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Developing pathways to assist parents to exit the child protection system in Australia

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Abstract

The prevalence of child abuse and neglect is an international concern that justifies the existence of child protection systems. An important first principle for all such statutory child protection systems is to ensure that the system itself does no further harm. It can be argued that there are specific circumstances within which well-meaning services have the potential to do harm: specifically, processes and actions that disempower parents by reducing their autonomy and capacity for positive action. Exploring the circumstances in which reduced parental autonomy impacts negatively on families is an important first step in developing procedures for working with families that not only avoid harm but are orientated to produce meaningful change. Two evidence-based programs are described that together have the potential to assist child protection practitioners to develop a collaborative helping partnership with families, clarify goals for change and support parents to achieve meaningful improvement in their family functioning. The programs described are both manualised and have empirical support for their effectiveness. The potential benefits for both families and practitioners working within child protection agencies in the two programs are described.

Keywords: *Child abuse, child protection, decision-making, evidence-based practice, family issues, parent–child interactions*

In 2006, approximately 3.3 million allegations of child abuse and neglect were made to child protection services in the United States. Of these allegations, 62% were investigated or received an alternative response, with nearly 30% of the investigations confirming that at least one child was a victim of child abuse or neglect (US Department of Health and Human Services, 2008). A similar picture has been found in Australia where, in 2005, there were 137,829 investigations involving 2.5% of children aged between 0 and 14. Of these 55,921 (41%) of the allegations were substantiated. These statistics indicate that a statutory authority that can intervene in the lives of families is essential for the care and protection of children. Under certain conditions, however, we argue that the involvement of the child protection system can work to the detriment of families and, indeed, may have the potential to do harm.

The processes and actions that child protection services and practitioners use to intervene in the lives of children and families can be one potential source of harm, particularly when these disempower parents, reduce their autonomy and capacity for positive action, such as the use of court orders that extinguish parental rights, and mandatory attendance at parenting programs. Such interventions may seem unavoidable when working in the best interests of children. Exploring the circumstances, however, in which reduced parental autonomy impacts negatively on families is an important first step in developing procedures for working with families that not only avoid harm but are orientated to produce meaningful change. A second, related, potential source of harm from statutory child protection involvement is a lack of clarity over the changes that families must make in order to successfully exit the child protection system. This can occur when expectations for families are not clearly defined, when there is a failure to develop robust plans and provide support aimed at enabling families to reach their goals, and when monitoring is conducted in a laissez faire manner rather than being

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facilitative and purposeful, in which the detail of progress and the effectiveness of plans are fairly scrutinised. While the consequences of failing to detect harmful parenting are obvious, less obvious are the consequences of failing to carry out monitoring that identifies and acknowledges meaningful improvements in family functioning. We argue that the failure to be specific about expectations of the family and/or a failure to acknowledge parental efforts to improve family functioning can leave families feeling frustrated, angry, and disillusioned, potentially leading to an exacerbation of family problems and further undermining the often fragile relations that exist between families and the practitioners of child protection services. We propose that the child protection system has a responsibility to (a) agree on clearly articulated goals with families so that they can demonstrate that they have reached a minimally acceptable level of parenting, (b) provide effective support to assist parents to achieve these goals, and (c) carry out regular monitoring and acknowledgement of any improvement in family functioning. This paper will discuss two manualised evidence-based interventions that we believe have the potential to address the problems associated with statutory involvement with families mentioned above. First we describe the family partnership (FP) model and discuss how the framework for working with families can increase a family's sense of control and investment in the helping process. We then describe the Parents Under Pressure (PUP) program, which has an integrated model for assessing a parent's capacity to change, and which aims to increase clarity over families' exit from the child protection system.

Parental autonomy and the child protection system

The child protection system almost by definition impinges upon and limits parental autonomy, through, for example, the obligation to be in contact with and the receipt of statutory services; court orders that restrict parental rights; and mandatory attendance at parenting programs. The work of Michael Marmot provides convincing evidence to show that systems that erode the autonomy of individuals or groups have the potential to do significant harm. The Marmot (2004) model proposes that deprivation of two fundamental human needs – autonomy to lead the life a person believes they have the right to lead and full social participation – results in psychological distress and, in turn, poor health. This model originated from studying the health status of civil servants working in Whitehall, London. In a 25-year longitudinal study, a clear correlation was found between an individual's position on the hierarchy within the civil service and rates of non-communicable diseases such as coronary heart disease and cancer. This was despite the fact that, irrespective of their job status, all the civil servants had access to clean water, abundant food supplies, access to the National Health Service and all the other privileges of a developed nation. Subsequent studies of health status in economically poor countries have found higher rates of non-communicable diseases among the most socially disadvantaged within those countries. Unexpectedly, when comparing people across nations it was found that an individual's position on the social gradient was a more important determinant of health status and life expectancy than their absolute level of poverty. For example, a person in a developed Western country may be more affected by poverty compared to someone in a developing economy – even though they are better off financially and materially in absolute terms – if they feel less socially engaged and are denied the autonomy to lead the life they feel entitled to lead. Black people in the United States, for example, have around four times the income of men in Costa Rica but approximately 9 years' shorter life expectancy (Marmot, 2004). Marmot proposed that the mediating factor explaining the relationship between a person's position on the social gradient and their health status is the activation of biological stress pathways. Studies in support of this have shown that limited heart rate variability (an indicator of sympathetic tone), delayed heart rate recovery after exercise, and raised cortisol levels are found in people of low social position. In summary, this model suggests that individuals, families and communities who feel that they are unable to participate in society and are enduring conditions inferior to the majority, experience chronic stress to a degree that impacts on health status.

Extrapolating Marmot's model to the area of child protection, interventions that are mandatory may actually do more harm that good, however well-intentioned, if the overall result is to diminish parental autonomy and control over the lives of families, often blighted by multiple deprivations, in the absence of genuine and sufficient attempts to facilitate change. One important example is the mandatory parenting program. Parents who are initially resentful and antagonised by statutory intrusion and obligation are unlikely to attend the parenting program in a frame of mind conducive to acquiring new parenting skills. As Budd (2005; Budd & Holdsworth, 1996) pointed out, attending a mandatory parenting program under these circumstances is more likely to be motivated by the opportunity to increase the parents' chances of having their children returned to their care. That is, attendance at a mandatory parenting program may be simply an opportunity, albeit limited, for parents

to achieve some control over their family life rather than an effective intervention to improve parenting skills. Instead of requiring parents to attend programs, what is needed is an approach to working with families that empowers the families through developing a respectful and effective helping relationship that is then used purposefully to facilitate and achieve change. This, of course, is not easy, because such relationships do not develop spontaneously, particularly when the family is engaged with services within the context of statutory authority. The development of an effective helping relationship takes a great deal of skill and care, and depends upon the active efforts of both helpers and parents. The FP model (Davis, Day, & Bidmead, 2002) is a manualised intervention that was developed specifically to promote effective engagement with families.

Family partnerships model and child protection

The FP model was developed to provide practitioners working with families with an explicit and detailed understanding of the dynamic processes of helping. In being made explicit, practitioners can more readily learn to guide and steer the helping process to achieve better outcomes with families. An explicit understanding of the processes of helping also helps practitioners make sense of and articulate any difficulties that can arise during the process of helping families to change. The model has a fundamental premise that relationships based upon the notion of partnership are likely to be more effective than expert, adversarial or simply supportive approaches.

The concepts and purpose of the model reflect longstanding evidence that therapeutic process factors correlated significantly with outcomes (e.g., Karver, Handelsman, Fields, & Bickman, 2006; Shirk & Karver, 2003), both in adult- and child-orientated treatments and irrespective of the treatment modality used. The quality of therapeutic relationship has been related to attrition rates in clinical practice (e.g., Kazdin, Holland, & Crowley, 2000; Shirk, 2001) and identified as the most important reason for treatment dropout (Garcia & Weisz, 2002). Kazdin et al. (2000) have proposed that these factors may be a more important influence in work with children with externalising difficulties and adult hostility. A series of qualitative studies (Barlow, Kirkpatrick, Stewart-Brown, & Davis, 2005; Day, Carey, & Surgenor, 2006; Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007) involving the developers of the FP model underlines the positive and negative reactions of families with complex psychosocial needs to their involvement with practitioners and the impacts on the helping process (Table I). These studies highlighted that helpful family–practitioner partnerships cannot be assumed to develop spontaneously or automatically. Within the context of child protection, developing an effective helping partnership will be particularly difficult because parents may well have had prior adverse experiences with services and have doubts about the motives, integrity, commitment and authenticity of the current practitioner. In the early stages of engagement families may, as a result of their lack of trust, be reluctant to open up and reflect objectively on their family circumstances, in an attempt to prove their competence and create a positive image of the family. In addition, the immediate impact of a stressful family ecology can make families more sensitive, reactive and hostile towards the practitioner.

The FP model attempts to address the difficulties in developing a partnership under adverse conditions. This is achieved by making explicit the elements of the helping process, which include the interpersonal skills and personal qualities of the practitioner and the nature and characteristics of the parents and practitioners – their strengths, difficulties and resources (Figure 1). The FP model conceptualises the process of helping as a series of tasks or stages in which the process of forming a partnership is inextricably bound up with the other tasks of the helping process, which include exploration, understanding, goal setting, strategy planning, implementation, review and ending.

Within the child protection context, a successful partnership is highly dependent upon the practitioners' capacity to communicate genuine respect for, interest in and commitment to parents regardless of the conditions that have brought about statutory involvement. It is vital that practitioners connect with and demonstrate an understanding of the parents and their unique circumstances. The FP model requires practitioners to share and relinquish aspects of their authority and expertise, which can be particularly difficult when they are in the position of managing and monitoring risk of abuse and neglect. An assumption of the FP model, however, is that parents are more likely to engage and become genuinely involved in the process of helping when their input, knowledge and ideas are genuinely sought and valued and when they themselves know that they can help to influence and determine what happens. When parents are encouraged to express their views and expectations openly, the quality and accuracy of information shared, explored and negotiated is improved, maximising the likelihood that appropriate and meaningful goals will be agreed upon. Further, the parents' resources are more likely to be effectively mobilised and committed to achieving change and positive outcomes.

Table I. Examples of positive and negative perceptions of practitioners

Examples of negative parental perceptions of practitioners	
Untrustworthy and threatening	"I always want to say and do the right things in front of (her) because I'm not sure what will happen if I don't."
	"You really do feel like they intimidate 'cos you're a Mum, you're a parent and you're sitting in doors and they're outdoors. They try and like, just pushing it down your throat till like it makes you feel like more of a bad parent."
Judgemental and stigmatising	"I didn't get help because I was scared . . . . . because I didn't want to be judged."
Lacking authenticity and commitment	"People shouldn't go around asking people how they are to say 'there, there dear, I'm sorry you feel upset' . . . . . And they go back on with their smart life and their nice car and their nice children and their nice home . . ."
	"You can tell they are there because they enjoy what they are doing . . . And (those) who are there just as a job . . . There is a difference . . . those who are in it just as a job . . . don't understand . . . it depends on the person itself . . ."
Examples of positive parental perceptions of practitioners	
Warmth	"I . . . expected someone . . . .quite stern and strict . . . (she was) very much a really friendly, jolly person."
Interest and empathy	"If they're to be effective in helping you as a parent, then they need to know what you as a parent go through."
	"She was interested in not just (my child) but me, and I found I was able to open up to her."
	"They are not just listening to what you say, they are hearing what you're saying as well as listening. Although they sound very much the same . . . . they are not."
Respect	"She talks to you like a human being, she doesn't treat you like you don't know anything."
Encouraging and empowering	"She always made me feel that what I was doing was right and they were my views . . . . . She always made me feel in control."
Non-judgemental and trustworthy	"She didn't ever opinionate . . . I didn't feel as if she would say, 'you shouldn't be doing this, you should be doing that'."
	"I feel now, no matter what my problem was that she wouldn't judge me . . . . . She knows me, she knows me really well . . . . I trust her, I trust her."

Note: Sources: Barlow et al., 2005; Day et al., 2006; Jack, 2005; Kirkpatrick et al., 2007.

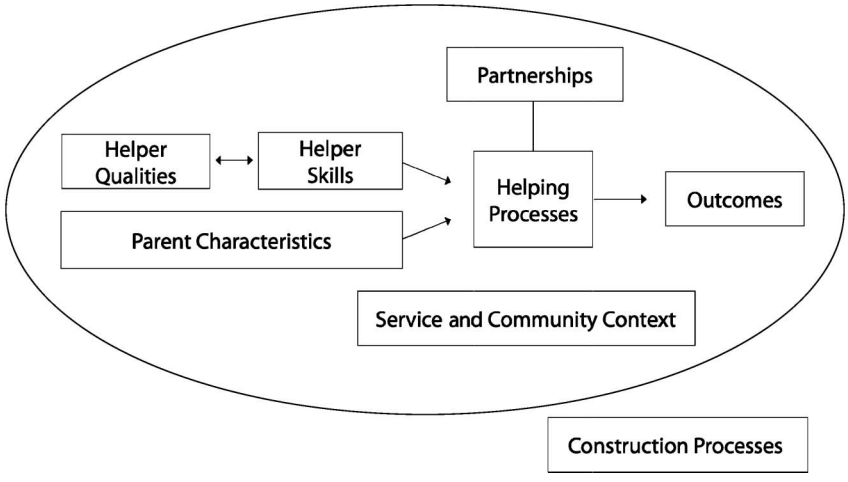

Figure 1. Family partnerships model.

Partnerships more realistically reflect the fundamental choices that parents can exercise when they are offered the opportunity to choose if and how they participate and contribute to the helping process. When this is successfully achieved and when a parent is able to take appropriate responsibility and credit for positive outcomes in their family, the FP model has the potential to increase parents' sense of control, autonomy and self-efficacy. Enabling and allowing partnerships to grow offers parents a relational experience that they can apply in other areas of their lives. Shared relationships of this type are also likely to be more rewarding for the helper and less stressful.

The FP model has been evaluated in a number of studies that demonstrate improved outcomes for parent and children as well as qualitative studies that

have elaborated and explored the model of helping (Barlow et al., 2007; Davis & Spurr, 1998; Kirkpatrick et al., 2007). Studies examining the FP training program have demonstrated its effectiveness in improving practitioner knowledge, skills and qualities (Davis et al., 1997; Papadopoulou et al., 2005). Establishing a working relationship of this nature may help to facilitate change in and by itself but this is unlikely when families face complex difficulties with few immediate resources.

Lack of clarity over successfully exiting the child protection system

Failure to clarify what families involved with welfare agencies must achieve in order to demonstrate that they can provide a safe and nurturing family environment for their children is an important source of distress that reduces the autonomy and control of the parents and can result in emotions such as anger, frustration, distress, shame, loss of dignity and sense of failure. From an ecological perspective, in which family functioning is determined by the social ecology within which the family is embedded, an increase in parental psychological distress can be expected to exacerbate family problems (Bronfenbrenner, 1979, 1986). Thus clearly specifying the goals that a family must achieve in order to exit the child protection system has the potential to improve family functioning. Below we consider factors that contribute to a lack of clarity over the changes that a family is required to make to exit the child protection system.

One influence that hinders the formulation of achievable goals for families arises when there is an emphasise on actuarial risk assessment over an assessment of the needs of families. Structured decision-making based on actuarial risk assessment methods were developed in response to evidence that child protection practitioners do not reliably predict the future behaviour of their clients. Risk assessment methods have become an important contribution to decision-making in child protection, particularly during initial contact with families when a reliable assessment of risk is required quickly in order to respond appropriately to the potential danger faced by a child (Shlonsky & Wagner, 2005). It is important to keep in mind, however, that research carried out to validate risk assessment methods evaluates the success of an instrument to predict future events such as a repeat notification of child maltreatment. The factors that are candidates for inclusion in an assessment of risk include both static risk factors (risk factors that are not amenable to change such as substance misuse during pregnancy, a past notification of child maltreatment, socio-economic status) and dynamic risk factors that are amenable to change (Schwalbe, 2008). Examples of dynamic risk factors include a parent's repertoire of parenting skills and level of social support. Risk assessment instruments that are loaded with items measuring static risk factors will not be sensitive to changes in the family and, therefore, are inappropriate for monitoring change. Also, because an assessment of risk does not provide a clinical formulation or understanding of the family, a risk assessment does not provide information on the aspects of family functioning that would be expected to be causal in promoting improvement in family functioning. For these reasons an assessment of risk assessment cannot clarify the changes that a family must make to demonstrate that they have achieved a minimally acceptable level of parenting, and it is also inadequate in monitoring clinically meaningful change in family functioning. In contrast, an assessment of family needs that emphasises the risk and protective factors that are potentially amenable to change can help to clarify the goals that a family must attain in order to exit the child protection system.

A second influence that creates uncertainty regarding expectations for a family's exit from the child protection system is the failure to clearly define the changes that are expected of a family. When goals are not clearly defined, changes that may occur in a family cannot be adequately measured and therefore will not be fully acknowledged. Harnett (2007) described a model for assessing a parent's capacity to change that includes a number of steps that address the problems outlined above. The capacity-to-change model involves (a) carrying out a cross-sectional assessment of the parents' current functioning and needs, (b) specifying operationally defined targets for change, (c) implementing an intervention with proven efficacy for the client group with a focus on achieving the identified targets for change, and (d) using objective measurement of progress including an evaluation of the parents' willingness to engage and cooperate with the intervention and the extent to which clearly defined goals were met. The aims of the capacity-to-change assessment model are to determine whether a family has the potential to eventually achieve a minimal level of parenting and clarify what further changes would be necessary for a decision to be made that the family can exit the child protection system.

Genuine and effective assistance for assisting parents

Harnett (2007) pointed out that to fairly assess a family's capacity to change, it is essential that there is evidence that the intervention used to assist parents to achieve their goals is sufficiently powerful to produce some meaningful level of change during the period of the assessment. Otherwise it may be falsely

concluded that a family's failure to change is the result of the family's poor motivation or ability to change rather than the real reason: an ineffective intervention. One intervention that has been found to produce short-term change in multi-problem families is the Parents Under Pressure program (Dawe & Harnett, 2007; Dawe, Harnett, Rendalls, & Staiger, 2003; Harnett & Dawe, 2008), a program specifically developed for multi-problem families that incorporates the capacity-to-change assessment model.

Several studies have shown that the Parents Under Pressure program can produce short-term change in high-risk, multi-problem families. This includes a series of single case studies (Dawe et al., 2003; Harnett & Dawe, 2008) and a randomised controlled trial (Dawe & Harnett, 2007). In these studies analyses were carried out to determine the level of change obtained at the individual family level using the reliable change index (RCI; Jacobson & Truax, 1991). The RCI is a statistic that determines whether there has been a clinically significant improvement or deterioration between baseline assessment and follow-up, calculated individually for each measure and each family. In both series of single case studies it was demonstrate that substantial improvements were found across a number of areas including: child abuse potential; parental stress; and child behaviour. Not all families, however, showed this improvement. In the first series, which included families who were on methadone maintenance, six out of eight families had a reliable reduction in child abuse potential (Dawe et al., 2003). In a sample of 12 families referred from a child protection agency, eight had significant reductions in at least one domain (Harnett & Dawe, 2008). Similar results were found in the randomised controlled trial, in which the Parents Under Pressure program was compared to a brief intervention and treatment as usual in families with a parent on methadone maintenance (Dawe & Harnett, 2007). Families who participated in the Parents Under Pressure program reported significant reductions in child abuse potential, parenting stress and child behaviour problems at the group level. At the individual level it was found that more than one third of families who took part in the Parents Under Pressure program reported a clinically significant reduction in child abuse potential (as measured on the Child Abuse Potential Inventory, CAPI; Milner, 1986). Importantly, however, more than one third of families who participated in the Parents Under Pressure program failed to show a significant reduction in abuse potential. These families were above the clinical cut-off of the CAPI at pre-intervention assessment and remained above the clinical cut-off after the intervention. Thus, while the Parents Under Pressure program can create change in multi-problem families, it is important to acknowledge that making significant and enduring changes in multi-problem families is difficult, and that for some families such changes may be difficult, particularly in the short term.

Conclusion and implications

Child abuse and neglect are a reality that justifies statutory intervention by child protection systems. A fundamental principle, however, of any child protection system should be to ensure that it is neither ineffective nor harmful. We have made the argument that under certain circumstances the child protection system can be harmful, specifically when statutory involvement acts to disempowers parents and fails to specify or acknowledge changes that the family need to make to achieve a minimal standard of parenting. Two evidence-based programs are described above that together have the potential to assist child protection practitioners to develop a collaborative helping partnership, clarify goals for change and support parents to achieve meaningful improvement in their family functioning. Because the program is manualised, the argument presented above can be empirically tested. For example, it would be predicted that if practitioners working within child protection agencies were trained in the two programs, families would have a more positive perception of the services being offered. Professionals would be expected to have greater confidence in decision-making and experience less burnout. Because expectations for the family would be clearly articulated and change more adequately monitored, it would be expected that there would be a decrease in the time taken to make decision about families. Finally, because the interventions are designed to improve family functioning, it would be expected that there would be reduction in re-notification rates. Carrying out research using rigorous methodology to test these predictions is clearly warranted.

References

Barlow, J., Jarrett, P., Mockford, C., McIntosh, E., Davis, H., & Stewart-Brown, S. (2007). Role of home visiting in improving parenting and health in families at risk of abuse and neglect: Results of a multicentre randomised controlled trial and economic evaluation. *Archives of Disease in Childhood*, *92*, 229–233.

Barlow, J., Kirkpatrick, S., Stewart-Brown, S., & Davis, H. (2005). Hard-to-reach or out-of-reach? Reasons why women refuse to take part in early interventions. *Children and Society*, *19*, 199–210.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, *22*, 723–742.

Budd, K. S. (2005). Assessing parenting capacity in a child welfare context. *Children and Youth Services Review*, *27*, 429–444.

Budd, K. S., & Holdsworth, M. J. (1996). Issues in clinical assessment of minimal parenting competence. *Journal of Clinical Child Psychology*, *25*, 2–14.

Davis, H., Day, C., & Bidmead, C. (2002). *Working in partnership with parents: The parent adviser model.* London: Harcourt Assessment.

Davis, H., & Spurr, P. (1998). Parent counselling: An evaluation of a community child mental health service. *Journal of Child Psychology and Psychiatry*, *39*, 365–376.

Davis, H., Spurr, P., Cox, A., Lynch, M., von Roenne, A., & Hahn, K. (1997). A description and evaluation of a community child mental health service. *Clinical Child Psychology and Psychiatry*, *2*, 221–238.

Dawe, S., & Harnett, P. H. (2007). Improving family functioning in methadone maintained families: Results from a randomised controlled trial. *Journal of Substance Abuse Treatment*, *32*, 381–390.

Dawe, S., Harnett, P. H., Rendalls, V., & Staiger, P. (2003). Improving family functioning and child outcome in methadone maintained families: The Parents under Pressure program. *Drug and Alcohol Review*, *22*, 299–307.

Day, C., Carey, M., & Surgenor, T. (2006). Children's key concerns: Piloting a qualitative approach to understanding their experience of mental health care. *Clinical Child Psychology and Psychiatry*, *11*, 139–155.

Garcia, J., & Weisz, J. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology*, *70*, 439–443.

Harnett, P. H. (2007). A procedure for assessing parents capacity for change in child protection cases. *Children and Youth Services Review*, *29*, 1179–1188.

Harnett, P. H., & Dawe, S. (2008). Reducing child abuse potential in families identified by social services: Implications for assessment and treatment. *Brief Treatment and Crisis Intervention*, *8*, 226–235.

Jack, S. (2005). A theory of maternal engagement with public health nurses and family visitors. *Journal of Advanced Nursing*, *49*, 182–190.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*, 12–19.

Karver, M., Handelsman, J., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature *Clinical Psychology Review*, *26*, 50–65.

Kazdin, A., Holland, L., & Crowley, M. (2000). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, *65*, 453–463.

Kirkpatrick, S., Barlow, J., Stewart-Brown, S., & Davis, H. (2007). Working in partnership: User perceptions of intensive home visiting. *Child Abuse Review*, *16*, 32–46.

Marmot, M. (2004). *Status syndrome.* London: Bloomsbury.

Milner, J. S. (1986). *The Child Abuse Potential Inventory* (2nd ed.). Webster, NC: Psytec.

Papadopoulou, K., Dimitrakaki, C., Davis, H., Tsiantis, J., Dusoir, A., Paradisiotou, A., et al. (2005). The effects of the European Early Promotion Project training on primary health care professionals. *International Journal of Mental Health Promotion*, *7*, 54–62.

Schwalbe, C. (2008). Strengthening the integration of actuarial risk assessment with clinical judgment in an evidence based practice framework. *Children and Youth Services Review*, *30*, 1458–1464.

Shirk, S. (2001). The road to effective child psychological services: Treatment processes and outcome research. In J. Hughes, A. La Greca, & J. Conoley (Eds.), *Handbook of psychological services for children and adolescents* (pp. 43–59). New York: Oxford University Press.

Shirk, S., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*, 452–464.

Shlonsky, A., & Wagner, D. (2005). The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management. *Children and Youth Services Review*, *27*, 409–427.

US Department of Health and Human Services, Administration on Children, Youth and Families (2008). *Child maltreatment.* Washington, DC: US Government Printing Office.