

# Report of the APSAC Task Force on Evidence-Based Service Planning Guidelines for Child Welfare

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## Abstract

This article presents the American Professional Society on the Abuse of Children (APSAC) Task Force report on the evidence-based service planning (EBSP) approach to child welfare services (CWS) plans and recommendations for practice. The focus of the policy report is on formal psychosocial services. CWS plans prescribe services to promote core child welfare objectives and to benefit children and families. The goal of EBSP is to construct service plans based on the general principles of evidence-based practice and prefer services with empirical support for clinical problems or needs associated with the causes or consequences of child abuse and neglect (CAN). EBSP aims to facilitate an overarching service approach that is collaborative, respectful, and includes services that are most likely to lead to outcomes on both family identified and child welfare mission goals. EBSP emphasizes a focused, assessment-driven, and science-informed approach that both favors plans that are sufficient and avoids overburdening families with compulsory services that address problems which are not directly related to the child welfare CAN referral.

## Keywords

service delivery, evidence-based practice, child welfare, child welfare workers, mental health services, professionals

This policy report aims to define and provide guidelines for a new service planning perspective in child welfare service (CWS) that we call “evidence-based service planning” (EBSP). CWS plans prescribe a service or set of services designed to meet CWS goals and benefit children and families. The CWS is increasingly embracing the use of evidence-based interventions (EBIs) in service plans (see Landsverk, Garland, Rolls Reutz, & Davis, 2011; <http://www.cebc4cw.org/>). Similar trends toward EBI are occurring in other behavioral and health fields including medicine, psychology, education, juvenile justice, and criminal justice. Yet, taking an “evidence-based practice” approach to service planning in any area (e.g., CWS and health) goes beyond simply preferring specific EBIs; it involves viewing service selection and planning through an evidence-based lens, such that principles of EBI (e.g., shorter-term, focused, skills-based, and measurement of outcomes) are incorporated throughout planning. The time is right to apply this framework to the CWS service planning process to maximize the effectiveness of service plans in terms of the content of the plans, the overarching EBI principles, and acceptability to families.

As a professional society concerned with the welfare of maltreated children and their families, the American Professional Society on the Abuse of Children (APSAC) has a direct interest in promoting best evidence policy approaches. A Task Force was formed in order to respond to current challenges in service

planning for CWS. The Task Force report provides (a) an overview of the CWS mandate and mission, and methods for achieving CWS goals, (b) the rationale and principles of EBSP, (c) a case example without and with application of EBSP, (d) specific evidence-based psychosocial services that target the clinical problems and needs associated with increased risk for child abuse and neglect (CAN) or which are the result of CAN, and (e) recommendations for professional practices related to service planning with families in the CWS. The intended audience for the report is CWS professionals and others involved in responding to families in the CWS (e.g., mental health professionals, Court Appointed Special Advocates, court commissioners/judges, parent’s lawyers, Child Advocacy Centers). The Task Force report and recommendations were approved

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by the following APSAC Board of Directors members in June 2013 (Elissa Brown, Toni Cardenas, David Corwin, Monica Fitzgerald, Lori Frasier, Tricia Gardner, Mike Haney, Ron Hughes, Julie Kenniston, William Marshall, Brenda Mirabel, Marilyn Stocker, Geri Wisner, Frank Vandervort, and Viola Vaughan-Eden), and reflect the position of the organization.

### **Child Welfare System Mandate and Mission, and Methods for Achieving CWS Goals**

The role of the CWS has been defined in a series of federal and state laws over the last 70 years. Arising out of the social work tradition and the Social Security Act, the child welfare mission has historically been characterized by two key goals—"safety" and "permanence"—operationalized as efforts to keep children safe and settled within a permanent family home, preferably with their own family when safely possible. With passage of the Adoption and Safe Families Act (ASFA) of 1997, the CWS mission was expanded to formally include a third goal—"well-being" for the children and families involved in the system.

The CWS mission is to achieve these three goals (Promoting Safe and Stable Families Amendments of 2001). In the more recent Child and Family Service Improvement Act of 2006, states are called upon "to prevent repeat abuse and neglect of children, improve services provided to families to reduce the risk of future harm (including better monitoring the participation of families in services), and strengthen upfront services provided to families to prevent unnecessary family breakup and protect children who remain at home" (see Findings section, ¶ 4). States are further encouraged to invest in "services that promote and protect the welfare of children, support strong, healthy families, and reduce the reliance on out-of-home care, which will help ensure all children are raised in safe, loving families" (see Findings section, ¶ 5).

Differential response (DR, [https://www.childwelfare.gov/pubs/issue\\_briefs/differentialresponse](https://www.childwelfare.gov/pubs/issue_briefs/differentialresponse)) is a recent policy development in the CWS. DR refers to diversion of lower risk cases from investigation of abuse allegations to an assessment track that focuses on engagement with families and insuring that families receive services. In the assessment track, no formal determination is made about whether abuse or neglect occurred. The idea is to reduce the potentially adversarial nature of the relationship between families and the CWS and, in turn, promote service engagement and uptake. There is broad agreement on the central idea of a more collaborative and respectful approach to responding to families whether cases are handled traditionally or via DR.

The CWS has the following two strategies to achieve its goals: (a) delivery of services to children and families and (b) temporary or permanent separation of children from an unsafe or risky environment. Both strategies can be used simultaneously. Child safety, as the paramount goal of CWS, is sometimes achievable only by out-of-home placement. However, in the majority of cases, children will remain in the home with the parent/parents who abused or neglected them (Child

Welfare Information Gateway, 2013). Among those children who are initially placed in care, many will eventually return to their families (Casanueva, Tueller, Smith, Dolan, & Ringeisen, 2014). Relatively few cases involve termination of parental rights. Therefore, in most cases, the long-term safety of the child will be pursued via the service plan for the family. Even among cases that may result in termination of parental rights, concurrent planning, as endorsed under ASFA, requires reasonable efforts and an active service plan designed to allow consideration of reunification. Service plans can and should be considered safety strategies because they are intended not only to remediate the harm due to past CAN but also to lower the risk of future CAN.

The service plan is the working document guiding CWS intervention into families' lives. It outlines the necessary steps to accomplish the three CWS goals of safety, permanency, and well-being, and specifies the recommended or often compulsory services for parents and children. "Successful completion" of the plan typically serves as the benchmark for resolution of CWS or court involvement. In some cases, CWS may not maintain an officially open case or formulate an official service plan. Services may simply be recommended and compliance is voluntary. EBSP applies to both mandated and voluntary service plans. Services address identified problems that resulted in child abuse or neglect or that placed the children at risk for harm (i.e., create safety and promote permanency). The plan also identifies services to repair harm to the children and create a family environment that nurtures children's healthy growth and development (i.e., enhance child well-being). Plans can and often should include services fitted to goals that are self-identified by the family or child.

Service plans specify formal psychosocial interventions (e.g., parenting programs, mental health therapy, and chemical dependency services) as well as other basic needs services (e.g., housing, increasing social support, and linkage to safety net services). In this report, we will address formal clinical or behavioral services. We recognize that adverse economic, environmental, or social circumstances (e.g., chronic poverty, unemployment, and lack of access to quality day care or health care) play a role in CAN. In addition to the types of psychosocial services addressed in this report, service plans can and should consider social support and safety net services that address these circumstances (e.g., Temporary Assistance of Needy Families [TANF], Medicaid, Supplemental Security Income [SSI], Supplemental Nutrition Assistance Program [SNAP], Section 8 Housing, Women Infants and Children [WIC], subsidized childcare, and Head Start). CWS service plans also may include other types of services, such as kinship care enhancement services, monitoring, and supervised visitation (for guidelines, see Romanelli et al., 2009).

While service plans are ubiquitous within the CWS, and there are some resources available that focus on case planning and decision making in child protection (e.g., <https://www.childwelfare.gov/responding/planning.cfm>), there is very little formal guidance on which to base the actual planning

process. For example, the National Association of Social Workers (NASW) Standards of Social Work Practice (NASW, 2005) mention the importance of recommending EBIs, but provide no direction about how to construct a plan. This situation leaves the CWS in the position in which plans are driven more by local practice than evidence-informed policy and in some cases, are driven by defensive responding to anticipated legal challenges to sufficiency and comprehensiveness of the plan.

### ***EBSP: Rationale and Principles***

EBSP is intended to address this gap in the policy and practice literature. One of the most important recent developments in the area of psychosocial interventions has been the advent of the evidence-based practice paradigm. There is an increasing body of knowledge on EBI that address the causes and consequences of CAN (Barth et al., 2005; Chaffin & Friedrich, 2004). More recently, attention has been focused on bridging the science–practice gap in CWS and service systems (Landsverk et al., 2011). Federal priorities and funding opportunities have highlighted CWS workforce development initiatives and targeted CWS training in EBIs for child mental health problems (e.g., Landsverk et al., 2011; National Center for Evidence-Based Practice in Child Welfare [HHS-2013-ACF-ACYF-CT-0595]). When services are mandated rather than sought voluntarily, as is typically the case in CWS, service planners incur an increased ethical duty to ensure that the mandated services have the promise of delivering the intended benefit and ideally can do so efficiently and without unnecessary burden.

***EBSP principle 1: Service selection prioritizes effectiveness and efficiency.*** In EBSP, EBIs are favored for service selection (Stambaugh, Burns, Landsverk, & Reutz, 2007). Not all services are equal with some more effective than others. This implies that the CWS must know what EBI are, which populations and outcomes they fit, which EBIs are currently available in their area, and which ones they will incentivize with providers in contracts and purchasing agreements. In some situations, there may be a compelling reason to select a service with less evidence for success, such as in communities where EBIs may be unavailable. For example, if a formally tested parenting intervention offered in a particular community is only available in English, an alternative might be sought for a non-English-speaking parent. The key would be whether the alternative program adhered to the fundamental evidence-based principles.

Many of the current best EBIs are far shorter in duration than traditional services. Most involve fewer than 20 sessions with planned discontinuation once objectives have been achieved. They usually have a clear structure and set of tasks for each session and are more focused and goal-directed than traditional services. EBIs tend to focus more on content than on process, and more on action/practice than on insight or self-exploration. Typically, EBIs rely on standardized measures or direct observation to determine the clinical target

(e.g., child behavior problems, parent stress, depression, etc.), and these measures can be readministered to easily and objectively assess progress (Weisz & Kazdin, 2010).

***EBSP principle 2: Focus and parsimony.*** If comprehensiveness has been the predominant watchword under traditional service planning (i.e., a program for every problem), focus and parsimony are the watchwords for EBSP. In EBSP, the top CAN-related priorities are identified, and then matched to a limited number of services, ideally EBIs that directly target the primary need/needs or problem/problems related to the CAN. Services that target presumed “underlying” issues or distal contributory processes are not mandated. For example, in the case of physical abuse, EBSP would favor an EBI that directly addresses changing parental discipline over one that aims to identify deeper, historical conflicts theorized to impair parenting behavior. Thus, focus can be defined as explicitly targeting the problems or needs that comprise CAN or are the specific consequences of CAN.

Parsimony means prescribing the smallest number of services that will accomplish the intended goal. Parsimony and focus should not be misunderstood as a justification for underserving cases with significant need, but rather as a shift in the direction of emphasizing clear objectives, structure, quality, depth, and intensity over service volume alone. By pursuing fewer targets with far greater depth and intensity, learning may be greater. For example, evidence-based parenting interventions involve intensive behavioral practice and skill coaching until the skill is consistently *demonstrated*, not just discussed. For most cases, since CAN is by definition a failure of parenting (by commission or omission), the priority focus for parents should be on improving parenting skills and the parent–child relationship. Similarly, since CAN often leads to emotional and behavioral problems for children, the other priority service would explicitly target the impact of CAN. Many EBIs deliver both of these benefits simultaneously. For example, an evidence-based parenting intervention may lower the odds of future abuse or neglect reports and also reduce child behavior problems. It also may reduce parental depression symptoms in some cases (Nowak & Heinrichs, 2008). Focus and parsimony are not equivalent to neglecting other issues entirely. Rather, it may be that effectively improving the main priority problem creates cascading general benefits (Chaffin et al., 2009). Parsimony also has additional advantages, including potentially decreasing wait lists, shortening placements, and mitigating multiservice incompatibilities.

***EBSP principle 3: Triage and sequencing.*** When multiple types of CAN-related services or interventions targeting specific problem areas are identified for families, triaging and sequencing can be important to ensure that basic or high priority services come first. Clearly, parents who do not have stable housing (i.e., living in a car), the most basic services (e.g., electricity), or serious mental illness cannot be expected to engage fully in other CAN services before those needs are addressed. Once stability is achieved (e.g., housing, detox,

and pharmacological treatment for schizophrenia), then additional primary CAN-related services could be added to the plan and/or prioritized. In most cases, the highest priority needs will be parenting and addressing the impact of CAN on the children.

In a triage model, the concept of “stepped care” is also relevant (National Institute for Health and Care Excellence [NICE], 2011). Stepped care refers to offering the least intensive level of care that is appropriate initially and then “stepping up” to more intensive care if necessary. When a parent has modest levels of problems and is sufficiently motivated to change, relatively brief and short-term services (e.g., two to three focused parent coaching/consultation sessions, Positive Parenting Program [Triple P; Sanders, 1999] Level 3; brief Motivational Enhancement for substance abuse) may be sufficient. With such families, it can be counterproductive to insist on intensive treatment initially, which can unintentionally cause increased dependence, resistance, and/or lower self-efficacy. In stepped care, less intensive services can always be “stepped-up” if necessary (e.g., to Triple P Level 4). Similarly, stepped care also implies the ability to “step down” in service intensity when a parent exhibits improvement, or when further observation leads to modification of initial risk assessment.

### *Engagement and Case Decision Making in EBSP*

An EBSP is only as good as the level of family participation in it. It is important that service plans are developed, taking into consideration the inherently coercive nature of child welfare intervention and its impact on engagement and motivation. The CWS, like the criminal justice system or other social control institutions, ordinarily enters a family's life uninvited, and power is unbalanced due to CWS authority to remove children from parents' care temporarily or permanently, as well as to order that parents take certain actions. Many parents at least initially dispute the contention that they are abusive or neglectful. By definition, at the point of referral and investigation, the parents still have the problems that contributed to the CAN.

Despite the inherently coercive nature of system involvement, skillful CWS workers and service providers strive to establish a positive working alliance because it creates a context more conducive to engagement, agreement on goals, and taking steps toward achieving those goals (Dawson & Berry, 2002; Kemp, Marcenko, Hoagwood, & Vesneski, 2009). In some cases, however, the relationship may retain some degree of adversarial or coercive flavor throughout, which can create service barriers. Obtaining parents' early cooperation and involvement in development of a service plan is predictive of better outcomes (Dawson & Berry, 2002; Kemp et al., 2009). Practice models like Solution-Based Casework (SBC; Antle, Barbee, Sullivan, & Christensen, 2009; <http://www.solutionbasedcasework.com/>) that emphasize developing a positive relationship with the parent, focusing on strengths and problem areas that are most relevant to the CAN, and involving the parents in selecting the targets for service plans have

preliminary evidence supporting greater family involvement and compliance with services in cases managed by caseworkers trained to do SBC.

CWS parents may be ambivalent about engaging in services or may object to CWS intrusion into their lives. Ambivalence is common for many conditions, thus there has been significant attention to developing effective motivational enhancement interventions (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005). There is specific evidence for the value of a motivational enhancement intervention in CWS. Chaffin and colleagues (2004) demonstrated that a combined motivational enhancement intervention with Parent Child Interaction Therapy (PCIT) substantially reduced child welfare re-referrals. Importantly, in a subsequent study, Chaffin, Funderburk, Bard, Valle, and Gurwitsch (2011) demonstrated that the motivational enhancement component only improved CAN outcomes when combined with the EBI (i.e., PCIT), but not when combined with usual care. Similarly, Carroll and colleagues (2001) found that parents involved in the CWS who received a single motivationally enhanced intake session were twice as likely to attend a subsequent substance abuse treatment session than were participants receiving a standard intake session. These findings suggest that integrating motivational enhancement into EBP may be especially important in CWS.

*Case decision making.* Under traditional service planning, successful “completion” of a service plan (e.g., attendance, participation, and completion for each service) has typically been the primary criterion for decision making to reunify a child with parents and/or close the case. Failure to complete can be the basis for keeping a case open, delaying reunification, or more rarely proceeding with termination of parental rights. However, establishing whether a service plan has been successfully completed can be challenging. Common issues include determining whether delays in accessing services, missed appointments, or sporadic attendance are legitimate markers of lack of progress, how much weight to place on the relatively common relapse into substance use, and whether participation or completion of a service (e.g., attended the requisite number of sessions) provides sufficient evidence that risk has been reduced.

Service attendance or retention is simple and objectively measurable, which makes it an attractive benchmark, but its relationship to risk reduction is complicated. Research with child welfare home-based services has found that completers have lower recidivism (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012). On the other hand, dropout is not always indicative of failure. In some situations, people who prematurely leave therapy may have achieved full or sufficient partial benefit. The literature on service engagement with voluntary service seekers indicates that many consumers drop out of services because they have improved sufficiently such that they no longer have need (e.g., Kazdin & Wassell, 1998). In some studies, these improved dropouts fare as well on clinical and behavioral outcomes over time as do service completers (see Weisz & Kazdin, 2010). Generalization of these findings to obligatory service settings, like CWS, is uncertain.



Substance use is a particularly complex area for determining service response. The modal child welfare case (neglect of a young child) involves a parental substance use problem or chemical dependency (e.g., Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). For substance-dependent parents, abstinence may be the ultimate goal. However, it is not clear that full and permanent abstinence is absolutely necessary for reasonable child safety or well-being; nor is the idea of full and permanent abstinence consistent with the literature on patterns of recovery over time (Marlatt & Gordon, 2005). Addiction is more accurately viewed as a chronic disorder, often with a waxing and waning course. Very high use may invariably impair parenting, but a parent engaging in occasional use or experiencing partial relapse may still be able to maintain an acceptably adequate household.

EBI models provide an excellent fit for the goal of moving beyond “completion,” defined as attendance, to measuring change in behavior that may be more closely linked to decreasing risk. The majority of EBI provide tools for tracking goals over time. Self-report measures may have limitations (e.g., faking good), but provide significant additional information to be considered in addition to attendance and completion. In addition, routine measurement and feedback provided to clinicians relates to greater and faster improvement in mental health outcomes among youth clients (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011). Many of these measures can also be used by caseworkers to screen for child or parent mental health needs and/or parenting difficulties and to monitor progress over time (<http://www.cebc4cw.org/assessment-tools/>).

Some EBIs (e.g., PCIT, SafeCare) include objective skill checklists against which parent or child skills are measured as they progress through the program. Although stronger than self-report, skill criteria checklists or observations during clinical sessions may also have limitations. Demonstrating skill acquisition does not guarantee that skills will be practiced outside of sessions or after services have ended. Despite these limitations, self-report measures and skill checklists offer numerous advantages and can augment attendance and completion data. There is preliminary support for the feasibility and benefit to CWS caseworkers using standardized tools to identify child mental health problems and make EBP referrals (Fitzgerald et al., in press).

**Case example: Without and with application of EBP.** Now that we have covered the principles of EBP and elements that have to be considered when taking an EBP approach, we use a case example to illustrate how service planning may look for a family involved in the CWS.

Nine-year-old Catalina is referred to Child Protective Services because of bruises. Investigation reveals that her mother’s boyfriend hit her with a belt and has done so before. He has also committed domestic violence on the mother with the last incident three years ago. He states that he hit her as “spanking because she doesn’t mind.” The mother often yells at Catalina and threatens her for discipline. Catalina has behavior problems

and has gotten in trouble at school for fighting. The boyfriend is the father of two preschool children in the household. The mother was abused as a child and aged-out of the foster care system, and has been in therapy in the past for depression. Her child welfare worker believes she may be using marijuana to “self-medicate.” The mother and boyfriend are currently unemployed. They are in jeopardy of eviction from their current apartment. Catalina is in foster care; the two younger children remain in the home.

A “business as usual,” Non-EBSP for this family refers Catalina for “counseling services”; her mother is referred for a psychological evaluation, a substance use evaluation and “follow treatment recommendations,” individual counseling, a parenting class, an anger management class, and domestic violence (DV) services and support group. The mother’s boyfriend is referred for a psychological evaluation and a substance use evaluation, an anger management class, and a DV-batterers group. In this non-EBSP, a number of concerns are evident. A total of 11 services are recommended for the family. Some services prescribed are generic and unfocused, described only as general modes of services (e.g., “counseling”). The demonstrated effectiveness of these generic services is at best unknown. Where services are more specifically named, they are not among those currently known to reduce parent-to-child violence (e.g., anger management classes), or are services with generally low efficacy (e.g., batterers group). The plan does not prioritize services that directly address the main CWS mission-relevant issue—that is, physical abuse by the boyfriend and coercive parenting by the mother. In fact, an EBI directly focused on the basis for the CAN referral (physical abuse) is conspicuously absent from the plan. Instead, the plan prescribes services, particularly for the mother, for a mixture of problems that are in the past, have previously been treated, or are of limited relevance to the main problem. The plan will require many months to complete, likely requiring visits to several different locations weekly, and the timetable for some of the services (e.g., substance abuse treatment) could complicate timely reunification of the child from foster care. In addition to a fairly lengthy list of services, the plan includes ordering the mother and the boyfriend to obtain psychological evaluations that potentially will produce recommendations for even more services. The service schedule could also exacerbate the family’s current unemployment problems.

In contrast, an EBP would begin with an assessment to determine whether Catalina has trauma-related impact or behavior problem in addition to the violent parenting. A referral would be made to one or possibly two treatment services depending upon the outcome of the assessment. If she has significant trauma impact, she would benefit by trauma-specific treatment (e.g., Cohen, Mannarino, & Deblinger, 2006). Because there is violent and coercive parenting present, a referral to an evidence-based parenting intervention that focuses on decreasing violence is indicated (e.g., Kolko, Iselin, & Gully, 2011). This intervention approach directly addresses attitudes toward violence, teaches coping skills, positive parenting, and parent–child

communication skills. In this family service plan, the mother and boyfriend are provided optional, voluntary referrals for EBI mental health services, substance abuse, and DV services. They would be encouraged to seek services that they deem helpful.

This case provides an illustration of an observation sometimes heard that CWS service plans are “boiler plate” or “kitchen sink” or both. That is, there is a standard list of services (e.g., a parenting class, counseling for mental health issues) typically targeting a wide range of issues that may or may not be relevant to the CAN problem or evidence based. Not infrequently, multiple services target the same problem area with little attention to the burden that accrues to the family or the increased risk of failure to successfully comply. For example, the service plan for substance abuse may include random urine analyses, participation in a professionally led treatment program, and attendance in self-help or support groups (e.g., Alcoholics Anonymous [AA]). In physical abuse cases, the plan might include a parenting class, individual parent mental health counseling, a parent-child bonding program, an anger management group, and individual child therapy.

We believe that the “boiler plate and kitchen sink” approach has arisen in part out of the “reasonable efforts” requirement of the law, which some interpret to mean that CWS must offer or provide every possible service before the goal of reunification is abandoned and an alternative permanency plan sought. In addition, CWS may face intense scrutiny and criticism if a case has a dramatic poor outcome; the failure to order numerous services can be construed as negligent. This is a variation of the “defensive practice” problem in physical medicine. CWS defensive practice may be less in response to tort claims, as in medicine, and more in response to media, judicial, administrative, or legislative reactions to a case that turns out badly. This can lead to a situation where there is uneven attention to the possibility of harms related to unnecessary assessments, treatments, and the risk that parents cannot complete plans due to burden, or do not receive the services that would ameliorate their main CAN problem. Courts, news media, lawmakers, and the public may hold CWS accountable for only the first type of harm, but remain unaware of the second type of harm or the fact that it may affect a substantially larger number of cases. Defensive practice also creates system-level harms by depleting scarce resources through misallocation, making them less available to those who truly need them.

Families involved with the CWS commonly do have multiple problems, and therefore the list of areas that could benefit from services can be extensive. A guiding philosophy, which we call “comprehensiveness,” has been the foundation for practice habits and public policy for several decades. In the face of multiple challenges and problems, and motivated by a desire to help, it is neither unreasonable nor naive to advocate for providing many services to those families deepest in need. Whether it is beneficial is less certain, and emerging science suggests that when it comes to formal psychosocial services, more is not invariably better, and sometimes may be worse. The research has been equivocal on whether dose-expanding approaches, even with care coordination, produce superior

outcomes (Bickman & Mulvaney, 2005; Chaffin et al., 2004). In addition to concerns about the burden on families, multicomponent plans run the risk of diluting the focus. Too many simultaneous service plan components interfere with optimal learning due to the sheer number involved, the necessarily limited specificity and focus on any one area, and time required to complete the overall plan.

As an example, EBP parenting programs have been found to deliver the greatest benefits and the greatest reduction in CAN recidivism when they are not combined with multiple other psychosocial services (Chaffin et al., 2004; Kaminski, Valle, Filene, & Boyle, 2008). This is not to suggest the converse that less is always better, or to excuse underserving families, but rather to point out that there quickly can come a point at which comprehensiveness becomes counterproductive, and to emphasize that this threshold may be lower than might previously have been imagined.

The service planning process also takes place in the context of unresolved social policy questions about the proper scope of the CWS mission, which further complicate matters. Should the CWS be concerned only with correcting the immediate and proximate problems that led to the reported incident of CAN and that directly pose a risk to child safety and well-being? Or, is the role of CWS to require improvements in child and family functioning more broadly, even when placed in a plan that is involuntary, and to address problems that may have limited direct connection to CAN? These questions have considerable implications for service planning, case closure, and reunification. For example, the standard for case closure or reunification can be higher than that for accepting the case into CWS or for removal from the home. In other words, in order to achieve resolution, a family might have to meet standards (e.g., complete abstinence from alcohol use) that would not trigger CWS involvement among the general population. The lack of consensus on the role for the CWS in terms of scope of focus likely contributes to the current approach to service planning in which comprehensiveness is often favored.

In sum, as illustrated in this case example, in the EBSP approach, the interventions recommended are EBIs for the identified problems (e.g., Cognitive Behavioral Therapy [CBT] for child abuse-related distress; behavioral parenting intervention that specifically addresses violence). The compulsory services are restricted to those directly related to CAN impact or addressing the CAN behavior of physical abuse. If the child does not have trauma-specific impact and the required services could be reduced to one, the families are encouraged, but not required to seek voluntary services for other problems and needs that are less directly connected to the CAN. This plan takes a stepped care or triage approach by beginning with the fewest possible services. If progress is not achieved, the plan could always be amplified or service intensity increased.

### *Evidence-Based Psychosocial Services for CWS*

In general, the EBI literature does not specifically include a CWS focus; however, it does provide guidance for a number

of clinical targets with CWS relevance. These include (a) parenting and parenting stress, (b) substance abuse, (c) parental mental health, and (d) child emotional and behavioral problems. There are several sources that review and list EBIs (e.g., Campbell Collaboration: <http://www.campbellcollaboration.org>; Cochrane Collaboration: <http://www.cochrane.org/cochrane-reviews>), government services (e.g., Substance Abuse and Mental Health Services Administration's [SAMHSA]'s National Registry of Evidence-Based Programs and Practices [NREPP]: <http://www.nrepp.samhsa.gov/>), and professional organizations (e.g., American Psychological Association [APA], American Academy of Child and Adolescent Psychiatry [AACAP]).

A primary resource for child welfare professionals is the California Evidence-Based Clearinghouse (CEBC) for Child Welfare (<http://www.cebc4cw.org/>). The CEBC identifies, evaluates, and disseminates information regarding EBIs relevant to child welfare cases. The CEBC categorizes services according to research support and relevance for child welfare outcomes. The Mental Health Practices in Child Welfare Guidelines Toolkit (<http://www.casey.org/Resources/Publications/pdf/MentalHealthPractices.pdf>) is another useful resource, including 32 mental health practice guidelines that cover the topics of mental health screening, assessment and treatment, parent support, and youth empowerment. In the following sections, we review specific EBI that address primary clinical targets with CWS relevance, as listed previously in (a) through (d), for parenting and child problems. Specific EBI are presented within primary CWS problem areas.

**Placement disruption.** In cases where the risk is not so high that children must be placed, Homebuilders seeks to prevent placement by providing parenting skill acquisition and case management to prevent children's placement disruption. Homebuilders is a brief (30–45 days) intensive multicomponent family preservation intervention designed for cases deemed to be at imminent risk for placement and includes specific activities to improve parenting and case management to connect families to other specific services. Although intensive family preservation programs have not always shown effectiveness in randomized trials, there is support for Homebuilders when implemented with fidelity (e.g., Aos et al., 2011). A key point about intensive preservation models is that, while they may avert placement in the short term, they do not necessarily reduce maltreatment in the longer term. These are brief services that are stabilization focused, and the task of longer term risk reduction may be contingent upon subsequent services.

**Parental neglect.** Neglect comprises the large majority of CWS cases and neglect situations often involve a range of problem areas. An efficient and effective approach designed to address this scenario in younger children is SafeCare<sup>®</sup>, a structured, evidence-based, home-based model for families. SafeCare (<http://safecare.publichealth.gsu.edu/>) is a compact model among home-visiting programs, requiring far less time than many home-based primary prevention programs, and the model was originally developed to address child neglect. Adopting the

SafeCare curriculum into an existing home-based service system has been demonstrated to reduce child welfare recidivism among parents of children aged 0–5 in a fully scaled-up statewide controlled trial (Chaffin et al., 2012).

**Parenting problems and child behavior problems.** These targets are grouped because CAN is fundamentally a problem of parenting (e.g., ineffective, unprotective, or violent), and many of the most effective child behavior problem EBIs are parenting models. An evidence-based parenting program is the modal service indicated for most case plans unless the CAN was the result of a situational circumstance (e.g., temporary homelessness, off psychotropic medication, and minor lapse of judgment). The current group of parenting EBIs differs from the conventional and ubiquitous “parenting classes” in that they are skill focused—that is, they focus on parenting as it is actively, observably, behaviorally delivered rather than how it is conceptualized or talked about. Some started out as treatments for child behavior problems and were adapted for abusive parents. Effective parenting interventions range from models involving only the parent to live-coached parenting interventions, to joint parent and child interventions.

One of the challenges for the CWS is that most parenting EBIs require or prefer parent–child sessions, so that parents can learn skills with their own children. Most emphasize skill practice between sessions which are a challenge if parents have no or very limited visitation with their children. Effective parenting programs require parental access and skill practice opportunities between parents and their children. A longer lag time between the EBI and practice opportunities with the abused or neglected child has been found to erode program benefits (Chaffin, Funderburk, Bard, Valle, & Gurwitsch, 2011). Parallel or separate interventions are unlikely to be as effective and would provide an insufficient basis for making reunification decisions.

**Parental substance abuse.** A substantial number of rigorous research studies have demonstrated that a range of treatments for substance use disorders is at least modestly and comparably efficacious (e.g., Dutra et al., 2008; Hettema et al., 2005; Prendergast, Podus, Chang, & Urada, 2002). A range of about equivalently effective interventions means that consumer choice in interventions can be expanded. Offering choices has itself been found to facilitate engagement and motivation (e.g., Miller & Rollnick, 2002). Although substance use is often a chronic and tenacious problem, the parsimony principle can still apply. Even very brief interventions can be as effective as longer duration interventions when specifically and strategically focused on motivation (e.g., Motivational Interviewing Interventions; Moyer, Finney, Swearingen, & Vergun, 2002). Few of the effective interventions require long-term intervention, except for AA and Narcotics Anonymous, which are intentionally designed to provide ongoing, indefinite duration support.

Meta-analyses suggest that treatment does have beneficial effects, but these benefits are often modest and fluctuate over

time (Dutra et al., 2008; Prendergast et al., 2002). The course of substance abuse can wax and wane, relapse is common, and relapse is not necessarily an indicator of a poor future treatment prognosis. Individuals who relapse can be encouraged to “try treatment again,” often with beneficial results. In the CWS, the primary focus needs to be on preventing impaired parenting, and putting provisions in place to buffer children against the parenting impact of relapse versus complete and permanent recovery. An evidence-based approach might include preferring brief motivational interventions and biological monitoring of use, along with offering choice in treatment approaches.

**Parental depression.** Depression is common among parents in CWS and has been linked to abusive and neglectful parenting. There is a very large literature on the treatment of depression. Despite controversies about psychotropic medication and its place in treatment, there is general agreement that antidepressant medication has a role along with several psychosocial approaches (Lee, Grace, & Taylor, 2006). Most EBIs are structured, focused interventions that teach specific cognitive skills, involve behavioral activation, encourage engagement in meaningful and rewarding life activities, and promote satisfying interpersonal relationships. Many of these psychosocial models are parsimonious and do not require a lengthy treatment course. Many parents in CWS are mildly or moderately depressed (Chaffin & Bard, 2011), and given the prevalence of multiple life stressors and negative events among CWS populations, it is not difficult to understand why. As quality of life improves, depression symptoms may reduce, and studies demonstrate improvements in parental depression after participation in a parenting EBI for CAN, even without a specific depression intervention (Barlow, Coren, & Stewart-Brown, 2009; Chaffin & Bard, 2011). Home-based parenting services, and presumably other services, also can be augmented with depression treatment elements with positive and durable results (Ammerman, 2013).

**Serious parental mental illness.** Mental illness such as schizophrenia, bipolar, or other psychotic disorders can result in CAN when medicines are discontinued or a regimen is no longer working. The dominant EBI for these conditions is pharmacological with psychosocial support. Therefore, it may be necessary to enroll the parent in a program that prescribes and monitors the proper dosage of medication and teaches active coping skills. There is also evidence for the effectiveness of family psychoeducation in which the family learns about the disorder and the signs and symptoms of relapse (Shimazu et al., 2011). Psychoeducation approaches may be either offered via mental health providers or through peer support programs that are available (e.g., National Alliance on Mental Illness [NAMI]: <http://www.nami.org/>). Where severe mental illness causes CAN (e.g., parent is only neglectful when actively psychotic), parsimony and focus suggest that the need for adjunctive parenting services may not be necessary, once parents are managing their mental illness.

Legal and ethical dilemmas arise when CWS mandates taking psychoactive medication as part of a service plan. Not only is this viewed as a greater intrusion than mandating a psychosocial service, but carries potential medical risks for the patient, including known chances for serious long-term or permanent adverse effects. Consequently, it is recommended that requiring parents to take psychoactive medication as part of a service plan be considered cautiously and only after consultation with a qualified medical expert. Caution is especially indicated when it comes to coercing psychoactive medication use where there are alternative effective options available.

**Parent anger and antisocial behavior.** Some parents who abuse and/or neglect their children are violent, both in intimate relationships and in general, and have current or past involvement in the criminal justice system. There is a body of literature describing interventions that are effective for antisocial behavior and have favorable cost-to-benefit ratios (Washington State Institute for Public Policy [WSIPP], 2012). The programs that have the best support are CBT interventions targeting attitudes that support violence or antisocial behavior, teach self-regulation and anger-regulation strategies, and develop skills to achieve goals in prosocial ways (e.g., Little, Robinson, Burnette, & Swan, 2010; Lowenkamp, Hubbard, Makarios, & Latessa, 2009). When antisocial behavior is directly related to the CAN, these types of programs can be effective.

**Child emotional and behavioral problems.** Many child welfare systems are actively engaged in positive efforts to become trauma informed, which mean increasing system sensitivity to the ways trauma can impact children. But this does not mean that all or even most children in the CWS require trauma-focused treatment. Only a minority of child welfare involved children, develop clinically significant levels of self-reported, trauma-specific distress (Kolko et al., 2010). Trauma-related symptoms are important to consider, but are not the only ones children may have. Part of engaging in evidence-based practice involves a systematic assessment to determine any emotional or behavior problems and matching EBIs to the identified problems. Fortunately, there is a large literature describing the many EBIs that are available for the various psychological conditions in children (Eyberg, Nelson, & Boggs, 2008; Silverman et al., 2008; Silverman, Pina, & Viswesvaran, 2008), as well as specific programs listed on the CEBC website.

**Other problems and needs.** Children or parents may have other, relatively uncommon, specific, or unique psychological disorders that require intensive services such as eating disorders or chronic self-harming behavior/suicidal behavior. There are EBIs for these conditions, but they may or may not be available in every community. In those cases, a service plan based on evidence-based principles may be the best alternative. Parents may have cognitive deficits or limitations. In many cases, standard EBIs can work and may work better than less structured services, if there is an extra emphasis on practicing and coaching specific skills especially in real-life situations. Some



models such as SafeCare have been specifically tested and supported with cognitively delayed parents. Services may need to include additional supervision and supports for a period of time while the skills acquisition solidifies. For cases in which child cognitive deficits are present and need to be taken into account when planning for child services, similar recommendations apply.

In summary, we believe EBSP is consistent with the legal standard of “reasonable efforts,” although it may seem unfamiliar to legal professionals steeped in traditional viewpoints and the comprehensiveness doctrine. Parents are provided access to the most effective services available for their specific problems related to CAN. Care is taken to reduce unnecessary burden and yet not stray from the central CWS mission. Progress is measured using standardized methods. In fact, developing an EBSP at the outset that is matched to CAN-related problems can set the stage for addressing those situations in which parents do not or cannot, change sufficiently within suggested timeframes for making permanency decisions.

## EBSP Recommendations for Practice

The Task Force makes the following practice recommendations that reflect the main EBSP principles.

1. Explicit adoption of engagement and motivational enhancement principles and approaches as integral to CWS practice.
  - Genuine inclusion of parents in service plans development.
  - Specific efforts to overcome barriers to participation in services.
  - Inclusion of motivational enhancement activities and/or sessions as part of service delivery.
2. Systematic assessment of family and child problems and needs as part of the service plan development process, preferably including use of standardized assessment measures.
  - The assessment may involve screening within the CWS or be part of the routine expectation at community service programs.
  - Periodic screening and assessment, and the development of efficient feedback systems, are recommended to ensure progress monitoring and optimal child and family outcomes over time.
3. Service selection prioritizes effectiveness and efficiency. Plans prefer evidence-based approaches.
  - Decision makers and service planners are knowledgeable and keep current about EBIs including availability in the local community.
  - When EBI are available, they are always preferred.
  - When EBIs are unavailable, services adhering to the principles and content of EBP are preferred (e.g., specific target, structured, time-limited, and systematic outcome monitoring).

- CWS systems use their purchasing power and contractual systems to promote the expansion of strategically planned evidence-based services in communities.
  - CWS systems educate frontline workers to identify and preferentially utilize evidence-based services. CWS systems monitor and audit cases where service delivery may deviate from evidence-based practice.
4. Service selection and planning is guided by focus and parsimony.
    - Plans prioritize services to change the behaviors comprising CAN, factors directly and proximally driving CAN, and to ameliorate its consequences.
    - Plans contain the smallest possible number of mandated services and address multiple service targets with single interventions whenever possible (e.g., one intervention for parenting and child behavior problems, a single intervention for substance abuse).
    - Plans monitor progress, preferably using standardized methods.
  5. Triage and sequencing guide service planning to ensure that basic or high-priority services come first. A stepped care approach is used.
  6. Service plans are goal driven and outcomes focused. Decision making is based on change and progress toward goals.
    - Attendance and completion of EBI is a core objective progress benchmark.
    - Evaluating change, using a variety of indicators or measures, augments attendance, and completion.
    - Harm reduction (i.e., improvement that reduces the impact of a problem on the child) may be sufficient where complete problem elimination is not obtained.
  7. Interventions are designed to lead to case closure and reunification at the earliest time period.

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