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Multidisciplinary assessment of child maltreatment: A multi-site pilot descriptive analysis of the Florida Child Protection Team model

Jason F. Jent^{a,*}, Melissa T. Merrick^a, Susan K. Dandes^a, Walter F. Lambert^a, Mike L. Haney^b, and Nicole M. Cano^a

^a Miller School of Medicine, University of Miami, United States

^b Children's Medical Services, Florida Department of Health, United States

Abstract

The Florida Child Protection Team (CPT) program is a statewide assessment model that was developed to provide objective multidisciplinary evaluations of complex cases of alleged child maltreatment. However, only limited research has examined the content and quality of CPT assessment practices. In fact, the limited research on the quality and content of child protection assessments in relation to child protection assessment “best practices” is a system wide problem. In the current study, we sought to systematically evaluate the assessment practices of a pilot sample of CPTs. Specifically, we were interested in gaining a better understanding of the population served by CPTs, the types of evaluations offered, the content of the assessments, clinical interpretations and findings, and recommendations. The results show areas in which CPT functions as an effective multidisciplinary assessment team and relative weaknesses in assessment practices that may require changes in CPT policy and/or additional training.

Keywords

Child protection services; Multidisciplinary assessment; Child maltreatment; Program evaluation

1. Introduction

The prevalence of child maltreatment continues to be a significant problem for the United States. Child maltreatment is defined as all forms of physical abuse, emotional abuse, sexual abuse, neglect, or negligent treatment resulting in actual or potential harm to a child's health, survival, development, or well-being in the context of a relationship of responsibility, trust, and power (World Health Organization, 1999). Child maltreatment affects approximately 900,000 children per year in the United States (USDHHS, 2006). Within the state of Florida alone, over 180,000 child maltreatment investigations are conducted annually by child protective services, and of those investigations, there is a 29 per 1000 substantiated child maltreatment rate (Florida Department of Children and Families, 2007).

In Florida, a medically directed, multidisciplinary statewide Child Protection Team (CPT) program was developed in 1978 to support child protective investigation activities in complex cases of child abuse and neglect (Children's Medical Services, 2007). The CPT program

*Corresponding author. Miller School of Medicine, University of Miami, 1150 NW 14th St., Suite 212, Miami, FL 33136, United States. Tel.: +1 305 243 7550. jjent@med.miami.edu (J.F. Jent).

operates on the premise that child abuse and neglect is a multifaceted problem requiring multidisciplinary evaluation. Child Protection Team records are provided to law enforcement, State Attorney, Child Protective Investigators, and other professionals as needed for treatment and evaluative purposes.

Florida statutes mandate that specific types of maltreatments must be referred to Child Protection Teams for medical evaluations and other necessary assessment activities. Mandatory referrals include those involving: injuries to the head; bruises to the neck or head, burns, or fractures in a child of any age; bruises anywhere on a child five years of age or younger; sexual abuse of a child; any sexually transmitted disease in a prepubescent child; reported malnutrition of a child and failure of a child to thrive; reported medical neglect of a child; symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected; and any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home.

All reports to the Florida Abuse Hotline are transmitted to both Child Protection Teams and Child Protective Investigators. Upon review and acceptance of a referral from child protective services, CPTs determine the appropriateness and necessity of one or more of the following services: forensic medical evaluations, child and family assessments, multidisciplinary staffings, psychological and psychiatric evaluations, and specialized and forensic interviews.

Twenty-four CPTs provide these services to all children in the state of Florida meeting criteria for referral in approximately 51 locations in the state. In order to maintain consistency in practices, the multi-disciplinary assessment activities at each site are guided by the Child Protection Team Program Policy and Procedure Handbook (Children's Medical Services, 2007) and ongoing state-sponsored training activities. However, only limited research has examined this statewide model to date.

In a study designed to evaluate the relative efficiency of Children's Advocacy Centers (CACs) and CPTs to standard child protective services practices, assessments conducted in CPTs and CACs were related to higher substantiation rates and investigative efficiency (Wolfteich & Loggins, 2007). Higher substantiation rates in CPT and CAC assessments relative to traditional protective services are likely due to more severe cases of child maltreatment being referred to CPTs and CACs, as well as more comprehensive assessments (e.g., forensic medical evaluation of victimized child(ren), specialized interviews with family) in these settings.

Despite demonstrating the efficiency and outcomes of CPTs, relatively little is known about the CPT assessment process and how the model relates to "best practices" for child protection assessments. That is, no study to date has examined the CPT assessment process' adherence to commonly cited child protection best practices including: defining the scope of the evaluation; using collateral information; assessing as many relevant family members as possible; conducting unbiased interviews; making qualified/conservative interpretations of assessment findings; acknowledging limitations of assessment/findings; providing descriptive data on risk and protective factors; making specific contextual recommendations based on assessment data; and refraining from making explicit recommendations about custody disposition (e.g., American Psychological Committee on Professional Practice and Standards, 1998; Melton, Petrila, Poythress, & Slobogin, 2007; Myers et al., 2002).

In fact, relatively few studies have evaluated the content and findings of child protection assessments altogether (Budd, Felix, Poindexter, Naik-Polan, & Sloss, 2002; Budd, Felix, Sweet, Saul, & Carleton, 2006). In one study that empirically evaluated a clinical child protection assessment model, the content of assessment reports was coded. Coded content

included demographic information about the individuals being assessed and evaluators, the type of evaluation conducted, the methods used, the referral source, the scope of the evaluation, the use of collateral information, the report/interpretation of findings, and recommendations (Budd et al., 2002).

Results indicated several domains where clinical practices deviated from recommended child protection assessment practices. Coding of evaluation reports revealed that referral questions were often vague. Collateral information and use of written collateral records were only utilized on a limited basis. Reports frequently emphasized parents' weaknesses over strengths and many evaluations failed to cite the credibility of the findings and limitations in the assessment process. Recommendations about case disposition were frequently made, suggesting that those in charge of making custody-related decisions may be influenced by recommendations rather than reviewing the data within the reports.

The findings from this study defined specific areas in which evaluations within their child protection assessment model deviated from recommended forensic guidelines and provided a baseline for enhancing assessment practices. In fact, later research of this child protection assessment model demonstrated substantial increases in adherence to recommended forensic guidelines for child protection assessments (Budd et al., 2006).

The generalization of these findings to other child protection assessment programs in other states is obviously limited due to variable definitions of child maltreatment and substantiation, as well as different models of child protection assessment (e.g., child protective services, multidisciplinary assessment teams, CACs). Nevertheless, Budd's research represents an important step in empirically evaluating child protection assessment practices by providing data driven methodology to enhance current practices.

Similar to the limited research that has been designed to empirically evaluate possible problems with current child protection assessments and provide recommendations to improve practices, the present study sought to empirically evaluate a pilot sample of CPTs' multidisciplinary assessment practices. In particular, we were interested in gaining a better understanding of the population that is served by CPTs, the types of evaluations offered, the content of the assessments, clinical interpretations and findings, and recommendations. Through an empirical analysis of current CPT multidisciplinary assessment practices, this study describes potential problems with current practices and makes recommendations about ways to enhance the quality of child protection assessments based on forensic child protection evaluation best practices.

2. Method

2.1. Sample

All CPT evaluations conducted between July 2005 and July 2006 from the jurisdictions of four South Florida CPTs that included at least one specialized interview were eligible for retrospective coding. The study included four CPT sites (1. Glades, Henry, Lee, and Charlotte Counties, 2. Palm Beach County, 3. Broward County, and 4. Dade and Monroe Counties). CPT final case summary reports of evaluations were randomly selected from the Child Protection Team Information System, a statewide electronic database of CPT evaluations. Of the 4895 evaluations conducted during the eligibility period, 845 CPT final case summary reports (Glades, Henry, Lee, and Charlotte Counties [$n=205$]; Palm Beach County [$n=88$]; Broward County [$n=257$]; Miami-Dade and Monroe Counties [$n=295$]) were randomly selected for the current study to achieve a power of .80. The number of reports selected per site was proportionate to the total number of evaluations conducted per site during the study eligibility period.

CPT final case summary reports included a description of the child maltreatment allegations, a summary of the assessments completed (i.e., forensic interviews, specialized interviews, psychosocial interviews, psychological evaluations, and medical evaluations), a description of protective and risk of harm factors, findings, and recommendations. A description of the specific types of evaluations summarized in final case summaries is listed below.

Medical evaluations include obtaining a medical history and conducting a physical examination that could include X-ray, laboratory or other diagnostic procedures, performed by a CPT physician or an advanced registered nurse practitioner, when a physical examination of a child is needed to assess allegations of abuse or neglect (Children's Medical Services, 2007).

Specialized interviews are interviews with a child or a member of the child's family for the purpose of gathering clinical data for assisting with the assessment of alleged child maltreatment (Children's Medical Services, 2007). Specialized interviews of children and others often serve as the key component in the assessment process. Without evidence of physical injuries or other witnesses to the abuse, the interview may be the only way to establish reliable, detailed information. It also provides information regarding the family functioning and history.

Psychosocial assessment is an evaluation of the history of the child and the child's family system, conducted by a case coordinator or other trained professional (Children's Medical Services, 2007). The psychosocial assessment includes separate interviews of all the key members of the immediate family unless specific reasons are documented, and may include interviews of extended family members or others who directly impact family dynamics and functioning. Emphasis is placed on the child and family's history as a context for the presenting abuse or neglect allegations. The assessment assists in assessing allegations, identifying risk factors in the case, identifying pertinent family dynamics, ascertaining family strengths and weaknesses, and determining the needs of the child and family.

A forensic interview is a structured interview conducted in a neutral, fact finding, legally sound manner by a case coordinator who has received specialized training in this area (Children's Medical Services, 2007). This type of interview is usually requested to help establish facts regarding possible child maltreatment to use in a legal proceeding. A forensic interview is conducted with the alleged victim child only, while a specialized interview may extend to family members or other parties in a child abuse investigation.

The Child Protection Team may recommend a psychological evaluation of a child or family member in order to provide a comprehensive assessment of an individual's emotional, behavioral, psychological, or intellectual functioning (Children's Medical Services, 2007). These evaluations are particularly helpful in identifying the short and long-term psychological effects of abuse, identifying factors that predispose families to the abuse or neglect of children, and in identifying and determining the appropriate mental health needs and interventions.

2.2. Measures

CPT reports were coded using a modified version of the Clinical Assessment Code Book (Budd et al., 2002), a coding system designed to evaluate the qualitative and objective content of evaluations within a child protection context. The Clinical Assessment Code Book included summary categories (213 items total): case identification and demographics; evaluation type, setting, and time frame; referral source and focus; background information; methods; reliability/validity information; findings; interpretations and recommendations; and evaluator credentials. In a previous empirical analysis of clinical assessments within a child protection context conducted by Budd et al. (2002), 174 items had an interrater agreement of 90% or higher and another 29 items had an interrater agreement between 75 and 89%.

In the current study, a modified version of the code book was utilized to code reports which included summary categories (148 items): case identification and demographics (82 items); evaluation type, setting, and time frame (7 items); referral source and focus (6 items); background information (14 items); reliability/validity information (6 items); findings (6 items); and interpretations and recommendations (27 items). Some language was altered from the original code book to match appropriate CPT terminology. Additional demographic items were included in the modified code book to capture all family members assessed by CPT. The methods category and other relevant psychological evaluation items of the Clinical Assessment Code Book were not included in the current study because there were not sufficient psychological evaluations completed by CPTs during the study eligibility period to adequately examine coding results. Finally, the evaluator credentials category was excluded from the modified code book because the study reports were de-identified and coders did not have access to credential information.

Within final case summary reports, CPT personnel are specifically required to list family risk of harm and protective factors and evidence identified during the course of the CPT evaluation (s). In order to empirically evaluate the specific contents of the reports, the Child Protection Team Coding Manual (CPTCM; Jent, Dandes, Merrick, & Rankin, 2006) was developed to code CPT evaluation reports for evidence, protective factors, risk of harm factors, and case disposition. The coding manual was developed by reviewing relevant child maltreatment literature and identifying specific risk of harm and protective factor variables to be coded. Variables were only coded if clearly identified as a risk or protective factor in the report. Summary categories initially included: risk of harm factors (63 items); protective factors (24 items); and evidence (3 items). Risk of harm factors were summarized in four categories: demographic characteristics (e.g., socioeconomic status; Connell, Bergeron, Katz, Saunders, & Tebes, 2007; number of children; Sidebotham & Heron, 2006); previous history of child maltreatment (e.g., Wood, 1997); caregiver characteristics (e.g., parental substance abuse; Chaffin, Kelleher, & Hollenberg, 1996; life stress; Kotch, Browne, Dufort, Winsor, & Catellier, 1999; parent mental health; Sidebotham, Golding, & The ALSPAC Study Team, 2001); and child characteristics (e.g., child behavior problems; Sprang, Clark, & Bass, 2005; child cognitive functioning; Marshall & English, 1999; children with disabilities; Sullivan & Knutson, 2000). Protective factors were categorized similarly: demographic characteristics (e.g., two parent household; Belsky, Youngblood, & Pensky, 1989); caregiver characteristics (e.g., perceived social support; Crouch, Milner, & Thomsen, 2001); and child characteristics (e.g., adaptive child behavior; Heller, Larrieu, D'Imperio, & Boris, 1999). Evidence was categorized into three summary categories: medical documentation of inflicted injuries/neglect; perpetrator admission of responsibility for allegations; and child disclosure. Based on the content of the CPT assessment, evaluators categorize the findings of the child maltreatment allegations as verified, some indication, or no indication. Allegations are categorized as verified "when a preponderance of the credible evidence results in a determination that the specific injury, harm or threatened harm was the result of abuse or neglect (State of Florida Department of Children and Families, 1998)." Allegations are classified as some indication "when there is credible evidence, which does not meet the standard of being a preponderance, to support that the specific injury, harm or threatened harm was the result of abuse or neglect." Allegation findings are categorized as no indication "when there is no credible evidence to support the allegations of abuse, neglect or threatened harm."

2.3. Procedures

Reports were de-identified by a CPT staff member not involved in coding prior to being coded by project-trained coders. Four research associates, who were not involved in conducting CPT evaluations during the study eligibility period, were trained as coders. Prior to coding reports, study coders practiced coding non-study reports until an overall interrater agreement of 90%

was obtained on 10 consecutive reports. Of the 845 randomly selected CPT reports, 128 reports (15%) were independently coded to assess interrater agreement on individual items. Weekly coding meetings were facilitated by a co-investigator who was not responsible for coding reports to resolve coding questions and reduce drift from coding procedures.

Interrater agreement for the modified Clinical Assessment Book ranged from good ($\kappa=.61-.80$; 8 items) to very good ($\kappa=.81-1.00$; 138 items; Altman, 1991). Two items had an interrater agreement below .60 and were excluded from all study analyses. All items of the CPTCM displayed good interrater agreement. Interrater agreement ranged from good ($\kappa=.61-.80$; 9 items) to very good ($\kappa=.81-1.00$; 79 items).

3. Results

3.1. Population served by CPTs

Of the 845 randomly selected final case summary reports selected from the Florida CPTs for inclusion in this study, the majority of target children assessed were African-American (37.5%), followed by 33.9% Caucasian, 24.7% Hispanic, 1.2% Asian American, and 2.7% are another race (see Table 1). There was a slight majority of girls (52.8%) over boys in the overall sample and the mean age was 7.6 years ($SD=4.5$). Thus, this represents an ethnically diverse sample that is reflective of the demographic composition of maltreated children in the state of Florida in general (Schuck, 2005). The majority of cases involved allegations of physical abuse (52.4%) followed by allegations of multiple forms of maltreatment (22.0%).

Approximately 70% of all children assessed at CPT received both a specialized interview and a medical evaluation. Since the majority of evaluations involved allegations of physical abuse, it makes sense that conducting both a specialized interview about the allegations and a medical evaluation to document any physical injuries were indicated. Approximately 12% of children received only a specialized interview, followed by 9% of children receiving a combination of specialized interviews and other interviews, along with a medical evaluation. The remainder of cases received a combination of specialized and other interviews (i.e., psychosocial assessment, forensic interview, psychological evaluation). There was variability amongst alleged victims of sexual abuse in regards to whether they assessed with only interviews or with a combination of interviews and medical evaluations. These differences are likely related to when the alleged sexual abuse happened and when it was reported to child protective services and/or law enforcement. The mean number of prior reports of maltreatment was 1.63 ($SD=2.45$), with only .51 prior substantiated reports of maltreatment ($SD=1.09$) for the overall sample. There were no notable differences between evaluation type and prior child protective services involvement.

3.2. Content of assessments

The overwhelming majority of cases (95.3%) were referred to CPT by the Department of Children and Families (DCF). As such, for the majority of cases, background information was made available to CPT in the form of worker/therapist contact (98.6%) and written DCF records (93.8%). Less than 5% of cases were referred to CPT by law enforcement agencies and even fewer cases were referred by hospital staff. Other collateral information was only obtained in 6.6% of cases, including information from police, hospital staff, and past mental health evaluations. Almost 99% of evaluations were conducted at CPT offices.

3.3. Clinical interpretation of findings

Table 2 displays the extent to which reports describe or interpret issues related to the reliability and validity of the evaluations and interviews themselves by evaluation type. Only about a quarter of all evaluation reports interpreted how the client's behavior may have impacted the

process of the assessment. Less than 10% of all evaluation reports described the limitations of the interview or evaluations that may have impacted conclusions about the allegations and/or recommendations. Even less caution was used in noting how cultural and/or language barriers, parental comprehension of interview questions, emotional stress during the evaluation, or other external factors may have limited the findings of evaluations. Further, most evaluations failed to make qualified conclusions about the evaluations (e.g., this child may be at possible risk for future harm without intervention vs. this child is at risk for future harm without intervention). All evaluation reports listed risk factors of assessed families, as they are required components of final case summary reports. However, as shown in Table 2, reports cited more risk factors than protective factors across all evaluation types.

3.4. Recommendations

The types of services or actions recommended by evaluation type are shown in Table 3. Almost all evaluations included recommendations for assessed families to potentially reduce future risk of harm. The three most common types of recommendation were those for therapy or counseling, parent training, and custody-related issues (e.g., placement, visitation, reunification, adoption). A little over half of all reports included a recommendation that did not fit into any of the initially specified categories, with following other recommendations already in place, changing parenting practices, and medical recommendations being the most prominent (3.4%, 2.0%, and 1.4%, respectively).

4. Discussion

The purpose of this study was to gain a better understanding of Florida's Child Protection Teams' multidisciplinary assessment practices through empirically analyzing a pilot sample of evaluation reports. The CPT program was developed to enhance the child protective investigation activities of law enforcement agencies and child protective services in complex cases of child abuse and neglect through multidisciplinary objective assessment (Children's Medical Services, 2007). In order to maintain assessment fidelity, the multi-disciplinary assessment activities by each site are guided by the Child Protection Team Program Policy and Procedure Handbook (Children's Medical Services, 2007) and ongoing state-sponsored training activities. However, only limited research has examined this statewide model to date. As such, descriptive analyses performed in this study provided important preliminary information about the population that is served by CPTs, the types of evaluations offered, the prevalence of different types of child maltreatment assessed, the content of the assessments, clinical interpretations and findings, and recommendations. A better understanding of CPT assessment practices will allow state administrators to build upon current assessment strengths and modify relative weaknesses of the assessment process (e.g., additional training, concise definitions of the objectives of specific evaluations, changes in CPT procedural policy).

The results found that almost 38% of target children seen at CPTs were African-American, followed by approximately 34% Caucasian and 25% Hispanic. While such an ethnically diverse sample of children is similar to the demographic composition of maltreated children in the state of Florida in general (Schuck, 2005), these numbers confirm other research that finds that African-American children are over-represented in the child welfare system (e.g., Morton, 1999; Perry & Limb, 2004). It is interesting that African-American children were served at an increased prevalence rate through CPTs and future research should specifically examine potential factors (e.g., large family size, poverty, young maternal age, and low maternal education; Kotch et al., 1999; Lau et al., 2003; Schuck, 2005; Wu et al., 2004) that may contribute to this overrepresentation.

Given the mandatory criteria for referrals to CPTs, it is not surprising that families with allegations of physical abuse, sexual abuse, or multiple maltreatment types (e.g., physical abuse

and sexual abuse) were evaluated the most frequently. Allegations of physical abuse and/or sexual abuse likely benefit from a multidisciplinary assessment approach more than allegations of neglect. Forensic medical evaluations gather necessary evidence (e.g., medical documentation/photography of injuries, cultures, specimens) to assist with making decisions about allegations and specialized interviews may assist with gaining child disclosures, perpetrator statements, and assessment of protective and risk factors. Allegations of neglect (other than medical neglect or failure to thrive) may be better served by child protective services, as caseworkers physically inspect the safety and nutrition available in homes. However, this is dependent on child protective investigators conducting thorough investigations, including safety plans and follow up. The increased prevalence of physical and sexual abuse allegations being evaluated by CPT suggests that child protective services and CPTs are appropriately allocating investigative/assessment resources.

Interestingly, the pilot sample evaluated on average had a history of at least one prior allegation of maltreatment per family. While we know that there is a moderate rate of recidivism amongst prior substantiated and unsubstantiated cases, one has to wonder if there is a potential selection bias amongst cases that are referred to CPT for multidisciplinary assessments. That is, it is possible that child protective services case workers view cases with a prior history of allegations as being more complex; having an increased risk of harm; and/or perceive that the case needs a more comprehensive evaluation to gain a better understanding of family dynamics, risk and protector factors, and evidence. Though this study did not compare child maltreatment cases investigated by child protective services and those seen by Child Protection Teams, future research that explores the referral and exception process, including what cases get referred to CPT (above and beyond mandatory referrals) versus cases that are exclusively investigated by DCF may assist with determining additional subtypes of child maltreatment allegations that should be referred to CPTs systematically.

The majority of children seen at CPTs received a specialized interview and at least one additional assessment (i.e., medical evaluation, psychosocial assessment, psychological evaluation, forensic interview). This confirms that CPTs are conducting comprehensive multidisciplinary assessments of allegations, family dynamics, and safety needs.

Findings revealed that over 95% of cases were referred to CPTs by child protective services, as is mandated by Florida statutes in severe and complex cases of abuse and neglect. While it follows that most CPT assessments utilize collateral information from child protective services as they are most often the referral source, it is concerning how few CPT assessments obtained and utilized information from other collateral contacts (e.g., physicians, mental health professionals, teachers, non-offender relatives). These collateral informants may have alternative perspectives on the allegations and safety/risk of harm considerations. Obtaining collateral information may be complicated by confidentiality limitations; however CPTs should work with child protective investigators to gather all pertinent information to inform their decision making and recommendations. However, utilizing collateral information from one source can potentially bias assessments, as child protective case workers' personal judgments and preconceptions about cases may impact how CPT assessments proceed (Arad-Davidzon & Benbenishty, 2008). While previous research about CPT assessment practices cites their efficiency as a relative strength, utilization of limited collateral contacts may diminish the CPT evaluators' ability to make objective balanced decisions about cases (Wolfteich & Loggins, 2007).

With regard to the clinical interpretation of findings, limitations observed during the CPT assessment were rarely cited raising concern over how findings are interpreted. This finding is alarming as assessment report conclusions and recommendations may be over interpreted or under interpreted by people who make custody and/or treatment recommendation decisions.

For example, a report that provides a description of a boy who does not disclose physical abuse by a parent but fails to cite that the boy has an expressive language delay may be misleading. In the event that the boy is truly being abused but could not express this to the interviewer, the under interpretation of the assessment findings may allow for this child to be exposed to subsequent physical abuse. Nevertheless, these findings are consistent with previous research examining clinical child protection assessment models (Budd et al., 2002). This indicates the need for CPT evaluators to receive additional training about how to effectively cite limitations of evaluation findings and/or objective systematic models need to be integrated into assessment practices to ensure that limitations of reports are reliably and consistently reported.

Most CPT evaluations interpreted findings in an absolute manner (e.g., “This case clearly represents physical abuse,” “This case does not represent physical abuse,” “This child will be exposed to future harm if allowed to remain in this parent’s care”). While CPT guidelines indicate the need for making decisions about case disposition, research regarding unsubstantiated cases suggests that families with no indicators of child maltreatment may be at high risk for recidivism (Drake, Johnson-Reid, Way, & Chung, 2003). Therefore, it is recommended that findings should be interpreted in a conservative manner based on the data available to ensure that conclusions about allegations and risk of harm are explained in a more qualified manner. This may reduce the likelihood that child protective services and/or other relevant institutions (e.g., law enforcement, family court, treatment providers) inappropriately interpret findings. For example, a child protective services worker may decide not to link a family to behavioral parent training because the findings of the evaluation stated in absolute terms that a child was not physically abused.

With regard to identification of risk and protective factors in CPT evaluations, reports cited more risk than protective factors. The philosophical approach of CPT evaluations has been on assessing risk, as opposed to protective factors. This is in part due to CPT’s statutory role to support the protective investigation and law enforcement, hence the emphasis on risk and child safety, as opposed to protective factors. While CPT assessments in many respects appear to be objective, there clearly is a bias present in that many families’ strengths go unrecognized. In this sense, families may be over-pathologized in the current CPT assessment model by focusing on family weaknesses. The assessment process could be significantly strengthened by adjusting to a balanced approach, which considers both strengths and weaknesses, which would better inform the work of other providers (e.g. therapists, case managers, community-based care workers) who will be providing additional short or long-term services to the child(ren) and their families.

A major strength of the current CPT assessment process is the provision of recommendations in over 90% of cases despite a substantiation rate of 43%. This represents a systematic move away from substantiated cases being viewed as the only families at risk for immediate or future harm. That is, most families regardless of case disposition were referred for additional support/intervention services in the hopes of reducing risk of future harm. The most common types of recommendations were those for therapy or counseling, parent training, and custody-related issues (e.g., placement, reunification, visitation, adoption). While recognizing and addressing the needs of families evaluated at CPTs is important, it is possible that many of these cases could have been linked to therapeutic services immediately by child protective case workers with additional intake screening, information gathered from multiple collateral informants, and consultation with CPT evaluators (Budd et al., 2002). Immediately linking families with support/intervention services instead of referring them for multidisciplinary child protection evaluations may reduce the risk of future harm; alter families’ perceptions of child protective services; and conserve CPT resources allowing sites to evaluate more complex cases of child maltreatment or allocate more effort to gathering collateral information for assessments.

The high prevalence of custody-related recommendations is concerning as some have advised against this practice (e.g., Melton, Petrila, Poythress, & Slobogin, 2007). Child Protection Teams are likely to evaluate the most severe allegations of child maltreatment and in some cases, making recommendations about custody may be warranted. However, CPT evaluators often do not have sufficient contact with the families or key collateral information to warrant such recommendations. While making recommendations about custody (e.g., removal of child/parent from home) may be indicated in some cases, the development of statewide criteria for making such recommendations is needed to ensure that this recommendation is given conservatively and cautiously to minimize unnecessary removal of parents or children from their homes and to preserve familial relationships and bonds.

The results of this study should be viewed with some caution. Our findings and recommendations are specific to a sample of Florida Child Protection Teams and results of this study may not generalize to other multidisciplinary child maltreatment assessment models in other states. Specifically, CPTs are predisposed to assess a specialized population (e.g., complex cases of physical and sexual abuse allegations) that meets specific criteria for referral. Additionally, coding assessment reports may not fully capture the entire content of assessment reports or the intent of the writer. However, given the legal use of these reports in custody-related decisions, we would hope that the writers of these reports include all necessary information about findings and risk and protective factors. Further, we were not able to control for possible omissions of relevant information (e.g., failing to cite active substance abuse by parents as a risk factor) by report writers that assisted in decision making about case disposition and recommendations.

Overall, results indicated several domains where CPT clinical practices deviated from recommended child protection assessment practices. Collateral information and use of written collateral records were only utilized on a limited basis. Reports frequently emphasized parents' weaknesses over strengths. Many evaluations failed to cite the credibility of the findings and limitations in the assessment process. Recommendations about case disposition were frequently made, suggesting that those in charge of making custody-related decisions may be influenced by recommendations rather than reviewing the data within the reports.

Nevertheless, this study represents an important first step in understanding CPT assessment practices and provides an important baseline about relative assessment strengths and needs. Future studies of the CPT multidisciplinary assessment model should evaluate if training in specific areas of need (e.g., citing limitations of assessments, increasing identification of protective factors) results in improved assessment practice. Given CPT's emphasis on identification of risk factors and evidence in assessment, future research should focus on determining how case demographics, risk factors, and evidence specifically contribute to the decisions about substantiation of child maltreatment allegations.

References

- Altman, DG. Practical statistics for medical research. London: Chapman and Hall; 1991.
- American Psychological Association Committee on Professional Practice and Standards. Guidelines for psychological evaluations in child protection matters. Washington, D.C: American Psychological Association; 1998.
- Arad-Davidzon B, Benbenishty R. The role of workers' attitudes and parent and child wishes in child protection workers' assessments and recommendation regarding removal and reunification. *Child & Youth Services Review* 2008;30:107–121.
- Belsky J, Youngblood L, Pensky E. Child-rearing history, marital quality, and maternal affect: Intergenerational transmission in a low risk sample. *Development and Psychopathology* 1989;1:291–304.

- Budd KS, Felix ED, Poindexter LM, Naik-Polan AT, Sloss CF. Clinical assessment of children in child protection cases: An empirical analysis. *Professional Psychology, Research and Practice* 2002;33:3–12.
- Budd KS, Felix ED, Sweet SC, Saul A, Carleton RA. Evaluating parents in child protection decisions: An innovative court-based clinic model. *Professional Psychology, Research and Practice* 2006;37:666–675.
- Chaffin M, Kelleher K, Hollenberg J. Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse & Neglect* 1996;20:191–203. [PubMed: 8734549]
- Children's Medical Services, The Florida Department of Health. Child Protection Team homepage. 2007. Retrieved October 13, 2007 from <http://www.cms-kids.com/CPTHome.htm>
- Connell CM, Bergeron N, Katz KH, Saunders L, Tebes JK. Re-referral to child protective services: The influence of child, family, and case characteristics on risk status. *Child Abuse & Neglect* 2007;31:573–588. [PubMed: 17537504]
- Crouch JL, Milner JS, Thomsen C. Childhood physical abuse, early social support, and risk for maltreatment: Current social support as a mediator of risk for child physical abuse. *Child Abuse & Neglect* 2001;25:93–107. [PubMed: 11214816]
- Drake B, Johnson-Reid M, Way I, Chung S. Substantiation and recidivism. *Child Maltreatment* 2003;8:248–260. [PubMed: 14604173]
- The Florida Department of Children and Families. DCF performance measures. 2007. Retrieved October 13, 2007 from http://dcfdashboard.dcf.state.fl.us/index.cfm?page=menu_pbb
- Heller SS, Larrieu JA, D'Imperio R, Boris NW. Research on resilience to child maltreatment: Empirical considerations. *Child Abuse & Neglect* 1999;23(4):321–338. [PubMed: 10321770]
- Jent JF, Dandes S, Merrick M, Rankin MJ. The Child Protection Team Coding Manual. Unpublished manuscript. 2006
- Kotch JB, Browne DC, Dufort V, Winsor J, Catellier D. Predicting child maltreatment in the first 4 years of life from characteristics assessed in the neonatal period. *Child Abuse & Neglect* 1999;23:305–319. [PubMed: 10321769]
- Lau AS, McCabe KM, Yeh M, Garland AF, Hough RL, Landsverk J. Race/ethnicity and rates of self-reported maltreatment among high-risk youth in public sectors of care. *Child Maltreatment* 2003;8:183–194. [PubMed: 12934635]
- Marshall DB, English DJ. Survival analysis of risk factors for recidivism in child abuse and neglect. *Child Maltreatment* 1999;4:287–296.
- Melton, SM.; Petrila, J.; Poythress, NG.; Slobogin, C. Psychological evaluations for the courts: A handbook for mental health professionals and lawyers. 3. New York: Guilford Press; 2007.
- Morton TD. The increasing colorization of America's child welfare system: The overrepresentation of African-American children. *Policy & Practice of Public Human Services* 1999;57:23–30.
- Myers, JE.; Berliner, L.; Briere, J.; Jenny, CC.; Hendrix, T.; Reid, T. The APSAC handbook on child maltreatment. 2. Thousand Oaks, CA: Sage Publications, Inc; 2002.
- Perry R, Limb GE. Ethnic/racial matching of clients and social workers in public child welfare. *Children and Youth Services Review* 2004;26:965–979.
- Schuck AM. Explaining Black–White disparity in maltreatment: Poverty, female-headed families, and urbanization. *Journal of Marriage and Family* 2005;67:543–551.
- Sidebotham P, Golding J. The ALSPAC Study Team. Child maltreatment in the “Children of the Nineties”: A longitudinal study of parental risk factors. *Child Abuse & Neglect* 2001;25:1177–1200. [PubMed: 11700691]
- Sidebotham P, Heron J. Child maltreatment in the “children of the nineties”: A cohort study of risk factors. *Child Abuse & Neglect* 2006;30:497–522. [PubMed: 16701895]
- Sprang G, Clark JJ, Bass S. Factors that contribute to child maltreatment severity: A multi-method and multidimensional investigation. *Child Abuse & Neglect* 2005;29:335–350. [PubMed: 15917076]
- State of Florida Department of Children and Families. Family safety and preservation allegation matrix. 1998. Retrieved October 13, 2007 from <http://www.dcf.state.fl.us/publications/policies/175-28.pdf>

- Sullivan PM, Knutson JF. Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect* 2000;24:1257–1273. [PubMed: 11075694]
- United States Department of Health and Human Services, Administration on Children Youth and Families. *Child maltreatment 2004*. Washington, D.C: Government Printing Office (US); 2006.
- Wolfteich P, Loggins B. Evaluation of the children's advocacy center model: Efficiency, legal and revictimization outcomes. *Child and Adolescent Social Work Journal* 2007;24:333–352.
- Wood JM. Risk predictors for re-abuse or re-neglect in a predominantly Hispanic population. *Child Abuse & Neglect* 1997;21:379–389. [PubMed: 9134266]
- World Health Organization. Report of the consultation on child abuse prevention. Geneva, Switzerland: 1999 Mar.
- Wu SS, Ma C, Carter RL, Ariet M, Feaver EA, Resnick MB, et al. Risk factors for infant maltreatment: A population-based study. *Child Abuse & Neglect* 2004;28:1253–1264. [PubMed: 15607768]

Table 1

Demographics of reports by evaluation type ($N=845$).

Characteristics of target child	Total sample ($n=845$)	Specialized interview only ($n=99$)	Specialized and other interview(s) ($n=69$)	Specialized and medical exam ($n=591$)	Specialized, other interview(s), and medical exam ($n=77$)
Age- M (SD)	7.6 (4.5)	8.80 (4.73)	9.04 (4.04)	7.19 (4.56)	7.27 (3.46)
Gender (%)					
Male	47.2	43.4	29.0	53.5	22.1
Female	52.8	56.6	71.0	46.5	77.9
Race/ethnicity (%)					
Black or African-American	37.5	27.3	17.4	36.4	31.2
Hispanic	24.7	26.3	21.7	25.5	20.8
Caucasian	33.9	43.4	58.0	28.9	41.6
Asian American	1.2	1.0	0.0	1.0	0.0
Other	2.7	2.0	2.8	8.1	6.5
Type of alleged maltreatment (%)					
Physical abuse	52.4	18.2	1.4	68.7	20.8
Sexual abuse	19.6	35.4	72.5	7.4	46.8
Emotional abuse	0.5	2.0	1.4	0.2	0.0
Threatened harm due to DV	1.1	6.1	1.4	0.2	0.0
Neglect	4.4	4.0	0.0	4.7	5.2
Multiple maltreatment	22.0	34.3	23.2	18.8	27.3
Prior allegations- M (SD)					
Total prior reports	1.63 (2.45)	1.55 (2.11)	1.70 (2.03)	1.62 (2.57)	1.73 (2.22)
Total prior substantiated reports	0.51 (1.09)	0.32 (0.73)	0.39 (0.65)	0.56 (1.19)	0.58 (1.01)

Table 2

Findings cited in reports by evaluation type ($N=845$).

Findings (%)	Total sample ($n=845$)	Specialized interview only ($n=99$)	Specialized and other interview(s) ($n=69$)	Specialized and medical exam ($n=591$)	Specialized, other interview(s), and medical exam ($n=77$)
Client behavior	25.4	37.4	20.3	24.4	22.1
Limitations cited	9.2	14.1	14.5	7.6	11.7
Cultural/ethnic/language barriers	2.0	3.0	1.4	1.9	2.6
Parent comprehension	0.1	0.0	0.0	0.0	1.3
Emotional stresses	3.0	4.0	4.3	2.5	3.9
External factors	4.3	6.1	4.3	3.4	7.8
Interview conclusions qualified	5.1	2.0	13.0	4.1	10.4
Medical conclusions qualified	4.7	N/A	N/A	5.1	12.0
Predictions/interpretations qualified	9.2	11.1	7.2	9.1	9.1
Other	5.2	9.1	8.7	3.4	10.4
Case disposition (%)					
Maltreatment verified	43.0	33.3	39.1	41.5	57.2
Some indicators of maltreatment	17.2	25.2	21.7	15.3	16.9
Maltreatment not indicated	39.9	41.5	39.1	43.3	26.0
Identified risk and protective factors- M (SD)					
Risk factors cited	5.7 (3.2)	5.40 (3.00)	5.55 (3.00)	5.62 (3.14)	6.84 (4.12)
Protective factors cited	1.5 (1.7)	1.98 (1.78)	0.88 (1.22)	1.49 (1.67)	0.83 (1.31)

Table 3

Reports offering recommendations by evaluation type (N=845).

Recommendations cited (%)	Total sample (n=845)	Specialized interview only (n=69)	Specialized and other interview (s) (n=69)	Specialized and medical exam (n=591)	Specialized, other interview(s), and medical exam (n=77)
Any recommendation	92.1	94.9	92.8	91.5	93.5
Therapy or counseling	60.9	69.4	81.2	54.2	90.5
Specific	54.4	59.6	66.7	49.2	74.0
Recommendation					
Parent training	38.3	23.7	20.3	44.7	33.3
Specific	27.7	11.1	5.8	34.7	18.2
Recommendation					
Substance abuse treatment	3.5	5.2	3.0	3.3	5.6
Support groups	4.7	3.0	8.7	3.9	9.1
Vocational/educational services	0.9	2.0	2.9	0.7	0.0
Homemaker services	0.8	0.0	0.0	1.0	0.0
Custody related	20.1	21.2	20.3	18.8	28.6
Recommendation					
Removal of child	6.7	5.1	2.9	7.4	5.2
Removal of parent	13.7	17.2	24.6	9.0	36.4
Additional assessments	26.7	30.3	34.8	22.7	44.2
Random drug testing	3.8	8.1	1.4	3.4	3.9
Family court intervention	4.9	1.0	8.7	4.9	3.9
Other recommendation	52.0	44.4	56.5	52.5	57.1