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Chronic Child Neglect: CYS Staff Perspectives on Repeat Clients

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ABSTRACT

Since the late 1960's, child protection agencies have acted under federal mandate to intervene in cases of child abuse and neglect. In accordance with state child protection laws, these agencies provide monitoring and support services to "at-risk" families. Despite these efforts, studies have shown that a record number of parents who receive services are re-reported to the agency for additional offenses within a short period of time. The available literature attributes recidivism to delayed or mismanaged interventions and adverse socio-economic conditions among parents, but research that considers employee perspectives on chronic neglect is scant. This paper explores inter and extra-agency perceptions of the phenomenon by asking the following question: *Which factors contribute to the continued neglect of children by parents who have received extensive agency services in the past?*

Survey subjects in County A and interview subjects in the Midwest, Southwest, and Northeast regions associated programmatic shortcomings, substance addiction, mental health issues, lack of parental motivation, and socio-economic depravation with recidivism. Both participant pools indicated that the agency's standardized, non-collaborative approach to case planning may be connected to recurring maltreatment during the post-service period. In their professional experience, resource quality and accessibility was meaningless without recipient engagement. They championed preventive programs and collaborative decision-making in their respective agencies as a means to decrease recidivism by empowering families—not government—to ensure the ongoing safety and wellbeing of their children. The collected findings add to our knowledge of the strengths and limitations of traditional interventions, and they highlight the need for additional training and alternative case planning methods that empower the biological family unit.

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ABBREVIATIONS/DEFINITIONS

CW: Case Worker

FSP: Family Service Plan

CAN: Child Abuse and Neglect

CYS: Children & Youth Services

OS: Ongoing Services

SEF: Socio-Ecological Framework

SP: Safety Plan

INTRODUCTION AND STATEMENT OF RESEARCH QUESTION

County A's[1] governing body established Children and Youth Services (CYS) in the late 1970's to protect children from abuse and neglect. In accordance with state law, the agency investigates maltreatment reports and provides comprehensive social services to thousands of children and families each year. Services commence with a family risk assessment; this tool helps CWs to identify victimized children's immediate needs and to determine caregivers' protective capacities. The agency's primary goal is to maintain children's safety in their own homes by facilitating crisis interventions and providing ongoing monitoring and support services. When clients cannot maintain safe living conditions, CYS transfers their children to temporary placement[2] so that parents can participate in rehabilitative services; if they make sufficient progress, CYS reunites the original family unit.

From my perspective as an Intake & Investigative Case Worker (CW) at CYS, it appears that the agency does not always fulfill its stated objectives. Most of the clients on my caseload who committed serious types of child abuse and neglect (CAN) last year had received extensive maltreatment prevention services from CYS in the past. During the same period, about 10% of the agency's total clients were reported more than once for CAN incidents (County A CYS, 2011-2012). The agency's extension of aid may come too late because current policy prohibits intervention until an act of abuse or neglect has already taken place. Moreover, the sheer number of false CAN reports that must be investigated each month make it difficult for CWs to

[1] Subjects' names, specific organizations, and locations have been omitted for the purposes of protecting confidentiality.

[2] "Placement" refers to the agency's transfer of a child from her home of origin to a relative's home or to a licensed foster care family. It should be noted that placement is intended to be the last resort when protective services are not sufficient to ensure the child's in-home safety.

concentrate their efforts towards protecting children who are truly at risk. My direct interaction with "repeat clients" during my tenure with the agency has convinced me that we must do more to prevent parents from perpetuating the cycle of chronic child maltreatment.

CYS approaches the problem of CAN from the socio-ecological framework (SEF), which proposes that human interactions are influenced by individual and systemic factors (Bae & Solomon, 2010). According to this complex model, parents with personal impairments such as substance dependence or mental health conditions and structural disadvantages such as limited access to community resources are more likely than caregivers without these limitations to perpetrate abuse. In theory, the SEF should encourage CWs to collect detailed information about each case and to tailor subsequent interventions according to the families' unique circumstances. My direct experience, however, indicates that many CYS employees presume clients to be "guilty until proven innocent", and department supervisors often advise CWs to initiate prefabricated, state-approved safety actions without taking clients' specific situations into account.

The purpose of this study is to determine how relevant and effective CYS' policies have been in terms of fulfilling its stated mission. The majority of County A's CYS clients—like other CYS agencies across the nation—are neglect perpetrators (DHHS, 2012). The presence of repeat neglect perpetrators suggests that our service delivery does not affect some parents' long-term desire and ability to adequately care for their children. My goal is to highlight the factors that contribute to this phenomenon and suggest new ways to prevent its occurrence. I expect my study to benefit the agency and future clients by identifying attitudinal themes among CYS employees towards repeat clients and by clarifying which policies work and which ones need improvement.

Which factors contribute to the continued neglect of children by parents who have received extensive CYS services in the past?

My sub-questions will be:

> **To what extent does CYS' interaction with client parents have a long-term effect on their attitudes and abilities as caregivers?**
>
> **How effective are CYS' services and resources at preventing chronic neglect?**
>
> **How do employees' attitudes towards neglect perpetrators affect recidivism rates?**

LITERATURE REVIEW

Key Words: child abuse, child maltreatment, repeat offenders/perpetrators, chronic abuse & neglect, multiple incidences of CAN, maltreatment prevention, perpetrator demographics, ecological factors, alternative prevention strategies, intervention techniques, CYS service provision, long-term effects

Historical Context

The "Children's Rights Movement" of the late 1960's culminated in the passage of *In re Gault*, by which the Supreme Court guaranteed 14th amendment rights for juveniles and effectively opened the formerly autonomous family unit to state regulation (Guggenheim, 2005).In response to increasing political support for child welfare efforts, the federal government approved the Child Abuse Prevention and Treatment Act (CAPTA)[3] of 1974, which established legal definitions of maltreatment and extended parental supervisory powers to CYS agencies across the nation. Most states followed suit with their own *parenspatriae*[4] directives, and the courts had usurped parents' final authority in childrearing matters by the end of the next decade

[3] The current federal definition for child abuse and neglect is "any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm" (CAPTA 111, 2010).

[4] "[Latin, Parent of the country.] A doctrine that grants the inherent power and authority of the state to protect persons who are legally unable to act on their own behalf " (*West's Encyclopedia of American Law*, 2008).

(ibid).

Since its inception, CYS has drawn criticism for its "anti-family" approach, failure to adequately protect children under its care, and infringement on parental rights. National child welfare statistics confirm that serious physical abuse incidents have decreased substantially over the last twenty years, but more than a quarter of parents who received CYS intervention services for neglect issues in 2010 were re-reported for similar offenses the following year (Bae & Solomon, 2010; NIS 2010). Many CAN cases go unreported, but at least 754,000 children were confirmed victims of multiple incidents of neglect[5] in the latest annual survey (Child Information Gateway, 2010). These statistics call the efficacy of CYS' services into question, and they indicate a clear need for policy-makers to re-examine the factors that contribute to chronic maltreatment.

Although the goal of CYS is to modify abusive caregivers' behavior, research shows that prior CAN history and involvement with the agency are the strongest predictors of maltreatment recurrence. Recidivism rates are highest among parents who are deemed "moderate risk" for abuse potential, which suggests that CYS provides services to the same population repeatedly (Hindley & Ramchandani, 2006). At present, researchers are uncertain whether CYS system factors contribute to recidivism, but it is clear that the agency provides more intensive investigative and rehabilitative services to repeat offenders.

The literature offers three conflicting explanations for repeat abuse: 1) The initial ongoing service period is too brief and imprudent (ibid); 2) Adverse socio-economic factors outweigh the benefits of any services CYS might provide (Bae & Solomon, 2010); and 3). CYS attempts interventions too long after maltreating behavior patterns have been established (Mathews &

[5] The count of child victims is based on the number of investigations that found a child to be a victim of maltreatment. The count of victims is, therefore, a report-based count and is a "duplicated count," when an individual child is the subject of more than one report (NCANDS, 2009).

Bross, 2008). The Supreme Court remarked in *Gault* that juveniles should be "made to feel that they are the object of the state's care and solicitude" (U.S. 15, p. 387). In order to fulfill this promise, CYS agencies across the country must make maltreatment recurrence prevention a stronger priority.

How Is Maltreatment Reported & Confirmed?

Each new maltreatment allegation, or referral, triggers an investigation and final status determination. Status determinations fall into one of three main categories: 1. "Substantiated": CYS confirms the allegation and the decision is upheld by a judge; 2. "Indicated": CYS finds reasonable evidence to confirm the allegation; or 3. "Unsubstantiated": The allegation is false (CPSL, 2009). Once the investigation has concluded, CWs conduct a risk assessment to determine what sort of services to provide. The National Incidence Study (NIS), a federally-funded child welfare database, compiles the total number of referrals, status determinations, and service provision figures from local CYS agencies into periodic reports for congressional review. Some states do not participate in every NIS, but the latest congressional report showed a promising 19% overall decline in substantiated and indicated maltreatment rates since 1993 (Sedlak et al., 2010).

Although confirmed maltreatment has decreased over time, the total number of annual CAN referrals has increased exponentially (Krason, 2007). This phenomenon is largely attributed to CAPTA's mandated reporting laws, which require any adult who interacts with juveniles in a professional capacity to report suspected maltreatment. Douglas Besharov, the first director of the National Center for Child Abuse and Neglect, and the leading expert who helped create current policies for CYS interventions, wrote in the mid-1980's that mandated reporting has generated an overwhelming number of false reports that "seriously hamper the effort to

combat actual abuse" (Krason, 2007, p. 311). In 2010, the NIS listed 3.5 million referrals: Of these, roughly sixty percent were investigated and approximately two-thirds of those were unsubstantiated (Child Welfare Information Gateway, 2011). Research shows a link between thorough risk assessments and decreased maltreatment, but many CWs' workloads are so heavy that they are only able to complete brief evaluations.

Although researchers cite the NIS more frequently than any other source, its statistics are surprisingly unreliable. First, the federal definition for maltreatment is vague enough to allow for multiple interpretations. Consequently, substantiation and service implementation rates vary by as much as 50% per year among some states.[6] In addition, the NIS does not account for differences among agencies' substantiation reporting policies: County A, for example, appears to have very low maltreatment rates because it substantiates physical abuse allegations but not neglect allegations, even though the latter comprises the majority of its referred cases. Most importantly, the NIS' portrait of nationwide maltreatment is incomplete because many states do not participate and because many hundreds—possibly thousands—of incidents go unreported every year.

How Does CYS Respond to the Initial Maltreatment Report?

Following an initial sixty -day family evaluation, the Child Protective Services Law (2009) requires CYS to conduct a "risk assessment" for all new cases in order to gauge the identified caregivers' potential to perpetrate abuse. The "overall risk level" determines the service trajectory for each case: "Low-risk" cases are closed, "moderate-risk" cases receive ongoing, in-home services, and "high-risk" cases are transferred to placement [CPSL (2009), Ch. 6362 (e) (f)]. A good example of a moderate-risk case might be a situation where an elementary

[6] For example, the number of annual maltreatment reports increased by 55% in New York between 1995 and 1998, and the total number of children in the state who were placed in foster care was twice as high in 1997 as two years earlier (Guggenheim, 2005, p. 195).

school reports a young student for truancy. The child can remain in their home because they are not at imminent risk of future harm, but the parents will receive ongoing agency services to ensure that the educational neglect does not recur. The primary goal for moderate-risk cases is to prevent the need for placement by maintaining children's safety in their own homes and reducing overall maltreatment risk [ibid, Ch. 6365 (a); Ch. 6368 (a)].

Ongoing services (OS) begin with the creation of the "Family Service Plan," (FSP) which outlines the goals a family will work to achieve under agency monitoring. The most commonly referred services on FSPs are parenting classes, counseling, and childcare assistance (Child Trends, 2012). The assigned ongoing CW monitors the children's ongoing safety directly by conducting regular home visits, and collaborates with intra-agency community service providers to confirm clients are participating in recommended service programs. After six months, ongoing service case workers review the FSP to determine whether additional monitoring is necessary; parents who have not made satisfactory progress must submit to an additional six months of ongoing monitoring services before their cases are closed.

If we assume that there is a direct relationship between CYS interventions and maltreatment prevention, the agency's services have been somewhat successful. The latest NIS (2010) reported a "55% [nationwide] reduction in physical abuse since 1990, but no significant decline in cases of neglect" (Child Welfare.Gov, p. 2). In 2010, 9.2 of every 1,000 children nationwide were first-time victims of maltreatment. Despite wide agreement among researchers and CWs in the field that the potential for repeat maltreatment is highest within the first few years of a confirmed CAN incident, only 61% of first-time victims received ongoing services at all, and families had to wait forty days on average after FSP completion for corresponding service programs to begin (Child Welfare Information Gateway, 2011).

Several studies have attempted to draw a direct link between CYS' service provision and long-term behavior modification among parents, but their data is inconclusive. Most studies are short-term and methodologically unsound (Mathews & Bross, 2008). More research is needed to determine if, for whom, and for how long the agency's rehabilitative efforts outweigh destructive ecological factors. A review of the literature on first-time ongoing service recipients reveals that mitigating circumstances, such as a family death, loss of a job, or funding cuts to community programs may increase the risk of CAN even when parents are receiving intensive preventive services (ibid). Case workers, who work directly with this population, might provide much-needed clarity regarding which factors contribute to CAN perpetration, how CYS interventions affect clients' interactions with their children, and clients' perceived service needs.

How Does CYS Respond to Subsequent Maltreatment Reports?

Most often, a family is re-investigated for CAN allegations and accepted for a second round of OS within five years of the first service period. Many critical reviews (Mathews & Bross 2008, Hindley & Ramehandani 2006) suggest that post-intervention clients continue to maltreat their children because CYS offers inadequate screening, resources, and assessments the first time around. Other studies indicate that receipt of post-investigative services reduces recurrence rates: Clients who receive no services within 60 days of case opening, for example, are two times more likely to recommit abuse, and those who receive the most intensive in-home services have lower re-reporting rates overall (Bae & Solomon, 2010).

The three most consistently identified ecological factors among duplicate CAN perpetrators are domestic violence, mental health issues, and single parenthood (Bae & Solomon, 2012). Researchers also link family composition to maltreatment recurrence rates because children with many siblings have higher duplicate CAN rates than other reported children. In

general, juveniles with a history of maltreatment are six times more likely to suffer chronic harm than their non-mistreated peers: In one study, 23% of substantiated CAN victims were re-victimized within 18 months of the first documented incident (Hindley & Ramehandani, 2006). As with initial CAN incidents, "neglect is the most common type of [repeat] maltreatment across all age groups," and babies are more vulnerable to ongoing harm than schoolchildren and adolescents (ChildStats., 2011).

The total rate of duplicate victims in 2010 was 10 per 1,000 children (Child Welfare Information Gateway, 2011). Duplicate victims have an arguably higher need for intensive monitoring and support than first-time victims, but the former did not receive substantially more services that year. Lack of training and coordination among CYS and other service providers may contribute to inadequate prevention techniques during the first ongoing service period; some first-time victims did not receive services at all, and 21% of children whose families did receive services after the initial investigation were reported as duplicate victims in 2010. Perhaps the most dramatic statistic of all in this dataset is the fatality rate: Of all child deaths in thirty-three reporting states, 12% had received ongoing services from CYS in the past five years (ibid, p. 60).

Although there is consensus in the literature regarding increased risk for a second CAN report once the first report is indicated, the relationship between the severity of the first report and subsequent reports is unclear (Hindley & Ramehandani, 2006). Risk projections for second maltreatment incidents are also unreliable because the available studies do not include matched controls. The short-term incentive for parents to comply with recommended services as a means to expedite case closure may also alter "re-offense" data so that perpetrators appear to have reformed. One large-scale study in Florida concluded that "client compliance" and "amount of progress towards FSP goals" during the ongoing service periods had no measurable effect on

participants' long-term parenting (ibid). Finally, it is very difficult to know how many perpetrators commit additional offenses because the statute of limitations requires neglect files to be expunged from agency records after three years, and it is nearly impossible to track ex-offenders across state and county lines (Child Information Gateway, 2011).

What are the Alternative Approaches to Prevention?

One of CYS' main shortcomings is its "back-end approach" to child welfare. By law, the agency many not intervene in family life until an act of abuse or neglect has already occurred. Research has shown that many initial unsubstantiated reports are re-reported within a short period, "suggesting that risks for such families may persist or escalate over time" (Slack, 2009, p. 47). In response, more than half of U.S. states have implemented alternative approaches to the traditional intervention model in order to expand prevention efforts. The main goals for alternative interventions are to alleviate the strain on limited CYS resources, reduce re-reporting, and better serve low and moderate-risk clients.

Alternative approaches include two sorts of programs that aim to serve distinct participant groups: primary prevention programs (PPP) target at-risk populations before maltreatment occurs, while recurrence prevention programs (RPP) target clients who have been reported to CYS for minor (e.g. "low-risk") child welfare concerns. The longest-running PPP is the Nurse-Family Partnership, a national program that deploys registered nurses into young, single mothers' homes to conduct pre- and post-natal educational visits for a period of 18 to 36 months. RPPs vary by state, but most assign low-risk cases that would ordinarily be closed to monthly "assessment tracks," in which "services are provided on a voluntary basis, and no formal investigation [or possible substantiation] of a specific maltreatment allegation is completed" (ibid, p. 47). At a minimum, the research to date does not indicate that alternative

approaches pose more safety risks for children than the traditional CYS intervention model.

The main outcomes for participants in alternative approach programs are promising. A follow-up study for the Nurse Family Partnership conducted fifteen years after the service period concluded that participants—particularly women from lower socio-economic backgrounds—took their children to fewer maltreatment-related doctor's appointments and had "80% fewer substantiated CAN reports than mothers in the control group" (ibid, p. 24). Likewise, RPP studies found that participants had lower re-reporting rates overall, "less severe subsequent reports", and "longer periods of time between reports" (ibid, p. 48). RPP studies also recorded high levels of client satisfaction with the assessment track's voluntary services. In addition to CYS' substantiation data, alternative approach programs have also implemented "parenting attitude surveys" to measure program outcomes: Both RPPs and PPPs yielded positive results.

Although alternative approach programs have generated nation-wide interest, only a handful of studies explore their direct effect on child maltreatment rates, and very little is known about their long-term effects. Of the seven most rigorous studies of RPP programs conducted between 1997 and 2004, only one tracked participant outcomes for more than two years. There are many PPP programs that follow the Nurse Family Partnership model, but corresponding studies support preventive impact findings with under-inclusive data. Substantiation rates and medical care visits are incomplete performance measures because they do not account for maltreatment that does not come to CYS' attention, or for parents who mistreat their children and evade detection by intentionally denying them medical care. Finally, alternative approach program data over-emphasizes the significance of a self-selecting group whose voluntary participation suggests a comparatively stronger predisposition to behavior modification than clients with higher risk levels who receive traditional intervention services.

What Are Case Workers' Critical Needs?

CYS demands an extraordinary amount of patience and emotional resilience from its employees. CWs often experience secondary traumatic stress, (STS) or "the emotional duress that results when an individual hears about the firsthand trauma experiences of another" (Sprang & Ross, 2011, p. 1). Two common symptoms of STS are a decreased sense of safety and trust (ibid, p. 2); my colleagues, for example, often tell me their direct experience with CAN perpetrators make them suspicious of their babysitters and neighbors.

As in other helping professions, "worker burnout" is common in child welfare. One national study on vicarious trauma in the field found that "more than 50 percent of participants in all states reported feeling "trapped and hopeless about their work" and "avoiding thoughts and feelings about their clients" (Price & Shackleford, 2007, p. 51). At times, CWs feel overwhelmed amidst the mass of paperwork, bureaucratic regulations, and angry parents; many of my young and inexperienced colleagues in County A, for example, left the agency after one year.

In my own experience, the most critical need for workers is to retain their commitment to the organization's mission. To this end, departmental supervisors hold supportive, weekly "check-in" sessions with CWs, and the county provides ongoing training workshops to keep workers abreast of new developments in the field. Self-care is also important; those who balance stress with good nutrition and exercise often fare best (ibid).

Conclusion

In summary, the available literature provides a great deal of information about the type and frequency of nationwide maltreatment incidences, but many questions remain unanswered. There is no clear picture of the true extent of CAN: The NIS does not include data from every state, nor does it account for CAN incidents that do not come to the attention of CYS. The substantiation statistics that are available are unreliable because there is no consistent definition

for maltreatment, and states may use their discretion regarding which types of maltreatment cases to report. Future research should attempt to clarify the impact of socio-economic factors on first and second maltreatment reports, particularly with respect to chronic neglect. Finally, there is a great need for additional longitudinal studies that explore the direct relationship between rehabilitative services and chronic neglect prevention.

RESEARCH METHODOLOGY

I was uncertain about my epistemological position for this study until I considered the implications of child welfare's overarching positivist framework. The processes by which the agency responds to maltreatment reports (i.e. information gathering, status determination, and service implementation) are based on two important assumptions about the nature of social reality: 1) "Reality is objective and can be empirically tested," and 2) "The researcher [in this case, the agency] is unbiased, emotionless, and nonpolitical" (Hesse-Biber, 2006, p. 14). An excellent example of the objectivist approach in agency policy is the risk assessment, which presumes that "causal links" between ecological factors and individual caregiving capacities can be "identified, predicted, and controlled" (ibid, p. 13). In my experience, positivist epistemology affords the agency considerable *reactive* authority in its dealings with CAN perpetrators, but it actively discourages workers from reflecting on current policy or suggesting preventive alternatives.

In direct contrast to the positivistic worldview, I believe that reality is subjective; therefore, my "research cannot be detached from [my] own presuppositions" (Groenwald, 2004). Accordingly, I elected to conduct an inductive inquiry into participants' "lived experience" with

chronic child neglect (Cooper, 2007). As my research progressed, I incorporated qualitative and quantitative data collection methods in this exploratory phenomenological study[7] with the more specific intention to describe the agency's response to the phenomenon from as many different perspectives as possible.

Sample

The total participant pool for the survey portion of this study consisted of 41 [primarily] female Intake and OS CWs between 21-30 years of age. Most had worked at the agency for three years or fewer. The survey pool was site-specific: I employed the purposive sampling method to select potential participants according to their "experience relating the phenomenon to be researched" (Groenwald, 2004, p. 9). All current Intake and OS case workers from two offices in County A were invited to participate in the project. In total, I received 17 completed surveys from Intake, and 24 completed surveys from OS.

I began the in-depth interviewee selection process with a convenience sample, or "selection of informants [based on] who is available, has…specialized knowledge of the setting..and is willing to serve in the role" (Hesse-Biber, 2006, p. 77). The interview selection process was open-ended; the only delimiting factors for subjects were non-affiliation with County A, professional involvement in the child welfare field, and willingness to participate in the study[8]. My sample size, albeit quite small, is sufficient for this project's purposes because I do not intend to generalize my findings beyond the confines of my specific organization.

7 "Phenomenological" research design serves to "identify phenomena through how they are perceived by the actors in a situation…and is concerned with the study of experience from the perspective of the individual" (Lester, 1999, p. 1).

8 See "Appendix I: Interview Reference Guide" for a complete description of subjects' academic background & professional experience in the field.

Data Collection

I followed all requisite Human Subject Review guidelines for research for the duration of this study. Prior to data collection, I obtained written project approval from the School for International Training and the cooperating institution (CYS in County A). Subjects were notified, both verbally and in writing, of their right to refuse to participate without penalty. Risk of harm for study participants was minimized for County A subjects with anonymous surveys. Interview subjects gave their informed consent to participate; as an added measure of security, they were given the opportunity to customize their own terms of reference (i.e. "A DHHS Administrator") and to review and edit their interview transcripts prior to this paper's submission for publication.

I created both data collection instruments with the intent to gather multiple perspectives on the research problem. The cross-sectional survey design served to "collect data to make inferences about a population of interest (universe) at one point in time" (Lavrakas, P.J. (null)). As an excellent supplement to the collected survey data, individual, in-depth interviews allowed me to "probe" for more information about emerging themes among seasoned, organizational leaders with professional ties to child welfare.

Survey respondents were asked to complete one anonymous, 3-page, mixed-methods questionnaire that included quantitative questions with continuous scale answer choices such as, "How often do you agree with CYS' overall policies regarding interaction with clients?" [Never, Not Often, Sometimes, Usually, Always] and open-ended qualitative questions such as, "Please briefly explain why you chose to work at County A" (ibid, p. 150). I chose the cross-sectional survey design in order to identify common attitudinal themes among County A employees about their work and the clients they serve (Creswell, 2009). In addition, I hoped the survey questions would draw participants' attention to any preconceived assumptions about their clients'

behaviors.

I conducted semi-structured, in-depth, individual interviews that centered around five "guiding" questions, which were designed to keep subjects on track, but also allowed them "freedom to talk about what is important to them" (ibid, p. 125). All five interviews were conducted via telephone; on average, they lasted between 60-90 minutes each. Subjects were encouraged to reflect on the research topic by providing examples and insight from their professional experience. Interviews strengthened my survey data in two ways: 1) They added in-depth perspectives on the central research question from a different population than the survey pool; and 2) They allowed me to interpret and clarify the collected survey data according to internal and external feedback.

Data Organization & Preparation

Following Creswell's (2006) steps for data analysis and interpretation, I organized my data according to source of origin and entered it into a Google Docs spreadsheet. Next, I reviewed the responses and generated lists of *in vivo* terms, or "labels..based in the actual language of the participant" (Creswell, 2006, p. 186). From there, I clustered common themes together into major topics and re-organized my data accordingly. Lastly, I coded responses line-by-line and condensed the topics into 4-5 distinct categories.[9] I also included an "other" category for all questions in order to capture unusual responses in my newly-designed data report.

Good qualitative research practice requires methodical analysis of written data. Consequently, I edited my initial labels and re-segmented textual responses several times before I determined final categories that most accurately represented the data. For example, I coded responses to the first qualitative survey question ("Please briefly explain why you chose to work

[9] Answers to the first open-ended question (Explain why you chose to work at CYS) were ultimately sorted into four categories, and answers to the remaining questions (Identify the Agency's main strengths & weaknesses for first and second-time clients) were sorted into five categories.

at CYS") into five final categories: "Professional/Academic Connection to the Field"; "Financial Motivation"; "Personal Interest; "Social Conscience"; and "Other". I followed the same process with Interviews. At the conclusion of the data-collection portion of this project, I created eleven data summary chart drafts to use for reference during the analysis period. For presentation purposes, I have since condensed those eleven charts down to seven (see Appendices D-H, K, and L).

Data Analysis

Survey data was collected in hard copies, entered electronically into GoogleDocs, and later entered into a master Excel document. Survey data was coded by themes and sorted into charts according to subjects' location and department of employment. Interview transcripts were typed in live time into Word documents, coded, sorted according to new themes, and finally entered into Excel for comparison. Multiple spreadsheet tabs with categorized charts allowed me to easily compare and contrast my findings between and among employees from each agency. At the final stage of analysis, I printed hard copies of each data chart to use for constant reference and fact-checking; these combined processes allowed me to conceptualize the accumulated results as a whole.

I examined each variable in my assembled data charts by using the "univariate analysis" method to "get a sense of the nature of the variation in the variables to be analyzed" (Singleton & Straits, 2009, p. 510). I organized illustrative quotes from open-ended survey questions into tables according to the number, or "frequency" of responses in each category, and I followed a similar procedure with interviews as a means to highlight major findings. In order to explore responses to multiple-choice survey questions, I tallied the number of answers in each category and inserted the totals into "percentage distribution" tables (ibid, p. 511). For example, in

response to the question, "What were the three most common services you initiated with first-time clients who were later transferred to OS?" 12 Intake CWs selected "Parenting classes." The percentage distribution method allowed me to put this number into a much clearer context for comparison: Utilizing this method, we can now see that 12 out of 17 Intake CWs (or 71%, a clear majority) initiated parenting classes.

SURVEY DATA PRESENTATION[10]

On the whole, Intake and OS CWs reported similar levels of mission orientation and organizational knowledge. The majority of respondents in both departments joined the agency for financial reasons. Recent MSW graduates aimed to apply degree-specific skills in the field, but many newcomers were simply motivated to gain general professional experience. Respondents also expressed personal interest in working with children and social motivations to help clients "resolve their problems" or "achieve independence." OS CWs reported stronger personal and academic connections to the field than Intake, but this was the only notable difference between departments.

CWs reported general agreement with County A's policies and their direct supervisors' decisions about their cases. On average, they rated their familiarity level with standard procedures and policies in their respective departments as "moderate." CWs also evaluated their competency skills as "moderate" in all of the following categories: family counseling; substance abuse/addiction and treatment; mental health diagnoses, medication, & treatment; and

[10] *Note: In order to preserve the integrity of participants' individual voices, I have reproduced survey responses exactly as they were written. Some quotes contain spelling and grammatical errors. These irregularities are intentionally untouched so that direct quotes may be presented in their truest form.

community resources. Although participants felt least equipped to deal with domestic violence, they indicated a good deal of certainty about their knowledge of child development.

I observed notable trends among responses for first-time clients and repeat clients in the following categories:

- *Connection to Resources:*
  Described as the agency's greatest strength in its service to both first-time and repeat clients, pending availability of family-specific programs.

- *Safety Management:*
  No significant difference between first-time and repeat clients in this category. Feedback was positive overall, particularly regarding safety plan implementation and monitoring.

- *Information Gathering & Transfer:*
  Participants' concerns included inappropriate focus on family history for repeat clients and timely transfer of case files from Intake to OS CWs for first-time and repeat cases.

- *Client/Agency Relationship & Communication:*
  Feedback was generally negative, particularly regarding repeat clients. Criticisms revolved around attitudinal and hierarchical themes.

- *Case Planning & Prevention*:
  Benefits noted for first-time clients were contingent upon accurate family assessments and agency follow-through on FSP goals. Viewed as generally less effective with repeat clients, due to overemphasis on "symptoms" vs. "roots" of family problems

First-Time Clients

- *Intake Caseworkers' perspectives*

Table 1 illustrates the most common reasons first-time clients were transferred to OS. When asked to identify the three primary risk categories that warranted transfers from a list of 16 possible options, they selected "substance abuse" (15/17, or 88%), "poor parenting skills" (7/17, or 41%), and either (6/17)"Truancy" or "Inadequate housing" (6/17) most frequently. Nearly all Intake workers initiated parenting classes and substance treatment services with first-time clients, and respondents selected "mental health services" and "collaboration with medical providers"

(8/17, or 47% each) as the third-most common service they initiated.

Table 1
Most Common Reasons First-Time Clients Were Transferred to OS

Risk Category	Number	Percent	Risk Category	Number	Percent
Substance Abuse	15	88%	Domestic Violence	1	6%
Poor Parenting Skills	7	41%	Lack of Cooperation	1	6%
Truancy	6	35%	Other	1	6%
Inadequate Housing	6	35%	Inadequate Finances	0	0
Previous Referrals	5	29%	Cognitive Impairment	0	0
Mental Health Issues	4	24%	Physical Abuse	0	0
Medical Neglect	2	12%	Criminal Involvement	0	0
Inadequate Supervision	2	12%	Parental Lack of Maturity	0	0

Total Number of Intake Respondents=17 **Total Number of Responses=50**
*Note: Percentages add up to more than 100% because each subject selected up to 3 response categories.

- *OS Caseworkers' Perspectives*

As Table 2 shows, the most common reasons OS CWs transferred clients to Placement were substance abuse (9/24), mental health issues (8/24), inadequate housing (8/24), and inadequate supervision (6/24). The most common services first-time OS clients received were substance treatment (19/24), parenting classes (15/24), and mental health treatment (14/24). It is unclear why housing assistance was not included as a commonly-provided service, considering survey respondents' reports of inadequate living conditions as a major reason for child placement.

Table 2
Most Common Reasons First-Time OS Clients Were Transferred to Placement

Risk Category	Number	Percent	Risk Category	Number	Percent
Substance Abuse	9	38%	Domestic Violence	0	0%
Poor Parenting Skills	4	17%	Lack of Cooperation	4	17%
Truancy	0	0%	Other	10	42%
Inadequate Housing	8	33%	Inadequate Finances	1	4%
Previous Referrals	0	0%	Cognitive Impairment	1	4%
Mental Health Issues	8	33%	Physical Abuse	3	13%
Medical Neglect	2	6%	Criminal Involvement	3	13%
Inadequate Supervision	6	25%	Parental Lack of Maturity	3	13%

Total Number of Intake Respondents (N=24) **Total Number of Responses=62**
*Note: Percentages add up to more than 100% because each subject selected up to 3 response categories.

Reported Strengths & Shortcomings

- *Connection to Resources*

Table 3 highlights a common sentiment between departments: Both Intake and OS CWs cited "Connection to Resources" as the Agency's primary strength in its service to first-time clients. They believed their respective departments were particularly adept at "finding, providing, and referring" appropriate services, especially substance treatment, mental health resources, and housing programs. However, respondents from both departments mentioned the lack of "family-specific" services as a major shortcoming.

Table 3 [11] *Reported Agency Strengths Re: Connection to Resources for First-Time Clients*	
Office 1, Intake Dept.	**Office 1, OS Dept.**
The ability to provide services such as parenting education, D&A assessments & psychological evaluations. **Finding resources--food, bed, MH, D&A, etc.** **Ability to provide numerous services to assist +support the family such as transportation +housing assistance, referrals to MH, D+A, + other providers, etc.** **[The Agency] is able to provide information about community resources that families may not have known existed.**	**Services offered and resources used.** **Community Resources. Helping w/housing. Helping w/utilities.** **Helping to access resources. Ensuring daycare/education for children.** **Help give the clients the assistance to get started.** **Make them aware of resources**
Office 2, Intake Dept.	**Office 2, OS Dept.**
Making sure proper services are provided to reduce further involvement. **Assisting in housing stability.** **Assist w/mental health.** **Connecting clients to services in the community.** **Makes clients aware of under-utilized community resources**	**Able to start services right away.** **Parenting class. Providing resources (vouchers).** **Assessing clients' needs and making referrals IF there is already an identified provider for the services needed….Helping with concrete needs such as bus tokens and food vouchers.**

- *Safety Management*

Safety monitoring [see Table 4] has become a high priority in County A because upper management aims to prevent fatal injuries to children who are under Agency supervision.[12] Intake CWs listed safety plans[13] as a strength in this category, and several OS respondents described the relationship between frequent "monitoring checks" and actual safety as directly

[11] Note: Two offices within County A participated in the survey project. To protect anonymity, respondents are identified in this section according to the following labels: "Office 1" and "Office 2".

[12] Professionals in the field often attribute current safety regulation enforcement to a highly-publicized case in the late 1990's wherein a family that was under agency supervision starved their juvenile daughter to death in the basement of their Philadelphia home. As a result of this horrific incident, CYS workers are now required to complete safety assessments, at minimum, every 30 days.

[13] Written contract between the Agency & client that temporarily manages safety "threats" (ex. active drug use) by decreasing children's exposure to the offending parent. Most plans require an outside party to monitor all children inside the home 24/7.

proportional. Procedural monitoring policies were particularly relevant: More than half (4/7) of all respondents mentioned safety "checks" or "home visit regulations." One OS CW, however, criticized safety plans as "inadequate and difficult to monitor".

Table 4
Reported Agency Strengths Re: Safety Management For First-Time Clients

Office 1, Intake Dept.	Office 1, OS Dept.
lots of safety checks. Supervision	Ensuring safety of children [policy] guidlines (How you see 1st time clients in the beginning 1x/week). Passion for providing safety in the home and making sure the basic needs of the child(ren) are met.
Office 2, Intake Dept.	**Office 2, OS Dept.**
putting safety plans in place.	[OS] Policy: Weekly visits for 8 weeks.

- *Information Gathering & Transfer*

According to the data presented in Table 5, one of Intake's primary functions is to gather relevant information about a family and transfer it to the ongoing worker, but the process may be complicated by a number of factors.[14] Regardless, both departments perceived agency policies and Intake's proficiency in this category positively on the whole in terms of frequent "contacts" and "information gathering" (3/4 OS CWs). Regarding agency limitations, Intake respondents mentioned "time restraints" on adequate collection and transfer of case information and OS CWs articulated concerns about the delay in information transfer between departments.[15]

[14] Although all child welfare agencies are presumably "on the same side," I had a very difficult time obtaining clients' intra-county case files because many agencies prohibit record-sharing.

[15] Historically, case transfer from Intake to SCOH has been an inefficient and time-consuming process. Intake CWs sent case files to the Clerical department to be typed, approved, revised, and re-submitted. SCOH workers often did not receive new clients' files from Intake for several months. However, the transfer process is improving rapidly: The Agency adopted an electronic filing system this year, which enables workers and Supervisors to upload and share documents instantaneously.

Table 5 *Reported Agency Strengths Re: Information Gathering & Transfer For First-Time Clients*	
Office 1, Intake Dept.	**Office 1, OS Dept.**
Contacts. **lots of follow-up w/family.** **Being able to assess and know that 1st time they're going to need services.**	**To identify the family issues** **good at gathering information.**
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
gathering info.	**Policy: Transferring worker required to get initial releases, photos prior to transfer.** **Obtaining records/information gathering**

- *Client/Agency Relationship & Communication*

Table 6 highlights respondents' top criticisms in this category, including the Agency's propensity to "judge" clients (2/14) or "force" them into services (2/14) by "threatening" to remove their children (2/14) when they refuse to cooperate. However, one OS CW wrote that if the CW is empathetic, "many parents [are] able to open up and ask for information or assistance when they [do not] have the previous support from family and friends". Another indicated that first-time clients' presuppositions about the agency affect their interaction with their assigned worker --both in the clarity of communication ("depending on the worker the family will…be educated about the purpose of OS and the expectations")-- and the nature of their relationship to the agency ("First time clients are less dependent…"). Two CWs noted that the Agency does well with "engaging and listening" to first-time clients and conducting "strengths-based" assessments.

Table 6 *Reported Agency Shortcomings Re: Client/Agency Relationship & Communication With First-Time Clients*	
Office 1, Intake Dept.	**Office 1, OS Dept.**
Sometimes empty threats are provided when clients show lack of motivation or cooperation. **Not holding the parents more responsible for their actions.** **Empty "threats"** **No true authority**	**Being too lenient on substance abusers.** **Making people do psychological.** **I don't think there are shortcomings, it's all in how the clients recieve the services. They may be resistant or accepting of the OS unit.** **Many times in Intake, supervisors automatically judge a client based on the referring information and they provide personal opinions, when they should not.** **Railroading people into services.**
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
lack of putting oneself in the client's situation and being overly judging about client situations. **Not giving proper explanations about the need for ongoing services**	**First time clients sometimes have wrong information about what services or what CYS's purpose really is.** **Collaboration w/the worker on decisions involving the family they are working with. Favoritism in decision making.** **to much hand holding**

- *Case Planning & Prevention*

According to participants from both departments [Table 7], agency interventions do not create behavioral change if they are not properly planned and managed. Most (5/7) OS CWs expressed frustration with County A's failure to emphasize self-sufficiency. Four Intake CWs and one OS CW viewed the ongoing service period as unnecessarily lengthy and overly intensive for some clients. They explained that "little to no change occurs" because the agency does not "help clients maintain independence after initial involvement." The majority (9/12) of respondents indicated that the agency's struggle to follow through with early service plan goals leads to "ongoing involvement" or re-involvement with first-time service recipients.

Table 7 *Reported Agency Shortcomings Re: Case Planning & Prevention For First-Time Clients*	
Office 1, Intake Dept.	**Office 1, OS Dept.**
Little to no change occurrs and/or clients remain with the agency for a long time. **Intensity of initial visits for clients who are at lower risk** **Clients sometimes only need minor help but then the Agency takes over.** **...When the caseworker is able to debunk [referral] allegations, sometimes supervisors do not listen and still find it necessary or not to provide the proper service or end involvement with the family.**	**... they are not given the proper resources to become independent.** **OS sometime enables clients by doing too much.** **Enables clients** **Rushing to request court supervision.**
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
No formal "structure" for how OS services are implemented. 5	**Preventive Not Emphasized.** **Helping clients maintain independence after initial involvement** **Keep families involved w/the agency too long and They become dependent on the agency**

Repeat Clients

- *Intake CWs' Perspectives*

As Table 8 shows, substance abuse was far and away the most common reason for transfer with repeat clients (16/17), but—interestingly, the second-most common reason cited was mental health issues (11/17) , and poor parenting skills fell to third most-common by a tiny margin than for first-time clients (6/17, as opposed to 7/17). Neither truancy nor housing was listed as particularly significant. The most common services workers initiated for second-time clients prior to transfer were substance treatment (15/18)[16], mental health services (12/17), and parenting classes (8/17).

[16] All but one (16 out of the 17) respondent reported substance abuse as the main reason they transferred second-time clients, but only 15 of the 17 cited "substance treatment" as one of the services they provided.

Table 8
Common Reasons Repeat Clients Were Transferred to OS

Risk Category	Number	Percent	Risk Category	Number	Percent
Substance Abuse	16	94%	Domestic Violence	1	6%
Poor Parenting Skills	6	35%	Lack of Cooperation	2	12%
Truancy	1	6%	Other	1	6%
Inadequate Housing	4	24%	Inadequate Finances	0	0
Previous Referrals	0	0%	Cognitive Impairment	1	6%
Mental Health Issues	11	65%	Physical Abuse	2	12%
Medical Neglect	0	0%	Criminal Involvement	2	12%
Inadequate Supervision	2	12%	Parental Lack of Maturity	0	0

Total Number of Intake Respondents=17 **Total Number of Responses=49**
*Note: Percentages add up to more than 100% because each subject selected up to 3 response categories.

As Table 9 illustrates, more than half of OS CWs reported they provided services to repeat clients for 18 months or longer, but transfers to Placement from OS were not common. When asked how many repeat clients they transferred to Placement, 9 reported less than 10%, 5 reported less than 20%, and 5 reported they had not transferred any. Most (63%) reported they conducted home visits, on average, between 2-3 times per month. The most common reasons for transfer to placement were substance abuse, mental health issues, and "other".

Table 9
Most Common Reasons Repeat Clients Were Transferred to Placement

Risk Category	Number	Percent	Risk Category	Number	Percent
Substance Abuse	12	52%	Domestic Violence	1	4%
Poor Parenting Skills	3	13%	Lack of Cooperation	3	13%
Truancy	2	9%	Other	9	39%
Inadequate Housing	6	26%	Inadequate Finances	0	0%
Previous Referrals	0	0%	Cognitive Impairment	0	0%
Mental Health Issues	10	43%	Physical Abuse	1	4%
Medical Neglect	4	17%	Criminal Involvement	2	9%
Inadequate Supervision	3	13%	Parental Lack of Maturity	3	13%

Total Number of Intake Respondents=24 **Total Number of Responses=62**
*Note: Percentages add up to more than 100% because each subject selected up to 3 response categories.

Reported Strengths & Shortcomings

- *Connection to Resources*

Table 10 contains perceived shortcomings regarding the agency's ability to connect repeat clients with appropriate resources. Both departments regarded the provision of needed treatment, particularly parenting education, substance intervention, and mental health services, as an Agency strength. Once again, Intake and OS CWs mentioned non-specificity of resources as a shortcoming. One CW remarked upon the consequences of over-generalized service plans: "Unfortunately, the repeat clients fell [feel] that the system failed them by doing everything for them or not getting them the services that they asked for while in OS."

Table 10 *Reported Agency Shortcomings Re: Connection to Resources For Repeat Clients*	
Office 1, Intake Dept.	**Office 1, OS Dept.**
making the same mistakes with service delivery **Unfortunately, the repeat clients fell (feel) that the system failed them by doing everything for them or not getting them the services that they asked for while in OS.**	**Not helping with job search/employment for Parents.**
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
--N/A---	**Lack of financial support.** **reinforce m/h attendance** **Too generalized for families we serve .** **Does not provide family specific services.** **limited providers. Cannot always find a different provider for a service that the family already had.** **Lack of financial support.** **Does not provide family specific services. Similar services that they had previously.**

- *Safety Management*

CWs provided minimal feedback for repeat clients in this category, but one Intake worker did mention a related attitude: "Rather be safe than sorry". One worker reported difficulties with maintaining contact to ensure safety, but another listed safety-related "supervision" as an Agency strength. County A's policy states:

> "…safety related information shall be [recorded] using the In-Home Safety Assessment Worksheet by the County Agency at designated intervals. The safety plan must also be continually reviewed and amended, if necessary, based on the gathered safety related information",[17]

documented "safety status" may vary depending on the individual assessor's perspective, but the actual safety management process is not different for repeat cases than for first-time clients.

[17] Final In-Home Intervals Policy, July 2012

- *Information Gathering & Transfer*

In Table 11, we see agency strengths regarding information gathering and transfer for repeat clients. General consensus among respondents in this category was that both processes are less time-consuming with repeat clients. The Agency's push for Intake CWs to "investigate more intensely the second time" was a positive factor for one Intake respondent. Another Intake CW's reported shortcomings involved perceived restrictions on case acceptance: "Agency knows there are issues (usually D&A or m/h) but can't get hard proof to keep a case open! These problems persist & we get more referrals…" Nearly all (3/4) OS respondents felt it was helpful to have a "history of..what worked/what didn't" with repeat clients. As with first-time clients, OS respondents focused on inefficiencies in Intake's initial case documentation and the "time lapse" in transfer of case files from Intake to the ongoing worker.

Table 11
Reported Agency Strengths Re: Information Gathering & Transfer For Repeat Clients

Office 1, Intake Dept.	Office 1, OS Dept.
Investigating more intensely the second time. HV. The hx The agency already has on the family helps to assess the new allegations. Knowledge of their history. The caseworker already has background information to compare to the present conditions Transfer process is easier	You can discuss why they returned, identify the issue… information about the clients (tend?) to be readily available. History of case what worked/what didn't.
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
having old files to look through. Familiar w/the extensive history of the family	Often many former caseworkers still work here, (therefore) CW gets good feedback.

- *Client/Agency Relationship & Communication*

Table 12 identifies strengths in the agency's relationship with repeat clients. Nearly all (4/5) OS workers identified strengths with repeat service provision on both sides in the Client/Agency Relationship & Communication category—on the Agency's end (e.g."building rapport") and on the recipients' side (e.g."clients are more resourceful"). Intake cited personal "familiarity w/family's history" as a particular benefit.

Table 12
Reported Strengths Re: Client/Agency Relationship & Communication With Repeat Clients

Office 1, Intake Dept.	Office 1, OS Dept.
still giving people a chance to fix things prior to getting services... The clients are already knowledgeable of CYS and their guard may be laxed to the point that they are open for help or services. Clients go back to same case worker if still w/Agency for a sense of familiarity.	building rapport w/the family. Clients are more resourceful. Return them to the right track.
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
Establishing a positive working relationship with clients based on previous experience w/ worker. Recognition of "generational" families	They know exactly what will happen if They are not compliant after a while. Reengaging, Counseling. Depending on the worker. the family ...will be informed and educated about the purpose of OS and the expectations.

Table 13 notes shortcomings in the agency's relationship with repeat clients. Intake workers documented negative aspects of the relationship: They described the Agency as a "bully" and the clients as "manipulative" and "uncooperative". OS Workers mentioned problems with clients' characters ("needy", "manipulative") and the Agency's lack of motivation on the second try ("Agency may not feel the family will change so little effort is given to helping them succeed") as a shortcoming. Both departments also repeated their criticisms regarding the Agency's tendency to "force" clients to participate in services in this category.

Table 13 *Reported Shortcomings Re: Client/Agency Relationship & Communication With Repeat Clients*	
Office 1, Intake Dept.	**Office 1, OS Dept.**
Clients sometimes have their cases closed because of lack of cooperation. **Assuming the werse.** **The agency judging the family by their hx.** **The family knowing how to manipulate the system.** **difficult to keep a case open when family is uncooperative w/o court involvement.** **The clients felt that they were basically bullied to do something and not treated or spoken to with respect.** **Clients get repeat chances that they show they do not deserve.**	**Harp on old issues.** **Enablement** **Clients may become needy** **Clients know how to manipulate the system** **Empty "threats."** **No true authority**
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
Depending on the circumstances, OS can be very negative and forceful w/clients because they were open several times in the past. At times, clients aren't "ready" for change so they will need more supports instead of the puntative workers	**No 3+4 chances.** **Due to previous (times?), the family is labeled and have to prove more and complete more services.** **Agency may not feel the family will change so little effort is given to helping them succeed.**

- *Case Planning & Prevention*

Table 14 shows agency strengths in case planning and prevention for repeat clients. CWs' responses for repeat clients did not differ much from their remarks about first-time clients in this category. One OS CW remarked upon long-term advantages for clients who receive OS more than once: "adequate parenting skills greatly improve." An Intake CW wrote that "use of previous record to get a big picture on the family" was also an agency strength. One OS CW, however, associated a surprising benefit with repeat services: "some caregivers become more self aware."

Table 14 *Reported Strengths Re: Case Planning & Prevention For Repeat Clients*	
Office 1, Intake Dept.	**Office 1, OS Dept.**
Use of previous record to get a big picture on the family-- **ability to monitor CH & parents' progress regularly**	**You can…offer other resources that can help long term.** **... resources are quickly mapped out to help intervene in the clients situation.** **Some caregivers become more self aware**
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
----N/A----	**Adequate parenting skills greatly improve.** **keeping the case open as long as the family still has needs, even if the family doesn't agree.**

Table 15 lists agency limitations in its case planning and preventive services to repeat clients. One Intake CW felt that case planning for repeat cases was "not getting at the root cause of the clients main issues". OS responses centered around inappropriate service periods (5/7) and assessment problems, such as "not resolving the same child welfare issues". As with first-time clients, several respondents (5/14) from both departments listed concerns that poor planning is creating dependency among some long-term recipients. Half of all respondents (7/14) referred to preemptive case closures or court supervision as contributing factors in the "cycle" of repeat client involvement with the agency.

Table 15 *Reported Shortcomings Re: Case Planning & Prevention For Repeat Clients*	
Office 1, Intake Dept.	**Office 1, OS Dept.**
There is not a guarantee that the client will follow through with requirements to end the cycle of being involved. Not getting the root cause of the clients main issues.	don't address the reoccurring issues. Consistent involment due to not resolving the same child welfare issues. Enables clients Rushing to request court supervision.
Office 2 , Intake Dept.	**Office 2 , OS Dept.**
The cases are closed too fast thus having them repeat the same offenses	They tend to keep some family for years with little to no end in sight. Sometimes a lot of paper work is completed before a caseworker or supervisor can talk to an attorney about a case and what is needed to get adjudication and an order for all the services needed. cases closed before issues were resolved. Keeping them open too long. Closing prematurely. closing them to soon. helping clients maintain independence after inital involvement. Preventive Not Emphasized

Survey Data Discussion

Case Workers perceived County A's services as minimally effective at preventing chronic neglect. They viewed both their own efforts to enact change and their supervisors' decision-making skills as organizational strengths, but they criticized agency policies for being too general and short-sighted. Case Workers also documented issues such as investigative time restrictions and "cookie-cutter" service plans as examples of limitations on their ability to conduct accurate family needs assessments and connect parents to appropriate resources.[18]

Survey responses regarding the relationship between organizational attitudes towards neglect perpetrators and recidivism rates were less clear. Participants frequently associated the County's pejorative approach with noncompliance among chronic perpetrators, but they did not

[18] It is unclear whether the resource connection problem stems from the administration's unwillingness to consider (or fund) family-specific services or an actual dearth of program options in the community.

apply the same syllogistic reasoning to reverse circumstances.[19] By and large, survey answers denoted significant detachment between service providers and recipients. Case Workers expressed distrustful attitudes towards repeat clients (as evidenced by their reliance on previously assigned workers for case histories rather than the families themselves) and intermittent bias against them (for example, by describing dependent clients as "manipulative" or "needy"). While there was no consensus on which side is ultimately responsible for preventing re-involvement, it is abundantly clear that Case Workers do not believe the Agency is addressing the root causes of child neglect.

INTERVIEW DATA PRESENTATION

Reported Service Needs & Provision

Table 16 illustrates resource needs and self/other perception needs among client parents. Interviewees agreed that parents need informal (social) and formal (social services) supports in order to succeed. The DHHS Administrator stated that economic stability was an important factor. From the two former CWs' perspectives, parental self-awareness is one prerequisite for a healthy relationship with their children. The Resource Specialist defined good parenting in terms of perseverance and role model capacity. Subjects pointed out that procreation does not establish ownership, but they offered different justifications: the retired CYS CW argued that every child is unique, and their needs are distinct from their parents', while the policy advocate suggested that juveniles' needs are inseparable from the family unit itself.

[19] Several CWs mentioned individual workers' communication and engagement skills, but they did not make a connection between these positive attributes and reduced recidivism.

Table 16 *Resource Needs & Self/Other Perception*					
	Retired CYS CW	**Family Therapist (former CYS CW)**	**DHHS Admin.**	**Resource Specialist**	**Policy Advocate**
Supports	..they might need D&A counseling, parenting classes, for an unwed, very young teen mom Like a blanket over the situation, hopefully that works	a healthy support system will really make a difference.	Economic stability..If you're in a lower class and are limited in resources, you need to have stability to meet your needs.	access to..resources they [are] lacking…	Family and connections are really important to healthy social and emotional development
Self/Other perception	You ..have a solid understanding of yourself. Parenting is not ownership…it requires recognition of the child as a unique person…	Sometimes, with [repeat neglect].. the first thought is they didn't understand it the first time. They just don't understand what it takes to be a good parent.	the difficulty is to get families to realize there was a problem...and take some ownership and accountability	[Our} lead Parent Parter [was]..a [former]Heroin addict who overdosed..[she went] through all of that and can still..help other people	It really goes to that fundamental question of whether you see children on their own or acknowledge them as part of a family.

As Table 17 shows, the overarching need among all subjects' clients was sound judgment. Interview subjects acknowledged a number of different variables, such as drug addiction and mental health issues, that might warrant poor decision-making (and initial maltreatment reports). All five subjects suggested that parents are role models for children, and their values are passed on to the next generation. The family therapist reported that community-sanctioned child abuse is more pronounced in rural areas:

Some of the folks who are in the system are so marginal that they're not gonna reach out for support. The Mom in a small town with [a picky child]-- the response she would get would be, 'Beat their ass until they eat'.

In contrast with the other respondents, the policy advocate argued that physical neglect is not always the product of unreasonable parents; rather, it is the symptom of financial limitations.

Table 17 *Family History & Parental Judgment*		
	Family History	**Parental Judgment**
Retired CYS CW	**I had a mother who[se] husband had died in the war..she [would] get off work and come home and drank to oblivion..then her oldest daughter had a baby and that baby came into custody.**	**[One family] had dirty houses, head lice …the kids would go to school dirty...Dad would do..A lot of the time..illegal stuff, dealing drugs to make money. And Mom was just sooo in love with him, had these kids when she was a teenager herself. They would come into the system& then 6 months later, they would come back.**
Family Therapist (former CYS CW)	**In our house growing up, if you weren't vomiting and or having diarrhea, you went to school. That was the value in our home.**	**Some parents really struggle, for example, low-functioning parents, their ability to retain might not be same as their neighbor with a college degree.**
DHHS Admin.	**if you come from a very dysfunctional family background, it's highly probable you'll be a dysfunctional parent.**	**Parents need…good or rational judgment. I see a difference [between 1st-time and repeat clients] in that the issues... are more chronic or severe . Generally, repeat clients' pattern would be substance abuse.**
Resource Specialist	**it seems to be working better with the new method of giv[ing] the parent a proverb role model [if] their parents weren't role models to them.**	**[Our Parent Partners] have had an addiction, and ha[d] a child taken away, and been reunified. Primarily they are mentors…so a mother freaking out will call at 3 in the morning, and they're trained to deal with that, to deal with pretty much everything.**
Policy Advocate	**when [CPS] talks about chronic neglect situations, [they] isolate some of these children from their families….it should really be a two-generation strategy.**	**Physical neglect is tied to poverty. Not every family should be treated the same way when they come into the system. We wanna be smart about how we approach them…parents often love their kids and want to do well for their family.**

Agency Strengths

In Table 18, interviewees provide examples of the benefits of CYS employees' experience. The DHHS Administrator pointed out the value of experienced CWs, who were "more likely to work to keep the family in the home" because they are less likely to overreact to perceived safety threats, and they are more familiar with alternative resources that prevent the need for foster care. The Resource Specialist described her organization's current "Parent Partners," whose children had been placed by CYS in the past because of their drug addiction, as particular assets. She explained that CYS reunified the Parent Partners' families because they

got sober; as a result, they are now able to provide exceptional support and first-hand knowledge to other parents who are struggling with the same issues.

Table 18
Agency Strengths Re: Employee Experience

	Retired CYS CW	Family Therapist (former CYS CW)	DHHS Administrator	Resource Specialist
Employee Experience	You're only gonna be as strong as your people are. Not everybody can do this work.	I think bringing in a more experienced worker can cut through the nonsense.	Seasoned workers are probably more likely to work to keep the family in the home.	Our Parent Partners [can] say, "I know how you feel." They've overdosed…they really do know. People find a lot of value in that.

As shown in Table 19, "Interconnectedness" between CYS and other public service agencies was another commonly-cited strength. On the whole, respondents with immediate physical and technological access to schools and law enforcement felt most like they were part of a team. The retired CYS CW explained that her agency's relationship with the local schools was helpful because the teachers "[helped] keep an eye on the kids." Finally, the Policy Advocate mentioned her local agency's decision to distribute screening and investigative responsibilities among several different supporting organizations (e.g. the statewide child abuse hotline and other child advocacy centers) as a benefit in terms of reducing CYS CWs' workloads.

Table 19
Agency Strengths Re: Interconnected Departments & Relationship With Schools

	Retired CYS CW	DHHS Admin.	Resource Specialist	Policy Advocate
Inter-connected Depts.	physical & technological connection to other social service depts	We have access to an array of formal services, and can coordinate resources when clients need them.	We're really like a living 2-1-1. But when you call [us], you know everyone. And we try to get the things that 2-1-1 can't refer you to.	We have the statewide Hotline, and CPS is not responsible alone …there are 5 different child advocacy centers which act as [investigative] hubs.

	Retired CYS CW	Family Therapist (former CYS CW)	Resource Specialist
Relationship w/Schools	we had CPS CWs that were assigned to the school… so.. your colleagues keep an eye on the kids	I did a lot of talking about CAN at schools. I'd say to teachers, "Listen to what the kids are telling you. Don't ignore them."	We're doing relationship building with the schools..they know who we are & they refer people to us.

Table 20 provides positive examples of the agency's commitment to organizational growth. Three of the five interview subjects commended their respective agencies for adopting new initiatives in safety assessments, work load reduction, and case planning. The Resource Specialist pointed out that her community service organization is working alongside a local CYS agency to instigate non-threatening investigative approaches; in her experience, dual-agency efforts have the potential to reveal entire contextual stories underneath alleged abuse. The DHHS Administrator also framed dual investigations as new opportunities to assess the agency's methods and function. It is worth noting that neither of the former two CYS CWs commented in this category because they had left their positions at their respective agencies before said initiatives began.

Table 20
Agency Strengths Re: Commitment to Organizational Growth

	DHHS Administrator	Resource Specialist	Policy Advocate
Commitment to Organizational Growth	**We just implemented the [national] model for assessing safety…the new model is a validated assessment tool.**	**[DHHS] has us tag along on the side, to do some things… to test them out and show what might work better.**	**This year, the legislature put 20 million dollars towards bringing us into alignment with national best practice standards [for caseloads].**

Agency Shortcomings

Table 21 highlights agency limitations in employee retention and appropriate workload allocation. All five subjects observed high turnover rates and burnout among their colleagues. The Family Therapist designated dual responsibility for the contentious relationship: "Clients feel like nobody's gonna listen…but on the other hand, workers are sometimes demeaning to parents." In part, the attitudinal issue may be attributed to vicariously traumatic experiences:

I have a client, she adopted two kids who were removed from their parents' care because Mom was a Meth head. The 4 month old kids were hospitalized with broken bones. So. It would be really hard to sit there and talk to parents like that when something horrible had happened to the children.

Three subjects also discussed heavy workloads as a contributing factor in burnout: "fighting among DHS and its contractors" and "huge waiting lists" for services were particular problems for the Resource Specialist and the Policy Advocate.

Table 21
Agency Shortcomings Re: Employee Retention & Workload Allocation

	Retired CYS CW	DHHS Admin.	Policy Advocate
Employee Retention	There's a lot of turnover, a lot of burnout. I've been out of field for 5 years, but sometimes I'll have a nightmare and be right back w/some awful stuff.	I struggle with worker turnover and burnout, especially in the Investigative unit…there you see the worst of the worst.	I grew up with a social worker mom, who did adoptions and foster care, so I've seen how frustrating that can be. You can feel so trapped.
	Family Therapist (former CYS CW)	**Resource Specialist**	**Policy Advocate**
Work Load	You've got 5 million [cases] a week. It's not that the workers are inefficient, just overwhelmed. I was the only worker in a small county and I had up to 30 families.	There's a huge waiting list for [the 5] Parent Partners & they're on call 24/7.	We're seeing a lot of fighting [among DHS and contractors] about who's responsible for what-it's detracting from the real systemic issues that need reform.

Table 22 highlights agency limitations regarding proper training for its employees. On the whole, participants contended that education and preparation for workers at their respective organizations was insufficient. The Family Therapist discussed the need for more effective training that is "useful in the field." The DHHS Administrator suggested that-- despite training seminars that promote "family-centered practice"-- workers tend to apply "cookie-cutter" solutions to family problems. The Resource Specialist expressed similar concerns: She recalled her organization's pattern of "throwing in the towel" when it appeared that client families could not organize adequate resources on their own.

Table 22 *Agency Limitations Re: Employee Training*			
	Family Therapist (former CYS CW)	**DHHS Admin.**	**Resource Specialist**
Training	**I see a need for more effective training among CPS workers..something that's gonna be useful to them in the field.**	**There's not really case planning. Even though we all believe in—train our workers in—family centered practice, it's very easy for workers to get caught up in the "cookie-cutter" approach to family problems.**	**We go through training [but] it seems like..when the family claims their resources aren't enough, we always fall back to, "Let's just give you these things," or throw in the towel, or do the work for them**

Table 23 highlights respondents' common barrier to effective service provision: limited funding. The Policy Advocate criticized the federal government's funding allotment in favor of out-of-home care as a possible incentive for placements, and the Family Therapist also discussed Medicare's barriers to timely treatment for willing participants. Ultimately, the DHHS Administrator argued, case plans that offer only one or two resources produce very few results because "I can give you a parenting class for 6 weeks, give you substance treatment…but if I still leave you with no job, no education, no way to provide for your family, it's inevitable you will come back".

Table 23 *Agency Shortcomings Re: Funding & Resources*					
	Retired CYS CW	**Family Therapist (former CYS CW)**	**DHHS Admin.**	**Resource Specialist**	**Policy Advocate**
Funding/ Resources	**You never have enough funds to do what you need. It's worse now…the economy is bad & people are trying to do more w/less.**	**.. if parents don't realize their substance use is causing a problem, that's a real waste of resources. Millions and millions and millions of dollars.**	**I think all agencies would acknowledge they're underfunded—in technology, specialized services-- we're limited in our resources**	**[We serviced] a lot of elderly folks that didn't have enough to eat…our target isn't even the elderly, it's families with children.**	**We are investigating about 1/2 of the reports we receive calls on every year, which is a lot more than other states.**

Table 24 illustrates agency shortcomings in terms of organizational flexibility. Participants listed concerns with CYS' size, age, and rigidity. The Resource Specialist and the Family Therapist observed CYS' inability to respond to unique locations and circumstances:

"DHHS is not able to adapt to different neighborhoods," and "second-time services are less tailored for the family." For the retired CYS CW, transporting children between remote locations was a logistical "nightmare." Overall, all five participants concurred that CYS interventions are frequently generic and overly "reactive."

Table 24
Agency Shortcomings Re: Organizational Flexibility

	Retired CYS CW	Family Therapist (former CYS CW)	Resource Specialist
Organizational Flexibility	[my] kids were in the middle of the state, & the parents were from Indian tribes, hours away, and trying to get visitation, doing cultural things with these kids, that was a nightmare.	I think possibly second- time around services are less tailored for the family, just repeating what they're already done.	DHHS [is] not able to adapt to different cities, neighborhoods, communities..[they] need different things. You can't throw one solution over a whole state.

Interview Data Discussion

Interviewee's perspectives on the agency's approach to and implementation of neglect prevention initiatives were varied. Some were more confident than others about the utility of standardized FSPs and SPs, but most felt the case planning process should be more collaborative. All respondents believed the agency should partner more closely with schools in order to identify and provide services to struggling families before they became "agency-involved." Interviewees also categorized cultural, linguistic, and economic differences between the agency and its clients as complicating factors in the case planning process. While each subject shared anecdotal stories and some quantitative evidence of success, they also indicated that positive outcomes were the exception to the norm.

One of the central tenets of Social Work is the belief that people can change for the better, but facilitating that process is quite difficult. Participants reported that poor training, lack of resources, and overwhelming caseloads impaired their relationship with clients. It was particularly difficult for inter-agency respondents to maintain faith in parents who presented as

unwilling or incapable of behavior modification. Reciprocal fear and doubt were common themes: providers thought some parents were intentionally deceitful, but they also recognized reactive patterns among colleagues who experienced child death or serious injury on their case loads. On the policy side, the immediate conflict was merely a symptom of a much larger problem surrounding legislative discomfort with--and subsequent demonization-- of the poor.

ANALYSIS

Cross-Data Comparison

This study examined the factors that contribute to chronic neglect among clients who have received extensive CYS services. Survey respondents associated substance abuse (68%), mental health issues (51%), and inadequate housing (24%) with recidivism, while interview respondents reported patterns with repeat clients that included socio-economic depravation and lack of parental motivation. All 5 interview subjects and the majority (71%) of survey participants also identified programmatic shortcomings as contributing factors in repeat neglect incidences. These results suggest that the benefits of CYS intervention are quite limited and may be outweighed by any number of pre-existing family circumstances.

The literature suggests that the agency's interaction with client parents does not have a long-term effect on their attitudes and abilities as caregivers (Mathews & Bross 2008, Hindley & Ramehandni, 2006). The results of this study clarified this argument: Providing family-specific services were available, respondents from both data pools (51%, or 21/41 of survey participants and 4/5 interview subjects) perceived intervention techniques as successful in low-severity cases with pre-networked clients who agreed with case plan goals. My own experience in this regard is

consistent with my findings: In most cases, lifelong parent/child interaction patterns are extremely difficult to change because one or more of the above-mentioned variables is usually missing from the equation.

There has been a record decline in nationwide physical abuse (NIS 2010), but it appears that the agency's persistent attempt to quantify and treat chronic family dysfunction with a standardized formula is ineffective because neglect rates remain constant (ibid). One-third of all survey respondents pointed out that the "root cause" of child neglect is often overlooked; instead, agency policy encourages workers to focus on treating the immediate symptoms of the problem. In addition, Interviewees suggested that CYS' ostensibly uniform approach to family evaluation is nearly impossible to enforce because individual bias, cultural upbringing, and diverse value systems among workers and their supervisors have a significant impact on perceived needs and subsequent safety interventions. Finally, my finding that clients with inadequate support networks are more likely to re-perpetrate CAN –particularly in severe substance abuse cases— lends supporting evidence to Bae & Solomon's (2010) SEF theory, which proposes that personal impairments decrease caregiving capacity.

Case planning only goes so far. Survey findings regarding the agency's connection of clients to resources were positive overall, but Interviewees—particularly those with direct agency experience-- argued that services are often limited, inaccessible, or unwanted. It is unclear why more than half (22/41) survey respondents reported dissatisfaction with the agency's prevention initiatives (or lack thereof) but general agreement with County A's policies. Perhaps this discrepancy is explained by current employees' unwillingness to overtly criticize upper management. On the other hand, it may simply be the product of young, inexperienced workers' limited perspective on policy's implications for practice.

Although I was not able to find a direct connection between employee attitudes and recidivism, my collected data led me to an important realization: Just as clients need support in order to succeed, so do agency workers. Perhaps as an attempt to protect CWs from work-related stress, the agency discourages workers from fostering emotional connections with their clients. However, this action may produce unintended consequences. From the first day of my internship, it seemed there was automatic distrust among all relevant parties throughout the entire process, from screening to case closure. Considering the high levels of interest in child and family wellbeing that drew most survey participants to the field, it is unsurprising that burnout, paranoia, and withdrawal are so common; in fact, this finding suggests that some County A employees suffer from the same vicarious trauma their supervisors aim to prevent (Price & Shackleford, 2007). While two of the Interviewees appeared to derive comfort from the fact that they could soften the resentment their clients felt by listening and empathizing, they reported that the pressure on individual workers to guarantee the safety of multiple families' children simultaneously was often too heavy to bear.

If it is true that staff motivation and commitment to mission is our greatest strength, perhaps extra-rigorous safety plans are not the built-in precaution that policy makers hoped they might be. At best, they appear to have a neutral effect—neither survey respondents nor interviewees indicated any change in their colleagues' commitment to ensuring child safety, permanency, and wellbeing after the implementation of new safety regulations. At worst, they produce a number of adverse consequences: increased tension in the client/agency relationship over SP enforcement, increased child removal rates, and decreased independence among clients.[20] Despite these widely-acknowledged shortcomings, the child death fear remains strong:

[20] The most common complaints I hear about Safety Plans from clients are, "You act like you don't trust me," and "You're treating me like a child."

County A lost two children this year, and safety regulations are tighter than ever before. Departmental supervisors might help to ameliorate the situation by adopting more flexible monitoring standards and by encouraging their workers to adopt creative, family-centered approaches to child safety.

Implications

These findings suggest there is an immediate need for County A to apply more funding to prevention efforts and alternative approach interventions. Prior research (Slack, 2009) has shown that Primary Prevention Programs (PPP) such as Nurse-Family Partnerships, which target at-risk populations before maltreatment occurs, produce outstanding results. Parents who have received agency services in the past most likely have completed the standard parenting class and counseling curriculum. Therefore, repeat clients may be more inclined to participate in family-stabilization programs in the alternative tracks, particularly if they are offered services on a voluntary basis. In addition to conserving limited Agency resources, PPP and alternative tracks contain the additional benefit of increased "buy-in" (i.e. internalization) among willing recipients.

Second, these findings point to the importance of re-framing County A's authoritative relationship with clients by introducing collaborative intervention measures that are specifically designed to strengthen clients' existing informal supports. For the past decade, many states—including OR, NE, ME, AZ, IL, and DE--have been experimenting with "Family Group Decision Making" (FGDM), an empowerment tool that encourages parents and extended relatives to design their own case plans. Preliminary studies (American Humane, 2010; J. Nice, 2006), in conjunction with Interviewees' positive feedback, suggest that FDGM is a promising solution to

recidivism because it mobilizes kinship stakeholders and designates them with the joint responsibility to ensure child welfare long after the Agency's retreat.

Finally, programmatic adjustments are in order. Survey and interview participants' concern regarding the implications of heavy caseloads were consistent with nationwide trends (Besharov, 1980, Krason, 2007, NIS 2010). On a few rare occasions, I have had the opportunity to take a colleague along with me to visit families who are the subject of serious maltreatment allegations. In those instances, I discovered that two heads were better than one, for two reasons: 1) We were able to conduct the initial assessment more quickly and thoroughly, and 2) The experience was half as emotionally taxing as it would have been otherwise. Therefore, I highly recommend that County A consider assigning cases to partnered CWs as a means to reduce workloads, increase efficiency, and stave off burnout.

Study Limitations

The main technical limitation in this project's design was its limited participant pool. I surveyed a convenience sample because it was necessary to study "naturally formed groups" (e.g. specific departments) within my organization (ibid, p. 155). Admittedly, unequal numbers of participants in the Intake and OS departments limited my ability to match participants according to certain attitudes and skill sets. Furthermore, while interviews served to clarify and expand upon survey results, subjects in the former data pool did not constitute a representative sample. Future studies with expanded participant pools and matched control groups are needed to determine the generalizability of my results.

It is important to note a major inconsistency between national statistics on recidivism (Federal InterAgency Focum on Child & Family Statistics, 2011, Children & Youth Services Review, 2012) and my own findings. Working from intra-state data, Bae & Solomon (2010)

conclude that the three most consistently identified ecological factors among duplicate CAN perpetrators are domestic violence, mental health, and single parenthood. Paradoxically, my respondents only perceived mental health as a major issue. It is unclear how much respondents' physical residence, personal interest, and current employment fields contributed to this result.

As County A continues to grapple with employee turnover, limited funding, and the frustrations involved in dealings with "noncompliant" parents, it will be important to consider new ways to stem the tide of endless referrals. In order to grow as an organization, policy-makers need time and space to reflect upon what has worked and what has failed in the past. Hopefully, this study contributes to the change process by highlighting workers' perceptions of recidivism as a critical factor in the agency's capacity to fulfill its stated mission.

Conclusion

This study aimed to answer the central research question: *Which factors contribute to the continued neglect of children by parents who have received extensive CYS services in the past?* According to survey participants, client recidivism is primarily rooted in programmatic shortcomings. Case Workers felt that County A's interaction with client parents is beneficial during the direct service period(s), but it does not produce long-term improvements in their attitudes and abilities as caregivers. They were also concerned with dependency [e.g. relational issues] and attitudinal factors such as blame and judgment. To paraphrase participants' own words, CAN interventions are meaningless unless the families accept them as relevant and the Agency also believes in parents' capacity to change.

According to Interview participants, inadequate social support is the primary reason for recidivism among CYS clients. Respondents did not make a substantial distinction between initial and repeat clients' circumstances, nor did they report applying markedly different

intervention techniques during the first and second service periods. They did, however, observe more severe family dysfunction and investigative intensity with subsequent referrals. Inter-agency staff mentioned individual motivation as a factor that contributes to recidivism more frequently than extra-agency respondents. However, the former ultimately conceded that extremely unstable parents are likely to return to the agency unless they develop sufficiency via strong formal and informal supports.

The extent to which agency services and its relationship with clients affects long-term parenting attitudes and behaviors remains unclear. While more than one interview respondent noted the inherently "adversarial" component of government intervention in private citizen's lives, they also offered numerous examples of the thanks they had received for their service. The DHHS Administrator captured both perspectives in their description of the agency/client relationship as "mixed" because—despite widespread perception of CYS as "punitive"—local surveys of former clients yielded appreciative results.

Recommendations for Future Research

Future research should include longitudinal studies, in which "participants, processes, or systems are studied over time, with data being collected at multiple intervals" (Singleton & Straits, 2009, p. 510). Longitudinal study design might help to identify the ways in which certain variables within the agency, such as program budget fluctuations, correspond to changes in client recidivism over time. Likewise, experimental design studies, which "aim to manipulate the independent variable while controlling extraneous variables," might help researchers determine whether new programs, such as FDGM, are producing better outcomes for clients than traditional interventions (ibid, p. 512). In combination, these two methods might shed light on the

differences between the factors that appear to contribute to chronic neglect (e.g. lack of informal and formal supports) and their relevance to the topic of inquiry.

While this study does highlight the preponderance of drug addiction in five states, longitudinal studies that measure public health and street drug availability are needed to determine whether Opiate abuse is increasing nationwide, and how such a conclusion might better inform child welfare policy in County A. Another practical consideration regarding substance abuse interventions is quality of assessments. My findings suggest that holistic evaluations, which specifically incorporate SEF factors, would produce the best results. Anecdotally, I have observed that my own chronically addicted clients also report a history of childhood rape and molestation. Thus, it may be worthwhile for future inquiries to examine sexual victimization therapy as a relapse prevention measure in conjunction with traditional treatments using predictive validity measures (Groenwald, 2006) to determine whether there is a correlation between the two variables.

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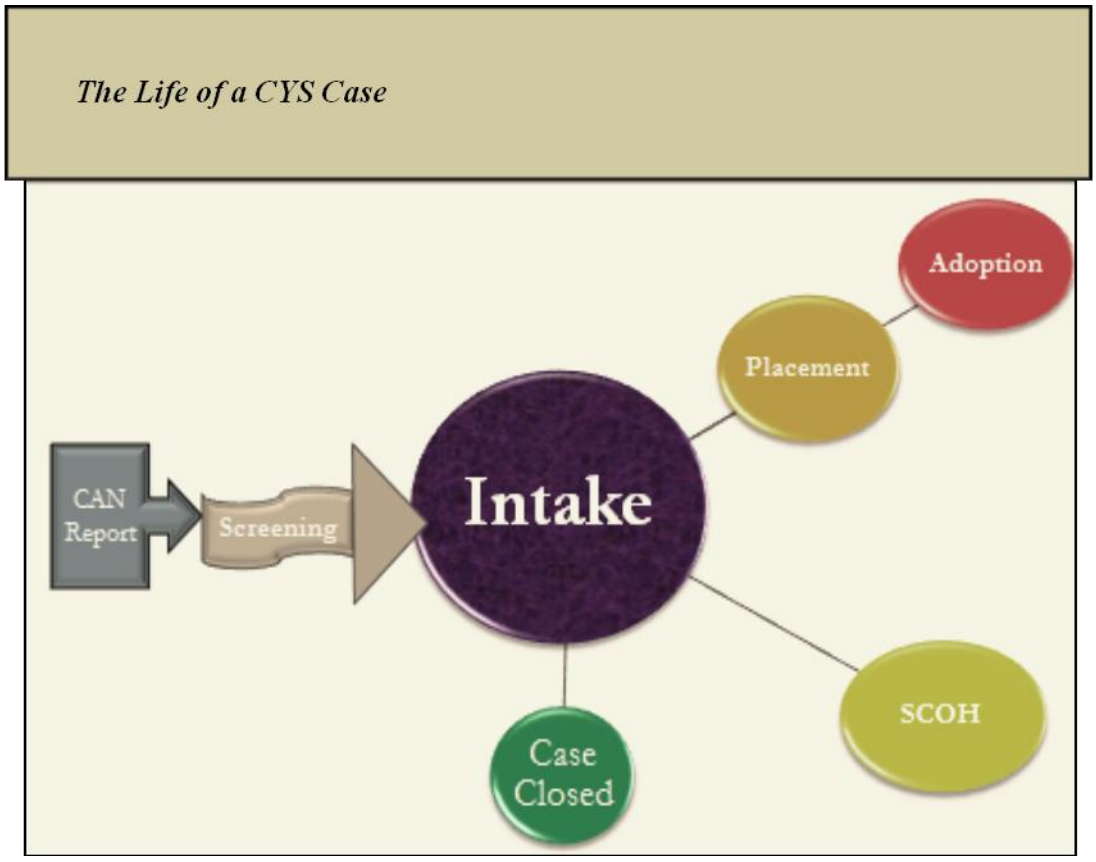
Appendix A: The Life of a CYS Case



Appendix B: Intake Survey Questionnaire

INTAKE CASE WORKERS SURVEY

[Please answer the following questions as they pertain to you.]

1. Age Range: [___21-25] [___ 26-30] [___ 31-35] [___36-40] [___ 41-45]

2. How long have you worked at CYS?: [___0-3 yrs.] [__ 4-6yrs.] [___ 7-9 yrs.] [___ 10-12 yrs.]

3. How often do you agree with CYS' overall policies regarding interaction with clients?
   [___ Never] [___ Not often] [__ Sometimes] [___ Usually] [___ Always]

4. What is your level of familiarity with standard procedures & policies for case management in your department?
   [___ None] [___ Beginner] [___ Moderate] [___ Advanced]

5. Please indicate how often you agree with the decisions your direct supervisor makes about your cases:
   [_ Never] [_ Almost Never] [_Sometimes] [_ Most of the time] [_ Always]

6. Please mark your skill level or knowledge in each of the following 6 categories:

- Family Counseling: [_None] [_ Beginner] [_Moderate] [_Advanced]
- Substance Abuse/Addiction & Treatment: [_None] [_Beginner] [_Moderate] [_Advanced]
- Mental Health Diagnoses, Medication, & Treatment: [_ None] [_Beginner] [_Moderate] [_Advanced]
- Domestic Violence Intervention: [_None] [_Beginner] [_Moderate] [_Advanced]
- Child Development: [_None] [_Beginner] [_Moderate] [_Advanced]
- Community Resources: [_None] [_Beginner] [_Moderate] [_Advanced]

7. Please briefly explain why you chose to work at CYS:

FIRST TIME CLIENTS TRANSFERRED TO OS

[The following questions apply only to your FIRST TIME clients (e.g. clients who had never received services from any CYS agency in the past) who were transferred to OS from Intake.]

1. Since you started working at CYS, about how many FIRST TIME clients did you transfer to OS?
   [__Less than 10%] [__ 10-20%] [__ 20-30%] [__ 40-50%] [__ More than 50%]
2. How many times (on average) during the intake period did you conduct home visits with FIRST TIME clients who were later transferred to OS?
   [__1 time] [__ 2-3 times] [__ 4-5 times] [__ 5-6 times] [__ 7-8 times]
3. How quickly (on average) did you transfer FIRST TIME clients to OS?
   [__Within 1-2 weeks] [__ Within 3-4 weeks] [__ Within 5-6 weeks] [__ Within 7-8 weeks]

4. From the options below, mark the 3 MOST COMMON reasons why you transferred FIRST TIME clients to OS:
   [These options apply to caretakers, not children.]

   __Substance Abuse __ Mental Health Issues __ Criminal Involvement

   __Inadequate Finances __ Domestic Violence __ Truancy

   __Inadequate Supervision __Physical Abuse __ Parental Lack of Maturity

   __Poor Parenting Skills __ Lack of Cooperation w/CYS __Medical Neglect

   __Cognitive Impairment __Criminal Involvement __ Inadequate Housing

   __Previous Referrals

   Other:_____

5. From the options below, circle the 3 MOST COMMON services you initiated for FIRST TIME clients who were later transferred to OS:

   __Parenting Classes __ Collab. w/medical providers __Substance Treatment

   __Mental Health Svcs. __Anger Management __ Daycare Assistance

   __Collab. w/academic providers __ Counseling __ Collab. w/law enforcement

   Other:_____

6. Please briefly identify CYS' main strengths in serving FIRST TIME clients who are transferred to OS:

7. Please briefly identify CYS' main shortcomings in serving FIRST TIME clients who are transferred to OS:

REPEAT CLIENTS TRANSFERRED TO OS

[The following questions apply only to repeat OS clients [e.g. You transferred them to OS after they had already received OS at least once from any CYS agency in the past.)

1. Since you started working at CYS, about how many REPEAT clients did you transfer to OS?
   [_Less than 10%] [_ 10-20%] [_ 20-30%] [_ 40-50%] [_ More than 50%]
2. How many times (on average) during the intake period did you conduct home visits with REPEAT clients who were later transferred to OS?
   [_1 time] [_ 2-3 times] [_ 4-5 times] [_ 5-6 times] [_ 7-8 times]
3. How quickly (on average) did you transfer REPEAT clients to OS?
   [_Within 1-2 weeks] [_ Within 3-4 weeks] [_ Within 5-6 weeks] [_Within 7-8 weeks]

4. From the options below, circle the 3 MOST COMMON reasons why you transferred REPEAT clients to OS: **[These options apply to caretakers, not children.]**

__Substance Abuse	__ Mental Health Issues	__ Criminal Involvement
__Inadequate Finances	__Domestic Violence	__ Truancy
__Inadequate Supervision	__ Physical Abuse	__ Parental Lack of Maturity
__Poor Parenting Skills	__Lack of Cooperation w/CYS	__Medical Neglect
__Cognitive Impairment	__Criminal Involvement	__ Inadequate Housing
__Previous Referrals	Other:_____	

5. From the options below, circle the 3 MOST COMMON services you initiated for REPEAT clients who were later transferred to OS:

__Parenting Classes	__Collab. w/medical providers	__Substance Treatment
__Mental Health Svcs.	__ Anger Management	__ Daycare Assistance
__Collab. w/ academic providers	__Counseling	__ Collab. w/law enforcement

   Other:_____

6. Please briefly identify CYS' main strengths in serving REPEAT clients who are transferred to OS:

7. Please briefly identify CYS' main shortcomings in serving REPEAT clients who are transferred to OS:

Appendix C: OS Survey Questionnaire

OS CASEWORKERS SURVEY

[Please answer the following questions as they pertain to you.]

1. Age Range: [__21-25] [__ 26-30] [__ 31-35] [__36-40] [__ 41-45]

2. How long have you worked at CYS?: [__0-3 yrs.] [__4-6yrs.] [__ 7-9 yrs.] [__ 10-12 yrs.]

3. How often do you agree with CYS' overall policies regarding interaction with clients?
   [___ Never] [___ Not often] [__ Sometimes] [___ Usually] [___ Always]

4. What is your level of familiarity with standard procedures & policies for case management in your department?
   [___ None] [___ Beginner] [___ Moderate] [___ Advanced]

5. Please indicate how often you agree with the decisions your direct supervisor makes about your cases:
   [_ Never] [_ Almost Never] [_Sometimes] [_ Most of the time] [_ Always]

6. Please mark your skill level or knowledge in each of the following 6 categories:

- Family Counseling: [_None] [_ Beginner] [_Moderate] [_Advanced]
- Substance Abuse/Addiction & Treatment: [_None] [_Beginner] [_Moderate] [_Advanced]
- Mental Health Diagnoses, Meds. & Trtmt.: [_ None] [_Beginner] [_Moderate] [_Advanced]
- Domestic Violence Intervention: [_None] [_Beginner] [_Moderate] [_Advanced]
- Child Development: [_None] [_Beginner] [_Moderate] [_Advanced]
- Community Resources: [_None] [_Beginner] [_Moderate] [_Advanced]

7. Please briefly explain why you chose to work at CYS:

[The following questions apply only to your FIRST TIME OS clients (e.g. clients who had never received OS services from any CYS agency in the past)

1. On average, how long did you provide OS services to FIRST TIME clients?
   a) Less than 6 months b) 6 months c) 1 year d) 18 months e) 2 years d) Other:_____
2. Since you started working at CYS, about how many FIRST TIME clients did you transfer to Placement?
   a) Less than 10% b) 10-20% c) 20-30% d) 40-50% e) more than 50%
3. How quickly (on average) did you transfer FIRST TIME clients to Placement?
   a) Within 1-2 weeks b) Within 3-4 weeks c) Within 5-6 weeks d) Within 7-8 weeks
4. How many times per month (on average) did you conduct home visits with FIRST TIME clients during the OS period?
   a) 1 time b) 2-3 times c) 4-5 times d) 5-6 times e) 7-8 times

5. From the options below, circle the 3 MOST COMMON reasons why you transferred FIRST TIME clients to Placement: **[These options apply to caretakers, not children.]**

Substance Abuse	Mental Health Issues	Criminal Involvement
Inadequate Finances	Domestic Violence	Truancy
Inadequate Supervision	Physical Abuse	Parental Lack of Maturity
Poor Parenting Skills	Lack of Cooperation w/CYS	Medical Neglect
Cognitive Impairment	Criminal Involvement	Inadequate Housing
Previous Referrals	Other:_____	

6. From the options below, circle the 3 MOST COMMON services that your FIRST TIME clients received:

Parenting Classes	Collab. w/medical providers	Substance Treatment
Mental Health Svcs.	Anger Management	Daycare Assistance
Collab. w/ academic providers	Counseling	Collab. w/law enforcement
Other:_____		

7. Please briefly identify CYS' main strengths in serving FIRST TIME OS clients:

8. Please briefly identify CYS' main shortcomings in serving FIRST TIME OS clients:

REPEAT OS CLIENTS

[The following questions apply only to REPEAT OS clients [e.g. You provided OS services to them after they had already received OS at least once from a CYS agency in the past.)

1. On average, how long did you provide OS services to REPEAT clients?
   b) Less than 6 months b) 6 months c) 1 year d) 18 months e) 2 years d) Other:_____
2. Since you started working at CYS, about how many REPEAT clients did you transfer to Placement?
   b) Less than 10% b) 10-20% c) 20-30% d) 40-50% e) more than 50%
3. How quickly (on average) did you transfer REPEAT clients to Placement?
   b) Within 1-2 weeks b) Within 3-4 weeks c) Within 5-6 weeks d) Within 7-8 weeks
4. How many times per month (on average) did you conduct home visits with REPEAT clients during the OS period?
   a) 1 time b) 2-3 times c) 4-5 times d) 5-6 times e) 7-8 times

5. From the options below, circle the 3 MOST COMMON reasons why you transferred REPEAT clients to Placement:
   [These options apply to caretakers, not children.]

Substance Abuse	Mental Health Issues	Criminal Involvement
Inadequate Finances	Domestic Violence	Truancy
Inadequate Supervision	Physical Abuse	Parental Lack of Maturity
Poor Parenting Skills	Lack of Cooperation w/CYS	Medical Neglect
Cognitive Impairment	Criminal Involvement	Inadequate Housing
Previous Referrals	Other:_____	

6. From the options below, circle the 3 MOST COMMON services that your REPEAT clients received:

Parenting Classes	Collab. w/medical providers	Substance Treatment
Mental Health Svcs.	Anger Management	Daycare Assistance
Collab. w/ academic providers	Counseling	Collab. w/law enforcement

   Other:_____

7. Please briefly identify CYS' main strengths in serving REPEAT OS clients:

8. Please briefly identify CYS' main shortcomings in serving REPEAT OS clients:

Appendix D: Reasons for Working at CYS

Figure 1

Please Explain Briefly Why You Chose to Work at CYS

Intake Respondents

Professional/Academic Connection to the Field	Financial Motivation	Personal Interest	Social Conscience	Other
*To gain experience in the field of social work. *Familiarity with the type of job. *I participated in the CWEB program for my BSW & really enjoyed interning with the agency. I felt like I was using more skills than any other job Iwould get.	*Need for a job. *It was the first job offer in 14 months of unemployment. *Benefits	*I choose to work at CYS because I enjoy working with families that have problems. *I wanted to work with children and families. * I like working with children. * I have an extensive background in customer services and a minor in Psychology, therefore, it is only fit for me to continue to work with people.	*I like to see when my family can begin to resolve there problems with the help of the agency. *I like to help ppl. *Dedication to children and families. * I like the fact of knowing I can really help them get out of bad situations. *To help the helpless children have a voice. To help families better care for thier children. To have a positive impact. * I wanted to begin working in a career that provided services that people needed, rather than what they wanted. I did not obtain a degree in Social Work nor did I ever imagine having such a job...[but] I have enjoyed my experience and I am more than confident that I can help others, even when they do not see it at first.	*I was curious.

Professional/Academic Connection to the Field	Financial Motivation	Personal Interest	Social Conscience	Other
	*I needed a job. *They hired me. *Initially because I needed a job w/benefits to support my children.	* It's my calling in life. *Specifically because I enjoy working with children and families. *I know we can't save them all but the few I did made a difference in my life!	*I'd like to help families in maintaining their households and keeping their children safe. * Once I started working here, I realized that I could make a difference in the life of a child who might not get a chance to get out from under the abuse.	

OS Respondents

Professional/Academic Connection to the Field	Financial Motivation	Personal Interest	Social Conscience	Other
* [The Agency] gives caseworkers experience in many fields--D&A, MH, foster care or in-home services, etc. *Good experience. *..for advancement opportunities. *I chose to work [here] in order to gain experience working with children and Families. I (intend?) to work overseas with Child Protection Services so working at [the Agency] wil help me gain in depth understanding of Policies and structures put in place to ensure safety of children. *Gain experience in the field. 555	*.. the benefits of a govt. job are a lot better than doing social work at a non-profit. * Better salary and benefits than previous job. 22	*I chose to work at [the Agency] because I wanted to work with kids. *Enjoy working with children and families. *Enjoy the field of social work. 333	* I have always wanted to help people become more independent and give them the tools, encouragement and self confidence to allow them to grow and help themselves and their families. *Wanted to help children and give them a voice when they cannot speak for themselves.222	*Change of enivorment.

Professional/Academic Connection to the Field	Financial Motivation	Personal Interest	Social Conscience	Other
*I used to be a TSS worker in the school setting. I felt as though the problems most of the children I worked with had originated from issues within the home. *I was looking for an opportunity to continue in the field of social work *Field of study. *Participated in the CWEB program. *I worked for ACS for 16 years in NYC. When I moved to this area I looked for a job in the same field.	*[The Agency] had job openings and is close to my home. *First place to hire out of college. * first reel opportunity after my graduation in 2009. We were already in the midst of the recession. *..I needed employment after being laid off. * I needed a job. * I had to give my year back [to the Agency] in exchange for payment of my tuition. I've been here evey since *Needed work.	* Wanted to work in the field of child welfare. *... Mostly the children. *I like working with children and families. 3/666	*I wanted to work at CYS so I could work from the root of the problem. *To work with families in need. *I wanted to be able to see if I made a difference in a family. 3/555	*...My wife had a job that did not allow her to be there for child care emergencies, so I had to be.

Appendix E: Agency Strengths in its Service to First-Time Clients

Figure 2
Agency Strengths in its Service to First-Time Clients **[Sureys]**

Intake Responses

Connection to Resources	Safety Management	Info. Gathering & Transfer	Client/Agency Relationship & Communication	Case Planning & Prevention
*The ability to provide services such as parenting education, D&A assessments & psychological evaluations. *Finding resources--food, bed, MH, D&A, etc. *Ability to provide numerous services to assist +support the family such as transportation +housing assistance, referrals to MH, D+A, + other providers, etc. *[The Agency] is able to provide information about community resources that families may not have known existed.	*lots of safety checks. *Supervision	*Contacts. *lots of follow-up w/family. *Being able to assess and know that 1st time they're going to need services.	*Giving people chances to fix things on their own before requiring CYS intervention. * If they are willing the family could have an opportunity to see what a child welfare agency does (not just "take" children). *By being on the outside and not passing judgement, many parents were able to open up and ask for information or assistance when they did not have the previous support from family and friends.	*Case management that helps develop a plan to prioritize objectives. *ability to monitor CH & parents' progress regularly

Connection to Resources	Safety Management	Info. Gathering & Transfer	Client/Agency Relationship & Communication	Case Planning & Prevention
*Making sure proper services are provided to reduce further involvement	*putting safety plans in place.	*gathering info.	-------	*Most times, I assume, these families do not need ongoing services for long and do not become reopened with the agency.

OS Responses

Connection to Resources	Safety Management	Info. Gathering & Transfer	Client/Agency Relationship & Communication	Case Planning & Prevention
*Services offered and resources used. *Community Resources. Helping w/housing. Helping w/utilities. *Helping to access resources. Ensuring daycare/education for children. *Help give the clients the assistance to get started. *Make them aware of resources.	*Ensuring safety of children *[policy] guidlines (How you see 1st time clients in the beginning 1x/week). *Passion for providing safety in the home and making sure the basic needs of the child(ren) are met.	*To identify the family issues * good at gathering information.	*Counseling on child welfare issues *Strengths based.	*...assist the family to become self sufficient and independent. *Coming up with goals to prevent removal of children.

Connection to Resources	Safety Management	Info. Gathering & Transfer	Client/Agency Relationship & Communication	Case Planning & Prevention
*Able to start services right away. *Assisting in housing stability. *Assist w/mental health. *Connecting cients to services in the community. *Makes clients aware of under utilized community resources *Parenting class. Providing resources (vouchers). *Assessing clients' needs and making referrals IF there is already an identified provider for the services needed, such as housing with CAADC or mental health with NHS or CCH. Helping with	*[SCOH] Policy:Weekly visits for 8 weeks.	*Policy:Transferring worker required to get initial releases, photos prior to transfer. *Obtaining records/information gathering	*First time clients are much less dependent on Help from CYS from what I have observed. First time clients have Not had any past experience with another CW that influences their perception or expectations of myself. *Engaging and listening. *Depending on the worker the family will be informed and educated about the purpose of SCOH and the expectations	*Completing service plans that explain why and how services are needed and will be provided

Appendix F: Agency Shortcomings in its Service to First-Time Clients

Figure 3

Agency Shortcomings in its Service to First-Time Clients **[Surveys]**

Intake Responses

Connection to Resources	Info. Gathering &Transfer	Safety Management	Client/Agency Relationship & Communication	Case Planning & Prevention	Other
*Making sure that the family are receiving the proper resources. *SCOH services are not involved enough, or not intense enough, for some clients. *Providing too many services at once. *Philadelphia has (fazed?) out services for clients who just need help w/housing or resources.	*Paperwork can't be done timely b/c of caseload so risk assessment is done later rather than sooner. *Not enough info. at times to transfer. *If there was a lot more support in the investigation instead of the allegations made my (by) those who always want to remain anonymous, then many cases would be closed. *Dealing w/highly needy clients is stressful when one is in intake trying to move cases quickly.	------	*Being too lenient on substance abusers. *Making people do psychological. *I don't think there are shortcomings, it's all in how the clients recieve the services. They may be resistant or accepting of the SCOH unit. *Many times in Intake, supervisors automatically judge a client based on the referring information and they provide personal opinions, when they should not. *Railroading people into services.	* Little to no change occurrs and/or clients remain with the agency for a long time. *Intensity of initial visits for clients who are at lower risk * Clients sometimes only need minor help but then the Agency takes over. *...When the caseworker is able to debunk [referral] allegations, sometimes supervisors do not listen and still find it necessary or not to provide the proper service or end involvement with the family.	

Connection to Resources	Info. Gathering & Transfer	Safety Management	Client/Agency Relationship & Communication	Case Planning & Prevention	Other
-4	*not having enough time to gather info. on family 5	------	* lack of putting oneself in the client's situation and being overly judging about client situations. *Not giving proper explanations about the need for ongoing services 7	* no formal "structure" for how SCOH services are implemented. 5	*staff turnover is a major shortcoming

OS Respondents

Connection to Resources	Info. Gathering & Transfer	Safety Management	Client/Agency Relationship & Communication	Case Planning & Prevention	Other
*Not helping with job search/employment for Parents.	*Proper assessment when closing cases. * Thorough proper transfer of info. when cases transfer. *The clients are not helped within the first month [after transfer]. *Time lapse		*Sometimes empty threats are provided when clients show lack of motivation or cooperation. *Not holding the parents more responsible for their actions. *Empty "threats" *No true authority	*... they are not given the proper resources to become independent. *SCOH sometime enables clients by doing too much. *Enables clients *Rushing to request court supervision.	*Lack of involvement of fathers.

Connection to Resources	Info. Gathering & Transfer	Safety Management	Client/Agency Relationship & Communication	Case Planning & Prevention	Other
*Not always have effective services. *Low needs assistance (mostly financial). *Referral to PACT when not necessary. *CYS does not provide sercices that are family specific. *since it is a single county providing sercies it is hard to find nitch services. For example, a client with a cognitive disability that would make it unlikely that she can ever safety parent her special needs child on her own but could do so with support. Unlike a large city such as New York or Philadelphia there are no long term supportive housing programs in Delco.	*Having a clear understanding of the families' situation *more info need on families back ground prior to meeting. *Too long before SCOH gets file & casenotes from transferring CW.	*For the most part safety plans are inadequate and difficult to monitor	*First time clients sometimes have wrong information about what services or what CYS's purpose really is. * Collaboration w/the worker on decisions involving the family they are working with. Favoritism in decision making. *to much hand holding	*Preventive Not Emphasized. *helping clients maintain independence after inital involvement * keep families involved w/the agency too long and They become dependent on the agency	*construction of agency not such to put Emphasis on more qualified + Experienced workers being on Front End---pay them more.

Appendix G: Agency Strengths in its Service to Repeat Clients

Figure 4

Agency Strengths in its Service to Repeat Clients **[Surveys]**

Intake Responses

Connection to Resources	Info. Gathering & Transfer	Safety Manager	Client/Agency Relationship & Communication	Case Planning & Prevention
*Services such as parenting education, D&A assessments & psychological evaluations. *Setting up services	*Investigating more intensely the second time. *HV. *The hx The agency already has on the family helps to assess the new allegations. *Knowledge of their history. *The caseworker already has background information to compare to the present conditions *Transfer process is easier	*Supervision.	*still giving people a chance to fix things prior to getting services... * The clients are already knowledgeable of CYS and their guard may be laxed to the point that they are open for help or services. *Clients go back to same case worker if still w/Agency for a sense of familiarity.	* Use of previous record to get a big picture on the family-- * ability to monitor CH & parents' progress regularly

Connection to Resources	Info. Gathering & Transfer	Safety Manager	Client/Agency Relationship & Communication	Case Planning & Prevention
	*having old files to look through. *Familiar w/the extensive history of the family	*Rather be safe than sorry" attitude.	*Establishing a positive working relationship with clients based on previous experience w/ worker. *Recognition of "generational" families	

OS Responses

Connection to Resources	Info. Gathering & Transfer	Safety Manager	Client/Agency Relationship & Communication	Case Planning & Prevention
*Assist w/mental health.	*You can discuss why they returned, identify the issue... *information about the clients (tend?) to be readily available. * History of case what worked/what didn't.		*building rapport w/the family. Clients are more resourceful. *Retum them to the right track.	*You can...offer other resources that can help long term. *... resources are quickly mapped out to help intervene in the clients situation. *Some caregivers become more self aware

Connection to Resources	Info. Gathering & Transfer	Safety Manager	Client/Agency Relationship & Communication	Case Planning & Prevention
*They are able to provide needed treatment programs to clients or at least direct them to treatment providers. *Collaboration with outside service providers.	*Often many former caseworkers still work here , (therefore) CW gets good feedback.		*They know exactly what will happen if They are not compliant after a while. *Reengaging, Counseling. *Depending on the worker and (winf?) the family will be informed and educated about the	*Adequate parenting skills greatly improve. *keeping the case open as long as the family still has needs, even if the family

*Note: Red text denotes "repeat comments" (i.e. the responses to the same question for first time and repeat clients did not change.)

Appendix H: Major Agency Shortcomings in its Service to Repeat Clients

Figure 5

Major Agency Shortcomings in its Service to Repeat Clients **[Surveys]**

Intake Responses

Connection to Resources	Info. Gathering & Transfer	Safety Managen	Client/Agency Relationship & Communication	Case Planning & Prevention	Other
*making the same mistakes with service delivery * Unfortunately, the repeat clients fell (feel) that the system failed them by doing everything for them or not getting them the services that they asked for while in SCOH.	*testing for drugs because of past versus issues relevant in current referral. * Agency knows there are issues (usually D&A or MH) but can't get hard proof to keep a case open! Those problems persist & we get more referrals--Need to be able to do more w/less proof.	*Maintaining Contact.	*Clients sometimes have their cases closed because of lack of cooperation. *Assuming the werse. *The agency judging the family by their hx. The family knowing how to manipulate the system. *difficult to keep a case open when family is uncooperative w/o court involvement. *The clients felt that they were basically bullied to do something and not treated or spoken to with respect. *Clients get repeat chances that they show they do not deserve.	*There is not a guarantee that the client will follow through with requirements to end the cycle of being involved. *Not getting the root cause of the clients main issues.	

Connection to Resources	Info. Gathering & Transfer	Safety Managen	Client/Agency Relationship & Communication	Case Planning & Prevention	Other
			*Depending on the circumstances, SCOH can be very negative and forceful w/clients because they were open several times in the past. At times, clients aren't "ready" for change so they will need more supports instead of the puntative workers	*The cases are closed too fast thus having them repeat the same offenses	

OS Responses

Connection to Resources	Info. Gathering & Transfer	Safety Managen	Client/Agency Relationship & Communication	Case Planning & Prevention	Other
*Not helping with job search/employment for Parents.	*Effective/thorough transfer of info. from past case. *time lapse		*Harp on old issues. *Enablement *Clients may become needy *Clients know how to manipulate the system *Empty "threats." *No true authority	* don't address the reoccurring issues. *Consistent involment due to not resolving the same child welfare issues. *Enables clients *Rushing to request court supervision.	*Lack of involvement of fathers

Connection to Resources	Info. Gathering & Transfer	Safety Managen	Client/Agency Relationship & Communication	Case Planning & Prevention	Other
*Lack of financial support. *reinforce m/h attendance. *Too generalized for families we serve . * Does not provide family specific services. *limited providers. Cannot always find a different provider for a service that the family already had such as PACT. *Lack of financial support. *Does not provide family specific services. Similar services that they had previously.	*Lack of case notes from past involvement		*No 3+4 chances. * Due to previous (times?), the family is labeled and have to prove more and complete more services. *Agency may not feel the family will change so little effort is given to helping them succeed.	*They tend to keep some family for years with little to no end in sight. *Sometimes a lot of paper work is completed before a caseworker or supervisor can talk to an attorney about a case and what is needed to get adjudication and an order for all the services needed. *cases closed before issues were resolved. *Keeping them open too long. Closing prematurely. *closing them to soon. *helping clients maintain independence after inital involvement. *Preventive Not Emphasized	* Poor communication between the units and the legal department (lawyers.) The lawyers all have day jobs and only work for CYS for about two days every two weeks. *construction of agency not such to put Emphasis on more qualified + Experienced workers being on Front End--pay them

Note: Red text denotes "repeat comments" (i.e. the responses to the same questions for first time and repeat clients did not change.)

Appendix I: Interview Reference Guide

- The DHHS Administrator: A current Department of Health & Human Services Administrator in the Midwestern region of the U.S.

- The Family Therapist (former CYS CW): A current, Medicaid-contracted family therapist with professional experience in the Drug Court Diversion program and long-term experience as an Intake & OS CW in a rural, Midwestern region of the U.S.

- The Retired CYS CW: A retired family practice therapist who worked as an Intake & OS CW for seven years in the Northeast and Southwestern U.S.

- The Resource Specialist: A Northeast-based resource specialist with an MSW degree who works for a community-building organization under DHHS contract to provide CYS program evaluations & facilitate new intervention initiatives in conjunction with local CWs

- The Policy Advocate: A public policy activist who lobbies for CYS reform in the local and state legislatures in the Midwestern U.S. through a non-profit organization that specializes in child welfare research & advocacy

Appendix J: Interview Questions

1. What do people need in order to be good parents?
2. Do you think the services Child Protective Agencies provides for neglect perpetrators make a difference in the ways clients parent their children? (If so, which ones and in what ways?)
3. In your experience, is there a difference between neglect perpetrators who receive ongoing services once & have their cases closed and those who are referred to ongoing services more than once?
4. Do you handle first-time neglect cases/clients any differently than second-time neglect cases?
5. What are the biggest strengths & limitations you see with state agencies' approach to child protection in neglect cases?

Appendix K: What People Need To Be Good Parents

Figure 6

What People Need to be Good Parents? **[Interviews]**

Category of Need	Retired CYS CW (AZ & DE)	Family Therapist	DHHS Administrator	Resource Specialist	Policy Advocate
supports	Hopefully a support system so you can vent	a healthy support system will really make a difference.	Informal & formal support system. Economic stability..If you're in a lower class and are limited in resources, you need to have stability to meet your needs.	access to..resources they [are] lacking...maybe they have 5 jobs & they're not feeding their child because they can't remember because they're not sleeping	Family and connections are really important to healthy social and emotional development
self/other perception	You need to be a good person first & have a solid understanding of yourself. Parenting is not ownership...it requires recognition of the ch as a unique person...	parents who perceived children as pieces of property...they'd say, "I'd rather my children go to some strangers' house than that S.O.B.'s house [on a safety plan].		..a [former]Heroin addict who overdosed..can go through all of that and still get up every day, look at herself in mirror, and help other people in the same situation.	It really goes to that fundamental question of whether you see children on their own or acknowledge them as part of a family.
learned behaior			I think you parent..how you were parented. So if you come from a very dysfunctional family background, it's highly probable you'll be a dysfunctional parent.	perhaps their parents weren't role models to them...	when you talk about chronic neglect situations...it should really be a two-generation strategy.
caregiving skills	it requires facilitation of [children's] developmental process.	Prioritize children's needs	Good or rational judgment		

Appendix L: Agency Strengths

Figure 7

Agency Strengths [Interviews]

Strength Categories	Retired CYS CW (AZ & DE)	Family Therapist	DHHS Administrator	Resource Specialist	Policy Advocate
Employee Experience	You're only gonna be as strong as your people are. Not everybody can do this work.	I think bringing in a more experienced worker can cut through the nonsense.	Seasoned workers are probably more likely to work to keep the family in the home.	Our Parent Partners [can] say, "I know how you feel." They've overdosed…they really do know. People find a lot of value in that.	
Interconnected Departments	physical & technological connection to other social service depts		We have access to an array of formal services, and can coordinate resources when clients need them.	We're really like a living 2-1-1. But when you call [us], you know everyone. And we try to get the things that 2-1-1 can't refer you to.	We have the statewide Hotline, and CPS is not responsible alone …there are 5 different child advocacy centers which act as [investigative] hubs.
Relationship with Schools	In DE, we had CPS workers that were assigned to the school…lots of ears and eyes in the system, so.. your colleagues keep an eye on the kids	I did a lot of talking about CAN at schools. I'd say to teachers, "Listen to what the kids are telling you. Don't ignore them."		We're doing relationship building with the schools..they know who we are & they refer people to us.	
Commitment to Organizational Growth			we just implemented the [national] model for assessing safety.. the new model is a validated assessment tool	[DHHS] has us tag along on the side, to do some things… to test them out and show what might work better.	This year.. the legislature put 20 million dollars towards bringing us into alignment with national best practice standards [for case loads]