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How Does a High Profile Child Death Impact Child Protective Service Workers?

Toya V. Clebourn-Jacobs
University of Pennsylvania, jayjoy128@comcast.net

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This study employed interpretative phenomenological analysis utilizing in-depth interviews with Child Protective Services workers to explore how a high profile child death impacts their services and work milieu. Participants were selected through purposive sampling recruited at Philadelphia's Department of Human Services, a large metropolitan child protective service organization. The narratives of N=10CPSworkers were examined for their lived experiences in their role as protective workers, the circumstances surrounding their crisis, and the nature of their social services world.

Results indicate that the intense media and public response following a high profile child death led to overly negative views ofCPSworkers as a whole, contributed to feelings of distress, weakened rather than improved communication with management, and lowered morale. Participants felt the Child Fatality Review process exacerbated many of these problems rather than ameliorated them. However, results also indicate that the overwhelming distress experienced after a high profile child death may have promptedCPSworkers to become more rigorous in their approach to assessing families, which, in turn, may have improved practice. Implications for social work and child welfare policy and practice are provided. Recommendations regarding agency management of public image, worker training, organizational change, social service practice and worker morale are included.

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First Advisor
Lani Nelson-Zlupko, Ph.D.

Second Advisor
Richard J. Gelles, Ph.D.

Third Advisor
Susan Kinnevy, Ph.D. and Roberta Iversen, Ph.D.

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How Does a High Profile Child Death Impact Child Protective Service Workers?

DISSERTATION

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School of Social Policy and Practice
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Toya Clebourn-Jacobs

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_____
Lani Nelson Zlupko, Ph.D.
Supervisor of Dissertation

_____
Richard J. Gelles, Ph.D.
Dean, School of Social Policy and Practice

Dissertation Committee
Susan Kinnevy, Ph.D.
Roberta Iversen, Ph.D.

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Dedication

To my dearly departed husband, Jamie - Thank you for supporting me in this journey, thank you for praising me, thank you for saying, “You can do this T,” every time I wanted to give up. You were my rock and my shoulder to lean on. I love you now and forever.

To my children, Jamie II and Jordyn - Always remember if you put your mind to it you can achieve anything. You make mommy smile everyday and fill my heart with love. Remember to always “walk in excellence.” I love you both unconditionally.

To my father-Harold, mother-Earlene, and brother-Harold II - Thank you for teaching me respectively: education is key, the power of staying positive, and patience. This is my foundation and greatest affirmations in my will to succeed.

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As CPS workers we must have the courage to tell our story and to tell our truth. As we make mistakes, we must learn from them and from each other.
Learning to be transparent will save a child's life, learning to be accountable will teach others how to save a child's life.

Abstract

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Results indicate that the intense media and public response following a high profile child death led to overly negative views of CPS workers as a whole, contributed to feelings of distress, weakened rather than improved communication with management, and lowered morale. Participants felt the Child Fatality Review process exacerbated many of these problems rather than ameliorated them. However, results also indicate that the overwhelming distress experienced after a high profile child death may have prompted CPS workers to become more rigorous in their approach to assessing families, which, in turn, may have improved practice. Implications for social work and child welfare policy and practice are provided. Recommendations regarding agency management of public image, worker training, organizational change, social service practice and worker morale are included.

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CHAPTER 1: INTRODUCTION

Statement of Problem

Children are among the most vulnerable populations in our society. Therefore the death of a child as a result of abuse or neglect often represents the tragic failure of our society to identify at-risk families and to protect vulnerable children (Brittain & Hunt, 2004). The National Child Abuse and Neglect Data System (NCANDS) reported an estimated 1,560 child fatalities from abuse and neglect in 2010. This translates to a rate of 2.07 children per 100,000 children in the general population. NCANDS defines child fatality as "the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor" (Child Welfare Information Gateway, 2012).

The child protection system was developed to help protect vulnerable children and intervene when there are safety and risk factors. Child protective services are defined as specialized supports and interventions for neglected, abused, or exploited children and their families. The mission of child protective services according to the National Association of Public Child Welfare Administrators (1999), is

> To assess the safety of children, intervene to protect children from harm, strengthen the ability of families to protect their children, or provide an alternative safe family for the child. The workers in child protective services focus on rehabilitating the family and the home through interventions and services that address the specific situations and conditions that lead to child maltreatment (Brittain & Hunt, 2004).

Therefore, when a child dies of maltreatment the response is particularly reactive.

Understandably there are calls for action, and assurances are sought that this will never happen again (Connolly, 2008). The goal of child protective service workers is to appropriately provide for and promote the safety of children who are alleged to have been abused or neglected and to ensure their safety from immediate threats and impending dangers (DHS Central, 2008). However, research indicates that even in the most well designed and well delivered community system of child protection, children will die from abuse or neglect (Brittain & Hunt, 2004).

> Between 2008 and 2011, Pennsylvania officially recorded that 147 children died from injuries substantiated as child abuse. An additional 177 children sustained injuries certified by physicians as a child abuse near-fatality. The age of the Pennsylvania children dying or nearly dying from child abuse is alarming. Nearly 80 percent of the fatalities and 90 percent of the near-fatalities involved a child who was 3 years of age or younger. And nearly 50 percent of the Pennsylvania children who died were in a family active with or previously known to the child welfare system (Cathleen Palm and Frank P. Cervone, 2013). - *Harrisburg Patriot-News*

It is every child protective service worker's goal to avoid making mistakes that contribute to the death of a child (Munro, 1996). Although child protective service workers aim to protect all children, some mistakes are inevitable because of the complexity of the work and the varying levels of workers' knowledge. Many times child protective service (CPS) workers are making decisions based on imperfect knowledge (Munro, 1996). Predicting which children are safe and which will be at risk is uncertain business. The CPS worker's aim is to reach the decision that is best according to his or her current general knowledge and understanding of the particular case (Munro, 1996). Although professional judgment is used to make predictions, children still die in situations that are difficult to see in advance (Connolly, 2008). Cases involving children remaining safe are overshadowed by cases where errors seemed avoidable. When CPS

workers are involved in well-publicized cases, where children endure terrible abuse before being killed, public outrage usually ensues (Munro, 1996). Public outrage arising from some well-publicized cases of severe abuse and child deaths may fuel the perception that CPS workers should be able to protect children; and, that if a child dies from abuse, that CPS workers have done something wrong or are incompetent (Munro, 1996). Should a vulnerable child die violently or as a result of extreme neglect, child protective services workers are, and feel, quickly castigated by the media.

One such high profile case is that of Danieal Kelly. This case involving the Philadelphia, Pennsylvania, Department of Human Services, fuelled media attention and professional criticism, because the disabled child who was supposed to be receiving child welfare services died from malnutrition on August 4, 2006. The case received a great deal of media attention, which gave rise to the impression that child protective services are generally incompetent, rather than such a case is an exception (Pritchard & Sharples, 2008). While it is true that public inquiries and media attention must be reported about child deaths in order to keep the general population informed of the tragedies inflicted upon children, it is also true that little attention is paid to the CPS workers that provide services to these children, and the impact that a high profile child death has on these workers. Research has indicated that the emotional impact of child deaths leads to stress, coping, and burnout. Accordingly, this dissertation seeks to add in-depth literature to the paucity of research given to this topic.

> *Fourteen-year-old Danieal Kelly, bedridden and nearly paralyzed with cerebral palsy, wasted away in her stifling Mantua apartment, gaping bedsores exposing her bones. When she died, she weighed just 46 pounds. The story of Danieal Kelly is the latest revelation of a child death that might have been prevented by DHS, the agency responsible for protecting the city's vulnerable children. A DHS caseworker visited the home at least three times in nine months without spotting*

> *the neglect, according to a city review of the death (Sullivan, Dilanian, McCoy, & Phillips, 2006).-Philadelphia Inquirer*

This dissertation will present various newspaper quotes from high profile child death cases. For the purposes of this study "high profile" cases will be defined as those that were well publicized in the media and received prolonged headline attention in local media newspapers or news stations. These quotes, which will be included throughout this research, highlight the avoidable mistakes made by CPS workers as well as negative media coverage given to CPS organizations after the death of a child. This paper will explore how media coverage helps form the generalized public opinion of CPS workers, which in turn impacts the morale and experiences of CPS workers. In addition, this paper explores how agency response to a high profile death further influences, positively and negatively, the lived experiences of CPS workers. Implications for practice are provided and discussed.

CHAPTER 2:

CHILD PROTECTIVE SERVICES THROUGOUT HISTORY

History of Child Welfare

The concepts of children's rights and social justice for children are not new. Historically, these concepts are considered older than civilization (Rycus & Hughes, 1998). The historical expressions of children's rights have been as varied and diverse as the many cultures that engendered social justice for children. However, the existence of rights for children has not prevented the emergence of behaviors that allowed or fostered exploitation or harm to children. Examining how past cultures have valued, related to, and cared for their children can provide insight into the evolution of current child protective services (Rycus & Hughes, 1998). This chapter provides a brief overview of how the protection of children has been attempted and codified throughout history, concluding with current day laws and practices.

History indicates that in the earliest recorded civilizations of Northern Africa there were strong cultural precepts enjoining socially just and altruistic behavior toward children. Inferences that children should not be exploited or harmed are included in the *Book of the Dead,* an Egyptian liturgical test that described behaviors potentially helpful on Judgment Day (Knoles & Snyder, 1968).

The Hammurabi Code, written in 1800 B.C., is one of the earliest records of a society's cultural dispositions and normative standards regarding children. However, the general principles that can be extrapolated from the specific provisions of the Code are often in conflict. Some parts of the Code allowed parents to use their children as collateral for loans and their children's indentured service as payment (Knoles & Snyder,

1968). Children could not be disinherited without due cause and could also be maimed by their parents for disrespectful behaviors. However, children owed their parents respect and reverence and, in return, parents were expected to care for and support their children (Rycus & Hughes, 1998).

Similar to the Hammurabi Code, the book of Exodus, in the Bible, provides insight to a Code of Conduct that has penalties for social injustice towards children (Fraser, 1976). The moral and ethical standards of the Old Testament of the Bible have influenced the development of subsequent religious and secular ethical standards throughout the world, including those related to the treatment of children (Rycus & Hughes, 1998). The subsequent evolution of the Judeo-Christian ethic was to be one of the most significant contributions to social justice and children's rights in western civilization (Rycus & Hughes, 1998).

Referred to as the Golden Age of Greece, between about 500 B.C. and 300 B.C., some Greek city-states had codes that were repressive to children. Infanticide was a common practice for unwanted children and was the recommended practice for a surplus of females and for any child with developmental disabilities (Rycus & Hughes, 1998). Abandonment and infanticide were accepted practices in Western Europe around the thirteenth century as well. Many families did not have the resources to support both older children and newborns; therefore the parents believed that in the best interest of the family the newborn would be sacrificed (Rycus & Hughes, 1998).

Over time, the concept of the state, local community, or society having a transcending interest and a responsibility to protect the rights of children expanded in scope to include a child's rights to at least a minimum measure of care and an

environment free from debilitating abuse or exploitation (Rycus & Hughes, 1998). By the end of the nineteenth century, child abuse and neglect had shifted from being a largely private matter to being one of public concern (Brittain & Hunt, 2004). In the United States the courts had begun to set precedents establishing children's rights and making parental rights contingent on their providing proper care for their children (Rycus & Hughes, 1998). The child protection movement in the US was tied to and gained momentum from other social justice reform movements that occurred throughout the country in the mid- to late 1800s (Brittain & Hunt, 2004). However, nowhere did there exist a formal organization for identifying and assessing child abuse and neglect. The evolving social consciousness regarding children's problems and rights culminated in the formation of the first such organization anywhere in the world. In 1874, in New York City, The New York Society for the Prevention of Cruelty to Children (SPCC) was established (Rycus & Hughes, 1998; Costin, 1985).

Also in 1874 concerned citizens became aware of the abusive circumstances of a single child named Mary Ellen Wilson. Mary Ellen was systematically beaten and cruelly mistreated by a couple who had assumed care of her at infancy (Hughes & Rycus, 1998). Mary Ellen was ten years old according to Brittain and Hunt (2004), when a neighbor noticed her plight. She was beaten with a leather thong and allowed to go ill clothed in bad weather. The neighbor reported the case to Etta Angell Wheeler, a "friendly visitor" who worked for St. Luke's Methodist Mission. In the 1800s child welfare was church based rather than government based. Ms. Wheeler tried to get help from police and the New York City Department of Charities but was turned down by the police who said there was no proof of crime and the charity said they did not have

custody of the child. The Mary Ellen case received detailed and continuous coverage in the New York daily papers (Gelles, 1996). Historical myths of this case claim Ms. Wheeler became frustrated by the lack of response from various social service agencies and sought support from the American Society for the Prevention of Cruelty to Animals (Brittain & Hunt, 2004). The SPCC was preceded by the American Society for the Prevention of Cruelty to Animals (ASPCA). The ASPCA took Mary Ellen's case to court and won a protective order (Brittain & Hunt, 2004). However, Gelles (1996) explains what actually happened is that the court chose to review the case because the child needed protection. The case was argued not by the ASPCA but by a colleague of the founder of the ASPCA. Mary Ellen was removed from her foster home and initially placed in an orphanage. Her foster mother was sent to prison for a year. The SPCC was formed in 1874, as a result of the Mary Ellen Wilson case (Gelles, 1996). Also in 1874 New York passed the Protective Services Act and the Cruelty to Children Act, thereby becoming the first state to enact legislation intended to safeguard the rights of children (Brittain & Hunt, 2004).

A part of the history of child protective services is the history of child welfare and the evolution of social values towards children and how those values became social and cultural norms. Within and among cultures, throughout history, there have been conflicting norms and behaviors that both sought social justice for children while also allowing their exploitation and harm (Rycus & Hughes, 1998). Different cultures treated children as commodities and exploited them economically. Some children were used socially, abused, discarded, and even killed. In more recent history societies have begun to recognize the rights of children. Many societies began to see that it was both a

pragmatic necessity and a moral obligation to support, care for, and protect children (Rycus & Hughes, 1998). Like the U.S., many societies have recognized that it is the state's responsibility and authority to guarantee the rights of children and protect them from harm. To achieve this goal, child protective service social workers in the U.S. have been guided by the philosophical principle of always acting "in the best interests of the child" for over a century. History indicates that past cultural norms have led to the evolution of professional norms, which promote the best interest of the child, in a safe, permanent, and nurturing home for all children (Rycus & Hughes, 1998).

Contemporary Child Protective Services

> *The tragedy happened in plain sight of Philadelphia's troubled Department of Human Services- an agency that failed her, city officials acknowledged yesterday (Sullivan, Dilanian, McCoy, & Phillips, 2006).-Philadelphia Inquirer*

Definition of Organizational Roles of Public and Private Agencies

The primary role of the Philadelphia *Department of Human Services (DHS)* is to protect children who are alleged to have been abused or neglected and to ensure their safety from immediate threats and impending dangers. DHS has three primary divisions that administer programs and services for the children and families within Philadelphia. The Children and Youth Division (CYD) is responsible for investigating all reports of child abuse and neglect and provides child and family-centered services to nearly 20,000 children and their families each year. These services are strategically designed to ensure the safety, permanency, and overall well-being of the Department's clients. CYD manages many of DHS' largest child welfare programs that provide services to the children and families that come into contact with DHS. CYD may purchase and utilize

the services of any appropriate *public or private agency* to meet the needs of the child and family. Services may include home-based services, placement services, adoption services, and other appropriate programs (DHS Central, 2008; The Philadelphia Child Welfare Review Panel, 2007). DHS is the umbrella organization for the primary child welfare organization whose CYD is known as Child Protective Services (CPS). CYD workers are commonly known as DHS Social Workers. This study refers to DHS social workers as CPS workers. Private agency workers are also known as CPS workers.

Who is Child Protective Services?

Child Protective Services (CPS) has emerged as the dominant public child and family service in effect "driving" the public agency and often taking over child welfare entirely (Kamerman & Kahn, 1990). Originally *child welfare* was described as a general and wide range of activities that focused on the well being of children. In 1929 volume one of the Social Work Yearbook entered "child welfare" as "services for delinquent children, detention homes, child development research, parent education, visiting teachers, psychiatric clinics for children, compulsory education, vocational guidance, social hygiene, physically handicapped children, mentally defective children, dependent children, and neglected children" (Ellis, 1929). However, in recent years, due to the publicity that has focused attention on the problem of child abuse and neglect, the term has been narrowed to mean almost exclusively child protective services, or services to protect children from maltreatment from their primary caretakers (Kamerman & Kahn, 1990). CPS constitute the core public child and family service, the fulcrum and sometimes, in some places, the totality of the system. There is an increase in demand for

child protection over other child welfare services because child maltreatment represents a significant social problem in the United States (Kamerman & Kahn, 1990). Child maltreatment represents one of the primary reasons that parents and children are referred or reported to child welfare agencies for service (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000). Brittain and Hunt (2004) define maltreatment as "an act or failure to act by a parent, caregiver, or other person as defined under state law that results in physical abuse, neglect, medical neglect, sexual abuse, or emotional abuse. Maltreatment is also an act or failure to act that presents an imminent risk of serious harm to a child" (Brittain & Hunt, 2004). As the CPS mission states, "To address child maltreatment, the agency will assess the safety of children, intervene to protect children from harm, strengthen the ability of families to protect their children, or provide an alternative safe family for the child. Child protective services are provided to children and families by CPS agencies in collaboration with community agencies in order to protect children from abuse or neglect within their families" (Administrators, 1999). Today Child Protective Services are one of the most controversial yet important areas of child welfare practice. No other program area is as frequently assailed by the media, criticized by citizen advocacy groups, and viewed with mixed feelings by child welfare staff (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000).

Typically, child protective services work is difficult and complex. Although not always realized due to the complexities of CPS work, the CPS worker is supposed to be directly involved in safeguarding the rights and welfare of children by embodying the principles, standards, theories, and techniques of social work as a method of interacting with people (Brittain & Hunt, 2004). CPS workers have specific roles and

responsibilities they are expected to perform in the complex work of protecting children and strengthening families. CPS workers are expected to evaluate and analyze a family's problems in response to allegations of maltreatment and make critical decisions regarding child safety, risk of future maltreatment, the needs, and existing resources of the family (Brittain & Hunt, 2004). It has been established that CPS workers fear making errors, especially the failure to take endangered children into care and the subsequent public response to deaths or severe abuse and neglect of these children (Kamerman & Kahn, 1990).

Public Scrutiny

Lindsey (1994) characterized child abuse that ends in death as "the ultimate exclusion:" an innocent purposely denied opportunity at life. The literature suggests that when even one child dies from abuse, the child welfare system comes under immediate scrutiny and questions are asked. "How was this allowed to happen?" the public demands. "How many other children are being clubbed to death in their cribs?" Or, "Are we wasting our money on these bungling child welfare bureaucrats?" Such questions have transformed the perception of child welfare agencies from benevolent, helping organizations into quasi-legal investigative, accusatory, protective service systems (Frost & Stein, 1989; Howells, 1975).

The media play a central role in sorting information and forming public opinion. The media cast an eye on events that few people directly experience and render otherwise remote happenings observable and meaningful. Media coverage of CPS typically includes headlines that are illustrative of tragic or horrifying incidents that tend to grossly

misrepresent the dimensions of the problems (Spector & Kitsuse, 1994). In this regard, media coverage of an issue that produces public outrage and in the case of a brutal death of a child can be angry and critical of a system that is seen as responsible for preventing the senseless death yet is somehow unable and unwilling to act (Lindsey, 1994). If an issue such as child deaths is to be established in modern society as a social problem requiring CPS intervention, the role of the media is crucial (Best, 1990).

Echoing the authors of empirical studies, Taylor (2008) suggests that when CPS workers are involved in cases concerning serious tragedy or failing services, coming to terms with the situation is difficult enough, but the likelihood of being publicly criticized by the public or media can make the experience even more traumatic. *Community Care*, an online newsletter for social workers and social care professionals in the United Kingdom featured Taylor's (2008) article, "Lifting social work morale after public criticism." Taylor (2008) suggests the ensuing effect of public criticism on morale, for CPS workers and the CPS organization as a whole can be immense, perhaps resulting in CPS workers losing all confidence in their own practice and the authority for which they work.

Taylor (2008) stated that when the death of a child hits the headlines, CPS workers everywhere may feel a collective shiver down their spines. Taylor explained that the case could have been met with nothing but shock and horror from all who heard of it but for those on the CPS frontline, the question, "What if this child had been on my caseload?" is likely to have stayed with them for days. What follows is a discussion of the contemporary world of CPS workers after a high profile death. This section will provide an introduction to the role and expectations of CPS, the impact of public scrutiny,

and the levels of stress experienced by CPS workers.

> *The effect of public criticism on social workers cannot be underestimated – some of the professionals involved in the high profile case left the frontline as a consequence (Taylor, 2008).*

The Public's Perception of the Profession of Child Protective Services

Zugazaga, Surette, Mendez, and Otto (2006) conducted an exploratory study of social worker perceptions of the portrayal of the profession in the news and entertainment media. A random sample of 665 MSW social workers who were members of the Florida Chapter of the National Association of Social Workers were surveyed regarding how they felt the profession was depicted in the news and entertainment media. Findings of this study showed that these social workers perceived the profession to be depicted negatively in both news and entertainment media.

The social work profession, which includes Child Protective Services, has long been concerned with how it is portrayed in the media (Franklin & Parton, 1991; Gabor, 1990; McGowan & Walsh, 2000). Reid and Misener (2001) conducted a rigorous, scientific cross-national study of the image of social work in newspapers in the United States and the United Kingdom. Using the LEXIS-NEXIS database of full text articles, a sample of twenty weeks was randomly drawn from sixty major newspapers over a four-and-a-half year period. The authors found 399 articles that made reference to social work. Of these, ratings of the image of social work were more positive in the United States than in the United Kingdom. In both countries stories about child welfare were found to be more negative than any other area of practice.

As part of the social work profession, CPS should be concerned with its portrayal

in the media since a wide array of its functions, which include retention, funding, and recruitment, have been shown to be influenced by the media. Research studies in the United Kingdom (UK) reveal that the constant criticism and misrepresentation of social services demoralizes social workers (Franklin, 1998). In a survey of 3,000 social work professionals in the United Kingdom, 92% thought that staff morale was damaged by the way the media report on social care ("Social Workers Wary," 2005). In addition, media representation of the social work profession have an impact on the conduct and professional practice of social work and influences the public esteem in which social workers are held. By informing and influencing the mood of public opinion, media representation ultimately affects social policy concerning social services, social workers, and their clients (Franklin, 1998). In general, media coverage often influences the prioritizing of resources within social service agencies most often in favor of child protection services to the comparative neglect of other social concerns (Franklin, 1998). Avoiding becoming the next case highlighted on the front page of the newspaper can be a powerful influence on the provision of social services (Zugazaga, Surette, Mendez, & Otto, 2006).

Grand Jury Report

On July 31, 2008, a Grand Jury released the findings of its investigation into the death of 14-year-old Danieal Kelly, a disabled girl who died of neglect while under the protective services of Philadelphia's Department of Human Services (DHS) and a private contract agency, Multiethnic Behavioral Health (Court of Common Pleas, First Judicial District of Pennysylvania, Criminal Trial Division, 2008). The literature has revealed the

public perception of CPS is negative; therefore, the release of the grand jury report may have further negatively shaped the public perception of CPS workers. Although the report gave factual information about the investigation of a child death, the depiction of CPS workers can be perceived as damaging. The Grand Jury issued a presentment recommending criminal charges against Danieal Kelly's parents and against employees of DHS and the private agency. The recommendations included the charge of murder against the mother and endangering the welfare of children against the father. In addition, two DHS social workers (CPS workers) were charged with endangering the welfare of children and recklessly endangering another person. The director of the private agency and one of the private agency's employees (CPS workers) were charged with involuntary manslaughter, endangering the welfare of children, forgery, and other related offenses. One of the DHS social workers, the director of the private agency, and three friends of the mother were also charged with perjury (Court of Common Pleas, First Judicial District of Pennysylvania, Criminal Trial Division, 2008). The Grand Jury also issued a report of its findings and recommendations for legislative action. The Grand Jury found that the child's death was easily preventable. The report identified serious problems at DHS and called for increased accountability and transparency at the organization (Court of Common Pleas, First Judicial District of Pennysylvania, Criminal Trial Division, 2008).

The impact of this report on CPS workers has influenced how the public perceives and understands CPS workers and their profession. Two CPS workers were charged with endangering the welfare of children, which is in direct contrast to the mission of CPS - assessing the safety of children and intervening to protect children from harm. This

raises the dilemma about what happens when the general public becomes confused, misinformed, or even hostile towards child protective service workers following such a case if they believe that all protective workers are equally remiss. It has been argued that the profession may become viewed as less able to fulfill its mission to helping those in need, particularly when members of the public begin to mistrust CPS workers (LeCroy & Stinson, 2004). As long as a public views CPS workers negatively, people may be less willing to change discriminatory practices or oppressive policies that are detrimental to these CPS workers (Allport, 1935; Linton, 1945). Furthermore, Lubov (1965) notes that public perception of CPS professionals is of critical importance. When historically CPS professionals have been regarded as the guardians of the vulnerable and disenfranchised members of society, cooperation with CPS workers was high. However, when the public's approval of the CPS profession wanes, recruitment into the profession suffers as does the professional credibility of CPS workers in both the public eye and in the eyes of other professionals (LeCroy & Stinson, 2004). The next chapter will discuss the resultant effects of public scrutiny on worker morale, communication, and organizational change as revealed in the literature.

CHAPTER 3: IMPACT OF CHILD DEATH WORK ON CPS WORKERS

This chapter reviews the literature on the effects of work-related distress such as morale shifts, burnout, and feelings of trauma. The chapter then focuses on how these effects impact the organization, internal communications, and how the worker begins to make decisions and cope.

Work Related Distress

According to Arroba and James (1987), when a child death occurs, CPS agencies come under public scrutiny and CPS workers become extremely stressed. Stress has been described as a response to an inappropriate level of pressure. It is identified as a response to pressure, not the pressure itself. Stress is seen as the product of complex interactions between environmental, i.e. the public and media and organizational demands, and the CPS worker's ability to cope with these demands (Collins, 2008). Taylor (2008) suggests when the demands of the CPS organization cause stress; CPS workers must feel supported by their managers for morale to remain intact. The dimension of the work is unique and may cause difficulties such as lower morale within the professional work environment (Regehr, Chau, Leslie, & Howe, 2002). Work becomes defensive and routinized, resignations are common and recruitment of new staff is difficult (Hill, 1990; Brunet, 1998). Morale is shifted from the norm of an already stressful environment to staff feeling depressed and anxious.

Regehr, Chau, Leslie, and Howe (2002) conducted a mixed-methods analysis of the impact of child death reviews and the subsequent changes to child welfare services on

child welfare workers. The research was conducted at the Children's Aid Society of Toronto, one of the largest board operated child welfare organizations in North America, which had been subject to two coroner's inquests into the deaths of children. The broader goal of this research was to understand stress and trauma in child welfare workers, one component of which was exposure to post-mortem reviews in the form of internal reviews, coroner's inquests, and civil litigation. Data collection involved both qualitative and quantitative methods. The quantitative survey was distributed to all staff following meetings describing the nature of the study. A total of 175 questionnaires were returned from front line, clerical and management staff. While actual numbers of staff employed by the agency over the 3 months of data collection vary, this number represents an approximate 33% response rate (Regehr, Chau, Leslie, & Howe, 2002).

The study focused on how the public inquiries into child fatalities have served to dramatically shift child welfare services. Regehr et.al.'s (2002) findings indicated that post- child death, protection work shifted from treating families to functions of surveillance, investigation, and collection of assessment evidence. The changes in child protection work caused a shift in morale, according to Regehr et.al.'s (2002) study, as workers felt that their initial intent to treat and service the family had become more regulated (Regehr et al, 2002). Workers in the study stated that in the past their work involved more than strictly protection. They believed that the work they formerly did positively contributed to children's lives beyond simply their safety. The focus on rules, standards, and accountability after the death was seen to limit practice. Workers indicated that documentation and avoidance of liability are now at the forefront (Regehr et al, 2002).

Another cause for morale shifts within the CPS organization appears to be the critical nature of inquests and the manner in which the CPS worker's personal and professional integrity is called into question. Conversely, child protection workers are rarely acknowledged for the positive work that they do. Workers in Regehr et. al's study stated they felt very criticized about the work they have done and the decisions they and their team have made (Regehr, et al., 2002). Similarly, Taylor's (2008) article of social work morale after public criticism, explains a manager in a CPS organization stated that most of the time workers get things right, but they have yet to find a way of getting this across to the public. Therefore, faced with public scrutiny, significant stress, and lowered morale, it is not surprising that there is a high turnover rate within child welfare. While improved services to children and families are definitely a worthy goal, the tone of post-child death inquiries and the outcomes have not come without cost to the CPS workers. Drake and Yamdama (1996) cited a two-year turnover rate of 46 to 90 percent in child welfare practice and Brunet (1998) reported 250 of 300 workers hired in British Columbia after the Gove report quit because of case overload. The high turnover rates were attributed to burnout caused by heavy workloads and lofty expectations; there are simply not enough CPS workers to keep the front lines sufficiently manned. The alarming loss of staff in this demanding and highly specialized area of CPS work within child welfare practice threatens the safety of children (Regehr et al, 2002).

Finally, the all-consuming nature of death inquiries and the length of time involved in the inquiries due to the subsequent inquests from outside agencies and the internal investigations have been found to take a toll on the social worker. Regehr, Chau, Leslie, and Howe (2002) identified the death of a child as the most emotionally

distressing critical event encountered by CPS workers. The inquiries following the death of a child are also perceived as significantly stressful because they re-expose the CPS worker to the details of the tragedy. The public inquiries themselves appear to have taken a tone of moral righteousness thereby adding to the morale shifts of a stressful environment to a more anxious atmosphere. Additionally, Regehr et al. (2002) found the inquiries led to "radiated distress." Inquiries into the death not only affect the workers involved, but the stress and distress radiate throughout the agency. Workers described feelings of empathy for colleagues who were undergoing the process of inquiry (Regehr et al. 2002). Workers watched as their colleagues were castigated by the media. The media attention or "frenzy" and ensuing public reaction had a significant impact on workers. The negative press about colleagues was perceived as unfair. According to one worker interviewed by Regehr et. al. (2002),

> There has been so much negative publicity, so many people have left the field, so many good competent people, people have taken early retirement, people who show a lot of potential even if they're young are getting out because why would you want to do this work (p. 895).

Although Regehr et.al.'s (2002) study identified that the media could be used as a means of educating the public, it also noted that no matter how much time is invested in placing a positive perspective on the work and taking reporters along the job, as soon as a problem arises, all the good will appears abandoned (Regehr et al., 2002). A positive benefit of public scrutiny noted in the study was that learning how problems that had occurred had led to development of plans for future service delivery. The study also identified that coordination and teamwork was not always optimal, but through the

inquiries some problems were rectified and some practice was improved (Regehr et al., 2002). Another benefit of public scrutiny was that the recommendations emanating from the process provide a useful beginning to altering and improving services to children in the child welfare system. Caution should be used in interpreting findings of this study because there was only a 33% response rate and this study represented one of the first times staff were asked about the impact of their work in the midst of high public outcry. As such, the comments may reflect a watershed of emotion that may not be indicative of everyday experience (Regehr et al., 2002).

In another study conducted on the topic of the impact of child death's and the changes child welfare workers experience, found that the effects child deaths have on child protective service workers were even more devastating. An empirical study completed by Regehr, Hemsworth, Leslie, Howe and Chau (2004) focused on the predictors of post-traumatic distress in child welfare workers using a linear structural equation model. Exploring the issue of work-related distress; the study integrates two concepts that explore the issue of stress in social workers: the impact of burnout and the impact of traumatic events. The study tests a hypothesized model for predicting post-traumatic distress in child welfare workers. Burnout was conceptualized as a state of physical, emotional, and mental exhaustion caused by exposure to chronic stress in the workplace. For CPS workers, traumatic events include exposure to child deaths, traumatic deaths of adult clients, threats of violence against themselves, and assaults against themselves (Regehr et.al, 2004).

The sampling strategy for this research was purposive, utilizing a sample of workers within The Children's Aid Society of Toronto, which provides services to

children and families in a city of three million people. The agency was selected for the study because it had recently undergone two coroner's inquests into the deaths of children in care (Regehr et al., 2004). A total of 175 questionnaires were returned from front line, clerical and management staffs, 156 of these were fully completed and useable in this analysis. This represents approximately a 30% response rate from the entire agency. However, there was a higher response rate for some areas. For instance, the response rate of intake social workers was closer to 40%.

Regehr et al's., (2004) study measured four categories of variables: individual, organizational, incident, and distress. *Individual factors w*ere measured using three subscales of the Bell Object Relations and Reality Testing Inventory. *Organizational* factors were estimated using three measurement variables; ongoing workload stressors, union support, and management support. Measurements for this construct were collected via a questionnaire designed by the researchers. *Incident factors* was estimated using two measurements, one representing time elapsed (the number of months since the most recent event), and one representing dosage of traumatic events (the number of these events which occurred in the past year). *Distress* was measured by two scales, the Beck Depression Inventory and the Impact of Events Scale (Regehr et al., 2004). The study used the structural equation modeling (SEM) framework to test a hypothesized model for understanding traumatic response in child welfare workers, which includes CPS workers.

Key findings were that after traumatic events, individuals frequently experience a range of intrusion, avoidance, and arousal symptoms, which fall on a continuum and can occur with such frequency and intensity that they meet the criteria for post-traumatic stress disorder (Regehr et al., 2004). As levels of distress increase, levels of reported

positive change also increased. This suggested that stress and trauma could be galvanizing for workers (Jones, 1993; Regehr et al., 2004). It also speaks to the ability of the individuals in this study to appreciate the lessons learned from adversity and to seek to use these insights to improve themselves and their professional practice (Tedeschi, Park, & Calhoun, 1996; Regehr et al., 2004). Another key finding was that powerlessness or lack of control has been related to burnout in child welfare workers. In addition, greater amounts of control that CPS workers feel over the outcomes of events appear to lower the level of posttraumatic stress and depression symptoms that they experience. This finding is consistent with that of other research that equates powerlessness and burnout (Guterman & Jayaratne, 1994; Regehr et al., 2004).

A major weakness of this study was the 30% response rate, which limits generalizability of findings and internal reliability. Another weakness was that the study includes only those who have continued working in child welfare and not those who left. High reported turnover rates in child welfare practice would support the notion that this study may provide a picture of those who survive and perhaps flourish in this type of stressful environment (Regehr et al., 2004).

Although some CPS workers may benefit from the pressure of inquiry, other research suggests the manifestation of stress is commonplace and nonproductive in social services. Jones' (2001) explored the current condition of state-run social work in England via interviews with experienced social workers employed by local authority social services departments across the north of England. Seeking to provide an opportunity for the views of front-line state social workers to be heard, Jones elicited the stories of social workers, which includes CPS workers. Findings included tales of

workers who were in tears, throwing papers onto the floor and walking out of their departments and people locking themselves in rooms or just disappearing from the office for hours on end. Going out sick for some time each week or month seemed routine in many agencies and was one of the most cited examples of a stress survival strategy in this study (Jones, 2001).

In whole, it appears that the demands of child welfare are significant and have a negative impact on many CPS workers. Additionally, post-child death inquiries appear to compound distress, contributing to decreases in morale, radiated stress, burnout, and significant levels of trauma. At the same time, some workers, it appears, are able to increase their practice rigor in response to heightened scrutiny, suggesting a potential benefit of high levels of investigation. What happens in terms of organizational dynamics, intra-agency communication and supervisor-supervisee dynamics is the topic of the section that follows.

The Organizational Impact

When CPS organizations experience a crisis, it is likely to be overwhelming not just for the individual CPS workers involved but also for the overall organizational function. Deaths by suicide or homicide are acutely traumatic, particularly to a social service setting, such as child protective services, where guilt, fear of recriminations for a failure to anticipate or prevent the deaths, affixing of blame, and glaring media exposure may be major components of the event as it is experienced by the members of the organization (Bloom & Vargas, 2007). A crisis is a condition where a system is required or expected to handle a situation for which existing resources, procedures, policies,

structures, or mechanisms are inadequate (Boal & Bryson, 1988). Crises threaten high priority goals and compress response time (Jick & Murray, 1982). In a crisis the daily operations or activities CPS workers are used to doing and are comfortable doing, may be called into question or deemed inadequate. The stage is now set for the possibility of disaster, new learning or both (Bloom & Vargas, 2007).

When an organization, such as CPS, is in crisis, the crisis is often sensed rapidly by everyone in the sphere of influence of the organization, regardless of how strenuously leaders attempt to contain the spread of information. Studies suggest that "emotional contagion," without cognitive input occurs within one-twentieth of a second, and although employees of an organization may not know what the problem is, they will know there is a problem (Hatfield, Cacioppo, & Rapson, 1994, p. 152). It has been shown that such tension can be felt within the organization within minutes or hours of a particularly disturbing piece of gossip, news, or crisis. Everyone in the organization can enter an alarm state, which includes compromised thought processes (Bloom, 2004).

Organizations under stress may engage in a problematic emotional management process that interferes with the exercise of good cognitive skills, such as making organizational changes driven by concerns to improve the quality of services without involving consultation with those who actually attempt to provide the services (Bloom, 2007; Jones, 2001). Studies have shown that often times following a high crisis situation individuals are held accountable for decision making, deflecting attention away from organizational responsibility for decision making (Monroe, 2005; Rzepnicki & Johnson, 2005). The resultant effect is that individual workers and supervisors are held liable, an outcome that increases the stress associated with the job. Monroe (2005) recommends a

change in focus from individual to organizational responsibility. In so doing organizations might uncover any underlying structural elements that create mistakes and poor decision-making practices within the context of child welfare (Dill, 2007). This research will aim at exploring underlying structural elements that foster mistakes and remedies to poor decision-making practices within child protective services. What follows is an examination of existing decision-making and coping processes among CPS workers, as studied to date.

Decision Making and Coping

Munro (1996) has indicated that CPS workers fear the public or media will publicly criticize them if they make mistakes. According to Munro, CPS workers aim to reach decisions without error, but some environments, such as CPS, are less forgiving of error than others, especially if the mistakes are seen as avoidable (Vincent, 1999). Human beings make frequent errors and mistakes or misjudgments in every sphere of activity. The decision-making process involved in determining which children are removed from their parents is, thus, central to the operation of the child welfare system (Lindsey, 1994). The challenging part of making decisions is that each decision has the risk of a false positive or a false negative. CPS workers can accurately assess a case; can assume a child is safe when in fact the child is at grave risk (a false negative); or assume that the child is at risk when the child is acutally safe (a false positive). Although child welfare agencies try to develop systems that can reduce both false positives and false negatives, the laws of probability theory are that one cannot reduce both false positives and false negatives at the same time (Gelles & Brigham, Child Protection Considerations

in the United States, 2011). The standard "No child will die" is unrealistic and makes failure inevitable (Cresswell & Firth-Cozens, 1999).

In fact, a sudden unexpected child death can cause considerable distress, leaving the CPS worker unable to cope with increasing work demands as a result of the death. Although research shows when a child dies there is a protocol for rapid response to the unexpected death or an overview, such as a Child Fatality Review Team, there is little evidence that CPS workers are trained in management of unexpected death (Garstang & Sidebotham, 2008). CPS workers are at risk of suffering emotionally from the death of a child. Garstang and Sidebotham's (2008) quantitative study entitled, "Interagency Training: Establishing a course in the management of unexpected childhood death," focused on a course to provide training in the multi-agency management of unexpected childhood death. This study reports the findings of a British survey of the heads of key organizations involved in the field of infant death and 81 individual professionals working in child health, police, or children's services, in order to question them about the feasibility of a training course in the multi-agency management of unexpected childhood death. The study's authors highlight the need for developing a training course in which one of the objectives is to recognize the training and welfare needs of the professionals involved in responding to childhood deaths, which includes CPS workers. Others in the field have concurred that training is an important component for maintaining staff capability and morale. High quality pre-service and in-service training is important as agencies attempt to provide new staff with essential practice skills, particularly since many new CPS workers lack educational training in social work (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000). Training CPS workers in unexpected child deaths

has been recommended to help better prepare workers for the inevitable. In addition to training, providing CPS workers with worksite counseling or peer support groups may help the workers cope with stressors experienced from a high profile child death.

CPS workers are at risk for emotional distress, therefore access to appropriate mental health services and/or peer support groups within the agency that provide counseling is important (Knapp & Mulligan-Smith, 2005). Worksite counseling, via peer support groups, includes a whole variety of methods aimed at helping CPS workers cope more effectively with stress (Hardy & Barkham, 1999). Effective coping responses can be categorized as constructive problem solving. CPS work requires the coping responses to master and overcome stressful situations. These responses include assessing and accurately judging the extent of the problem, situation, or distress, seeking and using appropriate problem-solving strategies, using resources and support systems, and engaging in activities that directly address and overcome the problem and restore equilibrium. When these strategies successfully mitigate a stressful situation, crisis or increased distress can be averted (Hughes & Rycus, 1998). The creation of a supportive work environment through worksite counseling or peer support groups can allow a safe place for the CPS worker to release emotions and talk about the specific trauma, such as a high profile child death, their fears and regrets, and could help minimize the symptoms they experience. Having worksite counseling or peer support groups in place in which workers can engage in individual or group discussion, exchange information, and provide support, might also reduce the likelihood of PTSD symptoms (Bloom & Vargas, 2007) or other stressors they may experience.

To date, no outcome studies on the impact of such groups have been made

available. Further efforts to improve outcomes for CPS workers are explored in the next chapter. Specifically, the role of Child Fatality Review Teams within child protective services and its impact on CPS workers are addressed.

CHAPTER 4: CHILD DEATH/FATALITY REVIEW TEAMS

Civic demand for further protection of children is evidenced in the creation of Child Death / Fatality Review Teams (CFRT). Child Death/Fatality Review Teams were organized in the 1970's to promote prevention of child deaths or serious injury and to improve social service delivery practices of CPS workers. Agency education stemming from review team recommendations, past reports, and case reviews can improve future practice. In 2007 Philadelphia's Child Welfare Review Panel reviewed its CPS organization. Several key areas in need of organizational improvement were highlighted. The CFRT report revealed that among the many cases reviewed, there was great variability in the way in which the organization serves its children and their families. There appeared to be a lack of a coherent framework to guide workers in their day-to-day work with families. The practices in these cases were symptomatic of the need for the CPS organization to provide more direction and structure to guide practice and decision making for cases involving children. There was inconsistency, confusion, or a lack of clear direction in the existing protocols needed to assure consistency in assessing risk and little evidence that risk was regularly reassessed across the life of the case. There was also no protocol for assessing safety and developing a safety plan (The Philadelphia Child Welfare Review Panel, 2007). If CPS workers are expected to evaluate and analyze a family's problems in response to allegations of maltreatment and make critical decisions regarding child safety, risk of future maltreatment, the needs, and existing resources of the family, then CPS organizations must improve their CFRT efforts to improve social service delivery practices of CPS workers (Brittain & Hunt, 2004). The CFRTs, thus, may play an important role in assessing the CPS organization's ability to

track and prevent child death or serious injury; however, does the CFRT process always help? In what ways has CFRT inquiry improved delivery of services, and in what ways has CFRT inquiry added stress to CPS workers? To better understand how these Child Fatality Review Teams impact CPS workers, the following chapter reviews the history of CFRTs, their mission, and how CFRTs function with child protective services.

Since the 1970s child maltreatment fatalities have gained the concern and attention of the government, professionals with the child welfare profession, and the general public. Reports of child maltreatment fatalities initially began to climb but have remained pretty stable for the past twenty years (R.J. Gelles, personal communication, July 30, 2010). When child maltreatment fatalities first caught public attention in the United States, one of the earliest organized efforts in response to these events was the development of review teams (Douglas & Cunningham, 2008). The first child fatality review team was established in 1978 in Los Angeles County, California (Gellert, Maxwell, Durfee, & Wagner, 1995). To gain a picture of the status of Child Fatality Review in the US, Canada, and Australia, Durfee, Tilton-Durfee, and West (2002) focused on the international movement of Multidisciplinary Child Fatality Review Teams (CFRT). Their study was designed to gather information regarding the mission of child fatality review teams, legal authority/confidentiality, structure, membership, funding/staff, data, technology, challenges, accomplishments, lessons learned, and future goals. Durfee et. al. (2002) found that the vast majority of agencies involved in CFRTs have a similar core membership, which includes Coroner/Medical Examiner, law enforcement, prosecuting attorney, Child Protective Services, and health/public health professionals.

However, Durfee et. al. (2002) found there was a need for improved multiagency collaboration. Many teams noted difficulties in obtaining and sustaining adequate resources for state and local teams. Some noted an inability to expand the focus of their review or to put prevention programs into effect. Several states noted slow or delayed submissions of data forms by local teams to state teams. Difficulties encountered in obtaining and sharing records were of concern because they can lead to inaccurate data, mismanaged cases, and an increased risk to children.

Other key findings of this study revealed most child fatality review teams noted a primary mission to prevent child death or serious injury. Many review teams focus on individual case management and improvement of intra- and inter-departmental teamwork. Some have developed prevention programs that involve the larger community. Multiagency review of a single case may change the course of the case including the pursuit of successful criminal action or removal of suspicion. Reviews of groups of cases may result in prevention activities. Analyses of risk factors may provide direction to major injury prevention programs. The overall multiagency review process itself increases cooperation and may create major system changes (Durfee et al, 2002). This study found that Child Fatality Review Teams have increased community awareness of the value of children's lives by bringing attention to their deaths and using the process to learn where changes can be made to improve services (Durfee et al., 2002). Intra- and inter-agency systems for intervention and prevention have been improved. Multiagency data systems have provided accountability and profiles of risk factors for policy and program planning (Ibid.) The intra- and inter-agency and multiagency systems improvement can be attributed to case managers, which includes CPS workers, utilizing

the team review process to change case outcomes before and after a child's death. CFRTs have improved multiagency interaction. The multiagency forum keeps the process of CFRTs vigorous, which creates a motivation to continue the process of these teams leading to preventable child deaths and serious injury to children (Durfee et al., 2002).

Douglas and Cunningham (2008) also explored child death review teams. Their study focused on recommendations from child fatality review teams and the results of a U.S. nationwide exploratory study concerning maltreatment fatalities and social service delivery. Data were collected between September 2006 and February 2007. All recent CFRT reports published in the U.S. between 2000 and 2007 were collected and reviewed in order to examine the recommendations of review teams. The data for this study are based on twenty-nine states (Douglas & Cunningham, 2008). Every month in nearly every state in the union, members of the social service and helping professions gathered to examine and discuss breakdowns in the social welfare system. They documented aspects of service delivery that potentially failed and may have contributed to the death of a child (Douglas & Cunningham, 2008). The end products of the meetings were formal recommendations concerning how to change the service system to better meet the needs of children and families to whom the children belong (Douglas & Cunningham, 2008). One recommendation made in response to child maltreatment fatalities was the need for improvements in communication and collaboration between agencies working with children and families: hospitals, health providers, law enforcement, and child welfare services. Another recommendation addressed the functions of the CFRT, including the responsibilities, functioning, and training of teams. Many recommendations concerned

risk factors of child maltreatment and proper assessment of risk for maltreatment. CFRT reports stressed the importance of proper training in order to improve identification, treatment and follow-up for risk factors (Douglas & Cunningham, 2008).

The study intended to perform a nationwide review of CFRTs but only collected and analyzed data from 37 of the 50 states available and of those 37 states, only 29 of the state-level reports provided recommendations concerning child maltreatment. Therefore the study had a small sample size of n=29 limiting the complexity of the statistical analyses that could be performed, but it was the first study to explore the findings and recommendations of the U.S. CFRT's nationwide. This study concluded that the effectiveness of CFRTs to implement new practice and policy procedures and to prevent future maltreatment fatalities is still unknown. This is an area that deserves concentrated attention in future studies (Douglas & Cunningham, 2008).

Although there is little evidence of the effectiveness of CFRTs, some cities and states have begun enforcing the creation of these teams through policy. One example of this is that Philadelphia's Department of Human Services (DHS) began implementing reforms in their CFRT in 2009. Act 33 of 2008 was signed by the Pennsylvania governor and went in effect in January 2009. The Act amended the Child Protective Services Law and set standards for reviewing child fatalities and near fatalities that are suspected to have occurred due to child abuse and/or neglect.

Several of the legal requirements of Act 33 for the Department of Human Services (DHS) include:

- DHS must establish an interdisciplinary review team to review child fatalities and near fatalities (defined as an act that places a child in serious or critical

condition as certified by a physician) that are alleged to be caused by abuse and /or neglect.

- The team must review the circumstances of the child's death or near fatality and the services provided to the family.
- The law allows for the reports to be made available to the public in a redacted format.
- The team must, within ninety days of the review, issue a written report to the DHS Commissioner, which is then forwarded to the Mayor and the Department of Public Welfare. The report must include:
    - An assessment of the strengths and deficiencies in terms of compliance with statutes and regulations and services to children and families
    - Recommendations to prevent future child fatalities and near fatalities
    - Recommendations regarding the collaboration of community agencies and service providers to prevent child abuse and neglect (Philadelphia Department of Human Services, 2010).

Since August of 2009, DHS has implemented the aforementioned legal requirements by establishing the Policy and Procedure Guide on the legal requirements for the interdisciplinary reviews of child fatalities and near fatalities, defined the responsibilities for the CPS workers regarding preparation for and participation in these reviews, and developed a protocol for the newly established review team (The Philadelphia Community Oversight Board, 2010).

According to the Oversight Board, Act 33 appears to be assisting CFRTs in the effort to decrease or eliminate child deaths by making recommendations to improve the services CPS workers utilize daily. CFRTs are responsible for increasing awareness in the community of the value of children's lives by bringing attention to child deaths. Increased communication and collaboration with CFRTs concerning the challenges within CPS can create better prevention programs that will help save lives. However, as a whole, CFRTs have been in existence in the US since the 1970s but are not standardized, are relatively unorganized, and remain unevaluated as to their effectiveness (Douglas & Cunningham, 2008). It appears that often the child welfare profession embraces techniques such as CFRTs without adequate review of practice (Gelles, 2000). Although the reform efforts of Pennsylvania's CFRTs intend to save lives, there appears to be little known about the impact CFRTs have on the CPS workers and if CFRTs are effective in improving outcomes for CPS workers. This study explores how CPS workers experience the impact of CFRTs and work related distress after a high profile child death.

Careful exploration of the literature on inquiries into deaths of children and the distress among CPS workers revealed a number of key issues. When child deaths occur, distress among the CPS social workers and throughout the organizations is heightened. A child death that receives intense media attention and/or public scrutiny has the potential of weakening the child protective service organization's identity and emotionally affecting the CPS workers. The public scrutiny of CPS workers can make the experience of a child death even more traumatic**.** Although the CPS workers are traumatized the public still demands changes to help prevent the next child death. Studies to date have focused on the stress and trauma CPS workers experience with research showing that

workers experience burnout, distress, PTSD, and shifted morale. However, little attention has been paid to how a high profile child death impacts the CPS workers. While CPS organizations have formed child fatality review teams to improve social service delivery practices and promote child death prevention, it remains unclear if they are effective and how CFRTs impact CPS workers during high profile cases.

What remains to be known is how do CPS workers experience the impact of a high profile child death? How do they view the media and CPS organizational response to the crises? In what ways does the media/public affect them, and are CFRTs – with their added scrutiny and oversight - perceived as helpful? The next chapter describes an original study designed to address these questions.

CHAPTER 5: RESEARCH METHODS

Purpose of Study

The main purpose of this study is to achieve a better understanding of how a high profile child death impacts child protective service workers. As little is known about how CPS workers are affected by high profile fatalities, this study a) examined the CPS workers' retrospective views and current perspectives on their experience of a child fatality in their organization that received high levels of public and media attention; b) reviewed the impact such experiences had on the worker; c) investigated the circumstances of whether or how CPS workers experienced morale shifts when or after a high profile child death occurs; d) examined the impact of CFRTs and their potential role in improving outcomes for the CPS workers, such as implementing prevention programs, improving communication between all agencies working with children and families, or implementing new policies or practice and learning if training for CPS workers is effective.

Methodology and Design

To successfully carry out this study, a qualitative in-depth interview method was chosen. A qualitative research interview can yield in-depth understanding about how a high profile child death impacts CPS workers, a topic of sensitivity and emotional intensity. The research has indicated that CPS workers routinely encounter crises and dilemmas that require empathy and understanding (Padgett, 2008). To capture the lived experiences of CPS workers, past and present, from the perspectives of those who lived it and create meaning from their experiences, the qualitative research sought *verstehen*

(deep understanding) or an *emic* perspective (i.e., focusing on the insider point of view, rather than an *etic,* or outsider's perspective) (Padgett, 2008).

Accordingly, the research topic was approached qualitatively from the perspective of interpretative phenomenological analysis (IPA). IPA has been informed by concepts and debates from three key areas of the philosophy of knowledge: phenomenology, hermeneutics, and idiography (Smith, Flowers, & Larkin, 2009). The aim of using interpretative phenomenological analysis was to explore in detail how CPS workers are making sense of their personal and social worlds (Smith, 2008). IPA used in this study sought understanding into how CPS workers in a CPS organization make sense of their major life experiences, such as the circumstances surrounding the crisis of a child death. IPA is a recently developed and rapidly growing approach to qualitative inquiry. It originated and is best known in psychology but is increasingly being utilized by those working in cognate disciplines such as human, social, and health sciences. IPA is phenomenological in that it is concerned with exploring experience in its own terms (Smith et al., 2009).

The development of phenomenological analysis is attributed to the early twentieth century writings of Edmund Husserl and the later developmental work by Giorgi (1985) and Moustakas (1994) in psychology and van Manen in education (2002). Phenomenological analysis (PA) explores the lived experience of a phenomenon (Padgett, 2008). PA is a philosophy as well as a method, which puts the focus on deeper meanings achieved by studying a small number of subjects through extensive and prolonged engagement to develop patterns and relationships of meanings (Padgett, 2008: Moustakas, 1994). PA recognizes that the researcher must rely on "bracketing" or

sidelining preconceptions about what is real. The researcher must bracket his or her own experiences in order to understand those of the participants (Nieswiadomy, 2003). Conversely, the purpose of IPA is to attempt as far as possible to gain an insider perspective of the phenomenon being studied while at the same time, acknowledging that the researcher is the primary analytical instrument. This researcher's beliefs were not seen as biases that need to be bracketed, but rather as being necessary for making sense of the experiences of the CPS workers (Smith, Jarman, & Osborn, 1999). Interpretative phenomenological analysis and phenomenological analysis demonstrate that the phenomenological thought is been developed in a variety of different ways. Therefore, reflexivity was viewed as an optional tool that enabled this researcher to formally acknowledge the interpretive role, rather than as an essential technique for removing bias (Fade, 2004). A major theoretical underpinning of IPA comes from hermeneutics, the theory of interpretation (Smith et al., 2009). IPA is phenomenological in that it seeks an insider perspective on the lived experiences of individuals and interpretative in that it acknowledges the researcher's personal beliefs and standpoint and embraces the view that understanding requires interpretation (Fade, 2004).

This approach is concerned with the detailed examination of human lived experience. IPA helped make sense of what was and is happening to the CPS workers and what the experience had been and may still be like for them in an idiographic process. Idiography is concerned with the particular. This study is a commitment to the particular in the sense of detailed depth analysis of the CPS workers. It is also committed to understanding how a particular experiential phenomena (death of a child) has been understood from the perspective of CPS workers, in a CPS organization (Smith et al.,

2009). Therefore, in order to obtain rich data from CPS workers, the researcher conducted the study at Philadelphia's Department of Human Services, a large city CPS organization.

Research Setting and Sample

The selection of this setting and participants for this research was a purposive sampling – a deliberate process of selecting participants based on their ability to provide the needed information (Padgett, 2008). The sampling was aimed at selecting participants who would best help the researcher understand how a high profile child death impacts child protective service workers and the inside perspective on this topic. The setting of this research was Philadelphia's Department of Human Services, a large city child protective service organization that has experienced heightened media attention after the death of a child. The organization has 1,800 employees and 100,000 children receiving varying degrees of care. Out of the 1,800 employees, 623 are case-carrying CPS workers who have an average caseload size of 12.2 cases. This CPS organization reported 52 child fatalities from 2001 to 2006 and in 2007 a high profile child fatality case emerged with intensive media coverage. This researcher chose this setting to gain "inside" perspective into the experiences of the CPS workers who were employed from 2006 to present. The researcher aimed to have readers of this study feel as if they had "walked a mile in the shoes" of CPS worker participants (Padgett, 2008). The participants were employed at the CPS organization's work site. The researcher is also employed at the work site, which provided accessibility to hundreds of CPS workers and familiarity with the policy and practices of the CPS workers' work site. To enhance rigor

and trustworthiness, protections were taken to minimize potential bias by the researcher (See Rigor and Trustworthiness Section and Study Limitations Section below).

Although the researcher had access to hundreds of CPS workers, a sample of approximately ten was utilized for this study because the primary concern of IPA is with a detailed account of the CPS workers' experience. The issue is quality, not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases (Smith et al., 2009). The in-depth interviews were carefully prepared, scheduled in advance, and took place in a conference room within the organization, which is a private setting conducive to providing a confidential environment. Advantages of conducting in-depth interviews were the amount of control the researcher had and the great amount of information the CPS worker were able to share. The in-depth interviews allowed for closer communication between researcher and CPS worker. The researcher was able to use more subtle cues to control the direction of the one-on-one conversations compared to what would have been necessary to guide a group discussion (Morgan, 1997).

The length of time for each interview averaged around sixty minutes. The participants were asked to set aside ninety minutes during lunch time hours to participate in the interview. The "Request for Volunteers" was sent via e-mail to participants (see Request for Volunteers, Appendix A). An "Information Sheet for Individual Interviewers" form was reviewed before the interview began and each participant was asked to check a "yes" or "no" box before the interview began (see Consent Form, Appendix D). The participants were responding to if the researcher needed further clarification of understanding of their interview responses, the research might contact the

participant. An extra copy of the information sheet was provided to participants to take with them after the interview. The information sheet informed interview participants that a $5.00 gift card would be given as compensation for participation.

The "Request for Volunteers" form informed participants that the study required at least ten participants who were randomly selected from the collection of volunteers that applied. The recruitment of CPS workers from a CPS organization was consistent with the purpose of the study of achieving a better understanding on how a high profile child death impacts child protective service workers by offering insight into a particular experience (Smith et al., 2009). The CPS workers were selected on the basis that they could grant access to a particular perspective. Inclusion to participate in the study was limited to case-carrying CPS workers who worked in the Intake and/or Ongoing Service Region Departments of the child protective services organization since 2006. These CPS workers were present during the high profile child death case that was highlighted negatively in the media. These workers completed the required On the Job Training (OJT), which specifically trains them to work with cases associated with child abuse, and/or neglect issues and had completed Child Protective Service Investigations and work with families on an ongoing basis. Exclusion to from participating in the interviews were CPS workers who were not direct service workers, had little contact with the families who are being investigated and/or serviced through CPS, and had not worked at the CPS organization for at least five years.

Note that the job title of the CPS workers in this study is "Social Work Services Manager." While CPS workers are often perceived by the media and public at large as "social workers," within the state of Pennsylvania, where the research was conducted,

there is an educational requirement to be considered a social worker. The worker must have a Masters degree in Social Work (MSW) to legally use the professional title of social worker. Participants of this study were not required to have a master's degree.

Data Collection

Data collection lasted approximately one month from April 8, 2011 to May 4, 2011. The researcher conducted two to three interviews weekly. IPA is best suited to work with data collection methods that offer rich, detailed, first-person accounts of CPS worker experiences. Interviews, observation, and documents were the best means of accessing such accounts for this study.

Interviews

Interviews were conducted as a conversation with a purpose. The aim was to largely facilitate an interaction, which permitted CPS workers to tell their own stories in their own words. Thus, for the most part, the participant talked and the researcher listened (Smith et al., 2009). The researcher conducted in-depth interviews (see In-Depth Interview Questions, Appendix C), which were audio recorded, scheduled in advance, required careful preparation, and took place in a private setting in which the researcher hoped to produce trust and candor. Audio recording allowed the researcher to concentrate on what was being said in the conversation and captured laughter, sighs, and sarcasm, aural aspects of the interview that were vivid and revealing (Padgett, 2008).

The plan for IPA in-depth interviews was an attempt to come at the research question "sideways." Research questions are often pitched at the abstract level, so it is

not usually helpful or effective to ask them directly of the participant. This researcher aimed to set up the interview as an event which facilitated conversation of the CPS worker's perspective on the media and public attention on high profile child death cases, any impact there was on their experience as a CPS worker, any morale shifts there had been as a result, and the impact of CFRTs and their effectiveness (Smith et al., 2009). The use of a schedule helped do this. A schedule is a way of preparing for the likely content of an interview. The questions were set out in an order that was most ideal or appropriate for the CPS worker. The order was flexible once the interview was underway, but the preparation of an open-ended schedule provided a mechanism to anticipate potential sensitive issues and to frame questions in suitable open forms (see In-Depth Interview Questions, Appendix C). An interview schedule was prepared. The researcher had to engage deeply with the CPS worker participant and their concerns, listen attentively, and probe in order to learn more about their life-world within the CPS organization. This ensured the richness of the data for analysis (Smith et al., 2009).

Observation

Observation, in addition to in-depth interviews was another data collection method. The researcher wrote field notes on the behaviors and activities of the CPS workers before, during, and after the interview. The researcher engaged in multiple observations during the course of the study. Written information such as *descriptive notes* entailing physical settings, accounts of particular events, or activities, and *reflective notes* of the researcher's personal thoughts, such as speculation, feelings, problems, ideas, hunches, impressions, and biases were recorded through field notes (Creswell, 2003).

Documents

To add to the written information that was obtained through observation, documents such as newspapers were used as a source of existing data (Padgett, 2008). Newspaper quotes from high profile cases impacting this particular CPS agency were gathered prior to the interview. They reflected the feelings or comments of CPS workers, newspaper writers, or those associated with the topic of high profile child deaths and will be added as archival materials. The newspaper quotes served as evidence or reminders of the past events that occurred after the child death. These documented public records of information allowed the researcher better understanding of the reactions of CPS workers, associated with the topic of high profile child deaths.

Data Analysis

The analyses of interview data were conducted to find the "essence" or common themes in their experiences (Padgett, 2008). The data sources for examining the research questions included: (a) demographic characteristics collected via the background pre-questionnaire; (b) researcher observations via field notes; (c) media material; and (d) interview material. Participants were given a short pre-questionnaire with demographic questions at the beginning of the interview that took about five minutes to complete (see Demographic Sheet, Appendix B). The demographic sheet consisted of a few background items that provided an accurate sense of who was being interviewed (Morgan, 1997). Participants then partook in an in-depth interview. To ensure that the data collected in the interviews reflected the participants' lived experiences accurately; the interview was audio-recorded. The benefits of audio-recording the interviews were

that the participant's words were preserved, original data were saved so the researcher could return to the source and check for accuracy, and the original sources could be checked to demonstrate the accountability of the data (Seidman, 2006).

The essence of IPA lies in its analytic focus. The focus directed the researcher's analytic attention toward the CPS worker participants' attempts to make sense of their experiences. Data analysis for this study was an iterative and inductive cycle (Smith, 2007), which proceeded by drawing upon the following strategies:

- Identification of emergent patterns, i.e. themes
- Development of a dialogue between researcher, their coded data, and their psychological knowledge, about what it might mean for participants to have these concerns, in this context, leading in turn to the development of a more interpretative account
- The development of a structure, frame which illustrates the relationships between themes
- The organization of all this material in a format which allows for analyzed data to be traced right through the process, from initial comments on the transcript, through initial clustering and thematic development, into the final structure of themes
- The use of supervision, collaboration, or audit to help test and develop the coherence and plausibility of the interpretation
- Reflection on the researcher's own perceptions, conceptions, and processes (Smith et al., 2009).

Rigor and Trustworthiness

Rigor refers to the degree to which a study's findings are authentic and its interpretations credible, as recommended by Lincoln & Guba (1985). Trustworthiness of the analysis was carried out fairly and ethically with findings that represent as closely as possible the experiences of the workers, which is similar to Steinmetz's method (1991). Rigor was verified through the use of *data triangulation* and *audit trail*. The study

utilized data triangulation through the use of multiple data sources: interviews, observational data, and documents. When the data from the interviews, field notes, and archival materials were convergent, the researcher was more confident of the observations and study conclusions, which is consistent with Padgett (1998). Data were accumulated from the archival material of newspaper quotes, CPS worker interviews, and fieldnotes from the researcher's observations leaving an audit trail. The researcher documented each step taken during data collection and analysis.

The components of the audit trail included the raw data, the research proposal, the interview schedule, audiotapes, fieldnotes, interview transcripts, and the final report. The researcher hypothetically filed all data systematically and transparently in such a way that someone else could check through the 'paper trail' (Smith et al., 2009). Lincoln and Guba (1985) developed criteria applicable to qualitative methods known as naturalistic inquiry verified trustworthiness of the analyses. Drawing direct parallels to quantitative research, credibility, transferability, auditability and confirmability are alternates to internal validity, external validity, reliability and objectivity. When the research procedures were documented and traceable but did not lead to the same conclusion, but had a logic that made sense to others, then *auditability* (or *dependability)* was achieved. *Confirmability* was achieved by demonstrating that the study's findings were not imagined or concocted but rather firmly linked to data (Lincoln & Guba, 1985). The researcher used these strategies of triangulation and audit trail to confirm auditabilty and confirmability in order to achieve rigor and trustworthiness.

Study Limitations

The professional and personal interests of a researcher conducting research within his or her own organizational setting can arise from sheer intellectual curiosity or the ultimate goal of improving one's own practice setting. This researcher had advantages of studying a topic that is familiar and the setting provided easier development of rapport. There was an acceptance and cooperation within the familiar setting providing comfort to the researcher. The ability to gain access to a research site and to participants was beneficial. The researcher also had prior knowledge about the topic through personal and professional experience (Padgett, 2008). There were advantages to studying the familiar; however, there were also disadvantages that could result in limitations to the research and threaten trustworthiness.

The research includes *researcher biases* as a threat to trustworthiness. However IPA emphasizes that the researcher's beliefs are not seen as biases that need to be bracketed, but rather as being necessary for making sense of the experiences of the CPS workers (Smith, Jarman, & Osborn, 1999). The researcher documented in the fieldnotes all observations and interpretations that were possible preconceptions or personal opinions (Padgett, 2008).

Given the researcher's insider status, there were risks of being too close to the research. The temptation to overstep bounds was strong because the research was within a familiar setting. Out of the ten participants the researcher was familiar with one participant. The researcher and the participant worked within the same department for about a year, but the researcher did not supervise the participant. Although the researcher was not in a supervisory role over any of participants, it is recognized that the participants

could possibly find it difficult to accept the researcher in this new role as a qualitative researcher, which could have affected their responses. The researcher's attempt to achieve trustworthiness was potentially threatened by the study limitations: *reactivity and respondent biases*.

The researcher's presence could distort the CPS workers' beliefs and behaviors; this is known as reactivity. Another limitation was respondent bias, which refers to a worker withholding information or possibly lying to protect his or her privacy or to avoid revealing some unpleasant truths (Padgett, 1998). While the researcher's presence could distort the CPS workers' beliefs, behaviors, and responses, the researcher's presence should not be minimized (Padgett, 1998). To minimize reactivity and respondent bias, triangulation was used as a strategy to reduce the threats to trustworthiness. As mentioned earlier, the researcher relied on field notes, interviews and archival materials (documents) to support each other, resulting in more confidence within the study conclusions (Padgett, 1998).

Ethical Practices and Human Subjects

The researcher obtained full Institutional Review Board (IRB) approval from the University of Pennsylvania prior to the onset of data collection. Ethical research practice was a dynamic process which needed to be monitored throughout data collection and analysis. An important starting point for this study was the avoidance of harm. The researcher evaluated the extent to which simply talking about sensitive issues might constitute harm for any of the CPS worker participants (Smith et al., 2009). Any participants identified as needing therapeutic services during the research interview

process could be linked to the therapeutic services that the CPS organization offers through its Grief Assistance Committee. All employees of Philadelphia's CPS organization have access to these services. Staff of the Grief Assistance Committee were accessed for consultation services as needed.

Due to the research involving face-to-face engagement, informed consent was an ongoing negotiated process. The participants were asked to review an information sheet similar to the consent form. The basic elements of informed consent are a brief description of the study and its procedures, full identification of the researcher and sponsoring organization, assurance that the participation is voluntary and the participant can decline or stop participation at any time, assurance of strict confidentiality to the maximum extent of the law, and any risks or benefits associated with participating in the study (Padgett, 2008). Informed consent must be obtained not only for participation in data collection, but also for the possible outcomes of data analysis. In particular the inclusion of verbatim extracts within the study was edited for anonymity. With regard to possible publication and presentation of analyses, the researcher gave the participants the option of reviewing data extracts from their own interviews that were and will be chosen to appear in any public-domain document (Smith et al., 2009). Keeping in mind anonymity, participant names were not used on the audiotapes. Each participant was referred to as Participant 1, Participant 2, etc, to maintain the confidentiality of the name of the participant. During the interviews, any other identifying information such as names or places mentioned, were not included in the transcriptions of the interviews, the researcher's field notes, or the demographic sheet. To assure identifying information was not revealed, the researcher explained that any names mentioned that referred to

participants' clients or others within the CPS organization would not be revealed or an alias would be used.

The CPS worker was assured that the participation in the study was voluntary and the CPS worker had the right to withdraw at any time without penalty. The CPS workers were notified of any risks or benefits associated with the participation in the study. The $5.00 gift card was considered an incentive payment, not a benefit, but rather a reimbursement. An assurance was given that strict confidentiality would be kept with the exception of mandated reporting by licensed professionals as required by state law (Padgett, 2008). There were no names identified on the audiotapes, except for the name of a high profile child death case. As a precautionary measure all audiotapes and laptops were kept in the researcher's possession in a locked office. No one else had access to these items.

CHAPTER 6: RESULTS

A total of ten child protective service workers were interviewed: seven Black, two White, and one Latino, and all participants were female (See Table 1). Five of the participants were divorced, separated, or widowed, four were single, and only one participant was married. All ten participants were college graduates and two held a masters degree. They covered a wide range of ages: 30 per cent age 26-35, 30 per cent 36-45, and 40 per cent age 46-55. The mean age of the sample was 40.5 years.

Table 1. Demographics

	(N=10)	
Gender		Number
	Male	0
	Female	10
Age Range		
	21-25	0
	26-35	3
	36-45	4
	46-55	3
	56-65	0
	66-75	0
Marital Status		
	Single (Never Married)	4
	Married	1
	Divorced/ Separated/ Widowed	5
Race		
	Black	7
	White	2
	Latino	1
	Asian	0
	Pacific Islander	0
	Other (Describe)	0
Highest Level of Education Completed		
	High School/GED	0
	College Graduate	8
	Master's Degree	2
	Doctorate	0

As shown in Table 2, seven of the participants worked as CPS workers at their current organization for 5 to 10 years, while two worked for 11 to 15 years, and one participant worked as a CPS worker at the organization for over 15 years. Six participants worked within the field of CPS for 5 to 10 years, two participants worked for 11 to 15 years, and two participants worked in the field for over 15 years. The number of years the participants worked within the field of CPS was similar to the years worked as a CPS worker at their current organization, alluding to the fact that for most of the participants this was their first and only job in the CPS field. Only one participant had held her current position for 1 year or less. Four participants were in their current position within the organization for 2 to 5 years, while three participants held their position for 6 to 10 years, and two have been in their current position for 10 years or more. The number of clients counseled in an average week in the past month varied. Two participants counseled less than 5 clients, five participants counsel 5 to 10 clients in an average week, while two participants counsel over 10 clients a week. The participants were asked to share how many cases they have had that involve child deaths. Seven had 0 to 2 cases; while the other three had 3 to 6 child death cases.

Table 2. Child Protective Service Experience

	(N=10)	Number
Years working as a CPS worker at your organization		
	< 5 years	0
	5 - 10 years	7
	11 - 15 years	2
	> 15 years	1
Years working within field of CPS work		
	< 5 year	0
	5 - 10 years	6
	11 - 15 years	2
	> 15 years	2
Years at current position		
	< 2 years	1
	2 - 5 years	4
	6 - 10 years	3
	> 10 years	2
*Number of clients counseled in an average week in the past month**		
	< 5 clients	2
	5 - 10 clients	5
	> 10 clients	2
Number of cases that involve child deaths		
	0 – 2	7
	3 – 6	3
	7 – 10	0
**1 participant listed "a lot"; 1 missing response*		

Interviews yielded seven themes regarding the lived experiences of CPS workers. The themes are: 1) “The High Profile Case” - the saliency of a high profile case to agency workers; 2) “The Impact of Public and Media Perception” - how CPS workers feel they are perceived by the public and media; 3) “Management Reactions” - CPS workers’ perceptions of leadership within the CPS organization; 4) “Worker Expectations: Internal and External” - the perceived pressures and struggles of the CPS worker; 5) “How Can Training Help Support the CPS Worker” - experiences of feeling unprepared when child

death occurred; 6) “Child Protective Service Workers Feeling Blamed” - how the CPS worker feels interrogated or blamed during the CFRT process; and 7) “What the Public Should Know” - the morale of the organization, the emotional affects impacting the CPS worker, and how they are coping.

The High Profile Case

All ten participants from the CPS organization identified the same high profile death case as a catalyst for major change in their agency. For the participants, that case was that of Danieal Kelly, who died in 2006. The child was disabled and died of neglect while supposedly under the protective services of Philadelphia’s Department of Human Services and a private contract agency, Multiethnic Behavioral Health, both child welfare agencies. Interviews consistently suggested that the changes that occurred following this case affected the daily and future practices of the CPS workers, how they function as CPS workers, and how the media and the public perceive the organization. The workers also seemed to recall this particular child death occurring around 2008 or 2009 and then the changes began. The emergent theme is described here.

Participant #7 was asked, “Do you think there have been changes within DHS since the specific child death you mentioned or when a high profile child death occurs?” Here is her response:

> I think there have been changes, and basically it’s due to [the case in question]. I think that’s where all the changes have stemmed from, and I think any other deaths along after that, they’re gonna start tweaking things and that’s how they’re gonna make the changes. But yeah, the changes have definitely been nonstop and

> coming on strong, and I don't think the changes are at all bad. I just think it's bad when you're trying to give us all the changes at one time. The paperwork has increased. There's always gonna be paperwork. That's not a problem, but now, like I said you want everything, to me, to be separated, and I don't think the paperwork is conducive to our families.

Participant #4 responded to the question this way:

> There have been a lot of changes since [the case in question]. Oh my God what hasn't changed? The accountability, the punitive atmosphere we work in, I think that we are all social working in fear at this point because of things that we see with other social workers when things happen on their caseloads, and people get fired and people get charged criminally and things like that. The stress for us is higher. The stakes are higher and again the punitive nature of the atmosphere is really not good for us.

Interestingly, participants spoke of the changes that occurred after the death as if the changes had just occurred last year, while in fact this particular child death occurred in 2006. Participants described considerable and ongoing changes occurring, some 4 ½ years after this death. Although [particular child death] died on August 4, 2006, of starvation and infection, the workers had different timelines of when [particular child death] died. Five participants thought her death occurred in 2008 or 2009, one participant thought it occurred a few years prior to 2006, and the other participants stated her death occurred a few years ago. To further expound on changes but adding timelines, Participant #5 responded to the questions, "Do you remember a time when the death of a child within DHS was followed by high media attention and involvement? Can you

describe the death? When did it occur?" by stating, "The [particular child death] case is a case that I am familiar with. It was in '08 when the big exodus occurred. I think it was in 2008 because I believe that's when several of our peers were indicted. A whole influx of people that I knew left".

Participant #10's response:

> The [particular child death] case occurred a couple years ago. I can't recall the exact date and year… The [particular child death] case stands out because that's when so many changes began. That's when these reforms began to take effect or had been implemented for DHS.

Participant #3 shared:

> The most recent one was the starvation case. I believe it was 2008. The family was receiving in-home services. They were being supervised by DHS and the victim child had physical disabilities and was left in her bed and essentially starved to death by the parent.

Participant #9 had a different perceived timeline:

> Yes, the [particular child death] case. I believe I had just come to DHS. I had been here for about a year or so and there was a lot of attention in the media. It was a child that was handicapped and the social worker and the provider agency failed to check on the child. They just failed the family completely. They didn't follow up like they should've done with this family. I believe the death occurred right before I came. I came to DHS in 2006 so it might've been a few years prior.

The participants seem to experience the [particular child death] case as if it were the turning point with the organization. It was the moment everything changed. They all

seemed very knowledgeable about what happened to the child and the CPS workers involved with the case. The participants all shared an experience that was a result of the case. The researcher could not help feeling connected to how they were feeling. She found herself silently in agreement with the statements of the workers. She also wondered if the workers confused the timeline of [particular child death]'s death with the Grand Jury report release date, which was July 31, 2008. The case was in the headlines in 2008 after the Grand Jury report was released. The media, via newspapers covered the case, now having more details from the Grand Jury Report. The participants seemed frustrated when discussing how they felt the media portrayed the CPS organization. The participants believed the media should inform the public of CPS involvement in the case; however they were frustrated over how the public began to perceive the CPS workers as a whole.

The day after the Grand Jury Report, August 1, 2008 the headlines of the [local newspaper] read:

"9 Charged In Deadly Neglect"
"Cover-up: Documents were forged, and falsified, report says"
"Case: DHS's care for an ailing girl was lacking and she died"

The Impact of Public and Media Perception

Participants continuously stated the public perception of CPS workers was misguided and the media added to this misconception. They felt the attention they received in the newspaper articles only reported negative information about CPS workers and did not give a fair depiction of their occupation. Participants explained that the public perception of CPS workers and their role was already critical; however, after a series of newspaper articles were written, some CPS workers were threatened by clients

and blamed for hurting children, yet the CPS workers were not given the opportunity to express how they felt. Four sub-categories that emerged from how the public and media perceive CPS workers are as follows: scrutiny, negative impact of the media, defending the role of child protective service workers, and educating the public. Each is presented here.

Scrutiny

The experiential impact of the public's scrutiny was clearly distressing for the participants. As the participants shared their stories they appeared angry, passionate, or frustrated. One participant even apologized for going off on a tangent after describing how she felt the community she tries to serve, now treats her. The participants' feelings could be interpreted as somewhat hurt or agitated because they believe the public, media, and/or other child welfare professionals believe they are incompetent. They believe the perception of CPS workers is tainted while the good work they may perform goes unnoticed by the public and media.

Participant #7 expressed:

> It seems like when there is a child's death and it's not publicized, you don't hear much about it because when you do hear about a highly publicized death, I don't even hear about anything else happening. When it's publicized, I guess we're now exposed and open ourselves up to whatever the public has to say or not say about what DHS did or didn't do. We're now being scrutinized more by everyone, even the professionals. I will be honest with you, the more our cases become public and the more it seems like we're not doing the job we're supposed

> to be doing, it seems we're getting less and less respect from our own professionals, let alone the public, so that's how it's changing.

Participant #7 also explained that when meeting with families/clients the first half hour is spent explaining what her role is as a CPS worker and trying to dispel the negative perception the family has about DHS. Participant #7 felt the negative media attention has an impact on her and went on to explain:

> At first I have to get their anger to come down and ya know they can get angry. Then the first thing they'll throw up is "oh well that's why that child died or you let that child die". So it's a lot of explaining to the public. It's very negative and it seems like the department doesn't do anything. If you had good PR I think it would be a different outcome. Sometimes it makes it harder to work with my clients especially if they find out families are suing DHS. They kind of scrutinize us the minute we don't do something, we do something, or we do something they don't like. They're ready to sue and it just makes the job a lot harder.

Participant #1 shared similar experiences when asked, "When a high profile child death occurs, what is it like for you?" Her response:

> If a high profile death occurs and it's in the media, particularly in the case that I had mentioned ([particular child death]), right after that I had to go to a hospital regarding another case, something completely different. This case was not as serious as the ([particular child death]) case, but the professionals and parents there were quite aware of the news media. I felt they placed more scrutiny on my safety decisions that day. The parents questioning, "Well you know this child died and you guys were involved. So how are you guys supposed to help us or

> how do you guys know what you're doing if you're in the media for this?" So it's hard when people question what we do and why we do it. It's a lot more stressful and a lot more explaining myself to the clients or professionals after something like that happened. The public view, not that it's good ever of child protective services, just because of the nature of what we do, it really hits rock bottom after something like that happens. In my experience, after the ([particular child death]) case, clients were more hostile and less likely to cooperate. It's a lot like pulling teeth more than usual because you're not getting them to cooperate. So all that adds up to me being stressed out and kind of overwhelmed.

Participant #2 response to the same question was, "You feel like you're on the spot. You're going to get a lot of scrutiny and attention." She added, "There's gonna be changes when a death occurs at DHS because we are scrutinized both within DHS and outside of DHS to see what could be better, how could we prevent these things from happening again."

The participants described feeling overwhelmed by the scrutiny of their profession. Being questioned by the families they serve and the other professionals they collaborate with seemed to stress the participants greatly. The difficulties they face interacting with the public appeared fuelled by the negative media reports. Although justly reported to the public, the negative media reports surrounding CPS workers who were neglectful in doing their job appeared to have a negative impact on the CPS workers.

Negative Impact of the Media

The participants discussed the media's influence on the public and how that impacts the CPS workers. They feel the media are at times selling stories, only providing negative accounts of incidents involving CPS workers. Participants complained there is an imbalance between what is reported about CPS negatively and positively. They did not feel the public or media knows about the positive work they do and there is no effort from the media to find out. However the negative media motivate the CPS workers to improve their job performance.

When asked, "What is it like to work for DHS when it is getting attention from the newspapers and other media" Participant #3 shared:

> For me personally, I expect it because when you work for the city you're going to be in the media. It's usually never positive but it's not for the faint of heart and I think it can help make some workers more accountable because they know they'll send [local news station personality] after us if we're going to mess up. It might make some workers accountable if the guy from [a local news station] is sent out.

Participant #1 responded:

> It's hard, stressful. Collaterals [professionals connected to the family] and families start questioning our abilities that we know what we're doing. They question even our placements because there's been negative things about our foster care placements in the media. Everything is, "I heard about such and such. How are you guys going to handle my case if you guys couldn't do this or couldn't do that?" So, it's stressful.

Participants feel as if they are under a microscope when visiting their clients. The clients are now questioning the CPS workers' ability to do their job. The trust the CPS workers are trying to establish when meeting the clients is now met with more questions than usual. The CPS workers described their role as difficult and overwhelming and even more difficult after negative media reports. Feeling negatively scrutinized, the participants believe they are receiving criticism due to the negative media attention received after the high profile child death.

Participant #6's response:

> It's very difficult. It's gotten to the point in my life where I don't even tell people where I work. If people ask me what I do for a living I tell them I'm a social worker for an agency in Philly. I will not tell them I work at DHS because the first time you mention working at DHS all they see is a baby snatcher and that we kill babies.

Participant #10 had a similar experience:

> You see picketers out there holding up signs saying that we kill babies. That's the hard part, the people with picket signs saying we kill babies, when that's not our job. That's not what we do. I wanna go to those people holding those picket signs and scream at them and rip their sign, but I know that is not the way to go about things. What really happened will come out, whether it was neglect on our side or neglect on the parent's side or someone else's side. The truth will eventually come out. But it's very difficult working for DHS and being called a baby killer.

Participant #1 discussed the attention received and how it makes her feel:

> It's very unwanted and then it makes me embarrassed to say or admit I work for DHS. I feel like we've gotten such negative publicity in the past that when T-shirts were handed out, as an appreciation with a big DHS logo, I felt like, "Where am I going to wear that to?" I feel like if I wore that to the supermarket, they might see the car that I got out of and when I leave the market, it might be keyed up. I don't think that the public views us very nicely. I'd rather tell people I work in risk management rather than tell them I work for DHS. The public opinion matters to me to some degree because I have to work with the public. The families that are watching the news may potentially be the next family I have to work with and now they've got this negative view. They are probably not going to cooperate with me and will give me a hard time.

Acknowledging their role or position as a CPS worker has become uncomfortable for some participants. They are feeling too uncomfortable to state where they work for fear of receiving some form of backlash from clients, the community, or other professionals. Instead of stating their job title, it's easier to give a pseudo name, which demonstrates the impact of the public criticism. The participants not only endure the public criticism but also watch as picketers hold up signs outside the CPS organization saying "baby killer." The worries encountered while working for the CPS organization has made it harder for the workers to appreciate what is given in an act of appreciation, such as a T-shirt.

The participants discussed the fear of seeing or hearing a news report about a child death and the impact it has on CPS workers. Participant #4 discussed how she feels when there is a news story on television concerning a child death that has CPS

involvement. She does not feel the support will be there from the CPS organization if the high profile case is her case. She described the worry she feels and the fear of possibly hearing her name. Participant #4 described her worries:

> Oh my God, scary, very scary because I remember thinking any minute they're going to say the social worker is… and I was just like please don't say my name. Please don't say my name. No one really has your back. So, it's scary. You're cringing like don't say your name. Please don't say your name while watching the news.

Participant #10 shared that her motto is, "If I can prevent my name from appearing in the paper that's what I wanna do".

Participant #5 believes some news stories are not giving correct information because they aren't given all the facts of the story. When discussing the impact of media attention she explained it is negative,

I would say that it has an impact on me. I would say one lie is good until another lie is told as an old supervisor used to say, meaning, people say anything, I've watched parents on the news. I know what they did and what they didn't do and like a friend said if it bleeds it leads. So the news will say anything, whether it's the newspaper or channel 3, 6, or 10. Whatever it is you watch. The media or public has a right to know information, but I don't have the right to say that's not true because…"

Participant #5 is reacting to feeling as if CPS workers have no voice. Due to "confidentiality" CPS workers cannot speak to the media about their cases. Therefore, while watching the news or reading a newspaper, if the story is about the CPS organization's involvement in a child death case, the workers may have information

about what happened and why but they are unable to express their opinions, or how they feel or even the facts of the case. The CPS workers may know the story given by the client or the story reported by the media may be false or incorrect; however, the story is printed or released. This can be upsetting to the CPS worker who may be familiar with the case. The worker now believes the media are not concerned with giving the public the all the facts of the case or all the circumstances surrounding CPS involvement. It now appears the media are only concerned with selling a story.

Participant #2's comments echoed this theme further:

> As far as the media, it's always negative. It's very imbalanced. The imbalance was greater before and after a child death and DHS is always portrayed as negative in the news. DHS sells newspapers.

In response, to the increased negative remarks from the public, the participants began to defend their role as CPS Workers.

Defending the Role of Child Protective Service Workers

Some participants felt the need to become defensive about their CPS organization and their role following a high profile child death. The participants described feeling pressure to defend the organization against remarks from the public referring to CPS workers as not doing any work. Clients are threatening to have CPS workers fired or threatening to contact the media for workers who are not "doing their job." The CPS workers feel they are being unfairly generalized due to the neglectful actions of a few CPS workers.

Participant #10 stated:

> To say the least you're constantly defending other social workers. You're defending the work that you do. You're defending the fact that you're a city employee and most Philadelphia citizens have a negative view of Philadelphia city workers anyway. They think we don't do any work. So, when child death happens of course it's always our fault because we weren't doing our job. So it's very hard because you are constantly defending your job and what you do and how well you do it.

Participant #3 expressed it this way:

> I've gotten more threats from families in that, if I don't do my job, I'm going to get fired. They're going to call [a local news station]. You know there is always the threat of, "well I'll just call the media" because they will expose us as the poor workers we really are. So I feel as if I always have to defend myself to the public that I'm not that worker, this isn't the same case and I'm still gainfully employed, thank you. So we're all more on the defensive now. I feel as if I'm more on the defensive now.

Participant #3 also mentioned, "I always feel the pressure to defend what I do or what we do here as social workers. I try to stress that in every profession there are good workers and bad workers and sometimes bad things happen to good workers and sometimes bad workers get their just desserts."

While understanding there are some CPS workers who are justly held accountable for their actions, the participants did not feel the public should assume all CPS workers are poor workers. Participants felt the need to defend their role as CPS workers in an effort to teach the public about the CPS profession.

Educating the Public about CPS Work

Some participants identified that following a high profile case there is an opportunity and need to help educate the public about child protective services. Some participants of this study viewed high profile death cases as providing an opportunity, perhaps one that was forced, to explain to clients and the surrounding community what CPS workers really do, what they do not do, and how they can help, not just hurt, families in need. These participants shared their experiences of clarifying with uninformed clients and others. When asked "What is it like to work for DHS when it's getting attention from the newspapers and other media," participants described how they worked to alter public perception about their role

Participant #8 stated it this way:

> I try to do the best job I know how to do and I love taking the opportunity to educate the public about what we do. You'd be surprised how many people don't really understand how we work and the power that we have or don't have. For instance, people think we just walk in your house and we can just take your children. It's a process. You have to speak to an attorney and the attorney has to speak to a judge. It's a process and I always like to inform people that we're here to help. It's not always a negative connotation. If it's any service that we can help you with, anything that we can provide you with, just feel free to ask us. It's not always about the negative.

Participant #3 responded to how she feels about newspaper, other media attention, and public opinion by sharing:

> Public opinion matters to me in that I try to educate them that there are positives. So usually after a high profile case and I'm visiting the home next week or month and it's, "oh that's why you guys are in the media because you're not doing your job." I always have to prove myself. It just makes me have to show who I am and teach the public we're not all like this. So, it's more educational. "You're here to snatch kids or you let kids die". No, that's not all we do. You know, we don't just snatch children. We have excellent programs that you don't know about and teaching them we're not all like this. So, it can be educational in a way.

Participant #6 shared her experience with clients when responding to negative public or media attention.

> If I'm engaged in a conversation with someone and that's all I'm hearing, I'm gonna make it clear that, yes, it is very unfortunate that a child death occurred, but please know that DHS is not just about negativity and seeing these children pass away and get hurt. Our goal is to make sure that they are safe. I can only say that I'm trying to put out a positive word on DHS, that it's not that bad.

By educating the public of the positive roles CPS workers play in their clients' lives, workers hope to demystify some of the beliefs the public has about CPS workers. It was clear from the participant's perception, that the public image of the CPS profession is misinformed. This next theme will discuss how the participants felt management, within the CPS organization, reacted after negative public and media attention.

Management Reactions

CPS workers in this study revealed that they do not operate in a vacuum. A major theme identified is that of the role of management. How managers and supervisors, leaders in the organization and so on react after a high profile case has significant implications for CPS workers. This section provides examples of how CPS workers feel influenced by management reactions.

In response to questions about the kind of support that is given and DHS's initial response to a child death, the participants discussed the reactions of management. Participants overwhelmingly emphasized not feeling supported by management; indeed, most felt further scrutinized/victimized by management rather than aided. Two participants discussed issues concerning trust. Participant #1 described an interaction with a supervisor by saying:

> Initially, right after a particular high profile death, it created a huge sense of paranoia with the supervisors towards workers. Supervisors asking, "Are you really doing this?" Workers saying, "You told me you did this." "Are you really doing that?" "How do I know you did that or how do I know you saw that person or that child?" It created distrust between workers and supervisors. In my own experience, one of my supervisors, while I was in supervision about a case, became very distraught and emotional. It was something I had never seen with a supervisor before and the supervisor really had a meltdown. The supervisor said, "Oh God, oh God, I can't get arrested for this job." The supervisor was like this because of the consequences of the other workers after a child death. This supervisor was saying this in reference to making sure I documented things

> exactly as they happened, making sure I had the correct incident reports, and making sure that every 'I' was dotted and 'T' was crossed. It was really bizarre. I didn't know what to say to the supervisor.

Participant #7 also experienced distrust issues after a high profile child death received media attention. She stated:

> It's tense; it seems like people are a little less trusting. I get the impression now when I work on the hotline, where I work for different supervisors, that they don't trust my assessment skills. It's disheartening because I've worked here for sixteen years and I want my job. I like doing this work or I wouldn't have been here for this long, doing fieldwork. But that's how it's becoming, everybody wants to cover themselves and they want you to do extra work so they're comfortable. It seems like we're no longer the investigators, what I say is no longer good. I need to bring back pictures (laughs) I need to have the families call and talk to my supervisor.

These participants thought supervisors within the CPS organization began to react out of fear. The fear of being arrested for not doing their job or monitoring their workers closely enough was worrisome for supervisors. Making sure the worker completed all the tasks involved in ensuring a child's safety was causing what appeared to be emotional distress for the supervisor. This type of response caused the workers to feel they were not trusted. Their assessment skills were no longer good enough for the supervisors. However, the supervisor's role is to guide all decisions made though consultation with the worker. The participants are describing some supervisors as becoming distressed over tasks that are a part of their role as the supervisor. It is unclear if these types of

responses from supervisors are due to the newly added responsibilities caused by policy and practice changes or were the supervisors not meeting expected role functions, which would mean the changes they feel are actually due to completing the job they should have already been doing. In addition to distrust issues between supervisors and workers, there were other initial responses from management. When asked to describe DHS's initial response when a high profile child death occurs, Participant #4 expressed it this way:

> Their [Management's] initial response is to pull your file and make sure you did what you were supposed to do so that they can cover their butts. They pull your file, they meet, they look at what you did or didn't do, they pick it to death, and then you go in front of the fatality review. Everybody sits around this big table and picks your work to death saying you should have done this and why didn't you do this. You're going through all of these things, but not once does anybody ever say, "How are you doing? How are you coping with all of this? How are things with you?" You can't process what just happened until a month, few weeks later because you're so worried about everything else and they have you running and running and running. If they feel like you were neglectful or negligent in your work, now you're getting written up and now you have to deal with that process. So now this kid that I had a relationship with and I saw is now gone and here you guys are, putting me through the ringer, but I made it out unscathed.

Participant #4 described what she feels happens when a child death occurs on the CPS worker's caseload and the initial steps the CPS organization takes to ensure the CPS worker completed his or her work correctly. The first step is to obtain the worker's case

to review documentation, which is followed by critiquing and verifying documentation within the worker's case. The worker attends a CFRT meeting to discuss the case but feels attacked by the comments and critiques made by others in the meeting. She pointed out there was a lack of empathy concerning her feelings. For the short period of time the worker was a part of the child's life, she too suffered somewhat of a loss, but the focus had to remain on the CPS worker's actions during the time she had the case. She admitted she couldn't even process the death herself until weeks later because she was busy completing tasks for the case. The participant also mentioned she made it out unscathed, referring to; she kept her job while others have been less fortunate. Other participants focused on the reactions of the top or higher leaders within management after a high profile child death.

Since 2006 to 2009 there have been three different Commissioners leading the CPS organization. Therefore, when the participants discussed the events that followed the high profile child deaths their mention of the Commissioner refers to different Commissioners during different timeframes within the CPS organization. Participant #8 responded to the same question concerning the CPS organization's initial response after a high profile child death:

> I think it was bad. The police come out and they support their people until the investigation is completed. Our Commissioner, if I remember correctly, came right out and blamed us right off the bat and said we coulda, shoulda did more, and an investigation is gonna take place. That hurt a lot of people to the core that do good work around here. I think most of us were upset about it and upset about the way it was handled by the higher ups and then you always have some people

> who place blame before they even know what happened. Some people's reputations around here precede them but I do believe that everybody should have the benefit of the doubt initially. I think most people are upset with this whole regime. Most people are feeling it's very punitive and that it's not very social worker friendly.

When discussing support from the CPS organization, participant #5 comments:

> This whole sanctuary thing, I feel that the top-heavy parts of the department are the ones who benefit from that. They're the ones not getting their hands dirty, in regards to what we do.

The Sanctuary Model is the CPS organization's attempt to embrace a trauma-informed method for creating or changing an organizational culture. It was implemented to effectively provide a cohesive context within which healing from psychological and socially derived forms of traumatic experience can be addressed. Participant #5 suggested the Sanctuary Model was implemented for top CPS officials in management and not for the CPS workers.

Participant #6 made further analysis about management explaining:

> They should actually talk to us, whether it's in immediate section meetings or immediate unit meetings or immediate region meetings. We don't have that. I can't say that we have that after these deaths. What we have is a lot of emails explaining to us what happened, how the child died, and I guess the grief counseling that they have. They don't talk to us and allow us to voice how we really feel to the higher ups meaning the Commissioner, the deputies, and so forth. Yes, these child deaths happen all the time but it seems the higher profile

> ones are the ones that cause the management to make changes immediately because they know that at one point they have to go back to the media and let them know what they are doing to make changes. I think they respond well to television and newspapers but not to the workers who are actually on the line and visit these clients in these homes. I don't think they responded well to us. I don't think we had the support in place for us at all. I can't say the management really understands how the workers feel.

The participants gave their interpretation of how they feel management or top CPS officials react after a high profile case. After comparing the support from CPS to other city workers' support systems, participants felt the management at the CPS organization should be more supportive after a child death receives media attention. One participant felt the top management official placed blame on the CPS workers too quickly, before investigating the circumstances surrounding the high profile child death. There was not enough communication from the CPS management explaining what happened on the child death case but rather emails to explain the circumstances of the death. The participants wanted more face-to-face contact from management informing workers of the details. Participants discussed the atmosphere of the organization feeling it is more punitive, and that affected morale. One participant proclaimed management doesn't know what the workers are going through. There was discussion of CPS workers needing an outlet to express how they feel. The connection between CPS workers and the top management officials in leadership roles appeared weak. The workers wanted to be heard; however the response from management was to the media, not the workers according to participants.

Although the participants feel the reactions of management have been unsupportive three participants differed in their experiences. Participant #1 recalls a more supportive, appreciative response:

> The commissioner will put a little letter out there that thanks us for all of our hard work and that's when I think they actually started observing the social work appreciation month. Over the last two or three years they've given us little tokens.

Participant #10 concurred:

> I think they've gotten a little bit better. Now the commissioner comes out with her statement, and before you didn't hear anything about the new media report. Now the commissioner will send an email out to everybody saying don't listen to the media and blah, blah, blah, and try to give a little bit of explanation as to what happened. They send out emails to try to give us a little bit more information, to let us know things happen. They ask that we continue to do our jobs, that we're doing a good job, and to keep up the good work. So they try to keep us encouraged. I guess they are trying to keep us motivated.

Although previously participant #4 described above not feeling supported, upon probing, the participant also shared experiences of the Commissioner calling workers to explain that they did not need to worry, they did a good job on their case, and everything would be fine. The participant described feeling appreciated after this interaction with the Commissioner.

Participants appreciated the letters or emails sent from the top management official. Receiving the job well done letters and emails giving explanation of the

circumstances surrounding media reports of a child death shows supports from management. This keeps workers feeing encouraged. Overall, there were negative responses from management and a few very positive responses towards workers. CPS workers expressed feeling influenced by these responses whether it was feeling unsupported in a punitive atmosphere or receiving words of encouragement and an appreciated interaction. The implications of these reactions will be raised in later sections.

Worker Expectations: Internal and External

Another theme that emerged from this study is that of internal and external turmoil the CPS workers face in the aftermath of a high profile child death. This theme adds contextual understanding to the participants' experiences of distress. Their fears and daily functions within the CPS organization are recalled in two categories: internal and external, which include six sub-categories, internal-- accountability and decision-making, second-guessing, job security, practice and external-- monthly visits and paperwork/workload and non-traditional hours. These subthemes are presented here.

Internal

Accountability and Decision Making

The participants described their feelings concerning accountability and decision-making. While understanding they are responsible for their actions and decisions made when determining the safety of a child, there are equal feelings of fear when mistakes are made. This was a common theme identified.

Participant #5 stated it this way:

> There's a lot of pressure, a lot of accountability, and there's a lot of responsibility. With responsibility comes accountability. Whether any of the cases ever hit the news you still are responsible for the families that you serve. It's a lot of pressure cause you want to make the right decisions and people's lives are in your hands.

Participant #10 shared:

> I do believe in the [particular child death] case, the workers that were involved should've been held accountable, because they were definitely derelict in their duties as a child protection social worker and they should've been held accountable."

Participant #8 discussed changes within the organization after the [particular child death] death and management's response to accountability:

> It's hard to say if the changes are negative or positive. I guess in some sense negative because it puts a lot more work on us and a lot more responsibility that I don't think I agree with, but I agree with accountability. However, I think they're taking the word accountability just too far, when you're dealing with human behavior and people. So they're making the job more stressful. They always come in the name of accountability and/or under the auspices that they're looking out for us, but most of us don't feel like it's about us at all. Most of us feel like they make decisions and do more things that are supposed to help the families that we serve, but indirectly it's been hurting a lot of our families and us personally.

The participant believes the intent of management, in emphasizing accountability, is to assist the workers in being more cognizant of their actions when making decisions. However, the participant feels the intent is lost when workers feel added stress due to accountability.

Participant #4 phrased it like this:

> I think we need to be accountable for what we do, because if it's blatant disregard, we absolutely need to be accountable. However, I think that they have taken it and ran with it. I think that it has gone so far that everybody's afraid. Everybody's afraid to make a decision because what if it's the wrong decision. We can't make a mistake because what if we make the wrong mistake. It's okay to be accountable but I think that they lost sight that we're people and we're not perfect and we're not going to be perfect.

Participant #6 emphasized, "We are human and we try our best but sometimes bad things happen."

Participant #8 also shared, "Allow us to be human. Mistakes are made unintentionally."

Understanding that CPS workers should be held accountable for their actions when good or poor decisions are made appeared unanimous among the participants. Participants explained that the nature of the CPS profession keeps the lives of clients in the hand of CPS workers. Therefore the pressure to make the right decisions is critical. Due to changes in the organization after a high profile child death, that pressure has been escalated. Now the word "accountability" has taken on another meaning besides responsibility. Participants discussed becoming stressed at the idea of being held accountable for human error. The fear of making errors caused the workers to make

more mistakes under pressure. These mistakes are indirectly hurting the clients the CPS workers serve. Now the fear of making mistakes lead CPS workers to begin to second guess their decisions.

Second-Guessing

The participants began to describe feelings of insecurity. The constant worry of making the right decisions and questioning what if the wrong decisions were made led to second guessing safety decisions. Participants shared experiences of how a high profile child death impacted them. Participant #7 stated:

> I got pulled in front of the state to explain everything I did. It wasn't my case but it was the first time I ever had a situation where I saw a child or took pictures of a child and then within one or two weeks someone told me the child died. It was very devastating to me. I was subpoenaed to court and spoke with the attorneys on both sides of the case. It was high profile; everything I said on the stand was in the newspaper. It made me start second-guessing what I shoulda, coulda, woulda, even though you are passing your work onto a supervisor to approve. You kind of start second guessing what you did and go through all that mental anguish. It's pretty scary because I don't believe anybody wants to leave a child at risk. So it's always that guessing and questioning what you do. I think a lot of it can be minimized, our anxiety, a lot of second guessing ourselves, jumping through hoops cause now we're trying to do more than we can possibly do. We can go out there one day and people can look fine to us. We can take the pictures

and the house can be in order and the second day we get bad news of a child death.

Participant #4 shared another experience related to second guessing, one which brought her to tears. The researcher provided tissue during the interview. The participant was very passionate about her experience with a high profile child death. She was somewhat guarded about revealing the name of the high profile case but eventually revealed who the child was in order to express her story. The researcher didn't realize the intensity of emotions that would be aroused during this interview. Participant #4 shared:

> I don't even know how to put it into words. (She began crying) I remember seeing it on TV, remembering the child, and was in shock. It was just shock, oh my God, and you start rewinding. Everything you did. Everything. You play it back and then you rewind again. Did I miss something? You worry about what's going to happen to you. You worry about everything. Everything. It was surreal. It was completely surreal. A child death never really goes away. Well, it really hasn't gone away. I still can't talk about it without (sniffle), you're still working but now you're looking at everything you're doing. Am I doing this right? You second guess yourself a lot and I think that you always carry that with you. You're constantly trying to make the right decisions and you're constantly worrying did I make the right decisions? It was in the newspaper and the news for like a week and if I said the child's name, you would know who it was. You're always undermining yourself and you're always rechecking. When people tell you a client's job is to lie to us and it's okay, because it's our job to

> find out what is the real story. It makes me more distrustful and it makes you more watchful and more paranoid because of the circumstances with my child death. I had the case and the people that the child was living with are the same people that killed her.

The researcher was somewhat in shock over the outpouring of tears. She had to hold back her own tears because she knew she had to get through this interview. This was the first participant who cried during an interview. She started crying on the second question and the researcher hoped she could make it through the rest of the interview. She was relieved that the participant had somewhat of an animated personality. The researcher and participant were able to laugh towards the end of the interview over other experiences she shared with me.

One participant shared how taking pictures and seeing a child one day and finding out the child was dead two weeks later was devastating. Then having to testify in court and having it made public, in the newspapers, added to the participant's reasons for second guessing. The participants discussed two different child deaths, but both began to question their decision to leave the children in the home. Unknown to the participants, the children were at risk. The workers left the homes thinking the children were safe. The workers were in shock when they found out the children died. They began to question every decision made when verifying a child's safety. "What did I miss?" was the question asked. The mental anguish of second guessing past and future decisions is constantly looming over the CPS workers. While trying to obtain the truth from families, feelings of distrust are more prevalent. This is intensifying paranoia within CPS workers. The CPS workers are trying to obtain the truth while assessing families; therefore

worrying about what is going to happen to them, if an error is made is overwhelming. Consequently second guessing safety decisions have become another stressor for the CPS workers.

Job Security

To help with further understanding the participants' experiences of internal distress, they shared stories of resignations and firings within the CPS organization and the impact of those. The fear of losing their job due to avoidable mistakes was a new reality after the death of [particular child death].

Participant #5 shared this response:

> I think in '08, with the case that I mentioned and the indictment, there was an exodus of some very key players here at the department. Whenever something hits the news there's a knee jerk reaction within the department because there's a lot of accountability. Hence, administrators were asked to retire. Even before that particular case got to the DA's office, who exposed some pictures, our commissioner at that time was asked to resign. The department has a knee jerk reaction and somebody has to be held accountable. Although a lot of children die at the hands of gunfire, which would then involve PPD (Philadelphia Police Department), they're not held at the same plateau that we are. It's just different when it's something that the department could have avoided at least in the media's eyes.

When asked, "How would you describe DHS's initial response when the child death you mentioned earlier occurred?" Participant #7 explained:

> Their response is to gather the necessary information if DHS is involved with the family and child. But unfortunately it's still that fear that the worker will be let go. They put forth an effort to gather the information to find out what's going on with the family and to speak with the worker and the supervisor. If there's really bad neglect on the workers part, we'll hear about it and if the worker did follow the law and did what they were supposed to do, you don't hear about it. We say you're doing a great job and we congratulate the worker and that's the end of it.

Participant #4 experienced a high profile child death case and responded this way:

> I made it out unscathed but I know other people who had high profile child death cases and they're not here anymore. They are gone and not because they quit.

Participant #3 added:

> There's this culture of paranoia around the job of working under all these threats. If something bad happens, you could get fired immediately without any type of union support. Now we are all living under this sort of fear that if I mess up one time that's my job. That's my livelihood and I'm going to get thrown under the bus.

Participants discussed a new culture of fear within the CPS organization. The immediate reaction of the CPS organization when a child death occurs is to hold someone accountable. As a result, CPS workers witnessed top officials at the organization being fired or resign. The participants feel the firings or resignations are a result of avoidable mistakes or negligence on the part of CPS workers. Although the CPS organization will gather information to assess how the death occurred, if the worker completed his or her job correctly and the child died, this information is not made public. However, if the

child death was preventable and the CPS worker made neglectful or avoidable mistakes, this information is announced publicly. Job security now feels threatened and CPS workers feel they can be fired with no support from the union. Due to this new culture of fear, workers are changing the way they practice CPS work.

Practice

Many changes occurred within the CPS organization. The participants experienced more accountability for their inactions. In response, the participants became more rigorous in their approach to daily activities as a CPS worker. The participants answered the following question, "When a high profile child death occurs, what is it like for you?"

Participant # 6 responded by saying:

> A couple years ago, maybe three, four years ago, I probably wouldn't do half the stuff I do now, but because of these high profile child deaths, I'm going into homes and I feel like I'm being a cop. I know it affects the families but at the end of the day my goal from the moment I walk in the door, I let them know I'm there to make sure the children in this home are safe. So I have definitely changed how I am with my families, with the clients, and the children. I know I've changed my way of practicing social work. It impacts me as a worker, it makes me feel like I need to do a little bit more. I don't wanna say it, but it drives me to the point of like OCPD (Obsessive Compulsive Personality Disorder). When I go into these homes now, I'm doing a lot more than I'm probably supposed to. I'm digging in closets. I'm digging in drawers. I wanna make sure that this doesn't happen with

> me. So in regards to impacting me, it makes me do more. It makes me strive so that it won't happen to me. I try to see my clients more than the one time per month that we're supposed to, to avoid a child death from happening.

Participant #10 further explained:

> It makes you cross T's and dot your I's a little bit more. It makes you become a little bit more thorough. For me I hold myself to a certain standard and I hold the provider's workers that I deal with to that same standard as well. I do work with families a little differently. I look at little things that I might not have looked at before. I question who's coming in and out of the home. Before I would question but not as detailed. I wanna know who he or she is, are they living here, are they from out of town, are they just staying here temporarily? I try to get some type of identification. Where are they sleeping? What's the real relationship? Not just, this is my play cousin or godsister. It makes you look at more details within that family.

The participants explained they are being more cautious when assessing families. By doing more than what is required, being more thorough, and upholding other professionals who work with the families to the same standards the CPS workers has set for themselves, they are ensuring the child's safety. The CPS workers are asking more than the usual detailed questions, about the people who interact with the child and the details of their relationship. Participants are worried that if detailed information is not gathered, what will be for CPS workers. The workers are changing their practice to avoid another child death.

Participant #2 discussed how a high profile child death changes the way you work with families or complete CPS investigations by adding:

> You go over your work to try to make sure that you didn't miss anything, that everything is in sync and clear. You realize it's going to be reviewed by the commissioner and the law department. So you want to cross your T's and dot you I's, making sure your position will be maintained and anything the news, the media, supervisor, or management want to know; you're on top of the information.

Participant #8's responded, "If you can be any more diligent, you try to be even more diligent in what you're doing."

Participant #9 concurred by saying, "I wanna do my job a little better, reevaluate what I'm doing."

Participants ensure there is clarity to their work, nothing is missed, and diligence is maintained. Better job performance is of the highest importance because top CPS officials and the media may review their work; therefore the work needs to be thorough. The CPS workers job security is maintained through good practice. The internal distress of accountability and decision-making, second-guessing, job security, and practice experienced by the CPS worker has a powerful impact on the external changes within the CPS organization.

External

Monthly Visits, Paperwork/Workload, Non-Traditional Hours

The participants continued to discuss many changes within the organization including new policies. These newer policies added more visitations to see children and new assessment tools. The workers discussed the impact of the policies on existing caseloads and the current non-traditional work hours. To accurately and most effectively describe the participant's experiences the next three sub-categories were integrated. The participants answered the following question, "Do you think there have been changes within DHS since the specific child death you mentioned or when a high profile child death occurs?"

Participant #10 expressed:

> There's going to be constant reform, constant new policies put in place to try to prevent deaths of children and always more paperwork that will need to be completed to try to ensure the safety of a child. So, after a child's death there's always going to be some type of change at DHS. There are quite a few changes; one is that we have to see children monthly. They say children five and under are to be seen monthly, as well as the other children in the home, which is something new because we were only scheduled to see children every three months or every six months. So, we're able to maintain that contact with the family monthly. We have the safety plan and the new safety assessment tool along with the risk assessment. These are tools that I think are trying to keep kids safe but, as we all know, pieces of paper don't keep children safe and out of harm's way. They created absolutely more paperwork that at times I still don't understand. I still

have a difficult time believing that this piece of paper will keep a child safe. However, when completing the safety assessment it does make me look harder at the family to see if I can see what safety or risk factors may be within the family so I can prevent them. Anytime we can implement something that keeps children safe or safer or try to prevent a death, I think that's always a positive. But I don't believe that the higher ups or chain of command realize that these instruments would cause us to be in the family's home longer. These instruments and visits often cause some of my peers to neglect their own children because they are saving the children who have services from DHS. That's one of the chief complaints that I hear is, "We're so busy saving the other children but our children are the ones that are being neglected." Also the pay, unfortunately, is a big issue. We're doing more work now than I can remember doing since coming here twelve years ago, and I'm not being compensated for it which sometimes makes it a little difficult to put that extra effort into or neglect my needs for others when I'm not being properly compensated. The paperwork is always a negative. I know you have to document everything, but it's too much paperwork and too little time for us to complete this paperwork with the time restraints in order to complete the paperwork. It's definitely a negative. The positive is you do get to spend more time with the family to get to know the family especially a newer family. They're always looking for ways to improve what we do. To make sure that the children of the city of Philadelphia are in fact safe.

Changes are implemented to policy after a high profile child death. New changes such as seeing children more often and using a new assessment tool are efforts to keep

children safe. However, the additional paperwork is time consuming. The CPS workers are spending more time in the client's homes in order to complete the safety assessments, but more time in the home to gather information was not considered when the new tool was implemented. The workers are working additional hours to complete paperwork but not being properly compensated for their time. In addition, by spending more time at work, they are neglecting their own children in order to ensure the children on the caseloads are safe. The participant's expressed that there is not enough time to complete the paperwork within the time constraints allotted for policy and within normal business hours.

Participant #8 added more information about non-traditional work hours:

> Well, we went from the quarterly visits to monthly visits. We went to this new structured notes system. I think some of its overkill. I have a problem with the way they have been disbanding work units and forcing people into non-traditional hours and days. You want us to be everything to everybody else's family but then you don't take into consideration what our supports are. You're forcing me to work till 7 o'clock or 8 o'clock at night on a regular shift not just for an emergency or a Saturday or Sunday. Other people who vie out of, carrying caseloads because they were burnt out or getting older or just couldn't do it anymore are now being disciplined for that and forced to carry caseloads. I don't really feel like any of the changes are positive. I feel like some of them can enhance what we've been doing but I don't think they're trying to make the agency better. In their eyes, they're trying to prevent any children from suffering unnecessarily, especially while they're in our care and I can understand that. I

> think the people who are running the agency now are being called "The Firm" because it's all attorneys who never really did this work. I don't know if they really totally understand what we do. Everything is just made policy, and I don't feel like the humanistic side is really there like it used to be. I think it's more like a business.

The participant discussed how workers feel forced to work non-traditional hours due to new work units created and to satisfy new policies for paperwork. The workers feel these policies were implemented but management did not consider that the workers might not have supports for their own families. The participant described workers feeling forced to work non-traditional hours and carry caseloads that are too much for them to handle. Changes are being made to enhance the quality of services but management does not understand how these new conditions are affecting the workers. There is a disconnect between top officials at the CPS organization and the workers. The top officials are viewed as attorneys who do not understand the role the CPS workers, causing the humanistic side of CPS to be more policy driven and creating a more business like atmosphere.

Participant # 1 discussed the changes by adding:

> The tasks of paperwork and how we do things has been affected. We have new forms, which are added to an already cumbersome load. I think there's more checks and balances, before I didn't feel someone was checking behind everything we do. Now we have the quality service review which checks behind what you did but it's added more stress to the job. I often find I can't complete the work in the amount of detail that they want. They want everything, down to

> the emails coming and outgoing, all kinds of stuff they want in the notes. Now I stay late a lot, come in early, and I'm trying to fit my sixteen hours of work into the eight hours they give me. There's more oversight and uniformity. We're doing the forms the same way, but there's so many of us, it's hard to make it uniform. They want quality and quantity but their focus is on numbers and statistics. The focus is on quantity even though they want quality. Since the monthly visitation was issued, I talked to some workers who have fifty to sixty children on their caseload. There are thirty days a month and only twenty working days. So you're trying to fit in seeing fifty or sixty children within twenty working days, not to mention, court and placements and everything else you might have to do. The quality has to be suffering. There is no way you could spend a decent half hour to an hour with each child individually, finding out what's going on with them when you're trying to make that kind of mandate. I think the monthly visitation is negative. Although seeing them more frequently would seem to be a positive thing, it's affecting the quality. I have talked to my coworkers who are having a hard time giving children the time they need. They are physically seeing them but aren't really having a detailed conversation as they would have before because they have to move on to their next visit. I feel this is a negative, but a positive is the added oversight.

Participants interpret the new changes such as added paperwork, as intended to increase the efficiency of services rendered to clients. In an effort to make sure all the paperwork is completed, the workers are staying late, coming in early, and working more

than eight hours a day. Quality service review is checking to ensure the paperwork is completed, but in doing so, added more stress to the CPS workers.

Overall the external changes such as new paperwork, monthly visitations, and quality service review, added more oversight to how the workers are servicing the families. The CPS workers mostly viewed the intent of these changes as positive; however the impact on the quality of service workers are providing is negative. The workers feel overwhelmed with high caseloads and more children to visit. There are only twenty working days in the month; therefore a heavier caseload and other unforeseen circumstances affects the quality time spent with the children. Management emphasizes the importance of quality and quantity, but workers feel more focus is on quantity, while quality suffers. The internal and external expectations of the CPS workers help to explain the circumstances surrounding the workers' turmoil. This next theme will address how the CPS workers feel about the measure of support within the CPS organization.

How Can Training Help Support the CPS Workers?

There were many instances when the participants addressed not feeling supported by the organization after a child death receives media attention. Learning to cope with a child death through training and how to prevent child deaths through CFRTs are two different ways the organization can support CPS workers. However, the participants shared varied experiences of how training can be supportive and how training can help workers feel prepared for unexpected circumstances.

All ten participants explained they were not given training on how to cope with unexpected child deaths but feel this type of training would be beneficial. They agreed that training would not prepare the CPS workers for a child death, but training would help prepare the workers for what to expect, the next steps that should be taken, and how to service grieving families. When asked, "Have you been given any training on how to cope with unexpected child deaths?"

Participant #7's responded:

> No, but I would believe that if they had training it would be beneficial. I think it would be beneficial because we're not really trying to face death, especially a child's death, while we do our work, even though it happens. It would benefit me because it's a little bit harder for me to deal with seeing a child for the first day or first week and then being told the child passed, 'cause usually the children are my first contact. So if I'm talking to these kids and developing a relationship and then all of a sudden I'm getting news that the child passed, I need to know how to deal with that. I also need to know how to deal with showing up on the same day of a child death, the family receiving the news, and there are fifty family members at the house. How can we still complete our investigation and still allow this family to grieve? Whether it was intentional or accidental there is still a grieving process. I'm still completing an investigation, and if there are other children in the home, we still continue to interview these children. The time frame of seeing the family within twenty-four hours or two hours, can it wait a couple a days at least, then go out there and let the family know we are involved and the reason? I know in the beginning for some workers it's very intimidating to go out there and

meet with a family and the family members, and they're just trying to get through that grieving process and here comes DHS. We need to know how to deal with that. We're dealing with the people's anger, their grief, and their loss, even their denial. If the death was caused at someone else's hands I'm pretty sure somebody can't believe that person would ever harm their child, so it's a lot of emotions at the time. I think DHS needs to do an investigation, but with some kind of format to go out there and deal with these families while they are grieving. We're not showing up after the funeral; we're showing up that day or the day after and need to have something in place. I don't think training will help me cope with the child death because you're never going to be prepared or ready when you hear the news that a child died on your caseload. However, grief should be addressed and probably hostility with the family, especially the parents, 'cause we're showing up, and if they've never been involved with DHS and we show up, that's a double whammy. The training should just address a lot of the emotions and how we as workers still need to do our job but show compassion. As far as coping, you develop a relationship with the child along the way; it's like anyone in your family dying, close to you. You're never prepared regardless if that person is sick, you're just never prepared. However, there should be a mandated training that focuses on how you can cope with or how DHS as an organization copes with handling the situation of communicating with the family after a child death. Only because if we have the training, there may not be a panic when it does happen. I think the training would be beneficial for the agency.

There appears to be a need for CPS workers to know what to expect when a family is coping with a child death. The participants discussed showing up at the family's home to complete an investigation while the family was still grieving and how difficult that is. They are met with different ranges of emotions: anger, grief, loss, and denial. Possibly a different approach is needed when addressing families who are grieving. The worker is not only dealing with the family's grief but sometimes a level of hostility towards the CPS worker who is known for investigating child abuse. Participants agree that training in learning to how to cope with an unexpected child death is not needed but how to be better prepared for handling the grieving families of these children is needed. Improving how the organization copes with communicating with these families would be beneficial.

Participant #3 shared specifically how the organization should cope with a high profile child death:

> I can't remember receiving training on how to cope with unexpected child deaths but I think training on this subject is beneficial. If they bring in the caseworkers that experienced a child death, if they are still in the department, it would be even more helpful. They can take you through the process of what did or didn't happen on DHS's part because sometimes you only get one side of the story and it could be jaded or tainted to look pretty or not. Training may not help you cope but maybe mentally prepare yourself. Everyone always says training can only do so much. It's like school can only teach you so much. It's when you're in the field and it actually happens to you that you get the best experience. I think if someone tells you this is going to happen, I can be prepared for the aftermath. So training

> might not help the coping, but it can help me mentally prepare for it. I think if the trainings came around every year, people wouldn't go because no one's going to think a child is going to die on their case that will reflect poorly on them as a social worker. I definitely think when on the job training (OJT) is brought back, they should touch on it, such as, this is what happened, this is what has been done in the past, these are some of the ways you can deal with it or prepare for it. I don't think it should be mandatory but maybe discussed in OJT. I definitely think they should try to bring in caseworkers that were associated with a child death case if they are still here. Pictures are definitely helpful. I saw the autopsy pictures from the starvation case, and they were horrific. I think workers will remember this is why we do what we do, to help kids from becoming a statistic. Bringing in all the old stuff would be helpful because this didn't happen somewhere else, what we're reading about. This happened in our house, and I think it's more effective when it happens in-house. There should be a mandated training that focuses on how DHS as an organization copes with an unexpected child death. I think workers would not go to learn how to cope with the death because I think everyone does it differently, but as an organization, I definitely think there should be something around that.

The participant believes having CPS workers who experienced a high profile child death share their experience with new CPS workers would be helpful. Hearing the CPS worker's point of view of what happened after having a high profile child death might mentally prepare the workers in understanding what happened in the past and what they should learn from it. Showing pictures of children from high profile child death

cases is another way workers can be reminded of why their role is so important. The participants were in agreement that a supportive method by the organization would be training on coping with the families after an unexpected child death. Another method of supporting the CPS workers is the Child Fatality Review Teams. However, the workers described feeling blamed rather than supported by the CFRTs in this next theme.

Child Protective Service Workers Feeling Blamed

The participants had diverse feelings about the Child Fatality Review Teams. Although the CFRTs were designed to prevent child death or serious injury most of the participants do not feel they are effective in child death prevention. However, participants believed the CFRTs were effective in creating new policies and practice, and a lot can be gained from the multiagency collaboration. Four participants felt the CFRTs are effective in implementing trainings and four other participants did not know if CFRTs were effective in implementing trainings. Overall the participants who experienced attending a CFRT meeting or knew other coworkers who attended did not feel supported. The participants shared experiences of feeling blamed or scrutinized.

Participant #2 initially did not know what the CFRT was until the researcher described in detail its role and function. She was not familiar with the CFRT but stated, "I am only aware of them after a child dies. I don't know what they do as far as child death prevention. I'm not aware of anything they support or familiar with their implementing trainings."

This was the last question in the interview. Participant #2 asked the researcher to turn off the recorder. The researcher had no idea what to expect. The participant was visibly

upset. When asked she expressed that she believes high profile child deaths can cause burnout, depression, and PTSD. The participant was overwhelmed at the CPS organization and felt there was no support. She was crying and discussed how hard it had been to be a CPS worker. The researcher asked if she understood the last question and she stated initially she was not familiar with the CFRT but now knew to what the researcher was referring and could add more to her previous answer. The researcher and participant talked for about fifteen minutes off the record. The researcher was surprised by her honesty. However, was glad the participant felt comfortable disclosing her feelings. Before leaving the interview the participant seemed happier, almost appearing relieved. The researcher thought the participants felt they have no outlet to express how they feel. This participant seemed to have gotten something off her chest that had been bothering her, possibly for a while. The researcher believes she is struggling with the pressures of being a CPS worker, wondering how many others feel the same way and what is their outlet?

Participant #2 added, "There is no communication until the review panel (CFRT) meets. You feel like you're being scrutinized. It seems the panel is accusatory. You don't know who the team members are, so we don't feel supported."

Participant # 3's response was filled with details that gave insight into what the CPS workers experience:

> I've been to fatality reviews. I think I've been to three or four recently. They talk about all the positives and the negatives, but again it's very worker specific and I think the workers who do their job, there's not going to be any recommendations other than "you need to do this more or the hospital needs to do this more and the

police need to do this more." To prevent the death in the first place somebody should have just been doing their job. I think they're helpful, and sometimes I think they're not. (Researcher asked, "When you say somebody should have been doing their job, you mean?") Like the worker in that fatality case should have been checking on the child. Fatalities that happen [on a worker's caseload] within the department should be handled differently. There should be more focus on who didn't do what versus let's just fire everybody to make it look good and start from scratch. That is not going to fix the problem of why wasn't this worker doing her job or his job? Were they just lazy? Were they overwhelmed and carrying too many cases and can't effectively do their job? Let's talk about that. So I don't think it addresses the real need. There are some positives that come from the CFRT but not to prevent child deaths from happening again. I believe the CFRT is effective in implementing training because I think people listen to what they have to say. So, if they want training, we'll get it. I absolutely believe CFRTs are effective in creating new policies and practice. In theory, I think everything always starts out with a good intention, but it's the practice piece of it that makes it very frustrating because, again, we're just social workers. We're not magicians. We can't magically make all the parents do all these things, and we have this great caseload. It's just not going to happen. We can't fit every family into this box or fit on this checklist, and they're helpful for a tool or a guideline but policy and planning and the makers of such said policy really, I think, need to hear what the workers go through. I think some of them are so far removed from the field or have never even been in the field. DHS needs to listen to the workers

who are in the field who are saying this is what we are seeing, this is what is happening. This is what we need help with as far as policy changing the way we do our work. I do not believe CFRTs are effective in child death prevention. Death is inevitable. It's going to happen. People are going to abuse their kids, and the best we can do is keep doing our jobs. It's not going to keep somebody from stabbing their child in the middle of the night once we walk out the door. 'Cause when we leave these families, they're going to do what they want. No matter how much training, no matter how much intervention we do, at the end of the day we don't live with these families and we can't make them not harm their children. CFRTs are supportive to a certain extent. I definitely think they acknowledge the goodwe do which feels good to say somebody outside the agency can respect I did a good job, but they also have errors in that they're the end all say all. So, whatever they say goes, and like I said people listen to them. As a social worker, you're at the bottom of the totem pole. So you just do all the grunt work but don't always get acknowledged for it. They'll say you did a good job, meanwhile, if the child died and you should of did this, it's like a catch 22, but I think there are some positive things that come from the CFRT. Well if it's not a worker they're blaming for the death. I've been to reviews for near fatalities where they pretty much blame the worker for it because the worker didn't move the child. In that particular case I felt like they could have been more supportive. I knew she was overworked and overwhelmed with her caseload. They slammed her and blamed her but they also didn't acknowledge she said, "I'm overwhelmed, these are the number of cases I have, this is the chain of events that led me to

> make this decision." They were like that really sucks and still blamed her without saying, "Wow you were doing a lot. We understand why you made this decision. Even though it wasn't the best decision, we can at least relate. You were overworked and your chain of command told you to do this. So okay, we understand why." Put yourself in our shoes for a moment. If we did mess up and we're explaining this why I messed up, I'm saying I did and this is why. They're just like you shouldn't have done that. Well, I'm telling you why. So for me, spending a day in our shoes would be helpful.

The participant felt there are positive and the negative aspects to the CFRTs. They are effective in implementing trainings, policies, and practice because the workers will listen to what they have to say. CFRTs policy recommendations start out with good intentions, but putting them into practice can be difficult. Implementation of new policies can be difficult and increase caseload sizes, making practice ever harder. The participants felt management does not understand what the workers are experiencing. However, the CPS worker's are ultimately responsible for doing their job, and if this does not happen the CFRT should find out why. There should be focus on the "real" needs of the CPS workers. The participant mentioned "We don't live with these families,"; and therefore, we cannot control their behaviors. CFRTs do not prevent child deaths because they are inevitable, but the CPS workers can continue to do their jobs. The workers at some CFRTs plead their cases of being overworked and overwhelmed that led to poor decision-making, but the CFRTs did not sympathize. Workers have felt blamed at CFRTs for the death of a child when actions were not properly taken to ensure child's safety. Feeling unsupported at the CFRTs appears to be common, but the participant

shared that workers were acknowledged to a certain extent when good work was done. This is unusual because being acknowledged for the good they do is not common for CPS workers.

The participant was detailed and knowledgeable about the CFRT's. She had the most experience due to her attendance. Although she had never attended for her own case, she observed enough CFRTs to give valuable insight as to how they made her feel, what the worker experienced, and the impact they have on CPS workers.

Conversely, Participant #10 did not know or was unaware of CFRT effectively implementing trainings or creating new policies and practice but felt the CPS worker was blamed during an attendance of a CFRT meeting. The participant expressed:

> The one that I attended I didn't find it helpful at all. I thought the coroner was about the blame game. He offered no recommendations. It was more or less finger pointing at the one that I attended. (Researcher: Well how do you believe the Fatality Review Team is effective in improving communication between all agencies working with children and families?) That type of meeting allows everyone to know who was involved. Because there are times when families are not forth coming about services that they are receiving. So, that is a time and place where connections can be made. Resources can be gotten or received because all parties involved with that child are sitting in that meeting. So there are definitely connections and resources to be gotten from that type of meeting. So I think that's a positive of the meeting. A negative is there is the finger pointing and blame game. I don't think that needs to be. I don't believe CFRTs are effective in child death prevention. Things just happen. It's different if it's a

> medically fragile child. That's different. In the one meeting I attended, the father murdered the child and they were in two separate households. His father came into the home, they had a fight, and basically strangled the child. I guess CFRTs can be supportive to workers or they need to be supportive to workers and not right away put blame on anyone. CFRTs can try to be a little more sensitive. If mistakes did occur let's see what we can do as a whole to correct those mistakes and not place blame individually.

The participant agreed that the "blame game and finger pointing" at the CPS worker was an unsupportive factor at the CFRT. If mistakes were made how can they be corrected versus blaming the CPS worker. A positive factor was the interagency collaboration. There is communication between all parties involved with the case allowing connections and resources to be shared. Interestingly, again, the participant did not feel CFRT are effective in child death prevention.

Participant #4 experienced a high profile child death; therefore her attendance at the child fatality review was for her own case. Her experience gives understanding into how she felt during and after the meeting and what she feels will be helpful in the future. When asked, "Do you believe the Multidisciplinary Child Fatality Review Team is effective in improving communication between all agencies working with children and families?" her response was:

> (She began laughing) That's a great question. NO! Absolutely not. It was a nightmare. That's what nightmares are made of, that review. They say they are there to review policy and see if we can come up with new policy that would prevent a child death from happening. That's not what it is. When you sit in a

> fatality review, they're picking apart every single step that you have taken in the life of this case. They took apart everything I did. Why didn't you do this? Did you do this? Why didn't you do that? We're going to blame you, so just go ahead and take it. That's what I felt. It puts people on the defensive, and because you have the wound and it's fresh now, you have people pouring salt in it. They're not improving communication because what ended up happening with mine was another organization involved (I'm pointing like this because I can still see them in my head and where everyone was sitting) wanted to pin it back on us and they kept saying, "Well, if DHS did their job." Well, if DHS did their job and I had to say to them, "we did not have contact with the child for a period of time but you did, and you didn't notice the child had injuries. You guys couldn't see that? You guys couldn't do this or that?" So, it's not giving communication. It was back and forth and it's like no, you, you, you. No, you, you, you. Before you get to the review board someone calls you and they say, "Well, we have some concerns with your work, and this is going to be a problem because you didn't do this," and so now your own people in your own agency are looking at you like, see this ledge? We're going to hang you off it, and we're all stepping back. So, you're going to be out there by yourself, Just so you know when you get into this meeting.

The researcher and participant began to laugh. The researcher felt as if they were in sync in understanding accountability.

Participant #4 did not believe CFRTs are effective in implementing trainings or effective in creating new policies and practice. Nor did she believe CFRTs are effective in child death prevention. Participant #4 explained:

> I say that because I think we as social workers try to control a lot of things. We try to control how this child is being parented and we try to control what the family does by making them go to parenting classes and all kinds of stuff. We can't control other peoples' lives and no matter what we do, unless we're going to live with them, we can't control what people do. CFRTs can be supportive by turning the fire down on the grill when you rake us over it. I can't even tell you how it would be supportive. The whole process is just not supportive. The whole process is not supportive at all.

The participant described the process of the CFRT as a nightmare. Again, the CPS worker experienced no support from the CPS organization during the CFRT. Feeling picked apart and blamed the participant stated this could lead to CPS workers becoming defensive. In addition, the usual interagency collaboration turned into finger pointing between agencies. Although the participants do not receive a lot of support during CFRT, they want to share with the public other factors they may not be aware of about CPS workers. The next chapter will help explain.

Due to her insider perspective, the researcher knows the workers have experienced the CFRT process at different times and stages of the process. As the CFRT process evolved from 2006 to 2011, they became less punitive. The participants were interviewed in 2011. The researcher should have asked when the participant or their coworker attended a CFRT because this would make a difference. She does not want to

lead the conversation, but she knows the workers are usually prepped before the case is heard in a CFRT meeting. The researcher thinks workers are sharing experiences of earlier CFRTs because currently, before each CFRT, the worker meets with her supervisor to make ensure the worker is prepared.

What the Public Should Know

Although the participants did not feel supported at times, they want the public to know they are dedicated to keeping children safe. They discussed the morale within the organization and how they are affected emotionally after a high profile child death occurs. Three categories emerged from what the public should know about CPS workers: the profession, morale, and emotional effects.

The Profession

The participants shared personal experiences of what is not known about CPS workers that could change the public's perception. The participants were asked, "What should the public/media know about CPS workers?"

Participant #10 stated:

> We are hard workers, we are committed, and most of us are committed to keeping our children safe. Most of us enjoy the job and are not in this job because of money, because there is no money. There's not enough money in the world to do this job. We are dedicated to our families, we care about our families, and we care about what we do. This is more than just a job.

Participant #1 shared:

> The public thinks this is just a job but it's not just a job. While yes, we get paid for it and yes, it's the way we earn our living, but we do care. You know, there are a lot of things they don't know about. There are a lot of workers who use their own personal money. If a child is being placed and he doesn't have underwear they'll go to Wal-Mart and get the kid underwear. The workers do not always get reimbursed for it. If a teenager is in Supervised Independent Living and trying to apply to colleges, while there's no requirement to make sure they can do so or they have a way to their orientation or tours, I know plenty of workers that have actually taken a child to that college, on a tour, or to the orientation. There are a lot of things that we do that the public does not know about.

The participants shared they are committed to the profession in spite of low paying salaries but still use their own personal money when necessary to assist client without obtaining reimbursement. Again, work hours were discussed.

Participant #6 discussed the nontraditional work hours:

> We work tireless hours to ensure that these children and that our families are safe and receiving all the necessary services. It's not uncommon for our worker to be here at the building at 7:00 a.m. and leave at 9:00 p.m. just trying to do work and do work for their clients.

Participant #3 discussed family and the dangers of the job:

> We miss our own family dinners and school functions. We work overtime to 10, 11, and 12 o'clock at night to save other children. We're not just mooching off the system to get a paycheck. We put our own families on the back burner to do

> this job, and I think just like they have "Parking Wars" TV show, where they follow the people around, they should follow us, because I think there would be a greater appreciation for the threats that we get from the community or situations we're put. Some of us get shot at, not me personally, but one of my co-workers was shot at while she was in the field placing children with the police. Those stories don't make the news and I think if people understand what we go through to ensure the safety there'd be a greater appreciation.

Participants described working long hours as common and missing their own family dinner or their own children's school functions to ensure the children they work with are safe. Meanwhile they often place, themselves in dangerous situations, such as being in or around the crossfire of gunshots, but these stories do not receive media coverage. Participant #5 concurred:

> It's a dangerous job and a dangerous position to be in. CPS social workers or CPS workers in intake do what the police do but without a gun and a badge. I remember learning in OJT that we're not the law, but we are. We represent the Child Protective Services Law, we represent the Adoption and Safe Family Act, and we represent the Juvenile Act. The police represent the Pennsylvania Crime Code. There are certain things we do that they can't. Hence, I can walk in a house because those laws allow me to whereas they would need a warrant. So it's a dangerous job and it's a dangerous position to be in. Often times we go out alone, and even if we went out in pairs, we're not carrying 322's. So because we're social workers, even if we went out in twos, sometimes you have a whole neighborhood or a group of people within three houses on the row home block

> talking a whole bunch of nonsense to you and threatening you. It doesn't matter what time it is, you still make sure the child is safe.

Participant #5 also shared:

> The mayor said that if something happened to his child he'd beat somebody's ass. We all know that he said that and then apologized later. The apology wasn't in the media. The way people responded. The DA is the one who said she wanted to get a response from the public and she got it. I had a client call me and tell me that it's caseworkers like you that make me understand why people follow you home and hang your children up in basements. I know a threat when I hear it.

It was extremely disturbing for the researcher to hear the threats the workers had experienced. She could not help but to recall her own traumatic situations as a worker. The researcher thought about when a police officer told her, "You go into homes I would never enter into without a weapon." The researcher is constantly reminded of how dangerous the job can be and all the workers can rely on is prayer and knowing how to utilize and remember their training and de-escalation skills when necessary.

Participants believed their profession can be similar to the police profession but without a gun and a badge. The CPS workers represent the Child Protective Services Law and the police represent the Pennsylvania Crime Code. Similar to the police, the CPS workers walk into dangerous situations where at times groups of people threaten them, but they have no protection. However, the worker will still ensure the safety of the child. The participants also reported receiving verbal threats not only from the clients, but also from top city officials. The constant threats against workers can cause a change in morale throughout the organization.

Morale

Overwhelmingly the participants discussed the morale within the agency as low. Since the changes within the organization occurred, the participants experienced shifts in the workload, job security, and morale. Their experiences give better understanding to how the workers become stressed.

Participant #5 expressed:

> The morale is very low. It gets lower after a high profile case. I think CPS workers felt the pressure after a child death occurred. I worked in the unit of one of the CPS workers who had been indicted. You were told to go out on the cases that the indicted CPS worker had. Other units of course didn't inherit any cases unless they were in another indicted social worker's unit. They didn't inherit the cases we had to go out on and go to court for and all those things. It's funny because even some of the clients who had my co-worker as their social worker watched the news. They have said some great things that the media will never hear because that was not the aim of the reporter. That's not the aim of the press. They don't want to hear that. It all depends on the angle they're trying to go for. The organization has a morale committee, but I don't think DHS as a whole has responded to workers' morale. We have that booster, that little newsletter that comes out. Maybe the department has in some way boosted the morale by having that newsletter. You learn about various workers; that's a perk because I do read it. I think it's positive. The morale of the workers affects DHS but then DHS affects the morale of the workers.

The morale is lowered when CPS workers see their coworkers been indicted in court. There are relationships developed among staff and between staff and clients. The staff and clients are seeing the media give depictions of workers that seem unfair to their character. The participant appeared frustrated in knowing that although there are different sides to the CPS workers, the public will never know about them and the media is only reporting one angle of the worker. In an effort to boost morale, a morale committee was formed and a newsletter spotlighting CPS workers was created. These morale boosters are needed in an organization where support seems limited.

Participant #3 felt strongly about the morale of the organization. She was openly expressive and laughing as she discussed morale:

> The morale sucks, and there hasn't been a child death recently that I know of. There were changes in morale when they fired workers that a lot of people liked and didn't feel were responsible for the death. It's pretty common knowledge when it sucks around the agency. You can just walk on the floor and feel it's very depressing on the third floor right now. We're getting slammed with emails about this is how we should cope with it, this is what we should do, and come talk to whoever from the bereavement people on the 18th floor. That doesn't solve the morale issue and firing people definitely doesn't make anybody feel any more secure in their job. Sessions are held. Come tell us what your problems are. We tell them, and they're like oh well, you got to work it out, we don't, we can't change it. I feel like they try to help but they're really not because you're asking us for all this input, but not really doing anything with it. You give us the chance to express ourselves but no change comes out of it from our end. It's always what

> management wants to see happen and not the workers' saying this is what we need to do our job better. This is what we need to cope better with our jobs. And they're like okay, thanks for the input, and still do what they had planned to do anyway. The morale of the workers affects DHS. We are overworked, bitter, fearful; workers are not getting quality work done. You're getting people who are just pushing paper to meet your mandate and call it a day, and you lose the quality of work which led to possibly why the child died in the first place, because the worker was overwhelmed just trying to meet the mandate, peeking in on the child without actually doing his or her job, and right now that's where it's at. You know, it's almost three years later and it still has an effect.

Participants described the morale as poor when CPS workers are fired, especially when some of the workers fired were well liked and the workers within the organization did not believe these workers were responsible for a child death. Job security is also a concern, but there is no outlet for the CPS workers to express how they feel. The workers also expressed management isn't taking their concerns seriously, the quality of service is suffering, and three years later after a high profile child death, it still has an effect on the organization.

Participant #6's expressed:

> The morale is very low. You have workers who will up and quit because they feel here's another child death. The media's going to say that DHS is not doing something. Why stay somewhere where you feel like you're not making an impact on the community? The morale changed after the child death I mentioned earlier. It's gotten lower. People are very depressed and it has a lot to do with the

work conditions, but most of it has to do with what happens when these children die on our caseloads. DHS knows about the workers' morale because DHS workers tell supervisors, who tell administrators, who tell directors who then go up the chain. It's not a secret how we feel. There is no difference in workers' morale if the child death becomes a high profile case because the morale right now is low, period, whether it's a high profile or not. It gets worse if it's a high profile child death because it's just a reminder to us and still in our face that DHS is not doing anything and all we're doing is allowing these children to get hurt. I don't think DHS responded to workers' morale. Fellow workers and units have come up with different ways of trying to boost morale. They have these morale committees where we try to do fun activities in the work place. It wasn't something set up by the management. That was something set up by other workers. Workers are there for workers. Management tends to cater to the media more so than the people who are actually doing the work. The morale of the workers affects DHS. Not every worker will still have this determined and dedicated mindset. Some of them are really tired and depressed. I don't want to say that they don't care because I believe that every worker cares. I just feel like all the good stuff that they're doing, if there's not praise, if there's always constant negativity being thrown in their face, "You're not doing this; this is what you're doing wrong," that's not going to help anybody.

Participants mentioned workers who all of a sudden quit the job due to the depressed conditions of the organization after a high profile child death. It is no secret that the morale is already low at the organization before a high profile child death.

However, it lowered after a high profile child death. The workers begin to lean on each other for moral support; however, some are still being affected by the constant criticism. Participant #9 shared a different experience concerning morale:

> I think the morale was pretty good. We know what the work entails and most of the workers are good workers. We feel the child death is unfortunate but you just do your job. It makes everyone evaluate the job they're doing and do the job to the best of their ability. However, workers are calling out and the attendance has changed, but DHS is also trying to keep morale lifted, keeping you encouraged and telling you're doing a good job all that kind of stuff. I guess it helps. Every little bit helps. The morale may be low but you still know you have to see the children. So you still have to do your job. You might not like it, you might not like the changes, but you still have to do your job low morale or not. The job has to be done.

This participant felt the morale was good. CPS workers are continuing to do their jobs, although calling out sick more often and attendance has lowered. The organization is trying to keep morale lifted in spite of the many changes to morale. However the emotional affects are impacting the CPS workers.

Emotional Affects

The participants were emotional as they expressed how they felt when a child dies. Their self-awareness of how it impacts them emotionally led to better understanding of why the CPS workers may experience burnout or depression, or suffer

from PTSD. The experiences are diverse but capture the shared distress of the CPS workers. Participant #6 shared:

> I would say that when we hear of child deaths, whether it's on our caseload or not, it always, it always bothers us. As workers we try to be in the homes and try to ensure the safety of the children, but it's hard when basically we realize the moment we walk out the door anything can happen. I'm emotionally affected. I don't know if it's because I have a child at home myself and I just think if that was him, but it's always hard just to know that it's an innocent person. It's an innocent child whose death several times, many times could've been avoided.

The participants shared how the CPS workers are emotionally affected by child deaths. It's frustrating knowing that when the workers walk out of the homes they have no control over what could possibly happen to an innocent child. Having a child of their own personalizes the experience of a child death.

Participant #3 felt the same emotions about her own children as well. She explained:

> I'm emotionally affected by the death of a child. My feelings have definitely changed since I've had my own children. I have a one year old so when things hit the media about a child who is that defenseless, it makes me sick to my stomach that someone could do something to a child that horrific, and just let them die as in the starvation case. You have to be a certain type of person to allow someone you supposedly love and gave birth to wither away. So for me as a parent, taking off my DHS hat, I can't even fathom letting my child cry for an hour, much less let her starve to death. So for me it affects me more personally. How could a

> parent do that versus, you know, this child needs to be rescued? It hits closer to home now that I have a child.

Participants shared that having children of their own makes hearing about the death of defenseless children unbearable. The CPS workers realize the importance of parenting and how valuable a child life is, and how children should never suffer at the hands of their parent.

Participant #1 shared similar feelings by saying:

> It's tragic and just imagining the child went through that. It takes a toll and they're children. They're vulnerable. I became saddened; my whole moral view of the City of Philadelphia became general, the way that parents parent their children. And for a little while after the child death case, it was hard to just look at regular kids on the street playing without thinking, are their parents doing what they're supposed to? Are they going to wind up dead? Even just watching commercials where there are happy babies and happy kids, I started to feel like its just false advertisement. I don't come across a lot of happy people, happy families in this work, and particularly after a high profile death. It kind of leads me down this morose thinking and view of our clients and families.

The participant changed the way she perceives the families due to not seeing many families that are intact. The worker is beginning to question the authenticity of all families, succumbing to a depressed way of thinking. The participants continued with many different experiences and ranges of emotions. However, Participant #2 expressed how she was physically affected by stating:

> The death of a child drains you. You're affected emotionally and physically, especially if you have high blood pressure. Your blood pressure will be raised, and if you have family at home, you tend to maybe isolate or withdraw. You rather not be open to talk to them because its confidential information and you're not able to share. The fact that you can't really share information can be penalizing. It causes additional stress. When the child death is high profile, it changes the way you are affected for a period of time. It makes you feel like you're in a bubble; everybody's watching you and paying attention to what you're doing. It makes you feel vulnerable to make an error because you're very tense and you're not thinking clearly. You're more on edge all the time.

Participants openly shared how a high profile child death affects them and the impact it has emotionally and physically, sharing a wide range of experiences. The death drains the worker and can cause stress and unhealthy high blood pressure for some CPS workers. Workers described symptoms of depression, burnout, and PTSD when describing their experiences. The participants wanted the public to know what they experience in the CPS profession, how it affects the morale in the organization, and emotional affects on the CPS workers.

CHAPTER 7: DISCUSSION

Ten CPS workers participated in a qualitative study, employing interpretative phenomenological analysis, utilizing in-depth interviews to achieve a better understanding of how a high profile child death impacts child protective service workers. The integration of the purpose of the study as it relates to the themes that emerged from the data confirms the experiences of CPS workers to be a direct result of a particular high profile child death.

While conducting the in-depth interviews, seven themes emerged and specific categories from these themes developed. The seven themes revealed a high profile child death is a highly salient event in the worklife of a CPS worker; the public and media perception are highly negative and erodes the professional confidence of CPS workers. When the workers feel unsupported by management and criticized for not meeting the expectations of the job, the morale of the organization and how the workers cope are affected.

The participants expressed challenges throughout the study concerning their feelings, experiences, and what has transpired at the CPS organization in recent years. While the researcher acknowledges the participant's feelings of being overworked, overwhelmed, and underappreciated, the researcher also noticed a tone throughout the interviews. Some of the participant's comments could be characterized as complaining. The feelings, emotions, and comments expressed by the CPS workers reflect their individual experiences. A number of these experiences can be explored through further research and some comments appear to be out of stress and frustration. It is important for the researcher to note that statements made by participants are subjective and may not

necessarily reflect the policies or protocols of the CPS organization. However, to achieve a better understanding of how a high profile child death impacts child protective service workers, returning to the original purpose, provides a framework for the study. The purpose focused on four specific areas throughout that the themes will be interwoven throughout to summarize the study.

Discussion of Themes

Child Protective Service Workers' Retrospective Views and Current Perspectives on Their Experiences (Themes 1 and 2)

In 1874 as a result of the Mary Ellen Wilson case, New York passed the Protective Services Act and the Cruelty to Children Act. This case received widespread attention and concerned citizens became aware of the abusive circumstances of a single child (Hughes & Rycus, 1998). The Mary Ellen case received detailed and continuous coverage in the New York daily papers (Gelles, 1996) similar to the Danieal Kelley child death in 2006. Danieal Kelly died as a result of neglect, receiving great attention and resulting in the current changes to policy and practice at Philadelphia's CPS organization.

The CPS workers in this study discussed the changes that occurred after the particular high profile child death and how it affected their practice. There are now differences in describing life before and after the child's death. The saliency of the Kelly case continues to impact the CPS workers five years later. The public outrage caused criticism against the CPS organization which resulted in removal of CPS staff and top management leaders in 2006. In fact, in 2008 a grand jury report was released which highlighted the details of the case. The reaction from the media and public was intensified. Munro (1996) explained that when CPS workers are involved in well-

publicized cases where children endure terrible abuse before being killed, public outrage usually ensues. The public outrage after the high profile child death fuelled the perception that the CPS workers had done something wrong or they were incompetent because they should have been able to protect this child from abuse (Munro, 1996). However, in the Kelly case, something was done wrong, avoidable mistakes were made and the CPS workers felt quickly castigated by the media.

Participants reported the media coverage was negatively imbalanced, grossly misrepresenting the dimensions of the problems CPS workers are facing (Spector & Kitsuse, 1994). The CPS workers shared that the scrutiny of being perceived as incompetent is stressful. The workers feel as though their roles are difficult enough without being criticized by the public or media. The media's influence has caused the public not to trust CPS workers. The research shows that in both the United States and the United Kingdom stories of child welfare were found to be more negative than those of any other area of social work practice (Reid & Misener, 2001).

When meeting with clients, the CPS workers were questioned more than usual because clients were questioning the CPS workers' ability to perform their job. The CPS workers discussed the pressure of defending their role when meeting clients and other professionals. It was especially difficult for workers when picketers outside their CPS workplace and the public viewed them as "baby killers." Working for an organization where public opinion is very low and strongly influenced by the media became increasingly more difficult. This study demonstrates LeCroy and Stinson's (2004) findings, that when the public's approval of CPS professions wanes, recruitment in the profession suffers as does the professional credibility of CPS works in both the public eye

and in the eyes of other professionals.

Within the contemporary world of CPS workers, the idea of being thrust into the media as the worker involved in a child death can result in worry and distress over the public criticism. Taylor (2008) suggests that when the death of a child hits the headlines, CPS workers everywhere may feel a collective shiver down their spines. The CPS workers agreed that upon hearing a child death case is in the media, there is an immediate reaction of fear. The idea that the case could belong to the CPS workers and the worry that their name could appear in the newspaper or media evokes fear. The workers also felt that when they see media coverage of CPS cases they are unable to express how they feel due to the "confidentiality" of the case. Therefore, the story given to the media could possibly be false or incorrect information could be given. However, the story is printed or released. Misleading or incorrect information led CPS workers to feel as if the media is only concerned with selling a story and not concerned with the repercussions the workers may face as a result.

It is important for the researcher to note that under the policies of the CPS organization, all information gathered by the CYD in the course of an investigation or assessment for service and subsequent provision of services is "confidential." The employees of CYD which include the ten participants are prohibited from disclosing information concerning the families known to the CYD organization unless it is within the course of performing their duties. Some participants explained the frustration they feel when the public does not know the details of the CPS cases and make negative assumptions based on what the participants perceive as imbalanced media attention.

The CPS workers receive threats from the public or families they service because

the participants feel the public only hears of the negative stories about CPS workers, due to the imbalance within the media reporting. Regehr et, al.'s (2002) study identified that the media could be used as a means of educating the public. The study also noted that no matter how much time is invested in placing a positive perspective on the work and taking reporters along on the job, as soon as a problem arises, all the good will is abandoned (2002). However, some CPS workers viewed the particular high profile child death that occurred as an opportunity to educate the public. The CPS workers explained that clients are asking more questions as a result of the high profile child death; therefore, the opportunity to explain to the public the role of CPS workers is more present. Public opinion matters, and workers felt by educating the public of the more positive roles CPS workers perform could possibly change the negative perception of CPS workers.

Although the impact of being castigated by the media and receiving negative attention from the public was stressful for the CPS workers, much of the info reported by the media was factual and justifiably released to inform the public of problems within the practice of child protective services. However, when CPS workers cannot respond to the media or share how they feel and there are no positive reports about CPS, an imbalance is created. The workers feel the public has formed a negative opinion about the CPS organization and it workers.

The Impact that Experiencing a High Profile Child Death Had on the Child Protective Service Worker (Theme 4)

The CPS workers shared their experiences after a particular high profile child death occurred and the negative public and media attention CPS received. Markedly, life at the CPS organization changed. Bloom and Vargas (2007) emphasize when CPS

organizations experience a crisis, it is likely to be overwhelming, not just for the individual CPS workers involved, but also for the overall organizational function. As the demands of the organization increased, the workers' feelings of turmoil and distress also increased. One participant described the CPS organization as "very chaotic and when a child dies, it institutes a flurry of activity." In agreement with Bloom and Vargas (2007), the workers explained that in the midst of the crisis, the daily operations or activities they were used to doing and were comfortable doing no longer worked. The stage was now set for the possibility of disaster or new learning or both.

The CPS workers discussed the internal expectations they have placed upon themselves as well as the external expectations of the organization. Although the workers did not express that their experiences were disastrous, they did feel the outcome of going through a crisis was overwhelming and stressful and possibly hurtful to their clients. However, the stage was set for new learning. Workers began to practice differently, becoming more rigorous in their approach to daily activities as a CPS worker. Regehr et al., (2004) also discussed in their research that as levels of distress increased, levels of reported positive change also increased. This suggested that stress and trauma could be galvanizing for workers (Jones, 1993; Regehr et al., 2004). The pressure to make the right decisions was heightened.

The CPS workers were learning from the past mistakes of other workers. More emphasis was placed on being more responsible for their actions and decisions when determining the safety of a child. As one participant stated, "With responsibility comes accountability." Being able to understand the CPS workers' contextual experiences of accountability is an important precursor to understanding why they feel pressure to make

the right decisions without errors, second guessing has increased, and job security is an added stress. Management within the CPS organization began to accentuate the importance of accountability. Workers described feelings more cognizant of their actions when making decisions, but there was no room for human error. The study connects with Munro (1996) and Vincent (1999), who explained that CPS workers aim to reach decisions without error, but some environments, such as CPS, are less forgiving of error than others, especially if the mistakes are seen as avoidable. The workers felt the pressure to make the right decisions. The fear of making mistakes lead to second guessing.

The workers who actually experienced a child death on their caseload were able to discuss the intensity of second guessing. The emotional trauma experienced by participants after finding out a child, whom they initially deemed as safe, died was devastating. They began to question their decision making. In hindsight, they worried whether they had done everything they were supposed to do in making an accurate assessment of the child's safety. As a CPS worker the ability to make reasonable decisions is an essential function in their role as CPS workers. Therefore, if the workers begin to doubt their ability to make decisions, that lack of confidence leads to second guessing. The worker's need for support after experiencing a child death becomes crucial. Support from the supervisor, whose role is to help guide decisions, becomes critical. Although the workers used their professional judgment to make correct predictions, children still died in situations that were difficult for them to see in advance (Connolly, 2008).

Another added stressor of the CPS workers was the fear of losing their job due to avoidable mistakes. Although the CPS workers aim to protect all children, it is inevitable that mistakes are made. But when the errors seem avoidable, and a child dies as a result, the public has a hard time accepting the excuses from the CPS workers. The CPS workers at this organization witnessed a domino effect of resignations and firings after a well-publicized child death occurred. Due to the avoidable mistakes made by CPS workers assigned to the child's case, the workers were held accountable for not preventing a child death. Policy and practice changed as a result, and further resignations and firings resulted. As one participant explained, this created a "culture of paranoia" because workers feel job security is now threatened. The CPS workers felt they could be fired with little support from their union.

The participants continued to reveal how life at the CPS organization was impacted after a specific child death. The external expectations of the organization included new policies, which added more visitations to see children, new assessment tools, and increase non-traditional work hours. The reform of the organization increased visitations to see children and paperwork in hopes of preventing the next child death. Workers who normally assessed children every three or six months were now seeing them monthly. For workers who had higher caseloads, seeing children monthly became difficult because with twenty working days in the month and newer assessment tools the quality of work was suffering. The new assessment tools were time consuming. The workers needed additional hours to complete the paperwork and one worker commented that time was taken away from her own family to ensure the work was completed. Workers complained of having to work non-traditional hours, over eight hours and

weekends, on a regular basis. Feelings of burnout were expressed. Research has suggested that powerlessness or lack of control has been related to burnout in child welfare workers (Guterman & Jayaratne, 1994; Regehr et al., 2004). The CPS workers felt forced into working longer hours in order to ensure the safety of children. The lack of control felt throughout the organization added more stress to the workers. While child safety is important, the workers reported management at the organization was emphasizing the importance of quality and quantity but the focus is on quantity while quality suffers. Seeing the clients more often was not conducive to the quality of work required to ensure safety.

How Child Protective Service Workers Experienced Morale Shifts After a High Profile Child Death Occurs (Themes 3 and 7)

The CPS workers discussed the circumstances surrounding their crisis and how it affected the morale of the organization. The crisis of a specific child death was the catalyst for leaders within the organization to begin making changes that were intended to prevent another child death and improve safety for children the CPS organization serviced. However, management reactions were interpreted by the workers as unsupportive and punitive, thereby affecting the morale of the organization. Workers discussed management at different levels and timeframes. Trust issues between workers and their immediate supervisors were raised. Top management leaders were viewed as unsupportive and bearing a weak connection to the CPS workers. The research has demonstrated that organizations under stress may engage in a problematic emotional management process that interferes with the exercise of good cognitive skills, such as making organizational changes driven by concerns to improve the quality of services

without involving consultation with those who actually attempted to provide the services (Bloom, 2007; Jones, 2001). This study offers good examples of why CPS workers need to feel supported by management and have open communication with top leaders within the organization. By doing so the workers will feel more appreciated, encouraging improvement of morale.

Taylor (2008) suggested that the demands of CPS organization can cause stress, but if the CPS workers feel supported by management, morale will remain intact. However, in the particular case being discussed, as the dimension of the work became more difficult, the participants felt management did not understand what they were experiencing. The participants also felt the public was unaware of how the impact of a high profile death affected the morale of the CPS workers. The morale of the organization was low. Regehr et al. (2002) study, explored how the public inquiries of a child death take on the tone of moral righteousness thereby adding to the morale shifts of a stressful environment to a more anxious atmosphere. Another cause for morale shifts within the CPS organization was the critical nature of these inquiries and the manner in which the CPS worker's personal and professional integrity was called into question (2002).

When talking about profession, the CPS workers in this study highlighted various experiences of positive work and situations that demonstrated their commitment and dedication to the work they do. Participants want the public to know CPS workers are committed to keeping children safe, that this is more than just a job because their salaries are low, but they care enough to stay. Participants use their own personal money to assist clients without requesting reimbursement. The workers mentioned the dangers of the job.

While working long hours, workers are being caught in or around gunfire, threatened by clients, and disturbingly berated by a top city official. However, they feel that these stories rarely, if ever, are reported to or by the media. The workers' experiences echo Regehr et al., (2002) study demonstrating child protection workers are rarely acknowledged for the positive work that they do. This study mentions the dangers as well as the positive work. CPS workers expressed a few stories involving dangerous situations that give meaning to the commitment the workers have and how these situations also caused a shift in lowering the morale.

Morale was described as depressingly low after a specific high profile child death occurred. Workers would suddenly quit the job because the morose impact of low morale at the organization. The impact of a child death also affected the CPS workers emotionally. Coupled with the low morale, one participant stated more workers are calling out and attendance is low. Jones (2001) provides important context to the existing study by describing how workers going out sick for some time each week or month seemed routinized in many organizations and is an example of stress survival. Regehr et al. (2004), Hemsworth, Leslie, Howe and Chau (2004) define burnout as a state of physical, emotional, and mental exhaustion caused by exposure to chronic stress in the workplace. From their depictions, implications for burnout emerged. The CPS workers described the nature of their social services world as increasingly stressful and depressed. After the organizational changes and media attention, a shift in morale followed, impacting the workers emotionally. The workers also shared how difficult it was knowing an innocent child died. Some workers thought of their own children and the

defenseless nature of a child. The tragedy of a child death was unbearable, draining the workers emotionally and physically.

The Effects of Child Fatality Review Teams and Training (Themes 5 and 6)

To relieve the emotional effects of a child death, it was important for the CPS organization to create coping and preventative child death measures to help support the workers. The workers discussed feeling unprepared to cope with unexpected child deaths. Although they do not expect children to die, it is sometimes their reality and they do not receive training to help cope. Garstang and Sidebotham (2008) study emphasizes that the sudden unexpected child death can cause considerable distress, leaving the CPS worker unable to cope with increasing work demands as a result of the death. The workers recognized training was needed. One participant expressed that seeing pictures from a high profile child death case was helpful in reminding the worker of the seriousness of their role as a CPS worker.

In addition, the families have suffered a loss and are still going through a grieving process when the CPS worker shows up at the home to complete an investigation. The CPS workers feel the CPS organization could improve the process of these investigations. The workers believed training in addressing how to interact with these grieving families would be beneficial. The training should highlight how to remain compassionate but still complete a thorough investigation. The study presented here is able to complement the work of Garstang and Sidebotham (2008) by giving understanding to how CPS workers feel when a child death occurs and there is no training on how to cope with investigating the family of the child who died. Their research highlighted the need for developing a

training course in which one of the objectives is to recognize the training and welfare needs of the professionals involved in responding to childhood deaths, which includes CPS workers. This study as well as others in the field have concurred that training is an important component for maintaining staff capability and morale.

To further help improve outcomes for CPS workers Child Fatality Review Teams within this CPS organization began reforms to prevent future child deaths by implementing Act 33. This Act amended the Child Protective Services Law and set standards for reviewing child fatalities and near fatalities that are suspected to have occurred due to child abuse and/or neglect. Through Act 33 the CFRTs established an interdisciplinary review team to review child deaths allegedly caused by abuse, reviewed the circumstances of the child death and the services provided to the family, make reports available from the CFRTs to the public in redacted format, and give a written report to the top management official at the organization who would then forward this report to the Mayor and Department of Public Welfare with recommendations for improvement in services to the families and preventative efforts. Although the CFRTs were implemented to improve outcomes for CPS workers, the workers had diverse feelings. The workers shared experiences of feeling blamed and scrutinized while attending CFRTs. The workers did not feel the CFRTs were helpful in child death prevention, however believed they were effective in creating new policies and practice and found the multiagency collaboration to be helpful. The CPS workers' experiences provided important context to how the workers feel about the CFRTs as opposed to why they were created. As Gelles (2000) points out, often the child welfare profession embraces techniques such CFRTs without adequate review of practice.

The CFRTs were viewed as accusatory and feelings of being unsupported at the CFRTs appear to be common. One worker expressed that while attending a CFRT for another worker who was "slammed," the worker received no support. Admittedly, the worker acknowledged feeling overwhelmed, had a high caseload, and made errors in decision making. However, there was no empathy because the expectation is the worker will ensure the child's safety. Douglas and Cunningham's (2008) study examined the breakdowns in the social welfare system. They documented aspects of service delivery that potentially failed and may have contributed to the death of a child. The study made recommendations to improve service delivery; however, the study as well as others does not fully address the needs of the CPS workers who feel the CFRT process is added stress.

One CPS worker described the impact of the reformed CFRTs as a nightmare. The worker said her case was picked apart and she felt blamed. The usual interagency collaboration turned into "finger pointing." Therefore, during the CFRT she felt she had to defend herself and there was no support from CPS organization. Durfee et al.'s (2002) study discussed how most CFRTs noted a primary mission to prevent child death or serious injury, but there is not enough collaboration within the agencies that are impacted by child deaths. It appears that the collaboration between the CPS workers and other agencies require changes to improve service delivery. The analysis of risk factors that exist within the family may need more attention from the agencies working with the families. However, there appears to be difficulty sharing information between some agencies leading to mismanaged cases and an increase risk to children. This study describes the prevention efforts made to ensure the safety of children in order to prevent

future child deaths: however, the research was sparse in examining the impact of the CFRTs on the CPS workers when "blaming" or "finger pointing" becomes a factor.

Findings Differing from the Literature

The literature provided little evidence that CFRTs caused additional distress to CPS workers or other child welfare professionals. The participants of this study, however, believed that while CFRTs were effective in creating new policies and practice and multiagency collaboration was helpful, the overall stress of attending the CFRT overshadowed the prevention efforts. The literature on CFRTs focused on the mission of the CFRT, the individual case management, and improving the intra- and inters-departmental teamwork (Durfee et al., 2002). However, the literature did not detail how the CFRTs made workers feel during a teaming.

The CPS workers admitted mistakes may occur while servicing children and families; however, the workers want the organization to be more understanding during teaming as to why these mistakes occurred and how these mistakes could be corrected, and to not place blame individually on the CPS workers. Workers discussed the devastating loss of a child on their caseload and how it affects them emotionally. In addition to that loss, the worker must continue to complete paperwork for the case and prepare for the CFRT. Therefore, after coping with a loss and then attending a teaming in which the worker felt blamed for the death of the child or for not noticing risk factors, the teaming was viewed by participants in this study to be traumatizing.

The workers' need for support from the CPS organization was expressed. One could speculate that the workers feel overwhelmed after the CFRT process and may need

supportive services such as counseling or time off work after the teaming. The CPS workers indicated high levels of stress while participating in the CFRT process. There is limited information present in the literature about the effects of CFRTs. Understanding the perceived emotional effects of CFRTs on CPS workers is potentially a new finding for future research.

Researcher's Unexpected Discoveries

During the course of this research familiar responses from the participants were expected. Stress, burnout, morale, etc. were familiar topics written about by other researchers; therefore, the researcher's presuppositions were supported. However, through discussion with one committee member with expertise in CPS, it was pointed out that the participants shared information that is not commonly known, such as: CPS workers are conducting investigations while families are grieving, and the families grieve even if they share some level of culpability in a child's death; CPS workers neglect their own children while ensuring the safety of their clients; and CPS workers are often faced with dangerous situations which may be amplified when a high profile child's death is highlighted by the media, as emotions from the public are high. This information is discussed in the following section.

Grieving Families

As a CPS worker herself, the researcher was aware of the families' grief after the death of a child and the immediate CPS involvement following that death. Generally, the CPS workers contact the family immediately after a report of a child death. The worker

will verbally offer the family condolences but must also explain that the purpose of their visit is to complete an assessment or investigation. Although the intention of the CPS worker is to be the least intrusive as possible while conducting the assessment/investigation, the family may not understand the reasoning for the workers' presence at such a sensitive time. The family is grieving and may have preconceived perceptions about CPS which may hinder their cooperation.

Furthermore, due to the timeframe, the CPS worker may feel uncomfortable as well, trying to conduct an investigation when the family has just suffered a loss. Although a thorough investigation is pertinent to ensuring there were no child abuse issues and no other children in the home are at risk, the timing of the investigation is difficult due to the family's recent loss. The CPS worker will need to complete the investigation immediately to gather initial statements and possible evidence of any sort of abuse. Although this may be a sensitive time for the family, it appears the CPS worker may benefit from training to understand why the investigation must be completed immediately and how to cope with families immediately following the death of a child. As an insider, the researcher believes in addition to the routine investigation letter that is given to the family, which explains the purpose of the workers' visit to the home, the letter should include an expression of condolence from the CPS organization. This could possibly allow the family to feel more at ease or open to discussing the nature of the child's death. Presenting the family with a letter that expresses condolences may also lessen the anxiety for the CPS worker as well. One CPS worker described how unsettling it can be for a family to receive a visit from CPS during their initial grief, especially if there had been an accidental death. The confusion of receiving a letter that states the purpose of the visit is

to assess allegations of possible abuse, and the family's possible negative perception of the CPS worker may hinder the initial contact between the worker and the family. The family is in a heightened stage of sensitivity even if they are culpable in the child's death. It is beneficial for the CPS worker to enter the home with a supportive letter that provides condolence as well as the purpose of the visit.

Neglect of CPS Workers' Own Children

Next, the expert and the researcher discussed the unexpected discovery of CPS workers who are faced with the neglect of their own children while ensuring the safety of the clients they service. Although as an insider the researcher was aware of this problem, she did not expect it to surface during the research. To give an example of this problem: workers are completing investigations until 9:00 p.m. due to the increased amount of time the worker spends in the client's home gathering information for the paperwork and new assessment tools. If the worker has children, returning home at night leaves the worker little time to spend with his or her own children. Therefore, balancing work and family life can be difficult. It is unknown if the workers have a strong support system at home, but choosing work over their own children appears to be a stressor for some CPS workers. The importance of family development is emphasized to the clients the worker services, but it appears the same concerns are not being recognized for the CPS worker's family. While understandably ensuring the safety of children is first priority for these CPS workers, the fear of failing to meet these expectations becomes overwhelming. They are unintentionally neglecting their own families in order to meet the mandates of the job. Given the fact that spending more time with the families serviced to gather

detailed information is part of completing the new assessment tools and for some workers a different approach in practice, the workers are challenged with time constraints. The ongoing challenge for CPS workers is how to meet the expectations and new mandates in a qualitative but time effective way. I also question if the workers' fear of making mistakes that lead to a child being unsafe or the "paranoia" of being fired causes workers to work non-traditional hours instead of going home. It is possible the workers' own fear of making a mistake does not match the reality of what will actually happen if the paperwork is not completed. The fear of being fired may be a part of the "culture of paranoia." It has been the researcher's experience as a worker within the organization that it is very difficult to be fired. As an insider, the researcher suggests CPS workers take a look at their own work habits and how they can create more conducive ways to minimize the time spent at work. This would increase the time spent with their own children which helps to ensure their families' well-being and development.

Facing Dangerous Situations

Another discovery was the dangers within the CPS profession. The participants shared that since the Danieal Kelly case, accounts of threats being made against them or even their children heightened. To hear that CPS workers' lives have been threatened through gun fire was unnerving. The participants regard themselves as dedicated to saving the lives of children but expressed their own lives or the lives of their coworkers have been put in danger. Self-protection was not mentioned by the CPS workers. As an insider, the researcher knows self-protection and de-escalation skills are emphasized in OJT but it is unclear if the CPS workers are consistently assuring their own safety when

meeting with families. These skills are especially important during the height of a high profile child death when the workers' fears escalate due to public response. The participants mentioned the threats from the public as well as high ranking public officials. Emotions of the CPS professionals as well as the public perception of CPS workers appeared to amplify during this time. Although dangers of the profession are common knowledge among the CPS workers within this study, the participants feel they are unknown to the public.

Introspectively, the researcher realized some CPS workers are possibly working in fear and out of fear due to the unknown situations into which they may walk and the pressures of keeping children safe through new policies and practices. The participants describe the public as unaware of their fears on the job and feeling unappreciated by the public. This points out a possible huge difference in the CPS workers' perception of themselves versus how they believe the public perceives them. Consequently, if the CPS workers feel overwhelmed with little support from management, morale is low and they feel the public does not appreciate them, these are possible job deterrents. Some workers could feel a lack of motivation or desire to remain a CPS worker, leading to a high turnover rate. As an insider, the researcher questions if the participants need to feel the public's approval and given more support systems within the CPS organization. More support could reduce stress and create a more positive work environment with fewer turnovers.

Implications

Implications for Public Image Management

Research elsewhere has shown that criticism and misrepresentation of social services demoralizes social workers (Franklin, 1998). The CPS workers of this study felt that the perception of CPS workers had been hurt by overly-negative, biased and unfair media reports. Although child death stories must be covered, it was perceived that the media did not balance negative aspects of CPS work with their positive contributions and efforts to ensure child safety.

Public image initiatives could be taken to educate the public through articles in the newspaper to highlight CPS workers and how they collaborate to improve child safety. Public service announcements and TV commercials have the potential to construct a new perception of CPS workers. This in turn might establish a new public image for CPS workers, possibly decreasing the pressure of defending their role when meeting clients and other professionals, decreasing threats received from the public or families they service, possibly boosting morale and improving interpersonal interactions. Reconstructing the image of CPS workers not only could promote a more positive perception of CPS workers to the public and shift the morale of the workers, it might also aid in attracting high potential workers to the field.

Implications for Training

Another supportive method to help CPS workers is training in the management of an unexpected death. CPS workers are at risk of suffering emotionally from the death of a child; however, interacting with the grieving family can also be difficult. It would be

helpful for workers to learn how to remain compassionate, while talking to the family in a way that does not present as accusatory but still complete a thorough investigation. The results of this study demonstrate the need for developing a training course for CPS workers who may potentially experience child deaths. The training must include objectives to recognize the training and welfare needs of the CPS workers involved in responding to childhood deaths. It would be helpful to workers if the training also included a self-protection component that reemphasizes what the workers learned in OJT concerning de-escalation skills. The self-protection component may teach what the workers what should be done in dangerous situations while visiting a family. Again this study as well as others in the field have concurred that training is an important component for maintaining staff capability and morale but the study also recognizes worker safety needs as well.

The results of this study also indicate CPS workers feel distress during and after the CFRT process. In the CFRTs effort to prevent future child deaths, the task of teaming a child death case with multiagency collaboration has at times become a "nightmare" for CPS workers. CPS has been accused of not maintaining the safety of children thus becoming the "blame" for the child death. "Finger pointing" during the CFRTs have caused workers to feel overwhelmed. CPS workers are leaving the teaming needing time to recuperate from the experience. Some CPS workers have attended CFRT without any support from the CPS organization, which was an unexpected result of the study.

The results of this study offer preliminary data on the emotional impact of CFRTs on CPS workers. Findings suggest that significant emotions can be generated during the CFRT process. The implications are that more collaboration between the CPS workers

and other agencies may be needed to improve service delivery and eliminate risk to children. Currently CFRTs ensure the safety of children in order to prevent future child deaths, however, this study implies there is an emotional impact on CPS workers when "blaming" or "finger pointing" is practiced or implied. A pressing need exists for the CPS organization to prepare the workers for the CFRT process. By offering the option of meeting with a trained professional in the CFRT process that will help the worker prepare and offering time off immediately following the CFRT may decrease the emotional impact of the CFRT. Another option for CPS workers would be training on depersonalization. Professional learning for workers to understand the CFRT process is not personal but a way to increase continuous quality improvement. The practiced or implied blaming or finger pointing can be apart the CFRTs efforts to pinpoint avoidable mistakes which are interpreted by the CPS workers as a personal attack. Providing supportive efforts will allow CPS workers to process how they are feeling, positively affecting their emotional well-being.

Implications for Organizational Change

The morale of the workers, according to their input, significantly lowered after the high profile child death was reported in the media. The results of this study indicate that agency management reacted to the child death by implementing new policies and practice. However, the new demands of the job were draining for the CPS workers. The study suggests the CPS workers were functioning in an environment where stress levels were already high, but the new demands increased stress. Trust issues and lack of communication with management added more stress. Workers felt unsupported and the

reactions of management were viewed as punitive rather than ameliorative. The organizational changes, management reaction, and media attention caused morale to lower, impacting the workers emotionally.

Taken together, these results suggest that to help CPS workers cope with the emotional effects they experience from a high profile child death, providing worksite counseling or peer support groups may be beneficial. Bloom & Vargas (2007) propose worksite counseling or peer support groups provide an outlet for workers to engage in individual or group discussion about organizational changes or exchange information about how they feel. The creation of a supportive work environment through worksite counseling or peer support groups could allow a safe place for the CPS worker to release emotions, feelings of burnout, which could help minimize the symptoms they experience. Workers might have a safe place to discuss the morale of the agency, how it makes them feel, and how to balance work and family life. Workers will also have a place to discuss strategies for self-protection skills to provide for their own safety while visiting families. Having worksite counseling or peer support groups in place will provide support and might also reduce the likelihood of burnout symptoms and improve morale and safety for the workers. Outcome studies on the actual benefits of such groups are needed.

Implications for Social Service Practice

This study captured that within the CPS world two types of stress emerged: unproductive stress and productive stress. The unproductive stress caused feelings of burnout, emotional exhaustion, and diminished morale which affected social work practice. Distressed CPS workers increase the risk of mismanaged cases and increase

risk to children. The evidence from this study suggests that CPS workers are experiencing turmoil in their effort to meet the internal and external expectations they have placed upon themselves as well as the expectations of the organization. The workers struggle with the internal expectations of accountability and decision making, second guessing, job security, and practice. The fear of making mistakes causes increased stressed among the workers. Workers begin to question their decisions; they worry about making mistakes that can cause job loss; however, with all the new expectations, additional stress, not less was experienced by CPS workers. There are challenging external expectations as well: monthly visits and paperwork/workload and non-traditional hours. The expectations of how CPS workers practice became more demanding. More time was needed than given, to successfully ensure the safety of children, and the workers interviewed here felt forced to work longer hours.

The CPS workers gave various descriptions of life after a high profile child death, but how some workers responded to stress productively with improved practice. The fear of making mistakes that could lead to another child death pressured workers to assess families more rigorously by paying better attention to details, asking more questions, and having higher expectations for the other professionals who work with the family. The workers' new practice skills suggest that their assessment capabilities needed improvement. The results of productive stress changed how some workers practiced and improved job performance, which helps to ensure child safety.

The changes in CPS practice occurred after a specific child death was highlighted in the media, and the organization and the workers realized changes were necessary to ensure child safety. However, worker input is needed to ensure these changes are

successful and conducive to the quality of work required to ensure safety. Requesting CPS worker input on new policy and practice ideas should be a requirement before new changes are implemented. Obtaining worker input through online questionnaires sent via email, focus groups, and having a top leader in management walk the floors asking questions could help build a connection between the CPS workers and management. It would also give the workers a buy-in or incentive to be more invested and/or active in future changes in the organization. Involving CPS workers in the organizational changes could also be motivating and help improve morale.

Limitations

The primary limitation in the interpretative phenomenological analysis study was that the sample was that of CPS workers who are currently working in child welfare. The sample may be comprised of workers who flourish under stress and are possibly motivated to perform better under pressure. There is a lack of representation of workers who are no longer working at the CPS organization as a result of buckling under the pressure or stresses, succumbing to burnout, or being fired due to making avoidable errors. The input of those workers is valuable in understanding the specific reasons for their departure from the organization. Knowing why they left the agency and/or under what circumstances provides more insight into how CPS workers are impacted by a child death. This insight may help prevent another child death or provide valuable information to future CPS workers concerning avoidable errors.

Another limitation is that the researcher should have asked the CPS workers to give examples of what types of specific errors are being made by the CPS workers, as a

result of added pressure or worry about accountability? It is unclear if mistakes are actually being made or if the fear of making mistakes is the identified problem. The workers reported the fear of making mistakes or making mistakes due to the added pressure. One participant stated, "Most of us feel like they make decisions and do more things that are supposed to help the families that we serve, but indirectly it's been hurting a lot of our families and us personally." In hindsight, the research should have delved more into asking specifically if mistakes are made, if so what are they, and how might those mistakes be hurting families. Understanding this problem is essential in training CPS workers to avoid making these types or errors.

Although the research did not observe any reactivity or respondent biases, a possible limitation was the researcher's participation in the study. The participants could possibly find it difficult to accept the researcher in this new role as a qualitative researcher, which may have affected their responses. Although the participants were aware of the researcher's employment at the CPS organization - and this may have helped open dialogue and foster a sense of compassion and understanding - it is also possible that workers may not have been as forthcoming with information if felt threatened by the researcher's employment at the organization. Future studies with non-agency employed researchers may help address this.

Conclusion

This research aimed to have readers of the study feel as though they had "walked a mile in the shoes" of CPS worker participants (Padgett, 2008, p. 36). This researcher believes this was acccomplished by participants' openly sharing how a high profile child

death affected them and the impact it had on them emotionally, sharing a wide range of experiences. The findings of this study illustrate how the death of a child devastates CPS workers causing distress and symptoms of burnout. The CPS workers' lived experiences give meaning to how the media can influence the public with the imbalance of negative media reports on CPS and how the morale of the organization is traumatized, thereby affecting the CPS workers.

The participants showed signs of being affected by their experiences throughout the course of interviewing. However, one common underlying tone that resonated with the researcher as well as the expert was the workers' feelings of ambivalence. They were clearly upset over the many issues radiating stress throughout the organization causing poor job performance, but felt the public and management within the organization did not understand why the performance was lacking. The participants worried about not doing a good job and morale lowering, but they equally worried about how to improve, i.e., "crossing T's and dotting I's." There was a constant worry that their best was not good enough. This ambivalence expressed by the CPS workers seems to be the current nature of their social services world. The constant conflicting feelings are natural within the profession of social work and were evident within the study. Yet throughout all the ambivalence and experiences, there was no common theme or underlying tone that acknowledged that the high profile death of Danieal Kelly was the fault of CPS workers. The participants recognize a better job could have been done to protect this child but did not uniformly express accountability in the role CPS workers played in the death of this child. This leads to further research recommendations and questions to be raised. Further research needs to be done to establish:

- Are workers not accepting responsibility for their actions when a child dies?
- How are CPS workers prepared to handle media fallout?
- Can CPS organizations better address the public about the role of CPS workers and the profession?
- How does CFRT emotionally affect CPS workers and what can be done about this?
- Does the morale of the CPS organization impact work performance?

Many other questions remain to be asked. Moreover, it is recommended this study be researched with a larger sample, including other CPS workers, such as supervisors, other members of management, specifically those in top leadership roles, and other professionals who work with the same families as the CPS workers. By interviewing more CPS workers, management, and other professionals, there will be a broader understanding of the impact a high profile child death has on all the professionals connected to CPS. In addition, workers who left employment following a high profile death, as well as responses of workers who were hired after a high profile child death could possibly yield new data.

Finally, the guilty verdict of two CPS workers (mentioned in Chapter 1) was released after an ongoing trial. One CPS worker was formerly employed by the metropolitan CPS organization, Philadelphia's Department of Human Services and was found guilty of reckless endangerment and perjury. The worker was assigned to the family of the specific high profile child death. The former CPS worker now faces up to fifteen years in jail. Future research should look at how CPS organizations and their

workers are affected by this guilty verdict. The reality of CPS workers facing jail time as a result of not doing their job correctly will yield sources of new data.

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APPENDICES

Appendix A: Request for Volunteers

Hello,

My name is Toya Clebourn-Jacobs. I am currently a doctoral candidate in the DSW program at the University of Pennsylvania School of Social Policy and Practice, looking for volunteers to participate in my research study. While a significant body of literature has been created concerning Child Protective Service (CPS), few have explored how a high profile child death impacts the child protective service workers. The main purpose of this study is to give better understanding on how a high profile child death impacts child protective service workers. The information you share will be kept strictly confidential.

Requirements to participate are:

- You are a case carrying CPS worker who has worked in the Intake and/or Ongoing Service Region Departments of the child protective services organization since 2006
- You were a CPS worker while a high profile child death case was highlighted in the media
- Completed required On the Job Training (OJT) which has specifically trained you to work with cases associated with child abuse and/or neglect issues
- Completed Child Protective Service Investigations and work with families on an ongoing basis

I am requesting your participation in this research study that will give you a chance to share your experiences.

Compensation
If you decide to participate you will be given a $5.00 Starbucks gift card at the time of the interview.

If you would like to participate please contact Toya Clebourn-Jacobs at toyac@sp2.upenn.edu or 215-490-4849.

Appendix B: Demographic Sheet

Demographic Sheet

First Name: _____

Years at your current position: _____

Years of working within field of child protective services: _____

Years of working as a CPS worker at your current organization: _____

Number of clients counseled in an average week in the past month: _____

Number of cases that involved child deaths: _____

Marital Status:

□ – single (never married)
□ – married
□ – living with partner
□ – divorced/separated/widowed

Age:

□ – 21 - 25
□ – 26 - 35
□ – 36 - 45
□ – 46 - 55
□ – 56 - 65
□ – 66 - 75

Highest Level of Education Completed:

□ – High School/GED
□ – College Graduate
□ – Master's Degree
□ – Doctorate

Gender:

□ – Male
□ – Female

Race:

□- Black
□- White
□- Latino
□- Pacific Islander
□- Asian
□- Other (Describe _____)

Appendix C: In-Depth Interview Questions

1. I would like you to take a minute to talk about child deaths within DHS.

2. Do you remember a time when the death of a child within DHS was followed by high media attention and involvement? Can you describe the death? When did it occur?

3. When a high profile child death occurs, what is it like for you? How does it impact you? (A high profile child death is one that is well-publicized and receives media attention.)
   Probes:
   a. Does a high profile child death change the way you work with families or complete CPS investigations? If so, how?
   b. Are you affected emotionally and/or physically by the death of a child? If so, how? When the child death is high profile, does it change the way you are affected?
4. Do you think there have been changes within DHS since the specific child death you mentioned or when a high profile child death occurs?
   Probes:
   a. Can you describe the changes or tell me a little more about these changes?
   b. Did the changes affect you in any way?
   c. Can you tell me a little more? Did you feel the changes are negative or positive?
   d. What changes are negative? What changes are positive? Why do you feel these negative or positive changes occur?

5. Does DHS offer any kind of support to discuss how you feel after a child death receives media attention?
   Probes:
   a. If so, what kind of support is given?
   b. Is it helpful or necessary?
   c. How do you cope with your feelingsin and out of work?
   d. What are your social supports?
   e. How do you feel DHS can help you after a child death?

6. Have you been given any training on how to cope with unexpected child deaths?
   Probes:
   a. Do you think training on this subject is beneficial? Can you tell me a little more about that?
   b. Do you believe training will help you cope with a child death?
   c. Do you think training should be mandatory?
   d. What should training look like?
   e. Should there be a mandated training that focuses on how you can cope with or how DHS, as an organization, copes with an

unexpected child death?

7. How would you describe DHS's initial response when the child death you mentioned earlier occurred?
   Probes:
   a. What do you think the reactions of your coworkers have been? (CPS workers, supervisors, administrators, directors, commissioner)
   b. Is there a difference in reaction if the death becomes a high profile case compared to a death that received no media attention?
   c. How has DHS responded towards you or your coworkers after a high profile child death occurs?
   d. Do you feel DHS is helpful to you or your coworkers after a high profile child death occurs?

8. What is it like to work for DHS when it is getting attention from the newspapers and other media?

9. How do you feel about the attention personally? Does public/community opinion matter to you?
   Probes:
   a. What type of attention does DHS usually receive after a child death? Is it negative or positive? Does it have an impact on you?
   b. How do you respond to negative and/or positive attention from the public/community and news media?
   c. Do you think there is an imbalance between how much negative or positive attention DHS receives? If so, is this imbalance greater or less after a child death? Explain?
   d. Does negative and/or positive media or public opinion affect the way you perform your job?

10. What should the public/media know about CPS workers?

11. What is the morale like at the organization after a high profile child death? Do you think there were changes in morale after the child death you mentioned occurred? If so, how did DHS know about the workers' morale?
    Probes:
    a. Is there a difference in workers' morale if the child death becomes a high profile case?
    b. How do you feel DHS responded to workers' morale?
    c. Was the response negative or positive/helpful?
    d. Does the morale of the workers effect DHS? If so, how?

12. Do you believe the Multidisciplinary Child Fatality Review Team is effective in improving communication between all agencies working with children and families? How and why?
    Probes:
    a. Do you believe CFRTs are effective in implementing trainings?

b. Do you believe CFRTs are effective in creating new policies and practice?
c. Do you believe CFRTs are effective in child death prevention? How and why?
d. Are CFRTs supportive? If so, how? If not, how can they be supportive to CPS workers?

13. Is there anything I've missed that will help me understand your experience as a CPS worker and the impact a child death had on you?

Appendix D: Consent Form

Information Sheet for Individual Interviews

How Does a High Profile Child Death Impact Child Protective Service Workers?

Introduction and Purpose of Study

You are being asked to participate in an interview. I am currently a doctoral candidate in the DSW program at the University of Pennsylvania School of Social Policy and Practice. While a significant body of literature has been created concerning Child Protective Service, few have explored how a high profile child death impacts the child protective service workers. The main purpose of this study is to give better understanding on how a high profile child death impacts child protective service workers.

What is involved?

You are being asked to participate in an interview that will last about an hour. The interview will be audio recorded, which is mandatory to participate in the research. The audio recording of the interview along with written and electronic notes taken during the interview will be transcribed to assist in analysis of the data.

I will ask you questions about:

- What it is like to work for an agency that is in the news media
- What the morale is like at the agency after a high profile child death
- How you cope with a high profile child death?

If I need further clarification of my understanding of your interview responses, may I contact you? (Please check one box)

☐ YES
☐ NO

Confidentiality:

The information you share will be kept strictly confidential. I will not share information about whether or not you participated in this research with anyone. I will never use your name, personal information or information about where you live in my write-up of the interview.

Nothing with your name or other identifying information (names and places mentioned in the interview) will be turned into my instructor. The only person who will be able to listen to the audiotape is the researcher. Once I have analyzed the interview and written my analysis/dissertation, I will destroy the audio recording, interview notes, and interview transcript.

I will remove anything that might serve to identify you, including geographic locations and names of particular individuals you might mention in the interview, in any paper or in any publication that results from this research.

If you feel any distress after being interviewed, you can contact the Grief Assistance Committee (GAC) for counseling. All information discussed with the GAC will be kept confidential.

Risks of participating:

The risks of participating are minimal. The ways that confidentiality will be protected have already been described. In the unlikely event that you find that what you discussed in the interview is upsetting to you after the interview is over, please be in touch with me. I will provide you with some names and numbers of individuals or agencies that can provide further assistance.

Benefits of participating:

Being interviewed will not help you directly. Some find that having a chance to share their story will be an interesting and possibly even a helping experience.

Compensation

If you decide to participate you will be given a $5.00 Starbucks gift card at the time of the interview.

If you have questions about the research after the interview is over, please feel free to contact me:

Toya Clebourn-Jacobs, MSW
toyac@sp2.upenn.edu or (215)-490-4849

If after talking with me you have other concerns, you can contact the chair of my dissertation committee who is supervising this work:

Lani Nelson-Zlupko, Ph.D.
School of Social Policy and Practice
University of Pennsylvania
3701 Locust Walk, Philadelphia, PA 19104
laniz@comcast.net or (302)-543-6296

Or you may contact the Institutional Review Board (IRB) at 215-573-2540.

Your participation is completely voluntary:

You do not have to participate in this interview. There will be no negative consequences if you decide not to participate. Any program or agency that you work with will not know whether or not you participated. Your decision to participate should not have an impact

on your employment or other aspects of your work.

If you do decide to participate in the interview today, you can stop your participation at any time. You can also refuse to answer any questions that you don't want to answer or respond to any further requests from the researcher.

I have had all of my questions about the interview answered to my satisfaction and you have been given a copy of this consent form.