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Navigating the Child Welfare System: An Exploratory Study of Families' Experiences

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Navigating the Child Welfare System: An Exploratory Study of Families' Experiences

by

Lianne Fuino Estefan

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
Department of Community and Family Health
College of Public Health
University of South Florida

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Keywords: child maltreatment, family centered care, qualitative, empowerment, parent

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Dedication

For my father, Michael Fuino

*To have been loved so deeply, even though the person who loved us is gone, will give us
some protection forever. ~J.K. Rowling*

Acknowledgements

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Abstract

Growing up in a family environment that includes child maltreatment can result in an array of negative consequences for children, including health, behavioral, developmental, and social difficulties, and these consequences can persist over the lifetime. Families who have come to the attention of child welfare services for child maltreatment are at particularly high risk for experiencing multiple concurrent problems, including intimate partner violence, substance abuse, and mental health issues, as well as other family challenges. It is essential to intervene effectively with this population. However, there are few qualitative studies of parent experiences in the child welfare system through which to better understand parents' perspectives and identify additional or more effective points of intervention. This exploratory study utilized a mixed-methods design, primarily focusing on in-depth qualitative interviews with parents in the child welfare system, to explore participants' lived experiences within the continuum of child welfare services. Participants in this study experienced a range of interconnected stressors that impacted both their ability to effectively parent their children as well as successfully complete the services required of them by the child welfare system. Qualitative interviews revealed that parents experienced an overall lack of empowerment, effective communication, and support through their experience with the child welfare system, until they accessed the therapeutic services they were required to attend near the end of their time in the system. Parents were more responsive when services were more supportive, rather than punitive, and individualized to their needs and strengths. This study suggests

that systematically implementing more individualized, family-centered services throughout the continuum of services provided by the child welfare system would be effective in intervening with families. Findings also indicate the need for continued qualitative research with parents to address both areas of intervention for families who have already maltreated their children and the prevention of maltreatment and other related stressors in families who are at risk.

Introduction

Purpose of the Study

Growing up in a violent home environment can result in an array of negative consequences for children, including health, mental health, developmental, and social difficulties. Families who have maltreated their children are often at risk for other types of problems, including intimate partner violence, substance abuse, and mental health issues. Studies have shown that child maltreatment and intimate partner violence co-occur in approximately 30-60% of families who experience one or the other of these problems (Appel & Holden, 1998; Edleson, 1999), especially for families involved with child welfare services (Hazen, Connelly, Kelleher, Landsverk, & Barth, 2004; Kohl, Barth, Hazen, & Landsverk, 2005). In addition, substance abuse is a common issue for parents involved with child welfare services, as many studies suggest that between one-third and two-thirds of parents have a substance abuse issue (DHHS, 1999) and some have found rates as high as 50-80% (Marsh, Smith, & Bruni, 2011). Parents involved with child welfare services have also been found to have higher rates of mental health problems than the general population (Park, Solomon, & Mandell, 2006; Staudt & Cherry, 2009). Gaps in both research and practice continue to exist in how to best achieve positive outcomes for maltreated children, especially those living in families with multiple challenges.

The original purpose of this study was to explore the experiences of families in the child welfare system that may be experiencing both child maltreatment and intimate

partner violence. However, in the course of the study, it became clear that families involved with child welfare services experienced stressors beyond intimate partner violence, including substance abuse and mental health problems, which were critical to the understanding of their experiences. Thus, the overall purpose of this study was expanded to explore, in-depth, the experiences of families in the child welfare system that may be experiencing multiple types of stressors, in order to identify points of intervention that will better protect children from harmful influences on their health, development, and safety. Using a family-centered perspective, this study sought to explore and understand the lived experiences of parents as they navigate the child welfare system and related therapeutic services, and whether the presence or absence of co-occurring stressors, including violence, substance abuse, and mental health issues, influenced that experience. In addition, this study examined the profile of families in a child welfare-related therapeutic parenting program, to determine the extent to which multiple family stressors are identified in this population, and the relationship of those risk factors to parents' change in parenting attitudes over the course of the intervention. A mixed-methods design, including in-depth interviews with parents in the child welfare system and a quantitative review and abstraction of program files, was employed to meet these objectives. The goal of this study was to create a set of recommendations to the child welfare system regarding additional types of intervention for families who may be experiencing multiple challenges.

Background and Significance

Children who grow up in stressful home environments, including those involving violence, are at increased risk for experiencing a variety of negative consequences. Recognizing this, the Centers for Disease Control and Prevention (CDC) identified family violence, including both child maltreatment and intimate partner violence, as a significant public health problem in the United States, and targeted the prevention of child maltreatment as one of their three main priority areas in injury and violence prevention. In the development of the national health objectives Healthy People 2020, the U.S. Department of Health and Human Services included multiple goals related to family violence prevention, including reducing nonfatal child maltreatment; reducing deaths due to child maltreatment; reducing physical and sexual violence by current or former intimate partners; and reducing children's exposure to any form of violence. In addition, a CDC-convened panel of child maltreatment experts determined that addressing the co-occurrence between child maltreatment and other forms of family violence was a "cross-cutting" priority relevant to more than one part of the public health model. In particular, the panel recommended the development of "interventions that can affect the precipitating factors and negative consequences of both" (Whitaker, Lutzker, & Shelley, 2005, p. 248).

Maltreated children may experience a range of negative health, behavioral, developmental, and social outcomes as a consequence of abuse. Negative consequences of violence for children include internalizing and externalizing behavior problems; increased potential for depression, anxiety, and post-traumatic stress disorder; difficulty with peer relationships; and cognitive problems (Herrenkohl & Herrenkohl, 2007;

Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Margolin & Gordis, 2000; Osofsky, 2003; Shipman, Rossman, & West, 1999). Studies of maltreated children have found that abused children are more likely to experience insecure attachments than non-maltreated children, which has been associated with a range of poor developmental outcomes, including difficulty forming relationships with peers in childhood, difficulty forming and maintaining romantic relationships in adulthood, and the perpetuation of the intergenerational cycle of violence (Baer & Martinez, 2006; Herrenkohl et al., 2008; Morton & Browne, 1998). Exposure to events that cause fear and anxiety in children have been shown to disrupt the architecture of the brain, potentially resulting in effects on how children learn and solve problems (National Scientific Council on the Developing Child, 2010). Adolescents who experienced violence as children have an increased likelihood of risk-taking behaviors, such as dropping out of school, becoming pregnant at a young age, and engaging in substance abuse, and also may experience higher levels of depression and attempted suicide (Herrenkohl et al., 2008; Margolin & Gordis, 2000). The Adverse Childhood Experiences (ACE) Study found that health problems, including increased risk for multiple risk-taking behaviors and chronic diseases, can persist into adulthood (Anda, Felitti, Bremner et al., 2006; Felitti, Anda, Nordenberg, et al., 1998).

Despite the myriad of negative consequences for children who grow up in violent families, exposure to violence in childhood does not always result in negative outcomes. Studies of overall competence have indicated that 10-25% of maltreated children achieve resilience (Walsh, Dawson, & Mattingly, 2010), a “dynamic process encompassing positive adaptation within a context of significant adversity” (Luthar, Cicchetti, & Becker, 2000, p. 543). In particular, the most consistently predictive factor of positive

outcomes is the availability of a positive relationship with at least one primary caregiver (Luthar, 2006; Margolin & Gordis, 2000; Rutter, 1987; Werner, 1993). This type of social support has been thought to reflect the role of positive parenting in child development (Masten, Hubbard, Gest, Tellegen, Garmezy, & Ramirez, 1999). In the absence of a positive relationship with a parent, trusting relationships with adults outside the family have also been shown to be protective factors, even in young children (Werner, 1993). Given the strength of this research, it is important to consider how to foster resilience in children who have been exposed to violence and other stressors.

Cumulative risk research strongly suggests that children are at risk for an increasing number of negative outcomes as the number of concurrent risk factors in their lives increases (Appleyard, Egeland, van Dulmen, & Sroufe, 2005; Felitti et al., 1998; Gerwitz & Edleson, 2007). Families who have come to the attention of child welfare services are at particularly high risk for experiencing multiple problems and overall family dysfunction. These stressors include intimate partner violence, substance abuse, mental health problems, lower socioeconomic status, and a history of abuse in the parent's family of origin (Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1998; Hartley, 2002; Herrenkohl et al., 2008; Herrenkohl & Herrenkohl, 2007; Kohl, Edleson, English, & Barth, 2005; Shipman, Rossman, & West, 1999), and the rates of the overlapping problems can be quite high. For example, researchers have estimated that 30-60% of families who experience either child maltreatment or intimate partner violence (IPV) will experience both problems (Appel & Holden, 1998; Edleson, 1999). In addition, Marsh and colleagues (2006) found that 30% of parents in the child welfare system who had a substance abuse problem had at least one other problem (e.g., IPV,

mental health issues, or lack of housing), 35% had two other problems, and 27% had three. The overlap of child maltreatment and these other associated family stressors suggests the need for approaches that consider the family holistically, and identify and intervene with the range of problems in the family. This approach to intervention has been identified both by the CDC's Division of Violence Prevention expert panel, specifically in regard to the co-occurrence of child maltreatment and IPV (Whitaker, Lutzker, & Shelley, 2005) as well as the Child Welfare League of America (CWLA, 2003) for families with multiple types of problems receiving child welfare services.

Because maltreating families with co-occurring problems often come into contact with multiple service systems, it is critical for service systems to accurately identify these issues. Physical violence, the most frequently used measure of IPV, is often under-identified by the child welfare system. Hazen, Connelly, Edleson, Kelleher, et al. (2007) found that 43% of families referred to the child welfare system were ever screened for IPV, and even when screening occurred, child welfare workers identified IPV in only one-third to one-quarter of cases (Kohl, Barth, Hazen, & Landsverk, 2005). This under-identification of IPV may be due to other stressors in the family, especially the presence of substance abuse, that overshadow issues of IPV in the child welfare response (Kohl, Barth, Hazen, & Landsverk, 2005). Studies have also indicated that IPV does not play a large role in the child welfare decision-making process (Kohl, Edleson, English, & Barth, 2005).

The lack of adequate systemic attention is not only limited to multiple forms of family violence. Substance abuse is a common issue for parents receiving child welfare services, as many studies suggest that between one-third and two-thirds of parents have a

substance abuse issue (DHHS, 1999). Parents involved with child welfare services have also been found to have higher rates of mental health problems than the general population (Staudt & Cherry, 2009) and are three times as likely to ever have had contact with child welfare services compared to parents without mental health problems (Park, Solomon, & Mandell, 2006). Despite the positive effects of integrating substance abuse treatment and child welfare services on women's reduction of substance abuse, comprehensive services are limited, resulting in unmet service needs (Marsh, Smith, & Bruni, 2011) and families with multiple problems may be less likely to make progress on treatment for substance abuse (Marsh, Ryan, Choi, & Testa, 2006). Libby and colleagues (2006) found that "at a national level for all families involved with child welfare...most of the caregivers with identified drug, alcohol, and mental health problems were not provided treatment services by those child welfare agencies" (p. 630). Studies have suggested that this may be due to the lack of formal coordination mechanisms between child welfare and other service systems, such as mental health (Park, Solomon, & Mandell, 2006). Further, families with multiple problems may have more difficulty reaching their case plan goals, suggesting the need for the child welfare system to target services to the specific needs of each family and assist them in achieving their goals (Marsh, Ryan, Choi, & Testa, 2006).

It is clearly essential to intervene effectively with this population in order to address family problems and ensure the safety and well-being of children. While increasing research attention has been given to systemic and programmatic issues, there exist few qualitative studies of parent experiences in the child welfare system (Alpert, 2005; Baker, 2007; Kapp & Propp, 2002). The lack of research is especially glaring in

regard to the extent to which parents feel in receipt of family-centered services (Alpert & Britner, 2009). In fact, according to Baker (2007), “there is a general dearth of information about how those most closely involved with and affected by the child welfare system [the parents] view their experience in it” (p. 1190). The limited attention in this area is particularly distressing because understanding parents’ perspectives is critical in designing interventions that are effective and responsive to family needs. In addition, Baker (2007) proposed collecting client satisfaction data as a means to empower parents and provide more family-centered services within the child welfare system.

Existing qualitative studies of parents receiving child welfare services have often examined power relationships between parents and the child welfare worker (e.g., Bundy-Fazioli, Briar-Lawson, & Hardiman, 2008; Dumbrill, 2006), and satisfaction with services (e.g., Baker, 2007; Palmer, Maiter, & Manji, 2005). Dumbrill (2006) found that the way parents perceive child protection workers’ use of power was the most important influence on shaping parents’ views and reactions to intervention. Other results of qualitative studies have indicated recurrent themes of communication between child welfare workers and parents (Kapp & Propp, 2002; Shim & Haight, 2006); parental feelings of hopelessness and helplessness as a result of involvement with child welfare services (Haight, Black, Magelsdorf, et al., 2002; Kapp & Propp, 2002); the need for supportive services (Haight et al., 2002), and a lack of respect by child welfare workers toward parents (Kapp & Propp, 2002). These studies indicate that there is a need to better understand how parents, especially those who may be facing multiple challenges, experience services.

The literature suggests that services provided by the child welfare system to families may not be appropriate for their particular needs (Barnett, Miller-Perrin, & Perrin, 2005; English, Edleson, & Herrick, 2005). Thus, understanding what families need and how services can most effectively be provided to the family as a whole is an important line of research.

Justification for the Study

It is clearly necessary to understand the issues of child maltreatment and co-occurring problems in the child welfare population in order to intervene effectively, prevent future occurrences of abuse and neglect, and protect the health and safety of the children in high-risk families. Failure to address co-occurring issues in families may lead to negative outcomes for children, including health and developmental problems, and consequences such as re-entry in to the child welfare system due to continued maltreatment. Little research has considered the parents' lived experiences of navigating the child welfare system, and how the presence or absence of violence, substance abuse, or mental health issues may influence that experience. The family-centered services perspective has been endorsed as a means to improve child welfare systems, but virtually no qualitative research has examined parents' perceptions of whether they are receiving family-centered services.

This study attempted to fill these gaps by investigating how parents perceive their experiences in the child welfare system and exploring whether their experiences differ by different types of problems. In addition, this study empowered parents to discuss their

experiences and voice their opinions regarding about services in a non-threatening environment.

Research Design

The original design of this study focused primarily on parents who both maltreated their children and experienced intimate partner violence, and understanding whether experiencing that overlap led to different experiences navigating child welfare services compared to parents who did not face that challenge. However, the iterative nature of the qualitative process demanded changes to the original research design and analysis plan. As would be expected from the literature, a significant proportion of participants in this study faced challenges related to substance abuse and mental health issues. In the process of data collection, it became clear that these issues were critical in the lives of families and the study would be incomplete without including them. Thus, the scope of the study was expanded beyond violence, in order to explore the responses and experiences of parents with different types of issues.

In addition, the data contained in the program files necessitated a change to the quantitative analysis. The initial research proposal included examining the relationship of stressors to child outcomes, as measured by the *Ages and Stages Questionnaire (ASQ)*. However, upon review of the files, it became clear that there was not enough data on the ASQ to complete these analyses. The files did contain complete pre- and post-test measures for the *Adult-Adolescent Parenting Inventory (AAPI-2)* for all adults who completed the program. The AAPI-2 measures change in parenting attitudes across five domains. The constructs that describe five areas of abusive and neglectful parenting

practices, and a brief description of what each construct measures, are: 1) Inappropriate Parental Expectations of Children (do parents inaccurately perceive the skills and abilities of their children); 2) Parental Lack of Empathy Towards Children's Needs (do parents perceive children's every day, normal demands as unrealistic, resulting in increased stress); 3) Strong Belief in the Use of Corporal Punishment (do parents use physical punishment as the preferred means of discipline); 4) Reversing Parent-Child Family Roles (do parents interchange some of the traditional role behaviors of parent and child, so that parents act like children looking to their own children for care and comfort); and 5) Oppressing Children's Power and Independence (do parents demand obedience and complete compliance to parental authority without allowing children to have choices or voice opinions) (Bavolek & Keene, 1999). The analysis was changed to incorporate this measure and examine the relationship between stressors and change in parenting attitudes instead of child outcomes.

The inclusion of the broader family stressors, as well as the change to measuring parenting attitudes, are reflected in both the revised research aims, as presented below, as well as in both the qualitative and quantitative analyses.

1. Aim 1: To explore the occurrence of intimate partner violence, mental health, and substance abuse in families in the child welfare system referred to an intensive parenting program, and the relationship of these issues to change in parenting attitudes.

Research Questions:

- a.) What is the overall profile of families referred to the intensive parenting program?

- b.) What proportion of families is identified as experiencing co-occurring stressors?
 - c.) Do parenting attitudes, as measured by the *Adult/Adolescent Parenting Inventory*, differ by whether violence has been identified in the family?
 - d.) Do parenting attitudes, as measured by the *Adult/Adolescent Parenting Inventory*, differ by whether substance abuse or mental health issues have been identified in the family?
2. Aim 2: To understand the experiences and service pathways of families who are navigating the child welfare system, who may also have co-occurring problems.

Research Questions:

- a) What are the subjective experiences of parents in the child welfare system?
- b) How do parents perceive the child welfare system and therapeutic agencies to operate, compared to how the system is designed to operate?
- c) How do parents' perceive what referrals were made and services were received, and does their experience vary by whether violence, substance abuse, or mental health issues are present?
- d) How do parents perceive their involvement in and understanding of their service plan?

Overview of Methods

This study employed a mixed-methods design (Tashakkorie & Teddlie, 1998). The background data, used to provide a basis for understanding the families in the population and address Research Aim 1, was obtained through of a review of files of the

Nurturing Parenting program, an intensive, 15-week therapeutic parenting intervention for families involved in the child welfare system or who are at risk of becoming involved with child welfare services. The Nurturing Parenting Program is offered in a group format, facilitated by two therapists, and individuals must attend as a parenting dyad. A dyad is defined as two adults who are involved in the child's daily life. Children age 2-12 attend a simultaneous children's group. Files were reviewed for all participants who completed the Nurturing Parenting Program between July 2008 and October 2010 using a structured file review instrument (see Appendix C). In total, the files of 62 families were reviewed, resulting in data for 124 adults (two caregivers in each family) and their children. Data were entered into a secure online database and transferred to IBM SPSS Statistics 19.0 for cleaning and analysis. Analysis consisted of descriptive analysis of the program participants, Pearson correlations to examine relationships between co-occurring stressors, and Related Samples t-tests to examine change in parenting attitudes before and after the parenting intervention.

The majority of information for this study was collected through in-depth qualitative interviews with a sub-sample of participants in the Nurturing Parenting program, and who either currently or previously received child welfare or preventive diversion services. Interview participants were recruited through presentations to participants currently in the program and flyers mailed to previous participants. In total, 21 individuals completed an in-depth, in-person interview: 11 mothers, 5 fathers, 2 boyfriends, and 2 grandparents who acted as caregivers. Interviews were conducted using a semi-structured interview guide, and questions were developed using family-centered care, the conceptual framework for this study (see Appendix B for interview

guide). Questions were designed to be open-ended, to allow the participants to describe their lived experiences and construct their own meanings of their involvement with child welfare services (Creswell, 2007). Interviews were digitally recorded and transcribed verbatim, and a second coder independently coded the majority of interviews. In addition to these measures to ensure reliability, triangulating data with the results of the file review where appropriate, clarifying researcher bias, and conducting peer reviews contributed to validating the qualitative data.

Definitions of Terms

Child Maltreatment. Each state has its own definition of child maltreatment, based on the federal law. The Federal Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Keeping Children and Families Safe Act of 2003, defines child abuse and neglect as 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 (Department of Health and Human Services [DHHS], 2009a).

Participants in this study were part of the child welfare system in Florida; thus, the state definitions of maltreatment were used in discussing maltreatment. According to the Florida Statutes, Chapter 39, *abuse* of children means any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Unless corporal punishment by a legal parent or guardian for disciplinary purposes results in harm to the child, it is not considered abuse. In the same statute, *neglect* is defined as when a child is deprived of, or is allowed to be deprived of, necessary food, clothing,

shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

Intimate Partner Violence and Conflict. Similar to child maltreatment, intimate partner violence has not been consistently defined across studies, and many studies limit their definition to physical or sexual forms of violence (Barnett, Miller-Perrin, & Perrin, 2005; Saltzman, Fanslow, McMahon, & Shelley, 2002). One of the more common definitions of the types of IPV has come from the Centers for Disease Control and Prevention, which defines IPV as physical, sexual, or psychological harm by a current or former partner or spouse. Intimate partners may be current or former spouses or non-marital partners; need not be in a sexual relationship; and need not be cohabitating (Saltzman et al., 2002). In addition to families in which violence is used as a means of power and control, often by men, Johnson (1995) identified common couple violence. Johnson described common couple violence as a more gender-symmetric form of violence that often erupts in couples as a result of a particular conflict in the course of everyday life and while it involves wanting to control the immediate situation, it does not involve systematic control within the family unit. Both of these types of conflict were considered in this study.

Child Welfare System. The overall goal of the child welfare system is to ensure the safety of children who have been abused or neglected, or who are at risk of abuse or neglect (Fluke & Oppenheim, 2010). According to the Child Welfare Information Gateway (2008b), the child welfare system is “a group of services designed to promote

the well-being of children by ensuring safety, achieving permanency, and strengthening families to successfully care for their children.”

In Florida, the child welfare system began using a privatized, community-based care model in 1997, starting in Sarasota County (Paulson, Armstrong, Jordan, Kershaw, Vargo, & Yampolskaya, 2004). The goals of community-based care are to improve the safety and well-being of children; create community ownership of child welfare issues; shift the responsibility for service delivery to local lead agencies; create a more integrated and comprehensive system; and increase the flexibility of available resources (Paulson et al., 2004). Florida utilizes a privatized, lead agency model of community-based care. This model involves the state contracting the responsibility for all child welfare services, except the initial investigation, to local, community-based agencies. These local agencies are responsible for coordinating and providing all services. The intent of the lead-agency model is to reduce the need for families to navigate fragmented individual services, increase access to services, and increase the sense of trust by parents (Paulson et al., 2004). Hillsborough County, the site of this study, began fully using a community-based care model in late 2002 and the lead agency for child welfare services is Hillsborough Kids, Incorporated (HKI).

Case Plan. Individuals involved with child welfare services are often required to have a case plan, a written document that may be prepared when a child becomes involved with a state child welfare agency. It is always required when the child welfare agency places a child in out-of-home care (e.g., in foster care or with a relative), and in 21 states, including Florida, a case plan is also required if the child and family are receiving any in-home services to prevent placement of a child into out-of-home care

(Child Welfare Information Gateway, 2008c). The state of Florida requires that the case plan include goals and objectives that parents must meet to achieve a safe home for their children; a timeframe for achieving those goals; and a permanency goal for the child. Florida statute requires that the case plan be developed in a face-to-face conference with the parent or, if the parent is unwilling or unable to participate, that this be documented. The parent must also be provided with a copy of the case plan (Child Welfare Information Gateway, 2008c).

Mandated Therapeutic Services. In order to achieve the goals and objectives of the case plan, parents are mandated to attend a variety of services. Depending on the particular goals and objectives of each case plan, parents may be required to attend parenting intervention programs, substance abuse treatment, mental health evaluation or counseling, intimate partner violence counseling (for both victims and perpetrators), or other types of services.

Conceptual Framework

It has been well-documented that families involved in the child welfare system experience a range of stressors and risk factors, and that an increase in risk factors corresponds to an increase in negative outcomes for children. In addition, many children in the child welfare system live with their families throughout the family's involvement with services, which indicates that there is a need to intervene with and engage the family in the service process. To achieve the best possible outcomes for children, it is necessary to design interventions that respond to the range of needs and strengths within a family.

Based on these ideas, family-centered care was utilized as the conceptual framework for this study.

Family-Centered Care

According to the Child Welfare League of America ([CWLA], 2003), a family-centered approach is a way of working with families “both formally and informally, across service systems, to enhance the capacity of families to provide care and protection for their children. It focuses on the needs and welfare of children within the context of their families and communities. Family-centered practice recognizes the strengths of family relationships and builds on these strengths to achieve optimal outcomes for children and families” (p. 30). It is an approach that views the family as central to the child’s well-being and is based upon the core values of providing services that engage, involve, strengthen, and support families in order to ensure the child’s well-being, safety, and permanency (Child Welfare Information Gateway, 2008a). Family-centered approaches are central to a system of care, a comprehensive approach that organizes community services into a coordinated, collaborative network to meet the multiple and changing needs of families (Stroul & Friedman, 1986). The core values of a systems of care include being *child-centered and family-focused*, with the needs of the family determining the type of services; *community based*, so that services as well as the decision-making process is located at the community level; and *culturally competent*, so that all services are responsive to the diversity of clients that they serve (Pires, 2002; Stroul & Friedman, 1986).

As applied specifically to the child welfare system, there are several key components to a family-centered approach. These include:

- Working with the family unit to ensure the safety and well-being of all family members
- Strengthening the capacity of families to function effectively
- Engaging, empowering, and partnering with families throughout the decision- and goal-making processes
- Providing individualized, culturally responsive, flexible, and relevant services for each family
- Linking families with collaborative, comprehensive, culturally relevant, community-based networks of supports and services (Child Welfare Information Gateway, 2008a).

One of the principle ideas underscoring this approach is the need to consider the range of needs, strengths, and preferences of the family. This focus is proposed to result in services that are individualized to address the specific range of issues within a family. In fact, Hodges, Ferreira, Israel, and Mazza (2010) believe that “the primary goal of a system of care is to provide individualized care through a broad array of services and supports” (p. 4). Ideally, this type of approach requires both identifying and acting upon the range of issues with which a family is coping in order to implement services that truly meet their needs and assist them in appropriately caring for their children.

A strengths-based approach is a method of addressing all family issues through “acknowledg[ing] each child and family’s unique set of strengths and challenges, and engag[ing] the family in developing and implementing the service plan. Formal and informal services and supports are used to create service plans based on specific needs and strengths, rather than fitting families into pre-existing service plans” (NTAECSC,

2008). Strengths-based practices are a shift away from the traditional treatment-based deficits model, which has traditionally been used by many human service agencies. Family engagement and empowerment are integral components of a strengths-based approach. Historically, parents have not been involved in the process of determining the range of services and supports that would assist them, and have been expected to meet the conditions of the case plan developed for them (Fluke & Oppenheim, 2010).

Theoretical Underpinnings

The family-centered care framework has underpinnings in several social science theories. These primarily consist of family systems, attachment, and ecological theory.

Family systems theory focuses on the idea of the family as a dynamic, changing system, and considers the family the unit of study instead of an individual within the family (Walton, 2001). This component of family-centered care includes the use of intergenerational approaches and communication patterns within families. In addition, it is the foundation for the concept of intervening with the problems of the family instead of focusing on the issues of only one individual.

Attachment theory suggests that early relationships, especially with the primary caregiver, lay the foundation for future expectations within significant relationships later in life. Problems with attachment often lead to poor developmental outcomes as children age. Early life experiences “place people on probabilistic trajectories of relatively good or poor adaptation, shaping the lens through which subsequent relationships are viewed and the capacity to utilize support resources in the environment. Thus, if early attachments are insecure in nature, at-risk children tend to anticipate negative reactions

from others and can eventually elicit these; these experiences of rejection further increase feelings of insecurity” (Luthar, 2006, p. 756). Walton (2001) posited that “effective family-centered practice in child welfare will include both a profound respect for existing attachments and strategies for promoting and strengthening attachments” (p. 75). Other researchers have also suggested that the nature and quality of attachment should be a factor in determining the types of services to provide to a family in the child welfare system. For example, Mennen and O’Keefe (2005) suggested that for families with secure attachments, intervention should focus on relieving the stressors that lead to the maltreatment and providing support for the family, rather than removing the child from the home.

Ecological theory addresses the concept that an individual develops and adapts within several “nested” systems. These “nested” systems include the microsystem, mesosystem, exosystem, and macrosystem (White & Klein, 2002). It provides a framework for understanding how individuals adapt to the changing environments of their lives, and reciprocally, how the environment adapts. Walton (2001) asserts that ecological theory can serve as a framework around the concepts of parental role, life stressors, and social supports. In the context of a family-centered framework, ecological systems theory provides the basis for the need for systems-level policies and support strategies for high-risk families.

Applications to the Child Welfare System

Historically, the family-centered approach to services was developed in the field of children’s mental health. However, it has been increasingly been referred to as a framework for other child-serving sectors, and the child welfare system has undergone a

paradigm shift over the past 10 years toward using a family-centered approach that involves both family involvement and engagement with the decision-making process (Fluke & Oppenheim, 2010). This paradigm shift resulted from studies that indicated the existence of serious deficiencies within child welfare systems across the country in terms of children's safety, permanency, and well-being. In light of this, a variety of organizations have advocated the appropriateness of this approach in the child welfare system, including the Child Welfare League of America (CWLA), the Department of Health and Human Services (DHHS), the Greenbook, and the Children's Bureau. The driving force behind this focus on family-centered approaches is the assumption that most children's development and emotional well-being are best ensured by keeping the child in the most family-like environment as possible, such as at home or with relatives (Walton, 2001). However, the focus of the child welfare system and related agencies is first and foremost on the safety of children. The primary goal is to assure children's safety and well-being, and placement outside the family is sometimes necessary if a child's safety is at risk.

In the Child Abuse Prevention and Treatment Act (CAPTA), Congress specifically indicated that, "the child protection system should be comprehensive, child-centered, family-focused, and community-based, should incorporate all appropriate measures to prevent the occurrence or recurrence of child abuse and neglect, and should promote physical and psychological recovery and social re-integration in an environment that fosters the health, safety, self-respect, and dignity of the child." In addition, the CAPTA guidelines have indicated that, "national policy should strengthen families to prevent child abuse and neglect, provide support for intensive services to prevent the

unnecessary removal of children from families, and promote the reunification of families if removal has taken place” (DHHS, 2009). The Florida legislature has also echoed this approach, and has recognized “that most families desire to be competent caregivers and providers for their children and that children achieve their greatest potential when families are able to support and nurture the growth and development of their children” (Florida Senate, 2010). Both pieces of legislation underscore the necessity of protecting children’s safety as the primary goal, but also recognize the need to strengthen and support families to appropriately care for their children.

The development of the Greenbook by the National Council of Juvenile and Family Court Judges (Schechter & Edleson, 1999) also supported the need for a family-centered perspective, specifically in the way services were provided to families experiencing both child maltreatment and intimate partner violence. The focus of their recommendations was primarily on the cross-system collaborations among child welfare, domestic violence, and dependency courts in order to effectively respond to these families. Recommendations from the Greenbook have “indicated that case planning should include interventions to address the range of family risks that contribute to the risk of harm to children” (Kohl, Barth, Hazen, & Landsverk, 2005, p. 1217).

One of the difficulties with utilizing a family centered framework in the context of child welfare is the question of safety for all family members, especially children. This question becomes especially relevant in terms of balancing family preservation and child safety. For example, the Adoption and Safe Families Act (ASFA) recently shortened the timeframe for reaching permanency and limits the “reasonable efforts” states must make at reunification (CWLA, 2003; Fluke & Oppenheim, 2010). However,

ASFA regulations also state that parents must be involved in the design of services that are aimed at ensuring safety and permanency (Fluke & Oppenheim, 2010). These issues are difficult to negotiate, given the constraints of the legal system and the inability or inappropriateness of some parents to participate in the process. These concerns may be further intensified in the application of these principles specifically to families who may be experiencing both child maltreatment and intimate partner violence. Because the child welfare system is concerned primarily with the safety of the child and domestic violence agencies are primarily concerned with the safety of the victim of IPV, tension and conflict can arise when trying to intervene in both of these issues within the same family. Given the significant co-occurrence of these types of violence and other stressors in families, research in this area is clearly needed.

Manuscripts

This study was designed to better understand parents' experiences and perceptions of child welfare services in order to design more effective interventions. The results of this study are presented in three separate manuscripts. As described above, the breadth and depth of data collected during the qualitative phase of this study necessitated adding a third manuscript to the two manuscripts that were originally proposed. The final manuscripts are as follows:

- 1) *“Exploring co-occurring family stressors in a child welfare parenting program and relationships to parenting attitudes.”* This manuscript addresses Research Aim 1 and its associated research questions. In addition, qualitative data were included to supplement the findings where appropriate.

- 2) “ ‘*It’s them in control, not you in control:*’ *Exploring parents’ experiences navigating the child welfare system.*” This manuscript addresses Research Aim 2, research questions 1 and 2.
- 3) “*Receiving mandated therapeutic services: Experiences of parents involved in the child welfare system.*” This manuscript addressed Research Aim 2, research questions 3 and 4.

Conclusions

In order to effectively promote the healthy development of at-risk children, “every risk factor we can reduce matters” (Appleyard, Egeland, van Dulmen, & Sroufe, 2005, p. 242). Children in the child welfare system are an especially vulnerable population to negative health and developmental outcomes. Thus, it is necessary to understand the particular range of threats to their health. In addition, it is necessary to understand how best to offer services to families and to reduce the stressors that contribute to maltreatment, in order to enhance their ability to protect and care for their children.

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Manuscript 1: Exploring co-occurring family stressors in a child welfare parenting program and relationships to parenting attitudes

Target journal: *Child Abuse and Neglect*

Secondary journal choice: *Child Abuse Review*

Abstract

Background: Families involved with child welfare services often experience a range of problems in addition to maltreatment, including intimate partner violence, substance abuse, and mental health problems. Children in these families are at risk for developing a myriad of negative health, behavior, learning, and attachment problems. Although parenting education programs are among the most routine interventions for families involved with child welfare services, there is relatively little data available about these programs in this population, especially for families with co-occurring problems.

Purpose: This study sought to explore the occurrence and nature of family stressors in parents involved in the child welfare system who have been referred to an intensive therapeutic parenting program, and the relationship of those stressors to change in parenting attitudes. *Methods:* Quantitative abstraction of parenting program files was completed (N=124) using a structured data collection instrument. Parenting attitudes were measured using the Adult-Adolescent Parenting Inventory (AAPI-2). Analyses

included descriptive and bivariate statistics, and related samples t-tests to examine change in parenting attitudes. In-depth qualitative interviews were conducted with a sub-sample of this population (N=21). *Results:* File abstraction revealed that parents in this population experiencing multiple co-occurring stressors ranged from 23% (fathers with both violence and mental health) to 39% (mothers with both substance abuse and mental health). Significant improvements in parenting attitudes were found as demonstrated by pre-test to post-test improvements in all domains of the AAPI-2 for most groups of mothers and fathers, including those with violence, mental health, and substance abuse problems. Qualitative interviews indicated that parents felt that they were learning from the parenting program and were supported by the facilitators. *Conclusions:* Parents who experience multiple problems are unlikely to be able to parent effectively, and thus are likely to need significant support and intervention. Additional understanding of the types of issues they face and whether particular intervention programs are effective for those groups would allow more targeted, individualized interventions.

Introduction

In 2009, child protection agencies received an estimated 3.3 million reports of child maltreatment, and of these, an estimated 702,000 children were found to be victims of maltreatment (DHHS, 2010). Studies have indicated that in addition to maltreatment, many parents in the child welfare system also experience a range of problems such as intimate partner violence, substance abuse, and mental health problems (English, Edleson, & Herrick, 2005; Kohl, Edleson, English, & Barth, 2005; Marsh, Ryan, Choi, &

Testa, 2006). The co-occurrence of these issues is a significant problem for the health and safety of many children in the United States.

The youngest children, from birth to age 3, are at the highest risk of maltreatment (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; USDHHS, 2010) and maltreatment can have serious, and often life-long, adverse consequences. Cumulative risk research asserts that the greater the number of risk factors present in a child's life, the greater the prevalence of developmental and health problems (Appleyard, Egeland, van Dulmen, & Sroufe, 2005; Sameroff, 2000). These negative consequences for children include internalizing and externalizing behavior problems; increased potential for depression, anxiety, and PTSD; difficulty with peer relationships; and cognitive problems (Herrenkohl & Herrenkohl, 2007; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Margolin & Gordis, 2000; Osofsky, 2003). In addition, attachment studies have shown that children raised in stressful home environments may be less able to bond to their adult caregivers (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008), which has in turn been associated with difficulty forming relationships in both childhood and adulthood and the perpetuation of the intergenerational cycle of violence (Baer & Martinez, 2006; Herrenkohl et al., 2008; Morton & Browne, 1998). Exposure to environments that produce stress and fear in children have also been linked to changes in children's brain architecture, which can lead to lifelong consequences for how children learn and solve problems (National Scientific Council on the Developing Child, 2010).

The accurate assessment of co-occurring stressors in maltreating families is critical in order to intervene effectively. Although adult intimate partner violence (IPV) is frequently associated with child maltreatment, it is often under-identified by child

welfare agencies by 20-30% (Kohl, Barth, Hazen, & Landsverk, 2005). There is also relatively little known about the types of intimate partner conflict that occur in families in the child welfare system (English, Graham, Newton, Lewis, Thompson, Kotch, & Weisbart, 2009). Researchers have suggested that the under-identification of IPV may be due to the presence and identification of other frequently co-occurring stressors in families. In particular, identification of substance abuse in the primary caregiver often overshadows issues of IPV (Kohl, Barth, Hazen, & Landsverk, 2005). Estimates of the percentage of parents with serious substance abuse problems involved in the child welfare system have ranged from one-third to two-thirds of parents (DHHS, 1999) to as high as 50-80% (Marsh, Smith, & Bruni, 2011). Further, studies have found caregiver substance abuse to be the single most potent kind of caregiver vulnerability factor in predicting child maltreatment substantiation (Wekerle, Wall, Leung, & Trocme, 2007). It is clearly critical to understand the range of stressors faced by each family, in order for interventions to be based upon a more comprehensive understanding of the family.

Within the child welfare system, parent training programs are among the most frequent interventions assigned to parents (Barth, 2009; Barth, Landsverk, Chamberlain, Rolls, et al., 2005; Hodnett, Faulk, Dellinger, & Maher, 2009). Despite this prevalence, there is not good national data available about the types of parent training interventions that are routinely used in child welfare settings (Barth et al., 2005). There have been even fewer studies of parenting interventions that are targeted to the family as a unit, despite the fact that stressors that impact the entire family are related to maltreatment (Beckman, Knitzer, Cooper, & Dicker, 2009). In addition, there is limited information on the effectiveness of parenting education programs, particularly the Nurturing Parenting

Program, for maltreating parents with specific co-occurring problems. Only one recent study (Hodnett, 2009) has examined the relationship between parent demographic characteristics on outcomes in that program.

The purpose of this study was to explore the nature and co-occurrence of family stressors, particularly violence, substance abuse, and mental health problems, in a sample of parents involved in the child welfare system who have been referred to an intensive therapeutic parent training program. In addition, this study sought to identify whether parenting outcomes, as measured by the *Adult/Adolescent Parenting Inventory*, differed according to whether or not partner abuse or conflict, substance abuse, or mental health issues were identified in the program files.

Methods

Sample

All information for this study was derived from families who have participated in the Nurturing Parents Program (NPP), an intensive, 15-week therapeutic parenting program for individuals who are involved in or at risk of becoming involved in the child welfare system. The program is administered in a group format; adult groups meet weekly for 2.5 hours, and are facilitated by two therapists. Topics covered in the group include empathy; effective communication; problem-solving; addressing and managing anger; expectations of children's behavior and child development; and types of discipline, including the use of corporal punishment, among others. A children's group, for children ages 2-12, meets concurrently. Adults participate in the program as a parenting dyad. In this program, a dyad is defined as two adults who are involved with the children's daily

life; individuals can be married, co-parenting, or have a familial relationship (e.g., mother and grandmother of a child). Individuals in this program have been screened to not currently be in a physically violent relationship, as measured by the presence of an injunction or disclosure of current physical abuse. However, this does not exclude other types of abuse within the couple, or a history of physical violence in the current or a past relationship.

Program files were reviewed for all classes of participants who completed the Nurturing Parenting program from initiation of the program in July, 2008 until October, 2010. In total, 62 cases were reviewed (each consisting of a parenting dyad), for a total of 124 individual adults. Of these, 81% completed the program. While parenting dyads do not have to be a mother-father couple, only data for mothers (or mother figures) and fathers (or father figures) are presented throughout this paper, because the number of other types of adults was too small to analyze. The final sample consisted of 56 fathers (46 biological fathers, 6 mother's paramours, and 4 step-fathers) and 61 mothers (58 biological mothers and 3 step-mothers). Participants were referred to the program by the following sources: 42% through the child welfare system as a requirement for a case plan; 24% through Child Protection Investigations as a preventive diversion effort before opening a child welfare case; 26% at risk for child welfare or diversion involvement through other agencies, such as Healthy Start; and 8% were self-referred.

A sub-sample of 21 program participants participated in in-depth, in-person interviews: 12 mothers, 7 fathers or boyfriends, and 2 grandparents who acted as caregivers. Fourteen of these participants were referred through child welfare services and 7 through the diversion program.

Data Collection

Data were collected primarily from reviews of program files, and were supplemented with in-person interviews for a sub-sample of program participants.

Program files contained multiple sources from which data were extracted (See Table 1).

Table 1: Data Collection Matrix for Program Files

| Component of Data Collection | Location in Program File | Operational Definition | Type of Analysis |
|---|---------------------------------|--|--|
| Parent demographic information | 2, 3 | Age, race, ethnicity, educational level | Descriptive |
| Child demographic information | 2, 3 | Gender, age, race | Descriptive |
| Type of referral | 1, 2 | Type of referral was either: 1) through child welfare system as requirement for case plan; 2) through CPI as a preventive diversion effort prior to opening a child welfare case; 3) at-risk for system involvement through other agencies; 4) self-referred | Descriptive |
| Reason for referral to child welfare system | 1, 2 | Based on the Florida definitions of maltreatment, in the following categories: physical abuse; neglect; domestic violence; substance abuse; sexual abuse; emotional abuse; homelessness; medical neglect | Descriptive |
| Intimate partner violence (IPV) or conflict | 1, 2, 3, 4, 6 | Reason for referral was violence; either parent had an allegation of IPV; program facilitator noted presence of violence or conflict | Descriptive Bivariate Correlations |
| Substance abuse issues (parent) | 1, 2, 3, 4, 6 | Reason for referral was substance abuse; parent had allegation of substance abuse; facilitator noted presence of substance abuse. Includes illicit drugs, abuse of prescription medications, and alcohol | Descriptive Bivariate Correlations |
| Mental health issues (parent) | 1, 2, 3, 4, 6 | Reason for referral was mental health or facilitator noted presence of mental health problems. Includes depression, anxiety, bipolar disorder, ADD, panic attacks, or other problems. | Descriptive Bivariate Correlations |
| Other parental stressors | 1, 2, 3, 4, 6 | Teen parent (first child born when parent was under age 21); prior termination of parental rights; history of abuse in family of origin; developmental disability | Descriptive Bivariate Correlations (selected stressors) |
| Parenting attitudes | 5 | The 5 sub-scales of the AAPI-2: 1) inappropriate parental expectations of children; 2) parental lack of empathy | Descriptive (mean sub-scale score) |

| | |
|---|------------------------|
| towards children's needs; 3) belief in the use of corporal punishment; 4) reversing parent-child roles; and 5) oppressing children's power and independence | Related samples t-test |
|---|------------------------|

1=biopsychosocial interview (at program intake); 2=referral to parenting program; 3=program intake summary; 4=facilitator progress notes after each session; 5=*Adult-Adolescent Parenting Inventory (AAPI)* pre- and post-tests; 6=other information or communication provided by child welfare case worker

File Review. Files were reviewed using a structured data collection instrument.

Abstracted information included: 1) demographic information about both parents and children; 2) type of referral; 3) reason for referral to child welfare system and nature of child maltreatment allegations, if they were made; 4) identification of past or present intimate partner violence or conflict issues within the couple; 5) other stressors faced by parents, including mental health and substance abuse as well disabilities, history of abuse in the family of origin, teen parenthood, and prior termination of parental rights; and 6) results of the pre- and post-test Adult-Adolescent Parenting Inventory. Table 1 illustrates the component of data collection; location in the file; operational definition; and type of analysis for each item.

To capture attitudes toward parenting and child-rearing, data from the *Adult-Adolescent Parenting Inventory (AAPI-2)* (Bavolek & Keene, 1999) was abstracted. Each participant completed the AAPI-2 before and after the parenting program, and these data were extracted from the file during the file review. The AAPI-2 is a 40-item, Likert-scale inventory that provides an index of child maltreatment risk using five constructs. The constructs that describe five areas of abusive and neglectful parenting practices, and a brief description of each construct's content, are: 1) Inappropriate Parental Expectations of Children (do parents inaccurately perceive the skills and abilities of their children); 2) Parental Lack of Empathy Towards Children's Needs (do parents perceive children's

every day, normal demands as unrealistic, resulting in increased stress); 3) Strong Belief in the Use of Corporal Punishment (do parents use physical punishment as the preferred means of discipline); 4) Reversing Parent-Child Family Roles (do parents interchange some of the traditional role behaviors of parent and child, so that parents act like children looking to their own children for care and comfort); and 5) Oppressing Children's Power and Independence (do parents demand obedience and complete compliance to parental authority without allowing children to have choices or voice opinions) (Bavolek & Keene, 1999). The AAPI-2 has an internal consistency (Cronbach's alpha) ranging from .83 to .98 (Hodnett, Faulk, Delinger, & Maher, 2009).

The information for each parent in the couple is kept in separate, but related files, although in each case, some principal information pertaining to both parents is stored in the file of only one member of the dyad. For example, the father's file contains the referral to the program, but the information in the referral may apply to either or both parents. Therefore, data were collected so that the parenting dyad and children in the family formed a "case," and data for each case was collected on one instrument to form a cohesive picture of the family unit. Children were listed as "Child 1," "Child 2," etc., based on their age, with the oldest child in the family listed first. All data were entered into a password-protected database on a secured computer.

Interviews. Participants were recruited for interviews through two mechanisms: brief presentations by the researcher to ongoing groups, and mailed letters to previous program participants. Potential participants recruited through either method contacted the researcher by phone or email; participants recruited through presentations were also invited to provide their contact information to the researcher if they were interested in an

interview. Parents were excluded if they did not speak English fluently, were not comfortable interviewing in English, were younger than 18 years, or did not have any involvement with the child welfare system or diversion services.

Semi-structured, in-depth, in-person interviews were conducted with 21 participants of the parenting program who had been referred to the program either through child welfare services or diversion services. Interviews lasted approximately 1 hour and utilized a flexible interview guide. The interview guide was developed using a family-centered framework and asked questions about the parent's involvement in the child welfare system; the types of services to which they were referred; empowerment; and whether services met their needs. For the purposes of this manuscript, only participants' comments regarding the parenting program will be presented. All interviews were conducted at a public location. If both members of the couple were interested in interviewing, interviews were held separately. A \$25 incentive was provided for participation.

Analysis

File Review. Data were entered into a password-protected database. Descriptive statistics were conducted on the overall sample as well as on the sub-samples of cases that were classified as having violence, substance abuse, or mental health problems.

Bivariate correlations were performed to examine relationships between the co-occurring risk factors (i.e., violence, substance abuse, and mental health). Related-samples t-tests were performed to examine pre- and post-test differences on the AAPI-2 across eight groups of parents: 1) all fathers; 2) all mothers; 3) fathers with violence issues; 3) mothers with violence issues; 4) fathers with substance abuse issues; 5)

mothers with substance abuse issues; 6) fathers with mental health issues; and 7) mothers with mental health issues. Mean standardized scores were also examined for each AAPI-2 subscale in each subgroup for both pre-test and post-test to examine overall change. All analyses were conducted using IBM SPSS Statistics version 19.0.

Interviews. Interviews were transcribed verbatim and analyzed using Atlas.ti. Prior to analysis, an a priori codebook was developed consisting of general, flexible themes, based on the interview guide. Analysis was ongoing as interviews were conducted and transcribed. Identification of emergent codes occurred throughout the iterative open coding process, and those codes were added to the codebook or used in place of the a priori codes as appropriate. A “second pass” through the data examined conditions and interactions, and determined which categories clustered together (Neuman, 2003). Once major themes were identified and organized, selective coding occurred in order to illustrate themes and make comparisons. For the purpose of reliability and validity, a second coder coded two-thirds of transcripts. After the researcher and the second coder coded each transcript independently, they met and discussed each transcript in depth, and came to consensus on the way codes were applied to the interviews.

This study was approved by the Institutional Review Board at the University of South Florida.

Results

Demographics

Parents. All data are presented by relationship to the child (i.e., fathers and mothers). “Fathers” are defined as biological fathers, step-fathers, or mother’s paramour;

“mothers” are defined as biological mothers, step-mothers, or father’s paramour. Other program participants, such as grandparents, were excluded from the analysis because the numbers were too small to be meaningful. The final sample consisted of 56 fathers (46 biological fathers, 6 mother’s paramour, and 4 step-fathers) and 61 mothers (58 biological mothers and 3 step-mothers).

Table 2 illustrates the demographic characteristics of fathers and mothers:

Table 2: Parent Demographics

| Characteristic | Fathers (n=56) | Mothers (n=61) |
|--|---------------------------|---------------------------|
| Age (median) | 34 years | 28 years |
| <i>Race/Ethnicity</i> | | |
| Caucasian | 54% | 53% |
| Black/African American | 20% | 28% |
| Hispanic | 23% | 16% |
| Asian | -- | 2% |
| Other race | 4% | 2% |
| <i>Education</i> | | |
| Did not complete high school | 27% | 21% |
| HS graduate/GED | 27% | 27% |
| Associate degree/attended some college | 28% | 34% |
| College degree or beyond | 8% | 9% |
| Technical degree | 14% | 9% |

Children. Most cases (44%) involved one child; 19% two children; 22% three children; and 15% 4-5 children. Children ranged in age from less than 6 months to 18 years. The median age for the oldest child in the family (Child 1) was 6.5 years; median ages for subsequent children were 6.0 years (Child 2) and 4.5 years (Child 3). Over half of the children identified in the study were male: Child 1 was male in 52% of cases, Child 2 in 61% of cases, and Child 3 in 46% of cases.

Child Maltreatment Allegations

The reason for referral to the child welfare system, when available, is presented for all participating fathers and mothers in Table 3. Allegations were not always available in the file, particularly for those families that were self-referred (8%) or who were referred to the program through a non-child welfare agency (26%). In addition, the referral form in some child welfare or diversion files did not contain the nature of the allegations. The percentage of fathers with physical abuse allegations was higher than for mothers, and the percentage of substance abuse allegations was higher for mothers than fathers.

Table 3: Reason for Referral to Child Welfare System

| Reason for Referral | All Fathers (n=56) | All Mothers (n=61) |
|----------------------------|-------------------------------|-------------------------------|
| Physical abuse | 25% | 20% |
| Neglect | 18% | 20% |
| Domestic violence | 13% | 15% |
| Substance abuse | 11% | 23% |
| Incarceration | 2% | 3% |
| Sexual abuse | 2% | -- |
| Emotional abuse | 2% | 2% |
| Homelessness | 2% | 2% |
| Medical neglect | -- | 2% |

Prevalence of Family Stressors

Table 4 illustrates the percentage of mothers and fathers experiencing various stressors. The files indicated a higher percentage of many issues for mothers compared to fathers, including mental health, substance abuse, violence and conflict, teen parenthood, and depression.

Table 4: Co-Occurring Issues for Fathers and Mothers

| Issue | Fathers (n=56) | Mothers (n=61) |
|-----------------------------|-----------------------|-----------------------|
| Mental health | 18% | 49% |
| Substance abuse | 27% | 43% |
| Teen parent | 11% | 30% |
| Violence/conflict (current) | 22% | 25% |
| Criminal activity | 7% | 22% |
| Depression | 7% | 16% |
| Sex offender | 7% | 5% |
| Prior TPR | 2% | 8% |
| Developmental disability | 4% | 7% |

Violence and conflict were significant issues for the participants in this program. In addition to the percentages of current abuse or conflict noted in Table 3 (25% of mothers and 22% of fathers), approximately two-thirds of participants had been involved in at least one past incident of abuse or conflict. Past incidents included both relationship abuse in prior romantic relationships as well as abuse in the family of origin (both exposure to IPV and child maltreatment as a child).

Relationships Between Co-Occurring Stressors

Files indicated that many parents experienced more than one co-occurring stressor. Of all mothers, 39% experienced concurrent substance abuse and mental health issues; 30% experienced current violence and substance abuse; and 29% violence and mental health. Similarly, of all fathers, 27% experienced substance abuse and mental health, 26% experienced current violence and substance abuse issues; and 23% current violence and mental health issues. This overlap in stressors was also described by participants in the in-person interviews, in which one-third of participants experienced at least two problems. Co-occurring stressors are also evident in the reasons for referral to the parenting program, as abstracted from the file. For example, families experiencing

violence or conflict were referred to the program for various reasons, not all of them involving relationship violence. For those families, other reasons for referral most often included issues of substance abuse, mental health problems, physical abuse or corporal punishment of children, and the specific need for young, first-time parents to gain additional parenting skills. Table 5 provides the results for the Pearson Correlations for selected family stressors.

Table 5: Pearson Correlations for Co-Occurring Stressors

| | Mental Health (F) | Substance Abuse (F) | Violence (F) | Teen Parent (F) | Prior TPR (F) | Mental Health (M) | Substance Abuse (M) | Violence (M) | Teen Parent (M) | Prior TPR (M) |
|---------------------|-------------------|---------------------|---------------|-----------------|---------------|-------------------|---------------------|----------------|-----------------|---------------|
| Mental Health (F) | -- | .350** | .018 | .187 | .248 | .168 | .066 | -.184 | .185 | .134 |
| Substance Abuse (F) | | -- | .350** | -.090 | -.075 | .077 | .314* | .149 | .210 | .104 |
| Violence (F) | | | -- | .187 | -.068 | .168 | .066 | .483*** | .097 | -.012 |
| Teen Parent (F) | | | | -- | .358** | -.180 | .021 | .117 | .442*** | -.110 |
| Prior TPR (F) | | | | | -- | -.139 | -.106 | -.082 | -.085 | -.039 |
| Mental Health (M) | | | | | | -- | .150 | .292* | -.117 | .282* |
| Substance Abuse (M) | | | | | | | -- | .242 | .134 | .123 |
| Violence (M) | | | | | | | | -- | -.089 | .212 |
| Teen Parent (M) | | | | | | | | | -- | .066 |
| Prior TPR (M) | | | | | | | | | | -- |

F=father, M=mother; Substance abuse = both drug and alcohol abuse; Mental health includes depression; Prior TPR=prior termination of parental rights.
 *p<.05, **p<.01, ***p<.001

Parents' Attitudes Toward Parenting

Standardized scores and paired-samples t-tests for the AAPI-2 instrument are presented for parents who completed both a pre-test and post-test. Table 6 presents results for all fathers and mothers. Results are also presented for each sub-group: parents with identified violence or conflict (Table 7), substance abuse (Table 8), and mental health (Table 9). Standardized pre- and post-test scores range from 1 to 10; higher scores represent more desirable outcomes (e.g., a score of 8 on the Inappropriate Expectations sub-scale indicates that the parent has more appropriate expectations of their child than a score of 4). Wilcoxon Signed-Rank tests were also performed for all sub-groups, and results supported those of the t-tests. Only the t-test results are presented for direct comparison between groups.

Table 6: Paired Sample t-tests for AAPI Results: All parents who completed program

| | Inappropriate Expectations of Children's Behavior | | Lack Empathy for Children's Needs | | Believe in Use of Corporal Punishment | | Reverse Parent-Child Roles | | Oppress Children's Power and Independence | |
|----------------|---|---------|-----------------------------------|---------|---------------------------------------|---------|----------------------------|---------|---|---------|
| | Pre | t | Pre | t | Pre | t | Pre | t | Pre | t |
| Fathers (n=45) | 5.20 | 9.73*** | 4.98 | 8.45*** | 5.53 | 8.18*** | 6.18 | 6.88*** | 5.71 | 4.65*** |
| | 8.02 | | 7.53 | | 8.02 | | 8.13 | | 7.20 | |
| Mothers (n=49) | 4.84 | 9.29*** | 5.10 | 5.76*** | 5.22 | 6.34*** | 6.16 | 6.62*** | 5.59 | 6.48*** |
| | 7.08 | | 6.67 | | 7.22 | | 7.78 | | 7.47 | |

***p<.001

Table 7: Paired Samples t-tests for AAPI results: Parents with Violence Issues

| | Inappropriate Expectations of Children's Behavior | | Lack Empathy for Children's Needs | | Believe in Use of Corporal Punishment | | Reverse Parent-Child Roles | | Oppress Children's Power and Independence | |
|----------------|---|--------|-----------------------------------|--------|---------------------------------------|---------|----------------------------|---------|---|--------|
| | Pre | t | Pre | t | Pre | t | Pre | t | Pre | t |
| Fathers (n=11) | 4.91 | 3.34** | 4.45 | 3.38** | 4.64 | 6.38*** | 6.00 | 2.51* | 5.27 | 2.09 |
| | 7.36 | | 7.00 | | 7.36 | | 7.45 | | 6.64 | |
| Mothers (n=14) | 5.14 | 3.69** | 5.07 | 2.67** | 5.43 | 3.85** | 5.36 | 6.68*** | 5.50 | 3.23** |
| | 6.86 | | 6.71 | | 7.43 | | 7.43 | | 7.29 | |

*p<.05; **p<.01; ***p<.001

Table 8: Paired Samples t-tests for AAPI Results: Parents with Substance Abuse Issues

| | Inappropriate Expectations of Children's Behavior | | Lack Empathy for Children's Needs | | Believe in Use of Corporal Punishment | | Reverse Parent-Child Roles | | Oppress Children's Power and Independence | |
|----------------|---|---------|-----------------------------------|---------|---------------------------------------|--------|----------------------------|---------|---|---------|
| | Pre | t | Pre | t | Pre | t | Pre | t | Pre | t |
| Fathers (n=12) | 5.08 | 3.00* | 3.92 | 5.61*** | 5.25 | 4.72** | 5.83 | 3.63** | 5.00 | 2.46 |
| | 7.33 | | 7.17 | | 8.08 | | 7.67 | | 6.33 | |
| Mothers (n=19) | 4.96 | 5.31*** | 5.28 | 3.33** | 5.40 | 4.18** | 6.24 | 6.61*** | 6.32 | 5.45*** |
| | 7.00 | | 6.84 | | 7.76 | | 7.84 | | 8.32 | |

*p<.05; **p<.01; ***p<.001

Table 9: Paired Samples t-tests for AAPI Results: Parents with Mental Health Issues

| | Inappropriate Expectations of Children's Behavior | | Lack Empathy for Children's Needs | | Believe in Use of Corporal Punishment | | Reverse Parent-Child Roles | | Oppress Children's Power and Independence | |
|----------------|---|---------|-----------------------------------|---------|---------------------------------------|---------|----------------------------|---------|---|---------|
| | Pre | t | Pre | t | Pre | t | Pre | t | Pre | t |
| Fathers (n=10) | 5.08 | 2.294 | 3.92 | 3.67** | 5.25 | 3.33** | 5.83 | 4.08** | 5.00 | 2.98* |
| | 7.33 | | 7.17 | | 8.08 | | 7.67 | | 6.33 | |
| Mothers (n=25) | 4.84 | 6.40*** | 5.10 | 4.93*** | 5.22 | 5.24*** | 6.16 | 4.13*** | 5.59 | 5.22*** |
| | 7.08 | | 6.67 | | 7.22 | | 7.78 | | 7.47 | |

*p<.05; **p<.01; ***p<.001

The results of these analyses indicate that parents in all sub-groups improved on each sub-scale. However, while fathers in the violence and substance abuse sub-groups improved on the oppressing power sub-scale, their improvements were not significant. In fact, fathers' lowest scores in all sub-groups were on the sub-scale that measured oppressing their children's power and independence. Mothers in the substance abuse sub-group scored the highest on the oppressing power measure, and this was the highest of any measure for either mothers or fathers in any group. Mothers in all groups scored lowest on the sub-scale that measured empathy for their children's needs

Parents Perceptions of the Parenting Program

While the AAPI results provided information on the parents' change in parenting attitudes from pre- to post-test, in the qualitative interviews (N=21), parents expressed their opinions about the Nurturing Parenting Program, including perceived benefits and challenges. Overall, parents had positive comments regarding this program. One-third of parents described that the program helped them change the method used to discipline their children because they learned alternatives. Reduction in corporal punishment was one benefit described by participants:

Yeah, I have calmed down. I will still spank every now and then, but I just grit my teeth...and deal with it differently. So yeah, it made a positive change and still is.

[Father]

Several parents also identified the impact of their parenting styles and specifically noted the impact that corporal punishment can have on children, such as teaching them violence. In addition to changing discipline practices, 9 of the parents also described that the program helped them with communication with their partner. Parents specifically

discussed that they had a better understanding and tools for how to cope with anger, and how to more effectively show respect for their partner.

In addition to specific comments on parenting practices, one-third of parents also mentioned that the facilitators of the parenting program were supportive, helpful, and concerned. These responses are in contrast to their general perceptions of child welfare caseworkers (see Manuscript 2). Parents mentioned that the parenting program was the first place where they felt providers were interested in their perceptions and concerns.

For example, one father said:

Well the caseworker didn't [ask about our concerns], but when they referred us to those people, the Child Abuse Council, they were really interested in the family life, and our concerns with the kids, what goes on with them and stuff like that.

[Father]

Several parents reported challenges associated with the program, particularly with implementing new parenting practices. For example, one mother described that the information provided in the program was a lot to take in all at once, and therefore difficult to implement. Two other mothers, whose children were in foster care, faced challenges because they wanted to implement the new skills immediately, but were unable to do so. One mother said:

It do be kinda hard learning stuff in the class, cause I can't go home and put into effect what I learned right then. I got to wait, but it's helping me, you know,

'cause I let it sink in and everything. [Mother]

Overall, parents expressed that they learned new skills from this parenting program, regardless of whether they initially did not want to be there, or whether they initially felt they did not need assistance with their parenting.

At first, like the first couple of weeks, I was like I can't believe I have to do this, and it's ridiculous. But it was all right. I mean the group, we got to know the people in our group and stuff, and they were people just like us. There was a couple that was our age, couples that were older. I liked the group thing, the way it was set up like that. [Mother]

The supportiveness of the group facilitators and group format of the class contributed positively to parents' perceptions, and perhaps made them feel less stigmatized, thus better meeting their needs.

Discussion

This study sought to describe the population of parents in a child welfare-related intensive parenting program with particular attention to the proportion of families experiencing intimate partner violence, substance abuse, or mental health issues; and to examine whether there were discernible differences in the parenting attitudes of those groups before and after the parenting intervention. While the qualitative data does not examine differences by sub-groups, it does provide insight into the parents' perceptions into the impact of the parenting program.

The review of co-occurring family issues indicated that more mothers have issues with violence, mental health, and substance abuse (that are identifiable in the file) than fathers. The reason for this is unclear, although it is likely at least in part due to the increased scrutiny of mothers compared to fathers by the child welfare system. It is

difficult to make generalizations, though, because the files contained limited information. However, between 23% and 39% of parents were currently experiencing at least two of those issues at the time they entered the program, and this data was reinforced by one-third of interview participants who disclosed multiple stressors. This is particularly of concern given what research has indicated about the cumulative negative effect of family stressors on child health, behavior, development, and learning (Anda, Felitti, Bremner, et al., 2006; National Scientific Council on the Developing Child 2010), especially over the lifespan.

Although this parenting program specifically aimed to screen out families with active physical intimate partner violence, the files indicated that approximately 25% of parents were currently experiencing some type of abuse or conflict in their relationship, and this may be an underestimate because not all abuse may be captured in the files. Kohl and colleagues (2005) demonstrated that nationally, child welfare workers primarily screen for physical abuse, and they often significantly under-identify intimate partner violence compared to what parents reported during interviews. The sample of parents in this program experienced a wider array of abusive and conflict behaviors in their relationships that have the potential to impact their ability to be effective parents, yet these behaviors were not formally recognized by the referring agency or were not noted in the referral to the parenting program. It was also particularly noteworthy that approximately two-thirds of parents in this study revealed past abuse in the psychosocial interview with program facilitators, yet few disclosed interventions for these problems. This suggests that different types of abusive behaviors may not be routinely addressed

through child welfare interventions, which was confirmed by interviews of parents in this study (see Manuscript 3).

Barth and colleagues (2005) determined that the Nurturing Parenting Program (NPP), while not the most commonly used parent-training program in child welfare, was a “possibly efficacious” intervention, for which the currently available research designs “have the capacity to show substantial likelihood of benefit” (p. 360). Little research to date has examined the program’s effectiveness for sub-groups of the child welfare population, including those experiencing other issues concurrently with maltreatment. The results of this study indicate that for this sample, although the group sizes were small for sub-group analysis, participants’ parenting attitudes improved significantly from pre-test to post-test for the entire population of parents who completed the program, as well as for members of each of the sub-groups. In fact, significant improvements were found in all AAPI-2 sub-scales with the exception of the Oppressing Children’s Power and Independence sub-scale for fathers with violence and substance abuse problems. It is difficult to determine why this is the case, but it may be due to the small sample size or the usefulness of this particular sub-scale in samples of fathers with co-occurring stressors.

Qualitative interviews with parents confirmed that parents felt that they were learning from the program, particularly in reference to changing attitudes towards corporal punishment and changing communication behaviors within the couple. Further, parents indicated that they felt supported by the group facilitators and sometimes the other parents in the group. This type of support and empowerment was generally not noted by parents in regard to the child welfare system as a whole (see Manuscript 2), but

did characterize other mandated therapeutic services to which parents were referred (see Manuscript 3). These findings indicate that there may be some advantage to the intensive, therapeutic nature of this intervention, especially as it is designed for the family unit and little research attention has been given to such programs to date (Becker et al., 2009). In light of the knowledge that family stressors contribute significantly to maltreatment, more rigorous evaluations of the Nurturing Parenting Program with child welfare populations may be warranted, as well as more qualitative research to further understand how parents' perceptions of the parenting interventions may impact their parenting attitudes.

This study was limited by a small sample size, which restricted the type of analyses that could be completed. In addition, the information was limited to what was available for abstraction in the program files, and files did not always contain the exact same information for every family. Without the information contained in the child welfare system records, it is not possible to draw conclusions about what types of problems were identified by the child welfare worker that may not have been included in the referral to the parenting program or communicated with the program facilitators directly. More detailed information from the child welfare worker, if available, would provide additional information on the circumstances of these families. Further, there was no comparison group with which to compare the AAPI-2 results, limiting the conclusions to only the participants in this particular intervention program. However, the multi-method approach to data collection allowed triangulation of information to offset some of these issues. This was particularly true for the information obtained from the qualitative

interviews, which demonstrated that parents' perceptions of the parenting program were supportive of their change in attitudes toward parenting.

This study contributes to the knowledge base regarding parents in the child welfare system with co-occurring problems. Parents who experience multiple problems in addition to maltreating their children are unlikely to be able to parent effectively, and thus are likely to need significant support and intervention. A better understanding of the types of issues they face and whether particular intervention programs are effective for those groups would allow more targeted, individualized interventions that may lead to increased success for parents.

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Manuscript 2: 'It's them in control, not you in control': Exploring parents' experiences navigating the child welfare system

Target journal: *Children and Youth Services Review*

Secondary journal choices: *Child Abuse & Neglect* or *Child Welfare*

Abstract

Background: Although families involved with the child welfare system often experience a range of stressors that require effective intervention, relatively few studies of child welfare services have involved examining the lived experiences of parents as they move through the system. Despite national guidance on family-centered care, few studies have directly considered parents' perspectives on how they experience the child welfare process from this perspective. *Purpose:* This study utilized a family-centered framework to explore the lived experiences of parents as they navigate the child welfare system, and to understand how parents perceived the child welfare system and associated therapeutic agencies to operate. *Methods:* Semi-structured, in-depth, in-person qualitative interviews were conducted with 21 participants of a child welfare-related intensive therapeutic parenting program, including mothers, fathers and father-figures, and grandparents who acted as caregivers. The constant comparative method was used for coding and analysis. *Results:* In tracking participants' navigation through the child welfare system, participants reported a sense of stigma that began with the child protection investigation and continued throughout most of their child welfare experience.

Participants experienced a marked lack of empowerment, including ineffective communication, throughout the investigation and in their ongoing relationship with the child welfare worker, and it was not until they reached mandated therapeutic services that their experience changed to substantially include more positive support. *Conclusions:* Implications for practice include the need for increased caseworker training on supportive communication techniques. Participants responded to positive support and engagement by caseworkers, and this should be infused throughout the continuum of child welfare services.

Introduction

According to the Department of Health and Human Services ([US DHHS], 2010), child protection agencies received an estimated 3.3 million reports of child maltreatment in 2009, involving approximately 6 million children. Of these, an estimated 702,000 children were found to be victims of maltreatment. Families involved with the child welfare system have been found to experience a range of related stressors. For example, families are at particularly high risk of experiencing co-occurring child maltreatment and intimate partner violence (IPV), though it is often under-identified by workers. For example, Kohl, Barth, Hazen & Landsverk (2005) found that 31% of the caregivers self-reported violence in the past year and 45% in their lifetime, although child welfare workers identified domestic violence in only 12% of child maltreatment investigations. In addition, substance abuse is a common issue for parents receiving child welfare services, as many studies suggest that between one-third and two-thirds of parents have a substance abuse issue (DHHS, 1999). Parents involved with child welfare services have

also been found to have higher rates of mental health problems than the general population (Park, Solomon, & Mandell, 2006; Staudt & Cherry, 2009).

Research has demonstrated that children who are exposed to multiple dimensions of family dysfunction are at increased risk of experiencing negative health and developmental consequences, including internalizing and externalizing behavior problems; increased potential for depression, anxiety, and PTSD; difficulty with peer relationships; and cognitive problems (Herrenkohl & Herrenkohl, 2007; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Margolin & Gordis, 2000; Osofsky, 2003). Young children may also be less able to bond to their adult caregivers (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008), which is associated with a range of poor developmental outcomes in childhood and adulthood, including difficulty forming peer and romantic relationships. Further, cumulative stress models suggest that as the number of risk factors increases, the potential for and number of negative consequences also increases (Appleyard, Egeland, van Dulmen, & Sroufe, 2005; Sameroff, 2000). Therefore, it is critical to assure that child welfare and associated interventions effectively address the range of family issues that may contribute to these problems.

The Children's Bureau (2007) has proposed that the principles of family-centered practice would support positive outcomes for children and families. According to the Child Welfare League of America ([CWLA], 2003), a family-centered approach works with families "both formally and informally, across service systems, to enhance the capacity of families to provide care and protection for their children. It focuses on the needs and welfare of children within the context of their families and communities. Family-centered practice recognizes the strengths of family relationships and builds on

these strengths to achieve optimal outcomes for children and families” (p. 30). A family-centered approach involves the meaningful participation of families in the process, including acknowledging that families are experts on their own needs; ensuring meaningful roles for family members; and providing opportunities for family members to participate in shared decision-making (National Technical Assistance and Evaluation Center for Systems of Care [NTAECSC], 2008). Despite the benefits of a family-centered approach, the child welfare system has historically not systematically considered the voices of parents in determining case plans and interventions for families involved with services (Kapp & Propp, 2002).

It is clearly essential to intervene effectively with families who have maltreated their children in order to address family problems and ensure the safety and well-being of children. While increasing research attention has been given to systemic and programmatic issues, there exist few qualitative studies of parent experiences in the child welfare system (Alpert, 2005; Baker, 2007; Kapp & Propp, 2002). The lack of research in this area is especially glaring in regard to the extent to which parents feel that they are receiving family-centered services (Alpert & Britner, 2009). In fact, according to Baker (2007), “there is a general dearth of information about how those most closely involved with and affected by the child welfare system [the parents] view their experience in it” (p. 1190). The limited attention in this area is particularly distressing because understanding parents’ perspectives is critical in designing interventions that are effective and responsive to family needs as well as empowering parents (Baker, 2007).

Existing qualitative studies of parents receiving child welfare services have often examined power relationships between parents and the child welfare worker (e.g., Bundy-

Fazioli, Briar-Lawson, & Hardiman, 2008; Dumbrill, 2006), and satisfaction with services (e.g., Baker, 2007; Palmer, Maiter, & Manji, 2005). Dumbrill (2006) found that the way parents perceive child protection workers' use of power was the most important influence on shaping parents' views and reactions to intervention. Other results of qualitative studies indicate recurrent themes of communication between child welfare workers and parents (Kapp & Propp, 2002; Shim & Haight, 2006); parental feelings of hopelessness and helplessness as a result of involvement with child welfare services (Haight, Black, Magelsdorf, et al., 2002; Kapp & Propp, 2002); the need for supportive services (Haight et al., 2002), and a lack of respect by child welfare workers toward parents (Kapp & Propp, 2002).

Despite national guidance on family-centered care, few studies have directly considered parents' perspectives on how they experience the entire child welfare process, and virtually no research has addressed this question specifically for families who may be experiencing multiple stressors. In addition, the majority of studies published to date consider only the mother's perspective, and few studies involve the experiences of fathers or male partners. In an effort to fill these gaps, this study utilized a family-centered framework to explore the lived experiences of parents as they navigate the child welfare system. In addition, this study sought to understand how parents perceived the child welfare system and associated therapeutic agencies to operate.

Methods

Participants

Participants were recruited through the Nurturing Parenting Program (NPP), an intensive, 15-week therapeutic parenting program primarily for parents in the child

welfare system or who are at risk of becoming involved with the child welfare system. Participants must attend the Nurturing Parenting Program as a parenting dyad. A dyad is defined as two adults who are involved with the children's daily life. Individuals in the dyad can be married, co-parenting, or have a familial relationship (e.g., mother and grandmother of a child). Individuals in this program have been screened to not currently be in a physically violent relationship, as measured by the presence of an injunction or disclosure of current physical abuse, as this would counter the therapeutic nature of the program. However, this does not exclude other abusive behaviors within the couple, or a history of physical violence in the current or a past relationship.

For the purpose of this study, potential participants were recruited through one of two methods: 1) a presentation by the researcher in active parenting group sessions during the recruitment window (May to November 2010); or 2) an introductory letter outlining the study with a request for participation that was mailed to past program participants. In the live presentation, the researcher was introduced by a program facilitator, gave a brief 10-minute overview of the research study, passed out a flyer and letter with contact information, and answered questions. At the conclusion of the presentation, program participants were invited to write down their first name and contact information if they were interested in being contacted by the researcher for an interview. The same flyer and letter was mailed to previous program participants. Interested individuals in either group could call or email the researcher to set up an interview. The researcher targeted parents of the children, including non-married couples. Both members of the dyad were eligible to interview if interested, although it was not a requirement for both to be interviewed, and interviews were conducted separately for

each individual. Participants were offered a \$25 incentive for participation in an interview. Potential participants were ineligible for an interview if they were not comfortable interviewing in English, were younger than 18 years old, or were not involved with either child welfare or diversion services. In total, 38% of participants in the live presentations participated in an interview and 11% of individuals who received a mailed letter participated in an interview.

The final sample consisted of 21 participants who had either a child protection investigation or child welfare case. In Florida, child welfare services are privatized and operated locally by community-based care (CBC) agencies. The Sheriff's department carries out Child Protection investigations separately. Participants in this study had either gone through a child protection investigation and were involved with the CBC agency (14 participants), or had a child protection investigation carried out but were screened as lower risk into a child welfare diversion program (7 participants).

Participants included 12 mothers, 7 fathers or boyfriends, and 2 grandparents who acted as caregivers. Of the 21 participants, there were 7 couples (5 married and 2 dating). Participants ranged in age from 21 to 63 years old; the average age was 32.45 years old. Participants had between 1 and 7 children (average of 2.75 children). Two-thirds of parents were unemployed.

Participants were involved with the child welfare system for a variety of reasons, including homelessness; parental drug and/or alcohol abuse; use of corporal punishment; medical neglect of a medically needy child/failure to thrive; domestic violence; child endangerment/neglect; severe physical abuse; and alleged sexual abuse.

Data Collection

Semi-structured, in-depth, in-person interviews were conducted with each participant. Interviews lasted between 45 minutes and 1½ hours. All interviews were conducted by the primary investigator at a public location chosen by each participant. If both members of the dyad wanted to be interviewed, interviews were held separately. Interviews were digitally recorded and transcribed verbatim.

Interviews were guided by a flexible interview guide that was designed to explore the lived experiences of how parents participate in and perceive the child welfare process, using family-centered care framework. Questions centered on the nature of the maltreatment; how parents were referred to services; the types of services received and associated barriers; empowerment, including their involvement in designing the case plan; family issues; and child issues. Questions were as open-ended as possible, in order to allow the participants to construct the meaning of their experiences (Creswell, 2007). Some items in the guide were adapted from the Florida Mental Health Institute's System of Care Practice Review (SOCPR) instrument. Questions were adapted from the Child-Centered and Family-Focused domain of the SOCPR; these questions address the needs and strengths of the family and whether those needs and strengths dictate the type and mix of services provided (Hernandez, Worthington, & Davis, 2005).

Data Analysis

All data analysis was completed with Atlas.ti qualitative data analysis software. Prior to coding, the primary investigator developed an a priori codebook, consisting of general, flexible themes based on the interview guide and the guiding framework of family-centered care. Analysis was ongoing as interviews were conducted and

transcribed. Identification of emergent codes occurred throughout the iterative open coding process, and emergent codes were added to the codebook or used in place of the a priori codes, with revised definitions, as appropriate. Next, axial coding, using the constant comparative method, was utilized in order to begin to organize the codes into ideas and themes, examine conditions and interactions, and determine which categories clustered together (Neuman, 2003). Once major themes were identified and organized, selective coding occurred to “look selectively for cases that illustrate themes and make comparisons and contrasts after most or all of the data collection is complete” (Neuman, 2003, p. 444).

The primary investigator coded all interviews, and a second researcher also independently coded half of the interviews until inter-rater agreement of each transcript reached at least 85%. After coding each interview, the researchers met to discuss similarities and differences in their use of the codes and come to consensus on their use of the codes and the coding of each transcript. Emergent themes were also discussed during these meetings, and codes were created based on these themes and added to the codebook by the primary investigator. The researcher’s primary focus was on reaching consensus between the coders. The researcher further validated the data by conducting peer reviews with both research and practice experts in order to provide an external check on the research process and findings (Creswell, 2007).

This study was approved by the Institutional Review Board at the University of South Florida.

Results

The overarching purpose of this study was to explore participants' lived experiences navigating child welfare services. The results indicated that there were several broad areas that were discussed by participants, including their understanding of why they were referred to services and their perceptions of the entire child welfare process. Both of these areas were substantially impacted by their interactions with the child protection investigators and child welfare caseworkers.

Understanding of the Situation

Nineteen of twenty-one participants stated that they understood why they were involved with child welfare services, and why they had to complete the tasks listed on their case plan. Their explanations varied based on their individual circumstances. For example, the mother of a child with special health care needs and her boyfriend both articulated that tasks were assigned very specifically to assure that they could care for the child when returned home. However, they did not understand why the child was removed from the home, or why she could not come home sooner since they were completing everything that was required of them. Other parents who had children in foster care, including a couple with serious drug problems, did express understanding of why the children were removed from them, even if they did not agree with that decision. Most parents expressed understanding that the overall purpose of the child welfare system was to protect children. For example:

I mean they have to look out for the welfare, you know, well-being of children.

[Father]

Participants described that they were most often not assisted by child protection investigators or child welfare workers to fully understand why their situation was considered maltreatment, but rather developed that understanding on their own. Four participants expressed that they did not understand why the situation was considered maltreatment. For example, one mother who became involved in services due to her homelessness said:

So [I gave birth to] our child. Basically, I'm telling nurses I'm homeless, I need a little help here – who do I talk to, what resources do you have? A couple of days later...I get this message from one of the nurses while my son's in NICU, that child protective investigators have been called. I'm like, child protection? What is this? And we basically get the message that, you know, when we called the person at that number, they said we got a report of abuse and neglect. I'm like, while my son's in NICU? He's been abused?...I didn't leave any bruise marks or break his bones or anything! I'm like, damn...It was kind of bizarre how that happened...So basically we had to find somewhere for all of us to stay, or to stay separately, or else the baby would be taken into custody of child protection.

[Mother]

Participants who stated that they had mental health problems, especially severe ones, had the most trouble understanding why their situation was perceived as maltreatment. Participants who had other problems, such as intimate partner violence and substance abuse issues, did not appear categorically to have the same issues understanding why their situation was classified as maltreatment by the authorities.

Parental Response to the Child Welfare Process

Throughout the course of each interview, participants described the emotional process that they experienced as a result of becoming involved with child welfare services. Often participants described confusion and anger at the initial child maltreatment investigation and referral to services; denial that there was a problem; resentment at service providers for interrupting their family life; anger and frustration; and, once they had begun to receive the therapeutic services, some acceptance and recognition that those services were helpful for them. One mother, who was involved for two different cases, summarized her emotional journey:

At first I felt really, I was, I had such a grudge at first. Because I was like, I went through all this to get my son home, and you're going to put me through this? I blamed [my husband's] ex-girlfriend, I blamed him a lot, I blamed the staff at the hospital, I blamed myself, and then at the end I was like, the only thing this is hurting is yourself...And I understood at the end why they were doing what they were doing, because it is for the children, and I understand that. [Mother]

Participants' emotional processes were seriously impacted by how they were treated throughout the investigation and their involvement with the child welfare system. Participants consistently described issues relating to communication, control by providers and lack of choice over their situation, empowerment, and respect. Participants' interaction with the child welfare process occurred according to a "timeline" as they navigated through child welfare services, including initial contact with Child Protection Investigations (CPI); involvement with the child welfare system (CWS) and the child

welfare case manager; and finally therapeutic services. Within the timeline, themes expressed by parents will be discussed as they relate to each component.

Child Protection Investigation

Participants' initial interactions with the system were always with a Child Protection Investigator (CPI). When discussing their experience with CPIs, the major areas described by participants were CPIs respect and concern for parents; control and choice (control by CPIs over the situation, and participant lack of choice over becoming involved with services); and communication.

Respect and Concern for Parents. During the initial investigation and interaction with the CPIs, participants expressed that while the investigators acted professionally, their attitudes toward parents were often abrasive and judgmental. Participants felt that investigators judged them as being lower class, and thus less worthy of respect:

I thought that they, they felt like they thought about me like I was a piece of white trash or something. And that's the way with their attitude and voices and everything. [Father]

While participants understood that investigators needed to do their job to protect children, some participants voiced the idea that the CPIs viewed them as guilty before the investigation began. This made it difficult for participants to react calmly and understand what they were required to do next. One mother described her desire for the investigators to be more understanding from their initial contact rather than acting like they were "Billy Bad."

Control and Choice. In their initial interactions with the CPIs, participants also reported that they did not have any control over the situation. One mother felt that when

the investigator came to her home to investigate, he automatically assumed that she and her husband would not comply with the case plan and that their case would go to court if they did not comply, instead of giving them the opportunity to follow up with services before making that assumption. Other participants described that being referred to “voluntary” diversion services was really not voluntary at all. One mother said:

It was supposedly a “voluntary” plan, but we had to do it or they would take the children. And when my younger child was born, with the DUI and the substance abuse, they made it seem like if something happened with that they would take all the children away. [Mother]

Communication and Helpfulness. Some participants felt that CPIs were very responsive to helping them access services, while the majority felt that the CPI was not particularly informative or helpful. Lack of effective communication played a significant role in this perceived helpfulness. For example, one mother expressed that she really did not understand why the investigator had referred her for preventative intervention services and that he just showed up one day and said they needed to participate. A grandmother, who helped parent her grandchild and whose daughter was the focus of the investigation, discussed the difference in communication style between two child protection investigators with whom she had been in contact:

The CPI treated [my daughter] like she don’t know nothing about kids. And he look at me and he’s like why you have so many kids? He look at me like, really bad. But I have an experience in the past a few years ago with another CPI. But she was really, really nice; really, really good. She was really young but she explained to me everything that I wanted to know and she referred me to a

counselor. But she explained step-by-step, step-by-step. This guy is totally and completely different way. [Grandmother]

Lack of effective communication also resulted in some participants feeling resentment. This was especially prevalent for parents whose children had been removed from the home. For example, one mother said:

I mean, it was an accident. Accidents happen and it's unclear if it's an overdose, so why speculate something that it's unclear? I deserve a second chance, I deserve my daughter back. They shouldn't just rip her and not tell me. They need to be more communicative especially, no matter if I was in the hospital or not, they should have at least come and talked to me and told me what was going on. [Mother]

Issues related to communication and helpfulness also extended beyond the initial investigation. Of the seven participants whose system experience ended with diversion (i.e., did not have a child welfare case opened), five specifically described a lack of follow-up. They said that service referrals were often given at the initial investigation or mailed separately. Participants described that a letter was mailed to their home saying that they had successfully completed services, but that there was no systematic follow-up to see how they were doing or if they needed additional support.

Child Welfare Services

Participants' experiences with the child welfare system included the child welfare caseworker, attorney, judge, and guardian ad litem. Participants were most likely to spend the majority of their time discussing their interaction with their caseworker, and thus this section will focus primarily on those comments. The participants' reaction to

the child welfare process and its emotional impact on them was moderated by their relationship to their caseworker, and how they felt they were being treated by the child welfare system. In general, participants expressed conflicting views about the caseworkers and the agency. Some parents felt that the caseworker and agency was not helpful to them; some felt that there were positive and negative aspects to their involvement. As illustrated below, none of the parents described an entirely positive experience in their interactions with the caseworker or the child welfare system.

Communication. All of the participants discussed communication as a very important component of their understanding of and reactions to the child welfare system. When participants reported good communication, they felt more respected and supported, and had a better idea of what was expected of them. For example,

Anytime [the caseworker] knows anything, he will tell us. If we have any questions, and if I ask him and he don't know, he will look into it or if he knows the answer, he will tell me...He told us he is not here to break up the family, he is here to help get the family back together. And if it was up to him, I would have been back home. [Father]

More often, when communication was poor, participants felt confused and unsupported, which led to fear and frustration. One mother described the lack of communication in her case as “scary and horrible.” Poor communication was related to fear and frustration because it resulted in the participants’ lack of understanding about what the “child welfare process” meant. One mother, whose husband was the primary focus of the case, described her confusion about what it meant to have a case plan assigned to her:

And I didn't know – what is this saying? Am I a child abuser because my name is on there? You know, explain it to me. What is it for – guilty or not guilty?

Nothing. I don't know what this is. And I tell them that. Now I have a case plan.

Case plan for what? Neglect for my child? What am I being charged with? What does this mean? Name goes in an abuse registry, what? Tell me. Let me know!

Nothing. They won't tell you anything. [Mother]

Communication regarding the non-involved biological parent was also an issue for both of the non-married participants in two couples, in whose cases the biological fathers of the children also had case plans. These parents felt that the communication regarding the biological parent's role and their ability to gain custody of the child was confusing and frustrating. For example, one mother described her experience with wanting the judge to grant her more visitation time with her daughter compared to her ex-husband, who was not compliant. She did not understand why this was not granted to her, since she had completed a significant portion of her case plan.

Participants described that they would appreciate communication that would assist them in a better understanding of the child welfare system in a more structured, methodical way. Suggestions from parents included better and clearer communication with their providers, both caseworkers and attorneys, and hard copies of guidelines.

Caseworker Supportiveness. A significant concern for all of the participants was the supportiveness of the individual caseworker. Participants often felt that their caseworkers were not responsive to their needs, even when they asked for specific assistance. Types of requested assistance included referrals to mandated services, such as drug treatment programs, as well as concrete assistance with family concerns such as

housing, transportation, and finding employment. One father described that he felt his caseworker was unresponsive and unsympathetic to the couple's need for housing, which was a required task in his case plan:

We've asked our worker several times to help us with our assistance on rent and stuff, and she said she cannot help us until the girls are in the home. Well okay, if you can't help us until the girls are in the home and they don't have a place to live, where are they going? [Father]

In addition, several participants noted that the services that the caseworker referred them to were more expensive than what they could afford. One mother stated that although the communication with her caseworker was improving, she had to "go behind her" and find free services.

There were a few descriptions of good support from the child welfare worker.

For example, one mother described:

I called my caseworker, I let her know what I am doing. I'll be like, I have two big slabs, I have four more drops to give her and she goes, "I'm so proud of you, you're really working for something." [Mother]

This same mother also expressed that she felt the child welfare system would work with parents if the parent is trying to do what is right for the child. Another mother described a similar supportive relationship with her caseworker: "*At the end, they really kinda believed in us, so then it was like, you know, it was easier to get through.*" These types of supportive relationships led to parents feeling more respected, and to a more positive experience with the caseworker and the child welfare system overall.

Control. As described above in regard to the child protection investigators, participants also discussed their lack of control in relation to the child welfare system. In these instances, participants often referred to the larger system instead of a specific caseworker. Most participants felt that they had a “check list” of case plan tasks they needed to complete, often without perceived support from the worker or system or an understanding of the complete child welfare process. In particular, participants universally did not feel that they had a voice in shaping their case plan. This led to a great deal of frustration, especially for those whose children were in foster care. In those cases, several parents felt that their children were being ‘held over their head,’ and if they completed the case plan, they would get the children back. A mother, in discussing her feelings of control in relation to both her child welfare caseworker and attorney, stated:

It’s so frustrating. Like you’re in their hands, and whatever they want to do, they are going to do...it’s them in control, not you in control. So you don’t have any choice but to do whatever. [Mother]

Several participants noted that while they did not have control over the situation, they had a more positive experience when the provider treated them as if they had a voice in the decision-making process.

Overall Experience: Lack of Concern and Empowerment. Despite some positive comments on the child welfare system and individual caseworkers, the overwhelming majority of parents had a largely negative experience with child welfare services. Parents described a marked lack of empowerment when interacting with the child welfare system and a general lack of concern by child welfare workers for the parents’ situation. In

particular, several participants commented that child welfare services were not primarily concerned with the parents. For example, one mother said:

It is frustrating...I mean yeah, they give you a case plan but they shouldn't even try because they don't help...When you got to do it all by yourself. I guess I could say they are not really for the parents, they are for the kids. But I don't know, they just make it so hard for the parents to get their children back, because they're not really helping the parents. They're just worried about the kids and where they're at. But that's not fair; it should be for both, both for the parents and children so they can be back together. [But it's] not for their parents...and what we are trying to do to help them. They're not, they're not helping. They just give you a case plan and say ok, do it, and hopefully you'll get your kids back. We'll make sure your kids are ok. It's just unfair. It really is unfair. [Mother]

Despite this lack of empowerment, all of the parents in this study, except one, spontaneously expressed their intention to comply with all aspects of the case plan. Their desire to comply was grounded in a desire to resume normal family life or have their children returned to their care, regardless of whether they agreed with being involved with child welfare services.

Therapeutic Agencies

Once contact with the child welfare case manager was established, participants were referred to particular therapeutic services based on their individual circumstances. These referrals most often were made late in the participants' involvement with the child welfare system. All participants in this study participated in the intensive parenting program; individual parents were referred to other services, including drug or alcohol

rehabilitation programs (8 parents), domestic violence services (for victims or perpetrators – 4 parents), mental health counseling (3 parents), and mental health counseling for the children (4 parents), among others. In general, parents spoke about these services in much more positive terms than they did when describing their experiences with other parts of the system. Despite some parents who expressed not wanting to participate in the services, the parents often felt supported and that their needs related to those individual services were being met. Additional details on participants' perceptions of mandated therapeutic services are beyond the scope of this paper. See Manuscript 3 for further details.

Participant Suggestions for Change

At the end of the interview, each parent was asked to describe what they would change about the child welfare system, and most were surprised that they were asked for their opinion. Overall, parents wanted the child welfare system to interact with parents differently. While a more detailed discussion is beyond the scope of this paper, the participants specifically noted the general need for more concern, respect, and communication from child protection investigators and child welfare caseworkers:

I would be more involved, more concerned about families that were affected.

Cause this is a long time thing that stays with both the parents and the kids. So I think it should be handled with more concern, instead of just, "ok, yeah."

[Mother's boyfriend]

Give someone a chance, you know. Let them explain their situation better. Cause they wouldn't even let us talk, it was like we had no say-so in all of it, you know? It was like, listen to us better, listen, listen. [Mother]

Discussion

The results of this study indicate that, in general, parents with varying types of problems – intimate partner violence, mental health, and substance abuse – report very similar experiences with the child welfare system. Parents framed their perceptions through an emotional process that they experienced as they moved through the child welfare system, beginning with the initial investigation. In some ways, the way they described their emotional process mirrored a grief reaction. Given the loss of control in their family lives, and sometimes the removal of their children to a foster home, this type of emotional reaction process may not be unexpected.

In tracking participants' navigation through the child welfare system, the overall assessment of parents is that they experienced a marked lack of empowerment throughout the child protection investigation and in their ongoing relationship with the child welfare worker, and it is not until they reached mandated therapeutic services that their experience may include more positive support. Because service referrals came so late in this timeline, the agencies that provided the mandated therapeutic services functioned as an isolated type of “final referral” along the timeline of participants' involvement in child welfare services, rather than an integrated part of the overall child welfare system. This presents a significant challenge in a system that relies on these service agencies to create safe, healthy family environments for children.

When discussing interactions with child protection investigators, participants primarily discussed lack of respect, judgmental attitudes of investigators, and powerlessness. In the county where this study was conducted, police officers conduct child protection investigations, and thus this abrupt behavior is not necessarily unexpected, given that investigators' training is centered around gathering facts and ensuring children's safety as quickly as possible. While the role of investigators is not necessarily to be nurturing, the approach described by participants in this study caused undue stress and frustration for parents, which contributed to a sense of stigma. As suggested by Palmer and colleagues (2006), "many of the negative experiences reported by parents might be avoided if CPS workers approached parents as partners in the task of caring for their children, rather than adversaries" (p. 821). This is an area in which ongoing training for child protection investigators should provide additional attention.

Communication was a major theme in regard to the case manager and the child welfare system in general. In instances of good communication, parents felt that they had a better understanding of their situation, why they were involved with services, and what it would take to achieve their goals. However, the majority of participants did not report this type of communication. Other studies, specifically focusing on foster care services, have also found that lack of communication from child welfare workers and confusion are themes routinely expressed by parents (Kapp & Propp, 2002; Palmer, Maiter, & Manji, 2006). In the current study, the lack of communication resulted in parents having an extremely limited understanding of the overall child welfare system, and what their involvement in it meant for them. It may be that caseworkers believe that parents understand the system because the providers themselves do, or they do not feel parents

care about or have the capacity to understand the ‘bigger picture.’ Caseworkers’ heavy caseloads may also play a role; they may feel that they do not have time to ensure that parents understand, but rather only to make referrals and track compliance. The end result of this was a serious lack of empowerment for parents to be able to navigate the system and have an active voice in how they could learn to better care for their children.

Parents also experienced a lack of empowerment based on the perceived supportiveness of the child welfare caseworker. In contrast to investigators, whose primary focus is ensuring safety, the role of the child welfare worker may be to be more nurturing. Parents expressed appreciation of supportive and nurturing relationships when they occurred, and noted that it helped make it easier for them to continue through services. However, parents more often described that caseworkers gave them lists of services and tasks to complete and were less concerned with empowering them to complete those services. It may be that the caseworkers are not trained to provide this type of service, there is not an adequate supervisory support structure, or are too overloaded with cases to give parents more time-intensive, supportive attention. It is particularly noteworthy that participants in this study described changes in their perceptions and experiences without major systemic changes; relatively small demonstrations of caseworker encouragement, such as acknowledging that parents were doing a good job, resulted in parents feeling more positive overall. This indicates that caseworkers should include more supportive, encouraging communication with their clients to help develop more positive results. For example, several participants in this study lacked knowledge regarding both child development as well as the child welfare process. This may be an opportunity for child welfare caseworkers to briefly explain

basic tenets of child development to parents, which would help them better understand both child development and the reasons for their involvement with child welfare services. This type of communication would also set the stage for more intensive education on these issues in the parenting classes.

Researchers have described that participation in child welfare services is often stigmatizing for parents (Alpert, 2005), and the results of this study indicate that the child protection investigators' initial approach of parents begins this stigma early in parents' system involvement. This sense of stigma is further compounded by the lack of empowerment reported by parents throughout their experience with child welfare services, until receiving therapeutic services. While Kapp and Propp (2002) found that lack of respect, particularly, contributed to helplessness and hopelessness on the part of the parents, thereby decreasing their motivation, the participants in this study did not report this. They expressed a continued desire to achieve their case plan goals and complete services, despite the challenges they faced. Services that are more family-centered and strengths-based would help to reduce the stigma that parents experienced. In fact, it is clear from the participants in this study that when parents attended the mandated therapeutic services at the end of their child welfare timeline, they felt that their needs were better addressed and thus felt more supported. It should be possible to track these types of positive outcomes throughout parents' involvement with the entire child welfare process, yet this was not possible in this study. Thus, the more supportive elements of the mandated therapeutic services (see Manuscript 3) should be infused into the system as a whole.

The Child Welfare Information Gateway (2008) describes a family-centered system of care as one that provides services that involve, strengthen, and support families through mutual trust, honesty, open communication, and involving parents as active participants in the decision-making process. The experiences described by parents in this study indicate that often, parents perceive that the system is not ‘for the parents’ and is only concerned with children’s safety. Alpert (2005) suggested that the mandatory nature of child welfare services is often inconsistent with the principles of family-centered care, making their translation into practice difficult. However, the results of this study suggest that both additional system-wide changes in practices and training and ongoing support of individual caseworkers are likely necessary, yet extremely difficult in systems with limited financial resources. Fostering changes in individual caseworker behavior, as described above, may be a more achievable initial improvement. In addition, creating “case aide” or “peer mentor” positions within the child welfare agency, in which previous child welfare parents could be employed, could help reduce the strain on caseworkers with high case loads and offer ways for parent aides to intervene where professional caseworkers cannot, in a fairly cost-effective manner (Briar-Lawson & Wiesen, 2001; Williamson & Gray, 2011). Other systems changes, such as developing increased inter-agency collaborations, may be more difficult and take more time.

This study had several limitations. First, it was a qualitative study of relatively small sample size, so the results are not generalizable outside this population. In addition, the sample was drawn from the participants of a parenting program, and participants volunteered. It is not possible to tell if the perceptions and experiences of parents who did not participate in this parenting program would differ from those in this

study, or how the parents who did not volunteer to be interviewed differed from the sample in this study. Limiting the sample to only participants who spoke English did not allow for conclusions to be drawn about other cultural groups who may have different experiences. However, it is certainly possible that many parents experience similar issues, especially in instances where the findings were almost universal in this population.

This study also has several important benefits. Many studies of child welfare case outcomes look at parent factors, but they are described in terms of what the parent *is* or *does*, not what the parent *feels* or *experiences* (Alpert, 2005). The qualitative nature of this study is critical in the examination of parental experiences with the continuum of child welfare services and how they may relate to their ability to parent in the future. In addition, this study provided the opportunity to examine parents' experiences throughout the timeline of their navigation of the entire child welfare process, not just within one specific component, such as after children have been removed from their care. This approach allows a fuller understanding of how parents experience various parts of the system, and how these parts are integrated (or not integrated). It also suggests the need for more longitudinal studies that follow parents from the beginning to end of their child welfare involvement. Further, this study included the voices of different types of participants, including those that are often underrepresented in studies on child welfare: fathers, boyfriends, and grandparents, as well as parents who experienced various types of family challenges (violence, mental health, and substance abuse, among others). Finally, some researchers have described the difficulty in accessing this population of parents, and an unexpected benefit of this study was the discovery that parents who

participated needed and appreciated the opportunity to talk about their experiences in a non-threatening atmosphere.

Conclusion

It is clear that exposure to multiple types of chronic childhood adversity has significant consequences not only for children across their lifespan but also for the families in which they are raised. It is critical to intervene effectively. As the practice of child welfare continues to move toward a fuller adoption of family-centered principles, it is essential to give voices to all family participants in order to not only better understand what parents need and how to apply this to service design, but to effectively engage them in the process of creating a healthy, safe family environment.

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Manuscript 3: Receiving mandated therapeutic services: Experiences of parents involved
in the child welfare system

Target journal: *Children and Youth Services Review*

Secondary journal choice: *Child Abuse and Neglect* or *Child Welfare*

Abstract

Background: Parents involved with child welfare services are often mandated to attend a variety of therapeutic services based on the stressors they face. Despite the need to understand how to best offer services to parents, there is limited research that examines parents' experiences with and barriers to accessing these services. *Purpose:* This study utilized a family-centered care framework to examine the experiences of parents related to the development of case plans and the provision of mandated therapeutic services as a result of being involved with the child welfare system. *Methods:* Semi-structured, in-depth, in-person qualitative interviews were conducted with 21 participants of a child welfare-related intensive therapeutic parenting program, including mothers, fathers and father-figures, and grandparents who acted as caregivers. The constant comparative method was used for coding and analysis. *Results:* Results indicated that while the therapeutic services themselves often meet the needs of family members, parents are not

empowered to influence the service plan; they face several important barriers to receiving services; and that case plans are not designed to take into account systemic family issues in addition to addressing the stressors of individual parents. *Conclusions:* Increased attention to comprehensive family assessments and engaging parents in the design of their case plan may provide mechanisms for increasing family-centered services in child welfare.

Introduction

In 2009, child protection agencies determined that an estimated 702,000 children were victims of maltreatment (DHHS, 2010). Many parents involved with child welfare services experience co-occurring problems such as intimate partner violence (IPV), substance abuse, and mental health problems (e.g., English, Edleson, & Herrick, 2005; Kohl, Edleson, English, & Barth, 2005; Marsh, Ryan, Choi, & Testa, 2006). For example, studies of women receiving child welfare services have found that approximately 45% of female caregivers had experienced physical IPV at least once in their lifetime, and 30% had experienced physical IPV at least once in the past year (Hazen, Connelly, Kelleher, Landsverk, & Barth, 2004; Kohl, Barth, Hazen, & Landsverk, 2005). Estimates of the percentage of parents with serious substance abuse problems involved in the child welfare system have ranged as high as 50-80% (Marsh, Smith, & Bruni, 2011) and have found caregiver substance abuse to be the single most potent kind of caregiver vulnerability factor in predicting child maltreatment substantiation (Wekerle, Wall, Leung, & Trocme, 2007). Parents involved with child welfare services have also been found to have higher rates of mental health problems than the general population (Staudt & Cherry, 2009) and are three times as likely to ever have

had contact with child welfare services compared to parents without mental health problems (Park, Solomon, & Mandell, 2006).

Families involved with child welfare services are thus often mandated to complete a range of interventions related to these problems, in addition to receiving services for their children. However, these types of mandated services are not always available in a timely and accessible manner for parents, especially in terms of solving complex problems like substance abuse and mental health in a short period of time (Alpert, 2005). In particular, the relationship between the relatively short time frames for families to reach permanency, as defined by the Adoption and Safe Families Act of 1997 (PL 105-89), and timely access to appropriate services can be a significant challenge for both caseworkers and parents to navigate. Further, research suggests that services provided by the child welfare system to families may not be appropriate for their particular needs (Barnett, Miller-Perrin, & Perrin, 2005; Beeman, Hagemester, & Edleson, 2001; Bolen, McWey, & Schlee, 2008; English, Edleson, & Herrick, 2005; Hazen, Connelly, Kelleher, Landsverk, & Barth, 2004), indicating the necessity of developing a greater understanding of both the barriers to access and the most effective aspects of services.

Despite the need to better understand how parents experience therapeutic services, and the idea that interventions are likely to be more effective when they take into account the client's perception of the problem (Marsh, Ryan, Choi, & Testa, 2006), there is a scarcity of research examining the perspectives of parents on the mandated therapeutic services they receive, particularly from a family-centered perspective (Alpert & Britner, 2009). As a strengths-based approach, family-centered care involves the meaningful participation of families in the process, including acknowledging that families are experts

on their own needs; ensuring meaningful roles for family members; and providing opportunities for family members to participate in shared decision-making (National Technical Assistance and Evaluation Center for Systems of Care [NTAECSC], 2008). While family centered care involves multiple principles, those particularly relevant to parents' experiences with mandated therapeutic services include focusing on the entire family instead of individuals; tailoring services to meet the specific needs of families; and empowering families to have input into service plan (Children's Bureau, 2007).

In contrast to the recommendations of the Children's Bureau, studies of parent involvement in more general child welfare services indicate that parents often do not feel empowered, but rather feel left out of the decision making process (Kapp & Propp, 2002; Lietz, 2011). Baker (2007) noted the need for an examination of empowerment issues for family members, particularly regarding barriers to involvement in services, including what makes it difficult for parents to attend treatment and planning meetings, participate in foster care visits, and participate in services. The limited existing qualitative research supports the Children's Bureau recommendations, suggesting that when parents do feel that services are responsive to their needs, they are more pleased with services (Lietz, 2011). However, there is little research that assesses the degree to which parents feel that they benefit from services (Alpert, 2005). In a study of data from the National Survey of Child and Adolescent Well-Being, Chapman and colleagues (2003) concluded that consistent with health services research, mandated child welfare services need to be relevant to families' needs and wishes, delivered as quickly as possible, and delivered in a manner with which the parent feels comfortable, especially for families with very complex problems. There is also a clear need to involve the voices of both victims of

intimate partner violence and fathers in studies of child welfare services, since both of these groups are often overlooked (Buckley, Whelan, & Carr, 2011). Further, while there is research on children's need for mental health services, there have been few studies of parents' use of mental health services within the child welfare system (Staudt & Cherry, 2009).

There is a clear need to better understand how parents in the child welfare system experience mandated therapeutic services. This study utilized a family-centered care framework to examine the experiences of parents related to the provision of mandated therapeutic services as a result of being involved with the child welfare system. Overall, this study sought to understand parents' perceptions of what referrals were made and services were received, and whether their experience differed by experience of intimate partner violence, substance abuse, or mental health problems; and to explore parents' perceptions of their involvement in and understanding of their service plan.

Methods

Participants

Participants were recruited through the Nurturing Parenting Program (NPP), an intensive, 15-week therapeutic parenting program primarily for parents in the child welfare system or who are at risk of becoming involved with services. Participants must attend the program as a dyad. A dyad is defined as two adults who are involved with the children's daily life; individuals can be married, co-parenting, or have a familial relationship (e.g., mother and grandmother of a child); individuals do not need to be married or co-parenting to be part of the program. Individuals in this program have been screened to not currently be in a physically violent relationship, as measured by the

presence of an injunction or disclosure of current physical abuse, as this would counter the therapeutic nature of the program. However, this does not exclude other abusive issues within the couple, or a history of physical violence in the current or a past relationship.

For the purpose of this study, potential participants were recruited through one of two methods: 1) a presentation by the researcher in active parenting group sessions during the recruitment window (May to November 2010); or 2) an introductory letter outlining the study with a request for participation that was mailed to past program participants. In the live presentation, the researcher was introduced by a program facilitator, gave a brief 10-minute overview of the research study, passed out a flyer and letter with contact information, and answered parent questions. At the conclusion of the presentation, program participants were invited to write down their first name and contact information if they were interested in being contacted by the researcher for an interview. The same flyer and letter was mailed to previous program participants. Interested individuals in either group could call or email the researcher to set up an interview. The researcher targeted parents of the children, including non-married couples. Both members of the dyad were eligible to interview if interested, although it was not a requirement for both to be interviewed, and interviews were conducted separately for each individual. Participants were offered a \$25 incentive for participation in an interview. Potential participants were ineligible for an interview if they were not comfortable interviewing in English, were younger than 18 years old, or were not involved with either child welfare or diversion services. In total, 38% of participants in

the live presentations participated in an interview and 11% of individuals who received a mailed letter participated in an interview.

The final sample consisted of 21 participants who had either a child protection investigation or child welfare case. In Florida, child welfare services are privatized and operated locally by community-based agencies. Participants in this study had either gone through a child protection investigation and were involved with child welfare services (14 participants), or had a child protection investigation carried out but were screened as lower risk into a diversion program (7 participants). Participants included 12 mothers, 7 fathers or boyfriends, and 2 grandparents who acted as caregivers. Of the 21 participants, there were 7 couples (5 married and 2 dating). Participants ranged in age from 21 to 63 years old; the average age was 32.45 years old. Participants had between 1 and 7 children (average of 2.75 children). Two-thirds of parents were unemployed.

Participants were involved with child welfare services for a variety of reasons, including homelessness; parental drug and/or alcohol abuse; use of corporal punishment; medical neglect of a medically needy child/failure to thrive; domestic violence; child endangerment/neglect; severe physical abuse; and alleged sexual abuse.

Data Collection

Semi-structured, in-depth, in-person interviews were conducted with each participant. Interviews lasted between 45 minutes and 1½ hours. All interviews were conducted by the primary investigator at a public location chosen by each participant. If both members of the dyad wanted to be interviewed, interviews were held separately, although it was not a requirement for both members of the couple to be interviewed. All interviews were digitally recorded and transcribed verbatim.

The flexible interview guide was designed to explore the lived experiences of how parents participate in and perceive the child welfare process using family-centered care framework. Questions centered on the nature of maltreatment; how parents were referred to services; the types of services received and associated barriers; parental empowerment, including their involvement in designing the case plan; family issues; and child issues. Questions were as open-ended as possible, in order to allow the participants to construct the meaning of their experiences (Creswell, 2007). Some items in the guide were adapted from the Florida Mental Health Institute's System of Care Practice Review (SOCPR) instrument. Questions were adapted from the Child-Centered and Family-Focused domain of the SOCPR; these questions address the needs and strengths of the family and whether those needs and strengths dictate the type and mix of services provided (Hernandez, Worthington, & Davis, 2005). This paper will examine the responses to questions regarding mandated therapeutic services, including parental involvement in designing the case plan and understanding of services, and barriers to accessing services.

Data Analysis

All data analysis was completed with Atlas.ti qualitative data analysis software. Prior to coding, the primary investigator developed an a priori codebook, consisting of general, flexible themes based on the interview guide. Analysis was ongoing as interviews were conducted and transcribed. Identification of emergent codes occurred throughout the iterative open coding process, and emergent codes were added to the codebook or used in place of the a priori codes as appropriate. Axial coding, using the constant comparative method, was performed next, in order to begin to organize the codes into ideas and themes, examine conditions and interactions, and determine which

categories clustered together. Once major themes were identified and organized, selective coding occurred to “look selectively for cases that illustrate themes and make comparisons and contrasts after most or all of the data collection is complete” (Neuman, 2003, p. 444).

The primary investigator coded all interviews, and a second researcher also independently coded the majority of interviews until inter-rater agreement reached at least 85%. After coding each interview, the researchers met to discuss similarities and differences in their use of the codes and come to consensus on their use of the codes and the coding of each transcript. Emergent themes were also discussed during these meetings, and codes were created based on these themes and added to the codebook by the primary investigator. The primary focus was on reaching consensus between the coders. The researcher further validated the data by conducting peer reviews with both research and practice experts in order to provide an external check on the research process and findings (Creswell, 2007).

This study was approved by the Institutional Review Board at the University of South Florida.

Results

Parents' Perceptions of Services Received

Service Types. Table 1 illustrates the type of services received by participants and their children, based on their responses in the interviews. All parents participated in the parenting program.

Table 10: Types of Services

| <i>Services for Parents</i> | |
|--|------------------------------------|
| Type of Service | Number of Parents Referred |
| Parenting program | 21 |
| Drug or alcohol rehabilitation program | 7 |
| Drug testing/urine drops | 6 |
| Substance abuse counseling/detox | 5 |
| Domestic violence classes | 4 |
| NA/AA meetings | 3 |
| Psychological evaluation | 2 |
| Mental health counseling | 2 |
| CPR class | 2 |
| CMS parent training | 2 |
| In-home social worker | 2 |
| CMS parent training | 2 |
| Children's First Response | 2 |
| Family Intervention Services | 1 |
| <i>Services for Children</i> | |
| Type of Service | Number of Children Referred |
| Mental health therapy | 4 |
| Physical therapy | 1 |
| Guardian ad litem | 1 |
| Speech therapy | 1 |
| Developmental screening | 1 |

*Services are those disclosed by parents in the interview. This may not be a complete account of all services assigned to each parent.

In addition to the services listed in Table 1, parents also discussed two tasks they were assigned: maintain stable income (7 parents) and maintain stable housing (7 parents).

Influence on the Case Plan. The participants in this study universally agreed that they did not have any say in determining the array of services and tasks that would go into their case plan prior to its development. One father said, “no, we didn’t have no say. They just said certain parents do certain things.” One mother described that she relinquished her influence into the case plan prior to its development in order to get her daughter back:

I told them, you know, before they made anything, whatever you guys need me to do, I'll do it. Because I wanted to be a better parent, I wanted to understand my daughter better, I want her not to be afraid of me. I want...to be there for her. I want to keep her from foster care again, so whatever they tell me to do I am going to do it, no questions asked. [Mother]

Some parents did report having a say in the specific program they would attend or the way they approached completing a task. For example, parents described that they found and attended a free parenting class in lieu of one that was assigned to them but required payment; advocated for permission to attend a drug outpatient program instead of an in-patient program; and chose particular methods to look for a job. Parents discussed their influence on services in these circumstances in terms of their child welfare caseworker not finding appropriate programs for them or not being responsive to their needs, rather than being empowered by anyone to take an active role in determining what types of services they would receive or how they would participate in them. This overlaps with barriers to services, as discussed in the “Barriers to Receiving Services” section below.

Understanding and Agreeing with Services. Parents were asked whether they understood why they were referred to the services and tasks listed in their case plan. All participants said that they understood why they were referred to the majority of services. They framed this understanding in terms of the circumstances that led them to their involvement with child welfare services. For example:

Because at the time all this stuff, all this incidents were going on I wasn't working, I didn't have a job, didn't have stable income. And because we never

really took the kids to the doctors all the time, because of our drug habit that we had. We just kind of skipped the appointments and didn't go and when they got sick we never really took them nowhere. So that's why I understand everything that's in there that we have to do. [Father]

Two mothers said that while they understood their case plan overall, they did not understand why they were referred to individual interventions within their case plan (specifically domestic violence classes and a family intervention program). Both of these mothers described that communication with their caseworker was a factor in their lack of understanding.

While parents understood the majority of services and tasks that they were assigned, their perspective on agreeing with completing those services was more complex. Many parents initially felt that they should not have to complete any services, but in the end agreed with having participated in them. Four parents specifically framed this in terms of feeling that their overall involvement with child welfare was unfair. For example, one mother, whose husband was the subject of the investigation, felt that because her husband was the one who made the mistake, she should not have to be involved. Another mother, who described becoming involved with the child welfare system because of a possible accidental drug overdose on prescription medication, said:

I don't mind going through everything because it's teaching [us], but for the circumstances it's not fair. [Mother]

Barriers to Receiving Services

Most of the participants (16) identified at least one barrier to receiving services. Transportation, difficulties with the child welfare caseworker, financial issues, and program eligibility were the most important barriers, both in terms of the number of participants who discussed them and their impact on the parents.

Transportation. Transportation was a barrier described by one-third of participants, and for these participants, it was a dominant barrier. Transportation problems included not having a car, and lack of money for gas or for bus passes to travel to services that were not close to the participant's home. One participant described how he and his girlfriend lived miles away from the parenting class, and had to walk home after the first class because the bus had stopped running when the class was over. Several participants also described difficulty in finding services that were close to their homes, as well as difficulties with their case manager assisting them with their specific transportation concerns. One mother described her experience:

I tried to get a bus pass somehow, and I tried going to [the drug treatment program] and Medicaid told the program that I can't do that because I'm not in the methadone program, so transportation is becoming difficult. Especially at the end because there are so many appointments. So, you know, [the child welfare agency] is trying to help me get a bus pass but I haven't heard anything of that, so transportation is, like, major. [Mother]

When child welfare workers or service providers assisted parents with transportation, the parents expressed gratitude because it made it easier for them to attend services. For example, two parents reported that the facilitators of the parenting program

had given them gas cards to assist with transportation to the weekly meetings; and one father, who was homeless, was surprised and thankful when his child welfare case manager gave him and his wife bus passes without a request.

Case Manager. One-third of participants described problems with the case manager as a barrier to accessing service programs. Participants felt that case managers in these instances were not responsive to their needs and concerns, particularly financial limitations and acknowledging the parent's level of comfort with specific intervention programs. For example, one father described his frustration in trying to begin a drug treatment program:

The worker was supposed to help me out fund-wise to get into a [drug rehab] program. And I waited and waited and waited. I mean, months went by. You know, still didn't have no referral, no nothing to get in. I was supposed to go to start my treatment. I didn't have no referral, she [case manager] said there were no funds...So months went by and I'm still waiting on all the stuff and I go back to court, cause it was just a check up, and the judge asked why I wasn't in treatment. And I told her why, I said because I am waiting on the worker to give me the paperwork and stuff I need to go in there. [Father]

Although this father could not financially afford to start drug treatment on his own, he also alluded to the difficulty that case managers have when adequate funds are not available to support getting parents into treatment. In contrast, a few parents said that their case manager was supportive and helped them overcome certain barriers, such as helping them get their child into daycare or helping to subsidize the cost of services.

Financial Issues. Two-thirds of the parents in this study were unemployed, and 11 participants discussed the cost of services, or other financial concerns, as significant barriers to receiving services. Many of the concerns in this area were related to medical or other health issues. One mother, who was a victim of domestic violence, discussed having to choose between mental health care for her or her daughter, who also had been abused by the father. The mother was forced to make the choice to pay for her daughter's medication and treatment instead of her own. Another mother discussed the relief that she felt when the child welfare system helped pay for her domestic violence classes and she was able to complete them:

Back in '07 I was drunk and I got in a fight with [my husband] and he called the cops on me. And I had to go to jail, and because of that I had to do domestic violence classes. And that was 26 weeks that I had to do...and that was really good. It actually took me quite a while because initially I had to pay for it. I had to pay \$20 and I was having all kinds of trouble. But when I got under [child welfare], that made it part of my case plan so they gave me a referral to go to intervention and it paid for all of my classes, so I didn't have to worry about it. All I had to do was worry about getting there. So I was able to complete them because I didn't have to worry about paying for them. [Mother]

Program Eligibility. Nine participants discussed concerns regarding being ineligible for programs that would help them meet the goals of their case plan. As mentioned above, the majority of the participants in this study were unemployed, and they discussed their unemployment as a barrier to eligibility for a range of programs, including housing assistance programs and Early Head Start. One mother, who was

homeless and unemployed, discussed finding out about a program that could potentially assist her with housing, getting in line early in the morning to find out if she and her husband qualified, and then learning that they did not:

Because there are certain requirements you had to follow, like you had to have a job and most of the programs that you try to get housing, you have to have a job.

Because they not going to give you no housing if you don't have no job. [Mother]

This was a major barrier for several parents, as both employment and housing were required components of their case plans and they were viewed as non-compliant if unable to meet these conditions. Another mother expressed frustration that her 14 year-old stepdaughter, who was the immediate reason for the child protection investigation, was too old to attend the parenting program with the rest of the family. Because other programs were offered at inconvenient times, such as while the participant was working, she was unable to find another program that was able to include her daughter directly.

Accessibility of Services. Four participants discussed difficulty in finding available services. This theme was discussed by participants who were involved with diversion services, but had not had a case opened with the child welfare system. The difficulty in finding services appeared to be related to services that intervened earlier, rather than the deep-end services accessed by many parents in this study. One mother, who was a victim of primarily psychological abuse by her husband, summarized her search for domestic violence services, and the frustration that she felt because she was not getting all the information she needed in one place:

Basically you have to be near dead for anyone to really help you. That's the sad part, why does it have to go that far? They just tell you it's not bad enough and it's true,

there are people worse. Why does it have to get that far, why can't you help us before it's that bad so it doesn't get that bad? Now I don't know if it ever would have gotten that far but there's a glimmer that tells me it could have. [Mother]

Parents' Experiences with Mandated Therapeutic Services

This section describes parental experiences with service types in the main areas of concern for this study: substance abuse, intimate partner violence, and mental health. Services for children are also discussed due to the lack of intervention for many children in this study. Participants' experiences with the parenting program are discussed in a separate manuscript (see Manuscript 1).

Substance Abuse. Seven participants discussed substance abuse issues that led to their involvement with child welfare or diversion services, and six participants described services to which they were referred. Services included group meetings, substance abuse counseling, drug testing, and intensive drug treatment programs. Participants, in general, spoke positively about the substance abuse services, and stated that they understood why they were referred to the programs. In particular, participants thought that substance abuse services were empowering and supportive, and were responsive to their needs. One father, whose son (born during the child welfare case) was voluntarily put up for adoption, discussed how his substance abuse treatment and counseling helped him develop more positive coping skills to deal with the trauma and avoid relapse. The mother below expressed that the drug treatment program met her needs in several areas, including her financial constraints and her need to feel comfortable in a drug treatment program:

It is [helpful]. Cause it goes on your level... for one you don't have to pay for it... If you don't have any money or anything you can still go in and get treatment. And you do your assessment and they tell you what they recommend. So if they recommend you do two days a week, that's what you'll do... It's really good. And I really like the workers there because, well, the one that does the groups, she is a recovering addict from six years ago. So she knows, it's more real. A lot of people that are there have been there and done that so they know how to help you and they know that if you're not comfortable with something or whatever, you're not going to succeed, if it's not what you want. So I really like that because they care. [Mother]

This mother also said that she felt more comfortable with her caseworker associated with substance abuse treatment than her child welfare caseworker, and therefore turned to that individual for support and information more than the child welfare caseworker.

Domestic Violence. Ten participants discussed past or present domestic violence, and others reported other types of conflict within the couple. However, only 4 participants were referred to domestic violence services, two of whom were referred for incidents prior to the child protection investigation. Similar to the response to substance abuse services, parents who had completed the violence programs felt that the programs were helpful. For example, one mother, who had completed batterer services for an incident when she and her husband were drunk, felt that the classes were beneficial because she learned about communication and controlling her anger.

In contrast to the responses regarding substance abuse services, parents who had been referred to domestic violence services also discussed some complex issues. The

first was the partner's reaction to the referral. One mother discussed the past physical abuse she sustained from her husband and his reaction to her having to attend services:

[H]e had put his hands on me really bad. I mean...I was almost dead. He really hurt me really bad. But that's probably why [child welfare] got involved in that case too. Then my husband actually asked me why do you have to go to [services] for that? And I was like, well they knew we had the domestic, because they could pull it up and see. And he almost like got mad a little bit – why did you tell them? I was like, I had to, they already knew, I had to tell them. And then I went to the 6 classes you have to go through. [Mother]

Although this participant denied any current abuse, she did not indicate that the caseworker discussed with her the possible negative impact this referral could cause in her relationship with her husband, or the need for safety planning. The second issue raised by participants was a lack of understanding about why they were assigned this particular task. A mother, who had not yet begun the domestic violence intervention services, said:

[It's] because of my baby daddy before. And it's like, I really don't even understand that because I don't have any domestic violence charges. It's because I was going through it with him...I'm not sure if it's me as like, like, I guess they have different roles, the domestic violence has different roles. I guess it's like counseling for domestic violence, something like that. [Mother]

In contrast to these mothers, one mother, who was screened into a diversion program, discussed having to struggle to find services that would help her. Despite persistent psychological and verbal abuse, she reported having to go to various agencies

to get small amounts of help from each one, because no one agency felt that her case was “severe enough” to offer her comprehensive services. After multiple child protection reports, in-home social workers were assigned and helped her get her husband out of the home.

Mental Health. Although 6 participants disclosed mental health issues, only 3 were referred to services (psychological evaluations and counseling). Participants’ responses to these services were more mixed than their responses to either substance abuse or domestic violence services, both in terms of both helpfulness and their agreement with participating. One mother felt that completing the psychological evaluation, which had resulted in a personality disorder diagnosis, and her participation in the resultant therapy were just, “*things knocked off the list*” that she needed to do to complete her case plan. In contrast, another mother said that mental health services met her needs:

[My caseworker] was telling me the last time I talked to her to her, that the doctor that did my psychological eval suggested that you get extra counseling and anger management. What, ok?! I know I’m angry about a lot of things, so give me anger management, give me all you could give me! I can use every anger class that I can get. [Mother]

Although three other parents also discussed having mental health issues, they were not evaluated and did not receive any mental health intervention through child welfare services.

Services for Children. When asked about services for their children, parents whose children were in foster care described that as a service. Most participants said that

their children did not receive any therapeutic services specifically through diversion or their child welfare case plan. Children that did receive mental health or other therapy services already had a diagnosed mental health or developmental condition prior to the parent's involvement with the child welfare system, and those services specifically targeted that problem. Only one mother said that her child was referred for a child development screening after the investigation, and one father expressed that his caseworker suggested that his 2-year old daughter receive play therapy, which he refused. Similar to the responses of several other participants, he did not believe that his child needed any help or services.

Discussion

Many child welfare systems are working towards incorporating family-centered, strengths-based principles into their practices. The results of this study indicate that there are systematic issues in the way the child welfare system operates in regard to the use of family-centered care. Results are mixed, but generally indicate that while the therapeutic services themselves meet the needs of family members, parents are not empowered to influence the service plan; they face several important barriers to receiving services; and that case plans are not designed to take into account issues that are faced by the entire family, in addition to addressing the stressors of individual parents.

Based on the participants' responses, of the major family issues considered in this study (i.e., intimate partner violence [IPV], mental health, and substance abuse), substance abuse problems most often resulted in the requirement for participants to access services. This finding is inconsistent with recent research (Libby, Orton, Barth, et al., 2006; Staudt & Cherry, 2009), which found that fewer caregivers with substance

abuse problems were offered and provided services than those with mental health problems. However, compared to intimate partner violence services, this is not unexpected. Recent qualitative research (Renner, 2011) found that caseworkers and supervisors were reluctant to explore IPV with families in their caseload, and national survey data has confirmed that IPV is rarely considered by child welfare workers to be a critical factor in their decision-making process (Kohl et al., 2005). While comparatively fewer parents were referred to intimate partner violence services in this study, those that were raised several important issues, including both a lack of information regarding why they were referred, and the potential for increased violence from the abusive partner as a result of the referral. These findings indicate implications for caseworker practice with all parents, not just those with partner violence issues. First, child welfare workers may need to provide clearer explanations to parents for why they are mandated to attend all services, not just those that are violence-related. In addition, extra training and supervisory support may also be needed for caseworkers to effectively assess parents for all co-occurring problems and refer them to the services that are appropriate for their needs.

There were several important issues raised in discussing the development and content of participants' case plans. A critical finding is that the participants in this study reported virtually no involvement in the development of their case plan, and little influence on individual services even after the case plan was developed. A family-centered, strengths-based approach suggests that parents should have input into the identification of their strengths, needs, and goals and the means to achieve those goals (Children's Bureau, 2007). Despite these challenges, parents indicated that they

intended to comply with their assigned services. In fact, several parents relinquished any input they could have had into the case plan in order to appear cooperative and compliant. This study also indicated that when individual services were targeted and responsive to parents' needs, parents were more likely to feel comfortable and engage in services. This was particularly relevant to substance abuse services, where parents felt understood and empowered to refrain from relapsing. These findings suggest that infusing similar strengths-based principles into the development of the case plan, especially increasing parental involvement, would help to increase parents' engagement and empowerment much earlier in their involvement with child welfare services. In contrast, when parents perceived that the caseworker was not responsive to their needs or helpful in gaining them access to services, it was a major barrier. It is also noteworthy that very few parents reported therapeutic services for their children, especially those without a previously identified health or mental health need. This is an area in which additional attention is needed, especially given the strong data that suggests exposure to multiple domains of chronic adversity can have lifelong impacts on children's health (Felitti et al., 1998) and that early exposure to circumstances that produce chronic fear and anxiety in children can disrupt children's developing brain architecture, resulting in learning and other problems across the lifespan (National Scientific Council on the Developing Child, 2010).

Another challenge related to case plan development is the indication by participants that case plans focused on addressing the needs of the individual parents, and contained comparatively less focus on broader family issues. In this study, parents worked on completing tasks in case plans that were parallel to each other, rather than in a

more cohesive way that focused on issues that affected the entire family, such as lack of transportation, housing, employment, and other problems that created difficulty for parents to achieve their goals. These issues were significant barriers to both accessing services as well as remaining in compliance with the case plan. While the primary goals of child welfare services are to ensure children's safety and work towards permanency, the well-being of all members of the family must be taken into consideration in order to achieve those goals. In family-centered practice, services are designed to strengthen, enable, and empower families to care for and nurture their children (Children's Bureau, 2007). It is clear that families need support with these important underlying issues in order to successfully complete their service plan and more importantly parent their children, yet virtually no services are designed to address these critical needs.

These findings underscore the need for services to be individualized to the needs of each family, and for parents to have input into the design of their case plans. There are several significant challenges that arise in this discussion. In individual families, issues such as developing case plans for families in which one parent must comply with a case plan and the other is volunteering to complete one present challenges in terms of what types of services to include and how to link these case plans together. In addition, families with active or suspected intimate partner violence need to be carefully assessed and interventions developed accordingly, based on the circumstances of the individual family. Safety planning for these families must also be addressed. It is imperative that services assigned with the purpose of protecting children from future harm do not inadvertently lead to additional violence in families where this is a significant challenge. Finally, there must be consideration that allegations, charges, or family issues that are

present prior to the child maltreatment investigation may have a significant influence on the family's current circumstance and ability to effectively meet their case plan goals. More comprehensive family assessments are warranted, with attention to these issues that are not the immediate precipitators of the child welfare involvement but are important to family stability nonetheless (Schene, 2005).

There are also issues present at the systemic level, particularly because the mandatory nature of child welfare services is not always compatible with the principles of family-centered practice (Alpert & Britner, 2009). Further complicating the issue are the financial constraints of the child welfare system and lack of available community services (e.g., Renner, 2011; Staudt & Cherry, 2009), which may not allow workers to refer parents to their preferred types of services. The range of issues that have been identified in this study indicate that changes are likely necessary on both the individual caseworker and system level. Further research regarding the mechanism for the development of case plans, including parental input into the types of services they will receive and the impact of this input on parents' perceptions and successful completion of mandated services, is needed.

Strengths and Limitations

This study had several limitations. First, it was a qualitative study of relatively small sample size, which limits the generalizability of the results. In addition, the sample was drawn from the participants of a parenting program, and participants volunteered. While a range of participant types (e.g., biological, father-figure, and grandparent), backgrounds, and experiences are represented in this study, it is not possible to tell if the

perceptions of parents who did not participate in this parenting program would differ from those in this study, or how the perceptions of parents who did not volunteer to be interviewed differed from the sample. However, it is likely that since many participants expressed similar concerns, parents in other populations may face similar issues. In addition, while barriers to service receipt was a specific topic in the interview guide, there was not a corresponding question relating to facilitators of service receipt. Where available, respondents' spontaneous descriptions of facilitators were included, but future studies should also more clearly investigate factors that increase the likelihood of successful program completion.

This study also has multiple important strengths. It is one of the first studies to examine the perceptions of participants involved with child welfare services of the mandated therapeutic interventions to which they were referred, and to explore both their experiences with those services and barriers to accessing them. In addition, the study included parents with multiple types of problems (violence, substance abuse, and mental health), which provides a range and depth of perspectives. Fathers and father figures were also included in the study, which adds to the small but growing body of qualitative literature that includes the voices of fathers in the child welfare system. Finally, the study was framed using a family-centered perspective, which will provide guidance as the field of child welfare continues to shift to this strengths-based perspective.

Conclusion

As child welfare systems across the country continue to move towards a more family-centered, strengths-based approach to service provision, it is critical to examine the issues that both promote and hinder parents' ability to access and engage with the

services they are required to attend. In particular, additional attention to implementing more comprehensive family assessments and engaging parents in the design of their case plan may provide mechanisms for increasing family-centered services in child welfare.

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Conclusions and Recommendations

Introduction

Significance of Topic

Exposure to child maltreatment can result in serious negative consequences for children's health and development, including physical, emotional, and mental health problems; social consequences; and cognitive problems (Herrenkohl & Herrenkohl, 2007; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Margolin & Gordis, 2000; Osofsky, 2003; Shipman, Rossman, & West, 1999); as well as difficulties forming secure attachments (Baer & Martinez, 2006; Herrenkohl et al., 2008; Morton & Browne, 1998). Research has indicated that child maltreatment often occurs in conjunction with other family challenges, including problems such as intimate partner violence, substance abuse, and mental health as well as stressors such as low income, unemployment, and lack of adequate housing. Cumulative risk research indicates that as the number of risk factors in the child's life increases, the number of potential negative consequences also increases (Appleyard et al., 2005; Sameroff, 2000). Child maltreatment and its associated family stressors have implications for health and well-being of children across their lifespan, from childhood to adulthood, including increased risk for multiple chronic diseases and several of the leading causes of death for adults in the United States (Felitti et al., 1998), as well as lifelong consequences for how children learn and solve problems due to

changes in brain architecture (Anda, Felitti, Bremner, et al., 2006; National Scientific Council on the Developing Child, 2010).

The serious negative consequences of child maltreatment and its associated stressors indicate the need for effective intervention for families who are already experiencing these problems. While there has been increasing research at the program level to determine effectiveness of particular programs and at the systems level to increase the effectiveness of the child welfare system, there has been relatively little qualitative research with the parents who are facing these issues to understand how they experience the child welfare system (Alpert, 2005; Alpert & Britner, 2009; Baker, 2007). In addition, there is virtually no qualitative research to understand how parents receiving child welfare services perceive the therapeutic services they are required to attend (Alpert & Britner, 2009). This lack of information is especially pertinent in relationship to how parents navigate through the entire child welfare system, from investigation to child welfare case management to mandated services, as most of the available research focuses on only one part of the process.

Further, although national guidance has supported the shift to a strengths-based, family-centered focus within child welfare services (Child Welfare League of America, 2003; Children's Bureau, 2007), this has not been an easy change to implement, especially for families with multiple problems. In particular, the deficit-focused approach to service provision traditionally used in child welfare services generally considers problem identification and problem-solving to be the main intervention strategies, rather than strengths and empowerment of families (Risley-Curtiss, Stromwall, Hunt, & Teska, 2004), and the adversarial, mandatory nature of services also contributes

to this difficulty (Alpert, 2005). While there is a relatively small but growing body of research that is beginning to gain the qualitative insights of parents, virtually none of this research has been conducted specifically using a family-centered framework. Utilizing a family-centered approach to research has multiple benefits, including adding to the knowledge base regarding parents' perceptions of the child welfare system, and empowering parents to tell their stories, which is a critical component of a strengths-based system. Ultimately, it will lead to a greater understanding of more effective intervention strategies for maltreating and at-risk families.

This study sought to fill these gaps in the research. The overall purpose of this study was to explore, in-depth, the experiences of families in the child welfare system that may be experiencing multiple stressors, in order to identify additional points of intervention and intervention strategies that will better protect children from harmful influences on their health, development, and safety. Using a family-centered perspective, this study sought to explore and understand the lived experiences of parents as they navigate the child welfare system and related therapeutic services, and whether the presence or absence of co-occurring stressors, including violence, substance abuse, and mental health issues, influenced that experience. In addition, this study examined the profile of families in a child welfare-related therapeutic parenting program, to determine the extent to which multiple family stressors were identified in this population, and the relationship of these risk factors to parents' change in parenting attitudes over the course of the intervention. The goal of this study was to create a set of recommendations to the child welfare system regarding additional points of intervention and intervention strategies for families who may be experiencing multiple challenges.

Overview of Research Design

The study utilized a mixed methods design and primarily focused on qualitative interviews with parents who were involved in the child welfare system either through an active child welfare case or participation in a preventive diversion program. The quantitative data provided the background and structure to examine the population and stressors they faced, while the qualitative interviews provided the majority of information. Participants were recruited from the Nurturing Parenting Program, an intensive, therapeutic 15-week parent-training program. The program primarily serves families who have maltreated their children and are involved with the child welfare system, or who are at risk of becoming involved with child welfare services. The Nurturing Parenting Program is offered in a group format, facilitated by two therapists, and individuals must attend as a parenting dyad. A dyad is defined as two adults who are involved in the child's daily life. Groups meet weekly for 2.5 hours, and cover a range of topics related to parenting practices and child development. Children age 2-12 attend a simultaneous children's group.

Quantitative data collection was conducted through review and abstraction of Nurturing Parenting program files for the entire population of participants in the program. The purpose of this review was to construct an overall profile of parents involved in the program, including the stressors most frequently faced by the families, and to examine significant relationships between these issues. In addition, the review of files allowed an examination of the change in parenting attitudes before and after the intervention program for eight groups of parents: 1) all mothers; 2) all fathers; 3) mothers with

violence issues; 4) fathers with violence issues; 5) mothers with substance abuse issues; 6) fathers with substance abuse issues; 7) mothers with mental health issues; and 8) fathers with mental health issues.

The focus of the study was on in-depth, in-person qualitative interviews with a sub-sample of participants in the parenting program. Participants were recruited through one of two methods: 1) a presentation by the researcher in active parenting group sessions during the recruitment window (May to November 2010); or 2) an introductory letter outlining the study with a request for participation that was mailed to past program participants. Potential participants either contacted the researcher via phone or email to request an interview, or provided their contact information to the researcher at the in-person presentations if they were interested in an interview. In total, 21 participants completed an interview, including mothers, fathers or father figures, and grandparents who acted as caregivers. The interview guide was designed using a family-centered framework, with open-ended questions to guide the participants to describe their lived experiences with child maltreatment, associated family issues, and navigating the entire child welfare system, including investigation, child welfare services, and mandated therapeutic services.

Conceptual Implications

This study utilized a family-centered care framework to explore parents' lived experiences navigating the child welfare system. The philosophy of family centered practice, as applied to the child welfare system, is that the best place for children to grow up is in families, and that providing services that engage, involve, strengthen, and support families is the most effective approach to ensuring children's safety, permanency, and

well-being. Based on this philosophy, several important principles form the basis of the family centered care framework. These principles include working with the family unit to ensure the safety and well-being of all family members; strengthening the capacity of families to function effectively; engaging, empowering, and partnering with families throughout the decision- and goal-making processes; providing individualized, culturally responsive, flexible, and relevant services for each family; and linking families with collaborative, comprehensive, culturally relevant, community-based networks of supports and services (Child Welfare Information Gateway, 2008).

This study suggests that these principles are applicable to studying families involved with child welfare services, and also have important implications for both intervention and prevention efforts with maltreating and at-risk families. This is a positive finding in light of the knowledge that many child welfare systems are moving toward adopting this approach in their practice, although they often face important barriers in implementing systemic change. However, in this study, few parents felt in receipt of family-centered, strengths-based services, which suggests that there is a great deal of work yet to be done.

The results of the quantitative file review formed the basis for developing a profile of the population in this study, and how their parenting attitudes changed over the course of the Nurturing Parenting Program intervention. Mental health problems, substance abuse issues, relationship violence, and teen parenthood were the most prevalent stressors for the parents who received services from the program. Many parents also experienced more than one of these stressors concurrently. Of all mothers, 39% experienced concurrent substance abuse and mental health issues; 30% experienced

current violence and substance abuse; and 29% both violence and mental health. Similarly, of all fathers, 27% experienced substance abuse and mental health, 26% experienced current violence and substance abuse issues; and 23% current violence and mental health issues. These results indicate that many of the parents in this study, and likely other parents involved with child welfare services, are faced with a range of complex stressors that not only affect their ability to effectively parent their children but also impact their experience with child welfare services and require an individualized, tailored response.

Through the interviews, parents described their experiences moving through the timeline of the child welfare process: from child protection investigation to child welfare case management to receiving mandated therapeutic services. Rather than being incorporated as an integrated part of the overall child welfare system, participants were referred to these services near the end of their child welfare involvement. Thus, the agencies that provided the mandated therapeutic services functioned as a type of isolated “final referral” along the timeline of participants’ involvement in child welfare services. This lack of service integration presents a significant challenge in a system that relies on these service agencies to assist in establishing safe, healthy family environments for children.

Parents framed their experiences through an emotional process that they experienced as they moved through the child welfare system, beginning with the initial investigation. In some ways, the way they described their emotional process mirrored a grief reaction, although parents did not necessarily describe their emotional reactions as a linear process. Given the loss of control in their family lives, and sometimes the removal

of their children to a foster home, this type of emotional reaction process may not be unexpected. Often, participants described confusion and anger at the initial child maltreatment investigation and referral to services; denial that there was a problem; resentment at service providers for interrupting their family life; and, once they had begun to receive the therapeutic services, some acceptance and recognition that those services were helpful for them. This emotional process described by parents was impacted by how they were treated by investigators, child welfare caseworkers, and service providers throughout their experiences with child welfare services.

Empowerment

Perhaps the most glaring issue that was raised in this study is the marked lack of empowerment of parents within the child welfare system. Parents with varying stressors (intimate partner violence, substance abuse, and mental health, among others), as well as parents who did not disclose any co-occurring stressors, described this type of issue. One of the clearest illustrations of a lack of empowerment was the participants' perception that their caseworkers were not effectively communicating information to them. In instances of good communication, parents felt that they had a better understanding of their situation, why they were involved with services, and what it would take to achieve their goals. However, the majority of participants did not report this type of communication. Some parents expressed a greater understanding of what it would take to properly care for their children in the future, but they derived this information primarily from the therapeutic services that they were required to attend. This, in turn, indicated that they did not receive this information until near the end of their involvement with the child welfare system. Parents reported very little empowering communication

directly from the child welfare worker or attorney. This was especially evident in a lack of guidance on what parents should expect from their child welfare involvement, how long they could expect the child welfare process to take, and other information regarding how to “navigate” the system. The interviews with parents suggested that the caseworkers were primarily managing cases, including assuring that parents completed their required services and tasks, checking on children who were in foster care, and providing referrals to therapeutic services when possible. Overall, parents did not feel that the individual caseworkers were offering them supportive services. There are several possible reasons why this may be the case, including a combination of an underfunded system, overburdened caseworkers, and a lack of ongoing training and support for workers.

In addition to communication between the caseworker and parents, virtually no parents in this study reported having any input into the design of their case plan, and they reported little influence on individual services even after the case plan was developed. In contrast, results also indicated that when parents attended the required therapeutic services toward during the latter part of their involvement with the child welfare system, services tended to be targeted and responsive to their needs, which led to parents being more likely to feel comfortable and engage in services. These findings suggest that infusing similar strengths-based principles into the development of the case plan, especially increasing parental involvement, would help to increase parents’ engagement and empowerment much earlier in their system involvement. This type of ongoing parental involvement is in line with the family-centered practice principles of engaging

with and empowering families throughout the decision-making process (Child Welfare Information Gateway, 2008).

Other studies (e.g., Kapp & Propp, 2002) found that when parents felt disempowered by case managers or other aspects of their child welfare involvement, they had increased feelings of helplessness and hopelessness, which possibly contributed to their failure to comply with the case plan. In the current study, interview participants felt strongly that they would do what it took to end their involvement with the child welfare system and return their family to “normal.” Due to the study design, it is not possible to determine the relationship between parental lack of empowerment and overall case outcomes, but it is apparent that parents in this study believed they were motivated to comply.

Stigma and Treatment of Parents

Related to the theme of empowerment is the theme of stigma and the lack of respect toward parents. This problem was especially prevalent when parents discussed their initial interactions with the system, which were with child protection investigators (CPI). Parents often felt like they were treated poorly from their initial interaction with CPI, which resulted in a great deal of undue stress, anxiety, and frustration from the outset of their experience. While the investigators were professional, their attitudes in dealing with parents were described as abrupt, abrasive, and controlling, which contributed to a sense of stigma. Some parents felt that they were treated as though they were less worthy of respect by the investigators. This was further intensified in other ways, such as when parents described that the initial investigation involved uniformed officers arriving at their home in police cars. This initial method of arrival and

investigator behavior often resulted in parents becoming defensive and angry, beginning a negative cycle in their relationship with providers, and increasing their feelings of stigma.

The stigma of being involved with child welfare services often continued in parents' involvement with the child welfare system, particularly in terms of lack of control over their situation or any aspect of the child welfare process, including the development of their case plan. This study supports the results found by Dumbrill (2006) regarding the importance of the way power is used in the caseworker-parent relationship, especially when power is used "over" parents to force them to comply. In contrast to this, when parents described receiving encouraging feedback and support from their caseworker or the child protection investigator, they had a more positive outlook on their involvement with services. This relationship was true even for the parents who did not agree that they needed to be involved with the child welfare system. Parents described positive feedback from providers resulting in their feeling as though they would be more able to complete their case plan, and having their caseworker believe in them made it easier to do so. It is noteworthy that it did not require a tremendous effort on the part of caseworkers or investigators for parents to feel this way. Small supportive comments, acknowledging that the parents were doing a good job, and the expression of the belief that parents could be successful all contributed to their more positive outlook.

Individualization of Services and Case Plan

Interview participants described many stressors in their lives, including mental health, substance abuse, intimate partner violence, and childhood abuse. In addition, one-third of participants who were interviewed experienced more than one of these stressors

at the same time. This finding was supported by the file review data for the entire population of parents in Nurturing Parenting, in which between 23% and 39% of parents experienced at least two concurrent stressors. The types of issues faced by families underscores the need to design interventions that truly take into account the particular circumstances of individual families. One example of this is the need for careful assessment and intervention in families where intimate partner violence may be an issue. It was clear that for one mother in this study, her assignment to a domestic violence intervention program could have increased the violence in her relationship. The dynamics of these types of situations cannot be underestimated, and need to be understood by child protection investigators and child welfare workers and incorporated into case plans. In addition, it is important to assess and recognize attachments between parents and children. Mennen and O'Keefe (2005) suggested that for families with secure attachments, intervention should focus on relieving the stressors that lead to the maltreatment and providing support for the family, rather than removing the child from the home. In some families, the number and extent of stressors may prevent this approach, but it is an area that is critical in the healthy development of children and one that may need additional attention.

In both the interviews and review of files, it became clear that parents also faced a variety of other challenges, including lack of transportation, lack of housing, difficulty finding childcare, and issues with their extended family. The focus of the child welfare system tends to be on identifying the maltreatment and creating a safe and permanent home for children. However, these other stressors, while not necessarily contributing directly to the maltreatment allegation, presented significant challenges for parents both

in their life circumstances and compliance with their case plan. For example, transportation was a major concern for participants in the interviews: parents disclosed that they sometimes struggled to attend the mandated services because the locations were not close to their homes and they had no other means of transportation. This was supported by file review data specific to the Nurturing Parenting Program, as some parents missed individual class sessions, or were dropped from the program due to missing too many classes, at least partially due to lack of adequate transportation. In some cases, service providers assisted parents in resolving these types of issues on a short-term basis, but parents did not describe any systematic method for dealing with these issues within the child welfare system.

In this population of parents, case plans focused on addressing the needs of the individual parents, and contained comparatively less focus on these underlying stressors that affected all members in the family. In addition, there was almost no attention in the case plan to the identified strengths of the family. For example, both the interviews and file reviews revealed that parents often felt that their strength was being a couple and doing activities as a family. In the interviews, parents felt that these types of strengths were not considered or addressed in the design of their case plan. In the shift to more family-centered services, working with the family unit to ensure the safety and well-being of all family members and strengthening the capacity of families to function effectively are important principles that must be addressed (Child Welfare Information Gateway, 2008), and this includes both a full assessment of both challenges and strengths.

Responsiveness of Therapeutic Services

Few studies have examined parents' perceptions of and experiences with mandated therapeutic services as a result of their involvement with the child welfare system (Alpert & Britner, 2009). Parents in the interviews, overall, felt that the mandated therapeutic services they received were often supportive and responsive to their needs. One example of this is the Nurturing Parenting Program. This program received substantial positive feedback from parents, both in terms of what they learned as well as their interaction with program facilitators. There was less negative feedback, which included some parents' concerns that they could not incorporate all of the lessons into their parenting practices. The interview data is supported by results of the file review, which showed positive changes in parenting attitudes after the program was completed compared to before for all groups of parents that were studied, including those with violence, substance abuse, and mental health problems. It is possible that the types of support provided by the program facilitators made them feel more positive about program and more confident in their ability to parent their children.

Positive feedback on the responsiveness of mandated services was not limited to the parenting program. Parents also expressed positive feedback about substance abuse services, where they felt that their needs were understood and empowered to refrain from relapsing. In particular, the interaction with facilitators who were recovered drug addicts made parents in this study feel better understood and supported. The impact of the responsiveness of these services on the parents in this study is critical, especially in assuring that interventions are effective as well as infusing positive aspects of therapeutic services into the entire continuum of child welfare interventions.

While many therapeutic services were helpful and responsive, they were not always available for parents. In particular, this study identified one mother who tried to access domestic violence services in order to leave an abusive relationship with her husband, but felt that no one agency was able to completely support her. It is unclear if the agencies were truly unable to help her, or if she was not able to get the answer she sought. In a broader circumstance, parents' preferred type of service may not be available due to financial constraints of the child welfare system. For example, a caseworker may not have the funds to get a parent into their preferred agency for drug treatment. This presents difficult challenges, especially when caseworkers are attempting to find services that best fit the needs of parents.

Services for Children

The interview participants indicated that most of their children did not receive therapeutic services unless they had a previously identified health, developmental, or behavioral problem. In the abstraction of program files, the Nurturing Parenting screened children under 5 years of age for developmental problems using the *Ages and Stages Questionnaire*, but the tool was not consistently used in all families until recently, and few children exhibited clinical-level developmental problems when screened. Research has found that many children involved with child welfare services have mental health challenges, including clinically significant ones, but are not assessed for them or do not receive services (Fluke & Oppenheim, 2010). Several parents in this study indicated that they did not think that services were necessary for their children to cope, yet many parents also indicated that their children were experiencing adjustment problems during their involvement with child welfare services. This suggests that parents may not be

linking these issues together, and is consistent with other qualitative research that found that mothers in the child welfare system had difficulties supporting their children psychologically (Haight, Shim, Linn, & Swinford, 2007). This indicates that not only do children likely need more services, parents may also need additional support in understanding child development and the impact of adverse experiences on their children.

Complicating the issue regarding services for children is the frequent perception of parents in this study that the child welfare system is primarily concerned with the safety of children, especially as it relates to foster care placements, rather than supporting parents to help them be better able to care for their children. Parents may be so focused on addressing their own problems, and the associated barriers to doing so, that they are unable to support their children. This again emphasizes the need for families to be comprehensively assessed, and for case plans to be designed around the needs and strengths of the individual family.

Need for Change and Associated Challenges

Parents in this study experienced a range of interconnected stressors that were related to their involvement with the child welfare system, yet nearly all of them stated that they wanted to be better parents. This study sought to identify additional types of interventions for families through investigating whether the services provided to parents, the way those services are provided, and the way the child welfare system operates, were facilitating this type of change for parents. The results suggested that individualized, family-centered services would be effective in intervening with parents, but that they are not currently being systematically provided.

Other researchers have identified the fact that child welfare systems have most often been designed in a way that focuses on an adversarial process and a punitive-based system that focuses on individual parents (Alpert, 2005; Risley-Curtiss, Stromwall, Hunt, Truett, & Teska, 2004). The Children's Bureau (2007) and Child Welfare League of America (2003) have determined that a strengths- and empowerment-based family-centered system is the gold standard of practice. In the Child Abuse Prevention and Treatment Act (CAPTA), Congress specifically indicated that "the child protection system should be comprehensive, child-centered, family-focused, and community-based, should incorporate all appropriate measures to prevent the occurrence or recurrence of child abuse and neglect, and should promote physical and psychological recovery and social re-integration in an environment that fosters the health, safety, self-respect, and dignity of the child" (US DHHS, 2009a). While the child welfare system in Hillsborough County, the site of this study, is currently beginning to move toward more family-centered services, the tension inherent in this movement is palpable. The results of this study support the current movement to incorporate family-centered strategies into the practice of the child welfare system in Hillsborough County.

It is also clear that there are significant challenges to implementing systemic changes that would lead to more family-centered services. Perhaps the most fundamental barrier is the lack of adequate funding for child welfare systems, which affects many areas of child welfare practice. For example, systems may not have the ability to recruit and hire the number of caseworkers that are needed, or to recruit caseworkers with advanced degrees. Individuals with advanced degrees may be better prepared to understand the complexity of the co-occurring issues that families face and

what types of interventions and supports may be necessary. The lack of resources also limits the amount and intensity of ongoing training and support that is available for current caseworkers. Regular education and support is necessary for caseworkers in their current practice, and critical if an effective shift in the system to a more family-centered approach is going to be possible. Strong supervisory support for caseworkers, especially small supervisor to caseworker ratios, is also important in order for caseworkers to function effectively. However, this type of supervisor support is often limited due to lack of resources. Funding deficits also may affect the ability of caseworkers to provide and pay for referrals to the services parents are mandated to attend. This creates not only serious challenges for parents with limited financial resources to remain in compliance with their case plan, but also complications in the parent-caseworker relationship when these dynamics are not communicated to parents.

Related to the challenge of inadequate funding is the high number of cases that child welfare workers must manage. High caseloads can lead to burnout and rapid turnover of caseworkers, especially in a system that does not have the resources to provide continued support and education. In turn, this necessitates the training of new workers. In addition, the high number of cases may result in caseworkers feeling that they do not have adequate time or energy to communicate with parents in depth, leading to their primary focus on tracking parent compliance and the associated challenges faced by parents who report lack of communication and support from their caseworker.

Implications for Practice

The results of this study suggest that there are implications for both child welfare interventions for families who are currently experiencing maltreatment and associated stressors, as well as both targeted and universal public health prevention implications.

Child Welfare Interventions

The child welfare system is designed to protect and ensure children's safety, permanence, and well-being. The results of this study suggest that the emphasis is on safety and permanence, and the focus on well-being is lacking in this system, and thus the system is not as effective as it could be. There is a clear need for more attention to issues pertaining to the well-being of the entire family, which will, in turn, increase the likelihood of safety and permanence for children.

Despite the significant barriers described above, changes are clearly necessary in the practice of child welfare in order to most effectively work with families and create safer, healthier environments for children. There are two sets of implications, those relating to: 1) individual caseworkers; and 2) system-wide policies and practices. It is likely that the changes proposed in the behavior of individual child welfare caseworkers will be easier to implement than more overarching system-wide change.

Implications for Individual Caseworkers. There are several implications for individual child welfare caseworkers and child protection investigators. The results of this study indicate that families feel more engaged when they feel respected and given options, feedback, and encouragement. In addition, communication emerged as an extremely important concept, particularly in regard to the status and process of the parents' child welfare case. Also, parents indicated the need for practical assistance with

individual needs, including housing, transportation, and employment. These are all aspects of strengths-based, family-centered casework. This suggests the need for caseworkers to act in a more supportive relationship to parents, rather than focusing on managing the cases in terms of monitoring parents' compliance with services and tasks.

A change in caseworkers' communication style would have a significant impact on the caseworker relationship with parents, and, in turn, the parents' understanding and engagement in services. To the extent possible, caseworkers should focus on supportive, informative communication with parents. Palmer and colleagues (2006) suggested that caseworkers' language in addressing parents should be such that parents do not feel personally attacked. In particular, training on effective, supportive communication is recommended. Such training could address how caseworkers could be more direct and forthcoming about challenges they face in getting referrals to services, especially with limited financial resources, and techniques for partnering with parents on finding appropriate services to meet their needs. In addition, effective communication from the caseworker should take into account how parents understand their involvement with child welfare services, and what they understand about the process. It is clear that what providers perceive is not always what parents understand, which often leads to confusion and frustration for parents. Caseworkers should be able to explain the child welfare process to parents in terms that they will understand, and also have materials available that are designed specifically for parents to keep for their reference. These types of steps will likely lead parents to be better able to engage in the child welfare process, and thus have more success.

To the extent that they have control over the referral process, caseworkers also need to provide service referrals to parents in a timelier manner. Both federal and Florida laws indicate that time to permanency should be as efficient as possible (Child Welfare Information Gateway, 2010; Florida Legislature, 2010). This creates an environment where parents must not only access but also successfully complete services for complex problems, such as partner violence, mental health, and substance abuse, in a relatively short time frame. Service referrals should come as near the beginning of the child welfare process as possible, so that parents have the greatest chance for success in both accessing and completing services in the given time frame. In addition, caseworkers should assist parents in determining the order in which they should access these services. This is especially pertinent for families with multiple issues, because they may have more difficulty reaching their case plan goals (Marsh, Ryan, Choi, & Testa, 2006), and may need additional assistance in organizing multiple referrals.

Implications for the Child Welfare System. Implementing the principles of family-centered care within child welfare systems is not an easy task, given the mandatory nature of most parents' involvement (Alpert, 2005; Fluke & Oppenheim, 2010). However, as noted in this study and others, parents respond better to more respectful, supportive treatment by providers, which supports the paradigm shift to a more strengths-based system. In Hillsborough County, where this study was conducted, there has been recent attention to shifting to more family-centered services from the child welfare leadership, including the implementation of family group conferencing. The results of this study support this shift from the parents' perspective. Implementing these types of changes emphasizes the need to not push families aside, but rather "focus on finding the

strengths and supports within the family that might help them improve the care of their children” (Palmer, Maiter, & Manji, 2006, p. 822). Overall, this study has demonstrated the need to infuse the supportive nature of many therapeutic services that parents receive only near the end of their experience with child welfare services into the entire continuum of the child welfare system.

Child welfare systems should also implement comprehensive family assessments, through which to more fully understand and better respond to the contributors to child maltreatment and other associated stressors. It is essential for there to be an assessment protocol that effectively identifies all types of family stressors and causal factors that affect children, not only those that directly relate to the maltreatment (Schene, 2005). This study indicated that there is a lack of attention to both stressors that affect the entire family, such as transportation and employment challenges, as well as family strengths, in both the initial assessment of families and design of case plans. In particular, there is a need for increased recognition to complex issues of overlapping child maltreatment and intimate partner violence. Comprehensive assessment models should include evaluation of both family challenges and strengths, should be an ongoing partnership with parents throughout the case, and require a consistent process of communication between caseworkers, families, and service providers (Schene, 2005). It is also important to effectively assess children’s overall well-being and coping mechanisms in addition to evaluating more logistical concerns regarding their safety, such as foster care placement. Children in families with multiple stressors are at increased risk for a variety of developmental and behavioral challenges, and careful assessment of these is necessary. Accurate identification of family and child challenges as well as strengths would help

individual caseworkers to provide more individualized services to families, and provide the opportunity to draw on other family and community supports that may help parents improve the care of their children.

In conjunction with comprehensive family assessments, there is a need for the development of more family-responsive case plans. Case plans should be designed in partnership with the input of parents, and should strive to address the underlying stressors that challenge the entire family and may make it difficult for parents to remain in compliance with their plan and reach their goals. Because there are a variety of family structures in families involved with child welfare services, case plan development must also be sensitive to the individual structure of each family, to address both challenges and strengths. This is especially applicable to cases where there are both biological parents and non-biological parent figures. The current process of case plan development may cause separated or divorced biological parents to become adversaries rather than working together, to the extent possible, to care for and support the needs of their children. Case plans should also take into account the benefits of supportive, reliable extended family in order to provide additional family- and community-based supports to parents.

Because families involved with child welfare services face a variety of stressors, they are often involved with other service systems. It is imperative for the child welfare system to have effective coordination with these other service systems, such as intimate partner violence, mental health (including both adult and child mental health services), and substance abuse. Other studies have identified that the lack of formal coordination mechanisms between the child welfare and mental health systems (Park, Solomon, & Mandell, 2006) and the diminishing availability of comprehensive substance abuse

treatment programs (Marsh, Smith, & Bruni, 2011) have resulted in difficulties for parents to receive the services that they need to succeed. Effective, integrated coordination, understanding of agency guidelines, and clear inter-agency referral processes would reduce the duplication of resources and services, and increase parents' chances for success when completing multiple types of treatments.

Change at the systems level should also include the development of methods to more directly engage parents in the operation of the child welfare system, and to empower parents to make changes to the system. Parents in the current study provided thoughtful and interesting answers when asked what they would do to change the child welfare system, and most indicated they had never been asked for their opinion on this topic prior to the interview. Researchers have identified several possibilities for fostering this type of parent engagement. For example, Williamson and Gray (2011) suggested that child welfare agencies could invite previous clients of the child welfare system to serve on advisory panels to help inform the development of agency policies and practices. This type of direct engagement of parents would assist in creating system change that is responsive to parent feedback. In addition, the system could create "case aide" (Briar-Lawson & Wiesen, 2001) or "peer mentor" (Williamson & Gray, 2011) positions within the child welfare agency, in which previous child welfare parents could be employed. These types of positions could help reduce the strain on caseworkers with high case loads and offer ways for parent aides to intervene where professional caseworkers cannot (Briar-Lawson & Wiesen, 2001). For example, a parent who has been through the child welfare system and is in recovery from a substance abuse issue could serve in such a position, and may more easily be able to relate to a parent currently facing these

challenges to help them successfully navigate the system. Employing past participants in such paraprofessional positions would also be a relatively cost-efficient way of creating change. While these types of changes require agency buy-in and supervision of family members (Williamson & Gray, 2011), they are creative ways to both further engage families and create a more family-centered service system while reducing some strain on overburdened caseworkers.

The implementation of system-wide changes are clearly limited by the significant underfunding and continuous risk of additional funding cuts in which the child welfare system operates. System-wide changes require the approval and support of the system leadership to help cultivate an environment where such changes would be supported, and to implement changes with limited resources. Thus, increasing attention to the behavior of individual caseworkers may provide a strong starting point requiring fewer initial resources.

Public Health Prevention

A wealth of research has indicated that exposure to abuse and other stressors in childhood can lead to a myriad of negative consequences for children across their lifespan. It is likely that parents have been experiencing these stressors, and children have been exposed to them, for months or years prior to coming to the attention of child welfare services. Therefore, in addition to implications for the current child welfare system, there are broader implications in terms of public health prevention. The Centers for Disease Control and Prevention (CDC) has noted that the public health approach to child maltreatment prevention is relatively new, but that prevention is essential (CDC, 2008). This study has found that that parents have a more positive outlook when they are

treated with respect and encouragement, which supports the results of other studies that have found that parents may be more responsive to interventions when there is no stigma of being involved with the child welfare system (Whitaker, Lutzker, & Shelley, 2005).

These issues point to the need for increased prevention and early intervention efforts for families at risk of child maltreatment. The CDC's strategic direction for child maltreatment prevention has focused on the framework of preventing maltreatment through promotion of safe, stable, and nurturing relationships between children and caregivers (CDC, 2008). One of the key components of this initiative is to address the social determinants of child maltreatment. The 2010 funding through the Affordable Care Act for evidence-based home visiting (EBHV) programs fits within this framework of both promoting healthy relationships and addressing social determinants of health, and may provide opportunities to implement effective programming for families at risk of maltreatment. Home visiting programs generally focus on improving parents' capacity and skills in relation to parenting as well as monitoring and improving health and developmental outcomes for children (Johnson, 2009). Despite this recent national attention to EBHV programs, gaps exist in the knowledge on how to build the service systems that are necessary to implement and sustain these programs to prevent child maltreatment and other adverse outcomes. Current EBHV programs under study in the nationally funded cooperative agreements include models that have been used around the country, such as Family Connections, Healthy Families America, Nurse-Family Partnership, Parents as Teachers, SafeCare, and the Triple-P program (Koball, Zaveri, Boller, et al., 2009). The results of these studies will provide greater clarity on the most

effective early intervention models and methods for building infrastructure that will support their wider implementation.

Both the public health approach and the serious negative influence of stigma on parents who are involved with child welfare services also point toward the idea of implementing a more universal child maltreatment prevention and parent support system. While the early intervention and the child welfare systems offer intervention for parents who are determined to be at-risk or who have already begun to maltreat their children, a universal prevention model would support all parents. Although the infrastructure at the national level needs to be developed to support a universal model, individual states have already begun to take this approach. For example, Maine has implemented a set of strategies designed to “support parents as children’s first teachers” (Johnson, 2009, p. 13). One of the state’s core strategies is to provide home visiting, including parent education and support, child development screening, and linkage to other community programs and resources, to any first-time family of a child up to 4 years of age, regardless of the parent’s level of risk, education, or income (Johnson, 2009). Within the new national initiative to support early home visiting, the shift to this type of universal model of service provision would provide support and assistance to all parents in an environment free of stigma.

Strengths and Limitations

Limitations

There are several limitations to this study. The study only focused on the population of parents involved in the Nurturing Parenting Program, which limits the conclusions that can be drawn. In the quantitative analysis, there were a limited number

of files to review, which restricted the types and complexity of analyses that could be completed. In addition, the information in the files was limited to what was available for abstraction in the program files, and, with the exception of the pre- and post-test measure of parenting attitudes, files did not always contain the exact same information for every family. Without the information contained in the child welfare system records, it is not possible to draw conclusions about what types of problems were identified by the child welfare worker that may not have been included in the referral to the parenting program or communicated with the program facilitators directly. Thus, it may be that parents in the program faced additional stressors that were not captured through either of these mechanisms. In addition, there was no comparison group with which to compare the change in parenting attitudes, which limited the conclusions to only the participants of this particular program.

The sample for the qualitative interviews was drawn from the participants of the Nurturing Parenting Program, and participants volunteered to be interviewed. It is not possible to tell if the perceptions of parents who did not participate in this parenting program would differ from those in this study, or how the experiences of parents who did not volunteer to be interviewed differed from the parents who did not respond to the interview request. However, the triangulation of data from both the file review and interview responses suggested that the sample of participants who were interviewed were similar to the overall population of Nurturing Parenting Program participants. In addition, parents described their own experiences and perceptions in the interviews, and their descriptions may have been subject to recall bias or the social desirability of pleasing the researcher. Limiting the sample to only participants who spoke English did

not allow for conclusions to be drawn about other cultural groups who may have different experiences. However, it is certainly possible that many parents experience similar issues, especially in instances where the findings were almost universal in this population.

Strengths

This study had multiple important strengths. The mixed method research design allowed the triangulation of data in several areas to strengthen the results. This was particularly true for the information obtained from the qualitative interviews, which demonstrated that parents' perceptions of the parenting program were supportive of their change in attitudes toward parenting and child-rearing. The quantitative results also provided important background for understanding this population of participants, and the context in which to interpret their comments in the qualitative interviews.

In general, there are relatively few qualitative studies of parents who receive child welfare services. Many studies of child welfare case outcomes look at parent factors, but they are described in terms of what the parent *is* or *does*, not what the parent *feels* or *experiences* (Alpert, 2005). This study is one of the first to examine participants' navigation throughout the entire child welfare system, and to construct a timeline of their experiences throughout child protection investigation, child welfare services, and mandated therapeutic services. This approach allowed the ability to examine, from the participants' perspectives, the broader systemic implications of how they perceive and experience the child welfare system, and the relationship of how they were treated to those experiences. This study is also one of the first studies to examine the perceptions of parents involved with child welfare services of the mandated therapeutic interventions

to which they were referred, including barriers to receiving those services and perceptions of various service types. Research in this area is critical in determining the particular qualities of interventions that are effective in intervening with this population of parents. Within the relatively small body of literature on parents' lived experiences in the child welfare system, there are even fewer studies that consider their experiences within a family-centered framework. This study utilized a family-centered framework, which allows the development of recommendations to the child welfare system within a context that is responsive to parents' needs and experiences.

Given the need to increase the qualitative information that is obtained from parents in the child welfare system, another important benefit of this study was the inclusion of the voices of different types of participants. These participants included not only mothers, who often receive the most attention in child welfare services and research, but also those that are often underrepresented in studies on child welfare: fathers, father figures, and grandparents. This study also gave particular attention to parents who experienced various types of family challenges (violence, mental health, and substance abuse), whose specific voices are also often underrepresented. A relatively unexpected benefit was the extent to which parents expressed empowerment and a desire to share their experiences through participation in the interviews. Some researchers have described difficulty in accessing and engaging this population of parents for a variety of reasons. It was clear in this study that participants needed a place to talk about how they felt about the investigation and their involvement with services, separate from actually receiving those services. Many participants were quite surprised at the end of the interview when they were asked what they would do to change their child welfare

system, and expressed that they were infrequently asked for their opinions. This study indicates that while it may be difficult to access parents who receive child welfare services, it is critical to include their perceptions and experiences in developing systemic change.

Future Research

The results of this study suggest several areas for future research, including both further analysis of data collected in this study and the design of additional studies.

Understanding family experiences and impact on case plans

Historically, the focus of child welfare intervention and research has been on mothers, who are most often considered the primary caregivers of the children, and often treated as responsible for the child maltreatment (Davidson-Arad, Peled, & Leichtentritt, 2008; Strega, Fleet, Brown, Dominelli, Callahan, & Walmsley, 2008). While there is a growing body of literature regarding the involvement of fathers, there are few qualitative studies that include fathers' perceptions and experiences. There is a need for additional qualitative studies to explore fathers' experiences; where they may be similar or different to their partner's experiences; and how the system may engage better with families as a whole, rather than placing blame on and intervening with separate individuals.

This study indicated that when both members of the couple were interviewed, mothers and fathers within the couple often perceived child welfare services differently based on who was named the primary target of the investigation and services. Parents described their individual case plan separately from their partner's plan, and referred to services they had to complete separately from their partner. There is a need for research to further explore these different perceptions and what the implications are for this kind

of treatment of parents as separate individuals. If case plans are designed separately for the “perpetrator” and the “other” parent, what are the implications for treatment of parents, children, and the entire family? What are the limitations of this type of approach in families where there is not one single perpetrator, but more systemic family dysfunction?

This study also indicated that parents had virtually no involvement in the development of their case plans. In the shift toward more family-centered systems, parental engagement and partnership in this process is critical. Further research regarding the mechanism for the development of case plans, including parental input into the types of services they will receive and the impact of this input on parents’ perceptions and successful completion of mandated services, is needed. In addition, more research is also needed on how to best engage parents in this process.

Additional attention to “father figures”

Many mothers who receive child welfare services are single mothers, though they may be in a relationship with or living with a boyfriend, fiancé, or other non-biological “father figure.” In both the child welfare literature and delivery of child welfare services, there is even less attention on non-biological father figures than biological fathers, yet there are implications for the support system around the child, who is actually providing it, and what this means for the family. Luthar (2006) suggested that supportive relationships with both mothers and fathers/father figures can be protective for children. The two father figures in this study were offered the opportunity to volunteer for a case plan, and both did so. However, they also noted that they were not always seen as a support system for the mother and children, and they were not included in official court

proceedings. The involvement of father figure becomes even more complicated when also considering the biological father – for example, is there a way to include a father figure while at same time giving the biological father an opportunity to complete the case plan? Does anything change if the biological father has not complied with any part of the case plan or been involved with the child prior to child welfare intervention? In this study, both of the father figures, and their partners, expressed concerns about the non-involved biological father, and what that would mean for their relationship with the children. Additional research to examine this dimension of the family system is necessary. This is a complicated area of research, especially when considering the complex structures of families involved with child welfare services.

Children's well-being, coping, and resilience

Additional research is needed to explore how parents perceive that their children are affected by the maltreatment and involvement in child welfare services (including foster care, if children are placed in care) compared to how the children are actually coping. In this study, unless the child had a specific medical or behavioral health condition, few services were offered to children, and parents felt that their children did not need any services to help them cope. Research has indicated that children involved with child welfare services, children in substance abusing families, and children exposed to IPV all are at risk for health and developmental problems, and thus intervention may be necessary for them. However, parents may not know to advocate for their children and what they may need. As suggested in the interviews, parents' understanding of child development and the impact of stressors on their children may be increased by their participation in parenting programs, but this is not guaranteed. It is important to more

deeply explore what parents understand about their children's wellbeing in these circumstances.

In addition, it is also important to examine the resilience of these children, especially very young children whose attachments may have been disrupted. Luthar (2006) suggested that insecure attachments may be offset by later positive relationships, but it is not clear how this applies to children in the child welfare system, or if the quality of those later relationships is the same as in those children who did not face the same types of early stressors. Additional research is necessary to examine whether children fare better in the long-term within this framework.

Parents' views of their strengths

In this study, parents said that almost no services/components of case plan were designed around parents' strengths, or designed to incorporate them. In general, there is very little information about the strengths of families involved with child welfare services, because the literature generally focuses on deficits and negative outcomes. While parents in this study often described their strengths as spending time with their children or doing activities together as a family, they also felt that very few providers asked them about these strengths in the course of their involvement with services, and thus they were not incorporated into case plans. In fact, parents who participated in the interview often expressed confusion when asked if their case plan took into account any of their family strengths. More exploration of this data is warranted.

Longitudinal qualitative research

More longitudinal qualitative research is needed with families involved in the child welfare system in order to answer questions about case outcomes from the parents'

perspective, and to continue to make them feel engaged (Alpert, 2005). Such research could provide additional depth to the data collected in the current study, and contribute not only to a better understanding of family outcomes, but more importantly how the issues and themes raised in this study may influence those outcomes. Longitudinal research designs could also include more intensive assessments of how parents experience mandated therapeutic services, and the ways those services are provided to parents, in relation to their outcomes. This may help to provide guidance on how child welfare agencies can incorporate the most supportive, effective aspects of mandated services into the entire child welfare system.

Conclusion

Child maltreatment is a significant public health problem in the United States, as maltreated children are at risk for a variety of negative health, behavioral, developmental, and social consequences across their lifespan. Families who have maltreated their children are often treated punitively by the child welfare system and the other service systems with which they have contact. This study has demonstrated that such families often face a range of interconnected stressors that affect both their parenting and their ability to successfully complete child welfare services. A shift to a more family-centered, strengths-based approach to intervening with parents, including improved communication techniques, more family-responsive case plans, and empowerment of parents throughout their experience with child welfare services, would provide additional support and help parents to be better able to parent their children. Future work in this area is needed not only to most effectively intervene with these families, but also to reduce the most prevalent stressors before they begin.

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Appendices

Appendix A: Review of the Literature

Introduction

Family violence is a significant public health problem in the United States. In 2009, there were 702,000 cases of substantiated child maltreatment in the United States (US DHHS, 2010). In addition, child maltreatment and intimate partner violence have been found to co-occur in approximately 30-60% of families that experience one or the other of these problems (Appel & Holden, 1998; Edleson, 1999). Family violence has been correlated with other family stressors, including mental health problems, substance abuse, and poverty. Children in families experiencing multiple stressors are at particularly high risk for a myriad of negative health and developmental consequences in childhood and throughout their lifetime (Appleyard, Egeland, van Dulman, & Sroufe, 2005; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998).

National health priorities for the United States, as set by Healthy People 2020, include the reduction of child maltreatment and fatalities due to child maltreatment, and a reduction in the rate of physical assault by current or former intimate partners. In order to reduce these rates and associated problems, and prevent the cycle of violence from continuing in families, increased attention to and intervention for families experiencing multiple forms of violence is necessary.

The systems that deal with these issues often operate using different paradigms that are often at odds. Until recently, “most communities have treated the abuse of a woman and the maltreatment of a child in the same family as separate phenomena having little to do with each other” (Schechter & Edleson, 1999, p. 1). In order to achieve the best outcomes for children, the agencies serving multiple violence families must work

together to address the problem of violence and its associated stressors within families, yet face significant challenges in doing so.

Prevalence of Child Maltreatment and Multiple Forms of Violence

Children's exposure to violence, including both direct maltreatment and exposure to other types of family violence, has been identified as a significant public health problem in the United States (Margolin & Gordis, 2000; Whitaker, Lutzker, and Shelley, 2005). According to the Keeping Children and Families Safe Act of 2003, child abuse and neglect is defined as "at a minimum, 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." In 2009, child protective services (CPS) agencies received 3.3 million reports of suspected child maltreatment, and an estimated 702,000 of these reports resulted in a substantiated case of child maltreatment (US DHHS, 2010).

Research in the intersection of child maltreatment (CM) and intimate partner violence (IPV) has proliferated over the past several decades. IPV has been defined as physical, sexual, or psychological harm by a current or former partner or spouse (Saltzman, Fanslow, McMahon, & Shelley, 2002). It has been estimated that approximately 30-60% of families who experience either CM or IPV experience both problems (Appel & Holden, 1998; Edleson, 1999). There are several reasons for the variation in these rates. For example, overlap rates differ between shelter and community samples. In addition, many of these studies considered only physical child abuse and physical domestic violence, but did not consistently identify either. Using a conservative estimate of physical child abuse, Appel and Holden (1998) found a median rate of

overlap of 40%. In addition, Edleson (1999) examined extreme cases of child abuse, and found that approximately 40% of cases in which a child fatality occurred also experienced domestic violence.

Estimates of co-occurrence tend to be lower among community samples than more high-risk samples, such as those derived from domestic violence shelters (Appel & Holden, 1998; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). For example, in their review of 31 studies of co-occurring child abuse and domestic violence, Appel and Holden (1998) identified 4 studies using community samples, and found an overlap rate of 5.6% to 11%. In a recent study of a population-based sample in North and South Carolina, over half of families who reported IPV also reported at least one form of child maltreatment, resulting in 8.5% of the total sample reporting both IPV and at least one form of child maltreatment. The relationship between IPV and harsh psychological punishment of children was the strongest (Zolotor, Theodore, Coyne-Beasley, & Runyan, 2007).

Other studies and reviews have supported the notion that experiencing multiple types of violence occurs with some regularity for many children in the United States, and that “children who have been exposed to only a single episode of one type of violence are a minority of victimized children” (Saunders, 2003, p. 361). In results from the Lehigh Longitudinal Study, a prospective longitudinal study of child maltreatment and other stressors, Herrenkohl and Herrenkohl (2007) reported significant correlations between domestic violence and physical child abuse ($r=0.16$), sexual abuse ($r=0.17$), and neglect (0.20). Results from the Adverse Childhood Experiences (ACE) Study, a retrospective examination of the long-term impact of child maltreatment, domestic violence, and other

household stressors in childhood on the health of adults in a community sample, found an even higher overlap. Among adults who had reported that their mother had been treated violently during their childhood, 31% experienced childhood physical abuse, 34% experienced childhood psychological abuse, and 41% experienced childhood sexual abuse (Felitti et al., 1998).

Most studies have examined the overlap of physical child abuse and physical battery. Fewer studies have specifically considered the relationship between other component forms of violence, such as neglect or child sexual abuse, and IPV. In an examination of confirmed child maltreatment reports, Hartley (2002) found that families experienced an overlap of neglect and IPV in 46% of cases reported for neglect. Using data from the ACE Study, Dong, Anda, Dube, Giles, and Felitti (2003) assessed the relationship between childhood sexual abuse (CSA) and the other nine categories of adverse childhood experiences. These categories included physical IPV, other forms of child maltreatment (physical abuse, neglect, emotional abuse), and other forms of household dysfunction (e.g., substance abuse, mental illness, criminal household member). The authors found a strong relationship between CSA and all of the other ACE measures, including a co-occurrence of CSA and physical IPV. Women who were sexually abused as a child were 2.6 times more likely to have lived in a household with a battered mother, and men who were sexually abused as a child were 2.3 times as likely to have lived in a household with a battered mother (Dong et al., 2003).

Focus on Families in the Child Welfare System

Research suggests that families involved in the child welfare system may be at especially heightened risk for experiencing multiple forms of violence and other related

stressors. Data from the National Survey of Child and Adolescent Well Being, a national probability study of children investigated for child maltreatment, indicated that approximately 45% of female caregivers had experienced physical IPV at least once in their lifetime, and 30% had experienced physical IPV at least once in the past year (Hazen, Connelly, Kelleher, Landsverk, & Barth, 2004; Kohl, Barth, Hazen, & Landsverk, 2005). Another study that analyzed police report data found that 55% of families in their sample had both child maltreatment and domestic violence assault police reports (Beeman, Hagemester, & Edleson, 2001). In a study of child welfare cases specifically examining the overlap of child neglect and domestic violence, 29% of cases included both child neglect and domestic violence (Antle, Barbee, Sullivan, Yankeelov, Johnson, & Cunningham, 2007). Because families receiving child welfare services are a particularly vulnerable population, issues as they pertain to these families will be highlighted throughout the rest of this review.

Patterns of Co-Occurrence

Limited research has examined specific patterns of co-occurrence of intimate partner violence and child abuse. Appel and Holden (1998) proposed several different descriptive patterns of co-occurrence, which modeled patterns of abuse in the family. Of the proposed models, the *marital violence* model, which suggests that the parents abuse each other and one or both abuses the child, has received the most attention in the literature. Jouriles and colleagues (2008) analyzed findings from two existing studies that compared the prevalence of the types of co-occurrence, and found that the marital violence model characterized over half of families experiencing both domestic violence and child abuse. In their study of families referred to CPS and also experiencing IPV,

English, Marshall, and Stewart (2003) found that females in the family both perpetrated and were victimized by domestic violence. In this sample, biological mothers were also the primary perpetrators of child maltreatment. This study did not directly test models of co-occurrence, but lends some support to the marital violence model.

While findings are clearly limited by the small number of studies, the marital violence model may suggest that co-occurring child maltreatment and intimate partner violence occurs in family systems that are experiencing overall patterns of dysfunction. This type of systemic family dysfunction indicates that services need to address these multiple issues simultaneously.

Methodological Obstacles

Researchers have identified several methodological obstacles to studying the co-occurrence of child maltreatment and intimate partner violence. In the first major review of the overlap, Appel and Holden (1998) identified five major issues in studying the overlap: the sample source, the criteria used to determine physical abuse, the source of the report, the referent period, and the individuals in the target relationship. Edleson (1999, 2001) described similar obstacles to studying the co-occurrence of child maltreatment and intimate partner violence. These barriers include the need to improve definitions of abuse, sample sizes, data sources, and measures used to study the overlap. Half a decade later, Hazen, Connelly, Kelleher, Landsverk, and Barth (2004) also described similar problems, including the broad range of prevalence estimates of violence, the lack of standardized measurement, lack of nationally representative studies, and small sample sizes of studies.

Definition of Maltreatment

In determining the source of variation in co-occurrence rates, Appel and Holden (1998) found that the criterion used to define child maltreatment in each study was the most important determinant. For example, using a more conservative measure of the Conflict Tactics Scale (CTS) or maternal report of child abuse tended to provide lower rates of co-occurrence, while the use of the CTS-Violence Index, which measures abuse in the past year, resulted in higher rates. Definitions and operationalization of maltreatment vary across studies, resulting in inconsistent findings across studies. In addition to definition challenges, most studies consider only physical child abuse and physical intimate partner violence (Herrenkohl et al., 2008, Hartley, 2002; Tajima, 2004), and do not specifically examine other forms of child maltreatment, such as neglect, or other forms of coercive control or emotional abuse in intimate relationships. Studies that do consider these types of exposures also suffer from problems of inconsistent definitions.

Sample Selection

Sample selection has also been identified as a challenge to studying co-occurrence. Many samples are identified through domestic violence shelters, and these families tend to experience higher levels of more severe violence, and may over-represent cases of co-occurring violence (Appel & Holden, 1998; Edleson, 1999; Hazen et al., 2004). The severity and length of violence are likely important factors in the examination of co-occurrence, but due to the way samples are derived, these issues are not often studied (Cunningham, 2003). In addition, families involved in the child protection system are often used to examine the effect of IPV in the context of

maltreatment. However, CPS reports alone have been found to seriously underestimate the presence of IPV in these families (English, Marshall, & Stewart, 2003). In addition to community versus high-risk samples, family characteristics have been limited primarily to heterosexual, adult couples. Little information has been gathered on the prevalence and patterns of co-occurrence in other types of families, such as adolescent couples, single parents, or homosexual couples (Tajima, 2004).

Referent Period

Appel and Holden (1998) also identified the referent period as a challenge. Studies have measured violence both over the lifetime and currently (i.e., over the past twelve months), and lifetime rates of IPV tend to be higher than the current incidence. This creates difficulty in directly comparing studies. Depending on the source, the period of “risk exposure” for intimate partner violence can differ even within the sample, which is sometimes dependent on the age of the participants. Although the effects can be controlled statistically, this is a particular problem with secondary sources and longitudinal studies (Renner & Slack, 2006).

Sources of Information

The use of a single source of information is another methodological hurdle. Frequently used single sources include case records review, self-report, and retrospective reports (Edleson, 1999). Records review, especially child protection records and worker assessments, can underestimate rates, and it is often not possible for researchers to determine how much information workers had about the presence of intimate partner violence in the case (Beeman, Hagemester, & Edleson, 2001). In fact, official reports of

maltreatment have been repeatedly described as underreports of actual child maltreatment (Renner & Slack, 2006; English, 1998).

In addition to research-specific challenges, methodological issues are evident in systems as well. For example, data sources are not often shared across the systems that address components of family violence. This is especially important not only for research, but for the responses of systems that intervene with families experiencing multiple forms of violence (Beeman, Hagemester, & Edleson, 2001). Similar problems are also seen in research fields that study the range of consequences of family violence and other related problems, contributing to the fragmentation of fields that study family and child violence (Saunders, 2003). To resolve these issues, there is a clear need to collaborate and cooperate across professional fields (Saunders, 2003).

Other Stressors in Families Experiencing Violence

Family violence often occurs within a broader context of family dysfunction. For example, the ACE Study examined the co-occurrence of a variety of childhood exposures, including physical, psychological, and sexual abuse; violence against the child's mother; household substance abuse; household mental illness; and imprisonment of a household member. Of adults who had been physically abused as children, 86% reported experiencing at least one other exposure, and 64% reported experiencing at least two. Similarly, 86% of adults who reported that their mother had been treated violently experienced at least one other adverse event, and 62% reported experiencing at least two (Felitti et al., 1998).

Herrenkohl and Herrenkohl (2007) found significant associations between multiple forms of child maltreatment (including physical and sexual abuse, neglect, and

exposure to domestic violence) and several different stressors, including family conflict (including marital problems, alcohol use/abuse, recent family breakup, and marital conflict), personal problems of the parents (including unfulfilled ambitions, lack of privacy, and responsibilities of parenthood), and external constraints on the family (including crime in the neighborhood, physical handicap/illness, and lack of home conveniences). Each of these composite factors was significantly correlated with both child maltreatment and IPV (Herrenkohl & Herrenkohl, 2007; Herrenkohl et al., 2008).

Research regarding cumulative risks for at-risk children strongly suggests that the accumulation of risk factors in a child's life impacts developmental outcomes; and the more risk factors, the greater risk for negative outcomes (Appleyard, Egeland, van Dulmen, & Sroufe, 2005; Sameroff, 2000). Given the results of these and other similar studies, an understanding of the stressors associated with family violence is critical. A review of the literature on specific stressors and risk factors is provided below for the stressors most frequently described in the literature.

Substance Abuse

Results of the Fourth National Incidence Study of Child Abuse and Neglect ([NIS-4], Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, & Li, 2010) indicated that substance abuse was a factor in approximately 12% of cases defined under the "Harm Standard" of maltreatment (i.e., an act or omission that resulted in demonstrable harm) for the child's most closely related perpetrator, and that it was a factor in the cases of approximately one in seven children who were seriously or fatally harmed. Broader estimates of the percentage of parents with serious substance abuse problems involved in the child welfare system have ranged as high as 50-80% (Marsh, Smith, & Bruni, 2011)

and have found caregiver substance abuse to be the single most potent kind of caregiver vulnerability factor in predicting child maltreatment substantiation (Wekerle, Wall, Leung, & Trocme, 2007). Felitti and colleagues (1998) demonstrated that substance abuse was present in the household for 34% of children who had been sexually abused, 22% of children who had been psychologically abused, and 19% of children who had been physically abused.

Parents with substance abuse problems involved with child welfare services tend to have multiple other stressors. Marsh and colleagues (2006) found that 30% of parents with a substance abuse problem had at least one other problem (such as IPV, mental health, or housing), 35% had two problems, and 27% had three. In addition, substance abuse in the household is perhaps the most frequently reported stressor associated with families experiencing multiple forms of violence. Multiple studies have found that families experiencing child maltreatment and IPV are significantly more likely to have at least one adult in the household (either a primary or secondary caregiver) with a substance abuse problem (Beeman, Hagemester, & Edleson, 2001; Hartley, 2002; Hazen, Connelly, Kelleher, Landsverk, & Barth, 2005; Kohl, Edleson, English, & Barth, 2005). In child protection cases with active IPV, 31% of primary caregivers had a substance abuse problem, compared with 8% of cases without violence, and an even more drastic relationship was seen for substance abuse in secondary caregivers: substance abuse was present in 51% of cases with active IPV, and 8% in cases without IPV (Hazen et al., 2005). In a community sample, Tajima (2000) found increased substance abuse among the male in the family for families experiencing co-occurring violence, compared to those experiencing either child maltreatment or domestic violence alone.

Mental Health Issues

Families who maltreat their children also may experience mental health issues. In the ACE Study, caregiver mental illness was found to be present in 37% of children who had been sexually abused, 30% of children who had been psychologically abused, and 31% of children who had been physically abused (Felitti et al., 1998). Data from the NIS-4 indicated that mental illness was a factor in approximately 7% of all child maltreatment cases when measured by the “Harm Standard” of maltreatment, and that 17% of children who were emotionally abused had a parent with a mental health problem compared to 5% of both physically and sexually abused children. Further, it was a factor for nearly one in ten children who were seriously or fatally harmed (Sedlak et al., 2010). Results of another study indicated that approximately 14% of mothers with a serious mental illness (defined as schizophrenia, other psychotic disorders, and major affective disorders) received child welfare services, compared with 11% of those with other diagnoses and 4% without a mental health diagnosis (Park, Solomon, & Mandell, 2006).

Depression has been the most frequently examined mental health issue in families experiencing both CM and IPV. Of families experiencing child maltreatment, caregiver major depression was identified in 41% of families with severe IPV, 30% with less severe IPV, and 19% of families experiencing maltreatment only (Hazen et al., 2005). A study that examined current and past intimate partner violence in families with child maltreatment found that depression in the primary caregiver occurred in 25% of cases with active intimate partner violence, 20% of cases with a history of IPV, and 12% of cases without (Kohl, Edleson, English, & Barth, 2005). When looking specifically at the overlap of child neglect and IPV, Hartley (2002) found that 25% of mothers in the co-

occurrence group had a history of mental health problems, compared with 6% in the neglect-only group. Other studies have confirmed the increased presence of mental health problems and depression in adults experiencing co-occurrence (Shipman, Rossman, & West, 1999; Tajima, 2004).

Socioeconomic Status

Socioeconomic status (SES) has been examined in many studies, and is one of the most well documented risk factors related to all forms of family violence. Children in families with low SES have been shown to be at more than five times greater risk of maltreatment than children in families of higher SES (Sedlak et al., 2010). In addition, Herrenkohl and Herrenkohl (2007) found that an aggregate measure of child maltreatment was negatively correlated with socioeconomic status. The impact of poor socioeconomic status has been consistently identified across sample types. For example, families drawn from domestic violence shelters that experienced both types of violence were more likely to report a lower socioeconomic status than non-violent families (Shipman, Rossman, & West, 1999). In a sample of families drawn from the child welfare system, families experiencing multiple types of violence were more likely to report living in poverty or difficulty paying for their basic necessities than families without domestic violence (Hazen, Connelly, Kelleher, Landsverk, & Barth, 2005; Kohl, Edleson, English, & Barth, 2005). Using a community sample from the National Family Violence Survey, Tajima (2004) found that families experiencing both child maltreatment and IPV had lower levels of education than families experiencing either type of abuse alone.

Prior Reports of Maltreatment

Several studies have indicated that prior reports of child maltreatment are more prevalent in families with co-occurring IPV and maltreatment. This may be particularly salient in samples derived from the child welfare system. For example, in families referred to the child protective system in the National Survey of Child and Adolescent Well-Being (NSCAW), 67% percent of families with a history of IPV had at least one prior report of child maltreatment, compared with 57% of families who were currently experiencing IPV and 46% of families who never experienced it (Kohl, Edleson, English, & Barth, 2005). Also using data from the NSCAW, Hazen and colleagues (2005) found that approximately 57% of families experiencing IPV had any prior report of maltreatment and 26% had a substantiated maltreatment report, compared to 45% and 18% of families without domestic violence, respectively. Studies have also indicated that in families with prior exposure to the child welfare system, the case worker is significantly less likely to identify IPV in the family (Kohl, Barth, Hazen, & Landsverk, 2005). This suggests an under-identification and under-reporting of the co-occurrence rate in families with child welfare history, despite the already high rates.

Age of the Child

In 2009, children in the age group of birth to one year had the highest rate of overall child maltreatment victimization at 20.6 per 1,000 in the population of the same age. Further, the youngest children were the most vulnerable to maltreatment: 33% of victims were under 4 years of age, and 23% were between 4 and 7 years old (US DHHS, 2010). Families experiencing IPV were also more likely to have a young child in the home, especially a child under 5 years of age (Margolin & Gordis, 2000). Beeman and

colleagues (2001) found that families experiencing both CM and IPV were more likely to have at least one child under 5 years old compared to maltreatment only families (50.6% and 40.5%, respectively) and less likely to have a child 12-17 years old (28.3% and 39.2%, respectively).

Perpetrator Characteristics

Studies related to demographic characteristics of the perpetrators have found conflicting results, especially when considering families experiencing multiple forms of violence. There are inconclusive results regarding the age of the parents. For example, Beeman and colleagues (2001) did not find any significant differences regarding age of the perpetrator when comparing families experiencing child maltreatment to families experiencing both child maltreatment and intimate partner violence. In contrast, Hazen and colleagues (2005) found that among a sample of caregivers of children reported for child maltreatment, young age was a risk factor for IPV.

Few studies have examined specific age groups, such as adolescent parents. In one longitudinal study of adolescent parents, Moore and Florsheim (2008) found that physical IPV prior to childbirth predicted physically punitive parenting for adolescent fathers. Conversely, couples who exhibited warm engagement with each other prior to the birth of their child were less likely to use physically punitive parenting. The authors concluded that the physically aggressive behavior may be a result of immaturity of the couple rather than a tendency to be violent.

Inconclusive results also exist for other perpetrator characteristics, such as race and ethnicity. Some studies have found that when comparing families experiencing IPV alone to those with IPV plus child maltreatment, no significant differences emerged with

regard to race and ethnicity variables (Beeman, Hagemester, & Edleson, 2001; Jouriles, McDonald, Smith Slep, Heyman, & Garrido, 2008). In a study of IPV victims referred to child protection services, race was not a factor when other demographic variables were considered. However, non-White victims of domestic violence tended to be younger, less educated, and poorer, and these characteristics were significantly associated with referrals to child protective services (Dosanjh, Lewis, Matthews, & Bhandari, 2008).

Results regarding gender of perpetrator are also divergent. Some studies have not found any gender differences in the overall comparison of families experiencing co-occurrence to those only experiencing maltreatment (Beeman, Hagemester, & Edleson, 2001). However, there is some evidence that the type of violence perpetrated differs by gender. For example, male perpetrators often have more allegations of physical and sexual abuse, while females are more likely to be accused of neglect (Beeman, Hagemester, & Edleson, 2001). Hartley (2002) found that mothers were more likely to be named as the perpetrator in co-occurring neglect and IPV cases (75%), compared to both those experiencing neglect only (54%), and those experiencing physical child abuse only. This may relate to issues of failure to protect, and the fact that the mother is often the primary caregiver; rates may be inflated because they are more likely to be investigated for neglect.

History of Abuse in Parent's Family

A history of childhood physical or sexual abuse has been associated with an increased risk of the co-occurrence in adulthood. For example, childhood physical or sexual abuse has been associated with a threefold increase in risk for co-occurring IPV and child maltreatment in adulthood (Renner & Slack, 2006). Shipman, Rossman, and

West (1999) also found that families experiencing co-occurrence reported a higher level of physical punishment in the father's childhood home. However, Tajima (2004) did not find any differences regarding violence in the parents' home of origin.

Other Related Factors

Other measures of family dysfunction have also been correlated with the co-occurrence of maltreatment and IPV. For example, criminal activity (Kohl, Edleson, English, & Barth, 2005; Jouriles et al., 2008; Hartley, 2002; Herrenkohl et al., 2008) and having a non-biological male in the household (Beeman, Hagemester, & Edleson, 2001; Hartley, 2002) have both been associated with dual-violence families.

Consequences of Childhood Exposure to Violence

Studying the consequences of exposure to both child maltreatment and intimate partner violence is both critical and difficult. For many years, the consequences of different forms of violence (e.g., child abuse, intimate partner violence, neglect) were examined separately. However, this approach failed to address the reality that outcomes attributed to one form of violence may be due to another form not studied, to interaction effects, and to cumulative exposures to multiple forms of violence and other related adversities (Sameroff, 2000; Saunders, 2003). Thus, to the extent possible, it is important to examine the impact of cumulative risk on children in order to understand how multiple forms of abuse overlap in childhood, and how these maltreatment experiences interact with other family and environmental stressors to impact health, development, and overall functioning.

Outcomes in Childhood

The effect of cumulative stressors can have serious implications for the health and development of children immediately and over their lifespan. Behavioral consequences have been the most extensively examined in studies considering multiple risks to children. Multiple risks, including child maltreatment, exposure to intimate partner violence, and stress, in early childhood have been shown to have a linear effect on deleterious behavioral outcomes in both childhood and adolescence (Appleyard, Egeland, and vanDulmen, & Sroufe, 2005). Children exposed to multiple forms of violence have also been found to more often experience both internalizing and externalizing behavior problems than children who have not (Herrenkohl & Herrenkohl, 2007; Margolin & Gordis, 2000; Osofsky, 2003; Shipman, Rossman, & West, 1999).

The short-term effects of exposure to multiple forms of violence for young children include feelings of isolation, guilt, shame and fear, along with symptoms of post-traumatic stress disorder and depression (Herrenkohl et al., 2008; Margolin & Gordis, 2000; Osofsky, 2003; Shipman, Rossman, & West, 1999). Children in co-occurring families may also have more difficulty regulating emotional experiences, poorer school performance, and increased difficulty with peer relationships than non-exposed children (Antle et al., 2007; Margolin & Gordis, 2000; Shipman, Rossman, & West, 1999).

In a sub-sample of the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) data, English, Marshall, and Stewart (2003) examined data on 261 children ages 4 through 6 in families referred to Child Protective Services (CPS). Children in families with both IPV and maltreatment exhibited decreased functioning, including both behavior and health problems. They found that IPV had an indirect effect

on child functioning, and was mediated through family functioning, caregiver health and well-being, and the quality of the caregiver interaction with the child. Examining a similar question longitudinally in adults, Edwards and colleagues (2003) also supported the finding that the family environment, including family functioning, may serve as a mediator to mental health outcomes in adults.

Adolescents also experience consequences as a result of co-occurring violence. Consequences in adolescents who have experienced family violence as children include increased rates of teen pregnancy, school dropouts, and depression. Adolescents have also been found to engage more often in other risky behaviors, such as perpetration of violent acts and substance abuse (Herrenkohl et al., 2008; Osofsky, 2003).

Outcomes in Adulthood

Experiencing multiple risks in childhood can also impact health and well-being as an adult. For example, results of the ACE Study indicated that there was a significant dose-response relationship between the number of adverse exposures in childhood and a variety of serious health conditions in adulthood, including heart disease, cancer, chronic bronchitis/emphysema, and history of hepatitis or jaundice. There was also a significant dose-response relationship found for the number of adverse exposures in childhood and health behavior risk factors in adulthood, including smoking, obesity, depression, and suicide attempts (Felitti et al., 1998).

Mental health problems in adulthood have also been identified as consequences of exposure to childhood violence. For example, using data from the Adverse Childhood Experiences (ACE) Study, Edwards and colleagues (2003) demonstrated that multiple forms of maltreatment in childhood were correlated with increased mental health

problems, specifically depression and anxiety, in adulthood. In their study, 18.9% of women and 9.5% of men who reported experiencing intimate partner violence and either physical or sexual abuse in childhood had a mental health problems. These effects were compounded for adults who reported experiencing all three forms of maltreatment (physical abuse, sexual abuse, and intimate partner violence) in childhood.

Childhood exposure to multiple forms of violence has supported the theory of the intergenerational transmission of violence. Women who were both physically abused and witnessed IPV as children have been found to be more likely to abuse their own children and be victimized by or perpetrate IPV as adults, compared to women who experienced physical abuse or exposure to IPVV alone as children (Heyman & Slep, 2002). In an analysis of the 1985 Family Violence Survey, Cunningham (2003) found slightly different results: the odds of perpetrating child abuse as a parent were significantly increased for individuals who had been hit as a teenager, who were exposed to IPV as a teenager, or both, compared to those who did not experience violence as a child. Adults who experienced maltreatment in childhood also have been found to have increased rates of unemployment, poverty, and Medicaid usage compared to adults who were not victimized in childhood. Because low socioeconomic status has been identified as a risk factor for the perpetration of child maltreatment, this may indicate a potential mechanism for the intergenerational transmission of violence (Zielinski, 2009).

Coohy (2004) compared women who both physically abused their children and were victims of intimate partner violence to three other categories of women: those who experienced IPV, those who physically abused their children, and those who experienced neither. Consistent with the results above, the study found that women in the co-

occurrence group were more likely than women who did not abuse their children to have been physically abused by and have had poorer quality relationships with their own mothers in childhood, and to experience more stressors in adulthood. Having been physically abused by her own mother in childhood was the most significant predictor of battered women's abusing their own child as an adult (Coohey, 2004).

Experiencing violence in childhood clearly has implications for health and well-being throughout the lifespan. "While it is plausible that abuse, neglect, and DV exposure are elements of a broader dimension of childhood adversity, they also reflect experiences of the family that are not one and the same" (Herrenkohl & Herrenkohl, 2007, p. 559). Thus, while multiple forms of violence and their other associated stressors, particularly substance abuse and mental illness, reflect childhood adversity, it is necessary to consider the needs of individuals and families when considering outcomes and designing interventions and systems.

Resilience and Protective Mechanisms

Child maltreatment, and its associated risk factors, has clearly been identified as one of the most potent factors that negatively affect children's developmental trajectories. Positive adaptation of maltreated children tend to be unstable over time, and "this degree of dysfunction is not surprising given that maltreatment connotes serious disturbances in the most proximal level of the child's ecology...parental care does not meet children's basic needs...and the family system as a whole is characterized by chaos and instability" (Luthar, 2006, p. 754-755). Despite the myriad of negative consequences for children who grow up in violent families, exposure to violence in childhood does not always result in negative outcomes. It is only in the past few decades that researchers (e.g., Garmezy,

Masten, & Tellegen, 1984; Rutter, 1987; Werner, 1993) have begun to address resilience, a “dynamic process encompassing positive adaptation within a context of significant adversity” (Luthar, Cicchetti, & Becker, 2000, p. 543). Resilience is not a static, fixed attribute of an individual, but rather one that may fluctuate over time and is responsive to changing circumstances (Rutter, 1987; Luthar, 2006). Studies of overall competence have indicated that 10-25% of maltreated children achieve resilience (Walsh, Dawson, & Mattingly, 2010).

Protective factors innate to the child have been the most extensively studied. These include high intelligence and academic competence (Margolin & Gordis, 2000; Masten, Burt, Roisman, Obradovic, Long, & Tellegen, 2004; Masten, Hubbard, Gest, Tellegen, Garmezy, & Ramirez, 1999; Werner, 1993); positive self-concept (Werner, 1993); internal locus of control (Werner, 1993; Cicchetti & Rogosh, 1997); and coping strategies (Margolin & Gordis, 2000; Masten et al., 2004; Werner, 1993). Coping strategies may be a particularly important protective factor for children exposed to multiple risks. Felitti et al. (1998) emphasized the importance of understanding the behavioral coping devices that are used to decrease the impact of multiple risk exposures on childhood development. Understanding coping strategies in children exposed to multiple risks and how they influence developmental outcomes may help researchers and practitioners develop ways to reduce the adoption of health risk behaviors as coping strategies in high-risk children, and instead foster more positive coping behaviors.

The most consistently predictive factor of positive outcomes is the availability of a positive relationship with at least one primary caregiver (Luthar, 2006; Margolin & Gordis, 2000; Rutter, 1987; Werner, 1993). This type of social support has been thought

to reflect the role of positive parenting in child development (Masten, Hubbard, Gest, Tellegen, Garmezy, & Ramirez, 1999). A strong relationship with one parent, even when the other is facing a challenge such as mental illness or substance abuse, can be protective. These relationships have been shown to be particularly important in infancy and early childhood due to developing secure attachments. While much of the research on protective relationships has been in relation to mothers, some research has also shown that strong relationships with nurturing fathers or father-figures can be protective (Luthar, 2006). Masten and colleagues (1999) specifically examined parenting quality as a predictor of resilience, and found that it was significantly related to competence in particular domains in both childhood (conduct) and adolescence (conduct, academic achievement, and peer social competence). Further, they found that the relationship between child competence and parenting quality may be transactional.

In the absence of a positive relationship with a parent, trusting relationships with adults outside the family have also been shown to be protective factors, even in young children (Appleyard, Egeland, & Sroufe, 2007; Werner, 1993). The supportive role of extended family may provide beneficial effects directly to children and indirectly, through parents' adjustment (Luthar, 2006). In addition, friendship quality and other measures of peer support have also been associated with positive outcomes in children exposed to adverse circumstances (Margolin & Gordis, 2000).

Theoretical Approaches to Understanding Family Violence

Several researchers noted that little attention has been paid to studying the co-occurrence of child maltreatment and intimate partner violence using a theoretical perspective, and that much of the research in the field has been empirical in nature

(Herrenkohl et al., 2008; Saunders, 2003). In studies that have used a theoretical approach, hypotheses have been derived from several theoretical approaches, including attachment theory, cognitive and social learning theory, and social development perspectives (Herrenkohl et al., 2008).

Attachment theory has been used as a framework to study child maltreatment. In studies of child maltreatment, abused children have been shown to be significantly more likely to develop insecure attachments than non-maltreated children (Baer & Martinez, 2006). Poor attachment has been correlated with a variety of adjustment problems for children, and thus is a critical component of child development to consider. English, Marshall, and Stewart (2003) found that the effects of intimate partner violence on children who had been maltreated were mediated through, among other factors, the quality of the caregiver's interaction with the child. Their findings supported the importance of the primary caregiver in co-occurring families, especially for very young children (English, Marshall, & Stewart, 2003), and have implications for the study of attachment theory in further examining outcomes for children in families with multiple challenges.

Attachment theory has also been recommended as a basis for decision-making in child welfare cases. Mennen and O'Keefe (2005) have suggested that the nature of attachment should be a major factor in the decision of what kind of services to provide to the family, including the decision to remove the child from the home. They have noted that this type of decision-making is particularly important for infants, since attachment relationships form early in life. This is especially salient in the discussion of failure to

protect, as little research has been done on how abuse, child removal, and placement into foster care are related to attachment (Mennen & O'Keefe, 2005).

Ecological theory has also been employed to examine the co-occurrence of child maltreatment and associated stressors, including IPV and substance abuse. In particular, it has been used to explain child abuse in the presence of IPV and has been recommended by the National Research Council as an appropriate framework to examine both the causes and consequences of violence (Little & Kantor, 2002). Tajima (2004) described ecological models as those that conceptualize abuse as “an interaction between the parent and child in the context of both the family setting and the larger social system” (p. 401). Ecological models are also possibly the most frequently used approach to studying outcomes in children exposed to multiple forms of violence. In particular, ecological models have been used to account for both risk and protective factors at the level of the individual child, family, and environmental that may influence the development of outcomes (Herrenkohl & Herrenkohl, 2007; Little & Kantor, 2002).

Despite the use of these theoretical approaches, explanatory models have not yet been fully developed that consider co-occurring violence a family problem. Some researchers have suggested the need to further consider family dynamics approaches, including attachment and family systems theory, to explain the consequences of overlapping forms of violence on outcomes (Edwards, Holden, Felitti, & Anda, 2003). Williams (2003) has also suggested the need to consider family violence a chronic problem or process, not an event, which has implications for which theoretical approaches are appropriate. In particular, Williams noted that co-occurring violence “can influence [child] development, family relationships, and support” (p. 444).

Individual models may need to be combined to more fully understand the dynamics of co-occurrence and its consequences. Because it is clear that the co-occurrence of maltreatment and intimate partner violence is a complex problem with many related factors, the use of multi-level models may be especially important.

Systems and Policy Issues

Failure to Protect

A full examination of the overlap of child maltreatment and intimate partner violence is not possible without considering the legal implications of childhood exposure to IPV. One of these implications is failure to protect, which occurs when IPV is committed in the presence of children, and the guardian fails to remove child from dangerous situation. This can result in children being removed from the care of the victim, and/or the victim being charged with allegations of child maltreatment.

Childhood exposure to IPV may be considered a form of overall maltreatment, neglect, or emotional abuse, depending on the particular CPS and state definition (Hazen, Connelly, Kelleher, Landsverk, & Barth, 2004). For example, in an examination of the maltreatment report of a sample of cases where maltreatment had been substantiated and CPS cases were opened, the neglect charge of “disregard for safety” was significantly more often associated with CM/IPV families (46.4%) than maltreatment-only families (24.1%). In the Midwestern state where this study was conducted, “disregard for safety” was a subtype of neglect often associated with DV (Beeman, Hagemeister, & Edleson, 2001).

There are multiple implications to the disclosure of violence and allegations of failure to protect. It is a particularly contentious issue between child welfare and

domestic violence agencies, due to their conflicting philosophical approaches. Child welfare agencies are concerned primarily with what is in the best interests of the child. There is a body of literature indicating that exposure to intimate partner violence is harmful to children, which may lead to a determination of child removal. However, there is no clear consensus on the threshold of dangerousness (Kantor & Little, 2003), and in cases of co-occurring violence, the determination of which consequences are attributable to which form of violence is extremely difficult to make. In contrast, domestic violence agencies are primarily concerned with what is best for the victim of domestic violence. A variety of researchers and domestic violence practitioners have indicated that an allegation of failure to protect re-victimizes the victim, by subjecting her to additional investigation and possible maltreatment charges (Alaggia, Jenny, Mazzuca, & Redmond; Edleson, 2001; Kantor & Little, 2003; Magen, 1999).

Many victims of IPV fear that their children will be taken away from them, either by the child welfare agency or the abuser, if they admit to violence. Victims may also be concerned about finances, in that a disclosure of violence may result in family separation and financial hardship (Jouriles et al., 2008). In cases where child welfare policies regulate the reporting of domestic violence, victims have been found to be less likely to disclose domestic violence or seek services for their family (Alaggia, Jenney, Mazzuca, & Redmond, 2007).

Victims may be pressured or expected to leave the violent situation. This approach fails to account for the batterer's responsibility in the violence, and does not address the concern that there are not adequate supportive resources for victims and children who leave violent situations (Magen, 1999). From a feminist perspective, these

issues underscore the victim-blaming attitudes that have been prevalent toward women experiencing these challenges, and can impact both the capacity to mother and ability of the victim to retain custody of her children (Williams, 2003).

While some states have moved to make exposure to IPV a category of child maltreatment under the law, researchers have suggested that a blanket assessment of childhood exposure to intimate partner violence as failure to protect is likely not appropriate. There is a need to differentiate between victims who are abusive toward their children or who are trapped in a situation and cannot adequately care for their children, and cases in which the risk to children is not as clear and needs more careful assessment (Magen, 1999). As with all concerns related to the co-occurrence of child maltreatment and domestic violence, issues of failure to protect are complex and difficult to resolve. Legal, domestic violence, and child welfare agencies are tasked with acting in the best interest of the individual, but it is not always clear how that should be implemented.

Identification and Services

The many families that experience child maltreatment, IPV and associated stressors point to the necessity of examining policy and practice issues within the systems that address family violence. Several studies have uncovered issues in the identification of families experiencing co-occurring violence. For example, in a study that used data from the National Survey of Child and Adolescent Well Being (NSCAW), the authors found that while child welfare workers identified domestic violence in 12% of child maltreatment investigations, 31% of the caregivers self-reported violence. Overall, both the child welfare worker and the caregiver reported domestic violence in only 8% of the

cases (Kohl, Barth, Hazen, & Landsverk, 2005). In a study using data from the Children and Domestic Violence Services (CADVS) study, a sister study to the NSCAW, 43.1% of child welfare agencies reported that all of the families referred to the child welfare system were screened for intimate partner violence, and 52.8% of agencies reported that they had a written policy for screening and assessment of IPV (Hazen, Connelly, Edleson, Kelleher, et al., 2007). Antle and colleagues (2007) found similar results: there was unreported domestic violence in 47% of the families, yet information about domestic violence was often documented in the child welfare record.

The provision of services is another systems issue that requires attention for families experiencing multiple challenges. Studies have suggested that while families experiencing co-occurring violence often experience a variety of related challenges, they may not be more likely to be referred to services than families experiencing maltreatment only (Beeman, Hagemeister, & Edleson, 1999; Kantor & Little, 2003). In addition, in families experiencing intimate partner violence, reports of potential child maltreatment do not always lead to recommendations or receipt of services that are different from those services that the family is already receiving (Jouriles et al., 2008). This has been confirmed in several other studies. Beeman and colleagues (2001) found that although CM/IPV cases were assessed by CPS workers to be at higher risk, they were less likely to be referred for services overall (68% compared to 89% of maltreatment-only families). These families were also more likely to be referred to the county attorney for prosecution than maltreatment-only families. Similarly, Antle and colleagues (2007) found that although cases of co-occurring neglect and IPV were assessed by child welfare workers to be at significantly higher risk than cases of neglect alone, they were less likely to be

opened by the child welfare system. This finding suggests that families were not receiving the services that they needed to prevent domestic violence from becoming a larger issue.

The evidence on assessment and service referral in dual-violence families is conflicted. While it appears that child welfare families experiencing domestic violence are often assessed to be at higher risk, this assessment is not often translated to case planning in terms of increasing the number or intensity of services. The presence of simultaneous family stressors results in additional challenges for providing services. Kohl, Edleson, English, & Barth (2005) found that families experiencing intimate partner violence were also burdened with multiple other problems that contributed to the response of the child welfare system, independent of the family's experience with intimate partner violence. This study also found that intimate partner violence is not the only, or most frequently used, criterion used to make decisions in child welfare cases, and that substance abuse may play a greater role.

The difficulties in provision of services is not only limited to CM and IPV. One study found that "at a national level for all families involved with child welfare...most of the caregivers with identified drug, alcohol, and mental health problems were not provided treatment services by those child welfare agencies" (Libby, Orton, Barth, Webb, Burns, Wood, & Spicer, 2006, p. 630). Another study found that while mental health and substance abuse services were offered to the majority of parents, they were not offered to all who needed them, and not all parents who were offered services actually had services provided to them (Staudt & Cherry, 2009). Specifically, there is a lack of coordination between the child welfare system and mental health services, and few states

have formal coordination mechanisms to link these services together (Park, Solomon, & Mandell, 2006). Comprehensive, integrated substance abuse and child welfare services have also been found to be diminishing in availability, despite positive outcomes for parents, leaving parents with unmet service needs (Marsh, Smith, & Bruni, 2006).

The results of these studies suggest the need for the careful consideration of risk and protective factors by personnel that work directly with families. While the focus of many studies has been on the child welfare system, the overlapping issues indicate that there is a clear need for improved and appropriate assessment procedures in the child welfare system and other associated systems, coupled with the provision of services that meet the range of needs of families affected by multiple issues (Hazen et al., 2004).

System Responses: The Greenbook Initiative

Given the multiple challenges that families with co-occurring child maltreatment and domestic violence face, and the problems faced by the systems that serve them, changing system responses has become a focus of policy and practice. In 1999, the National Council of Juvenile and Family Court Judges (NCJFCJ) developed the Greenbook, a set of policy recommendations to address system-level issues related to the co-occurrence of child maltreatment and intimate partner violence. The purpose of the guidelines was to provide a framework for changing policy and practice, through a collaborative approach, for families experiencing the co-occurrence of child maltreatment and intimate partner violence (Greenbook Initiative National Evaluation Team, 2008). The NCJFCJ recognized that communities needed a mechanism for bringing together administrators, staff, and community members to expand community services (Banks, Dutch, & Wang, 2008).

The Greenbook recommendations focused on creating system-wide and inter-agency change among three systems that serve families experiencing multiple forms of family violence: dependency courts, the child welfare system, and domestic violence service agencies. The principles for reform focused on “establishing collaborative relationships; taking leadership to provide services and resources to ensure family safety for those experiencing child maltreatment and domestic violence; developing service plans and referrals that focus on safety, stability, and well-being of all victims of family violence; and holding domestic violence perpetrators accountable” (Greenbook Initiative National Evaluation Team, 2008, p. ii). The cross-system, collaborative Greenbook approach has been recommended by a variety of researchers in the field to address problems found in studies of service systems (e.g., Beeman, Hagemester, & Edleson, 2001; Hazen et al., 2004; Kantor & Little, 2003).

Collaboration Barriers

Developing effective collaboration was a struggle for some of the Greenbook demonstration sites, due to the different philosophies and organizational structures of the partner agencies. The conflicting perspectives of partner agencies manifested primarily in the handling of controversial issues, such as failure to protect due to intimate partner violence, information sharing across systems (especially in regard to confidentiality of IPV victims), and batterer engagement (Banks, Dutch, & Wang, 2008; Banks, Landsverk, & Wang, 2008). Consistent with other literature on collaboration, other issues regarding the process of collaboration that arose were the constant attention required to cultivate relationships among partners, specifically relating to barriers regarding power and trust; the need for a commitment from the leadership of partner agencies; the necessity of needs

assessment and analyses to develop priorities and plan services; and the need for multidisciplinary and front-line approaches for the collaborations to be most effective (Banks, Dutch, & Wang, 2008).

Child welfare agencies also specifically identified barriers to planning and implementing Greenbook activities. For example, intimate partner violence trainings were optional and offered only basic information; high staff turnover was a serious problem in keeping training information current in the workforce; collaboration with DV agencies was hampered by concerns about the confidentiality of adult victims; and workers had a difficult time tracking the cases that included intimate partner violence due to inadequate screening tools and data systems (Banks, Landsverk, & Wang, 2008).

Domestic violence agencies participating in the Greenbook demonstration sites also experienced struggles related to cross-systems collaboration, especially in regard to power differentials. For example, “many DV stakeholders reported feeling that because of limited resources, philosophical differences regarding consensus versus hierarchy, and systemic differences related to be the one system outside the authority of the state, their voice was less powerful than the voices of others, particularly with regard to the courts” (Malik, Ward, & Janczewski, 2008, p. 948). In contrast, results from the evaluation with regard to the courts suggest that while dependency judges often did take charge in collaborative efforts, they were able to manage the task of leadership and being part of a community collaborative at the same time, and held a more positive view of the equality in collaboration than did the domestic violence agencies (Malik, Silverman, Wang, & Janczewski, 2008). However, courts faced challenges in collaborating across court jurisdictions (e.g., dependency, family, civil), which emphasized barriers to case planning

and services faced by family members involved in multiple court cases at the same time (Malik, Silverman, Wang, & Janczewski, 2008).

Domestic violence service agencies also continued to struggle with the issue of child maltreatment within families experiencing intimate partner violence throughout the collaboration. Reports from service personnel indicated that agencies were not entirely responsive to dealing with dually victimized families, and that agencies had difficulty changing internal agency practices with regard to this issue (Malik, Ward, & Janczewski, 2008).

Evaluation Outcomes

Despite several considerable cross-system challenges to implementing the Greenbook recommendations, the overall evaluation showed that the sites made significant collaborative efforts to change policies, services, and outcomes (Greenbook National Evaluation Team, 2008), and evaluations of the demonstration sites indicated many positive outcomes. For example, Banks, Landsverk, and Wang (2008) specifically examined the outcomes for child welfare agencies. Results of the evaluation indicated that within child welfare agencies, there was an increase in intimate partner violence training (58% at baseline and 75% at follow-up), the establishment of written guidelines regarding intimate partner violence, and increased collaboration and resource sharing with domestic violence agencies. Results also indicated that active screening for intimate partner violence increased and peaked at the mid-point of the initiative, suggesting that ongoing issues with implementation were a problem. Similarly, domestic violence agencies also reported a high degree of cross-training and adoption of screening instruments (Malik, Ward, & Janczewski, 2008). Although there was a large variation

across sites, Banks, Landsverk, and Wang (2008) found that overall, there was a significant increase in child welfare service referrals for victims of DV (35% at baseline to 65% at follow-up), which suggests steps were taken to overcome one of the most critical problems identified in previous studies.

The evaluation indicated that one of the most successful changes was to create specialized positions; in particular, to co-locate domestic violence advocates within the child welfare system. These specialized positions helped to increase the sharing of resources with domestic violence service providers, assisted in working with batterers, and changed practice within institutions by bridging the gap between agencies so that they could address some of the most controversial issues, such as confidentiality and failure to protect (Banks, Dutch, & Wang, 2008; Banks, Landsverk, & Wang, 2008).

Positive changes were also made in the dependency court system. As the overlap of intimate partner violence and child maltreatment continued to fuel controversy around failure to protect, some demonstration sites developed separate case plans for perpetrators and victims of intimate partner violence (Malik, Silverman, Wang, & Jancewski, 2008). Some court systems also changed the language of their court petitions to reduce blaming of the non-offending parent (Banks, Landsverk, & Wang, 2008).

Addressing Families with Multiple Challenges: The SafeStart Initiative

In addition to increasing systems collaboration and responses, programmatic efforts have been developed to serve families experiencing multiple challenges. According to Shipman, Rossman, and West (1999), clinical intervention should focus on changing the family's "broader social context to reduce family adversity as well as addressing specific difficulties in the family unit" (p. 100). While this is a difficult

undertaking, some programs have developed models of “multiple system intervention...[which] combine actual living assistance with educational opportunities designed to reduce socioeconomic disadvantage, training to increase healthy partner and parent-child conflict management and anger expression, and therapeutic assistance for parents and children” (p. 101).

The SafeStart Initiative, funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the U.S. Department of Justice, aims to broaden knowledge regarding evidence-based interventions to address children’s exposure to family violence (Safe Start Initiative, 2008). SafeStart employs the use of wraparound, family centered services for young children exposed to family violence. Although there have been limited systematic evaluations of such programs, some evaluations are beginning to emerge. For example, The Child and Family Interagency Resource, Support, and Training Program (Child FIRST) is a wraparound program that offers targeted caregiver-child intervention, individualized service planning, and care coordination to families to address the mental health and developmental needs of children under 5 years old who have been exposed to family violence, and the variety of challenges faced by their families (Crusto, Lowell, Paulicin, Reynolds, Feinn, Friedman, & Kaufman, 2008). Results of the evaluation indicated that families received 84% of the recommended services within 90 days, suggesting that the program was successful in implementing care coordination, despite barriers to services. The evaluation also found that children experienced fewer traumatic events while in the program; decreased frequency of trauma symptoms; and children who received more services for a longer period of time

demonstrated the most improvement. Parents in the program also reported significant decreases in parenting stress (Crusto et al., 2008).

Conclusion

Families who maltreat their children likely need additional supports, especially because child maltreatment is also associated with multiple other challenges, including intimate partner violence, substance abuse, and mental health problems. However, research and program evaluations suggest that they are not getting the support or services that meet their needs. Thus, re-victimization and repeated exposure to violence continue to occur, leading to increased negative health and developmental consequences for children, re-referrals into service systems and, sometimes, removal of children from the home. Family systems theory and attachment theory, among others, suggest the need to intervene with the family as a whole – using a family-centered perspective that deals with the multiple needs of the family, rather than separating problems as if they are not related. Children’s outcomes will likely be better using such a perspective in the development of services, because factors that promote recovery and resilience will thus be enhanced. The need for effective, cross-system, family-oriented responses to this problem cannot be underestimated, yet the ability to create system-wide change in this complex environment has proven challenging. Despite the challenges, “comprehensive strategies are [clearly] needed to identify and intervene with children and families who are at risk for adverse experiences and their related outcomes” (Felitti et al., 1998, p. 255).

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Appendix B: Interview Guide

| Topic | Questions | Question Source | A priori codes* |
|-----------------------------------|---|---|--|
| Introduction | Tell me about your family. What are their names (so we can talk about them)? What is their relationship to you? | Developed for study | Family_structure |
| Family Strengths | What do you like best about your family? What do you like best about your children? | System of Care Practice Review (SOCPR) SOCPR | Strength_family Strength_child |
| Concerns about Family | Do you have any concerns about your family? | SOCPR | Issues_family |
| Family History | Now that we've talked about your current family, I'd like to talk a little bit about you. Tell me about the family that you grew up in. For example, what were your parents and siblings like? Did your parents ever say mean things to you or your siblings? Hit you or hurt you physically? | Developed for study | Familyoforigin Familyoforigin_abuse |
| Presence of violence and conflict | How do you resolve disagreements in your current relationship? Have you ever been in a relationship where someone said mean things to you? Hit you or hurt you physically? Made you do things sexually you didn't want to do? Have you talked about these issues with any of your service providers (e.g., Nurturing Parents, HKI)? <ul style="list-style-type: none"> • [If yes] How have they responded? [If no] Why not? | Developed for study | Familyconflict Relationshipvio Relvio_report |
| Children | Now let's focus on your children. How do you feel that they are they doing? Do you have any concerns about | Developed for study | Child_wellbeing Child_location |

| | | | |
|------------------------------|--|---|--|
| | <p>them?</p> <p>Where are your children living now?</p> <p>Do they understand why you are involved with child welfare services?</p> | | Child_understand |
| Service Pathways and Receipt | <p>We have talked about your family, you, and your children. Now, let's talk about whether your concerns about your family are being met by the system and the services you are receiving. Do you know why you were referred to the Nurturing Parents Program?</p> <p>Tell me about the types of services that are listed in your HKI (or diversion) case plan. What types of services are listed for you? What about for your children?</p> <p>Do you have a copy of your service plan?</p> <p>Have you received all of these services? Have your children? [If no] What challenges have you faced in getting services?</p> | <p>Developed for study</p> <p>Developed for study</p> <p>Developed for study</p> <p>Developed for study</p> | <p>Maltreatment</p> <p>Service_types</p> <p>Copyofplan</p> <p>Service_receipt Service_barriers</p> |
| Empowerment | <p>What has it been like for you to get services?</p> <ul style="list-style-type: none"> In your opinion, did you and your family get to influence the final HKI (or diversion) case plan? Over the past year, have there been any meetings that you were invited to, to talk about the services you would get or to talk about your concerns for your family and your | <p>SOCPR (adapted)</p> <p><i>Probes also adapted from SOCPR</i></p> | <p>Empower_influenceplan</p> <p>Empower_attendmtg</p> <p>Empower_understandsvcs</p> <p>Empower_agreeplan</p> |


| | | | |
|-----------------------------|---|--|--|
| | <p>child? Describe the meetings.</p> <ul style="list-style-type: none"> • Do you understand the services you are receiving or why you have to attend certain programs or services? • Are you and your family in agreement with the plan? Are you enthusiastic about it? <p>Are there times in the meetings when other people make you feel like you are not a good parent?</p> | | Empower_goodparent |
| Appropriateness of Services | <p>Do the goals of your HKI service plan reflect the concerns about your family that we discussed earlier?</p> <p>Does your service plan reflect any of the strengths of your family that we discussed earlier? Are those strengths recognized in other ways?</p> <p>Do you think you and your family are getting the kind of help you need right now? [If yes] Why? [If no] What would you change?</p> | <p>SOCPR (adapted)</p> <p>SOCPR</p> <p>SOCPR</p> | <p>Service_appropriate</p> <p>Caseplan_strengths</p> <p>Needsmet</p> |
| Overall | <p>What would be the one thing that you would change to make the system work better?</p> <p>Is there anything else that you would like to talk about?</p> | Developed for study | Change_system |

**Emergent codes were added to this list during the iterative open coding process.*

Appendix C: File Review Instrument

Checkbox® 4.6

http://hscm2.hsc.usf.edu/checkbox/Forms/FormEditor.aspx



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Welcome: [lestefan](#)

Home → Survey Manager → Survey Editor

Survey Editor - Dissertation File Review

Current Survey Language: English

Responses have already been collected for this survey. Making changes to questions, such as by deleting options and/or removing matrix rows or columns could cause existing answers to be deleted.

Survey Manager Survey Editor Style Properties Permissions Activation Languages Test Survey

New Page Preview Print Export

View: All Pages

Add Item | Branching

Hidden Items

Branching Rules:
No branching rules.

This page does not contain any items.

Page 1

Add Item | Copy | Delete | Conditions

Page Conditions:
No conditions.

| | | |
|--|-------------------------------|---|
| Item 1 | [Message] | Edit Move Copy Insert Export Delete |
| <h2>Demographic Information</h2> <p>Conditions: There are NO conditions. This item will always be displayed.</p> <p>Active (Deactivate)</p> | | |
| Item 2 | [Open-Ended Single-Line Text] | Edit Move Copy Insert Export Delete |
| <p>*Assigned File Number</p> <input type="text"/> <p>Conditions: There are NO conditions. This item will always be displayed.</p> <p>Active (Deactivate)</p> | | |
| Item 3 | [Open-Ended Single-Line Text] | Edit Move Copy Insert Export Delete |
| <p>Date of Data Collection</p> <input type="text"/> | | |

Conditions: There are NO conditions. This item will always be displayed.
[Active](#) ([Deactivate](#))

Item 4 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

Participant #1 Initials

Conditions: There are NO conditions. This item will always be displayed.
[Active](#) ([Deactivate](#))

Item 5 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

Participant #2 Initials

Conditions: There are NO conditions. This item will always be displayed.
[Active](#) ([Deactivate](#))

Item 6 [Radio Buttons] Edit | Move | Copy | Insert | Export | Delete

Method of Referral to NPP:

- HKI
- Diversion/HSCO
- Self-referred
- Other

Conditions: There are NO conditions. This item will always be displayed.
[Active](#) ([Deactivate](#))

Item 7 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

Specify "other" source of referral to NPP:

Conditions: There are NO conditions. This item will always be displayed.
[Active](#) ([Deactivate](#))

Item 8 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

Date of referral to NPP

Conditions: There are NO conditions. This item will always be displayed.
[Active](#) ([Deactivate](#))

Item 9 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

Date of first NPP session

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 10 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

Date of Program Completion

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 11 [Radio Buttons] Edit | Move | Copy | Insert | Export | Delete

Did participants complete program?

Yes
 No

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 12 [Radio Buttons] Edit | Move | Copy | Insert | Export | Delete

Stage of case at referral to program

Diversion
 Post-shelter
 Post-adjudication
 Pre-TPR
 Self-referred (no case)
 Unknown
 Other

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 13 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

If referred at "other" stage of case, specify:

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 14 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

Reason for referral to NPP:

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 15 [Radio Buttons] Edit | Move | Copy | Insert | Export | Delete

Number of children in family in NPP:

1
 2
 3
 4
 5
 6

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 16 [Matrix] Edit | Move | Copy | Insert | Export | Delete

Child Demographics

| | Gender | Age | Race/Ethnicity |
|---------|---------|---------|----------------|
| Child 1 | Select: | Select: | Select: |
| Child 2 | Select: | Select: | Select: |
| Child 3 | Select: | Select: | Select: |
| Child 4 | Select: | Select: | Select: |
| Child 5 | Select: | Select: | Select: |

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 17 [Matrix] Edit | Move | Copy | Insert | Export | Delete

Participant Demographics

| | Gender | Age | Race/Ethnicity | |
|---------------|---------|---------|----------------|---------|
| Participant 1 | Select: | Select: | Select: | Select: |
| Participant 2 | Select: | Select: | Select: | Select: |

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 18 [Radio Buttons] Edit | Move | Copy | Insert | Export | Delete

Relationship of Participant 1 to Children

Mother
 Father
 Stepmother
 Stepfather
 Mother's paramour

- Father's paramour
- Grandmother
- Grandfather
- Other relative
- Family friend
- Foster parent
- Other

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 19 [Radio Buttons] Edit | Move | Copy | Insert | Export | Delete



Relationship of Participant 2 to Children

- Mother
- Father
- Stepmother
- Stepfather
- Mother's paramour
- Father's paramour
- Grandmother
- Grandfather
- Other relative
- Family friend
- Foster parent
- Other

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 20 [Message] Edit | Move | Copy | Insert | Export | Delete



FAMILY ISSUES

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 21 [Matrix] Edit | Move | Copy | Insert | Export



Nature of Child Maltreatment Allegations

| | Allegations | | | | | | | | | |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | physical abuse | sexual abuse | neglect | medical neglect | abandonment | emotional abuse | homeless | substance abuse | incarceration | domestic violence |
| Participant 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Participant 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 22 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

↑ ↓ **Description of Child Maltreatment Allegations**

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 23 [Matrix] Edit | Move | Copy | Insert | Export | Delete

↑ ↓ **Family Issues Documented in the File**

| | developmental disability | MH problem | depression | drugs | alcohol | Issues | | | | | | |
|---------------|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | | | | criminal activity | physical illness | sex offender | crime victim | teen parent | prior TPR | othe |
| Participant 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Participant 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 24 [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete

↑ ↓ **Description of Other Family Issues (e.g., transportation problems, language barriers, etc.)**

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 25 [Message] Edit | Move | Copy | Insert | Export | Delete

↑ ↓ **IPV/Family Conflict Issues**

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 26 [Radio Buttons] Edit | Move | Copy | Insert | Export | Delete

↑ ↓ **Is there evidence of past or present family conflict?**

Yes
 No

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 27 [Matrix]



Participant 1 Family Conflict

| | Describe IPV/Family Conflict Issue | Timing of Issue | Role in Event | How Issue was Identified by whor |
|--|------------------------------------|--|--|----------------------------------|
| | <input type="text"/> | Select: <input type="button" value="v"/> | Select: <input type="button" value="v"/> | <input type="text"/> |
| | <input type="text"/> | Select: <input type="button" value="v"/> | Select: <input type="button" value="v"/> | <input type="text"/> |
| | <input type="text"/> | Select: <input type="button" value="v"/> | Select: <input type="button" value="v"/> | <input type="text"/> |
| | <input type="text"/> | Select: <input type="button" value="v"/> | Select: <input type="button" value="v"/> | <input type="text"/> |

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 28 [Matrix]



Participant 2 Family Conflict

| | Describe IPV/Family Conflict Issue | Timing of Issue | Role in Event | How Issue was Identified by whor |
|--|------------------------------------|--|--|----------------------------------|
| | <input type="text"/> | Select: <input type="button" value="v"/> | Select: <input type="button" value="v"/> | <input type="text"/> |
| | <input type="text"/> | Select: <input type="button" value="v"/> | Select: <input type="button" value="v"/> | <input type="text"/> |
| | <input type="text"/> | Select: <input type="button" value="v"/> | Select: <input type="button" value="v"/> | <input type="text"/> |
| | <input type="text"/> | Select: <input type="button" value="v"/> | Select: <input type="button" value="v"/> | <input type="text"/> |

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 29 [Message]

[Edit](#) | [Move](#) | [Copy](#) | [Insert](#) | [Export](#) | [Delete](#)



CHILD OUTCOMES

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 30 [Matrix]



ASQ Results

ASQ given at week 11 or 15

| | Social Emotional | Gross Motor | Fine Motor |
|--|----------------------|----------------------|----------------------|
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | | | |
|---------|--|--|--|
| Child 2 | | | |
| Child 3 | | | |
| Child 4 | | | |
| Child 5 | | | |

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 31 [Matrix] Edit | Move | Copy | Insert | Export | Delete



Child Welfare

| | Placement at Program Start | Placement Change(s) | Placement at Program End |
|---------|----------------------------|---------------------|--------------------------|
| Child 1 | | | |
| Child 2 | | | |
| Child 3 | | | |
| Child 4 | | | |
| Child 5 | | | |

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 32 [Message] Edit | Move | Copy | Insert | Export | Delete



PARENTING

Conditions: There are NO conditions. This item will always be displayed.

Active (Deactivate)

Item 33 [Matrix] Edit | Move | Copy | Insert | Export | Delete



AAPI Scores

| | Inappropriate Expectations (pre) | Lack Empathy (pre) | Corporal Punishment (pre) |
|---------------|----------------------------------|--------------------|---------------------------|
| Participant 1 | | | |
| Participant 2 | | | |

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 34 [Message] Edit | Move | Copy | Insert | Export | Delete

STRENGTHS AND GOALS FOR FAMILY

Conditions: There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Item 35 [Matrix] Edit | Move | Copy | Insert | Export | Delete

Family Strengths

| | Description of Strength | Where noted (psychosocial, notes, etc) |
|-------------|-------------------------|--|
| Strength 1 | <input type="text"/> | <input type="text"/> |
| Strength 2 | <input type="text"/> | <input type="text"/> |
| Strength 3 | <input type="text"/> | <input type="text"/> |
| Strength 4 | <input type="text"/> | <input type="text"/> |
| Strength 5 | <input type="text"/> | <input type="text"/> |
| Strength 6 | <input type="text"/> | <input type="text"/> |
| Strength 7 | <input type="text"/> | <input type="text"/> |
| Strength 8 | <input type="text"/> | <input type="text"/> |
| Strength 9 | <input type="text"/> | <input type="text"/> |
| Strength 10 | <input type="text"/> | <input type="text"/> |

Conditions: There are NO conditions. This item will always be displayed.


Active [\(Deactivate\)](#)

Item 36 [Matrix] Edit | Move | Copy | Insert | Export | Delete


Goals for Family


| | Describe Goal | Where Goal is Noted | Challenges Identified in Meeting Goal |
|--------|----------------------|----------------------|---------------------------------------|
| Goal 1 | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Goal 2 | <input type="text"/> | <input type="text"/> | <input type="text"/> |


| | | | |
|---------|----------------------|----------------------|----------------------|
| Goal 3 | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Goal 4 | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Goal 5 | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Goal 6 | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Goal 7 | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Goal 8 | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Goal 9 | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Goal 10 | <input type="text"/> | <input type="text"/> | <input type="text"/> |

 **Conditions:** There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)


Item 37  [Open-Ended Single-Line Text] Edit | Move | Copy | Insert | Export | Delete


 **Additional General Comments:**


 **Conditions:** There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)

Completion Events Add Item

Item 1  [Message] Edit | Move | Copy | Insert | Export | Delete

 Thank you for taking the survey.

 **Conditions:** There are NO conditions. This item will always be displayed.

Active [\(Deactivate\)](#)



About the Author

Lianne Fuino Estefan earned a Bachelor's degree from The George Washington University in 2002, and a Master's Degree in Public Health, concentrating in Maternal and Child Health, from the University of South Florida in 2005. She has been a project coordinator and program evaluator for various projects at the Harrell Center for the Study of Family Violence and an undergraduate instructor and adjunct faculty in the College of Public Health, University of South Florida. She is the co-author of multiple program evaluations and technical reports. She is currently the Program Coordinator for the Maternal and Child Health Leadership Training Program in the College of Public Health at the University of South Florida. She has held leadership positions in local and national public health organizations, and is currently the Secretary-Elect of the Maternal and Child Health Section of the American Public Health Association.