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A Systematic Assessment for Potential Compassion Fatigue Among CPS Workers in West Texas

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ABSTRACT

Working in child welfare is a career that frequently exposes staff to trauma. Child welfare staff routinely witness the worst types of harm to children including extreme physical abuse, drug exposed children, children who have been repeatedly sexually abused, and even child fatalities. The impact of these repeated exposures is an emerging area of study. The effect of witnessing trauma is often referred to as compassion fatigue or secondary trauma. The focus of this study is to review current literature that deals with the issues of compassion fatigue in child welfare staff and compare the findings in hopes of identifying reoccurring recommendations and identifying areas for future research. This systematic review examines five previously published studies on compassion fatigue, burnout, and secondary trauma in child welfare. This study resumes where a previous study by McFadden, Campbell, and Taylor concluded. Of the five studies included in this review, there were no new findings. The findings of each study were aligned, not only with each other but also with a previous review conducted by McFadden, Campbell, and Taylor and one by West, both conducted in 2015. It does not appear that the Texas Department of Family and Protective Services has taken note of the problem of compassion fatigue and how it effects staff. This failure to respond to the problem has resulted in numerous problems for the agency, including the recent staffing crisis, the decision to lower the requirements for new hires within the agency, and the Children's Right Lawsuit and subsequent ruling against the Texas Department of Family

and Protective Services. If agencies are going to be successful at having healthy workers caring for children then the issue of compassion fatigue must be addressed, and soon.

A Systematic Assessment for Potential Compassion Fatigue Among CPS Workers in
West Texas

A Thesis

Presented to

The Faculty of the Graduate School of Social Work

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In Partial Fulfillment

Of the Requirements for the Degree

Master of Science

In Social Work

By

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CHAPTER I

INTRODUCTION

The problem of child abuse and neglect has always existed and presents itself in many ways in virtually every society. Bingham, Delap, Jackson, and Settle (2015) report that during the early 20th century the British response to child sexual abuse, in one of the world's most advanced societies, was to not mention the abuse due to "the desire to avoid scandal, downplay harm and blame the victim" (p. 45). It was believed "an additional factor that led to lighter sentences was the tendency to blame children for having invited or elicited sexual advances" (p. 46). In the United States one of the earliest documented cases of child abuse was in the late 1800s involving Mary Ellen Wilson in New York City. Mary Ellen Wilson was severely abused and neglected by her foster parents. After great effort by a concerned individual, the New York Society for the Prevention of Cruelty to Children was established in 1874 (Shelman & Lazoritz, 2003).

Today in the United States we have very clear and specific measurements to clarify what is and is not abuse. The Centers for Disease Control (2015) identifies child maltreatment as "all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role (e.g., clergy, coach, teacher)" (para. 1)." The CDC goes on to identify four different types of abuse or maltreatment. The four types of abuse or maltreatment include physical abuse, sexual abuse, emotional abuse, and neglect. The Texas Department of Family and Protective Services (2016) has identified additional standards of abuse and maltreatment to include medical neglect,

physical neglect, abandonment, refusal to accept parental responsibility, sex trafficking, and labor trafficking.

Abuse and maltreatment have been associated with multiple social problems within our society. Fang, Brown, Florence, and Mercy (2012) report that in 2008, there were 579,000 substantiated cases of nonfatal child maltreatment and 1,740 cases of fatal child maltreatment, which resulted in a total economic burden of \$124 billion. They further report, “compared with other health problems, the burden of child maltreatment is substantial” (p. 163). They further identify indirect cost of child maltreatment as

lifelong adverse health, social, and economic consequences for survivors, including behavioral problems, mental health conditions such as posttraumatic stress disorder, increased risk for delinquency, adult criminality and violent behavior, increased risk of chronic diseases, lasting impacts or disability from physical injury, reduced health-related quality of life, and lower levels of adult economic well-being (p. 157).

The impact of trauma to those outside agency personnel who have been tasked with protecting victims of child abuse is one of the lesser known problems caused by the child abuse epidemic. Figley (1995) identifies this as “the cost to caring” and further suggests that “professionals who listen to clients’ stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care” (p. 1).

Those who do this type of work day in and day out pay a high price to care for those who are the victims of abuse or neglect. The price includes issues such as weight loss or weight gain, sleeplessness, depression, intrusive thoughts, hypervigilance, and a whole host of other physical, mental, and emotional problems. There have been

numerous works dedicated to issues such as compassion fatigue, secondary trauma, and worker burnout (Fowler, 2015; Knight, 2010; Ledoux, 2015; Lizano & Barak, 2015; Sacco, Ciurzynski, Harvey, & Ingersoll, 2015; Sprang, Craig, & Clark, 2011). The questions to be answered include: How is compassion fatigue identified? How does it differ from other trauma related conditions such as secondary trauma, vicarious trauma, and worker burnout? How is it treated? The last question to be answered is how compassion fatigue affects workers, particularly child welfare staff, due to the particular circumstances faced by child welfare staff.

CHAPTER II

LITERATURE REVIEW

Definition of Compassion Fatigue

Figley (1995) suggests that, “Professionals who listen to clients’ stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care. Sometimes we feel we are losing our sense of self to the clients we serve.” (p. 1). Stamm (1997) also notes “the great controversy about helping-induced trauma is not ‘Can it happen?’ but ‘what shall we call it?’” (p. 1).

All helping professions, including law enforcement, first responders, mental health workers, nurses, teachers, and others who deal directly with trauma, are affected by compassion fatigue. These are all career fields that involve a great deal of stress that can be physically and emotionally taxing. School teachers are forced to interact daily with children who come to school from all types of home backgrounds, many of which include abuse and neglect. Teachers’ responsibilities do not change regardless of the number of students in the class suffering from some type of trauma. Teachers are applauded as being parental figures to the children they teach. With that in mind, it is easy to make the correlation between a child’s trauma and the impact it has on the teacher.

Mental health professionals interact daily with people who are not aware of their own mental health challenges and who often become combative when their delusions, hallucinations, or other faulty beliefs are challenged. Nurses who work in hospice settings

face the reality of death numerous times during their shifts. Nurses who work in emergency room departments also face challenges as they see critical patients and are tasked with assessing their needs and acting quickly to ensure they get the proper care. The Big Country Homepage (Garner, 2016) recently covered a local story in which a newborn infant was found murdered in her home. It is believed that the child, who was born in the home, was murdered by her mother, father, or both, and then disposed of in the home. Situations like these are not uncommon for first responders such as paramedics, fire fighters, and law enforcement. Child welfare staff are no exception to repeatedly seeing trauma.

When looking at the phrase *compassion fatigue*, it is important to understand each term individually in order to fully comprehend the meaning. Compassion, as defined by Merriam Webster (2016), is “sympathetic consciousness of others' distress together with a desire to alleviate it” (para 2). Webster also notes the simple definition of “a feeling of wanting to help someone who is sick, hungry, in trouble, etc.” (para. 1). Fatigue is defined as “weariness or exhaustion from labor, exertion, or stress” (para 2) or “the state of being very tired; extreme weariness” (para 1). When combining the two terms it is easy to understand that compassion fatigue is a feeling of tiredness or exhaustion that is the result of caring for others. Exploring the term more deeply, it is easy to recognize that fatigue can go beyond a physical feeling of exhaustion. Rather, it is a physical, mental, social, emotional, and psychological exhaustion that is a result of caring for and showing compassion to those individuals who are experiencing trauma. The idea that one can care too much is not uncommon in those who struggle with compassion fatigue.

Other Trauma-Related Conditions

The study of trauma has recently become a more widely known area of inquiry. This is partly due to the increased media coverage of traumatic events such as wars, mass casualties, terrorism, natural disaster, and many other things. This area of study has been identified as traumatology, which Kurtz (2008) defines as “a field of study and treatment of physical and psychosocial wounds and injuries caused by events (natural, or human-caused) that are fear-inducing and/or stressful” (para.20).

One of the most well-known conditions related to traumatology is post-traumatic stress disorder. This condition has received emphasis recently in relation to war veterans and military personnel. According to the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (2013), individuals diagnosed with posttraumatic stress disorder must meet eight different criteria. The diagnostic criteria are outlined in Table 1. It is important to note that the diagnostic criteria A4 specifically focuses on the exposure of professionals to trauma.

Table 1

Posttraumatic Stress Disorder

<p>A. exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:</p> <ol style="list-style-type: none"> 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others. 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). <p>Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.</p> <p>B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:</p> <ol style="list-style-type: none"> 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). <p>Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.</p> <ol style="list-style-type: none"> 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). <p>Note: In children, there may be frightening dreams without recognizable content.</p> <ol style="list-style-type: none"> 3. Dissociate reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) <p>Note: In children, trauma-specified reenactment may occur in play.</p> <ol style="list-style-type: none"> 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). 5. Marked psychological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). <p>C. as evidenced by one or both of the following:</p> <ol style="list-style-type: none"> 1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
 1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
 4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
 5. Markedly diminished interest or participation in significant activities.
 6. Feelings of detachment or estrangement from others.
 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
 1. Irritable behavior and angry outburst (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects.
 2. Reckless or self-destructive behavior.
 3. Hypervigilance.
 4. Exaggerated startle response.
 5. Problems with concentration.
 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the psychological effects of a substance (e.g., medication, alcohol) or another medical condition.

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed; pp. 271-272). Washington, DC: APA

It is important to note that although the DSM-5 criteria for posttraumatic stress disorder include exposure to secondary trauma, there is no separate diagnosis for secondary traumatic stress.

Figley (1995) defines secondary traumatic stress as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress resulting from helping or wanting to help a traumatized

or suffering person” (p. 7). Figley further reports that secondary traumatic stress can be compared to other parallel phenomena such as a father mimicking signs of a woman’s pregnancy or spouses feeling the same illnesses as their partner. When you are in close relationship with someone their joys often become your joys, but likewise, their hurts become yours also.

Figley (1995) discusses the differences and similarities between primary and secondary traumatic stress. The stressors, re-experiencing trauma events, avoidance or numbing of reminders, and persistent arousal, for both primary and secondary traumatic stress are very similar. Figley (1995) identifies stressors for primary traumatic stress as “serious threat to self or sudden destruction of one’s environs” whereas secondary traumatic stress stressor includes “serious threat to traumatized person and sudden destruction of traumatized person’s environs” (p.7). The main difference between primary and secondary traumatic stress is that with primary traumatic stress the trauma occurred to the individual who is experiencing the traumatic stress, while with secondary traumatic stress the trauma occurred to another individual who is close to the individual who is experiencing the traumatic stress. There are several terms that are inter-related and each describes secondary trauma conditions. These terms include compassion fatigue, vicarious trauma, worker burnout, and secondary traumatic stress.

Stamm (2005) identifies compassion fatigue or vicarious trauma as work related, secondary exposure to extremely stressful events, as cited in Van Hook and Rothenberg (2009). McCann and Pearlman (1989) describe vicarious traumatization as “an accumulation of memories of clients’ traumatic material that affects and is affected by the therapist’s perspective of the world” (as cited in Figley, 1995). Diaconescu (2015)

defines secondary or indirect traumatization as “the deeply negative transformation of professionals in the area of cognitions and fundamental beliefs about the world when they involve themselves empathically repeatedly with clients who report traumatic experiences” (p. 59). Each of these terms focuses on how compassion fatigue is developed. Compassion fatigue is the end result while secondary trauma and vicarious trauma are each aspects of how compassion fatigue is developed.

Another term used to discuss trauma is burnout. Stamm (2010) demonstrates that compassion fatigue is the result of burnout and secondary trauma. Figure 1 demonstrates Stamm’s viewpoint on how professional quality of life is dependent on the balance of compassion fatigue and compassion satisfaction. Professional quality of life is “the quality one feels in relation to their work as a helper” (p. 8). In order to have professional quality of life, there must be an appropriate balance of compassion satisfaction, which is “the positive feelings about people’s ability to help” (p. 8), and compassion fatigue. Like most situations there must be a balance between negative and positive otherwise people can suffer physically, mentally, socially, emotionally, and psychologically. Stamm further reports:

“The negative effects of providing care are aggravated by the severity of the traumatic material to which the helper is exposed, such as direct contact with victims, particularly when the exposure is of a grotesque and graphic nature. The outcomes may include burnout, depression, increased use of substances, and symptoms of posttraumatic stress disorder.” (p. 8).

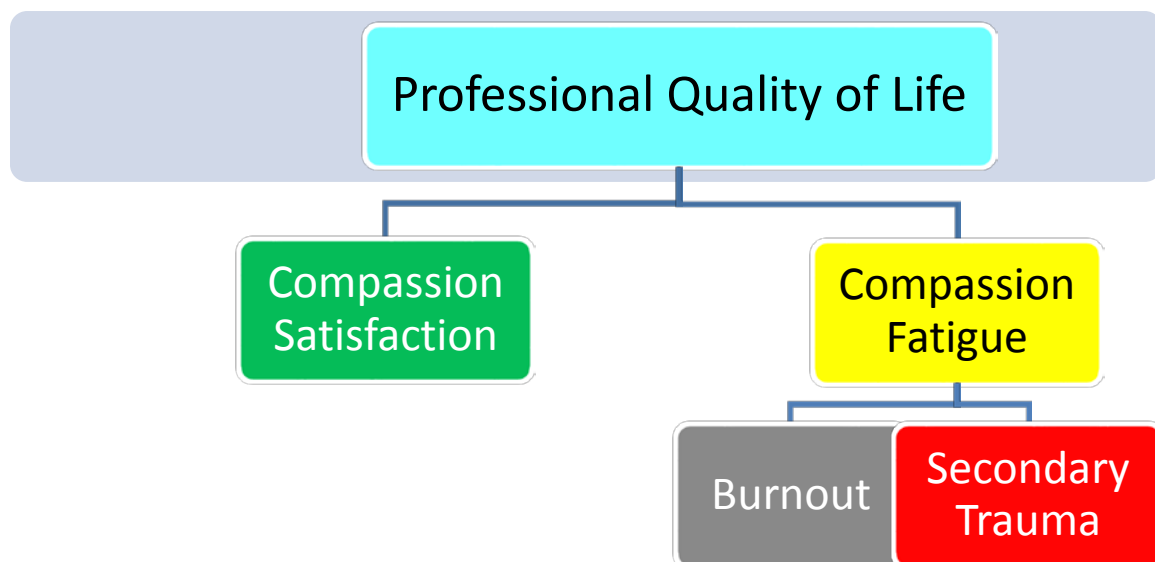


Figure 1. Professional Quality of Life. *Source:* Stamm (2010).

One tool used to identify the level of professional quality of life is the Professional Quality of Life Scale (ProQOL) Compassion Satisfaction and Compassion Fatigue Version 5 (see Appendix A). Stamm (2010) describes this tool as “the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events” (p. 12). While the ProQOL is not a diagnostic test, it can be helpful as “a guide in regard to an individual’s or organization’s balance of positive and negative experience related to doing either paid or volunteer work” (p. 19).

Conrad and Keller-Guenther (2006) believe that although compassion fatigue and burnout are similar problems, compassion fatigue is vastly different in the fact that it can occur as the result of one single exposure to trauma. In their study, Conrad and Keller-Guenther use the Compassion Satisfaction/Fatigue Self-Test for Helpers that was developed by Figley and Stamm in 1996. They quote Figley and Stamm by stating compassion fatigue is “the symptoms of work-related PTSD” and burnout is “feeling

hopeless and unwilling to deal with work” (p. 1075). Sprang, Clark and Craig (2011) report burnout as being “the result of nontraumatic but stressful work conditions such as long hours and overwhelming workload, and typified by symptoms of emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment” (p. 151). Burnout can come as a result of other work-related stress that does not involve the burden of dealing with others traumatic experiences.

Effects of Compassion Fatigue

There have been numerous studies on the impact of trauma on a person’s mental and physical health. Secondary trauma also impacts physical and mental well-being. Many studies have found that the effects of secondary trauma are very similar to post-traumatic stress disorder. Compassion fatigue is closely related to secondary trauma so one could conclude that there are also implications to one’s well-being as a result of compassion fatigue.

Cerney (1995) reports that people suffering from compassion fatigue deal with problems such as sadness and depression, insomnia, anxiety, psychic overload, loss of objectivity, nightmares, and intrusive thoughts. The problem of compassion fatigue affects each individual differently. The issue of compassion fatigue has become such a widely known problem that many fields of study, including nursing, mental health, social work, and even the legal field, have dedicated studies and literature on the issue.

Child Welfare Organization

In the state of Texas the process of reporting and investigating allegations of child abuse and neglect can be a complex process. In order to better understand the data, it is imperative that one understands the process. Once someone suspects abuse or neglect of a

child, a report is made to the state-wide hotline, either online or by phone. Texas law requires reports of abuse or neglect be made by individuals who suspect abuse or neglect of a child or an elderly person. The Texas Family Code outlines who should report and when reports should be made (Appendix A).

The report is taken by a hotline worker who then determines if the report meets the criteria for abuse or neglect as set forth by the Texas Department of Family and Protective Services including physical abuse, sexual abuse, emotional abuse, medical neglect, physical neglect, neglectful supervision, refusal to accept parental responsibility, or abandonment. If the report meets the criteria, the case is sent to the local region in which the family resides.

In Texas there are 11 different regions. Abilene, Taylor County, Texas is in the part of the state identified as Region 02. Other counties in Region 02 include Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Kent, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stephens, Stonewall, Throckmorton, Wichita, Wilbarger, and Young. Figure 2 shows the Texas Department of Family and Protective Services Regions, and Figure 3 shows the counties that constitute Region 02.

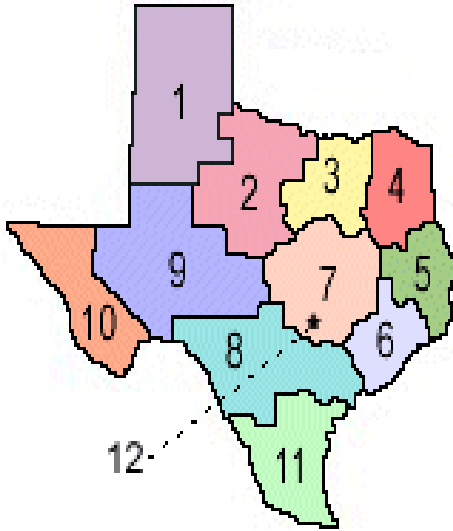


Figure 2. Texas regions. Source: Texas Department of Family and Protective Services DFPS Offices. (2016). Retrieved from https://www.dfps.state.tx.us/contact_us/map.asp



Figure 3. Texas Region 02 counties. Source: Texas Department of Family and Protective Services Region 02 Counties. (2016). Retrieved from <https://www.dfps.state.tx.us/images/maps/counties/region02.gif>

Reports are investigated and the investigation staff are tasked with determining a disposition of either reason to believe, ruled out, unable to determine, or unable to complete. Once the disposition has been determined the investigation staff must also determine what, if any, safety and risk factors are in the home. If there are safety and risk factors that would lead the investigation staff to believe that abuse or neglect will likely occur again in the future, then protective services can be started. In Texas there are both family preservation and family substitute care services available for families.

Family preservation services are offered in an attempt to work with the family on identified issues while the family remains together. The child or children can remain in the parents' home with safety measures in place or can be voluntarily placed outside of the home with family or friends.

Family substitute care services are offered after it has been determined that the child or children are no longer safe in the home and they have been legally removed and placed in substitute care. Family substitute care is often referred to as the foster care system. At that time the Department of Family and Protective Services has legally intervened and been appointed as the temporary managing conservator of a child. After a child has been placed in the temporary managing conservatorship of the Department of Family and Protective Services, a time-clock is started. The Texas Family Code mandates that these types of cases be resolved within 1 year from the date the child was taken out of the parents' home. The Texas Family Code does allow for a one-time extension for no more than 6 months if the courts determine that extenuating circumstances are present. At the end of those 12 or 18 months a dismissal date is set. The dismissal date is the final date the case can stay open under a temporary order. Prior to reaching the dismissal date

of a case, a final order must be rendered by the courts or a trial must have begun. If a final order is not rendered and a final trial has not commenced, then the case is dismissed by operation of the law. This is outlined in section 263.401 of the Texas Family Code as seen in Appendix B.

The possible resolutions in these cases can include a return to either parent, termination of parental rights, permanent managing conservatorship to the Department or permanent managing conservatorship to another individual such as a family member, friend, or even foster parent. Individuals who had a pre-existing relationship with the child or children prior to them entering the Texas Department of Family and Protective Services care can be eligible for benefits for the child or children through the Permanency Care Assistance Program. In order to qualify for the program the family or individual must become a licensed foster home for the child or children, have the child or children in their home as a licensed foster placement for 6 consecutive months, and sign a permanency care agreement prior to being awarded permanent managing conservatorship.

The courts, attorneys, and Department of Family and Protective Services determine which resolution would be in the child or children's best interest and present a case to either the judge or a jury to determine the final order in a case. After a final order is rendered the time-clock stops and the Department works to ensure that legal permanency for the child or children occurs as soon as possible either through adoption or permanent conservatorship to an individual. The Texas Department of Family and Protective Services handbook section 6211 identifies permanency as "the term used to refer to a child exiting from DFPS care into an appropriate, permanent setting" (para. 1).

National Data

National data are available through the United States Health and Human Services Commissions Administration for Children and Families. The Administration for Children and Families (ACF) website (2015) documents its mission: “To foster health and well-being by providing federal leadership, partnership and resources for the compassionate and effective delivery of human services” (para. 2). Under the guidance of ACF, the Children’s Bureau was created.

According to the Children’s Bureau website (2015), the bureau Partners with federal, state, tribal and local agencies to improve the overall health and well-being of our nation’s children and families. With an annual budget of almost \$8 billion, the Children’s Bureau provides support and guidance to programs that focus on: strengthening families and preventing child abuse and neglect, protecting children when abuse or neglect has occurred, and ensuring that every child and youth has a permanent family or family connection. (para. 1)

The Child’s Bureau is responsible for the annual child maltreatment report. This report is created using data provided by individual states on child abuse and neglect.

In response to the 1988 amendments to the Child Abuse and Prevention and Treatment Act (CAPTA), the National Child Abuse and Neglect Data System (NCANDS) was created. The NCANDS website (2015) describes its purpose: “to collect and analyze data on child abuse and neglect known to child protection services agencies in the United States” (para. 1). Each year data are submitted by states and the annual report is created and available on the Children’s Bureau website. Data are submitted from each of the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico.

The Child Maltreatment Report (2013) has information reported by individual agencies for the time period of October 12, 2012 through September 30, 2013. For federal fiscal year (FFY) 2013, there were 52 states that provided data. States include the District of Columbia and the Commonwealth of Puerto Rico. According to the report, the estimated child population is 74,399,940. CPS agencies received an estimated 3.5 million referrals that involved approximately 6.4 million children. This reflects an increase of 11.6% from 2009. According to the report, of those 3.5 million referrals, only an estimated 39% were screened out, which left 2.1 million reports that received a response from the local CPS agency. The report also indicates there were an estimated 679,000 confirmed victims. This reflects a rate of 9.1 victims per 1,000 children. This is a 3.85% decrease from 2009. Child Maltreatment further suggests “the effects of child abuse and neglect are serious, and a child fatality is the most tragic consequence” (p. 54). There were 1,484 child fatalities reported in the 2013 Child Maltreatment Report but the report also notes that nationally there were an estimated 1,520 children who died as a result of abuse or neglect. The difference between these numbers is due to the Child Maltreatment Report (2013) reflecting only the 50 states that reported child fatalities versus the estimated number calculated based on all 52 states. The estimated national average was calculated by multiplying the national fatality rate by the child population for all 52 states and dividing by 100,000. This results in the death rate being 2.04 per 100,000 children in the population. The child fatality rate decreased by 12.7% from 2009. Child Maltreatment reported there were 395,000 confirmed victims of child abuse that received post-response services in the form of either in-home services or foster care services. Of those 395,000 children, 144,000 received foster care services while 251,000 received in-home services.

Texas Data

According to the Texas Department of Family and Protective Services public annual report (2014) for fiscal year 2014, the total state child population was 7,266,760. The total child population of Taylor County was 33,477.

The annual report (2014) shows that Taylor County had 2,316 of the initial intakes alleging abuse or neglect out of the 254,276 reported for the state. For the state of Texas there were 168,164 completed investigations. 40,369 (24%) were confirmed findings of abuse or neglect. Of the remaining 127,795 (76%) unconfirmed investigations completed, 107,797 were ruled out, 16,622 were unable to determine, and 3,376 were unable to be completed. In Taylor County 1,579 of the 2,316 intake reports were actually investigated. Of those 1,579 investigations completed in Taylor County, 530 (33.6%) were confirmed findings of abuse or neglect. Of the remaining 1,049 (66.4%) unconfirmed investigations completed, 910 were ruled out, 123 were unable to determine, and 16 were unable to be completed. Although a majority of investigations, for the State of Texas as well as Taylor County, were not confirmed findings of abuse or neglect each case required a thorough investigation. Each investigation requires staff to complete face to face contacts, contacts with relevant collaterals, and documentation in the case record.

The annual report (2014) further finds that of the 168,164 investigations completed for the state of Texas, 19,717 were referred for family preservation services and 8,079 were referred for family substitute care. Of the 1,579 investigations completed in Taylor County 325 were referred for family preservation services and 91 were referred for family substitute care.

During the period reviewed there were 46,823 children under the legal responsibility of the Department of Family and Protective Services for the entire state of Texas. Of those children, 361 were identified as being from Taylor County.

The annual report (2014) identified that 16,912 children were reported as exiting the Department of Family and Protective Services' legal care for the state of Texas. Of those children, 5,192 were reunified with their mother, father, or both through family reunification, 601 were exited through custody being given to a family member or fictive kin through the Permanency Care Assistance program, 4,488 were exited through custody being given to a family member or fictive kin without the aid of the Permanency Care Assistance Program, 2,647 were exited through adoption by a non-relative, 2,528 were exited through adoption by a relative, 1,246 were emancipated, and 210 were listed as other exit.

According to the annual report (2014), Taylor County had 110 children who exited the Department of Family and Protective Services' legal care. Of those 110, 47 were reunified with their mother, father, or both through family reunification, 9 were exited through custody being given to a family member or fictive kin through the Permanency Care Assistance program, 19 were exited through custody being given to a family member or fictive kin without the aid of the Permanency Care Assistance Program, 12 were exited through adoption by a non-relative, 12 were exited through adoption by a relative, 10 were emancipated, and 1 was listed as other exit.

These high numbers make working with the children and families very difficult. The annual report (2014) identified the turnover rate in DFPS as 25.2%. In 2014, 34.5% of all staff had less than 1 year experience, while 28% had 1-3 years' experience, and

only 37.5% had more than 3 years' experience. The turnover rate makes it very difficult for remaining staff to successfully complete their job duties, which leads to increased turnover. In 2014 DFPS worked with the Stephens Group to complete a thorough and comprehensive operational assessment, and recommendations were made.

Tavormina and Clossey (2015) suggest continued adherence to the U.S. Department of Health and Human Services, Administration for Children and Families, National Clearinghouse on Child Abuse and Neglect Information manual from 1994 which suggest maintaining a caseload of no greater than 13. According to the Texas Department of Family and Protective Services public annual report (2014) for fiscal year 2014 the average daily caseload for Region 02 was: Investigations 17.6, Family Based Safety Services 19.3 and Substitute Care 30.1. Each of these averages is higher than those of the suggested caseload.

According to the Stephens Group report (2014) "turnover is a complex challenge stemming from poor supervision, workload, rate of pay (particularly in oil-rich areas), unpaid overtime, stress and fear, inconsistent or long hours, inability to achieve an acceptable work/life balance, and unclear career path" (p. 35). All of these issues lead to issues of compassion fatigue due to the unfavorable working conditions.

Impact on CPS Staff

Frequent and reoccurring trauma is often a problem faced by many helping professionals. First responders such as law enforcement, EMTs, and firefighters deal with numerous traumas almost every day in their work. Counselors also deal with trauma on a regular basis. Although counselors may not see their clients daily or have new traumas presented to them frequently throughout their workdays, because of the nature of the

client and counselor relationship those traumas can be difficult for counselors. Child welfare staff are no exception to this theory. Similar to first responders, child welfare staff may see many different traumatic situations during their workday. Also, like a counselor, child welfare staff builds on-going relationships with clients which again exposes them to repetitive trauma.

Diaconescu (2015) references work done in 2011 by H. Yoon and states, “out of the social workers who work with victims of violence, the ones who work in the area of child protection present higher scores on the scale of traumatic stress than the ones who work in the area of adult protection” (p. 59). Conrad and Kellar-Guenther (2006) quote a study completed by Meyers and Cornille in 2002 which reported “37% of child protection services workers practicing in a southern state were experiencing clinical levels of emotional distress associated with secondary traumatic stress” (p. 1073).

Sprang, Craig, and Clark (2011) identified one main reason child welfare staff may become so invested in their work that they develop compassion fatigue, stating “the stakes are high, since these professionals may be the only deterrent to fatal maltreatment for infants and young children” (p. 151). The role of the child protection caseworker is a difficult role to manage. Child protection workers must constantly evaluate the safety of the children and home environment, deal with parents who display a number of emotions and problems, comply with organizational policies and procedures, document all interactions in case records, and report to others involved in cases such as attorneys or guardian ad litem, foster parents, and child placing agency staff members. These are just a short list of the daily tasks assigned to child protection workers.

O'Reilly, Wilkes, and Luck (2014) did a study that focused on the impact of compassion fatigue on child welfare staff who were also parents. Many working parents report family-work conflicts, but those parents working in child welfare seem to experience different levels of family-work conflicts that not only affect their personal and home life but also their role as parents. Issues identified by this study include hypervigilance in parenting, intrusive imagery, inability to maintain appropriate family-work boundaries, inability to have appropriate empathetic responses towards parents of child abuse victims, and questioning of parental practices

CHAPTER III
METHODOLOGY

Search Strategy

This systematic review was conducted based on recommendations made by Miller (2015). In March 2016 the following databases were searched: PsychINFO, Academic Search Complete, Social Work Abstracts, SocINDEX, Family and Society Studies Worldwide, Texas Reference Center, Family Studies Abstracts, CINAHL, and ERIC. An initial search was completed using the identified search terms, which include: “compassion fatigue” OR “secondary trauma” OR “burnout” AND “child abuse” OR “child welfare workers” OR “child protection”.

Inclusion and Exclusion Criteria

To be included references must meet additional criteria of: (1) available electronically, (2) peer-reviewed journal article, (3) published in the English language, and (4) published between January 2013 and March 2016. This systematic review is a continuation of the previous systematic review done in 2015 by McFadden, Campbell, and Taylor. The previous study was accepted for publication in 2013 so in order to be included in this study the articles must have been published from 2013 to present. Abstracts were reviewed for all results that appeared to be relevant, and any that met the criteria were included in the final sample.

CHAPTER IV

RESULTS

Figure 4 is a flow diagram that details the search and screening process. An electronic search completed in March 2016 yielded 50 potential articles. The search completed removed exact duplicates prior to providing search results; however an additional 18 duplicates were removed. Each article was examined for relevance; 27 additional articles were excluded as a result of this examination, leaving 5 articles as the source for this systematic review. Reasons for exclusion varied but included articles that focused on child victims of abuse, child abuse interviewing and assessments, medical problems that result from child abuse, and child abuse therapy. These articles did not present any findings related to child welfare workers or the issue of compassion fatigue.

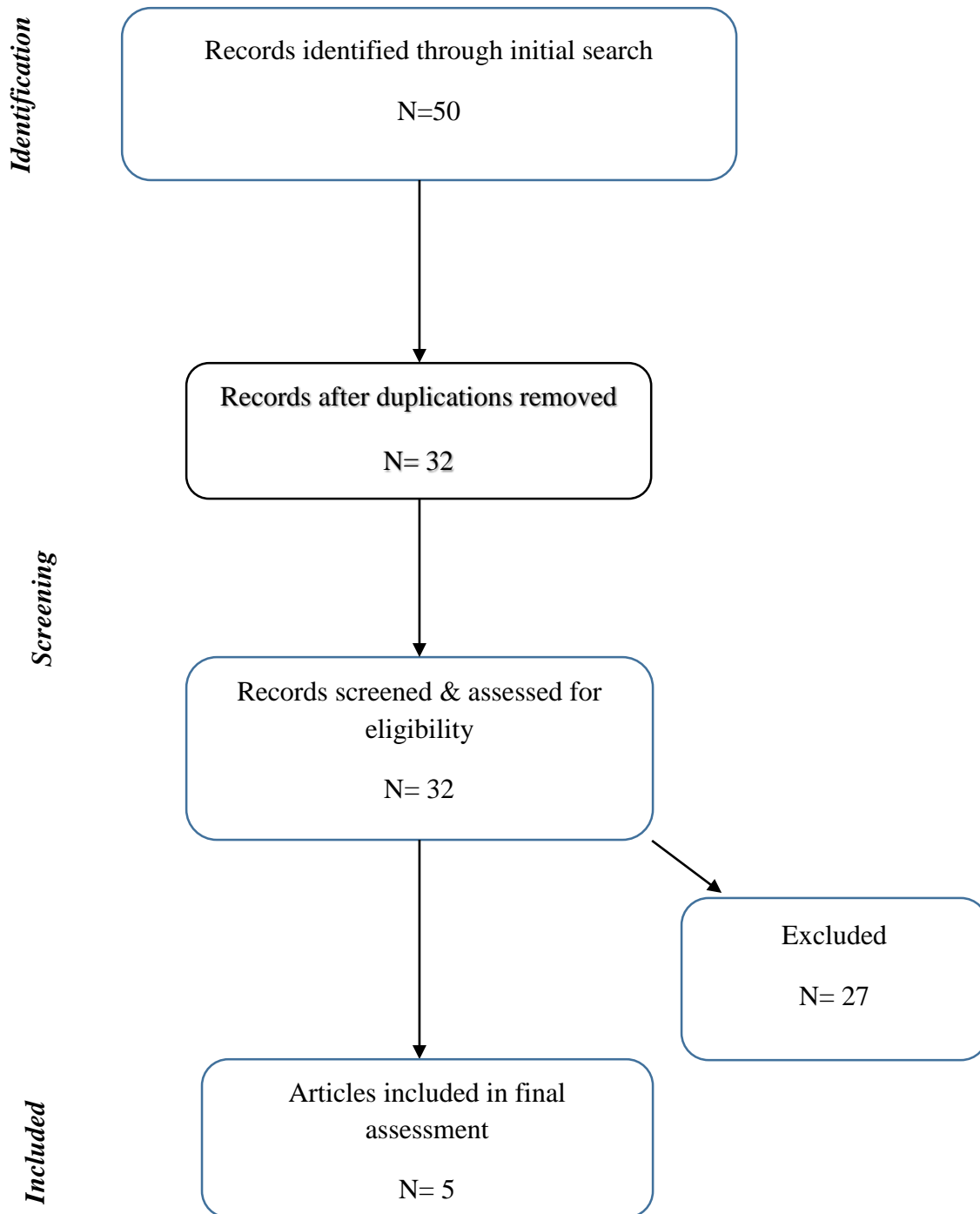


Figure 4. Search results flow diagram.

Description of Studies

Each of the five studies included in this review focused on social workers in the area of child welfare. Studies were published in four different journals including Child Abuse Review, Journal of Evidence-Based Social Work, Child & Family Social Work, and Children and Youth Services Review. Publication dates ranged from 2013 to 2015, which covers dates after a previous systematic review conducted by McFadden, Campbell, and Taylor which was accepted for publication in November 2013. Table 2 provides key information found from each study.

Table 2

Studies of Compassion Fatigue Among Child Welfare Workers

Study ID	Study Author (year)	Participants	Intervention	Measures
S01	Reeves, Drew, Shemmings, & Ferguson (2015)	24 total participants from health centers in southeast England including: 11 control; 5 health visitors; 8 social workers	Monitor implicit emotional responses to 'Rosie 2', a child protection simulation designed to train child protection professionals.	Overall emotional valence score. Calculated as the intensity of happy minus the intensity of the negative emotion with the highest intensity.
S02	Douglas (2013)	385 total participants including: 265 child welfare workers that have never experienced a Child Maltreatment Fatality (CMF) on caseload and 105 child welfare workers who have experienced a CMF on caseload.	Comparison of child welfare workers who have experienced a CMF with those who have not and identify the influence of CMFs on PTS Symptoms.	PST Symptoms measured using the Posttraumatic Stress Disorder Checklist (PCL). The civilian version of the PCL was used. There is no cut-off score to indicate PTSD so the chosen score was 45, which is the same as that used in a study of breast cancer patients.
S03	Tavormina & Clossey. (2015)	12 total participants from public child welfare agencies in a rural region of the United States including: 10 bachelor's level CPS workers and 2 MSW level CPS workers.	Examine child protection workers' perceptions of crisis, methods used when addressing crisis, and personal effects work has on emotional health.	Qualitative inquiry using a grounded theory approach.

S04	Mandell, Stalker, Wright, Frensch, and Harvey. (2013)	Phase 1 had 226 participants from four Ontario child welfare organizations. Subsamples of those workers were included in Phase 2 based on ideal Phase 1 scores. 16 workers were included in Phase 2.	Identify workers who had differing levels of emotional exhaustion (EE) and job satisfaction (JS) and evaluate how individual characteristics impacted outcomes for workers.	Mixed-method. A shortened Workplace Study survey was used during Phase 1. Phase 2 utilized semi-structured qualitative interviews.
S05	Salloum, Kondrat, Johnco, and Olson. (2015)	104 child welfare case managers and supervisors from a private child welfare organization in South Florida including: 85 case managers and 19 supervisors.	Examine the role of Trauma-Informed Self-Care (TISC) on compassion satisfaction, burnout, and secondary trauma.	Professional Quality of Life Version 5 (ProQOL 5) was used to measure burnout, compassion fatigue, and compassion satisfaction. A trauma-informed self-care measurement tool was created to determine trauma-informed self-care strategies.

Samples

Sample sizes ranged from 12 to 385 participants. Three studies included child welfare staff from the United States (S02, S03, S05), while two others included child welfare staff from other locations including Southeast England (S01) and Ontario (S04). Most studies dealt primarily with child welfare caseworkers; however one study (S05) included case workers and supervisors. One study included women only (S03); of the four that did have male participants, all had more female participants than males.

Designs

Each study reviewed had a different research design. One study (S01) looked at implicit emotional responses during a child welfare simulation and measured emotional

valence. Two other studies dealt with measures of post-traumatic stress symptoms, burnout, compassion fatigue, and compassion satisfaction (S02, S 05). One study included only qualitative information (S03), while one was mixed-method and included a quantitative study and a semi-structured qualitative interview (S04).

Findings

Three studies (S02, S04, and S05) focused on measures of compassion fatigue and post-traumatic stress symptoms. Each study found a similar conclusion which is that child welfare staff do suffer from compassion fatigue and post-traumatic stress.

One study (S02) found that 12.5% of the child welfare staff included in the study met the cutoff for post-traumatic stress disorder, which is higher than the rate of 3.5% for the general population.

Another study that focused on measures of compassion fatigue (S04) identified that 35% of the child welfare staff included in the study experienced high levels of emotional exhaustion based on ProQOL measures for compassion fatigue, burnout, and compassion satisfaction. The study further found that 32.7% of participants were in the moderate range and 31.7% were in the low range for emotional exhaustion. 46.3% ranked in the high range for job satisfaction, 37.8% in the moderate range, and 6.7% in the low range. Individuals who ranked high on emotional exhaustion scale and low on job satisfaction scale were described as “overwhelmed, defeated, and out of steam” as well as “not having the capacity to survive these perceived conditions”. Workers in this group “experienced multiple physical effects, including sleeplessness and deterioration in diet and physical fitness, and relatively fewer of the satisfactions”. (p. 388). Those who ranked low emotional exhaustion levels and high job satisfaction levels were able to

identify realistic and attainable objectives. Those with high emotional exhaustion levels and high job satisfaction levels “made statements about putting the job first and being ‘150%-ers’”. (p. 390). It is important to note that each category looked at how emotional exhaustion, which can be compared to compassion fatigue, can co-exist with job satisfaction. When there is a balance between the two it appears those workers are most successful.

The third study dealt with measures of compassion fatigue and post-traumatic stress symptoms (S05). This study “examined the role of trauma-informed self-care on compassion satisfaction, burnout and secondary trauma” (p. 54). Nearly one-third of workers reported high levels of burnout and secondary traumatic stress and low levels of compassion satisfaction based on ProQOL measures. Higher levels of burnout were reported in those with more than one year of child welfare work experience. Self-care methods commonly utilized included requesting & expecting regular supervision & supportive consultation, utilizing peer support, attending regular safety trainings and working with a team within the agency and provider community. The least common utilized methods included attending trainings dedicated to secondary trauma, balancing caseloads, accessing agency support groups such as Employee Assistance Programs, and written plans for work-life balance. The study found that trauma informed self-care was not related to secondary stress.

Additional measures recorded were emotional responses to witnessing abuse or neglect scenarios (S01). This study found that there were higher negative emotions among the control group than the health workers and social workers including health workers showing very little anger (7%) and disgust (3%) while social workers showed

higher proportions of these emotions (18% and 20%). Health workers also expressed more sadness (34%) than social workers (10%). There was no conclusions given as to why there were differences between the health workers and social workers. The control group had elevated proportions of anger (30%) and surprise (39%) during the game than both professional groups, possibly due to professionals' abilities to hide emotional responses. This is an important finding, as Reeves et. al. (2015) report that Conrad and Kellar-Guenther (2006) suggested that burnout is associated with increasing emotional distance from people and situations. Further research is needed to determine how emotional responses impact levels of compassion fatigue and burnout in child welfare workers.

One qualitative study (S03) reported “that crisis in CPS work is omnipresent and ongoing” (p. 8). Additionally it was reported that “workers feel overloaded by the work, and suffer from low morale and frustration over resources, funding and incompetent colleagues” (p. 8). Additional reports include the need for additional training, lower caseloads, and additional support from administrators and community. Additional concerns for workers were that their views of the world and others were compromised to the point that they developed inappropriate coping skills.

Texas Staff and Compassion Fatigue

Texas child protective services staff are not immune to issues other private and public child welfare staff face. If anything, the issues may be intensified due to the constraints placed on state agencies. Some key issues that come up when addressing problems within child welfare organizations include work demands such as high caseloads and long work hours, salary and benefits, and organizational issues such as

policies and procedures. Johnco, Salloum, Olson, and Edwards (2014) identify strategies to address workplace problems including reduce caseloads, provide assistance, increase salary, improve benefits, provide contingent rewards, offer transportation assistance, improve court relations, provide additional training, assist workers in determining priorities, use data to track progress, improve communication, improve hiring practices, and increase the focus on worker safety.

In a study conducted by Van Hook and Rothenberg (2009) it was found that “higher levels of compassion satisfaction were correlated with both lower levels of compassion fatigue/secondary trauma and burnout” (p. 48). Based on these findings it should come as no surprise that in an agency where there is a turnover rate of 25.2%, entry level salaries range from \$32,000-37,000 annually, and workloads are higher than those suggested for successful casework; workers are feeling overwhelmed, underappreciated, and unable to continue. These feelings cause levels of compassion satisfaction to decrease and the levels of compassion fatigue to increase.

CHAPTER V

DISCUSSION

The results of the studies included in this analysis provide compelling evidence that compassion fatigue and its related issues are a very real problem for child welfare staff. Of the five studies included, none present anything to suggest that this is not a problem for child welfare staff, not only in their professional lives but in their personal lives as well. Reeves et al. (2015) believe “research to date on compassion fatigue, burnout, and secondary trauma indicates that there are long- and short- term effects on workers exposed to child protection” (p. 361). Each study examined suggested that compassion fatigue is a real issue for CPS staff and may constitute the need for specialized support.

In addition to the measurable findings in each study, other important information was found. Salloum et al. (2015) report:

Child welfare workers are at a risk of negative emotional outcomes, including burnout and secondary trauma. These symptoms can have detrimental outcomes for the individual workers, the organizations they work for, along with the children and families they work with, making it important to understand the factors that may be protective against these outcomes. (p. 59)

Tavormina and Clossey (2015) recognize that there were limitations to the study conducted, including small sample size, but report:

There are things that are known about CPS that are consistent with these study results, including the multi-problem nature of the families CPS workers deal with, the high level of sense of burnout and vicarious trauma in the field, and the finding that these workers noted how disruptive it is to remove children from their homes. (p. 9)

The problem with compassion fatigue is that while it is an increasing area of study there continues to be discrepancies about what it is. Due to that fact there have not been any clear direction on how to handle it. Add to that the problem of lack of research particular to child welfare staff, there is no way to determine to what extent child welfare staff deal with compassion fatigue and what to do in order to assist workers who do deal with it.

CHAPTER VI

CONCLUSION

The question is not whether compassion fatigue exists in child welfare staff but rather how prevalent is the problem and how does it impact staff. An emerging theme from each study in this review is that it is believed that additional research is needed. Additional research is needed in order to accurately address these issues as well as to determine what implications compassion fatigue has on a person over time. One of the main limitations on studies of compassion fatigue in child welfare staff, primarily dealing with staff in West Texas, is the lack of studies conducted by the agencies designated to handle child welfare cases. In the State of Texas, the Texas Department of Family and Protective Services has attempted to touch on the issue of compassion fatigue by conducting the Sunset Review. This review however, did not include any studies conducted on caseworkers, managers, or support staff within the Texas Department of Family and Protective Services to assess their feelings of compassion fatigue, burnout, secondary trauma, or any other identified issues related to the continued exposure to trauma through their work. The studies included were limited to public and private child welfare agencies in rural United States, south Florida, Ontario, and England. In literature found prior to the period under review, only one study was found on child protection workers (Conrad & Kellar-Guenther 2006). In that study Conrad and Kellar-Guenther (2006) state that “to date there has been little research on the prevalence of secondary traumatic stress among child welfare workers” (p. 1074). While it is clear that state and

county agencies have very strict confidentiality issues to consider when approaching any type of research study, it is imperative that, in order to accurately assess staffs level of compassion fatigue and its implications on practice, studies be done periodically if not regularly.

If state or county agencies are not going to conduct studies on this serious problem then they should at least review the findings of other studies and attempt to implement the suggestions made as a result of those studies. Examples of the suggestions made include specialized crisis intervention training (Tavormina & Clossey, 2015); developing written plans for work-life balance (Sallou et al., 2015); and increasing supervisor support (Douglas, 2013; Mandell et al., 2013).

Right now it does not appear that the Texas Department of Family and Protective Services has taken note of the problem of compassion fatigue and how it affects staff. This failure to respond to the problem has resulted in numerous problems for the agency, including issues with retention. This is evidenced by the recent staffing crisis going on across the state, especially in the Dallas/Fort Worth area. On March 21, 2016, news columnist James Ragland reported:

Here's the alarming reality: The Texas Department of Family and Protective Services, the agency that oversees CPS, has been up to its neck in strife for a long, long time. Even the agency's own workers are fed up with the foster-care system because it over-works them, under-pays them and lays too much blame on them when inevitable problems arise. That's why so many good workers are leaving the agency in droves, aggravating a staffing shortage that leaves many vulnerable kids

in the lurch. The staffing shortage is especially acute in Dallas County, which now has only about one-fifth of its 161 CPS investigator slots filled.

In an attempt to alleviate the staffing crisis, the Texas Department of Family and Protective Services have changed its hiring requirements, and has received severe backlash over the decision to hire non-degreed people. On May 18, 2016 news columnist Robert Garrett wrote,

The move has drawn criticism from former CPS program director Susan McKay, who argued the agency should strengthen educational requirements, not weaken them. McKay told the newspaper it takes at least a master's degree to “understand the underpinnings of the kinds of things that lead to maltreatment of children.

This is a last-ditch, knee-jerk way to resolve a problem that's been building for years,” she said.

Although the idea of bringing in new staff would hopefully alleviate some of the issues that lead to compassion fatigue the concern becomes whether individuals without professional degrees will be able to cope with the issues that are presented to CPS employees on a daily basis. If they are not and they leave the agency it further perpetuates the cycle.

The Texas Department of Family and Protective Services website (2016) identified its vision as follows:

The Texas Department of Family and Protective Services: is recognized for innovative, effective services; builds strong, effective partnerships with clients, communities and state leaders; provides effective leadership that is accountable

for its actions and communicates openly with clients and stakeholders; supports staff who are highly motivated, diverse, ethical, well trained, and professional.

In order for Texas Department of Family and Protective Services to truly attain those ideals set forth in the agency vision, it must recognize the need for further intervention in regards to compassion fatigue among its staff.

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APPENDIX A

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never

2=Rarely

3=Sometimes

4=Often

5=Very Often

- _____ 1. I am happy.
- _____ 2. I am preoccupied with more than one person I [help].
- _____ 3. I get satisfaction from being able to [help] people.
- _____ 4. I feel connected to others.
- _____ 5. I jump or am startled by unexpected sounds.
- _____ 6. I feel invigorated after working with those I [help].
- _____ 7. I find it difficult to separate my personal life from my life as a [helper].
- _____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
- _____ 9. I think that I might have been affected by the traumatic stress of those I [help].
- _____ 10. I feel trapped by my job as a [helper].
- _____ 11. Because of my [helping], I have felt "on edge" about various things.
- _____ 12. I like my work as a [helper].
- _____ 13. I feel depressed because of the traumatic experiences of the people I [help].
- _____ 14. I feel as though I am experiencing the trauma of someone I have [helped].
- _____ 15. I have beliefs that sustain me.
- _____ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
- _____ 17. I am the person I always wanted to be.
- _____ 18. My work makes me feel satisfied.

- _____ 19. I feel worn out because of my work as a [helper].
- _____ 20. I have happy thoughts and feelings about those I [help] and how I could help them.
- _____ 21. I feel overwhelmed because my case [work] load seems endless.
- _____ 22. I believe I can make a difference through my work.
- _____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
- _____ 24. I am proud of what I can do to [help].
- _____ 25. As a result of my [helping], I have intrusive, frightening thoughts.
- _____ 26. I feel "bogged down" by the system.
- _____ 27. I have thoughts that I am a "success" as a [helper].
- _____ 28. I can't recall important parts of my work with trauma victims.
- _____ 29. I am a very caring person.
- _____ 30. I am happy that I chose to do this work.

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APPENDIX B

Texas Family Code, Chapter 261, Subchapter A, Section 261.101

Sec. 261.101. PERSONS REQUIRED TO REPORT; TIME TO REPORT.

(a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter.

(b) If a professional has cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section [21.11](#), Penal Code, and the professional has cause to believe that the child has been abused as defined by Section [261.001](#) or [261.401](#), the professional shall make a report not later than the 48th hour after the hour the professional first suspects that the child has been or may be abused or neglected or is a victim of an offense under Section [21.11](#), Penal Code. A professional may not delegate to or rely on another person to make the report. In this subsection, "professional" means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

(b-1) In addition to the duty to make a report under Subsection (a) or (b), a person or professional shall make a report in the manner required by Subsection (a) or (b), as applicable, if the person or professional has cause to believe that an adult was a victim of abuse or neglect as a child and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of:

- (1) another child; or
- (2) an elderly person or person with a disability as defined by Section [48.002](#), Human Resources Code.

(c) The requirement to report under this section applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, an employee or member of a board that licenses or certifies a professional, and an employee of a clinic or health care facility that provides reproductive services.

(d) Unless waived in writing by the person making the report, the identity of an individual making a report under this chapter is confidential and may be disclosed only:

- (1) as provided by Section [261.201](#); or
- (2) to a law enforcement officer for the purposes of conducting a criminal investigation of the report

APPENDIX C

Texas Family Code, Chapter 263, Subchapter E, Section 263.401

Sec. 263.401. DISMISSAL AFTER ONE YEAR; NEW TRIALS; EXTENSION. (a) Unless the court has commenced the trial on the merits or granted an extension under Subsection (b) or (b-1), on the first Monday after the first anniversary of the date the court rendered a temporary order appointing the department as temporary managing conservator, the court shall dismiss the suit affecting the parent-child relationship filed by the department that requests termination of the parent-child relationship or requests that the department be named conservator of the child.

(b) Unless the court has commenced the trial on the merits, the court may not retain the suit on the court's docket after the time described by Subsection (a) unless the court finds that extraordinary circumstances necessitate the child remaining in the temporary managing conservatorship of the department and that continuing the appointment of the department as temporary managing conservator is in the best interest of the child. If the court makes those findings, the court may retain the suit on the court's docket for a period not to exceed 180 days after the time described by Subsection (a). If the court retains the suit on the court's docket, the court shall render an order in which the court:

(1) schedules the new date on which the suit will be dismissed if the trial on the merits has not commenced, which date must be not later than the 180th day after the time described by Subsection (a);

(2) makes further temporary orders for the safety and welfare of the child as necessary to avoid further delay in resolving the suit; and

(3) sets the trial on the merits on a date not later than the date specified under Subdivision (1).

(b-1) If, after commencement of the initial trial on the merits within the time required by Subsection (a) or (b), the court grants a motion for a new trial or mistrial, or the case is remanded to the court by an appellate court following an appeal of the court's final order, the court shall retain the suit on the court's docket and render an order in which the court:

(1) schedules a new date on which the suit will be dismissed if the new trial has not commenced, which must be a date not later than the 180th day after the date on which:

(A) the motion for a new trial or mistrial is granted; or

(B) the appellate court remanded the case;

(2) makes further temporary orders for the safety and welfare of the child as necessary to avoid further delay in resolving the suit; and

(3) sets the new trial on the merits for a date not later than the date specified under Subdivision (1).

(c) If the court grants an extension under Subsection (b) or (b-1) but does not commence the trial on the merits before the dismissal date, the court shall dismiss the suit. The court may not grant an additional extension that extends the suit beyond the required date for dismissal under Subsection (b) or (b-1), as applicable.