "follow-up" with you indicates nothing was accomplished. Although DHS may be unable to share with you details about an ongoing investigation, you should continue to report any new concerns that might arise after your initial report.

### Step 1: Oral report

You must **immediately** make, by telephone or face-to-face, an oral report of the suspected child abuse and neglect to DHS, followed by a written report. (DHS contact information and written requirements are provided in this pamphlet). You should be prepared to provide, if known, the following information when making a verbal Children's Protective Services report:

- Child's current address as well as past addresses if known and the address where the alleged incident happened if different.
- If the alleged perpetrator lives with the child.
- Alleged victim's full name, birth date, and race.
- Alleged perpetrator's full name. If known, provide the relationship of the perpetrator to the child.
- Statements of the child's disclosure and context of the disclosure. For example, was the child asked about the injury, or did they volunteer the information?
- History of the child's behavior and patterns of attendance may be helpful to the investigation.
- Why you think the child is being abused, neglected, and/or maltreated.

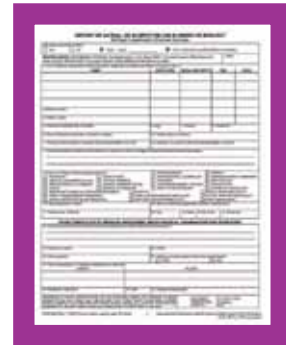
Be sure to document the log number for your records (provided by the Protective Services intake worker).

**You SHOULD NOT attempt to investigate the matter yourself.** Investigation and appropriate action are the responsibility of Children's Protective Services, a division of the Michigan Department of Human Services, the state agency responsible for child welfare.

### Step 2: Follow-up written report

**Within 72 hours after making the oral report, the reporting person shall file a written report** with the DHS office in the county where the child is found or resides. The report must be mailed or otherwise transmitted to this DHS office. The local county DHS office can be found through the statewide DHS hotline or DHS Web site, both listed in this pamphlet. The 72-hour period includes weekends and holidays.

For the written report, DHS encourages reporters to use its Form DHS-3200, which includes all the information required under the law. You should complete form items 1-21. One report from an agency will be considered adequate to meet the law's reporting requirement. Keep a copy for your own records. Do not place a copy in the patient's record.



### Step 3: Reporting obligations to person in charge of facility

You must notify the person in charge of your facility of the suspected abuse/neglect that the report has been made with DHS. You must provide the person in charge with a copy of the written report.

**Note: Reporting the suspected allegations of child abuse/neglect to the person in charge of your agency does not fulfill your mandated requirement to report directly to DHS.**

## Reference and contact numbers

The Department of Human Services (DHS) statewide number is **1-800-942-4357**. Personnel staffing the statewide DHS number will connect the mandated reporter to the local DHS office for purposes of reporting the suspected or actual child abuse/neglect directly to the local DHS office for investigation.

**DHS-3200 Form** can be requested from the local DHS office and can be accessed at: [www.michigan.gov/dhs](http://www.michigan.gov/dhs) or [www.michigan.gov/documents/FIA3200\\_11924\\_7.pdf](http://www.michigan.gov/documents/FIA3200_11924_7.pdf)

**Local county DHS offices** can be accessed through the DHS Web site at: [www.michigan.gov/dhs](http://www.michigan.gov/dhs)

If a mandated reporter is dissatisfied with the response of the county DHS, he or she may call the **Mandated Reporter Hotline at 1-877-277-2585**.

### **Childhelp USA, National Child Abuse Hotline 1-800-4-A-Child (1-800-412-4453)**

Childhelp hotline is staffed 24 hours a day, seven days a week, by professional crisis counselors who have access to a database of emergency, social service, and support resources.

**Michigan Office of Children's Ombudsman** is charged with the oversight of Children's Protective Services, adoption and foster care services.  
1-800-642-4326

### **Child Pornography Tipline 1-800-843-5678**

**Common Ground Crisis Line  
1-800-231-1127  
248-456-0909**

**Listening Ear Crisis Hotline  
517-337-1717**

**Michigan Assault Hotline  
1-800-NO-MEANS-NO**

**Michigan Parent Help Line  
1-800-942-4357**

### **National hotlines and helplines**

#### **National Domestic Violence/Abuse Hotline**

1-800-799-SAFE  
1-800-787-3224 TDD

#### **National Runaway Switchboard**

1-800-RUNAWAY  
1-800-786-2929

#### **National Suicide Hotline**

1-800-SUICIDE  
1-800-784-2433

#### **No Abuse Helpline**

1-800-996-6228

#### **Rape, Abuse, and Incest National Network (RAINN)**

1-800-656-HOPE

#### **RAPLine (Michigan Runaway Assistance Program)**

1-800-292-4517

#### **School Violence Hotline**

1-800-815-TIPS





*This pamphlet was inspired by the dedication and donation of Judith Mynsberge, a classroom teacher for 32 years, and by Marcie Schalon, an MSU alumna whose care for children is further informed by her background in child welfare.*



This pamphlet was prepared by the Michigan State University Chance at Childhood Program, with assistance from the Michigan Department of Human Services and the MSU College of Human Medicine, Department of Pediatrics.



This project was supported by Grant No. 2007-SK-BX-0001 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, US Department of Justice. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the US Department of Justice.

The Chance at Childhood Program is sponsored by:



*For more information, contact:*

MSU Chance at Childhood Program  
541 E. Grand River Avenue  
East Lansing, MI 48823

517.432.8406

<http://chanceatchildhood.msu.edu>





SECTION MEMBERSHIP APPLICATION FOR EXISTING BAR MEMBERS

Please check the section(s) you would like to join and submit with prepayment.

Table with columns: SECTION, No., COST. Lists various legal sections such as Administrative & Regulatory Law, Alternative Dispute Resolution, etc., with checkboxes and associated costs.

total: \$ (add both columns)

All orders must be accompanied with payment.

Check # \_\_\_\_\_ is enclosed, made payable to the STATE BAR OF MICHIGAN.

P Number \_\_\_\_\_

Please charge the below credit card:

Name \_\_\_\_\_

VISA: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Address \_\_\_\_\_

MasterCard: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

City \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Please return to: State Bar of Michigan Finance Department 306 Townsend Street Lansing, MI 48933-2012 Fax: (517) 346-6365

Email \_\_\_\_\_

Prices are subject to change without notice.

STATE BAR OF MICHIGAN  
MICHAEL FRANCK BUILDING  
306 TOWNSEND STREET  
LANSING, MI 48933-2012

NON-PROFIT  
U.S. POSTAGE PAID  
LANSING, MI  
PERMIT NO. 191

