

Increasing Collaboration Between Nurse-Family Partnership and Child Protective Services

A Multiple Case Study

6/30/2015

Venice Ng¹, MPH, CHES
Roman Ayele², MPH
Suzuho Shimaskai², MPH, DrPH (c)
Christina Ostrom³, MSW, LCSW
Gregory Tung², PhD MPH
David Olds¹, PhD



School of Medicine
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

Funded by the Colorado Department of Human Services

¹University of Colorado, Prevention Research Center for Family and Child Health

²Colorado School of Public Health

³Invest in Kids

Table of Contents

- Acknowledgements 14**
- Acronyms and Abbreviations 16**
- Executive Summary 18**
- Introduction..... 22**
- Methods 24**
- Results 28**
- SECTION I. ORGANIZATIONAL STRUCTURE..... 28*
 - NFP Organizational Structure and Policies.....28
 - Core Elements of NFP28
 - Organizational Policies 32
 - Mandatory Reporting.....32
 - Consent Forms34
 - Caseload 35
 - Enrollment Period36
 - Length of Program.....37
 - Organizational Procedures 37
 - Referrals and Retention37
 - Staff Meetings, Supervisions, and Other Supports39
 - Community Partner Meetings.....40
 - Education and Training41
 - Curriculum.....43
 - Client Termination43
 - Paperwork and Documentation44
 - Internal Organizational Structure45
 - Service Areas**45
 - Staff Structure and Division of Caseload46
 - Location.....47
 - Community Advisory Boards.....48
 - CPS Organizational Structure and Policies49
 - Structure52
 - Prevention52
 - Intake55
 - Ongoing57
 - Specialized Teams58
 - Generalists59
 - Supervisors59
 - Differential Response60
 - Procedures.....61
 - Reports.....62
 - Cases64

Community Referrals	66
Meetings.....	69
Family Engagement Meetings.....	69
Internal Meetings.....	73
Policies.....	75
Screening and Assessments	75
Interacting With Mandatory Reporters.....	76
Confidential Information.....	77
Training	78
Internal Organizational Culture.....	79
<i>SECTION II. SCOPE OF WORK.....</i>	<i>81</i>
Background of NFP Nurses.....	81
Learning About NFP.....	82
Length of Time With NFP.....	82
Formal Education.....	83
Previous Work Experience.....	83
Learning About Assessing and Reporting Child Abuse	84
Past Reporting.....	85
Other Experience With DHS	85
Impact of Previous Experience on Current Work.....	86
Background of Nurse Supervisors.....	87
Length of Time With NFP.....	87
Previous Work Experience.....	87
Background of CPS Caseworkers.....	88
Length of Time With DHS	88
Formal Education.....	88
Former Work Experience.....	89
Background of CPS Supervisors	90
Length of Time With DHS	90
Formal Education.....	91
Former Work Experience.....	91
Background of Other Community Partners	92
Scope of Work of NFP Nurses	94
Role and Scope of the NFP Nurse Home Visitor	94
Nature of Home-visiting.....	96
Role in Mandatory Reporting.....	96
General Challenges to Home-visiting.....	98
Caseload	99
Composition of Caseload	101
Burden of Workload.....	102
Client Recruitment and Retention.....	104
Client Transfer from Nurse to Nurse.....	106
Client Transfer from Site to Site.....	106
Enrolment and Retention Strategies.....	107
The Nurse-client Relationship	110
Developing and Maintaining the Relationship.....	110

Barriers to Maintaining the Relationship	112
Client Visits	114
Initial Client Enrollment Visit.....	114
Ongoing NFP Curriculum-related Visits.....	115
Safety on Home Visits	116
Visits Involving CPS.....	117
Other Reasons for Visiting.....	117
Alternative visits.....	118
Client Strengths	119
Education and Work.....	119
Client’s Care of and Interaction With Child.....	119
Acknowledgment of Risks and Desire to Improve	120
Consistency and Family Support	121
Cultural Implications.....	122
Father’s Presence.....	122
Resilience and Overcoming Obstacles	123
Assessing Risk and Working With High Risk Clients.....	124
How Nurses Assessed Risk	124
Community Referrals and Other Resources.....	129
High Risks	131
Clients with Experience of IPV	132
Approaching IPV With Clients.....	134
Clients with Mental Health Concerns	135
Approaching Mental Health Risks	137
General Substance Use	139
Alcohol Use.....	142
Marijuana Use	143
Methamphetamine Use	144
Heroin, Cocaine, Narcotics, and Other Drug Use	145
Approaching Substance Use Risks With Clients.....	145
Clients with Developmental Delays, Disabilities, and/or Medical Needs	147
Approaching Developmental Delays	149
Family History and Social System Risk Factors	150
Physical Environment and Housing Risk Factors.....	150
Approaching Environmental Health Risks	152
Social Environmental Risk Factors	153
Young Mom and Low Education as Risk Factors.....	153
Previous Involvement with CPS or Law Enforcement.....	155
Other Risk Factors.....	157
Responding to Child Abuse/Neglect.....	158
Sexual Assault or Statutory Rape	158
Neglect	159
Abuse	162
Approaching Suspected Child Abuse/Neglect	163
Fatalities.....	164
Nurse Safety	164

Reporting Child Abuse or Neglect	165
Role as a Mandatory Reporter	165
Approaching Mandatory Reporting With Clients.....	166
Determining When to Report.....	168
Confidence in Reporting.....	171
Gray Areas to Reporting.....	173
Situations that were Reported	175
Situations that were Not Reported	178
Reporting Frequency.....	180
Reporting Process	181
Transparency With the Client	183
Other Areas Related to Reporting.....	184
Other Areas of Work.....	184
Supervisory Resource.....	185
Scope of Work of Nurse Supervisors	186
Orienting New Staff	186
Ongoing Education	186
Support and Guidance.....	187
CABs and Community Outreach	188
Understanding Nurse Workload and Burden	189
Joint Visits.....	190
Caseload	190
Other Areas of Work.....	191
Challenges to Scope of Work.....	191
Nurse Home Visitor Perspective of the Supervisory Role	192
Scope of Work of CPS Workers	193
Role of Intake/Assessment Workers	193
Supervisors' Perception of the Intake Role.....	196
Role of Ongoing Workers	196
Supervisory Perspectives of the Ongoing Caseworker Role.....	198
Role of Generalists.....	198
Role of Screeners and Trainers.....	199
Role of Lead Caseworkers.....	200
Role of Caseworkers from Other Units.....	201
Role of Prevention Workers	202
Supervisory Perspectives of the Prevention Role	202
Role of the CPS System	203
Casework for CPS Workers	204
Caseload	204
Case Management	205
Building the Client Relationship	206
Attending Various Meetings.....	209
Outreach and Training.....	210
Client Visit.....	211
Initial CPS Visit.....	211
Open Cases with the Mother or Child.....	211

Supervised Visits	212
Interactions with NFP on Visits	212
CPS Meetings.....	213
Client Strengths	214
Client Performance	214
Professional Service Involvement	215
Support from Family and Peers.....	216
Risk Assessment	217
Reporting Process	217
Types of Assessments	218
Assessment Process	219
How Caseworkers Assessed for Risk and Safety	220
Assessment for Prevention Workers.....	224
Ongoing Assessment	224
Placement and Service Planning	225
Clients With Substance Abuse.....	227
Approaching Substance Use	228
Clients With Mental Health Concerns	231
Clients Experiencing IPV.....	232
Socioecological Environment as a Risk Factor.....	233
Developmental Delays and Special Medical Needs	234
Low Education and Young Parents.....	235
Abuse and Neglect	237
Medical Neglect	237
Educational and Other Forms of Neglect.....	238
CPS Custody	238
Fatality.....	239
Reporting of Child Abuse	240
Reporters.....	240
Reporting and Screening Process.....	242
Impact With Enhanced Screening.....	244
Reasons for Reporting.....	244
Challenges with Reporters	245
Other Areas of Work.....	246
Transferring Units	246
Voluntary Cases.....	246
Skills Needed for CPS Work.....	247
Supervisory Resources	247
Scope of Work of CPS Senior-level Workers	248
Roles and Responsibilities of Supervisors.....	248
Roles of Administrators	252
Roles of Directors	255
Consultation for Mandatory Reporters	256
Caseworker Perspective of the Supervisory Role	257
Role of CPS.....	258
Scope of Work for Other Partners	258

Public Health Directors	259
Center Director and Clinicians	260
Other Positions	261
Client Visit.....	263
Client Strengths	263
Risk Assessment Among Other Partners	264
Risk Factors	266
Physical and Sexual Abuse	267
Reporting Child Abuse or Neglect	267
<i>SECTION III. CPS AND NFP</i>	<i>268</i>
NFP Perceptions and Interactions With CPS	268
Perception of CPS	268
Perceptions of CPS Organizational Culture	271
Perception of how CPS Viewed NFP	272
Perception of Clients' Perceptions of CPS	273
Knowledge of CPS	274
Reporting to CPS	274
What Protocols Followed Reporting	275
Knowledge of Other People Reporting to CPS	276
Knowledge of Prevention Programs.....	278
Contacts and Context.....	278
Interactions With CPS	279
Mandatory Reporting.....	280
Mutual Clients with CPS	281
Training, Meetings, and Conferences	283
Use of a Liaison	284
Referrals from CPS	284
CPS Prevention Programs.....	285
NFP Perspectives on Collaboration Efforts Between NFP and CPS.....	286
Stronger Collaboration	288
Training and Meetings	288
Valued as Professionals.....	289
Face-to-face Interactions	289
Collaborating With Mutual Clients.....	291
Collaboration with CPS Prevention Programs.....	291
Weaker Collaboration.....	292
Minimal Interaction.....	292
Lack of Communication.....	293
Lack of Knowledge	293
Variation in Interactions Within Multi-county NFP Sites	294
Lack of Professionalism	294
NFP Perspectives of Barriers to Effective Collaboration	295
Lack of Knowledge and Understanding	295
Communication Challenges	297
Philosophical Misalignment and Individual Attitudes	299
Stigma	301

Challenges Around Mandatory Reporting and Treatment Planning	303
Challenging Factors Within CPS.....	308
Other Various Barriers.....	308
NFP Perspectives of Opportunities for Collaboration.....	310
Education Opportunities	312
Education for NFP	312
Mandatory Reporting	312
Child Welfare	314
Education for CPS.....	318
Networking Opportunities.....	319
Other Opportunities to Improve Collaboration Efforts	320
Reporting Child Abuse and Neglect.....	320
With Mutual Clients	322
Changes for CPS to Consider	322
Opportunity for Changes Within NFP.....	323
On Community Perceptions	324
On Prevention Initiatives.....	324
CPS Perceptions of and Interactions With NFP.....	325
Perceptions of NFP	325
Perceptions of NFP as a Program	325
Perceptions of NFP Nurses.....	328
As Mandatory Reporters.....	329
Philosophies to Mandatory Reporting.....	331
Perceptions of NFP Clients	331
Perceptions of Other CPS Workers' Knowledge of NFP	332
Knowledge of NFP	333
Eligibility and Enrollment	333
NFP Referral Sources.....	336
Knowledge of NFP Services	337
Scope of Work.....	337
Frequency of Visits.....	337
Knowledge of CPS Interactions With NFP	338
Mandatory Reporting	338
Practices, Procedures, and Structures	338
Physical Interactions With NFP.....	339
Initial Interactions	339
Regarding Mutual Clients.....	340
Use of Liaisons.....	342
NFP Reporting Child Abuse and Neglect	342
Training	344
Other Meetings and Events.....	344
Referrals to NFP	345
Referral follow-up.....	346
CPS Perspectives of Collaboration Efforts With NFP.....	348
Varying Levels of Collaboration	348
Mutual Clients	351

Training and Consultation	354
Barriers to Collaboration.....	356
Lack of Knowledge and Interactions.....	356
NFP Program-related Challenges.....	358
NFP Nurses as a Challenge.....	361
Mutual Clients	365
Stigma and Preconceived Notions.....	367
Other Barriers to Collaboration.....	368
No Barriers to Collaboration.....	369
CPS Perspectives of Opportunities for Collaboration	369
Benefits of NFP	370
Education and training	371
Education for CPS.....	371
Education for NFP	375
Relationships With NFP	376
Building Relationships	376
Maintaining Relationships.....	377
Opportunities When Serving Mutual Clients.....	379
CPS Referrals to NFP	381
Areas of Programmatic Improvement for NFP	382
NFP Reporting to CPS	383
Multi-county NFP Sites	384
Other Agencies	384
Other Organizations’ Perceptions and Knowledge of CPS and NFP.....	385
Knowledge of Interactions.....	385
Perceptions of Interactions	386
Perceptions of NFP Nurses as Mandatory Reporters.....	387
Perceptions of NFP Referral Process.....	387
Perceptions of Collaboration.....	388
Perceptions of Barriers to CPS-NFP Collaboration	388
Factors Within CPS	389
Stigma	389
NFP Program Elements	390
Other Barriers to Collaboration	390
Perceptions of Opportunities to CPS-NFP Collaboration.....	391
Areas for CPS to Consider	393
Educational Opportunities for CPS	393
Areas for NFP to Consider	394
<i>SECTION IV. OTHER AREAS OF WORK.....</i>	<i>395</i>
Education and Training for NFP	395
Prior Training and Education on Mandatory Reporting	395
Existing Trainings and Education	396
Assessing Risk.....	396
Mandatory Reporter Training	396
IPV-related Trainings.....	398
Substance Use Trainings	399

Other Trainings and Education.....	400
Learning on the Job.....	400
Lack of Training and Education.....	401
Identifying Risk.....	401
Mandatory Reporting Training.....	401
Opportunities for Future Trainings and Education.....	402
General Training and Education Needs.....	403
Assessing Risk and Neglect.....	404
Substance Use Trainings.....	405
IPV-related Trainings.....	406
Mental Health Trainings.....	406
Frequency of Trainings.....	407
Preferred Learning Style.....	407
Education and Training for CPS.....	409
Existing Training and Education.....	409
Requirement.....	409
General Job Responsibilities.....	410
Assessing Risk, Early Intervention, and Mandatory Reporting Trainings.....	412
Differential Response Training.....	414
Community Resources.....	414
Structure of Education and Training.....	415
Need for Future Education and Training.....	416
Job Responsibilities.....	416
Structure of Additional Education and Training.....	418
Education and Training that CPS Offers.....	418
Designated Educator/Trainer.....	419
Education and Training for the General Community.....	419
Mandatory Reporter Training.....	420
One-on-one Consultation.....	422
Education and Training for Other Partners.....	423
Scope of Work.....	423
Existing Trainings for CPS and NFP.....	424
Opportunities for Additional Education and Training.....	424
Cultural Implications for NFP Nurses.....	425
Clients' Culture.....	425
Community Culture.....	428
Cultural Implications for CPS Workers.....	428
Clients' Culture.....	428
Community Culture.....	430
Cultural Aspects for Other Partners.....	431
Other Knowledge Among NFP Nurses.....	431
Knowledge Within Scope of Work.....	432
Knowledge of Community and Clientele.....	432
Knowledge of Community Assessments.....	433
Knowledge and Utilization of Community Organizations and Resources.....	434
Parenting and Child-caring Resources.....	434

Mental Health Resources	437
Housing Resources	438
Other Types of Community Organizations	439
High Fidelity Wrap-Around Services	442
Public Assistance Services	443
Other Knowledge Among CPS Workers	444
Knowledge Within Scope of Work	444
Knowledge and Utilization of Community Organizations and Resources	446
Medical Providers.....	447
Resources for Alcohol, Tobacco, and Other Drugs.....	448
Resources for Mental Health and Developmental Disabilities.....	449
Parenting Resources.....	451
IPV-related Resources	452
Military Resources.....	453
Housing Resources	454
Other Community Organizations	455
CPS Prevention Programs.....	456
Public Assistance Services	457
Community Meetings.....	457
Other Knowledge Among Other Partners.....	458
Child Welfare	458
Pregnancy Services and In-home Nurse Providers	461
Knowledge of Community and Clientele	463
Knowledge of Other Community Services	463
Collaborations With Other Organizations Among NFP Nurses	465
Weak Collaboration	466
Strong Collaboration.....	467
Collaboration With Schools.....	467
Collaboration With Law Enforcement.....	468
Collaboration With Mental Health Providers.....	468
Referrals From Other Organizations	469
Other Types of Collaborations	469
Contributors to Stronger Collaboration.....	470
Collaborations With Other Organizations Among CPS Workers.....	471
Varying Levels of Collaboration	471
Informal and Formal Services	472
Collaborating With Medical Staff	473
Collaborating With Schools	474
Working With Law Enforcement.....	475
Collaboration in CPS-related Meetings	475
Collaboration Among Other Partners	476
<i>SECTION V. OTHER CHALLENGES AND OPPORTUNITIES.....</i>	<i>477</i>
Other Challenges for NFP.....	477
Enrollment and Retention	478
Relationship Challenges With the Client.....	480
Practice-related Challenges.....	482

Gray Areas and Mandatory Reporting	482
Impact of Lacking Training and Education	483
Nurse Safety	483
Other Work-related Challenges	484
Client-related Barriers	485
Challenges With Clients With Mental Health Concerns.....	487
Challenges With Substance Use Among Clients	489
Challenges With Clients With Developmental Delays	491
Challenges With Environmental Health	491
Challenges with IPV.....	492
Challenges With Clients With Previous or Current CPS Involvement	493
NFP Program Challenges	493
Challenges With Other Organizations	495
Other Challenges for CPS	497
Casework Challenges	497
Challenges in Assessment	499
Relationship Challenges With Clients.....	501
Other Casework-related Challenges	501
Client-related Barriers	503
Challenges With Clients With Mental Health Concerns	503
Challenges With Substance Use Among Clients.....	504
Challenges With Clients With Developmental Delays.....	504
Challenges With Cultural Aspects	505
Supervisory Challenges.....	506
Challenges with CPS Organizational Structure	507
Education and Training Challenges.....	509
Community Perceptions	510
Challenges With Other Organizations and Resources	510
Challenges for Other Partners	513
Other Opportunities for NFP.....	515
Opportunities in Nursing Practice	515
Opportunities in Supervisory Practice	516
Opportunities for the NFP Program and Structure.....	517
NFP as an Opportunity for Clients	519
Opportunities for Collaboration With Agencies	519
Other Opportunities for CPS	521
CPS Organizational factors	521
Opportunities for Collaboration With Other Organizations.....	523
Opportunities for Mandatory Reporters.....	524
Opportunities for More Resources	525
Other Miscellaneous Opportunities	525
Opportunities Among Other Partners.....	526
For Child Welfare.....	526
For the NFP Program	527
For Organizational Collaboration With Other Agencies	528

Conclusion	530
Appendix A	534
Appendix B	536
Appendix C	538

Acknowledgements

The Prevention Research Center for Family and Child Health would like to thank all of the individuals who participated in this research study. This project was funded as part of “Keeping Kids Safe and Families Healthy 2.0” – the enhanced Child Welfare Plan through the Colorado Department of Human Services.

Acronyms and Abbreviations

AA	Alcoholics Anonymous
ASQ	Ages and Stages Questionnaire
ATOD	Alcohol, tobacco, and other drugs
CAB	Community advisory board
CBMS	Colorado Benefits Management System
CCR	Colorado Community Response
CDHS	Colorado Department of Human Services
CPS	Child Protective Services
CPT	Child Protection Team
CSPH	Colorado School of Public Health
CU	University of Colorado
D&N	Dependency and neglect
DANCE	Dyadic Assessment of Naturalistic Caregiver-Child Experiences
DHS	Department of Human Services
DHHS	Department of Health and Human Services
DSS	Department of Social Services
DR	Differential Response
DV	Domestic violence
ER	Emergency room
ETO	Efforts to Outcomes
FAR	Family Assessment Response
FOC	Father of the child
FTE	Full-time equivalency
GED	General Educational Development
HCP	Health Care Program for Children with Special Needs
HIPAA	Health Insurance Portability and Accountability Act
HRA	High Risk Assessment
ICU	Intensive care unit
IJK	Invest in Kids
IPV	Intimate partner violence
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
MOU	Memorandum of Understanding
NICU	Neonatal intensive care unit
NFP	Nurse-Family Partnership
NSO or NFP NSO	Nurse-Family Partnership National Service Office
OB/GYN	Obstetrics/Gynecology
PICU	Pediatric intensive care unit
PRT	Permanency Roundtables
PTSD	Post-traumatic stress disorder
RED team	Review, Evaluate, and Direct team
STAR	Strengths and Risks Framework
TANF	Temporary Assistance for Needy Families
TDM	Team Decision Making
THC	Tetrahydrocannabinol
WIC	Special Supplemental Nutrition Program for Women, Infants, & Children

Executive Summary

The aim of this multiple case study report was to assess the level of organizational collaboration between the Nurse-Family Partnership (NFP) and Child Protective Services (CPS) in Colorado, as well as facilitators and barriers to effective collaboration between these agencies. A multiple case study was conducted, primarily informed by key informant interviews with NFP nurses and nurse supervisors; CPS caseworkers, supervisors, and senior-level workers; and other community partners familiar with NFP or CPS and/or involved in child maltreatment prevention. The findings indicated that organizational collaboration between NFP and CPS varied tremendously within and among sites and the majority of NFP and CPS staff perceived a need to strengthen local organizational collaboration. The report concludes that organizational collaboration has led to successes in effectively serving high-risk clients. It is recommended that the Colorado Department of Human Services (CDHS) and the NFP National Service Office (NSO) consider policy and programmatic changes to facilitate stronger organizational collaboration between the NFP and CPS.

Introduction

In February 2013, Colorado's Governor John Hickenlooper announced an enhanced Child Welfare Plan named "Keeping Kids Safe and Families Healthy 2.0". The plan built upon Colorado's existing Child Welfare framework and proposed to enhance existing services and introduce new practices, including prevention initiatives to support families even before they became part of the Child Welfare system. Indeed, prevention services were deemed necessary to support families at risk for abuse and neglect. As part of the enhanced Child Welfare Plan, CDHS provided services and funding that could help families address a broad range of factors that impact their stability and safety. Such services and funding for coordination of prevention strategies were provided to three programs: the NFP, SafeCare, and Colorado Community Response (CCR).

The NFP is an evidence-based, voluntary, nurse home visitation program designed to improve the health and development of first-time low-income mothers and their children. In a series of randomized-controlled trials, the NFP program had consistent effects in improving prenatal health, child health and development, and maternal life-course, as well as decreasing childhood injuries and the incidence of child abuse and neglect. In Colorado, the NFP has the capacity to serve over 3,500 families in 61 of 64 counties, operating through a variety of local implementing agencies. Strengthening the NFP's ability to reduce child abuse and neglect requires continuous improvements in the implementation of the program model and better collaboration with local CPS. To strengthen collaboration efforts between local teams of NFP nurses and CPS workers, there was a need to understand the types of collaborative efforts currently existing in the state of Colorado and examine factors that facilitate or create challenges towards collaboration. Through CDHS funding from the state's enhanced Child Welfare Plan, a partnership involving the University of Colorado (CU), Invest in Kids (IIK), and the NFP NSO conducted a quality improvement project of the NFP program, with the goal of preventing child maltreatment through improved organizational collaboration, enhanced nurse education, and increased enrolment of clients in the NFP program.

Methods

A multiple case study approach was used to explore how collaboration could be improved between NFP and CPS to prevent child abuse and neglect. A grounded theory approach was adapted and used to gather qualitative data through focus groups with NFP nurses and supervisors as well as key informant interviews with NFP nurses and nurse supervisors, CPS caseworkers and supervisors (e.g. senior level Child Welfare workers including supervisors, managers, administrators, and directors), and various community partners. Through a snow-ball sampling method, a total of 130 qualitative interviews were conducted with NFP staff (54/130), CPS workers (65/130), and other community partners (11/123) over seven NFP sites serving 15 counties in Colorado; breakdown as listed in Table 1. Interviews conducted were digitally recorded with the consent of participants, transcribed by a contracted transcriptionist, and validated by CU research members to ensure accuracy. Data analysis was conducted using NVivo 10, with the development of a codebook through an iterative process. The codebook informed the development of a thematic interview guide that was used to approach qualitative interviews. Coding consistency was assessed using percent agreement, kappa statistics, and expert validation. After each transcript was coded, vertical memos were written for each interview to capture key findings. Horizontal memos were then written based on themes generated from the interview data across all seven participating sites. Thematic horizontal memos were then integrated to form the Results section of this multiple case study report.

Table 1: Number of Participants and Interviews

	Initial Interviews	Follow-Up Interviews	Total Interviews
NFP Nurses	42	2	44
NFP Nurse Supervisors	8	2	10
CPS Caseworkers	32	1	33
CPS Supervisors	30	2	32
Community Partners	11	0	11
TOTAL	123	7	130

Results

Variations in levels of collaboration between CPS and NFP existed within and between the seven NFP sites analyzed in this multiple case study. Among many sites, there existed some level of collaboration between individual NFP nurses and CPS caseworkers around training and education on mandatory reporting, approaching gray areas to mandatory reporting through consultations, working jointly with mutual clients, and working together on community-wide initiatives, groups or meetings like NFP community advisory boards. In a couple of sites, several individual nurses and caseworkers had a point of contact in the other agency (ranging from a designated nurse liaison to specific workers with whom they had previously interacted) who helped to facilitate interactions and collaborations. In several sites, there was also a lack of collaboration between the two organizations mainly due to a lack of knowledge and/or awareness of one another. Interestingly, the perceptions in level of collaboration varied within several sites and between positions in both organizations; often with senior-level workers perceiving a stronger level of collaboration than frontline workers.

There existed a desire to improve or enhance existing collaboration efforts among both CPS and NFP workers in many sites. However, a few individuals expressed strong concerns regarding organizational collaboration between CPS and NFP. These concerns were mainly a result of past personal experiences and stigma associated with CPS that could potentially transfer onto NFP if organizational collaboration was too close. Many strategies were suggested to improve or enhance organizational collaboration, including: opportunities to interact and engage with one another; developing points of contact in one another's agency; educational opportunities to learn about each other's organizational structure, processes, and scope of work, including those related to how to work together when serving mutual clients; and policy or programmatic changes that needed to take place to facilitate stronger collaborations. Having a consistent contact person was considered necessary and important for both CPS and NFP workers: CPS workers wanted to have a point person to gain clarity on the NFP program and to make referrals, while NFP nurses wanted to have a CPS contact to ask about mandatory reporting, gray areas in their practice, and to follow up with when they made reports to CPS. In addition, educational opportunities were especially emphasized as necessary to build collaboration among NFP and CPS workers, in that workers from both agencies desired to learn in-depth about each other's program objectives, goals and eligibility (for NFP), organizational structure and processes, scope of work, and general practices. Finally, strategies towards working with mutual clients were shared by workers from both agencies and included: better communication (such as a stream-lined referral process, follow-up on referrals to NFP or reports made to CPS; facilitated sharing of consent forms), focusing on client strengths and engaging with the family, and increased organizational interactions to discuss cases and/or treatment planning (i.e. through CPS family engagement meetings or staffings).

Challenges to organizational collaboration were also expressed by many caseworkers and nurses across all sites to include: NFP programmatic and eligibility restrictions thereby limiting the chance of serving mutual clients; CPS workload and burden; philosophical misalignment between the agencies; individual attitudes towards one another's agencies; and community stigma towards CPS. Many caseworkers explained that a barrier to collaborating with NFP was the strict NFP eligibility restrictions of being a first-time mother, because CPS primarily worked with multiparous mothers; having a small portion of mutual clients limited the opportunity to interact and collaborate frequently. It was also difficult for caseworkers to refer to NFP due to the program's referral timeframe (preferably during pregnancy or up to 30 days postpartum); CPS did not become involved with first-time pregnant women and infrequently became involved with infants until past 30 days of birth. On the other hand, many NFP nurses found that CPS workers' workload and busy schedules limited their ability to interact and follow up with nurses. In addition, there existed a perception that CPS and NFP were misaligned organizationally and philosophically among some NFP nurses and CPS workers; NFP was considered as a preventive program while CPS was perceived as a reactive agency. Finally, caseworkers and nurses recognized that individual attitudes as well as stigma associated with CPS posed challenges that were difficult to overcome, especially when individuals were not open to having any interactions with the other agency. It is important to acknowledge these perceived barriers to collaboration when considering future efforts.

Beyond organizational collaboration, many NFP and CPS workers across most sites shared similar experiences in working with clients of different cultures and with complicating risk factors, such as mental health, substance use or abuse, developmental or cognitive delays, special

medical needs, intimate partner violence, and environmental health. Workers from both agencies spoke about the need for developing relationships with their clients but NFP nurses tended to value the nurse-client relationship and client strengths more than CPS caseworkers. In fact, valuing the nurse-client relationship, at times, hindered nurses' ability to make a mandatory report with the worry that clients would terminate their participation in the program if they reported. This finding highlighted the need for additional education and training on maintaining the nurse-client relationship before and after a CPS report was necessary.

Risk assessment and gray areas regarding their scope of practice were similarly shared by both CPS and NFP workers. Workers from both agencies took part in risk assessments with their clients within their scope of practice. However, different tools and assessment skills were used; caseworkers tended to differentiate risk from safety while NFP nurses focused on ongoing assessment and utilized the nursing process in their practice. Gray areas for workers from both agencies were similar and included marijuana use, severe mental health, failure to thrive, and developmental delays. Having similar gray areas showcases an opportunity for NFP and CPS workers to interact and learn together. Such opportunities may involve mutually relevant topics that are beneficial within their scope of practice, for example: motivational interviewing, building and maintaining relationships, and strengths-based approaches.

Implications

These findings highlight areas of improvement to strengthen organizational collaboration among local teams of NFP nurses and CPS workers. It is important to acknowledge the main facilitators and barriers perceived by CPS and NFP workers that contribute to effective collaboration when considering future collaboration strategies. Moreover, the results have contributed to several practice-integrated elements within the larger NFP quality improvement project funded by CDHS to prevent child maltreatment. The research helped to inform education for Colorado NFP nurses and nurse supervisors based on needs identified from the qualitative data. Topics included in the nurse education were strength and risk assessments, mandatory reporting, approaching marijuana use, maintaining the nurse-client relationship, and intimate partner violence. The data also contributed to the development and implementation of regional trainings and Lunch and Learns between teams of NFP nurses and CPS workers to strengthen local collaboration by offering a venue for knowledge and information sharing. Finally, the research findings have informed the development of key recommendations to CDHS and the NFP NSO related to policy and programmatic changes towards strengthening organizational collaboration.

Conclusion

In summary, the level of organizational collaboration among NFP nurses and CPS workers varied within and across seven NFP sites in Colorado. Among some sites, there existed strong collaboration efforts where CPS and NFP staff were able to effectively support high-risk clients. Most NFP and CPS workers felt it necessary, however, to strengthen existing local collaboration efforts so as to better serve high-risk clients. Both NFP and CPS workers suggested ways to improve collaboration, including: educational opportunities to learn about each other's agency; developing points of contact; and policy or programmatic changes. Workers from both agencies also shared challenges towards building collaboration, such as: NFP programmatic restrictions; CPS workload and burden; philosophical misalignment; and stigma. These findings highlight opportunities towards improving organizational collaboration between local teams of NFP and CPS workers to prevent the incidence of child abuse and neglect in their communities.

Introduction

In February 2013, Colorado’s Governor John Hickenlooper announced an enhanced Child Welfare Plan name “Keeping Kids Safe and Families Healthy 2.0”. The plan built upon Colorado’s existing Child Welfare framework and proposed to enhance existing services and introduce new practices. One of the major emphases of this Child Welfare Plan was to create new and enhance existing prevention services to support families even before they became part of the Child Welfare system. Indeed, prevention services were deemed necessary to support families with basic issues such as unemployment or poverty, which could place the family at risk for abuse and neglect. As part of Governor Hickenlooper’s enhanced Child Welfare Plan, the Colorado Department of Human Services (CDHS) provided additional services and funding that could help families address a broad range of socioeconomic, educational, cultural, and health factors that impact their stability and safety. Such services and funding for coordination of prevention strategies were provided to three programs: the Nurse-Family Partnership (NFP), SafeCare, and Colorado Community Response (CCR).

The NFP is an evidence-based, voluntary, nurse home visitation program designed to improve the health and development of first-time low-income mothers and their children. The program has three main goals: (1) to improve pregnancy outcomes by helping women improve their prenatal health; (2) to improve children’s subsequent health and development by helping parents provide competent care of their child; and (3) to improve parents’ economic self-sufficiency by helping them make choices consistent with their values including completing their education, finding work, and planning subsequent pregnancies. In a series of randomized-controlled trials, the NFP program had consistent effects in improving prenatal health, child health and development, and maternal life-course, as well as decreasing childhood injuries and the incidence of child abuse and neglect. In fact, the NFP has been identified as the intervention with the strongest evidence of any in the world that prevents child abuse and neglect, as well as being the only early childhood intervention that meets the Coalition for Evidence-Based Policy “Top Tier” of evidence.

In Colorado, the NFP has the capacity to serve over 3,500 families in 61 of Colorado’s 64 counties, operating through a variety of local implementing agencies. The NFP in Colorado is funded through the Colorado Nurse Home Visitor Act, which allocates funds from the Tobacco Master Settlement Agreement, with Medicaid matching dollars. Starting in 2010, some local programs also began receiving funding from the federal Maternal Infant and Early Childhood Home Visiting (MIECHV) program under the Affordable Care Act. All programmatic and clinical support for implementation of the NFP in Colorado is provided by Invest in Kids (IIK) and the NFP National Service Office (NSO) through a subcontract with the University of Colorado (CU).

There is a need to strengthen the NFP’s ability to reduce child abuse and neglect through continuous improvement in the implementation of the program model and better collaboration with local Child Protective Services (CPS). In the original trial of the NFP, there was a reduction in the rates of substantiated reports of child maltreatment and nurse-visited cases were identified as having lower thresholds of severity because nurses are mandatory reporters, increasing maltreatment surveillance and reducing recidivism. The original trials of the NFP were conducted in counties in which close collaboration existed between NFP nurses and local CPS, which meant that nurses could make reports with confidence that CPS workers would work

with them to ensure the safety of the child and work towards supporting parents. In replication of the NFP program in Colorado, there has been considerable variation in the degree to which such collaboration exists.

Through CDHS funding from the state's enhanced Child Welfare Plan, a partnership including researchers from CU and the Colorado School of Public Health (CSPH), community partners from IIK, and nurse educators from the NFP NSO was formed to conduct quality improvement of the NFP program as the NFP Augmentation team. The NFP Augmentation team aimed to prevent child abuse and neglect through three major goals: (1) improve collaboration efforts between local teams of NFP nurses and CPS workers; (2) increase nurse home visitor knowledge and ability to address risks for child abuse and neglect; and (3) increase enrollment in the NFP program. The emphasis of this multiple case study was led by researchers from CU and CSPH to develop an understanding of the types of collaborative efforts currently existing in the state of Colorado and examine factors that facilitate or create challenges towards collaboration between NFP and CPS. The intent of gathering data for this multiple case study was to inform the conducting of work to achieve the three main goals as aforementioned related to the broader NFP quality improvement project as funded by CDHS.

Understanding that the level of collaboration between NFP and CPS varied tremendously across the state, there was a desire to learn from a wealth of existing collaborative experiences from both NFP nurses and CPS workers. To understand the level of local collaborative efforts between NFP and CPS, grounded theory was used in this multiple case study to explore what existed in the field and to generate a theory that was truly grounded in data through an abductive process of data collection and analysis. Abductive reasoning involves making an observation and developing a hypothesis that accounts for the observation, ideally seeking to find the simplest and most likely explanation; this process allows for data collection and analysis to occur simultaneously. By adopting grounded theory, the nature of the research process continually evolved and was informed through data collection, reflection on these data, and iterative development and revision of approaches over time to test hypotheses generated from the data. Such a process also allowed for information to be integrated into other aspects of this practice-integrated project as the data were analyzed, such as education and training for NFP nurses and CPS workers, as well as created the opportunity to continuously improve the research being conducted.

Methods

Data Collection

Our research team used a multiple case study approach to explore how collaboration could be improved between NFP and Child Welfare to prevent child abuse and neglect. We initially interviewed an NFP state nurse consultant to gather her insights on the general landscape of NFP and its varying levels of collaborations with Child Welfare across sites, which informed the selection of NFP sites across Colorado to ensure an array of sizes, geographies, collaborations with Child Welfare, and complexities of internal structures and practices among our participating sites. We also considered the capacity of each site to ensure that NFP nurses and nurse supervisors would be able to continue their daily responsibilities while participating in our research study. Six NFP sites were identified through the interview with the state nurse consultant. When the initial list was reviewed by the State Prevention Steering Committee (a group created under the Governor's Child Welfare Plan to discuss and advise the three prevention programs: NFP, SafeCare Colorado, and Colorado Community Response), a representative from another county requested to be included in the research study. Ultimately, we selected seven NFP sites to participate in our research study: the six sites identified through the interview with the state nurse consultant along with the site represented on the Prevention Steering Committee. These sites spanned across fifteen counties with some sites only serving one county while others served two to five counties.

The units of analyses in this multiple case study included the seven (out of 21) NFP sites across Colorado that were selected to participate along with their corresponding Child Welfare agencies and partnering community organizations. For each of these seven cases, our research team used an adapted grounded theory approach to gather qualitative data through focus groups with NFP nurses and nurse supervisors as well as key informant interviews with NFP nurses and nurse supervisors, Child Welfare caseworkers and supervisors (i.e., senior level Child Welfare workers including supervisors, managers, administrators, and directors), and various community partners.

Two members of our research team conducted focus groups between October 2013 and April 2014 with five of the seven selected NFP sites. Each focus group was conducted prior to key informant interviews at that site. These focus groups included all NFP nurses and nurse supervisors from participating sites but did not include individuals outside of NFP such as Child Welfare personnel. The purpose of these focus groups was to share an overview of the research study, build rapport with NFP sites, and learn about the types and extent of interactions that were occurring between NFP and Child Welfare at each site. Focus groups were not conducted with the remaining two NFP sites because it was not feasible for the research team to make two separate trips to one of the sites and the other site had requested participation and thus already had knowledge of the research study and a working relationship with the research team. However for the site that did not request participation, a brief overview of the research study was provided to NFP nurses and nurse supervisors prior to conducting the interviews.

Between October 2013 and June 2014, four members of our research team conducted 130 interviews (Table 1). Interviews were conducted in-person, via phone or through skype audio (i.e., without video). Interview length ranged from approximately thirty minutes to an hour and a half; variations occurred within and across sites depending on the depth and breadth of

information each participant shared. For each case study, interviews were initially conducted with NFP nurses and nurse supervisors. The majority of nurses and all of the nurse supervisors at each of the seven NFP sites participated in the interviews. Participation among nurses was left to the discretion of site’s nurse supervisors. Reasons some nurses were not asked to participate included: being a recent hire with limited NFP experience, never having interacted with Child Welfare, and inaccessibility. The participation rate among NFP nurses and nurse supervisors asked to participate in the research study was 98% (50/51). The person who declined participation was an individual who left NFP during the course of our research study.

Table 1: Number of Participants and Interviews

	Initial Interviews	Follow-Up Interviews	Total Interviews
NFP Nurses	42	2	44
NFP Supervisors	8	2	10
Child Welfare Caseworkers	32	1	33
Child Welfare Supervisors	30	2	32
Community Partners	11	0	11
TOTAL	123	7	130

Child Welfare caseworkers and supervisors as well as other community partners who participated in this research study were identified through snowball sampling. Child Welfare caseworkers and supervisors were identified by NFP nurses and nurse supervisors based on who they thought it would be helpful for us to speak with. Additionally, some Child Welfare caseworkers and supervisors referred by NFP nurses and nurse supervisors provided names of other Child Welfare colleagues for further snowball sampling. If an NFP site did not identify Child Welfare staff for interviews, we contacted director(s) of the Department of Human Services (DHS), Department of Health and Human Services (DHHS) or Department of Social Services (DSS) for the county or counties which the NFP site served. The director(s) then identified caseworkers who could participate in our research study or delegated to a manager or supervisor to carry out this request. The participation rate among Child Welfare workers was 86% (62/72). The ten Child Welfare caseworkers and supervisor who declined participation provided reasons such as being too busy, going on parental leave, or did not respond to our recruitment request. Once a Child Welfare caseworker or supervisor agreed to participate in our study, some were emailed a list of general themes for discussion during the interview.

Community partners were identified by NFP and Child Welfare participants based on who they felt would be important to include in the research study given our overarching aim to improve collaboration between NFP and Child Welfare or because they were familiar with the functions and processes of NFP and/or Child Welfare. Community partners who participated in our research study included public health directors, council coordinators, public service workers, public health nurses, center directors, and program coordinators. The participation rate among community partners was 79% (11/14). The three community partners who did not participate did not respond to our recruitment requests.

Potential participants were initially contacted by email, unless the research team only had a phone number for that individual. If potential participants did not respond to the initial email, generally, another one or two emails were sent and/or one or two phone calls were made. Once participation was confirmed and an interview was scheduled, a research team member also sent a reminder email during the week leading up to the interview. In this reminder email, general interview themes were occasionally included to inform participants about the general topics that would be discussed. Several telephone interviews also had to be rescheduled due to “no-shows”.

Some of the initial interviews were conducted by two researchers but all subsequent interviews were conducted by one of four research team members. While most were one-on-one interviews, three of the interviews were conducted jointly with two participants. Reasons for joint interviews included participants wanting to describe a shared experience (e.g., a scenario with a client in which both interview participants were involved), ease of scheduling, and participants requesting the structure for added comfort. As indicated in Table 1, seven participants were also asked to participate in follow-up interviews either because there was inadequate time in the first interview to discuss all of the themes or the research team wanted to probe deeper on something that was brought up during the first interview.

At the beginning of each interview, we read the research protocol and consent (Appendix A) to the participant(s), offered a written copy of the research protocol, and requested verbal consent to participate in our research study and to record the interviews. Only one participant requested not to be recorded; this person’s responses were used to generate new themes in the iterative interview process with each new case but were not included in the formal data analysis. Once verbal consent was obtained, we asked open-ended questions to learn more about the interview participant’s work, particularly as it related to improving collaborations between NFP and Child Welfare, including their scope of work, experiences with and knowledge of Child Welfare and/or NFP, and mandatory reporting. Data-driven themes were iteratively identified and reflected upon, which led to the development of an interview guide that informed future questions that became more concrete with each additional case.

All of the interviews were digitally recorded and transcribed by a contracted transcriptionist. Three of our research team members then validated the transcripts to ensure accuracy.

Ethical Considerations

This study was approved by the Colorado Multiple Institutional Review Board (COMIRB) and ethical considerations were made to ensure minimal burden of participation through voluntary participation, minimal time of involvement, and only asking questions related to one’s work experiences (i.e., we did not ask any personal questions). Additionally, in order to prevent fear of retaliation and to promote open discussions, our research protocol was modified to de-identify all participants and sites. The original protocol (Appendix A) allowed for identification of individuals and site and thus proposed to integrate site-specific cases. Some interviews from the first six sites were conducted using this original protocol. However, after beginning interviews with the third and fourth sites, our research team began receiving feedback from participants that they were not entirely comfortable sharing honestly about their experiences because they would be identified. For this reason, we submitted an amendment to our research protocol to de-identify all participants and sites. Once approved, we went back to the participants with whom we had

already conducted interviews and informed them about the protocol change. We also modified the consent form and began using the updated consent (Appendix B) with all participants after the protocol change was approved in March 2014. Although there were individual variations within and across sites, in general, participants seemed to feel more comfortable sharing more in-depth information subsequent to the protocol change. Given the modification, we also decided to conduct a multiple case study rather than site specific case studies.

Data Analysis

Data analysis was conducted using NVivo 10. A codebook was developed through an iterative process with two research team members who initially conducted a line-by-line comparison of their coding and created definitions for the codes; the codebook was then refined with input from a third and then fourth research team member through broader discussions based on coding statistics. Initially, a few of the transcripts in the first case were quadruple-coded to assess coding consistency across our research team. Coding consistency was also assessed using percent agreement and kappa statistics. Although both measures were used to assess coding consistency, we used the kappa statistic as the primary benchmark and aimed to stay above 0.4 for the majority of the codes. Once this was achieved, the transcripts for the remaining six cases were coded by three of the research team members. For each new case, at least one NFP transcript and one Child Welfare transcript were triple-coded to continue assessing coding consistency. If coding consistency statistics were poor (i.e., the kappa statistic was ≤ 0.4), we discussed the areas of concern, redefined codes, recoded the same transcript, and/or triple coded another transcript to continue assessing coding consistency.

After each transcript was coded, we wrote a vertical memo (i.e., a memo for each interview) to capture the key findings from that interview. Each of the 130 memos was reviewed by at least one other person to ensure that all of the key findings from the interviews were drawn out into the memo. Once the vertical memos were complete, we wrote horizontal memos (i.e., memos based on themes generated from the data across all interviews) based on the various themes that arose across the seven cases. Thirty-seven horizontal memos were written in total, where each memo was reviewed by the remaining three research team members and underwent an expert validation process by members of the NFP Augmentation Team which consisted of nurse consultants and educators, though not inclusive of Child Welfare. The thematic horizontal memos were then integrated to form the Results section of this multiple case study.

Results

Findings from interviews among CPS and NFP workers from seven NFP sites serving 15 counties are summarized below in four main sections: organizational structure, scope of work, CPS and NFP, and other areas of work.

SECTION I. ORGANIZATIONAL STRUCTURE

NFP Organizational Structure and Policies

Across all sites, many NFP nurses consistently discussed the core elements and organizational policies that directly impacted their work. Frequently discussed core elements of NFP included its strengths-based approach as well as the voluntary nature of the program. NFP organizational policies discussed included when clients could be enrolled in the program, the length of the program, nurses being mandatory reporters, the use of consent forms, and a full caseload being 25 clients. Although there were some variations across sites, many nurses across multiple sites also discussed aspects of their organizational procedures such as recruitment and retention strategies, assessment tools, the NFP curriculum, access to clients' medical records, team meetings and supervisions, and education and training opportunities. Aspects of internal organizational structure such as staff structure and caseload divisions, location, and community advisory boards (CABs) were also discussed by some sites. Many nurse supervisors across most sites did not talk as extensively about organizational structures and policies compared to the nurses.

Core Elements of NFP

Multiple nurses and a nurse supervisor across many sites described NFP as a strengths-based program where nurses built off of a mother's strengths rather than solely focusing on the negatives. Most of those who mentioned this felt that NFP being strengths-based was an important aspect of the program and something that distinguished it from Child Welfare. Although most of the nurses did not feel that this approach prevented them from identifying and addressing risks for abuse and neglect, one nurse supervisor felt differently. This supervisor perceived NFP's strengths-based approach to occasionally limit a nurse's ability to objectively assess child neglect and abuse because they were trained to always look for the positive side of every situation.

One nurse stated, "Yeah. NFP, we really focus on the strengths and what they do well. You know, and obviously, we bring up stuff that needs to be worked on or talked about, but I think CPS does a lot more of, 'You're doing this wrong and that wrong and.' - You know? It's maybe more of a threatening environment for our clients."

Another nurse from another site shared, "So, you know, looking - You know, ours is a very strength-based program, which I really appreciate. And, again, I'm - You know, I'm sounding very negative about Social Services, but they're - I don't - My experience has been they haven't necessarily been that way, maybe in the past. I mean, maybe things are changing, and that would be really good, I think. But, you know, we really look for the strengths and, yeah, I guess that's what I want to say."

Another nurse from a different site stated, “And, I was kind of surprised, but we come in with a different view that’s more strength-based. They have a caseload that’s many, many people more than what they really should have. They’re stressed. They’re trying to accomplish certain goals within a certain timeline. And, we have a different point of view. We’re working at their strengths and then working on things a little bit longer than what they do. So, we have a different pace that we work with our clients on.”

Another nurse shared, “We assess risks based on strengths is our approach. We go in and really look at, you know - We have a really tough - We kind of have really difficult clientele. So, if you can find the good and what they’re doing really well and focus on that and start at that level with the praise and look what you’re doing. And, then bringing information in regards to that. It’s kind of, I think, all of NFP’s approach to really look at that.”

A nurse supervisor from a different site stated, “And, getting over that where we’re so strength-based, and we’re looking at the positives in our clients—sometimes to a fault, I would have to say—you know, because - ‘Well, yeah, she’s not doing this, but she’s really doing this well.’ (*laughs*) You know? I mean, you really - When you’re looking at neglect and abuse, you really have to see it for what it is instead of go, ‘Well, maybe she was just upset that day.’ You know?”

A few nurses and a nurse supervisor across a couple of sites who described the strengths-based approach of NFP also shared that their work was very client-centered. As such, the program worked with clients to deliver services that were most applicable to the direct clients (i.e., the parents rather than the parents of teenage parents) and aimed to build self-efficacy among the clients. Nurses also strived to engage and empower clients to take responsibility for any services they may need by informing them about available services but not making calls or submitting paperwork on their behalf.

One nurse stated, “The, yeah, I had very few that um-- there’s been one or two where the parents of the client have pressured them to keep the baby and then the client has been unhappy when the baby gets to be around a year and they want kind of move on with their life and they feel like they can’t. It’s really interesting dynamics because a lot of times the family is almost making the baby a reason they can’t go back to school and can’t get a job. So the program is kind of counter that where it’s, you know, what do you want to do, what’s your heart’s desire, where would you like to see yourself? Okay, what’s holding you back? And very often it’s because the family won’t watch the baby. Okay, well are you aware that there’s daycare available for your baby? Are you aware that there’s these programs that can help you pay for some of these things that you need?”

Another nurse from the same site stated, “I’m a very big advocate. I don’t like to do a lot of things for my clients. You need to initiate it. You need to do it. Only in certain situations am I the one that is initiating that. I’m like you need this. You know, you need to do it for yourself. I don’t think that’s teaching you anything if I just do it for you. So that’s kind of my personal practice approach that might be different from another nurse who is just like okay, I’ll call Housing Authority for you. I won’t do that. That’s, I

mean, you need to do that. Here's the resource, here's the information. Okay, you have cellphone minutes, great. You need to call. I'm not doing it for you."

A nurse supervisor from a different site stated, "And so, that's what I've tried to teach them, too, is, 'You know, somebody has to be in charge. And, you're in the client's home, so you're a guest. You're still the expert. And, you still are the one that has the position and really the position of power to say, 'This is the way you've gotta do this. This is the best way to do this.'" You know, and this is always client-centered. The program is client-centered. I said, 'At the same time, you're working with people who don't know. And, if you're not helping them by clearly educating them, you're not being effective. And, they're not going to come out of this program going, 'Wow, that was one of the best experiences of my life.'" They're gonna go, "Well, that was a waste of my time. I didn't learn very much.""

One nurse from a different site shared, "His mother lives in California. The father is not involved. And so, but what I saw going on in that house is like, hmmm, I wonder how long this is going to last because it was almost like they were controlling the young boy. The parents were controlling him, and the mother would always sit right there in on our visits. And, these kids would like roll their eyes at her because she was inputting more than allowing the kids. And so, I really had to say, you know, the program is for the children. They do best that way. But, you know, at least for now if they can at least answer the questions themselves that really helps me figure out, you know, how I can best go about helping them as well. And, they benefit more from the program that way. They feel part of it instead of her."

A few nurses from one site also emphasized the importance NFP placed on nurses building strong relationships with their clients. They shared that aspects of NFP such as providing in-home visits and seeing clients every two weeks allowed nurses to provide clients with a lot of support and to have strong relationships with their clients. One nurse from this site also shared that she believed the focus on building strong relationships with clients allowed nurses to really understand their clients' cultures and provide services accordingly, unlike CPS whose clients had experienced various cultural misunderstandings.

One nurse stated, "Well, you know the program is relationship-based, and so it is about establishing trust, and, um, you know a relationship was based a lot on support."

Another nurse stated, "You know, I said she is still in the program, but not with me anymore so she may still continue to have a medical/professional in-house and we visit every 2 weeks and, you know, kind of told her about our program a little bit and she was like wow that's really cool."

Another nurse shared, "Because we're visiting every two weeks, we develop a relationship—and granted, there is some bias because we are more focused on looking for the positive things that we can build on with our clients, too. But, ultimately, that's what DHS and us both want is to see this family succeed."

Another nurse stated, “So, that’s where I love the Nurse Family Partnership approaches. Because it can allow for a lot of different cultural expectations and beliefs. And, sometimes, in the past days, when we had DHS cases, there were lots of cultural misunderstandings - I had one child that the family, I can’t remember if they were from India or they were Buddhist from Thailand. Anyway, the child had some bruises that ended up being from healing. The cups, it was from the cups. And they, there were some acupuncture marks and they were called in because of this being abuse when really it wasn’t abuse and so the family really felt offended because it was a lack of respect for the culture. And with NFP, we’re so much more tuned into their culture and, ‘Help me understand. Tell me what this is about. Help me to know what’s going on.’ - It’s been very, I think it empowers the family a little bit more and they’re able to share a little bit more of their culture or we might have a little bit more information because, I think, part of that’s the history taking at the beginning, too, and the time that we spend in building that rapport with the client.”

Another core element of NFP that was emphasized by numerous nurses across most sites was the voluntary nature of the program. Many of these nurses described having needed to explain this to clients as well as to CPS caseworkers to ensure that they knew that NFP was not a program that could be court-mandated. Some nurses also described that the voluntary nature of NFP made it appealing to some clients and allowed them to feel like they were empowered to make the decision to invest in developing their parenting skills by participating in the program.

One nurse stated, “So, you know, my role was to say, ‘Well, I’ve seen her this many times. And, these are the things that she said she wants to work on. We haven’t quite gotten to them yet. She’s still working on’ - whatever, whatever the goals were. At that point in time, you know, I had one experience in those meetings where the woman who was her caseworker when she was a child tried to tell me, ‘Well, you know, even if she’s not feeling good, and she cancels the visit, you still need to be in that home and weighing that baby.’ And, I was like, ‘Well, this program is voluntary,’ so I had to, again, reeducate ...”

Another nurse from a different site stated, “It gives - It empowers them because then they can choose - They understand this is voluntary. ‘I choose to do this. And, if I need a month off because I’m angry at everybody, or I don’t - I can do that.’”

One nurse from another site shared, “So, her caseworker actually called me. Found out she was in our program, called me, and I could find - You know, I don’t know her name off hand, but of course, it’s in my charting. But, she was like, ‘She’s in your program. That’s awesome.’ She goes, ‘You know, we’re going to tell her she has to continue to do your program.’ And, I’m like, ‘Well, it’s voluntary, so she doesn’t have to do our program’ And, she’s like, ‘Well, we’d like her to continue to be in your program, but we are going to make it mandatory that she do parenting classes, and she has to do this and this and this.’”

Although not as heavily discussed, a couple of nurses from different sites also mentioned that NFP was an evidence-based program. One nurse mentioned this in reference to why she was interested in working for NFP while another questioned whether or not CPS knew that NFP was

an evidence-based program. A few other nurses from different sites also shared that they viewed NFP as preventive and that this allowed the program to be proactive in reducing child abuse and neglect rather than only intervening after it had occurred.

One nurse stated, “And, um, I was very attracted to this position because of its positive outcomes and the fact that it is research based, um, to back that up. And I really enjoy working with young moms and their babies.”

While describing a joint meeting between CPS and NFP, another nurse from a different site stated, “They’re going to some evidence-based framework as well that they had some training on, and they kept, you know, saying ‘evidence-based,’ and they were asking about our framework, the STAR [Strengths and Risks Framework] thing that we’re going to be working on. And, we kept saying, ‘Well, you know, we are the beginnings of that evidence-based program,’ but I don’t know if anybody told them we were an evidence-based program. *(laughs)*”

One nurse stated, “Yeah. Absolutely, because I think that’s one of our missions for sure, is getting in there from the very beginning and trying to make a difference and prevent that from happening. And that’s what we hope to avoid.”

Another nurse from a different site stated, “And so, I see the Nurse Family Partnership as very preventative.”

Another nurse from a different site stated, “So, you know, that is something, I think, that’s important to look at. And, I try to, you know, kind of proactively address that. Like, ‘I don’t come in and open your cupboards and look in your refrigerator, you know, that’s isn’t’- Our program is, you know, much more oriented toward prevention and, you know, the relationship with the client.”

Organizational Policies

Numerous nurses across all sites talked about NFP’s various organizational policies. While not all policies were discussed by nurse supervisors, nurse supervisors from two sites shared about a few of their policies.

Mandatory Reporting

The policy that was most frequently discussed by nurses and nurse supervisors related to the legal obligation of nurses as mandatory reporters. Many nurses from most sites stated that they explained this to clients at their initial visit when going over all of the consent forms. A few nurses across some sites specifically mentioned that they did not explain this during the initial conversation about what NFP offers but waited until the client decided to enroll. Many nurses across multiple sites also shared that they discussed with clients that they would inform them prior to making a report to CPS.

One nurse supervisor stated, “‘You put your child in danger. I have to let them know this.’ You know, and we start out every client begins with knowing we are mandated reporters.”

A nurse from a different site stated, “So, not when we’re explaining the program to them, but once they’ve decided to join the program in our consent form there is, um - It talks about the program and then, and it says that, you know, it talks about HIPAA [Health Insurance Portability and Accountability Act] and how everything they say with us is private and it says, ‘Except for in special circumstances such as—‘And, then it talks about the mand—the mandatory reporting.”

Another nurse from a different site stated, “Mm-hmm. That usually - I disclose that when, upon enrollment. When I explain the program to the client, and then, when the client says, ‘Okay. I would like to go ahead and enroll,’ and then we go over the forms, and the consents. And, there is a consent about the release of information, about the HIPAA, and there’s a spot that talks about that we are mandatory reporters, and I let the clients know that I am a mandatory reporter. And, if I ever were to suspect child abuse or neglect, you know, or a mom is struggling with mental illness or things like that, that I am obligated to report. And, I always say that, that, ‘So far, it hasn’t happened in my career, but if I ever feel that I need to do that, I will let you know beforehand.”

Although many nurses from most sites talked about being mandatory reporters, organizational procedures around mandatory reporter trainings varied. One nurse supervisor shared that everyone had received mandatory reporter training while nurses from a different site stated that they had limited training opportunities. A nurse from one site also shared that any changes or updates to mandatory reporting laws were shared with them by their supervisor, while another nurse explained that mandatory reporter trainings had been added to their onboarding orientation.

A nurse supervisor stated, “Well, we’ve all had training as mandatory reporters. DHS has done trainings locally here. We have one policy that’s a county policy - Actually, it’s a Health Department policy about reporting sex abuse and human trafficking. So, what it really says in this policy is that we are all mandatory reporters and we must report child abuse or neglect, and if you don’t, there - You can be liable for criminal action. So, that says that.”

A nurse from another site stated, “...for two or more years haven’t had the formal training on, although now my supervisor, since this last report, she gave me the protocol of everything you fill out, so I feel a little bit better about it.”

Another nurse from the same site stated, “Just, I’ve had quite a few trainings on child abuse reporting and all that. I mean, not the reporting itself, just the trainings on recognizing child abuse and what to do. So I’m very comfortable with that. The reporting I would like, and we were telling our manager, which apparently came after this last year, they started putting it into our orientation.”

In response to how changes or updates to mandatory reporting laws were handled, a nurse from another site stated, “Right. Um - I mean, if there’s any changes either [nurse supervisor name removed] talks to us individually about what those changes are, or in our weekly meetings.”

Only one site discussed organizational procedures around what to do when making a report. However, nurses within the site had varying perceptions of the appropriate protocol to follow. One nurse explained that nurses were encouraged to talk with the client and to involve them in the reporting process while another stated that she had always been told to call the supervisor first. One nurse also described that after the last time she had to make a report, her supervisor provided her with the protocol of all the forms that need to be completed for the health department when making a report.

One nurse shared, “And so I did report it, um, you know we use, uh, a form that the health department has formulated, but they ask a lot of intake questions over the phone now.”

Another nurse stated, “I would call my supervisor first. And that’s what they always, like, tell us is - They know that we’re out in the field on our own but if something comes up even with, um—even just, like, homicidal, suicidal, domestic violence, child abuse, and neglect and all that, we should call in first.”

Consent Forms

Many nurses from multiple sites shared about their procedure of completing signed consent forms with their clients. Nurses stated that the consent forms were typically signed during enrollment and were used to be able to share information with a variety of agencies including Child Welfare, health providers, and the NFP NSO. A few nurses across a couple sites also specified that they informed clients that even though they were asking them to sign a consent form, they did not need client consent to make a report about child abuse or neglect. A few nurses from different sites also discussed that sometimes new consent forms were signed with additional organizations as new service providers were added to a client’s case.

One nurse stated, “First visit with the consents that we have them sign. We have a consent, I don’t know if you’ve seen it or not, but it’s for case management. So I explain to them that this is, these are the different agencies that as I’m checking the boxes that we can communicate with and give them examples how I might need to use care coordination, that sort of thing. What does that look like cause a lot of them aren’t familiar with what that term is and what it means. So explaining that to them and then saying, you know, the only one on here. I said I’m going to check [county DHS name removed]. However, I don’t need you to sign the consent for me to report to them. And then I explain to them I’m a mandated reporter, it’s a condition of my license if I suspect child abuse or neglect that I have to report it. I always tell them, but ideally it is something that we have a conversation about beforehand.”

Another nurse from the same site stated, “Right, I kind of, I include that under the whole HIPAA topic, because we do talk. One of the consents that they sign is about the information we exchange with the NSO. The other one is the information that we exchange with community agencies on their behalf, and when I talk with them about the NSO consent that they’re signing, you know, I let them know that they’re assigned an anonymous number and that the information that they complete, that they answer on the forms that we complete throughout the pregnancy and throughout the entire program are submitted using that number only.”

A nurse from another site shared, “As far as mental health, there’s a private therapist and I refer to them and occasionally, if it’s someone who it seems like that it would be helpful for, we’ll get them to sign a consent so that we can talk.”

While many nurses understood that having signed consent forms with clients was part of NFP’s policies, a couple nurses from one site experienced some confusion around what could or could not be shared between NFP and CPS. In particular, they were unsure about what CPS could or could not share with them even though they had signed consent forms from the clients because they were challenged in getting information about their clients from CPS.

One nurse stated, “You know, I feel as though we have consent to talk with Social Services regarding clients and especially ones that are already within the system, but it’s kind of unclear what information they can and cannot share – like location of the client, that I’m having a hard time getting a hold of, you know, like where they’re at. Even simple things like that have been a challenge, collaborating in that way, so, you know, that sort of information as a whole – what they want to share and what they don’t want to share, I think would be helpful. And not just location, but beyond that. What is the situation at home? What are they working on? Things like that, as well. What can they share with us? What can’t they share? It was interesting that they couldn’t even share location (*laughing*) with me.”

Another nurse shared, “She was already in and working with another nurse prior and then I’m the new nurse taking over and just having a tough time making the connection anyway, because I’m the new nurse, and, you know, with a lot of agencies, they’d probably help, like WIC doing immunizations and things like that, as they popped up, I would try to catch someone in the office. But, you know, trying to connect with Social Services and having an understanding of where they’re at and where I can connect with them. I really haven’t gotten anywhere. No one has been able to tell me that information, so it’s been difficult and made me unsure of what my HIPAA rights - you know, what was okay for me to share with them then, too. We do have consent, so it’s interesting what they’re willing to share with us at times, so - anyway, that’s probably it that I’ve had.”

Caseload

Some nurses across multiple sites shared that NFP considered a full caseload to be 25 clients. However, many of those nurses discussed the challenges of maintaining a full caseload, especially with other responsibilities and as clients got ready to graduate from the program. A few nurses from a couple multi-county sites also discussed policies related to the division of their caseload across the different counties. They explained that when counties were funded for a certain percentage, a corresponding amount of clients and/or nurse full-time equivalency (FTE) was then devoted to that county.

One nurse simply stated, “Full is 25.”

Another nurse from a different site shared, “But, if I’m supposed to be at 25, I want to be at 25. And, I want to do my visits. But, when you have a high-acuity case, it takes - You have to do a lot of extra charting. You’re calling people, you’re doing extra work. I

guess, as an - And now, with this DANCE [Dyadic Assessment of Naturalistic Caregiver-Child Experience] - I don't even know how I'm going to fit DANCE in. That's another whole piece. I don't know if you're aware of that."

Another nurse from a different site stated, "Yeah. Yeah. Definitely. So, you know, when you're graduating you want to try to keep your load - You don't want to drop off all of a sudden and then have to pick back up. So, you know, occasionally you may go over for a while or you may go under for a little bit. So, it is a juggling act. You just kind of - And, I'm learning it because I'm still fairly new. And, I haven't graduated anybody yet. So, in May is my first graduation. Yeah."

In reference to dividing up their caseload between two counties, one nurse stated, "I believe we can have 10%, is that right, that's not right 'cause we are funded for [redacted] and 10% would be [redacted], that's not right because we can have 12 and I have 6."

In reference to a second county that they serve, another nurse from a different county shared, "Right now I have four and I'm - There's a 12 client caseload down there and [nurse name removed removed] and I split that in half..."

Enrollment Period

Many nurses across most sites talked about the various enrollment criteria for NFP. These factors included the clients being first-time low-income parents in pregnancy or the baby being less than 30 days old. However, a couple of nurses from different sites also noted that NFP prefers to enroll clients during pregnancy and that Colorado is unique in that it permits the enrollment of clients after a baby is born.

One nurse stated, "But, yeah, a lot of questions were asked about what we do, who's eligible. You know, and of course, our window of only being able to sign up until Baby is 30 days old, first-time parents, you know, really narrows it down in their realm of things."

Another nurse from a different site stated: "It's more for, do they qualify under, you know, for, um, how much money they make."

Another nurse from a different site stated, "I got the referral on the 15th. I saw her that same day, but the baby—no, I'm sorry. I got the referral on the 16th. [CPS caseworker name removed]—by the time [CPS caseworker name removed] got to us, faxed - anyway, it came Monday morning. I saw - The baby was born [redacted] night. I saw the baby - I saw her after the baby was delivered, which is not how we like to do it, as you know, in Nurse Family Partnership."

Another nurse from a different site stated, "Yeah. I feel like, with everybody, I - You know, in Colorado, we can put moms on after the baby's born - I think in a lot of other states, you can't. But, in Colorado, you can."

Length of Program

Multiple nurses across most sites and a nurse supervisor from one site discussed the length of the NFP program. Most referenced the length in regards to the stability it offered to clients and the difficulty that nurses and clients often had when the visits had to stop at the end of the two years postpartum. However, one nurse shared that in order to ease the transition, nurses had reduced the frequency of the visits and also provided the clients with a photograph of them during the last visit.

A nurse supervisor stated, “I don’t know. It’s just kind of one of those things because, in this program, you’re working with these families for two and a half years. You - It’s a partnership, and you really want to make sure you’re going down the right road because it can blow up, and you lose the client.”

A nurse from another site shared, “Well, like I said it’s new. So, we start seeing them once a month at-- When the baby turns 21 months. And that, you know, that is of course-- Like I have one gal that I see. She just - Her baby just turned 21 months, but I kind of feel like I still need to see her. So, I might see her for another month the regular every two weeks. But, for the most part, you see them once a month. And, you kind of wean yourselves away from each other. And, kind of get them used to not seeing you and me not seeing them because I actually kind of miss them. I really do actually. And, so far I only have two that I’m doing that with right now. So, like I said it’s really new to me. But, our last-- our last two visits, I’m going to take one of my little clients to the art center. And, that’s what most of the girls do. We take pictures and then our last visit we give them their graduation certificate and pictures that are framed.”

Another nurse from a different site shared, “And, she said, ‘[nurse name removed]’ - And, I said, ‘Yeah.’ I said - She goes, ‘We have to stop seeing each other when the baby turns two.’ And, I said, ‘Yes.’ And, she said, ‘Why is that?’ And, I said, ‘Well, that’s the NFP rules.’ And, she goes, ‘I don’t want you to stop coming.’ So, that was - Made me feel really good. I said, ‘Well, thanks, [NFP client name removed]. I’m glad you care about me.’ *(laughs)*.”

Organizational Procedures

Several nurses across all sites and a few nurse supervisors across multiple sites shared about organizational procedures. While nurses still tended to talk more about organizational procedures compared to nurse supervisors, more nurse supervisors talked about organizational procedures than they did about organizational policies. Most nurses and nurse supervisors who shared about organizational procedures spoke about procedures for referrals and client retention, internal resources such as staff meetings, supervisions, and other support systems. Other organizational procedures discussed by many nurses across a few varying sites related to education and training, NFP’s curriculum, accessing client information through medical records, community partner meetings, and client termination.

Referrals and Retention

Many nurses across most sites and a couple nurse supervisors from different sites spoke about their procedures for obtaining referrals and recruiting new clients. Most of these nurses and nurse

supervisors shared about other programs and organizations that they had worked with in order to obtain referrals. In most cases that were described, clients approached other programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Presumptive Eligibility, pregnancy centers, and school based-health clinics to seek their services and were then referred to NFP as an additional resource. As such, less was discussed around strategies or procedures that NFP actually implemented in order to obtain referrals.

A nurse supervisor from one site shared, “We are back to doing PEs, because PE was supposed to go away. You know, there was not supposed to be a Presumptive Eligibility process because you’re supposed to be getting on immediately. You’re on. No more PE. Well, it’s not happening, so we are doing PEs. We’re making appointments again, and... And so, so that’s where we get most of our referrals.”

Another nurse supervisor from a different site stated, “Also, I wonder if [public health department name removed] is, very, or - we’re, we have a higher risk population and so we’re more aware of these issues. We may see the pediatricians able, you know, dealing with things at a different level. We also have school-based health, so we have a lot of our young women in school-based health clinics being seen.”

A nurse from another site shared, “Yeah. The majority, I feel, of our referral sources are from Public Health here. So, the moms, a pregnant mom will come and apply for Medicaid and then our Public Health nurse here will refer her to our program or to WIC and then we’re also working on getting our, increasing our caseloads, so we go over to the hospital pretty regularly just to see if there’s any first-time moms over there that might, you know, need a little bit - want a little bit of support because we can enroll the moms until they’re 30 days postpartum. Yeah and then. We also, we attend [organization name removed]; we attend their meetings. That’s for the OB/GYN over there. They’re all in a building, so that’s what’s nice.”

A few nurses across a couple of sites described their organizational procedures around the distribution of referrals. Both sites tended to have a point person, the supervisor, who distributed referrals to nurses. One site distributed referrals weekly while referrals at the other site occurred more on an as-needed basis. The nurses were then responsible for contacting the clients and scheduling times to meet with their assigned clients to discuss the program.

One nurse stated, “Well, we receive referrals from our supervisor every [day of week removed], and we call them personally. And then if they agree to sign up with the program, then we schedule them, like tomorrow I scheduled two.”

A nurse from another site shared, “And then, when I need, when I let [nurse supervisor name removed] know that it’s time I need a couple more referrals, she gives me a couple, and I usually try to keep only two or three referrals at a time, so I don’t have too many out there.”

A few nurses from two sites also shared about their procedures related to transferring clients. A few nurses from both sites spoke about internal transfers and described that when nurses resigned, their clients were redistributed among the other nurses. One nurse shared that clients

who experienced changes in their nurses sometimes questioned whether or not they wanted to continue with the program. A nurse from a different site shared that they strived to do joint visits with the outgoing and incoming nurses, whenever possible, and that this strategy had helped them to retain many of their existing clients. Another nurse from a different site also described her site's procedures related to external transfers. When clients moved out of one service area, nurses filled out a transfer form and submitted it to the site to which the client was moving. The nurse shared that there were often challenges with this process because the nurses were not informed about the client or the status of the transfer by the receiving NFP site.

One nurse shared, "Yes. So, I currently have a girl - Yeah. So, kind of what happened is we had a nurse that resigned. And so, we got her - You know, we divvied up her girls. And so, I received one of her girls. So, when I called her to meet for the first time, and said, 'Hey, you know, we're going to meet now.' She said, 'Oh, I don't know if I want to be in the program anymore.' And, I said, 'Well, is it because switching nurses' because sometimes girls do that. She goes, 'Well, I don't know. Can I think about it?' And, I said, 'Absolutely.' I go, 'Why don't I call you back - You think about it. I'll call you back in a few weeks and see how you're feeling.'"

Another nurse from a different site stated, "We - how we do it at our site is, we always do joint visits together if we can help it, with the other nurse, the previous nurse. And she knew for a while; she was in a graduate program. She knew for a while she would be leaving, so she had extra time and we try to do it with all nurses, but we did the joint visits, and our retention has been really good from her caseload. I think it was 93% or something, and they aim for - I'm not sure exactly what it is, but 50 to 70%, I want to say. Yeah, it was good. I retained all her clients that I received."

Another nurse shared, "Um - Let's see, I think it could work more smoothly somehow. I know we have like a transfer form that we fill out and send over to the appropriate agency. And, I've gotten them, and I've sent them, but I haven't really had any contact with any other nurses. My girl that went to [receiving site removed], I hadn't heard anything, so I had set up a call and that's how we found out that she had started but then stopped. Otherwise, I kind of don't know unless my girls tell me."

Staff Meetings, Supervisions, and Other Supports

Multiple nurses across almost all sites described their procedures for supporting staff. Such support systems were consistent across most sites and included team meetings, weekly reflective supervisions, and case conferencing. One nurse also mentioned staff retreats and one nurse supervisor from another site mentioned the CPS hotline as a support for nurses uncertain about whether or not to make a report. Nurses across these sites described having used these support systems to address challenging situations with clients where they did not know whether or not to make a report, how to best support the client, or felt that there was an ethical dilemma about which they were uncertain how to best proceed.

One nurse shared, "You know, NFP, we have retreats, we have team meetings, we have reflective supervision, you know, every week. And so on. We have lots of support."

In describing the process for when nurses are uncertain about whether or not to make a report, one nurse supervisor stated, “They would call and talk with me, we will review it or you know if I’m not here, maybe [nurse name removed] who is my senior nurse. I encourage them to call and ask, whenever they don’t know to call the hotline.

Another nurse supervisor from a different site shared, “And, sometimes, when we have had a case where I’ve worked with a nurse, I’ll ask them to present it as a case conference, so that everybody can learn from what they’ve had to go through with it. And, there’s no - There’s really no judgment on this team of each other, which is really great. You know, and they just - They most likely will have talked to the other nurses as much as they could before they even bring it to me. So, they’re all aware of it. I mean, I find that out all the time where, you know, they’ll bring it up in team meeting, ‘Oh, that’s the one you were talking about the other day, isn’t it?’ (*laughs*) You know, but that’s how strong this team is.”

A nurse from another site explained, “It’s been nice, too, because with Nurse Family Partnership, we can bring difficult cases that have a little bit of an ethical dilemma to our case conference time and gain input into how other people would deal with that, what our, for instance, our Nurse Practice Act might say or what our mandates are for reporting, or really understanding the issues of what we do. Most of the time, if it’s a real specific issue, we’re dealing with that in our scheduled time with our supervisor where it’s confidential.”

Community Partner Meetings

A few nurses and a couple of nurse supervisors across multiple sites shared about their organizations’ involvement with community partner meetings. One nurse supervisor spoke about having attended meetings for different coalitions and partnering health organizations or received notes from those meetings in order to stay informed about their work and potential areas for collaboration. Across multiple sites, the few nurses and a couple of nurse supervisors who spoke about their involvement in community partner meetings shared that the meetings were beneficial but that it was challenging to attend them due to their limited time and competing priorities.

One nurse supervisor stated, “Well, we have the MIECHV group that’s running out of Early Childhood Council. Again, there’s a human service group on resources, but one of our partners in [program name removed] attends so we get that information. So rather than all of us attending all of these things, they do attend that. And then I get that information from [name removed], [program name removed] sends us updates all the time.”

Within the context of participating in Child Welfare meetings, a few nurses and a nurse supervisor across a few sites described their involvement in Child Protection Team (CPT) meetings – a larger team involving community stakeholders that retroactively review and discuss cases, including how they were assigned or closed – as well as High Fidelity Wrap-Around meetings – a voluntary process created through House Bill 1451 that uses outcomes-based and strengths-based approaches, encourage natural supports beyond agencies such as neighbors, relatives, and friends, and promotes creative problem solving and the blending and granting of funding and services. A couple nurses and a nurse supervisor shared that their respective sites

had designated representatives who attended their local CPT meetings. One nurse also shared that previously, nurses from her site used to rotate the responsibility of attending the CPT meetings but that they too now had a designated person. Unfortunately, this nurse felt that the previous structure allowed for more personal relationships compared to the new structure. One nurse also talked about her site's involvement in Wrap-Around service meetings. She felt that these meetings were important and allowed for a client-centered model.

One nurse supervisor shared, "So, but we do also have - We have a - It's like a Child Protection Team here in [county name removed]. They meet every other week. I'm not part of that, but our boss, [name removed] is. She sits on that team. And, you know, that's something else that sometimes we do is I'll go to her, 'Have you heard of this family in Child Protection?' You know? I mean, we all - We all sign the confidentiality agreement. We all - You know, it doesn't go outside of here, but she's on the team. So, I can also find out if that child, if that - 'Does this name sound familiar? Or, is this.' - You know, I mean, because if they're already - The heads-up is already there, I might not need to add to it if they're already thinking about this family, you know. But, our program as nurses in-home what we are concerned with carries a lot of weight with Social Services."

A nurse from a different site stated, "Right. Yup. Well, we have two public health nurses and then [name removed], our supervisor, the director of public health. They have a schedule and somebody usually attends their CP team."

A nurse from another site shared, "And we've lost that. So that nurses don't get to do that, it's a designated person in the community and they do that and then we had a certain division that, where they had one nurse that went to all the CPTs rather than kind of an assigned day that was yours to go. I think that when we did that, we got a little bit more attention because they knew you were at the table, they knew who you were and there was a more personal connection of what you were saying. So but I don't think that would really be necessary. Um - we have some CPTs that we go to with, for our clients."

In reference to the Wrap-Around service meetings, one nurse stated, "So, I think the once a month meetings were really critical because then everybody was there, we're talking with the patient. It maintains the integrity of the NFP model by not talking behind their back and making decisions with their involvement. There have been a couple cases where I was at the visitation house with some abuse, or we were meeting at the guardian ad litem's office, situations where the baby may have ultimately gone into foster care or been relinquished to another family member or something like that.

Education and Training

Multiple nurses and nurse supervisors across a few sites shared about their processes around nurse trainings. Most supervisors and nurses spoke about ongoing trainings but a supervisor from one site talked specifically about the orientation process that nurses initially went through upon hire. This nurse supervisor shared that new nurses were required to take a 30-40 hour online training followed by a one-week in-person training in Denver prior to seeing any clients. Another nurse supervisor from the same site also mentioned additional educational resources that nurses received upon starting such as a handbook and access to the online intranet.

The nurse supervisor stated, “Well they have, when they first start, they have an online class that they have to do and stuff, 30-40 hours online, unit 1. And then they have to go to Denver for unit 2 training, and that’s a whole week. They can’t start seeing any clients until they finished unit 2. And the expectation is that they will have built their caseload to full caseload by between 7 and 9 months, because you don’t want to overwhelm them. So it takes you know about a year long before they’re actually functioning at full caseload.

The same nurse supervisor continued to state, “Part of the orientation we’ve identified what are the core, you know, components that they need to receive that are just going to be common for everyone coming in. And child abuse and neglect is one of those core elements of the orientation. So they, the nurse supervisor covers that with them, they have, you know, a handbook that they can have a hard copy, or they can look online on our Intranet. And so they have that resource available. And then they’re advised that they need to contact their supervisor, you know, if they have concerns.”

Other nurses and nurse supervisors from different sites described ongoing education and training processes that occurred in a more fluid and somewhat improvised manner. Supervisors from a couple other sites described ongoing nurse education and training to occur on an as-needed basis through weekly supervision and case conferencing. These supervisors as well as nurses from another site discussed that group trainings around mandatory reporting and motivational interviewing occurred in a semi-formal fashion but that they were not necessarily a set annual occurrence. Although such trainings were often offered to nurses as supervisors deemed them as necessary, a nurse from one site also spoke about a professional development committee that helped their site provide such educational and training opportunities to their nurses.

One nurse supervisor shared, “So, as far as training, I think a lot of it is learning as you go. And, using our case conferencing and one-on-one’s, you know, to support new nurses through the process, so...”

In regards to their process for educating nurses about mandatory reporting, another nurse supervisor stated, “We would review the policy with them in house on hire and then if there is an opportunity, such as last year, all the staff went to hear [expert name removed] speak on child abuse reporting. And then each week when I meet with nurses, or if they are in the field, I ask them to let me know if there’s any situation that has any questionable pieces to them.”

The same supervisor continued, “Those are just designed at the agency level I don’t know. And actually I don’t know if mandatory reporting is every year, it changes. Some years depending on what needs to be discussed.”

A nurse from a different site shared, “No. The motivational interviewing was over the course of several weeks. We’d set aside, I think it was like three or four hours a month, for a while. And, that was through NFP.”

Another nurse stated, “I also do participate on the Professional Development committee here so organizing educational things for the nurses, team building stuff. That’s kind of the role of the Professional Development committee.”

Curriculum

A few nurses from a couple of sites shared about their sites' set procedures related to delivery of the NFP curriculum. Some aspects of the curriculum described by these nurses included discussions around substance use, including how to educate clients about the risks of marijuana, transitioning babies to solid foods, and healthy communication styles and relationships. Across both sites, the set curriculum was conveyed to clients through verbal teachings and using facilitator guides and handouts.

One nurse shared, "That we can't ever be a nurse again because we didn't call. So, but that's the - The setting up the situation at the very first visit is really important. The, um - Yeah. And, very often, the way the curriculum is arranged, usually about that third visit, we're talking about substance abuse and dangers and risks and things like that. So, it's really opening up that door very early into the program."

Another nurse from a different site shared, "About marijuana: But, that basically, what we've been directed to do is just, you know, do safety teaching like we would for secondhand smoke. 'You shouldn't smoke around your children. You should always smoke outside. Blah, blah, blah, blah, blah' - Although they can't smoke outside because that's illegal, so now we're seeing a lot more of it, they're smoking in the home with the kids."

Another nurse stated, "Again, the client or the nurse across the hall had to call DHS on a baby that was 8-1/2 months old and 11 pounds, which isn't okay and the mom wanted to be exclusively breastfeeding still and wasn't wanting to start solids and, which our curriculum says starting solids 4 to 8 months and I'm like you have to wonder if they think that it's okay to wait until 8 months to start solids which is not."

Another nurse shared, "So, it's been really rewarding. The facilitators offer a lot of help for our clients. Sometimes, it may be overwhelming to read during the visit. But, some moms really function well leaving it and they'll look at it later. Especially some of the communication modules on learning how to talk with people. The - I find that I have a - With younger people, they really are naïve about a lot of relationship issues. I love the way that Family Partnership includes a lot of issues with the dads. We live in a military community, and I've had several parents with a PTSD issue..."

A different nurse stated, "I haven't personally to her yet, but we - I, you know, generally, we talk a lot about - We have, you know - NFP has a lot of handouts on, you know, violence, nonviolence, those are some those nice handouts that we have."

Client Termination

A couple of nurses and a nurse supervisor from a few different sites discussed their procedures around client termination. One nurse explained that nurses had to discontinue client visits after a client lost custody of their child. Similarly, a nurse from another site shared that if a client did not have custody of their child for thirty days, nurses were unable to start-up their visits again. A nurse supervisor from another site shared that termination of a client had occurred when there was a safety concern for the nurse.

One nurse explained, “So, yeah. Once you - Once you lose custody - You know, the baby went to foster care, that’s - I can’t see her anymore, so.”

A nurse from a different site stated, “So I think the best case scenario did happen, although once the custody gets taken away and the mom doesn’t have the baby for thirty days, you can’t step back.”

A nurse supervisor from another site shared, “And then, myself and [name removed] - Because [nurse name removed]—if she had her choice, she would have continued to see the client because she’s always the client’s advocate. I, on the other hand, looked at her safety issue, and I had huge concerns about her being anywhere near that gentleman, and she was not letting him out of her life. He was still going to be part of her life. So, that’s when we just said, ‘No. You can’t go in there anymore.’ And, we just sent her a letter stating that she was no longer in the program. That was it. And, it was strictly - It was a safety decision that I definitely stand by, so...”

Paperwork and Documentation

A few nurses from a couple of sites spoke about their sites’ procedures around paperwork and documentation. A nurse from one site described that there were documents that were submitted to NFP but that documentation occurred in different ways across nurses due to their subjective nature. Nurses from both sites shared that NFP had a tremendous amount of paperwork in which clients and nurses often became inundated. One nurse specifically discussed the challenges of balancing all of the paperwork with other responsibilities and that the added workload frequently led to nurse burnout.

One nurse explained, “Evidence [Efforts] to Outcome. It’s kinda what we call everything that we turn into NFP.”

Another nurse from the same site shared, “So - and then the other thing I think is documentation can be a very gray area because it’s all narratives, depending on how we document. I don’t know if this is what you’re looking for, but everybody can document different. We have a rating system for our problems and goals, like based on their knowledge, behavior and what’s the last one? I can’t think of it right now, but depending on how we rate them, it could be different between the nurses. That’s a huge gray area that our facility is aware of right now that we’re trying to work on and get further training.”

A nurse from a different site stated, “It’s another - They keep adding - They keep adding more paperwork and adding - They haven’t taken away our caseload, taken away anything. They keep adding stuff to our job. I’m working much harder than I did when I started this job. Well, and part of is, I know, I’m a better nurse. I’m not... I mean, I have more - I know more, you know. But, I would say for nurse burnout—and, I know that there is issues in other sites—they’re losing nurses. They need to reduce - Either... If they still want us to do all this stuff, they need to reduce our caseload. Or, say, reduce the amount of visits we need to see the clients.”

Internal Organizational Structure

Several nurses across all sites and a couple nurse supervisors from different sites discussed their internal organizational structure including when their sites were formed, their locations, their staff structure and division of caseload, and their CABs. In regards to the length of time their programs had been around, a nurse supervisor from one site and a nurse from another site mentioned that their sites were only created within the last couple of decades. This demonstrated that NFP sites were much newer compared to Child Welfare agencies. The nurse supervisor also mentioned that their multi-county site was split into two sites in recent years.

One nurse shared, “And, I learned about - It was in a newspaper article about Nurse Family Partnership. And then, my first degree was in [redacted]. I was a teacher. And so, that was interesting to me. And, I just thought that would be really a cool thing to help moms. And, but when I graduated from nursing school in [year removed], Nurse Family—at that time, Nurse Family Partnership wasn’t in [county name removed]. So, my first nursing job was at the hospital, and I was there for [redacted] years in, in med surg/ortho neuro.”

A nurse supervisor from another site stated, “So, it just never came up. I just - You know, I mean, I know it happened, but not for me, you know, personally. But, I don’t really have any. And - our director of Social Services is very supportive of NFP. He plays... He was a key player in getting it going here when they started back in [year removed]. So, he very much was supportive of it. And, he’s still the director over there, so - So, I think we have a very good rapport. He’s on our CAB. We have - Actually, we have one of the caseworkers on our CAB, too.”

The same supervisor also stated, “Okay. I have been with NFP since we started in [county name removed] and [county name removed] counties back in [redacted] when we started the site. And, I am currently - I was a home visitor. I took on the supervisor role about [redacted] years ago. And, we were a multi-county site at the time, so we had two supervisors at our site. And, [redacted], I stepped out of the role for a year, but the process was that we split sites, and so now we’re our own site of two counties: [county name removed] and [county name removed] counties because we were a [redacted] county site. So, I also am a home visitor as well. And so, now I’m back in the supervisor role.”

Service Areas

A few nurses across multiple sites described the boundaries of their service areas. Although nurses from urban areas discussed serving clients across county lines due to the transient nature of their clients, a nurse from a single county site described that they did not provide services outside of that specific county. A few nurses from a couple of the multi-county sites described that nurses were assigned to different counties and certain counties were allocated varying FTE based on funding.

One nurse stated, “No, we don’t cross county line. We’re [county name removed] only.”

A nurse from a different site stated, “Well, I’m part time, so I’m in [county name removed], which we’re funded for one full-time person, so there are two of us there; myself, and then [nurse name removed]. I don’t know if you interviewed her.”

A nurse from another site shared, “Sure. The first one wasn’t in our county, because I’m one of the two nurses that does [county name removed] as well, up in the mountains here.”

Staff Structure and Division of Caseload

Numerous nurses across multiple sites and one nurse supervisor described their varying staff structures and how they divided their caseload. Multiple nurses and nurse supervisors across many sites described that 25 clients was a full caseload but one nurse supervisor specifically described that sites were funded for a certain number of clients and that being fully staffed meant having a nurse for every 25 clients because funding was based on how many groups of 25 clients were being served. Another aspect of dividing caseloads that was discussed at a different site related to providing culturally and linguistically appropriate services. A nurse from this site described that nurses divided up their clients based on the nurses’ abilities to communicate in different languages. A couple other aspects of staff structure that were discussed included the transient nature of some nurses due to their military affiliation and the use of committees such as marketing committees and professional development committees to carry out their work effectively.

One nurse supervisor stated, “Okay, we have, we’re funded for two hundred and fifty families, so when we’re fully staffed we have ten nurses.”

A nurse explained, “Well, she’s the Spanish-speaking nurse. She just does Spanish-speaking, and then I do the English. A total of - Our caseload - We can take 25 clients.”

A nurse supervisor shared, “That’s good. But, we have a very, well, we have a transient population here in [county name removed] with the military installations. And we also have a transient workforce. So, right now [percent redacted] of my staff are married to military.”

The same supervisor explained, “So, we have a marketing committee, and we’re working on identifying you know a comprehensive strategy and doing community outreach, and then also making sure that the primary thing is making sure our team is healthy and that we’re working together.”

A nurse supervisor from one site specifically discussed how the site divided up supervisory roles and responsibilities. She explained that the level of FTE for supervision had been predetermined and that the two supervisors shared this time as well as the tasks such as direct nurse supervision, orientation, professional development, administration, budgeting, and reports.

One nurse supervisor stated, “And the way it’s been is that there’s my position at [percent time redacted] and then a supervisor, nurse supervisor, at [percent time redacted]. So we’re funded for [percent time redacted], up until the next contract, I believe we’re going to have two full time supervisors.”

The same nurse supervisor continued to explain, “So what I did is have the nurse supervisor who has four nurses, and then she’s in charge of the orientation and new staff coming on, and it’s a very comprehensive orientation, and then she’s also responsible for the professional development for all of the staff. So then I do more the administrative part of it, with you know managing the budget, submitting reports, kind of thing. And reviewing, well both the nurse supervisor and I review our ETO reports, so.”

Location

Many nurses across most sites discussed how their location impacted their work. Multiple nurses across a few sites shared that being co-located with their local DHS provided many benefits such as being able to see clients while they were in the building for other services and having improved collaboration with CPS. However, nurses from a couple of sites shared that despite the benefits of co-location, being on separate floors or being located off to the side of the building that was less frequently visited by staff and clients led to less interaction and thus less collaboration than entities that shared a floor or hallway.

One nurse stated, “Well, I just feel like it’s - You know, we’re in the same building, but the Health Department is here and DHS is here, and we don’t, you know, cross over much. And so, I feel like there’s a separate feel, a feel of “this is this team,” and “this is this team.” So, that’s a barrier. And then, I guess, I think as nurses, we feel like, ‘Oh, my gosh, this family needs so much help,’ and we feel like, ‘Why isn’t CPS doing anything?’ You know? And, I know their process is different than our process, so I think we, as nurses, kind of feel like they should be doing more or something.”

A nurse from another site shared, “Yes, we did, through the Child Protection Team and, then, over that time between, since I started NFP in [redacted], in between that time, I was still seeing [CPS caseworker name removed] during team meetings because, you know, historically, Social Services and Nursing have been part of one big, overall team under one Director. And I think that really has helped communication and trust, to see each other because we’re [redacted] and we run into each other at parties together, and historically the Director for Human Services used to be public health nurses, the last two Directors and [name of current Director removed], too, the present Director, have been public health nurses, so there’s that crossover between Public Health to Social Services all [redacted], doing parties and Christmas parties, getting together and seeing people, meeting people at the mailbox and talking to them, you know, stuff like that.”

Another nurse from a different site stated, “Part of it, too, is we’re kind of on the edge. We’re kind of off to the end of our department and we don’t interact real closely with other clinics so people don’t really see us a whole lot, um to kind of associate. We always have to tell people where we are because they don’t really know where we are and how we’re connected with things, but um, the um. I like being in the same building. I mean I’ve been able to meet clients at different appointments. I mean one was waiting for food stamps and they had a long wait and we were able to do our visit, you know, while they were waiting.”

One nurse shared, “Some of them are very good at collaboration; however, the manager of WIC, I had to verify their enrollment in WIC a few times and she’s always willing or

if I need to pull growth charts, she's always willing to get those for me. Our departments are [location name removed] so I think it's easier in that realm whereas CPS is [location name removed] and they don't see us on a regular basis. I think if maybe it went along the lines of CPS, too, is if we had more type of trainings together and they saw our faces more often, they would be more willing to work with us because it's like our clients – they don't really - they're kind of leery of the program until they meet you and see your face, then they find out you're not so bad or scary and they're a lot more open.”

A couple of nurses from one site also discussed the benefits of being co-located with organizations beyond Child Welfare. Such benefits included having received referrals from a co-located organization that served a similar clientele and having health professionals from other organizations provide support and serve as a resource for case studies.

In reference to having received many referrals from a particular health service organization, one nurse stated, “And, then us being housed there, of course, they help us out, so...”

Another nurse from the same site shared, “So, she's here all the time. She's actually downstairs in our mental health department. And so, she'll come up once a month when we do case studies, and just sit in on them.”

Community Advisory Boards

The majority of NFP sites discussed representation on their local CABs. These CABs had met, for the most part, quarterly and involved representation from a variety of community organizations including: local mental health services, various church organizations (e.g. Catholic Charities), hospitals, homeless shelters, and other early childhood programs (e.g. Families First). Some sites expressed that a representative from WIC and/or Temporary Assistance for Needy Families (TANF) also sat on the supporting councils. A couple of sites mentioned that they had tried to recruit a diverse group of local individuals who had been affiliated with NFP.

One nurse stated, “Usually, I mean, they're just there as, you know, as our advisory board for the Nurse Family Partnership. We tried to get, you know, a good mix of our community and who is involved with our program.”

In one site, nurses and nurse supervisors shared that representatives from CPS (or DSS) were present, engaged, and interactive on the CAB. A nurse supervisor from another site expressed that CPS used to have representation on the board but due to time constraints, the representative no longer participated. Several NFP nurses from another site spoke about utilizing the TANF representative on their CAB to better bridge current gaps with their local CPS.

One nurse stated, “Actually, we have several of the caseworkers and the head of Social Services on our CAB meeting - usually, I mean, they're just there as, you know, as our advisory board for the Nurse Family Partnership. We tried to get, you know, a good mix of our community and who is involved with our program.”

Another nurse shared, “Yeah, not that - No. I mean, we - [DHS representative name removed], a person who sits on our board, on our - She, she oversees the TANF part, the

food stamp part. Not the Child Protective part, but um - But, I think we have her, that connection, and I think we're going to probably, hopefully utilize that— Yeah. In the near future.”

Several sites expressed that their CAB representatives attended the meetings to provide updates on their programs. As well, these organizations who sat on the CAB were usually those that provided services for NFP clients and supported the NFP program. In addition, some nurses from several sites had frequently outreached to other organizations and invited them to sit on their CABs. A couple of nurses from different sites also shared that the CABs had allowed them to stay better connected with represented organizations and thus maintain stronger relationships.

One nurse supervisor shared, “Yeah. So, we - we do a lot of referring. The homeless shelter also is part of our community advisory board. We have a representative come, and she gives an update, and she visits with us. We have low-income housing. We have people come from [local hospital name removed], different church organizations that support us and come in. We have a [national nonprofit name removed] locally here that provides some direct services to families.”

One nurse stated, “Yeah. Most of them don't have a clue who we are and like this is the most populous county in the state. Not only should you know who we are, you should be referring people to us. Would you like to be on our community advisory board? I mean like - yeah that's all I do.”

In talking about the local Child Welfare agency, another nurse supervisor stated, “Yes. Well, last - Our first CAB, which was in November, the director could not attend, so he sent one of his lead caseworkers in his place. Now, we're having our next CAB next week, and it sounds like both of them are coming. So, I don't really need both of them there, but they're both coming this time, so— So, I think they'll - They'll tag team it after that, but—“

A nurse from another site stated, “Yeah. There is. You know, I think, especially with Georgia and everybody being in the program so long, that they've developed good relationships. Usually with at least one person from those different organizations. And, they like, you know, some of them will sit on our advisory board or ... So, you know, just being able to see them more than once a year helps I think with establishing that. And, like we have play groups at Catholic Charities. So, we're monthly - I mean we're pretty consistent that we see them.”

CPS Organizational Structure and Policies

Similar to NFP nurses and nurse supervisors, many CPS caseworkers and supervisors from all sites shared about their agency's structure and policies. Many caseworkers and supervisors from these sites expressed that the overarching goals of CPS were to keep children safe and to reunify families. A few caseworkers and supervisors from different sites mentioned that traditionally, these were not the goals of Child Welfare and some mentioned that the current goals also did not always align with what the public believed. However, numerous case workers and supervisors

emphasized that keeping children safe while remaining in their homes were the true objectives of Child Welfare. Additionally, some caseworkers from different sites acknowledged that the “system” was not a good parent and that if children could not stay in the home, caseworkers tried to have them placed in kinship care over foster care and foster care over institutional care. Many caseworkers and supervisors across multiple sites also commented that the new approach had allowed them to work more collaboratively with families and to have greater success. A couple supervisors from one site and a caseworker from another site also shared that if someone believed that the goal of CPS was to remove children from their home, they were unqualified to be a caseworker.

A caseworker explained, “And we call it concerns. You know, I don’t go in there are judgmental, and I tell them, ‘I’m not here to judge you.’ You know, a lot of times they’ll say, ‘Well you’re saying I’m a bad parent’ and I’m like, ‘No’ you know. That’s not what I’m saying, I’m saying you’re a parent who is going through some things that we need to help you work on and we’re here for support, not to judge you, but you know, our job is to ensure that your children are safe and uh, that their wellbeing is being taken care of. And how are we gonna work together to do that?”

In reflecting on how the objectives of Child Welfare has changed, one supervisor shared, “And now, it’s really about going out and seeking, you know, natural services and supports and resources for this family. And, how can we prevent legal action? How can we keep the family together? Even if we have to get kind of crazy creative with it. You know? I mean, we’ve - We’ve come up with some very creative plans to keep kids in homes whereas, traditionally, [redacted] years ago, we would just say, ‘Nope, you know, we’re going to remove.’ And - And so, it’s been really neat to say and - Because I think that, you know, that’s, I think, aided in the success of families making those changes is, you know, when they don’t feel that, you know, it’s so punitive, that their kids are removed the second they do this or that. So, it’s been a real shift in practice, so...”

One supervisor explained, “And, if that’s not safe, our next route is to put them with people they know, kinship placement. And, it - Kin may mean family, or it may mean neighbor, friend, somebody like that who is familiar to the child. Next would be foster care, would be family foster care, and that may be a stranger to the child. And then, the most restrictive form of care is our institutional care or our residential child care facilities.”

One caseworker stated, “If you don’t think that kids are better off with their families, then I don’t know what to tell you. You’re in the wrong place because we’re not going to be - We don’t - We just don’t rip babies out. It’s not what we do. (*unintelligible*) people think we do. And, I make fun of that, but we’re not, that’s not what we’re here for.”

In regards to having potential caseworkers understand the objective of CPS, another supervisor explained, “That’s one of our questions when he hires you... On - When you’re interviewing for a job here, that is a question that he asks, and if you get it wrong, you don’t get a job.”

Another supervisor from the same site stated, “And then, our job is to respect also the fundamental liberties of families to raise their kids as they can, as long as it’s not an unsafe way to raise a child - They are who raise kids. Not the government - And, I’ve told these guys from the very beginning, ‘This is what we do around here.’ - It’s at the very beginning of the Children’s Code.”

A few caseworkers and supervisors from different sites also discussed that an objective of Child Welfare was to provide prevention services to help prevent families from entering the CPS system. Even for families that came into the system, some supervisors from different sites mentioned that they worked to build their strengths and provided families with the various supports they needed so that they no longer needed to be involved with CPS. Such supports included referrals and resources to address their struggles as well as education on child abuse prevention.

One supervisor shared, “And, my philosophy was, ‘No, we’re social workers.’ And, we need to look at, how do we help families—even if there’s not abuse and neglect—or, but they’re red-flag kind of families that we know that are out there that we can really work at doing prevention work. And, that if we don’t do the prevention work, they may eventually become a Child Welfare open case, and we don’t want that. And, if we can work with kids and families prior to them becoming an open referral, we’re better off. The family’s better off. It’s easier to go from a lesser known crisis than going from a big crisis of abuse and neglect, and to make the changes and to be more of this open system of, ‘We’re here to help families,’ and not just do the old school of, ‘We’re going to just do investigations.’”

Another supervisor from a different site stated, “I wanna say this is a really good time in Child Welfare. All the years that I’ve even worked in Child Welfare I’ve never seen so many initiatives that I’ve seen now that are family focused on building strengths within the family unit. It’s a really good time at keeping families together and trying not to make families dependent upon systems such as Department of Social Services. It’s always a challenge, you know, you get involved with families, you provide ’em with the support that they need and then when you leave, sometimes the families struggle. And so, my dream is that we’ll be able to continue to, uh, find ways of supporting families after we are not involved with their lives, and um, I think that the state department is looking at developing more funding, flexible funding streams to support family needs that are, in ways of prevention. Preventative ways so that children do not become victims of abuse or neglect. So I’m excited about that, looking forward to that.”

Given these objectives, a couple of supervisors from one site discussed how success was measured based on whether or not clients entered or re-entered the CPS system. The supervisors shared that they did not base success on whether or not families were reported on since they could not control that but instead examined whether or not the report warranted an assessment and if so, the outcomes of that assessment. If the report resulted in the need for an assessment, they considered it partially successful if it was unfounded or inconclusive and unsuccessful if it was founded.

One supervisor explained that a case is considered to be successful “If the family says their goals have been met, for that team. Now, for the Community Response team, they’re called community case managers – that particular team, I consider it successful when we go back six months later and look at their TRAILS history. We look at - did they have referrals? If referrals came in, were they screened out? Because I don’t think it’s fair to determine whether or not a family is successful by whether or not someone calls in a referral, because some of the referrals are like- You can’t help it if someone calls on you. What you can help is, you know, what the outcome of that is.”

The same supervisor continued, “So, we consider it successful if it is still screened out. It’s not being up to the level of the law. Now, if they go out and they look at it again, like an assessment, and it’s unfounded or inconclusive, we consider it partially successful. But if they come back into the system, then it wasn’t successful. Because even though we tell families we’re closing, they can call us every day for the next six months if they want to, for anything that they want. It’s not a closed door to them. In fact, we’re constantly telling them, ‘Call us if anything comes up. We don’t have to reopen if you just need extra support or you can’t find a phone number, or whatever it is.’ So, we only consider it to be unsuccessful if they found it in assessment.”

Structure

The majority of caseworkers and supervisors from all sites discussed some aspect of the varying divisions and programs within the structure of Child Welfare. The most commonly discussed divisions and programs included prevention, intake, ongoing, and supervisors but smaller counties tended to have more generalists and some of the larger counties also had additional more specialized teams. Many caseworkers and supervisors across a few sites also shared about the structural changes occurring with their transition towards becoming a Differential Response (DR) site.

Prevention

Numerous caseworkers and supervisors from most sites discussed having a prevention program or preparing to begin implementation of a prevention program. The primary prevention programs discussed included aspects of DR (which will be explained later on), SafeCare, aspects of Program Area 3, Colorado Community Response or Community Case Managers, and related programs. Unlike other aspects of Child Welfare, most of these prevention programs were described as voluntary and thus, not court mandated. They also typically worked with families that were considered to be “high-risk” or had a history with CPS. However, many of the programs varied in regards to the age range of their service population and some aspects of their approach. The most commonly discussed were Colorado Community Response or Community Case Management and another related prevention program (name removed to prevent site identification). For example, the related program worked with children age 5-19 where families were struggling due to the child’s behavior whereas Community Case Managers worked with families where there was a greater need for intervention with the parents rather than the child and thus children were between ages 0-18. A supervisor from one site also stated that families used to have to be screened out prior to participating in prevention programs but two supervisors from different sites mentioned that families could now participate in their prevention programs without being in TRAILS, the Statewide Automated Child Welfare Database in Colorado.

However, one supervisor explained that if a family involved in prevention needed to be investigated for child abuse or neglect, their involvement with the prevention program was halted and thus, prevention and intake could not occur concurrently.

One supervisor described when a referral would be made to prevention: “A lot of times right as- So, if a referral comes in about concerns with a family, that’s the time we would make it. So, when they’re identified to, you know, our Child Welfare system as a family that’s either at risk or there’s concerns, that’s when we’d make that referral. Mm-hmm, yeah.”

In describing her interactions with potential clients, one caseworker shared, “Well, when they first meet me they are very adversarial (*laughing*) because I am associated with DHS and Child Welfare. But I pretty much come in with an open mind. I give them the...they have the opportunity to decline services...They can. We are 100% voluntary...We are not mandatory...No. I’m not court mandated.”

A supervisor shared, “So, [county name removed] actually has been, I want to say in the business of prevention for - not that we aren’t all, so officially doing prevention work for the past [redacted] years. They have two specific teams that I supervise – one is called the [program name removed], which has been involved for 11 years. That one really looks at the kids who...when we get a referral for the behavior of the child that the parents don’t know how to deal with anymore, and they’re like, ‘Take my child.’ Or, ‘I can’t handle this anymore.’ Or, because of the child’s behavior, they’re the a higher risk. You know, some of the kids with ADHD, ODD, mental health issues, or they’re just running away – you know, all of those issues and the parents are like, ‘I can’t do it anymore.’ So we have a case management team that is a multidisciplinary team that looks at those families and does intensive comprehensive case management services with them.

The same supervisor continued to state, “The community case managers really work on where the parent needs the help more than the child needs the help. And a lot of times what I’ll do is, if we’re not sure, I’ll send the community case managers in first. They’ll assess the situation and then they’ll move it over to [program name removed], where they need more long-term support.”

Another supervisor explained, “And, the other part of it is, when a family, when a Prevention worker is working with them, if a concern comes in about abuse/neglect, they have to stop their work, so that we can conduct our assessment and investigation prior to beginning. So, sometimes, it will disrupt the services that they are providing for families, trying to mitigate some of that risk, and so that’s another frustration that they might have to stop progress, and then start back up and then stop, and so that’s - That’s difficult because we can’t work side by side, you know, continuously. They have to back out while we’re doing what we need to do, so - Yeah.”

Another widely discussed aspect of prevention was the shift in Child Welfare towards DR. A number of caseworkers and supervisors from multiple sites were familiar with DR and eager for the transition to occur. They explained that DR had seven components including aspects such as

family engagement, enhanced screening, and Review, Evaluate, and Direct team (RED team) and they viewed Family Assessment Response as the prevention piece. However, most explained DR as a shift in the overall approach of Child Welfare rather than a separate prevention program. The DR approach emphasized the involvement of families, training of communities, and identifying high-risk families. (Additional aspects of DR are further described under the Differential Response section.)

One caseworker explained, “So it’s a little more, there’s, Differential Response is really kind of a way to lessen the impact that we have on families when we come in, it’s more what can we do to engage families, as we are supportive, we want to help with change and make behavioral changes, it’s not a ‘Did you do it, yes or no and if you did, ok, we fined you for it.’ It’s much more about we want to do some prevention, we want to. And so there will be High Risk Assessment workers and then there will be FAR which are Family Assessment Response.”

One supervisor noted, “And, what we’ve tried to do is reach out to these different groups and say, ‘Look, we’re really trying to be more social workers, not just, you know, that’s why we got involved with the Differential Response program, so that we could be more of an advocate and social workers to work with families and help families.’...”

Another supervisor shared, “Well, I mean, there is a whole lot of change going on and with change you’re always going to have some bumps in the road and things to iron out. I think, looking at the greater picture, like it’s going to pay off, but right now there is a whole lot of change going on and DR will change, and it will change how we do our practice. So instead of responding to all allegations of abuse and neglect, like, it’s a high-risk situation.”

One caseworker said, “And so, we’re getting ready to do like DR, and there’s just a different way of doing Child Welfare... Yeah. So, I’m kind of excited about doing DR here and, you know, kind of training our community that we’re all responsible for these kids. Yes, we are here as the statutory agency to rein—to enforce the laws and stuff, but really, as a community, we need to do everything that each piece can do: the schools, the medical field, you know, everything to keep our kids safe.”

In regards to the specific changes that were expected to come with DR, a few caseworkers and supervisors across multiple sites described the dual-track - High Risk Assessment (HRA) and Family Assessment Response (FAR) – with the assignment to each track determinant of various scenarios and factors. In addition, within the DR model, response times to the report ranged from immediate responses for high-risk cases (HRA) to five-day responses for low to moderate-risk cases (FAR). Many caseworkers also described the RED team process which integrates multiple perspectives when determining how an alleged case should be handled. (These aspects of DR are discussed further under the Intake and Procedures – Reporting sections, respectively.)

One caseworker stated, “And, family engagement is one of those. Our RED teams that I’ve talked about is another one of those, and then, how we assign – So – well, the other part of that, the last part, the biggest part of it, of course. So, we do the traditional, what we call assessments. And, in the DR model, it’s called high-risk. So, but they also have

a FAR component, which is a Family Assessment Response, which is more of a prevention. So, they don't go out to investigate families. They go out to engage and look at how they can offer resources, services and support."

In describing the transition, a caseworker stated, "Referrals will go down two different tracks. A high-risk track and a Family Assessment Response track. So I will be doing the initial investigations but with lower-risk scenarios essentially. So right now, we have immediate, five days and three days. And so they are in training us, they are giving us that are going into the FAR positions, three and, I think, five day. I just got my first one, my first five day— and sort of learning that because of learning the paper trails and how to sort of just be familiar with the assessment because a lot of the family engagement is, the Family Assessment Response. Sorry. Is assessment; it is just a lower risk."

Another supervisor stated, "Yes. Differential Response means that, you know, what we do now is called the high-risk assessment track, or the traditional track. There are a lot of- You saw out there the team that was sitting here. That's a RED team: Review, Evaluate and Direct. That's one of the components of Differential Response where you have a team that looks at the referrals from the day before that weren't emergencies that need you to go out on now, and they're gonna review those and make the determination, 'What are we going to do on these?'...But, the alternative track, or in Differential Response, will allow us to be able to provide more services in that direction. And, those are to be preventative services. And, the whole idea is, these are only going to be open 60 days."

Intake

Intake caseworkers (also referred to as investigators or response workers) were described by numerous caseworkers and supervisors across all sites as those who assessed allegations of child abuse or neglect. Once a report was made, the case was assigned a response time for how quickly the victim child needed to be seen: 24 hours for immediate safety concerns, 72 hours for moderate risk, and 5 working days for lower risk. Many caseworkers and supervisors explained that this response time was often determined by the RED team where the RED team researched the family's criminal and Child Welfare history. The RED team was also described as a framework that was used to review the family genogram and discuss current safety concerns, dangers, risks, gray areas, strengths and supports for the family, and next steps.

One supervisor shared, "It's the same, yeah. So, Intake is - That's the - We're called the - They're called Response Intake. We've changed the titles a couple times, but with Intake, the actual goal is to investigate reports of suspected/known, suspected or known child abuse or neglect. And so, that's the function within the Intake position or title. And, then our direct responsibility is to assess for risks, safety, determine what, if any, course of action or intervention needs to happen at the time of our assessment. And then, we would carry forward with filing court actions, if needed, removal of children, setting up services or making referrals to resources that would be beneficial for families or that could prevent interventions from us through, you know, court actions or case actions, so."

One caseworker stated, "We are - We're given response times, and that response time is met by making a face-to-face contact with that child. If there's an injury or an immediate

safety concern, we have 24 hours, eight to 24 hours to see that child. Then, we have a 72-hour response to see that child or a five working day response, so we've got those differing response times."

A caseworker shared, "Well, from the time the reports come in, the assessments, from the time it comes in, it goes through a battery of procedures that we have. So the research team gets it and they pull in any history, um that may be related to the family, any criminal history and then it goes to the RED team, and then we kind of like spread it out and kind of look at it. Then a decision is made whether or not it needs to be assigned for investigation. Just because someone makes a report does not mean it's gonna automatically get assigned."

Another caseworker explained, "I don't know if anyone's told you about that. So, once a report comes into the hotline, they get researched to see if there's any criminal history, or any like DHS history, and then it goes into RED teams. And so a RED team is 5 people, there has to be a supervisor, and then there's case workers in there as well. And then, we basically tear apart a referral, we do a genogram, we find, we read through the report to determine if there's any like danger or harm, if there's complicating risk factors that are kind of on the edge. Um, we go through the agency history, the criminal history, try to find strengths and supports in the family, like if they're already involved in services and things like that. Um, and then based on the criteria from Volume VII on how they need to be assigned or what constitutes kind of the safety concern, that's how we determine what they have to be assigned. So it's kind of a long process. Um, and we just go through them one at a time and kind of determine if they need to be assigned or now."

Many caseworkers and supervisors across multiple sights shared that intake caseworkers then had 60 days (though some sites preferred 30 days) from when a report was made to assess for risk and safety and make a decision about what would happen with the family. The final decision could include: 1) a founded case where the case becomes ongoing, court action is filed, and/or children are removed; 2) an inconclusive case where families are encouraged to become a voluntary case and/or are referred to additional resources; or 3) an unfounded case where the allegation is not believed to be true and the case is thus closed.

One supervisor said, "Sure. So, well - So, we're mandated by law to be out of there in 60 days. We - At 30 days, we're supposed to be done, but they give up to 60. So, in 60 days' time, you know, if you have an answer, whether it be, 'I'm good to go. I'm out of your life,' or, 'We have some pretty big concerns here. We need to open a case.'"

One supervisor shared, "After we take the call, which is usually done with an intensive screening, an enhanced screening tool, which asks some specific questions about whose in the household, what are the strengths of the family, what do you think the needs of the family are, the vulnerability age of the child, things like that. Um - once that all information is done, it generally will go to what's called the RED team process, which is Review, Evaluate, and Decide [Direct]. Which means that we review the report, we evaluate whether or not it meets the Colorado Children's Code definition of abuse and neglect to include what are the family supports, cultural competencies, vulnerability of

the child, credibility of the informant, and then any danger/harm concerns that we might have as well as the history.”

Another caseworker stated, “And if there are or there’s questions whether or not there’s a lot of safety concerns, you can make referrals within the community, open up the case, you know, file a dependency and neglect petition in the courts- and order the parents to participate in a treatment plan or sometimes, you know, there is not truth to the allegations and then you can close your case with whatever the findings are, you know, there is “unfounded,” “founded,” and “inconclusive” are basically the summary.”

Within Intake, multiple caseworkers and supervisors from one site extensively mentioned having a designated position that primarily took the reports through their hotline, conducted investigations, and made referrals to other services. They shared that the individuals in these positions served an important role as liaisons to the community because they were typically the first point of contact.

One supervisor shared, “Well, right now what we are doing with our other two new community programs is if we feel it’s appropriate when we screen in the morning, like, oh this would be good for Safe Care or something, then we just write on the top of it and the [position name removed] who manage our hotline do those referrals.”

One caseworker explained, “And those are [position name removed], I’m not sure exactly, but they also do all the intakes. So they are the first responders, the first connectors for our reporters. So they are the ones that are going out and doing those mandatory trainings, so that people know what to report, and what the perimeters are.”

Ongoing

Multiple caseworkers and supervisors from a couple of sites discussed that their department also housed a unit of ongoing caseworkers. They shared that if an investigation could not be closed after thirty or sixty days, it was transferred to an ongoing case where a treatment or case plan was developed. Some sites also described having various units within their ongoing division based on the age of the children, where some worked with infants and toddlers while others worked specifically with adolescents.

One caseworker stated, “That doesn’t include all the assessments that we do and my subsidized adoption cases and you now, all of that. So once you have a caseload, that means it’s an ongoing case that you’ve done an assessment on the family and determined, you know, we can’t close it after 30 or 60 days, there’s enough of a concern that we need to, uh, develop a treatment plan for this family in order for the children to remain safely in the home.”

One supervisor shared, “We, our primary focus is school age children. So we usually focus on the 6 to 12 and we have a unit that more focuses on the babies and one that does all the adolescents. Right now we’re a little bit short staffed in, um, the other unit, that [specialized unit name removed], so basically at this point we’re getting a lot of the infants into our caseload cause of the overflow is what we get.”

Specialized Teams

Many caseworkers and supervisors from a few sites described other divisions and specialized teams that focused on a particular task or service population. Such programs related to Child Welfare (i.e., not adult protection) included the Military Team, Teen Pregnancy Unit, Sexual Abuse Unit, Institutional Safety Assessment Team, Expedited Permanency Planning, Children's Intensive Treatment Program, Foster Care workers, Foster Care and Kinship Support workers, Facilitators, and Educational Liaisons. Specialized units such as the Military Team, Teen Pregnancy Unit, and Sexual Abuse Unit worked with unique populations that often required additional knowledge and understanding of the challenges and available resources for such clients. The Institutional Safety Assessment Team assessed abuse or neglect allegations in institutions, the Expedited Permanency Planning Unit was required to have children six and under in a permanent home within a year of removal, and the Children's Intensive Treatment program worked closely with families to provide life skills including hands-on parenting skills development. Foster Care workers worked with children in the foster care system while Foster Care and Kinship Support workers worked with the adults taking care of the children who were removed from their home. Facilitators were hired by the department to help facilitate family engagement meetings and Educational Liaisons worked to build strong relationships with local schools and school districts.

A supervisor shared, "Um, I'm current employed with [county name removed] Department of Social Services as a Child Welfare supervisor. I supervise the [program names removed]. I typically supervise [redacted] caseworkers and [redacted] case aide at any time. Um, our primary role is, um, cases involving children six and under, um, providing intensive in-home treatment to the family if the children are at home or if they were removed from the home, providing intensive hands-on parenting, um, teaching various things in order to — to reunify the children with the family. On the other hand, we're also doing Expedited Permanency, which means the children have to be in a permanent home or we have to have a permanent plan for the children. Typically in our county we like to have that identified within 90 days of the case opening; however, by law it needs to occur within a year's timeframe."

One caseworker explained, "Yeah, the foster care worker she is the foster care — she licenses recruits, licenses, and monitors foster care. She also does adoptions, um, finalizes adoptions of children within our systems and has some — also some follow up for post adoption services. When people adopt from our county they can get some assistance from us in the future if they need to. Um, so I also, um, having performed her job when she's not here and, when she's on extended leave or whatever then I perform her job and I do adoptions or foster care as well when she's not here."

Another supervisor stated, "Yeah and so that's a specialized team. We also have a specialized team, which is what we call an ISA team, which is an Institutional Safety Assessment team. They investigate any abuse or neglect allegations in institutions. So anything that is licensed, licensed or unlicensed daycare centers, residential treatment facilities, foster homes, kinship homes, um or mental health facilities like [organization name removed], [organization name removed], things like that where kids are. They're required to be licensed by the state, but they are still in a caregiver role over children. And so those are institutional investigations and they're done a little bit differently."

Generalists

Many sites had caseworkers with specific roles such as intake and ongoing but a few caseworkers from different sites also described their roles as generalists. They shared that in larger counties, each caseworker may be assigned a specific task but in smaller counties, caseworkers often carried-out multiple roles. Therefore, they performed intake and ongoing duties as well as addressed legal issues, made community referrals, and handled terminations. However, sites varied in whether or not the same caseworker would see an entire case through. A caseworker from one site mentioned that doing the intake for a case did not mean that they necessarily received the case if it became an ongoing case; but, another caseworker from a different site shared that they continued with the case if their investigation turned into an open case, unless they already had a heavy workload and were able to transfer the case to another caseworker.

One caseworker explained, “Generalists means that we do intake, we do ongoing, we might do adult protection. So, pretty much the whole umbrella of what Child Welfare serves, we would do.”

Another caseworker stated, “So, in a big county like the metro counties, there will be for example one person doing one job where in a small county like us, one person will do many, many jobs, and you have to be proficient in all those areas. So, um, I — you know, my job for example I have to know everything about intake function. I have to know everything about foster care and adoption and adult protection services as well.”

Another caseworker shared, “Ok, um, I have been with this agency in the protection of a child, in the capacity of a child protection worker for [redacted] years last month. And um, I’m a generalist. I’ve done supervision, I’ve done, uh, just casework, I say just casework. Because it’s not just casework when you’re a generalist, uh, we do, you know, we take the referral and, uh, if we’re assigned the referral, we do the assessment, we determine if it’s an ongoing case, we do the ongoing case. If it goes all the way to a court case, a dependency neglect action, goes all the way maybe through termination of parental rights, uh, and then we, uh, also do the adoption.”

Supervisors

Many caseworkers and supervisors across all sites described the specific roles of supervisors. Responsibilities of supervisors varied within and across sites with some only overseeing a few managers and/or caseworkers while others had dozens of people working under them. In addition to providing supervision, roles of supervisors included giving support and feedback, meeting with caseworkers to staff cases, monitoring programs, overseeing the budgets, attending state meetings, writing reports, developing staff, negotiating with referral agencies, making decisions, and monitoring/managing workers’ caseloads and workloads. Although most supervisors did not carry cases themselves, a few across a couple of sites mentioned having to carry cases when they were understaffed or if they wanted to finish their existing caseload as to not have to transfer their clients to a new caseworker.

A supervisor stated, “So my role with, uh, with the caseworkers is to, uh, provide, um, supervision, um, oversight, uh to decisions that are made at all levels, from screening decisions, like when we first get referrals in, um, do we accept it for an assessment, you

know, investigate whatever the allegations are, um, so I'm involved in those front level decisions to decisions around do we open a case, do we, um, you know, request, uh, um file motions with the court to take custody of children. And of course the county attorney files those motions, but I'm involved in those decisions with the caseworkers and the county attorney's office. Um, I, uh, oversee all the information that goes into the state database, the trials database, and I review case files with the caseworkers, um, and I am involved in, you know, ultimately I guess, the buck kinda stops with me in terms of decisions that we make on cases. Um, whether that's removal, returning kids home, I help the caseworkers in terms of sort of clinical decision around what, you know, treatment planning, I review court reports that the caseworkers write to submit to court and approve those. I, um, I negotiate rates with out of home placements."

Another supervisor reflected, "So, ultimately, I feel like I'm continuously developing staff, developing my managers to be leaders, developing my supervisors to be leaders, so it's a continuous- In a lot of ways, it's similar – it's just my clientele is a little different. So, I'm just working with people who have a need or a desire to want to work within Child Welfare, and I'm just helping develop them and move them along in that system. Or maybe they want to go work somewhere else after they've been here for a little while, right? – recognizing this is not the place for me, but that's okay. Or I want to do something different. So, I think it's always a challenge working with people. There's no magic line. There's no- You don't have this protocol or procedure thing of this is how you do it, so that's why I like it.

Another supervisor shared, "Yes. So all the administrative stuff, you know, reports for the state, um, anything like that I do. I monitor their training; make sure they receive the proper training, the number of hours they need. I monitor that we have coverage in our unit at all times, um, I monitor their caseloads. So I meet with each of them. It's an open door so they're in my room all the time but we meet officially at least once a month to discuss caseload and we meet as a unit at least once a month, um, to see if we need to make any changes to the caseload so one worker is not overwhelmed and one's not having enough to do. Um, I do manage the on-call; make sure we have coverage there."

One supervisor stated, "Uh, only, I do right now because I'm down a caseworker, so I'm carrying a couple of cases. Uh, typically I don't carry cases though, when I'm fully staffed."

Differential Response

Many caseworkers and supervisors across a few sites discussed the structural changes in Child Welfare as a result of transitioning towards a Differential Response (DR) site. In addition to the prevention, the dual-tracks (HRA and FAR), and RED team aspects described earlier, two other key aspects of DR were shared by many CPS workers. The first was around increasing family engagement. The DR approach aimed to support families to make the necessary changes in their lives and minimize the burden placed upon them by Child Welfare. Furthermore, it was emphasized as a family-focused approach to treat families as partners in the decision making process.

One caseworker shared, “So, um, our county I think is moving into Differential Response in the next little bit here, which I think will be a little bit better because I think it works more incorporating families in the process versus just kind of coming in as the investigator.”

Another caseworker stated, “So it’s a little more, there’s, Differential Response is really kind of a way to lessen the impact that we have on families when we come in, it’s more what can we do to engage families, as we are supportive, we want to help with change and make behavioral changes, it’s not a ‘Did you do it, yes or no and if you did, ok, we fined you for it.’ It’s much more about we want to do some prevention, we want to. And so there will be High Risk Assessment workers and then there will be FAR which are Family Assessment Response.”

A supervisor explained, “So, it’s - I think it’s changed, but it’s positive change, and it’s really helping us to refocus how we engage families and how we do our practices, so yeah, I think it’s - It’s needed, so - Yeah.”

The other aspect of DR that was emphasized by a few caseworkers in one site was the involvement of communities. They explained that the community would be trained to have a role in preventing and addressing child abuse and neglect and that these issues would thus become the responsibility of the entire community and not just Child Welfare.

One caseworker stated, “Yeah. So, I’m kind of excited about doing DR here and, you know, kind of training our community that we’re all responsible for these kids. Yes, we are here as the statutory agency to rein—to enforce the laws and stuff, but really, as a community, we need to do everything that each piece can do: the schools, the medical field, you know, everything to keep our kids safe.”

Another caseworker shared, “And I’ll be doing the Family Assessment Response. Which I love. I can’t wait. Because that’s what I, that’s where I come from. Working with families, getting down on the floor, playing with their kids while you’re talking about what’s going on. And that’s a less, so I’m very excited for all of that. So we have a component that’s coming in that’s gonna be really kinda working with our community, cause our community sees us as bad guys.

Another caseworker explained, “I mean we are really trying with the Differential Response model, it really is trying to pull the community in and making the community responsible for child abuse and neglect and being available and really just not laying everything on DHS.”

Procedures

Numerous caseworkers and supervisors from all sites described the various procedures within Child Welfare. These procedures related to reporting, cases, referrals, and meetings. While some procedures were consistent across sites, there were also some variations across sites especially in regards to meeting frequencies. There were also variations within and across sites in regards to caseloads.

Reports

Numerous caseworkers and supervisors from all sites shared about their reporting procedures. Many caseworkers and supervisors from most sites discussed having a hotline for their specific county that they widely publicized and that anyone could call anonymously to make a report. However, sites varied in that a couple had designated staff – either an individual or specific unit – whose primary responsibility was to answer the hotline, and others rotated that responsibility across multiple caseworkers. A few caseworkers and supervisors from multiple sites also shared that they had on-call caseworkers who took calls from the hotline even outside of regular business hours. In addition to the hotline, one site mentioned that reports could be made in-person, via fax, and through email as well.

One caseworker stated, “Yeah. We - We are set up so that we share - You probably know from doing other interviews that each county handles their own sort of screening. Calls come in to each county independently.”

One supervisor explained, “The community knows that number. I mean really, it’s on billboards, park benches and it’s [redacted]. You would call that and then you would be greeted by what’s called a [position name removed], which stands for [redacted], or I’m sorry [redacted]. They’re gonna take the calls from the reporters and they’re going to go over kind of what to expect in the calls, disclose that they’re able to remain anonymous, and just take the call.”

Another supervisor shared, “On-call — because we’re required to have a child protection worker available 24 hours a day 7 days a week. So, we have a calendar — every worker is required — and it’s when you, um, are hired it’s part of the job duties that you are assigned a week of on-call every 7 weeks because...”

Another supervisor stated, “We take reports right away, so if somebody does call and it’s even after hours, we’ll have a caseworker call and follow up with them immediately. Um, if the call comes in from another county, they’re supposed to get in touch with us directly - and we have caseworkers, again, 24/7 to be able to do that.”

One caseworker shared, “Okay, so we have one full time worker that it’s her full time job to take the hotline. She’s been doing that for [redacted] years, um, and when she is at lunch or something or wherever and other people have to, um, do that and they’ve also receive training in taking hotline calls.”

One supervisor said, “So we take phone calls 24 hours a day, 7 days a week. The bulk of our calls come in during regular business hours, which is 8 to 5. We do have a number of calls that come in after the hours as well. But during, when we receive our report and we not only do we receive phone calls we also get faxed reports and we have an e-mail system that takes reports as well. It is called [redacted] and so people can e-mail reports to us as well and that number has increased significantly over the last couple of years - They can also walk in as well.”

Many caseworkers and supervisors from most sites discussed their recent transition to a more detailed screening process that some workers described as enhanced screening. They described

the enhanced screening process of DR to include more extensive questions not only regarding the allegation but also about the family's strengths, the child's condition, domestic violence (DV), and what the reporting party thinks should happen. Furthermore, these sites described having a team such as a Daily Assessment Team or RED team where non-urgent reports were discussed thoroughly to determine the most appropriate response. Numerous caseworkers and supervisors from multiple sites also shared that the new screening protocol included three response times that could be designated to each case – immediate, three calendar days, or five business days – based on the severity of the case.

One caseworker shared, “And, then the other questions we ask every caller about domestic violence. So, if they're aware of any domestic violence in the home no matter what they're calling about. And, then we ask about child functioning. And, then the strengths and supports. And, then we always ask the caller what they think should happen. Whether they think this child should be removed. Whether they think they just want this family to get some more support. Or, they just wanted to report it because they are a mandatory reporter. We want to know like what their opinion is of what we should do with the family.”

Another caseworker said, “So, people call into the hotline, um, they make a report, and from there, um, it either goes—it's usually they're directly assigned to a worker if it's, like, an immediate—there's imminent risk and danger for a child, that needs to be addressed instantaneously...Or it goes through our RED team process. Our RED team process we focus on looking at, um, we have about five people who are on each RED team. We assess the family's, you know, name. We do a genogram. We do look at any past criminal or DHS history. We assess, you know, for danger and harm situations and any complicating risk factors, some maybe gray areas for the family.”

One supervisor explained, “And so, we will do - A lot of times, when we're reviewing assessments, we have two - We call them RED teams, and they're Review, Evaluate and Direct. And so, when assessments come in, when reports of abuse or neglect come in, then a team will sit down and review each one of those with the supervisor that facilitates that to determine whether it meets our state criteria for maltreatment and whether we assign that or not. Some of those cases, there's a lot of risk in what's being presented, and so that's where we'll determine, “Is this a family that could benefit from Preventions to go out and address some of those risks to prevent them from coming into our Child Protection?”

Another supervisor shared, “We're trying to get more information out of those initial calls---because that's really the start of our case, our potential case and we need to have as much information as we can. And then from that time, the referrals are then screened in what's called DAT, and that stands for Daily Assessment Team, a group of what will be one supervisor, and three case workers. And then [unit name removed], the [liaison position name removed] will then screen whether those referrals need us to go out on an immediate, a three-day, or a five-day, and then we can also just like to screen out calls and refer them to say NFP or Safe Care or Community Response and not penetrate our system.”

Another supervisor stated, “And in some ways, we’re currently doing these things already, but the RED team’s approach is a structured, evidence based approach that’s being used throughout the state and has been determined to be a consistent, effective way of assessing, um, safety, permanency and wellbeing of the children and families. So when we get those calls, I think the caller, there’s a process that you explain to the caller, how the case is gonna be handled when they call and why you need the information that you’re asking them for. Which I think is a more engaging process and will give us more information about the family in order to be able to make the right decisions to support that family and build upon maybe their strengths and things that they’re already good at.”

Cases

The service population of caseworkers varied within and across sites depending on their positions. Although it was discussed that caseworkers worked with the entire family and not just one person in any given household, many caseworkers and supervisors across a few sites explained that the CPS clients always had a postpartum child who was typically under the age of 18, after which they were transitioned to adult protection. For this reason, CPS could not work with pregnant mothers without other children in the home even if they were using drugs or engaging in other high-risk behaviors that could compromise the life of the fetus. Although most cases were closed once the child was above age 18, a couple of caseworkers shared that those experiencing extreme difficulties could stay in the system until the age of 21.

A caseworker stated, “So, we can be - That’s one thing that our program can do is we don’t have to - We don’t work with just the one client, we work with the family systems model, so we would work with everyone in the family...”

Another caseworker explained “Well, once we - Really, from the beginning. Once the referral is made, if they’re accepted to the program, I think that’s the point, you know, the nurse and I, the nurse and whoever is working with us, you hit the ground running because if you- Depending on, really, we don’t open - Technically, we don’t open on pregnant kids. We are open on the mother. But, you can’t open a case on a fetus kind of thing.”

A supervisor shared, “And we don’t hear about the mothers prenatally. You know, people try to, you know, I have this pregnant lady whose using drugs, well call us when the baby’s born. ’Cause we don’t, you know what I mean. I said we know it’s terrible and it’s horrible, but we can’t do anything till the child is here.”

A caseworker stated, “We’re not good parents, but at the same time, for whatever reason that we didn’t have another family member step up or community, you know, community people step up to take this child, we have to do our best to make sure that, once that child gets to 18 and gets emancipated, that I’ve helped them get the skills or directed them to the skills—because I have three of those right now—that, for as long as they’ve been in the system, and as long as they have the case, that I made sure they have the services and have what they need, so when we do turn, close their cases at 18 ½ and 19, that we’ve left them with enough of a foundation to succeed, given that we removed from their parents at ten.”

Another caseworker said, “And, they were never wanted to be adopted or were not adoptive-eligible. The difficult ones, where we get these new cases with 17-year-olds that are—for whatever reason—we get them open at 17, and we’re trying to place a teenager at a home, who we didn’t have any knowledge of for the first 17 years, but if we can’t get them home quickly or get them with a relative, we’re having - We have a year, year and a half. We can keep them to 21, yeah. Unless they’ve got really big problems, we don’t (*unintelligible, both speaking at once*) that long. So, we’ve got a year, you know, a year and a half, to get a youth ready to be on their own.”

Multiple caseworkers and supervisors across a few sites described their caseload and whether or not they had any restrictions on the number of cases they could carry. Such restrictions varied within and across sites, often depending on their unit. Some caseworkers with more intense cases such as those working in core services or Expedited Permanency Planning tended to have caps on the number of cases they could have and thus had fewer cases compared to general caseworkers who did not have caps and could have close to 20 cases. (Core services are those provided to children at imminent risk of being placed out-of-home and each county has an allocated budget to pay for such services.) A few caseworkers and supervisors from a couple of sites also discussed how caseloads shifted depending on the number of reports they would receive, how quickly cases were terminated or closed, and whether or not they were fully staffed. Caseloads could also vary based on family size and structure because one case could include a single mom and one child or it could include a mom with multiple children and multiple fathers.

One caseworker stated, “Um, it’s high for the amount of cases that I’ve had throughout all the years that I’ve been here, that’s the most that I’ve had within [redacted] years. We don’t have a cap in our unit, so that, it could exceed 17.

A supervisor commented, “So pretty much right now, the majority, especially you know, the caseworkers, I think on average, um, my workers have about 16 cases.”

A caseworker explained, “Currently I’m carrying nine cases. I normally carry, um, I would say - We have a capacity. We have a cap in our unit because we’re a core service and because we provide intensive in-home services — so our cap is 12 cases and that’s a lot. I mean that’s like — for us it’s a lot because we do our own visitations, our own home visits. Everything we do, we do because we have a visitation center and there’s staff there. They, um, supervise visitations but they don’t do ours because we’re a core service. We have to do all our own visitations with parents. So, that takes a lot of time. So, currently I’m carrying nine. I was carrying 10 up until about a week and a half ago I did have termination on a case so, of course, once that occurs it’s transferred to another unit and the cycle is you get a new case, you start fresh, that sort of thing.”

A caseworker in Expedited Permanency Planning shared, “And it originally started with the ones that would be referred would all be 6 and under and they were families that by whatever criteria was used, um, seemed more invested. And again, by law we have, we’re supposed to have a caseload of 10 or under. And a few times, that hasn’t happened, and I think we can go up to 12. But the idea was that we could really work a case with families that were invested.”

Another caseworker stated, “We, in our unit, have, carry a caseload of, we can get down to 6 or 7 when it’s slow, or a lot of our cases are all shutting down, um and we can carry up to 12. And a lot of times we’re in about that 10, 11, 12 range. Um, but then sometimes, um, just recently, I had had probably like 3 or 4 all go for, kind of closure or termination basically, um, and so, they all happened at once it seems like, um, and about last year, not this year, it just seems like at the beginning of the year, for me, for my, and it’s just random, but it just, for me and my type of thing, the beginning of this year I had all, I had 12 cases and turned around, and 4 were going for termination all at the same time. And I turned around, I wanna say it was last February, um, it was a very stressful month and I had 8 terminations in 6 weeks. So then you’re getting rid of like 8 cases very quickly, but then you’re picking them, pretty much picking them all back up. But for a very short amount of time, it’s like ok, they’re dwindling down, um, and so, I mean I literally had 8 in 6 weeks, and then you’re trying to get the cases closed, which is also another, um, the cases, how cases around here work is, in my opinion, or a lot of kind of see is that it’s very intense at the beginning, a lot of chaos.”

One supervisor shared, “It didn’t and it was just crazy. So, um, right now I have a cap in my unit. I think by CDHS guidelines I can max out at 12 cases per worker, but I try and keep it at 10 because that’s really what’s manageable. I mean, but, you could have a case of 10 with three kids and three dads and a mom. So, um, and they’re really, like, 13.”

A few caseworkers and supervisors across multiple sites discussed the frequency of their interactions with their clients. They shared that they were required to visit clients once a month but that they monitored their progress more often either through telephone communication with the client or through updates from other service providers that were seeing the client more regularly.

One caseworker shared, “I can go - I’m free to go out every single day, but by law, I’m only required to see them once a month. But, if there’s something that I’m missing or a need I haven’t identified, or the guardian ad litem hasn’t identified, and you have, then you tell me. I’m open to feedback.”

Another caseworker explained, “Yeah, we contracted with you to do the services or to do this therapy. Yeah, you’re in there three times a week. I’m in there once a month. Now, I’ll talk to people more than that. Yeah, you’re in there more than I am. But, hello, the County is paying you for a service to help our mutual client. You give recommendations. You give us our monthly reports. You report progress, you report noncompliance.”

Community Referrals

Numerous caseworkers and supervisors from all sites discussed having referred clients to other programs and organizations. They explained that Child Welfare did not provide all of the resources that a family may need and thus they worked with other Department programs and community agencies. Some examples of the types of programs and organizations to which clients were referred to included: mental health providers, WIC, child care providers, housing agencies and shelters, educational programs, and parenting programs. Contractual relationships were not required for programs within the same department but most caseworkers and supervisors discussed having Memorandums of Understanding (MOU) or contracts with outside agencies.

One supervisor shared, “Or how to access needs for their children and families that they work with. Too often people think that, um, uh, Department of Social Services has a responsibility to take care of the whole family and all of their needs and they don’t realize that we ourselves depend upon professionals outside of us...”

Another supervisor stated, “They’re not contracted, we are the main provider. Main um - eligibility site for those programs. So those are all done within this department and this entire floor is all of Department of Human Services. So our Food Stamp workers are located here. Our TANF workers, our daycare workers, everybody is located here.”

Another supervisor explained, “So, yeah, what we’ve done is we’ve worked with our county attorney’s office. We got a copy of [county name removed]’s contract—they have a contract with some community agencies—and, we’ve created an MOU, basically cut and pasted that contract. And, our county attorneys looked at it, and it - I mean, we know we’re violating—currently—the state statute. But, it’s a risk we’re willing to take because we know it’s important for families.”

Many supervisors and some caseworkers across multiple sites also commented on the importance of having the clients sign a release of information so that they could talk freely with the other providers and manage their cases most effectively. However, supervisors and caseworkers varied within and across sites in what a release of information allowed. Some believed that having a signed release of information allowed them to share anything about the client while others were unclear about the level of information they could share. While the supervisors and caseworkers who discussed releases of information understood the legal importance of having them, a few caseworkers and supervisors from a couple of sites also shared some challenges to obtaining them. Some commented on how getting the releases and service authorizations had delayed care for clients and others discussed the challenges of keeping track of obtaining releases for every new service a client was provided.

One supervisor commented, “And so, it’s real clear on, ‘Here’s the confidentiality law’ - several laws are listed. You know, ‘You know you have to follow confidentiality,’ and just try to be real clear. So, a broader MOU, so in this example with NFP, [name removed], the Director of the Health Department would sign it as the agency with our director. And then, attached is an individual confidentiality statement that each nurse would sign. Because what we know is, contracts and MOUs at agency level don’t get down to staff level. And so, we’re trying to cover both steps.”

One supervisor explained, “Because that’s how we get to where we need to be. Um, so, you know, anything... Anything that we think might be pertinent to them, anything - Any changes that we know that’s going with the client and vice versa. They share right back with us. Now, there’s - I think they have maybe - I don’t know this for sure, but I think they might have a few more restrictions on what they can share. I don’t know that. But, there’s no restrictions once we get that signed release we share everything because our goal is to make these children safe in their home, and if we can do that, then let’s do it.”

Another supervisor shared, “But there has to be some working out with our county attorney about releases of information or confirmation, so I don’t know how all of that has done in terms of what we can release and how much and that kind of stuff, but something has happened with that where we are not violating, you know, of course, you know usually confidential issues so. But they usually make those referrals for us and then I have an assessment worker that wants to close the assessment and make a community referral, then they fill it out and we kick it over to the [community liaison unit name removed] and they send it out and then they have just been tracking those for us.”

Another supervisor stated, “Yeah, it can be a process and we actually just made changes to our service authorizations in that lots of times, although the service auths [authorizations] should be like way on the top of your to do list, sometimes they were getting behind on those. So, obviously if we are not getting families referred to services timely then we are holding up the case and you know, potentially kids are away from families longer than they need to be. And that’s not okay.”

A few caseworkers and supervisors across multiple sites explained that the ways in which referrals occurred varied for clients who were screened out and for clients with open cases. Clients who were screened out but presented some risk were often informed about voluntary programs offered in the community. The two key challenges experienced with voluntary services was that the clients could not be referred by CPS unless a release of information was first obtained by the client and due to the voluntary nature, participation could not be enforced. For clients with open cases, caseworkers would identify services that the family needed and then worked with court providers that were contracted with CPS. For such cases, a couple caseworkers from one site also described using family engagement meetings (described further below) as a forum for discussing enrollment into new programs and services. Another difference described by a few caseworkers and supervisors from a couple of sites was that clients with open cases could be offered services that were paid through the CPS department’s core services funding which were not available for voluntary cases that were screened out.

One supervisor explained, “Right. So, we do - So, anytime we’re looking at - We have court cases and non-court cases, and so what we have to do is we have to identify what services a family needs in order to, I guess, identify the reason we’re involved. And so, we have what we call court providers. And, they are contracted providers. They can be substance abuse, mental health, parenting, mentoring, all sorts of different service providers that we contract for, you know, we do psychological - I’m trying to think of some of the other things that we do - In-home parenting, visitation - And so, yeah, so they are actually contracted with the department. And then, we do referrals to them.”

One caseworker stated, “No, many of them are voluntary. Most of them are free and voluntary. A lot of community services are free and voluntary and then there are other ones — there are other ones that are paid for by Medicaid. There is a therapeutic, um, group that takes Medicaid and their therapists go into the home. And then there are ones that, um, we can contract with. Then, of course, if we open a case we can pay for — pay for them via what we call core services. So there is a variety of methods to help the families but there are lots of free and community volunteer agencies that go into homes.”

One supervisor shared, “In fact, all screened out referrals, referrals that we don’t except because they don’t meet criteria and assessments that we close after we’ve completed our assessment/investigation, they go to Community Partnership and they’ll be offering and providing services to those families on a voluntary basis.”

Another supervisor said, “So, what we have talked about is, so we have people answering our Child Protection Hotline, and so if it’s a screened-out referral, and it meets, you know, high-risk, moderate to high-risk that we’re not going to - Probably low to moderate even. If we feel like the family needs some help, our [specialized community liaison unit name removed], they will do the referral to NFP. Or, WIC. Or, whatever is at the Health Department, and we—or Safe Care, whatever it is.”

A caseworker stated, “And I’m thinking of course, in order to make a referral, we would need to have that sign of release. You know, the two ways we could do it is if we’re gonna make the referral, have them sign a release of information, cause otherwise we can’t give their information, or we can just tell them this is available, here’s how you can get in contact with the nurse family partnership on your own.”

One supervisor shared, “Core is a client that’s involved with Child Welfare system with an open case...It’s a pot of money that we’re able to get them certain services. But it’s required they have a Child Welfare case open.”

Meetings

Numerous caseworkers and supervisors from all sites described the various meetings that were included in the Child Welfare structure. These meetings included those with clients such as family engagement meetings as well as internal meetings such as team/unit meetings, department-wide meetings, supervisions, and CPT meetings.

Family Engagement Meetings

As an aspect of DR, family engagement meetings were described by numerous caseworkers and supervisors across most sites. A few caseworkers and supervisors from some sites shared that the IV-E Waiver required that these meetings occurred within seven days after a case was opened and continuously for every 90 days. The IV-E Waiver was described as federal funding provided to support the needs of families while also requiring Permanency Roundtables (PRT) – meetings to help develop a plan and facilitate the process of getting children to permanency – as well as periodic family engagement meetings. In one site, family engagement meetings were called Team Decision Making (TDM) meetings which were described to involve the family, community, and CPS to make Child Welfare decisions around placement. There was variability within one site with the family engagement meetings where most caseworkers and supervisors shared that the meetings occurred every 90 days but one supervisor thought that they occurred every 30 to 45 days. A different supervisor from this same site also specified that the requirement for having the meetings every 90 days was for out-of-home placements, and for children in the home, the meetings were only required to occur every six months. A few caseworkers and supervisors across a couple of sites also explained that the family engagement meetings also occurred as needed, at the family’s request, when there was a change in placement, or if there was a change in the treatment plan.

One caseworker stated, “And we did that along with the Permanency Roundtables. Um, as part of IV-E Waiver... Permanency Roundtables are when uh, children have been in the county’s custody, I believe it’s for, I don’t know if it’s 6 months or a year, it’s really hard to say, but we also do those every 90 days and what that is is, when children are in out of home care, we need to have what’s called a permanency plan done um, for under 6 it’s for 6 months out of home and over 6 it’s at a year... So that we can try to come up with a permanency, not just come up with a permanency goal but get them to permanency.”

One supervisor shared, “And then, because we decided to become a IV-E Waiver county, and the IV-E Waiver mandates these family engagement meetings occur every 90 days, we adopted the every 90-day model. So, the goal is to get everyone involved in the case together every 90 days, if it’s out of home, every six months if they’re in home, and talk about all of the dynamics of the case with the family’s voice and perspective driving the discussion. That’s the plan.”

Another supervisor from the same site said, “And then, we - And then, that will usually happen within seven days of opening the case, we have to have those in. And then, we will do them after that every... They do another one, I think, 30-45 days after that, or as soon as needed. And then, they - We’ll do that any time there’s a - To consider a placement change or removal, they’ll have to have one prior to that as well, and then periodically throughout the case just for updates and where people are at within their, you know, with - Where they’re at on the case and where they’re at with completing services and things like that.”

A caseworker stated, “But we’re still going to do it. So, when there’s court action or even just opening a case, we want within seven days of that to have a family engagement meeting—which, before that, didn’t happen. I mean, we had meetings but it’s really focusing on the family more than what just as professionals, ‘We think you need this.’”

Another supervisor explained, “We’re already doing the family engagement, and like I said, right now with our [redacted], you know, it’s been a little bit more challenging with the initial and then with the 90 day and stuff like that. So I know we have to a change of placement is what I’m told or change in treatment plan or the different things like that or at the workers request or family’s request, I can see where eventually where ok, we have all these different people who are not on the same page but get a team meeting and discuss.”

Many caseworkers and supervisors across a few sites described that the initial objective of the family engagement meetings were to address placement issues but they had also been useful in comprehensively examining the resources available to families. These meetings brought together numerous supports that a family had in order to garner multiple perspectives on the family’s strengths and areas of need. The collective group would develop a treatment plan and work collaboratively to help advance the family to prevent the removal of children or minimize the length of time that children were placed outside of their homes.

One supervisor explained, “Well, okay, so TDM—Team Decision Making— it’s a group decision-making model that was developed and tested by Annie E. Casey. And, they spread it throughout the country. [County name removed] adopted that model about [redacted] years ago...The TDM model is primarily designed to deal with placement issues, initial removal and change of placement for kids and families.”

One caseworker stated, “It’s usually - Well, they can happen at any time. They happen- They happen if there needs to be a change of placement, if- They usually happen if there- Like, usually when there’s an assessment or investigation opened, they happen- I mean, after the interviews are completed. Usually, they’ll happen during that time, so that they can make a plan of what needs to be done and moving there. So, that’s where I would see it really fitting with Nurse Family Partnership. They happen throughout a case as well. But, that’s where you would find out, you know, if there’s a new baby and a new mom.”

Another caseworker shared, “Yes. Um, I mean, it’s - Though it’s kind of the same thing. It’s - Everybody sits down at the table, kind of says, ‘Hey, this is what’s going on. How do we assess these safety concerns? What resources do you need to be of support to you? What are the great things that are happening? What are the concerning things that are happening? How do we move forward with a good plan?’”

A supervisor said, “The goal, the main goal of the strategies that we’re doing is to shorten the time that- Well, one, to prevent - To prevent placement, shortening the time that kids are in placement if they do have to go to placement, and shortening the duration that families have open cases and case involvement with [county name removed].”

Multiple supervisors and a couple of caseworkers from a few sites shared about the potential participants of family engagement meetings. They explained that participants could include anyone involved in a family’s treatment plan as well as any supports that the family wanted to involve in the meetings. Some examples of such individuals included service providers (e.g., medical providers, NFP nurses, Wrap-Around service providers), guardian ad-litem, extended family members, neighbors, and friends from religious communities.

One supervisor described, “Anybody who - The attorneys involved. Some counties don’t, for their family engagement meetings across the country, don’t have attorneys at the table. We have our guardian ad litem at the table. We have our respondent parent attorneys at the table. And, it’s something we’ve done with our [family engagement meetings] because, in some places, you know, there’s concerns about it being like a court hearing and- We’ve been able to establish that they’re active participants, and they - One of the things we know through these 90-day meetings is that it’ll make court hearings go smoother from what we know from other counties who do them. Court hearing will go smoother.

Another supervisor explained, “It’ll be the case worker, it’ll be the facilitator, and it’ll be anybody that is involved in the case. It could be anybody that the family feels is a support to them, so if it’s an aunt, uncle, or anybody that they feel would be there to support them in this process— The supervisors need to be there or should be there.

Really anybody that's a part of that treatment team could be there, the guardian ad-litem, service providers, that kind of stuff."

A supervisor shared, "You know, and going forward, we have - family engagement is a big part of what we do with families, and we have family engagement meetings, and so going forward, it - You know, if we knew a family was involved with the Nurse Family Partnership, that would be somebody that we would expect and want at our family engagement meetings. And, when we talk about family engagements, we're looking at the worries, the strengths, the supports and the plan to service, for services and things that can help support the family. And so, that, they would be a big part of who we would want at the table through that family engagement meeting."

Another supervisor stated, "Again, what you'll do is you will invite - I mean, there might be a table of 20 people there because you have—and, the families can invite any support that they have. I mean, if they have, you know, 15 neighbors that want to come, they can bring 15 neighbors. If they have church, you know, church families or, you know, that's where you would have substance abuse, any service. So, it could be a room that's filled with people. I mean, sometimes, it's just the parents, nobody else, though. Just - Yeah. They really get to, you know, be the experts on their family, so..."

When describing the potential participants in family engagement meetings, most caseworkers and supervisors from a couple of sites described having a trained facilitator hired through the department as a neutral party who invited the other participants and helped run the meetings. The facilitator was described as a trained individual from the department who could help identify the families' needs and bring the group to a consensus in regards to the treatment plan. They would also help everyone maintain their roles – including the family being experts on themselves – and allowed caseworkers to fully engage in the discussion without having to worry about any facilitation tasks. Given the numerous people involved in the family's life, the facilitator was also described as having the responsibility of ensuring that the most appropriate services were selected for each family and that the families were not overburdened by the services.

One supervisor shared, "And, they [facilitators] keep everybody within the framework of the meeting, and the rules of the meeting. We have some established rules, you know, in terms of being respectful, let everybody talk. The facilitators are trained that the family is the expert on their own family. And so, everybody has to have the ability to talk. Everybody has a role in the meetings. And then, the facilitator, their responsibilities also include, as I said before, making sure the right people are at the table. If we're talking about something that the right people aren't at the table, we can't make those decisions. We've got to make sure - And, many times, we will bring them in by phone. We'll bring them in - You know, there's many things we can do right then and there without having to delay it to another time."

A supervisor explained, "What it also looks like are the participants that are involved. That's another change we're making is the fact that, in the past, the caseworkers have been responsible for inviting—and, the family has been responsible for inviting—who comes to the table. Well, the family invites through the caseworker. Sometimes, not all the players are there. In this new format, there's an assigned facilitator on every case that

will be there through the life of a case. And, they'll be the ones who are inviting the teams. So, as we identify what, who's not at the table, we're going to be looking for who we're going to invite to the next meeting, and bring those people to the table."

Another supervisor stated, "The facilitator - The facilitator is - Their role coming in now is, they'll know the case. They'll - So, as the assigned person going through the family, everybody, we're not going to have retell the case every time. But, the facilitator's role is that we are always looking for what is the least restrictive means necessary. We don't want to overburden families. Sometimes, too many services—well, not many times, all the time—too many services are a bad thing."

A supervisor said, "Their job is to facilitate, to find out what the information is, to identify what is risk, what is safety, how we're going to mitigate those things. And then, search for the right service that is going to be the best suitable for the family, and the success of the family. Whether it would be the location of the service, the language of the service and the cultural appropriateness of the service - Does it provide the right, just the right fit for the family? And, I mean, there's a whole combination of things that we just don't want to go with what's our favorite service provider out there, but what is going to be right for the family."

Internal Meetings

Numerous caseworkers and supervisors from all sites shared about the various internal meetings that they had among Child Welfare staff. Many caseworkers and supervisors from most sites explained that they had regular standing meetings but the frequency of those meetings varied by site. Team/unit meetings typically occurred monthly but division meetings occurred monthly or quarterly. Additionally, a few caseworkers and supervisors from a couple of sites also talked about having bimonthly or quarterly department meetings, and a few caseworkers and supervisors from some of the same and some different sites shared having weekly or monthly leadership/supervisor meetings.

One caseworker shared, "We have quarterly meetings for all Child Welfare. We also have monthly Response or Intake Caseworker meetings – that kind of stuff like Nurse Family Partnership is brought up. But I think we're all aware how people get overwhelmed, and if it doesn't apply to them right then and there, it goes in one ear and out the other."

A supervisor stated, "You know, it would be nice every once in a while and you know, we're inundated with trainings and new initiatives but every month we have what we call a joint team meeting. That's where all of ongoing, all of Child Welfare and we all crowd in this room. And sometimes we have somebody come and do a 30 minute to an hour presentation. You know, it can be 15 minutes."

A supervisor stated, "And then, we have—about every other month—all-staff meetings where the public health department, all the departments are there, in our staff meetings, and we give updates, talk about what we're doing in each department and different changes and other things, so that everyone knows what's going on so we can be more cognizant of that."

Another supervisor explained, “Yeah. They - In fact, sometimes, we’ll - When we have our meetings, we do that. We have our supervisory meetings where the director for public health, who’s under me, so we have our Child Welfare director, or I mean our Child Welfare supervisor, who is also the supervisor of [program name removed], the Eligibility supervisor, Child Support Enforcement, myself, the public health director and our accounting director. So, we all meet once a month, and we really talk about some of these things, you know, and how we work together.”

A number of caseworkers and supervisors across multiple sites also discussed other types of internal meetings such as staffings and supervisions. Staffings were described as opportunities for caseworkers to provide an update on a case while also using colleagues as resources to ask for feedback and advice regarding the case. Similarly, supervisions were an opportunity for caseworkers to also get feedback regarding a case but typically occurred as a one-on-one session with their supervisor rather than a team of caseworkers. The structures around these meetings varied across sites where some sites staffed cases once a week whereas others only staffed cases every ninety days after the initial one that occurred within 30 days of opening a case. Supervisions also varied where some sites had ongoing weekly supervisions and others, typically smaller sites, had less formal supervisions as needed.

One supervisor stated, “Well, um, when we get a referral, if they need to staff the case, then it would be done within the first 30 days—the initial one. And then, say it’s opened into a case, they’d do it every 90 days.”

Another supervisor shared, “Once a week, we have a staffing, and in the program they have to introduce the case after they’ve done an intake and assessment and come up with goals. Then they actually formally introduce the case and they introduce what the issues are to the whole team. And they’ll say, ‘You know, the family came in for this. After the assessment, we identified these strengths and these challenges.’ And that type of thing. ‘This is what the family would like to work on. These are the kind of issues that are going on. Here are the challenges. Does anyone have any suggestions?’ and formally introduce it. I also meet with all of them between once a week and once a month, where they are constantly updating on every case. And at any time that they hit a wall, they will come back and say, ‘Remember that family I introduced?’ and then they’ll staff it and just start brainstorming ideas. Then they also staff the case at 90 days and 120 days, just to update, and then they officially close the case, saying what kind of outcomes and indicators that they met, what kind of goals were met, what kind of challenges were present, what did we learn from the case, moving forward to other cases. They do that whether the family disengages or we close successfully.”

A supervisor stated, “I - I don’t know - You know, I - I guess we’re lucky because, you know, we have such a small office that we don’t have the weekly supervision or the whatev—I don’t even know what that crap is. Like, my door is open.”

A few supervisors and caseworkers across some sites also shared about CPT meetings. Though presented as internal meetings, CPTs consisted of external individuals who helped review cases and the actions taken by CPS. Sites varied in the frequencies of their meetings with CPTs meetings occurring twice a week, weekly, or every other week at different sites.

One supervisor explained, “Well, the purpose of the Child Protection Team is to review the department’s response to reports of child abuse and neglect. That’s one responsibility. The other responsibility is then to become part of collaborator: What are the solutions?”

A caseworker shared, “...we have a board that we meet every Wednesday that is, we have a hospital, a person from the hospital that works with the VA, she comes down and she’s involved with the Child Protection Team findings. What they do is we let them know how the call came in, what were the concerns, the children in the home, um, tell ’em a little about the interview, what we found, what we didn’t find. Did we open a case, did we not open a case? And did we find, you know, did we respond timely, um, did we offer services, did we do everything to not contribute to not placing that child out of the home?”

The same caseworker continued, “We meet twice a week and we go over, and they sign off on our cases for the state.

A supervisor stated, “We also have our Child Protection Team meetings, and our Child Protection Team meetings happen [redacted]...And that might be a place that if somebody had a concern and just wanted to come, there’s a team a people and it’s a community, um, so police are there, um, I believe [organization name removed] is there. You know, a lot of different people. And so if somebody just wanted to discuss a case, that might be an appropriate time for them to come and say, ‘okay, I don’t know about this but can I pass this by you guys and see what you think?’ They could have, you know, a multidisciplinary answer to their question.”

Policies

Numerous caseworkers and supervisors from all sites discussed policies related to a variety of areas. Some of these areas related to screening and assessments, interacting with mandated reporters, confidentiality, and training requirements for caseworkers.

Screening and Assessments

Many caseworkers and supervisors from most sites discussed having started using an enhanced screening process and that this was something that was being required by the state. A few caseworkers and supervisors also specifically mentioned the Children’s Code and Volume VII as a resource they used to determine whether or not an allegation met the legal standard for abuse or neglect. These resources provided definitions for abuse and neglect along with the appropriate assignment and investigation for each allegation. However, a few caseworkers and supervisors described occasions where the Children’s Code would conflict with other policies such as state laws (e.g., marijuana use) or standards for abuse and neglect used by other entities (e.g., military or tribes).

One supervisor explained, “So, and the enhanced screening is something that the entire state has mandated implementation for all counties by, I think, next July or August...”

Another supervisor shared, “If a - For us to become involved, we - The allegation has to meet the legal threshold for abuse and neglect. That allegation has to include abuse or neglect in the report for us to be able to respond. If it’s an immediate response, if it’s a no-brainer, if it’s obviously a clear allegation of abuse or an allegation of significant abuse or neglect, we’ll respond immediately...”

A supervisor explained, “Again, regardless of my personal feelings back and forth, it has really caused a disruption in the Child Welfare world because they didn’t change the children’s code. You know, the children’s code still has parameters as far as investigating people with drugs so, just because it’s considered a legal drug now, it still causes as much problems as it ever has, probably more so actually because now people are saying, ‘Well, it’s legal. I can do whatever I want.’ No, you still can’t drive with a child, you still can’t do this, you still can’t do that – just like alcohol. And so, it’s been- It’s a lot of educating them, as well. The moment we start talking about it in the framework of alcohol, then a light kind of seems to go on, but a lot of them don’t see it that way at all.”

A caseworker stated, “We are so limited. It is the most gray area and quite frankly I think it was legalized too quickly because there’s not good guidelines. You know, there’s conflicting guidelines in the Children’s Code versus what our state has and so it makes things very messy and complicated because—And there’s no guideline for levels either.”

Another caseworker shared, “Um - with Family Advocacy in particular it’s that we have very similar roles but very different roles and so they try to investigate for the Army or the Air Force what’s going on. We have different criteria for child abuse, child neglect, the Army versus the state. Very different. Um and it’s just a matter of communication with them.”

Interacting With Mandatory Reporters

Many caseworkers and supervisors from multiple sites discussed two primary policies related to their interactions with mandatory reporters. The first was that state law did not allow them to disclose the identity of reporters – including mandatory reporters – to the family. Although families often asked about or suspected who reported them, caseworkers were required to explain that they could not divulge that information. The second policy described by multiple caseworkers and supervisors from a few sites was that mandatory reporters be notified about the case they reported. By law, they were to be provided with an update within 30 days of the report, informing them of whether or not the case was assigned. In addition to being notified about the findings of the case, mandatory reporters who had an ongoing relationship with the child were to be provided with updates about the case (regarding the child, not the parents) and all mandatory reporters were to be notified when a case was closed. One supervisor also explained that it was the supervisor’s responsibility to ensure that these notifications were sent to the mandatory reporter.

One supervisor stated, “Um - You know, the only thing I do want to clarify is that, um, when we do have reports from mandated reporters—actually, anybody that reports a report—because I know I’d said that we did have two—I think—two nurses that had made a report. Like, we - Our state law does not require us to disclose that to the parents.

So, a lot of times parents will want to know who reported. But, we're- By law, we're not allowed to report that, so I just want to make that clear, that even though I might have said that they were the reporter parties, more in the context of what do they know about when to report. That's information that we are, by law, not allowed to disclose to families—when we go out to assess for safety or the concerns. A lot of times, parents will try to figure it out, you know, I mean, they can- Most of the time, they can figure it out, and so, you know, they'll oftentimes say, 'Well, we know who it was,' and so a common response for us is we just don't confirm or deny, you know, whatever suspicions or accounts they have. So, that's the only thing I want to just make clear—is that, you know, we do have an obligation to call reporting parties to get more information and stuff, and so we do work closely with reporting parties on gathering new information or additional concerns, but that's something that we never - We never share with families. So, and I know sometimes families are, try to be clever about, 'Well -' You know, they'll tell people, 'They told us it was you.' (*laughs*) And so, I'm like, 'Nope, we didn't.'"

One caseworker explained, "And then of course when we do our assessment we can't say who the reporting party is, but then maybe we can bring up, you know 'Maybe you can get involved with nurse family partnership' and 'Oh, I already am' kinda thing. So, you know, so, that's kinda how we, uh, have learned about it."

Another caseworker stated, "You know, so, any and all information that that nurse can give us, we take. Also, we are mandated within 30 days of accepting a referral and doing an assessment to get in contact with a mandated reporting party and let them know what's going on and what the steps are."

A supervisor shared, "Right. So, when it's - Okay, so if a nurse, if a mandated reporter—so it could be any, and they are mandated reporters—and, when any mandated reporter makes a report to the department, again, by law, they will be called for- If it's assigned, they will be called to let them know it was assigned and to gather more information. If it was not assigned—meaning it was screened out because they didn't believe it met the criteria—they will also, by law, have to have to get a call to say it was not assigned to assessors who investigate, and so they will know either way."

Another supervisor explained, "It - We always - Always. We always have to do it, yeah. I mean, that's something- So, from a supervisor's standpoint, when it's assigned, we have actually checklists, and so it's like I go through and I have to, we look for contacts to the reporting party, and whether or not they get a letter or not, and an assessment will not be closed unless those things are met. So, I can say for myself it's a hundred percent, because if it's not, then I have my workers do it."

Confidential Information

A few caseworkers and supervisors from multiple sites described the policies around confidential information. They consistently explained that a release of information signed by the client was required in order for caseworkers to discuss the case with other agencies such as NFP or other service providers. In regards to collaboration between CPS and NFP, one major impact of this requirement that was described by some caseworkers and supervisors from a couple of sites was that if CPS received a report about a pregnant mother engaging in risky behaviors, they could not

refer the mother to NFP without her consent. Another aspect of confidentiality described by one site that was not mentioned by others was that cases could be discussed among county agencies if there was an open assessment.

A caseworker explained, “Um, the guideline that I’ve been taught to follow is to, any time I talk with an individual or an agency, I have to get written permission from the client. And in this case, because it is a medical provider, there’s a specific health, um, confidentiality release that the client has to sign, giving me permission to talk with that provider.”

A supervisor shared, “It would be nice to be able to contact NFP with names and information regarding those families that they could reach out to, but because of confidentiality we cannot do that. And so that’s probably one of the biggest concerns that I might have regarding catching those families that we do know about before the child is born, but we can’t do much with a referral or anything else until that time.”

Another supervisor stated, “It doesn’t - If there’s an open assessment, you can share county to county information.”

Training

Many caseworkers and supervisors across most sites described the training requirements for Child Welfare caseworkers. A few caseworkers and supervisors from a couple of sites described that upon hire, new caseworkers were required to undergo a specific training for new hires. The sites described varying training processes where one described a seven week Academy provided by the state whereas the other site described an ongoing training caseworkers attended one week out of each month for the first few months.

One supervisor stated, “Okay, so it’s. The Academy is through the state of Colorado and the workers go for about seven weeks of training, some of it say, not all of the weeks are in the classroom but say they have five weeks in the classroom and two weeks is doing computer based studies. After they complete their Academy they come back with on-the-job training, workbooks that they shadow people, learn that way, and then they’re going to bring it back to their supervisor and have different discussions, whatever the OJT prompts but. Then there’s that additional, you know- put what you’ve learned into practice.”

A caseworker explained, “So, um the training for new caseworkers has kind of changed over the course of years, um for a while it was called the core program, and caseworkers were going once a month for four or five months and for like a week, and uh, they were holding caseloads at that time. Um, and so they were getting the information, um, which is basically the same information, almost, that we, when I started we got. Um, me and two of the other caseworkers were the very first, when they did the new worker training, um, we were the very first, uh, caseworkers to go through that program. The first class. And that class changed from once a month, for a week for several months to eight straight weeks up in Denver, coming back down for like a day or two, uh, like, and it would randomly change each week, but.”

Many caseworkers and supervisors from multiple sites also described the ongoing training requirements in order for caseworkers to remain certified. They stated needing at least 40 hours of training hours per year that they needed to track themselves. The hours could come from a variety of trainings including mandatory reporter training, interview training, and early intervention and prevention trainings.

One caseworker stated, “And we do have to do a lot of training hours, 40 training hours a year to keep certified.”

A supervisor explained, “So that’s signing up for different classes through the state, or it could be different classes that the community is offering. And then they are responsible to keep track of their training—and that would be part of a state audit when they come in to look at employee files. They’re going to look at the training and make sure that workers are getting 40 hours.”

A caseworker shared, “And then, we go to 40 hours of training every year. You know, from anything to dealing with substance abuse to Child Welfare to ethics to, you know, all the trainings that we have available in the Training Academy. Interviewing kids - It’s a ton of training that we get.”

Another caseworker stated, “Well we have to take a minimum of 40 hours a year in training related to our job so that means 40 hours of training in Child Welfare, child abuse and neglect and that deadline shuts off the end of this month.”

Internal Organizational Culture

Internal organizational culture was discussed much more extensively by CPS caseworkers and supervisors than NFP nurses and supervisors. First, caseworkers and supervisors discussed the shift in how CPS assessed risk. In one site, they discussed no longer being so investigatory about the actual incident but looking at the family system and what behaviors were going on in the family that led to the incident where the child was hurt. They also discussed identifying support systems that could help the families and having worked with them to change behaviors through more of a preventive approach. Similarly, they expressed excitement around DR and the research around it.

A supervisor stated, “So the research is out there for DR - DR was starting when I was leaving [county name removed] and I know they were one of the five pilot counties and we expect Colorado to do it, so I think we are really excited after. I know that our administrators are ready to get on board with that. But of course there are always going to be those ones where we have to stick with the traditional model but I think that this is something new and people are pretty excited about it.”

Another supervisor stated, “Well, I mean, there is a whole lot of change going on and with change you’re always going to have some bumps in the road and things to iron out. I think, looking at the greater picture, like it’s going to pay off, but right now there is a whole lot of change going on and DR will change, and it will change how we do our

practice. So instead of responding to all allegations of abuse and neglect, like, it's a high-risk situation."

Second, many sites were furthering community collaborations as an integral part of their work. One site talked about its family engagement program, a new approach that aligned with the values of the department and aimed to connect clients with a variety of resources. The family engagement facilitator was tasked with identifying what risks a family was experiencing and how those risks could have been mitigated by searching for the right services that would have been best suited for the success of the family. Factors considered through this process included the location of the services, the cultural and linguistic services that were available, and overall fit with the family. Family engagement was also an integral part of the new approach and a few caseworkers and a supervisor shared that they were working to look at better ways to support the families in areas beyond CPS which may not always have been what was most needed.

A supervisor noted, "So, it's just a shift in our practice and it's a huge community collaboration and work is already in the process of looking a lot differently to better support families and families can be supported in areas other than Child Protection Services when that may not always be what is needed."

Some caseworkers and supervisors from one site also discussed other shifts in their approach such as viewing families as the experts on themselves rather than the caseworkers (i.e., families knowing themselves better than the caseworkers can know their individual contexts) and responding to high-risk situations in addition to allegations of abuse and neglect. Through this, these CPS workers also mentioned that they needed to respond to cases differently based on their level of risk (e.g., using HRA for high-risk situations).

One supervisor stated, "That, and then just through training with [name removed] on the signs of safety and partnering, partnering for safety, just really a (*phone ringing*) a huge shift in the caseworker not being the expert on the family that the family is the expert on the family and the kids."

Another aspect discussed by several caseworkers across multiple sites was the impact of working in a small community. Some challenges included having to wear multiple hats, needing to be proficient in many areas, and being spread out very thin. However, many caseworkers and supervisors from these sites felt that there were many more strengths to being in a small community. Such factors included having a multidisciplinary team, good communication, being more team oriented due to being able to walk over to NFP or other services, long standing relationships with clients and community partners, everyone having their eyes on the kids, easy access to resources since a lot of the same faces were in the same places, and being open to new professionals.

One caseworker stated, "So, in a big county like the metro counties, there will be for example one person doing one job where in a small county like us, one person will do many, many jobs, and you have to be proficient in all those areas. So, um, I — you know, my job for example I have to know everything about intake function. I have to know everything about foster care and adoption and adult protection services as well. And, um, so that means not just supervising the caseworkers and being responsible for

helping them with their decisions. We're very involved with their safety decisions that are being made. Um, so not just involved with, you know, supervising them for deadline-related issues. You know, this has to be closed at such-and-such a date. You know, you're opening a case, you have to get these documents done, but also, um, you know, personnel issues. Um, there are many, many initiatives being rolled out at the state level, which mean more work for us."

A male caseworker from one site also shared his perspective of organizational culture and how he fitted into the picture as the only male caseworker in his county. He described that everyone had the same role in terms of formalities and protocol but that they had independence in how they individually operated. Everyone had their own professional approach and motivations of why they had a passion for the work but he viewed himself as being stylistically more assertive in dealing with some parents with criminalistics-minded behaviors. He faced issues head-on and was often asked by other caseworkers to go on visits with them if they did not feel safe or because they felt that he could relate better with the father of the child (FOC). As a younger professional, he also felt that he was able to relate better with clients in general who were closer to his age.

The male caseworker stated, "So my position in the unit is a little bit different than I think the rest of the gals. You know, they're all great in their own regard. All the people in my unit have their own professional approach and are very good and have their own motivation of why they have a passion to do this job. And so I think I'm still even probably the newest worker in my unit and so I've been able to gain and learn from the other gals in my unit has just been, it's structured me into what I am now as a caseworker. It's just, you learn every day, there's never a dull moment. Um, no case is the same."

He continued to say, "Well, for me, um just first off stylistically, you know, I'm a little, probably a little bit more assertive in dealing with some of the parents. You know, you're dealing with criminalistic-minded behavior, you know, type of parents that, you know, very gamey, very manipulative, very calculated, you know, and things like that. So when I, I kinda of face issues head on. There's times when some of the gals in my unit will ask me maybe to go on a home visit with them if they don't feel safe or if they need me to talk with a respondent dad because maybe they just feel like I can associate with him better. I am [redacted] years old you know, so I can kind of relate with a lot of our parents you know. I'm the same age as a lot of our parents and our clients. So from that standpoint also, some of the gals in our unit are a little later in their years and don't share that with them, but nonetheless, you know, so but that's what's been beneficial for me too, is their experience and how, what I can, what I know my boundaries are."

SECTION II. SCOPE OF WORK

Background of NFP Nurses

Many nurses from all sites shared about their educational and professional backgrounds. Numerous nurses across all sites discussed the length of time they had been with NFP and their

prior work experiences. Many nurses across most sites also shared about how they had learned about NFP, their educational background, learning about assessing and reporting child abuse, past reporting, former experience with DHS, and how these experiences had impacted their current work as NFP nurses.

Learning About NFP

Numerous nurses across most sites described how they first learned about NFP. Many nurses from multiple sites shared that they learned about NFP while job searching and coming across a job posting or the NFP website. A few nurses from different sites had learned about NFP during the internship process of their educational program (either having been placed at an NFP site or having talked about the program with classmates) while some other nurses across a couple of sites had learned about NFP during a previous job where they had referred clients to NFP. A few nurses from different sites had also learned about NFP from friends who had either worked for NFP or had been clients of NFP.

One nurse shared, “So, when I moved here, and I started looking for jobs, there was no labor and delivery positions open. And, I saw an ad for Nurse Family Partnership, and it said, you know, experience in maternal/child preferred. So, I looked it up, and it just seemed like the perfect fit.”

Another nurse stated, “Oh, I - In nursing school, I followed—for my public health rotation—I followed a Nurse Family Partnership nurse and loved how she could make a difference in people’s lives and autonomy and invest in the children for the future, make an impact that will be, you know, last generations and lifetimes. And, I’ve just always had a natural affinity towards maternal/child health. So, this was like the perfect way to do all that, so it was my dream job, you know, since nursing school. So, when I found an opening, I jumped on it.”

Another nurse explained, “I knew about it just because, as - Working in the clinics, we were part of the referrals for them. And so, but I was just a [redacted] at that time. So, I was always interested in the program. And, when I went to school and one of the nurses had quit, and I knew her pretty well, she just recommended and said, ‘You’d be great for this program. You should apply.’ And, I did, and I got it.”

Length of Time With NFP

Several nurses across all sites shared about the length of time they had been working with NFP. Nurses varied in their length of time with NFP within and across sites. Some had only been working with NFP for a few months while others had been working as NFP nurses for over a decade.

One nurse shared, “Well, I’m a nurse home visitor. I’ve been with Nurse Family Partnership just about [redacted] months now and I came here as a new graduate from school, so that’s it.”

Another nurse stated, “Well, I’ve been with the Nurse Family Partnership program for [redacted] years now and I came from a hospital background.”

Another nurse explained, “And so, I’ve been a nurse for [redacted] years. And, worked public health, worked at the hospital. And then, started working with NFP [redacted] years ago.”

Formal Education

Several nurses across most sites described having received formal higher education and training. A few nurses across different sites shared that they were a Registered Nurse, one of whom also had a master’s degree. Many nurses across multiple sites stated having a bachelor degree primarily in nursing but a few also had bachelor degrees in related fields such as human development, family studies, and psychology. A couple nurses from different sites – in addition to the one who was also a Registered Nurse – indicated having a master’s degree as well.

One nurse shared, “Okay. So, I’m a registered nurse with NFP since [redacted]. Um, let me see - I graduated in [redacted] from [redacted], then I got my BSN in [redacted] here.”

Another nurse stated, “I have a background in labor and delivery when I worked in [redacted]. And, I also have a degree—besides my nursing degree—I have a degree in [redacted].”

Another nurse shared, “And, I’m an RN, and I have a master’s degree in counseling.”

Previous Work Experience

Numerous nurses across all sites shared about their past experiences. A few nurses across different sites stated that their current position with NFP was their first job after finishing school. Other nurses across all sites had various levels of experience in related and unrelated fields to nursing. Such variations existed within and across sites. Several nurses across all sites had prior experience in related fields such as women’s health, pediatrics, Neonatal Intensive Care Unit (NICU) and Pediatric Intensive Care Unit (PICU), labor and delivery, OB/GYN (Obstetrics/Gynecology), prenatal education, and family practice. Many nurses across all sites also had other health related experiences either in addition to or instead of a maternal and child health background. Such areas included medical-surgical nursing, emergency room, nursing home, hospice, orthopedics, adult rehabilitation, psychiatrics, geriatrics, occupational therapy, physical therapy, speech therapy, immunization, neuro-trauma, intensive care unit (ICU), medical assistant, children with special needs, school nursing, and public health nursing. Multiple nurses across many sites also shared that they had specific experience with home-visitation. However, such experience varied across sites where some nurses had home-visitation experience with infants and children and others had home-visitation experiences but with adults. Additionally, a few nurses from different sites stated that they had experience working with high-risk clients such as children with special needs and young moms.

One nurse stated, “This was my first job out of nursing school, and prior to that...I did just a mishmash of random stuff: some retail management, some call center background,

financial services, things like that. So, this was my dream job out of nursing school, and so I'm really happy to be here."

Another nurse explained, "And, my background is - I've been a nurse since [year redacted], almost all of it in pediatrics. So, yeah. I've been a pediatric nurse for however long that is, [redacted] years...And so, anyway, my experience is pediatrics, PICU, NICU, emergency room, all that kind of stuff."

Another nurse said, "Okay, so, I told you a while ago I'm from [redacted], so my first job there is I worked in a long term psychiatric facility, and then I also worked at a nursing home, so, and then when we moved here, a little over [redacted] ago, I worked at [organization name removed], which is an acute treatment for in-patient psychiatric facility again. So my background is mostly psych."

Another nurse shared, "I graduated out at [university name removed] about [redacted] years, and I started on pediatrics at [hospital name removed] and worked there for about [redacted] years. And, since then I have been working out in the community going into homes doing homecare. Some pediatrics. Some adult patients. Seniors in the community."

Another nurse stated, "Because, also, I worked with more vulnerable children when they were premature, or you know, health concerns and young moms and their child was feeding issues and things like that, but so, I've not had that with NFP, so."

Learning About Assessing and Reporting Child Abuse

Multiple nurses across different sites shared that they had learned about assessing and reporting child abuse prior to joining NFP. Most nurses described having been taught in nursing school that they were mandatory reporters, how to identify reportable events, and how to report for children and adults. A few nurses from different sites also shared having become more familiar with child abuse and mandatory reporting through other careers such as being a public health professional, dietician, or school nurse.

A nurse explained, "No. I was just going to add on education of how I learned. My nursing school program was very, very good in educating about child abuse and protection and I went to [university name removed]."

Another nurse stated, "Basically, just- I mean, in school you learn what reportable events are and that you are a mandatory reporter in the Century Codes. There are some guidelines that you have to follow, that you should be aware of. I can't remember what the Century Code is here, what the number is, not that it matters but it's in the Nurse Practice Act I guess."

Another nurse shared, "And so I've held a variety of different positions, um, the majority of my career has been in public health, I was a school nurse for [redacted], and so, um, I was very familiar with child abuse reporting through that position that I held. And I've been with NFP now for about [redacted]."

Past Reporting

Multiple nurses from many sites shared about previous experience making CPS reports prior to their position with NFP. Many nurses from different sites had made reports for drug use (postpartum or babies who tested positive at birth). Some nurses also shared that they had made reports for medical neglect, mental health concerns with a parent, or other types of abuse. A couple of nurses from different sites also shared that they had reported to Adult Protective Services but had not made a report to CPS.

One nurse stated, “I’ve not made an actual report in this position. At my, a previous job, I’d done several reports.”

Another nurse explained, “So, in the hospital we- In the nursery so far I’ve never ever seen a report for child- for actual, you know, like abuse, physical abuse. It’s always been drug related, and that’s what we report on. So, as soon as we get a mom that tests positive for any type of drug, we report and then we test the baby. If the baby comes up positive, you know, again we call and let them know that the baby is positive. And, typically they’ll have a case worker come out within the 24 hours it appears.”

Another nurse stated, “Screening clients, like when we’re admitting clients at the hospital, we do screening. We ask them about suicidal thoughts, we ask them about abuse, have you had any abuse at the home, or have you had involvement with protective child services or adult protective services. And then from that point there’s a referral made if there’s a positive on any of those. And also, if we suspect, assessing and documenting, notifying their physician and also just contacting the Department of Social Services.”

Other Experience With DHS

A few nurses across different sites shared that they had prior experience with DHS. Some nurses had a background in social work and had worked directly with DHS while others worked at health organizations such as other NFP sites or clinics that collaborated with DHS, either by referring clients to DHS or having DHS refer clients to them.

One nurse shared, “I’ve been a nurse home visitor for [redacted]. Before that, I worked as a public health nurse for [redacted], and then, before that, I was actually in - I worked for Social Services. I have a background in social work.”

Another nurse stated, “Right. It wasn’t NFP. Or it was a different one, but yeah, we worked very good together and you know, just having a lot of trust in them [CPS] and faith in them, but they also had that with us and would actually just talk to us and say, this is what, this came up on the net, any concerns? We were like no or you know, yes we did or we’re gonna make a report, but no we didn’t have any concerns.”

Another nurse shared, “And, during that time, I’ve done multiple things. We were more generalists. We had prenatal clinics and well-child clinics, adult clinics. We had a home visit caseload for [program name removed], for referrals that we received. Early on, we had referrals we would receive from Department of Human Services for children with

failure to thrive or neglect or where they were phasing out things, and they wanted a nurse in the home.”

Impact of Previous Experience on Current Work

A few nurses across some sites shared how their previous educational, professional, and personal experiences had helped them to better fulfill their current roles as NFP nurses. Some nurses from different sites talked about the benefits of their educational degrees in nursing and/or other fields due to the job requirements of having a nursing degree or having a different perspective that they could offer such as psychology, education, counseling, or social work. Others shared that their personal struggles or having been a former NFP client themselves helped them relate better with clients or that previous experiences allowed them to become familiar with reporting child abuse. Although most nurses shared about the benefits of prior experience, one nurse shared that a negative encounter with CPS during a previous job had left her less trusting of CPS.

One nurse shared, “It was a position - When I started working here, they had all the nurses they needed for the program, but the more I learned about it, it was - I felt like it was a job that was written specifically for me. I mean, it was - It was like my perfect job. At the time, I had my associate’s degree in nursing and bachelor’s is required, so I actually went back to school, got my bachelor’s so that, when there was an opening in our local NFP, that I would be considered. So, I went back and got it specifically for this job.”

Another nurse stated, “I think that it gives me a really broad perspective of kind of some of the stuff that clients go through. Moving a lot, I moved around a lot. Not having any money, not having any kind of a big girl job. I, mean I had jobs and I waited tables and I had okay jobs. You know \$12 or \$13 an hour kind of customer service kind of things, but nothing that I really used because I have 2 degrees. My first degree is in Psychology. Nothing that I really used, you know, so I feel like it give me a pretty broad perspective and understanding of a lot of my clients and where they are coming from and what their struggles are and I know where they are at. You know, I don’t think that a lot of people can say that about some of their clients.”

Another nurse shared, “I’ve been a nurse home visitor for [redacted]. Before that, I worked as a public health nurse for [redacted], and then, before that, I was actually in- I worked for Social Services. I have a background in social work...So I worked with TANF families and with Public Assistance. And then I went back to school for nursing and then got into NFP. I felt like it fit well with social work and nursing.”

Another nurse explained, “Well, I have, like I said in [redacted] I did a report...And that was an extremely negative, very, very negative. I got asked, I think I said this in the group interview, but I got asked what is your motivation for reporting this?...So that was my first interaction with DHS and it put a very sour taste in my mouth. Like, ‘what do you mean this is my motivation?’ I am a mandated reporter and I’m concerned about the welfare of a child. There should be no need for any other questions. I’m a professional. So I was a little put off like what was this, is this how you treat people who are trying to

help?...So it made it, I guess, a scary experience. I like I don't want to involve myself with these mean people. Quite honestly.”

Background of Nurse Supervisors

In general, NFP nurse supervisors did not share as much about their background as nurses. In particular, very few nurse supervisors described their educational background or how they had learned about the NFP program. However, multiple nurse supervisors across different sites shared about their length of time with NFP and several nurse supervisors across most sites discussed having previous experience in the health sector.

Length of Time With NFP

Multiple nurse supervisors across different sites discussed the length of time that they had been with NFP. All of the nurses who shared about their time with NFP had been with NFP for several years – six to fourteen years – and all tended to have been with NFP longer than their site's nurses. A few nurse supervisors from different sites also explained that they had been NFP nurses for a few years prior to becoming NFP nurse supervisors.

One nurse supervisor explained, “Okay. I have been with NFP since we started in [redacted] back in [redacted] when we started the site. And, I am currently - I was a home visitor. I took on the supervisor role about [redacted] years ago.”

Another nurse supervisor stated, “I've been up here [redacted] years, [redacted] years as a Nurse Family Partnership nurse and [redacted] years as the Supervisor.”

Previous Work Experience

Several nurse supervisors across most sites shared about their previous work experience. Similar to the nurses, nurse supervisors varied in their work experience but all nurse supervisors had prior experience in the health sector. The specific fields in which nurse supervisors had worked included NICU, psychiatry, public health nursing, labor and delivery, hospital nursing, pediatrics, and postpartum nursery. A few nurse supervisors from different sites also shared that they had prior experience working with vulnerable populations such as children with developmental disabilities and at-risk teens.

One nurse supervisor explained, “I have been a public health nurse since [redacted], working part-time and did maternal child health, as far as, you know, doing home visits after women delivered their babies, and then, did well-baby checkups.”

Another nurse supervisor shared, “Okay. I am the supervisor for the [county name removed] Nurse Family Partnership program. And, I have been a nurse since [redacted]. I worked [redacted] years in adolescent psychiatric inpatient care. Then, I had a private practice for almost [redacted] years doing individual, family and couples counseling.”

Another nurse supervisor stated, “So, I think my background really helps with that because, you know, the teenagers I worked with were functioning, usually, 4-6 years

emotionally younger than they were chronologically. *(laughs)* And, you had to treat them that way. And so - And, I did work with some developmentally disabled kids, too. You know, so you just kind of have to change your mind set a little bit to find the right way.”

Background of CPS Caseworkers

Numerous caseworkers across most sites shared about their background. Several caseworkers from most sites described the amount of time they had been with DHS for their current positions as well as former positions within the same or other departments. Many caseworkers across most sites also shared about their educational background and former work experience. In general, caseworkers across most sites had been with their current place of employment longer and were more likely to have had graduate level degrees, compared to NFP nurses.

Length of Time With DHS

Several caseworkers across most sites shared about the length of time that they had worked with DHS. Such experiences greatly varied within and across sites and ranged from a few months to over twenty years. Additionally, most caseworkers across several sites had former work experience with DHS prior to their current position. Several caseworkers across many sites had worked in other units within Child Welfare (e.g., investigation, intake, ongoing, sexual abuse, foster care, crisis care, etc.) or in divisions within DHS (e.g., TANF, food stamps, Medicaid, adult protection). A few caseworkers across some sites also had former work experience with DHS in other counties or states.

One caseworker shared, “Okay, um, I’m an intake worker for [county name removed] Department of Social Services since [redacted]. But I have [redacted] years experience. I’ve worked in [state name removed] as well as [county name removed] Department of Human Services. I have done pretty much investigations. I’ve done ongoing—ongoing—and in-home services, sexual abuse, and I’ve been an ongoing supervisor and an intake supervisor for Child Welfare...”

Another caseworker explained, “So, um, I’ve been with the Department of Social Services for over [redacted] years. I’ve worked in the capacity of Child Welfare this entire time. I’ve actually worked in a few different units. I was a crisis worker previously, um, as well as an intake worker, which is the same — same unit, and, um, and a foster care coordinator before I had come back to this unit. So, I’ve been in this unit two times.”

Another caseworker explained, “...and then, 8 years ago we moved to [redacted] and I came on with DSS at that time, and so I’ve been with DSS for [redacted] years, I have worked with the food stamp, Medicaid and TANF program as a case manager, and then I moved over to Child Welfare.”

Formal Education

Numerous caseworkers across most sites shared about their educational background. Although there was some variation within and across sites in regards to their field of study, collectively, caseworkers tended to be highly educated with several caseworkers across most sites having a bachelor's degree and many caseworkers across multiple sites also having a master's degree. The majority of caseworkers across most sites had focused their undergraduate studies in an area very much related to their jobs as caseworkers such as social work, criminal justice, psychology, counseling, and sociology. There was a little more variation among the graduate programs in which caseworkers studied, which included fields such as special education and rehabilitation, in addition to the more aligned areas of social work, psychology, and counseling.

One caseworker shared, "Well, I have a Bachelor's Degree in psychology. And, then I have about a half of credit - half of my Masters completed in counseling."

Another caseworker said, "Um, I have, uh, a bachelor's degree in sociology and I have two minors in criminology and psychology."

Another caseworker stated, "So, um, I have, um, gained by bachelors in sociology, and, uh, um with an emphasis of criminal justice. And then a business administration. But I did take a lot of the social work, social, you know, type of classes there..."

Another caseworker shared, "I got my Master's in Social Work from the [university name removed] and just felt like I wasn't, I wanted to not be in bad situations, I wanted to be more preventative and to deal with family's issues at home instead of waiting until they blew up and trying to fix things later on."

Another caseworker said, "I got an associate degree, and I moved to [state name removed] and I got a bachelor's degree in sociology and then I got a Masters in sociology with a minor criminology."

Former Work Experience

Several caseworkers across most sites described their former work experience. Although a few caseworkers from different sites had gone directly from college to their current position without any other work experience or came from unrelated fields such as construction and serving at restaurants, numerous caseworkers from most sites had work experience in related fields prior to their current position in Child Welfare. Such areas included curriculum-based in-home education, working in schools, working with developmentally disabled children, residential treatment centers, child placement agencies, Head Start, mental health centers, hospitals, domestic violence centers, crisis centers, special education, youth corrections, and speech therapy.

One caseworker shared, "Um, this is actually my first job out of college."

Another caseworker stated, "I've been a case manager here [redacted] months. Prior to that, I worked in a school district these last two years, and with at risk families, so I have that perspective."

Another caseworker explained, “Some background that I have is I have worked for local child placement agencies before prior to coming here. Worked mainly with, you know, working in family visitation, family bonding between parents and children.”

Another caseworker said, “Um, let me see, I’ve done three internships, um, one working with adolescents at the state hospital, um, one working with elderly in a nursing home, and then, um, oh, what else? I’ve also done a lot of, well let me see, two internships and then I’ve done a lot of volunteer work in, you know, in the field.”

Background of CPS Supervisors

Numerous CPS supervisors, administrators, and directors from most sites shared about their professional and academic backgrounds. A number of CPS supervisors, administrators, and directors from most sites shared about the length of time they had been with DHS, their educational background, and their former work experience. Compared to NFP nurse supervisors, CPS supervisors, administrators, and director were more likely to have worked in other positions within the same organization of their current position (i.e., at NFP versus at DHS, respectively) and also tended to have worked at their respective organization for more years.

Length of Time With DHS

Similar to caseworkers, CPS supervisors, directors, and administrators tended to have worked with DHS for an extensive period of time. Although a couple of CPS supervisors from different sites had only worked within their department for a few months, several CPS supervisors, directors, and administrators from most sites had worked within the department for over a decade; a couple of CPS administrators and directors from different sites had worked at their respective department for over twenty years. Several supervisors from all sites had also worked as caseworkers prior to becoming CPS supervisors, administrators, or directors much more so than NFP nurse supervisors who had previously been NFP nurses. Such CPS supervisors, administrators, and directors had worked in a variety of areas within Child Welfare including intake, investigation, ongoing, adoption, and generalist. A couple CPS administrators and directors from different sites had also served in supervisory roles within DHS at other counties prior to their current supervisory position.

One director said, “I was - I worked in a variety of social work settings, and then I settled on an interest in Child Welfare. I started working here as an ongoing child protection caseworker. I did that for [redacted] years.”

Another director shared, “I worked in [first county name removed], I worked in [second county name removed], and I’ve been here for [redacted] years almost, so I worked around and I’ve been in, probably since [year redacted], I’ve been in Child Welfare working. So I guess that’s a while. So I’ve done that. I’ve been a caseworker. My specialty was sex abuse treatment and working with incest victims. Since I’ve been in [third county name removed], I was just a generalist and I moved up to a supervisor and now director.”

A CPS administrator stated, “Sure. Um, I am a Child Welfare administrator in [first county name removed]. I’ve only been here [redacted]. I previously was in [second county name removed]. I held a variety of positions there; started off as a child protection worker, became a youth in conflict ongoing worker, then a supervisor, and then moved from there to a TANF manager, and from there back to a Child Welfare manager, um, and then now to — to, um, — to [first county name removed].”

Formal Education

Several CPS supervisors, administrators, and directors from most sites shared about their educational background. Similar to caseworkers, many CPS supervisors had a bachelor’s degree in a related field such as social work, psychology, sociology, criminal justice, human development, and family studies. A few CPS supervisors and directors from different sites also stated that they had a master’s degree in social work or therapy. One CPS supervisor was also a licensed clinical social worker.

One CPS supervisor shared, “And, I started off as a - I have a - At that time, I had my bachelor of social work, so I started off as a caseworker II - And then, I got my master’s in social work...”

Another supervisor stated, “I am the [title removed] for [county name removed]. I have been in my position for almost [redacted] years, but I am a, I have my masters in social work and I’m LCSW, licensed clinical social work and I started as a caseworker through Child Welfare and worked my way up.”

A CPS administrator explained, “I have a bachelor’s degree in social work. About [redacted] years in the fields of CPS in 3 different states. I’ve been ongoing, intake and ongoing supervisor and intake supervisor and currently I’m the [title removed] for [county name removed], which means I oversee the entire Child Welfare program or CPS program as well as the adult protection program...”

Former Work Experience

Numerous CPS supervisors, administrators, and directors from most sites shared about their former work experience. As previously mentioned, most CPS supervisors, administrators, and directors had prior work experience within DHS. However, many CPS supervisors, across most sites also had other work experience outside of DHS. Several CPS supervisors, administrators, and directors across many sites had former work experience in related fields such as community-based programs, home-visitation programs, child placement agencies, foster and adoptive care, youth corrections, case management, organizations for adults with developmental disabilities, psychiatric hospital, residential treatment facility, and shelters for adolescents. A few CPS supervisors and directors from different sites also had previous work experience in unrelated fields such as public relations, marketing, recruiting, business, banking, finance, and working as an independent contractor. A few CPS supervisors and administrators across multiple sites also described having had prior supervisory and management roles.

One CPS supervisor shared, “I started my career with them, working with adults with developmental disability as a residential program manager. And then, I moved into the Early Intervention and Family Support Services program as a coordinator for that program.”

A director stated, “I did that for three years hate it, went to bookkeeping, cause my previous background was banking. So it was a little crazy for me coming here from banking.”

Another supervisor explained, “But prior to this, I mean, I had a lot, through the work I did with child placement agency I developed curriculum to, training curriculum for foster and adoptive parents...”

Another supervisor said, “Well, um, before I came here I worked at a residential treatment facility in the [redacted] area - and then I supervised a team in that facility for I think about [redacted] years. Um, I graduated from college with a degree in [field of study removed] and started working in, started out at a shelter for adolescents, and then in this residential treatment program, and then when I left there, I applied here, and I don’t know.”

Background of Other Community Partners

A number of other community partners from most sites shared about their background including length of time at their organization, formal education, and prior work experience. A few people disclosed the length of time that they had been at their current organizations which varied from a few months to over twenty years. Many of the community partners from different sites had formal higher education degrees. A couple of community partners from different sites had undergraduate degrees, a few from a couple of sites had master’s degrees, and a few others from a couple of different sites had clinical doctorate degrees. Most of these degrees were in nursing, although one bachelor’s degree was obtained in liberal arts and one master’s degree was obtained in organization and management.

A public health director stated, “So, um, I’m—I’ve been—my current position is I’m the director of [county redacted] Public Health Department. And, um, I’ve been in this position now for just over [redacted] and [title removed] before that for [length of time removed], and before that I was the [title removed] for [redacted] years. And before that I was [title removed] and before that I was a [title removed] for the Public Health Department. So, I’ve been here for [redacted] years.”

The same public health director went on to share, “Yeah, and my background is I’m actually a pediatric nurse practitioner and I also have my doctorate in nursing. It’s a clinical doctorate.”

A maternal and child health public health nurse shared, “Well, I am a RN with a - with a Master’s Degree in Nursing of children and pediatric nurse practitioner certification, and

I have worked here with [organization name removed] since spring of [redacted], as a maternal/child public health nurse.”

Another public health director explained, “Well, I am the Director of [county redacted] Public Health, and I started here in [year redacted]. We had just moved here a couple of months previous from the [redacted], although we lived in [location name removed] before I started school at [location name removed]. So I’ve been in this position going on [redacted] years, and previous to this, my background is nursing. I have a B.S.N. in Nursing and I have a B.A. in the liberal arts area and then I also have a Masters in Nursing, with a pediatric nurse practitioner focus.”

Multiple community partners from most sites described their previous work experience. Many had prior experience working in the health field in positions such as emergency room nurses, pediatrics, oncology nurses, general nurse practitioners, and doctors. One community partner had also worked for NFP in the past. Additionally, a couple of people from one site had previous work experience in other areas including education and nonprofit management. A few other community partners from a couple of sites also had experience working with their local CPS or DHS.

A public health director shared, “So, primarily I’ve worked as an ER nurse for [redacted] years and pediatric nurse practitioner for [redacted] years and did some oncology nursing along the way.”

Another public health director explained, “So, um, I’m—I’ve been—my current position is I’m the director of [county redacted] Public Health Department. And, um, I’ve been in this position now for [redacted] and [position title removed] before that for [redacted], and before that I was the supervisor of our NFP team for [redacted] years. And before that I was an at home visitor with NFP and before that I was a [title removed] for the Public Health Department. So, I’ve been here for [redacted] years.”

A community program coordinator stated, “My background is - Let’s see, I worked in the education field. I was a teacher, middle school Principal, and I also worked at the [state education agency removed] for [redacted] years...”

A public defender shared, “Um, I—my professional background is I used to work for Child Protection in [redacted] County. I was not a caseworker. I worked as, um, a detention alternative coordinator - but I did also for a time work, um, taking the abuse and neglect reports while I was an undergrad - And so somebody who would screen the child abuse and neglect reports, enter them into the system, um, identify the urgency of the response time, um, make sure that somebody—a supervisor over me—would train them and then assign them to the case... I also worked with juvenile intakes – which means that, for example, a family would have an issue at home with a teenager. They would bring them in, we’d help set up the mediation services for the family and also get them involved with other child protective services as necessary. We would also—my primary job involved screening kids who are brought in on detention.”

Scope of Work of NFP Nurses

Across multiple sites, many nurses were consistent in their perceptions and definitions of their role and scope of work as an NFP nurse home visitor. Many nurses spoke about a pre-determined number for expected caseload size and shared their strategies for client recruitment and retention. In addition, in many sites, most nurses shared their perceptions of the key elements of the program that they consistently adhered to, including developing and maintaining the client-nurse relationship, using motivational interviewing and therapeutic communication, ensuring participation in the program was voluntary, and collecting data for NFP NSO's Efforts to Outcomes (ETO) – NFP's electronic data system to which nurses had to send in forms for each client. As well, many nurses described their approaches to working with high-risk clients, with clients of different cultural backgrounds, in mandatory reporting, and in preventing child abuse/neglect. Finally, across multiple sites, many nurses explained the use of supervision and other resources as well as continued education to improve their practice.

Role and Scope of the NFP Nurse Home Visitor

Across all sites, most nurses described their role of NFP nurse home visitors as educators and supporters of their clients. Many nurses in some sites further described their role as the client's advocate or cheerleader. These nurses shared that they met their clients where they were at, followed their client's desires, and encouraged their clients to pursue their goals and dreams. Some nurses from several sites described their role in enforcing the idea that the client was the expert on her and her baby's lives. As well, several nurses from some sites shared the perspective that their role was to specifically build a client's self-efficacy, to empower clients to be independent.

One nurse stated, "Relationship is probably, is the whole focus of this program. And, it's like learning how to - the give and take and the consistency and the cheerleading when people - So, you know, a lot of people just don't have a, have never had a cheerleader you know? And, they just sometimes just need somebody to say, 'You can do it,' you know? And so, that's - And then, every person is so different you know?"

Another nurse expressed, "Being an advocate for the client is a big part of it, especially if they are doing their best, you know?"

Another nurse stated, "You know, by letting me know. So, you know, acknowledging that the client's the expert on her life and where she's at and what she's dealing with is- is really important. And then, you know, letting her know that, you know, 'I appreciate your letting me know that it wasn't going to work, and we've got other times.'"

Other nurses in several sites spoke about the need to be nonjudgmental, open, honest, and transparent with their clients; this had helped to build the relationships between nurses and clients which were expressed as an integral element of the program. Several nurses from multiple sites also emphasized the need to respect clients because they were guests in their clients' homes. In addition, some nurses from multiple sites expressed utilizing strategies such as motivational interviewing, therapeutic communication, effective listening, positive reinforcement, building on strengths, being present, and being comfortable in the silence as part of their practice.

One nurse stated, “I’m not there to judge them, or the way their house looks, I just want to promote child development in the healthiest way possible.”

Another nurse expressed, “And that, you know, I’m going into their home. I still have to respect that it’s their home.”

Another nurse expressed, “Stuff like that. Reassuring the mom. And you know, the, the positive reinforcement. Like, ‘You’re the expert on your baby. You know best, okay? If you don’t agree with something I’m saying, that’s cool. Let me know. If you don’t agree with something your doctor’s saying, let them know.’ Giving them, like- trying to help them develop that self-efficacy and, you know, internal self-esteem to be able to, you know, speak up for themselves. And say like, ‘Hey, this is what I think is going on.’ And stuff, like that.”

Another nurse stated, “So, just probably more listening and just more- I mean, being present. I did a lot of like, like being conscious, being- I am comfortable in the silence too. In the silence, often comes a response. And so, just being comfortable, being present. Yeah.”

Almost all nurses from all sites recognized their role as a nurse, as a medical professional going into the home, and their role to utilize their nursing assessment skills to observe and assess the environment during each visit. Some nurses from some sites described their role as not a friend, but as a nurse who supported the client. At the same time, some nurses from a couple of sites felt that a nurse home visitor was not responsible for solving all of a client’s problems nor was she capable of changing people. In some other sites, several nurses described their scope of practice to parallel that of case managers such that they assisted clients in accessing services and needs. One nurse from one site spoke specifically about having planted the foundation for their clients to succeed later on in life, despite the clients not graduating from the program. This nurse also shared that her scope of work involved normalizing parenting such that everyone had challenges and everyone must make changes for the betterment of their child; this normalization had helped this nurse focus on improving a client’s maternal health and her child’s health outcomes.

One nurse stated, “So, you know, I see myself like, I’m a nurse. I’m a medical professional going to a home. We don’t do anything medical in the program, but I use, you know, my assessment skills to, obviously, assess, assess the environment every time I go in.”

The same nurse shared, “I’m not their friend. I’m their nurse. And so, when I say, you know, like I need to - Like, I can’t be tied to the outcomes, which can be hard sometimes when, you know, you have a relationship with someone, and you’ve seen them lots and lots and lots. And, you feel like you should be able to fix something, but again, it’s not my role to fix their lives. It’s my role to be their support for them to fix their lives.

Another nurse stated, “And, it’s still that supportive role to help them access services and needs, but sometimes, with my moms with attachment disorders, we may make, do a PIPE on music and get some of their music out, so it’s kind of meeting their needs as well. Or, working on an activity like making a placement together or rolling a ball back

and forth or going to the park and just playing and really just talking with the mom of doing some things – not because they love their children, and some of these moms can't attach to their baby – but they can do some things to still enhance things. They can get coordinated with a daycare center who can provide some emotional attachment for that baby during the day.”

Another nurse expressed, “Because I think half of the time we're doing case management. I always refer them to the [location where DHS is co-located]. And, like food stamps and, like, cash assistance and all of that. We do that – very often since we are serving low income moms.”

Nature of Home-visiting

In various sites, some nurses shared about their perspectives of home visiting and approaches towards working with their clients. In one site, one nurse highlighted that her scope of work entailed home visits with high-risk, first-time mothers; compared to other sites, where most nurses described their duties as conducting home visits with first-time mothers (no acknowledgment of risk level). Another nurse from the same site shared that although she worried about some of her clients due to high-risks, she felt that at least she was present in the client's home and was able to act as a second set of eyes. Some nurses in others sites recognized NFP as a preventive program. These nurses embraced the prevention emphasis of the program and believed that their work helped to reduce risk factors in their clients' lives through supporting their clients in achieving their heart's desires. In some sites, some nurses also shared the philosophy of utilizing a community approach to support clients. These nurses felt that by utilizing and collaborating with Wrap-Around, DHS, and/or other community services, they were better able to focus on delivering the NFP program.

One nurse shared, “What are my duties? Doing home visits with high-risk, first-time moms and helping them be the best parents they can be and be a support to them and teach them about parenting and child development and their health and their goal and assisting them with all of that.”

Another nurse shared, “Yeah, absolutely, because I think that's one of our missions for sure, is getting in there from the very beginning and trying to make a difference and prevent that [child abuse/neglect] from happening. And that's what we hope to avoid.”

Another nurse regarding mobilizing community supports for her client suggested, “Yeah, yeah. Then, we can focus really much more on the program and it doesn't deter so much, you know, when- Yeah. When they have that. Because, until recently, we really haven't had like if they're- the counseling- well, it's great because the clients that, you know, that need it, so I'm really happy about that, that that can be for some of them, yeah.”

Another nurse stated, “The more the merrier has always been a motto of mine. More brains that is. Good ones, more good brains. Talk about ideas, plans, and things.”

Role in Mandatory Reporting

All nurses from all sites recognized their role as mandatory reporters and believed this role was necessary. However, there existed a difference in perspectives among some nurses from some

sites with regards to nursing practices in mandatory reporting. Some nurses from some sites perceived that their role was to report suspicions and information and not to actually investigate allegations of child abuse or neglect. Some nurses from some sites also described what was not in their scope of practice, including: determining whether or not a house was safe for the baby and whether or not a mother was fit for caring for her child.

One nurse stated, “As long as I don’t see any danger, there’s no child maltreatment or issues, and they’re doing what they need to do, I don’t report. Whereas there’s people that are saying, ‘Every time we see, we need to report.’”

Another nurse stated, “Because we work with families really closely. That I – likely, we’re the first responders.”

Another nurse shared, “Because I also know - I used to work pediatrics. It’s only my responsibility to report if there’s some concerns or issues. It’s the Department of Social Services to look in and do their investigation to figure out what’s actually going on in the home and what needs to be done as far as education and parenting classes and that sort of thing.”

Another nurse stated, “But there is so much that’s outside of our scope of practice when we’re doing this job. Like, you know, determining, ‘Is this a safe home for the baby or not.’ You know? ‘Should the mom really have the baby?’ Like, we can make recommendations, but that’s not really our responsibility to make those decisions.”

Another nurse stated, “The doctor. I need to hear what- And, I need to know - has - who actually is going to make a decision because I don’t think it’s my role as a Nurse Family Partnership to decide if this baby is - you know it’s a Social Services issue.”

Other nurses felt that sometimes their role as a nurse educator conflicted with that of a mandatory reporter. In fact, one nurse felt that her role was to educate, not necessarily to report every negative or potentially dangerous thing in which her client engaged. Her approach was aligned with prevention but she felt conflicted because it was necessary to keep a child safe to report to CPS. Another nurse from one site suggested the challenge in her job was the judgment she had to pass to determine what was reportable to CPS. Related to determining reportable cases to CPS, some nurses in multiple sites shared anxiety in accurately identifying such cases, making timely and appropriate reports, and approaching the situation with the client humanely.

One nurse stated in regards to transparency with clients and mandatory reporting, “No, I would let them know, I think. You know, I think that’s the right thing to do. I mean, again, I don’t feel like that’s my job there. My job is not to be a reporter. My job is to educate so that they don’t need something like that. You know?”

So, it’s kind of a little bit of a conflict, but you don’t- you also don’t want to turn your eyes to something that’s dangerous. So, you know- I think if they know that, you know, that’s why you’re there and then you’re able to clearly say, you know - you know, ‘This is absolutely the last thing I would want to do.’ You know? ‘But, I feel like your child’s in danger,’ you know?”

Another nurse shared, “I wish I could say - I wish that, you know, in the perfect world, there’d be a list of criteria that would say, ‘Okay, this, this, this and that are met, so okay, I need to call Child Protective Services.’ That would be ideal (*laughs*). But, therein lies the challenges of our job is just, you know, that judgment.”

Another nurse expressed, “They make me feel like I think one of the things is my own liability, that I’m not picking up on certain things. Say, okay, with growing marijuana in the home, if I’m not asking certain questions and something were to happen, either the child were to ingest something or say they grow something that will catch fire, something like that, would I be responsible in some way for that? I know I would feel like I could have done more or should have done more, but would I really be responsible for that? And so that increases my anxiety around my own clients. I don’t know, because my tendency is to not look for those things that are not inquire-able about, those particular things, and focus on mom and the child. It makes me anxious that I haven’t looked into that more, haven’t thought about that more, that I didn’t find out the information and how am I going to present that to the family without sounding judgmental or making them feel uncomfortable with me being in the home – all of that. So those would be the biggest sources of my anxiety around...”

General Challenges to Home-visiting

In some sites, some nurses shared about challenges within their scope of work. Some nurses shared that it was more difficult to develop relationships with clients (and thus more difficult to positively impact their lives) when they were enrolled into NFP post-partum because there was a shorter amount of time to connect with the clients. One nurse from one site found it difficult to make phone calls to clients to check up on their progress; she felt like a salesman trying to maintain a client. Another nurse from another site found herself often completing charting after hours because she preferred to spend her regular hours visiting clients. Other nurses from several sites shared that they had answered their clients’ phone calls after hours or even while on vacations (even though they were not supposed to) because they felt they were the only support in their clients’ lives.

One nurse stated, “And she was 17 and she’d already had her baby. And, that one’s been - I just think she’s not invested. You know? So, it’s hard to build a relation – I think it’s easier when they’re pregnant and you have all this time build it.”

Another nurse stated, “Exactly. That’s the hard part. I’m not the salesman. I don’t like calling people and being like, ‘Hey’ - Yeah, no it’s, it’s not as bad. That was one thing that took the most getting use to though, was just making the phone calls, but it’s not that bad.”

Another nurse shared, “I spent a lot of time after hours charting because I wouldn’t start charting until the end of the day. I still do that now. I go home and chart. I know I’m not supposed to, but I want to be with my clients, so.”

Another nurse stated, “And, in fact, when I contacted – that was this past summer - I was on vacation when I found out because the mom had been taken into a 90-day hold. And, I wasn’t able to locate her. I couldn’t figure out- and then, I went on vacation, and she

contacted me while I was on vacation. So, I was trying, from New York, to get a hold of people here.”

In addition, some nurses from several sites shared the desire to build their clients’ self-efficacy but experienced challenges in balancing that desire with successfully connecting clients to services without creating client dependency on the nurse. Finally, in several sites, some nurses shared the concept of self-blame or secondary trauma when their clients did not reach their goals, the client dropped out of the program, or the client needed to be reported to CPS.

One nurse stated, “It depends on the client because there’s just so much that we can do. We offer information, give them, like, application forms but just to a certain point that we can’t really do everything for them, and like, get their application and hand it upstairs. We can’t really do that for our clients - But we’re, like, cause our role is just to give information and help them throughout but not to the point that enabling them to – be very dependent on us since they are going to graduate after two years.”

Another nurse stated, “It’s kind of our answer to - We’re supposed to teach self-efficacy. So, our answer is, oh here’s a list of all the resources in the community and, you know, you don’t have enough formula for the week. You may start with these people and call these people and these people. So, we definitely help them - yeah. Provide the information so they can - and, with most people if they’re really desperate, yes, they don’t have any problems. And, if they’re that needy and you really know it, we’re going to help them. But, secretly.”

Another nurse shared, “So I took that as I’m not doing my job good enough. I am not educating them well enough that these babies aren’t gaining enough weight. I mean there is always that possibility that it’s a biological issue, metabolic issue, you know something like that, but 9 out of 10 times they are feeding their babies enough and they don’t know.”

Another nurse stated, “You know, and I know that. But, it’s still tough. And we have to process that too. And, also it’s secondary trauma for us when we’re in those situations. So, we - I’ve found that, usually if there’s a difficult situation like that, I have canceled visits afterwards. I have just kind of walked the mall or just - I have time where I can go to the gym that I - I’m not real effective for another visit.”

Caseload

Almost all nurses from all sites regarded a full caseload to be 25. This number for caseload was lower if nurses worked part-time; where part-time nurses working a certain percentage of time generally held a caseload of the same percentage of 25 (e.g. 75% FTE would equal 18 or 19 clients).

One nurse stated, “I just went from three-quarter time to full-time, so right now, I have about 20 - 20 to 21 clients. And, I’m supposed to be up to 25, so I’ll be getting there soon.”

Another nurse stated, “Well, a normal full caseload is 25 active clients.”

The abilities of nurses to maintain a caseload of 25 varied within and across sites. In some sites, some nurses successfully maintained a caseload of 25 or higher, usually with several transient or hard-to-reach clients. Within the same sites and other sites, some nurses had difficulties in maintaining (or building) caseload. In fact, these nurses recognized that there existed an expectation to quickly reach or consistently maintain a caseload of 25 clients. Specifically, many nurses from two sites spoke about the extreme importance of maintaining caseload due to legislative funding but that their colleagues or they themselves often failed to meet such requirements. Maintaining caseload was at times more difficult for sites that had a transient nurse population. In fact, one site in particular experienced this more than other sites. Nurses and the nurse supervisor from this site expressed that nurse attrition had an effect on client retention despite fairly successful transition rates. For example, transferring a client from a leaving nurse to a new nurse affected a new nurse’s ability to manage her time with attending trainings and orientation along with retaining and visiting clients.

One nurse shared, “Yeah, I’ve never had an issue with that. I always, mostly I kept 25-28 clients on my caseload.”

Another nurse expressed, “Right now? That’s kind of a joke because I can never really figure that out. I’m, you know because it’s in flux all the time. I think I’m at about 24. And, but you know, but there’s some, like I always say there’s, I would probably have about 5 or 6 missing in action. So it’s like, it’s not that I haven’t seen them in the last month, but it’s like I need to pull them in to reschedule appointments and stuff.”

Another nurse stated, “Right now I have 27 active clients and 5 that I see maybe once a month or that I haven’t seen for about 45 days. So, total I have about 32 clients, but 27 active.”

Another nurse stated, “Well, my caseload in this particular- At this particular site, we’ve been struggling with the caseload, and I don’t know exactly why, but we just- somehow it’s hard - it has been hard for pretty much every nurse, including myself, to maintain a full caseload. So, I don’t know exactly. I just can speculate.”

A nurse supervisor stated, “Until another nurse comes on, and then usually the way it, because we try to make sure that the other nurses, their workload isn’t too much. We don’t wanna lose them either. Because, like, I’ve seen that snowball effect where they’re like “You know, I can’t keep up with this”. So and then when you bring somebody new on, unless you have the fortune of having a nurse who’s already gone through NFP training, we have to send them to training, and that’s very time consuming.”

Most nurses from all sites shared a fairly consistent process to maintain caseload. Nurses had notified their supervisor that a client was graduating or had dropped the program. Nurses had received contacts and names of potential clients and made cold calls to explain the program and its benefits. A visit was then scheduled to enroll the client.

One nurse stated, “So, once you see that you’re going to be graduating in the next couple of months, you get these referrals and, you know, typically she gives you about two to three at a time. Because a lot of them it’s hard to get a hold of them. Their phone numbers have changed. You know. So, you get at least a couple and then you call them. And, if you get a hold of them you just kind of over the phone say who you are and that you would like to meet with them and show them the program. And, the majority of them say yeah I would love to. And so, you make an appointment with them. You go to their home, introduce the program, and from there if they enroll that’s where you start. And then, if they choose not to, then you move onto the next referral and just go from there.”

Another nurse shared, “You’re supposed to start looking for new clients when your clients reach - Or, when the client’s child reached about 20 months, 20, 21 months, so that you can fill - That they can already be there as your other clients leave...”

Composition of Caseload

In several sites, some nurses talked about the composition of their caseload. Most nurses shared that their clients were usually younger (under 22 years of age) and mostly single. Some nurses from one site shared that their caseload compositions had changed over time, with less teen moms and less Spanish-speaking clients than previously. Other nurses from other sites highlighted that sometimes their caseloads were more transient, in the military, or of tribal membership. Some nurses in some sites described having clients from all stages: pregnancy, new born, and toddlers, while some nurses from some sites held a caseload of clients in one stage (e.g. all were turning one year or nine months old). Depending on the site, some bilingual nurses served only monolingual Spanish speakers, bilingual and of Spanish-origin, or a mixture of Spanish-only or English-only speakers. One nurse from one site shared that her caseload consisted of mostly high-risk clients.

One nurse shared, “It used to be my caseload would be half to three-quarters teenagers. Right now, I have no teenagers. I haven’t for a couple of years. So, I think they’ve done more birth control efforts through public health classes in the high school- It is a good thing. But our caseloads look so different as far as age than it used to- And we don’t seem to get as many Spanish-speaking referrals as we used to that...”

Another nurse expressed, “And I think, you know, usually it’s 75% Spanish that I have and, that I speak actually Spanish with them.”

Another nurse stated, “Um, for the most part, I- I mean, I have- I have an incredible caseload of high-risk clients. I don’t know why. But, it’s just my caseload. Um, for the most part, there’s not an issue. There’s no difference between them until I report -And then, it becomes a different situation.”

Another nurse stated, “Most of my caseload is just now turning one and nine months because of the way it just laid out.”

Burden of Workload

In addition to the expectation of maintaining caseload, a couple of nurses from several sites expressed the need to reduce their caseload based on the acuity levels of their clients. In fact, one nurse from one site described learning about research to address this issue in her NFP unit two training. She also spoke about a colleague who tended to work with schizophrenic clients and should carry a lower caseload because such clients required more nurse involvement to maintain the relationship. Another nurse from another site felt that the minimum required number of visits per week was too much for her workload.

One nurse stated, “Right, that’s my, yeah. I like to hanging out in the 28 to 30 range and you know, [nurse supervisor name removed] gets a little upset cause we are supposed to maintain 25, but you know I thought I heard something during unit 2 a year and a half ago about doing research on acuity and based on the acuity of your clients being able to carry more or carry less. So, one of the nurses, she is interviewing right across the hall right now, for whatever reason attracts schizophrenics. So, she should probably only carry, honestly, like a caseload of 20 because they are so involved and she is so fantastic at her job and at maintaining those relationships that they want her to go to therapy with them. And so in order to get them in the door, so that they will be compliant with medications and therapy schedules, she does, and that takes a lot of time. And so it is hard for her to stay at 25. Me on the other hand I did my BSN in [redacted] months, [redacted] months at [redacted]. I am the master of time management and so I can hang out at 28 with a handful of somewhat higher acuity clients and be just fine.”

Another nurse shared, “I see 20, we have 25 clients. And, we’re supposed to do 12- well we’re supposed to do a minimum of 12 visits a week, which is an awfully lot.”

Several nurses from different sites shared their experiences in working with clients involved with CPS and/or higher-acuity clients. These nurses felt that high acuity cases involved greater time involvement to collaborate with other agencies, additional charting, and increased emotional investment. One of the nurses felt that she was only capable of managing a limited number of clients (three to five) with CPS involvement because of the increased time involvement, flexibility with scheduling needed, and emotional burden. Another nurse from another site shared that due to client involvement with CPS, she had needed to change visit schedules with other clients so that she could attend court dates.

One nurse stated, “To be honest with you, when you have a case like [client name removed], or a case like this [client name removed], it’s like a high-acuity case out of your 25. And, I- well I’m - this is just me. I believe in staying at caseload. I believe in trying to do the job, trying to do my visits. I mean, to me, I- I’m just- this is my way. You know, we had to do strength-based training, and one of my strengths is consistency. I’ve gotta - if I have something I’m supposed to, I do it. That’s just the way I am...But, if I’m supposed to be at 25, I want to be at 25. And, I want to do my visits. But, when you have a high-acuity case, it takes - you have to do a lot of extra charting. You’re calling people, you’re doing extra work.”

Another nurse shared, “The other thing is that I’ve found that I can only carry about three DHS cases that are really intense. Rather than 25 cases. Well, actually, if I had- well, I

could carry up to five. But, if I have more than that, it's too overwhelming for me emotionally. Because I'm having to structure time. I'm having to plan a little bit more carefully. I have communication time involved. And so, the supervisors have been really good in the past that, if I've needed to modify my schedule or, for instance, not take any new ones while I have some DHS cases, because they know it takes more time. Then I'm able to do that- for a short-term. And, that really helps. But, especially with going to court. If there is court time, I know in the past, it takes a lot of time to prepare, then you get there, and they don't need you. Or, it's been rescheduled. Or, they decide to do an oral interview instead. Or, something different because things change. That's a little bit more intense."

Another nurse stated, "I've had to switch clients around on their regular days that we are meeting. And then, because of these court dates, because of these meetings, I've had to switch clients around a lot. But, other than that, it's okay."

Finally one nurse from one site suggested that her charting may have been negatively impacted due to building a caseload too quickly. Another nurse from another site shared that increased paperwork and incorporation of augmentations like DANCE (Dyadic Assessment of Naturalistic Caregiver-Child Experience – a new NFP assessment tool for examining bonding between mother and child and for documenting behaviors and developmental milestones in infants) were positive, but there needed to be a reduction in caseload to balance this addition to nurse's workloads. In fact, this nurse believed that the added workload had contributed to greater nurse attrition.

A nurse shared, "I think, to be honest, I think it was disservice to me being a new grad in this field because I feel that my charting has quite possibly suffered because I built my caseload so fast and that is something that I have been asking for ongoing reviews and have gotten some."

Another nurse stated, "... and now, with this DANCE - I don't even know how I'm going to fit DANCE in. That's another whole piece. I don't know if you're aware of that- We just went to DANCE training in November, and it's a mother-child dyad where you're supposed to watch your clients for five minutes, and then you chart on them to help them- give - tell them what their strengths and what - which is really good, but we're supposed to do it on the client four times - four times during the time we see them, in addition to everything we do with them."

She goes on to state, "It's another- they keep adding- they keep adding more paperwork and adding... they haven't taken away our caseload, taken away nothing. They keep adding stuff to our job. I'm working much harder than I did when I started this job. Well, and part of it, I know, I'm a better nurse. I'm not - I mean, I have more- I know more, you know. But, I would say for nurse burnout – and, I know that there are issues in other sites – they're losing nurses. They need to reduce- either- if they still want us to do all this stuff, they need to reduce our caseload. Or, say, reduce the amount of visits we need to see the clients. Or, you know, maybe I chart too much. I don't know, but it's getting- the workload has definitely increased a bunch."

Client Recruitment and Retention

Across all sites, many nurses shared similar processes in client recruitment and retention. Most NFP sites had fairly consistent and similar referral sources; these included: the public health department, WIC, Medicaid, and schools or school districts. Other sites had also received referrals from private physicians, hospitals, and local baby, pregnancy, or OB/GYN centers. One site in particular worked directly with the military to ensure appropriate referrals to NFP.

A nurse stated, “Most of them come from either WIC or pregnancy center. They go to find out they’re pregnant from pregnancy center, or to confirm their home pregnancy tests and pregnancy center is very good. And then also WIC, if they’re a little further along, they’ve usually heard about WIC. And so they go to sign up and WIC will refer them.”

Another nurse shared, “Yeah. The majority, I feel, of our referral sources are from Public Health here. So, the moms, a pregnant mom will come and apply for Medicaid and then our public health nurse here will refer her to our program or to WIC and then we’re also working on getting our, increasing our caseloads, so we go over to the hospital pretty regularly just to see if there’s any first-time moms over there that might, you know, need a little bit...want a little bit of support because we can enroll the moms until they’re 30 days postpartum. Yeah and then. We also, we attend [community organization name removed]; we attend their meetings. That’s for the OB/GYN over there. They’re all in a building, so that’s what’s nice.”

Another nurse stated, “You know, I think there’s someone there at the base. I’m not sure exactly who it is, I think it’s that person who does the, kind of a liaison that does family intervention kinda counseling. And I’m pretty sure that’s how we’ve gotten our referrals from the military.”

Some sites benefited from their site’s organizational structure and received referrals from internal clinics or Eligibility programs. For example, one site was based out of a community health center that delivered the majority of babies in the town; this site received all first-time pregnant mother referrals from the OB clinic. Several other sites were based out of the county Departments of Public Health where WIC and Eligibility were also located; these programs consistently referred to NFP. However, not all sites benefited from their organizational structure. For example, one site, despite being organizationally structured under a local health agency with multiple clinics, had faced challenges with receiving referrals from their agency; some clinics or providers were not familiar with the program. Additionally, self-referrals (client seeing a marketing poster and calling NFP) or client referrals (graduated or current client referring her friends to NFP) were common in some sites. These sites had usually been in the community for a longer duration and elicited a positive image among community members.

One nurse supervisor stated, “Logistics really helps because we’re all right here, and they all know what we do and, you know, so that’s - That’s where we get most of our referrals.”

A nurse expressed, “I think a majority of our referrals come from [community organization name removed] you know, because they’re, um - For one, you know, I think the population that they serve is the same population we’re kind of, you know, trying to target with this program - And, then us being housed there, of course, they help us out, so.”

Another nurse stated, “Some are self-referred. They see our poster and stuff like that, and they call in and say, “Hey, I want a nurse.” Or, their friend’s in the program or their sister or, you know, that kind of stuff. So, we get referrals that way, too.”

Another nurse supervisor shared, “And then, the next in line would be client referral. We have a lot of people who tell other people because I’ve been doing - We’ve been doing this for going on 14 years now, so—a lot of - I’m on a third generation, like the third sister right now in the same family. So we have a lot of that, you know, so word of mouth is huge for us.”

Some sites had experienced periods of lower referrals; during these times, outreach efforts were emphasized. In some other sites, more referrals were needed due to new nurses who were building up their caseloads. Some nurses and nurse supervisors from other sites explained that they had received an abundance of referrals to the extent that potential clients had been waitlisted.

One nurse stated, “Which in [location name removed] is a struggle to, you know, to have enough referrals. Or you know, we’ve always - We’ve never had a waiting list or anything like that, so.”

A nurse supervisor shared her concerns on building caseload, “Holding steady. I am a little concerned that we do need to pick up the pace on the referrals, as I have two nurses right now who, they’re halfway in building up their caseloads.”

Another nurse supervisor articulated client capacity at her site, “Shortly after that, we got like two or three referrals from our Department of Social Services on families who already had their babies—and, they were positive for drugs. And, they wanted to refer them immediately to us. And so - And, at the time, we were at capacity of clients. And, we were getting ready to expand and down a nurse and all this stuff was - It was like, ‘Oh -’ And, they weren’t really appropriate for NFP.”

Outreach to community agencies was common among all NFP sites; but, as stated, some sites actively participated in these activities more than others due to a lack of referrals from the community. Several nurses from various sites shared that outreach activities had included giving community presentations, taking workers to lunches, informal check-ins, and holiday cards or gifts. One site had also divided outreach duties among its nurses while another site dedicated meeting time to brainstorm possible outreach activities.

One nurse stated, “So sometimes that. But, and we do a lot of outreach in the community. Or that - We kind of make that a regular part of our job and just chatting, going in and chatting with people. We used to take people out to lunch but they cut our money.”

Another nurse shared how her site used division of labor in outreach efforts, “So, we are set to go out - We’ve actually divided - Each nurse has a clinic that will be assigned to them. And, we’ll go out and directly recruit to that clinic and try to get new referrals. Which has worked for us. In the last - I’d say three, six months, we’ve had one clinic that, before this year, I think has never referred an NFP client to us. And now, we have a doctor who’s on board and loves NFP. And, I think she must send us - I’d say, at least 10 a month. I mean, she’s just...”

Another nurse stated, “Yes. We constantly work on outreach efforts. We, as a team here, the local nurses, we meet every other month, and we just - We just talk about our outreach, and we brainstorm, ‘What can we do to, really, enroll these clients who might be eligible?’ And, you know, we brainstorm how to really connect with the providers in the community, and how to get that message, you know, to them and ask them to help us and so on. So, we have been, and at this point, we just don’t feel that we’re very successful, but we keep looking at new ways, how to do it.”

Client Transfer from Nurse to Nurse

As previously explained, across all sites, some nurses explained that they sometimes received clients from nurses who were retiring or leaving NFP. Most sites implemented joint visits where the new nurse met the client with the previous nurse; so that introductions were made and a relationship was slowly built between the new nurse and her client. Joint visits allowed the new nurse to understand the dynamics between the previous nurse and the client, as well as provided an opportunity for the client to process the change that was to come. Some sites had also transferred clients to another nurse at the client’s request; this transfer occurred more frequently in one site as compared to others. Requesting a new nurse had resulted from the nurse making a CPS report on the client or due to a clash of personalities between the nurse and client.

One nurse recalled, “I just let her lead those visits particularly and then I just introduce myself, gave a little bit of background of myself, and just reassured them that if they have any questions or concerns or whatever, for any needs they have, they could contact me at any time, and they were all extremely open, and I think that it falls back on the relationship that she had established with them, too.”

Another nurse shared, “And, that’s the tough thing that I think a lot of our new nurses have difficulty with when you develop a relationship with the mom, and you’re starting to make some progress, and then something happens, and... And then, you don’t... You have to close them. Or, they say you don’t want them, and you have to transfer to a different nurse or... Or... I think it’s a little bit more difficult. It’s... I find that I’m probably looking at ways I can restore that continuity. For instance, if one nurse has called, and the client still wants our program, but she doesn’t want that nurse.”

Client Transfer from Site to Site

Nurses had also transferred their clients to other NFP locations if their clients moved away. This seemed to occur in almost every site and involved a transfer of the client to another NFP location within the state of Colorado or to another state in the USA. Other times, there was not an NFP site in the area that the client was moving to; this created challenges for the nurse because she was unable to connect the client with resources. Some sites transferred clients to other NFP

locations more frequently than other sites due to the transient nature of their clientele. Most sites had a formal process which had involved sending forms as well as information about a client's risks and strengths to the new NFP site, as explained in the Organizational Structure section.

One nurse stated, "Yeah. I mean, sometimes, there's a - Uh, let's see - I had somebody that moved to another state. And, she was interested in staying in the program, so I reached out to Texas and got her set up, and she went into that, did that there."

One nurse supervisor expressed, "So, we get people moving in and out of the county a lot. So, we'll get transfers in, and our folks go. And, sometimes, they're kind of on the cusp or on the edge of reports, but we don't really know where they're going, and if they go someplace where there's not NFP, we can't facilitate a transfer for them. So, but it is a - It's a tough thing. The nurses really struggle."

Another nurse stated, "We just send the basic kind of information over to the, you know, the Risks and Strengths, to the new nurse. We just tell them we have a client that's moved to this address."

Follow up with regards to whether or not the client was successfully transferred and continued the program was inconsistent within and among sites. Some nurses had followed up with clients directly to see if they had enrolled at their new location; while other nurses did not follow up with neither client nor NFP site after transferring information to the new NFP location.

A nurse shared her process for transferring clients, "Um... Let's see, I think it could work more smoothly somehow. I know we have like a transfer form that we fill out and send over to the appropriate agency. And, I've gotten them, and I've sent them, but I haven't really had any contact with any other nurses. My girl that went to Ohio, I hadn't heard anything, so I had set up a call and that's how we found out that she had started but then stopped. Otherwise, I kind of don't know unless my girls tell me."

Another nurse recalled, "I did. That one, we contacted, number one, to make sure they had space to take on the new client. Number two, I send over a transfer form with relevant information. And, that's about it. And, this family is known for not having phones. They didn't have a stable address that I could say that they could go to... Hmmm. Yeah, I let it go once they said they got the transfer stuff."

Another nurse stated, "We call the supervisor, and then the supervisor assigns it to a nurse, and then we visit with the nurse. And then, typically, I do a joint visit with the new nurse and myself and the client."

Enrolment and Retention Strategies

Enrolment and retention strategies were shared among most nurses in many sites. Some nurses in several sites frequently suggested the first visit to be at an alternative location such as schools, hospitals or libraries. This helped ease any client's worries about allowing a stranger into her home and/or had facilitated a quicker enrolment process. For example, one nurse described a first encounter with a potential client as occurring at the hospital and involving enrolling the client

into the program right away; as compared to the first encounter being by phone followed by enrolment at a home visit.

A nurse stated, “So, I just - I just basically enrolled her in the program because she’s in the hospital, brand-new baby, I didn’t try to like, you know, do too much that first visit.”

Another nurse recalled, “I guess some of the referrals that I’ve called that have been hesitant for one reason or another—and, I don’t know what those reasons might have been—I’ll offer to meet them at like the library or, you know, somewhere a little more neutral, so they can kind of get to know you a little bit before they just let you into their home because that’s a very personal thing, whether they have something going on or not. And, I think sometimes that’s helped to at least get your foot in the door.”

Across most sites, more experienced nurses tended to be open and honest about the program and the commitment it required at the initial visit. These nurses were also more accepting of disinterested clients and had moved on to the next potential client; rather than wasting energy to recruit a client who may end up dropping in the future. Less seasoned nurses in various sites had spent more time attempting to recruit a client by making multiple phone calls or visits, or emphasizing the flexibility of the NFP program (such as conducting monthly rather than bimonthly visits or scheduling visits at alternative locations other than the home).

One nurse shared her recruiting strategies, “So, you know, you learn after a while to, you know, how to - You know, in the beginning, I felt like I was - Yeah. (*laughs*) Begging. Now, it’s a little different and, um... And, being honest up front with them, you know, about the program and what it entails and, you know, that if they’re committed and, you know, sometimes you know those that are kind of riding the fence that you give them an out if they don’t want to do that.”

Another nurse expressed the realities of recruiting clients, “And, you can only do so much, you know? I’ve had a few referrals - I had one referral that I was working on where I had talked with her, and she seemed really, really interested in the program, and then, the two times that I went to go sign her up, she wasn’t there. And then, after that second time, she just never called me back. But, she had schizoaffective disorder, and so I think it was, you know, that paranoia that, ‘Someone’s going to come check up on me....’”

Another nurse stated, “Yeah, when I’m usually signing up somebody, I’ve - This has sort of been an evolution, too, because I did lose a new signup because she was in a very chaotic situation, living in a motel with her boyfriend, and we signed up at the hospital. And then, I told her I could keep meeting with her at like a coffee shop or whatever until they got a place because they were - You know - Or, I could come to the hotel. It didn’t matter.”

A few nurses across a couple of sites talked about communication techniques they utilized such as sending letters and cards or texting and calling when they did not hear back from their clients. Other nurses from some sites allowed for flexible visit schedules with their clients. A couple of nurses from two other sites shared that when clients became upset after suspecting that the nurse

had reported them to CPS, they transferred the client to another nurse in an attempt to keep the client in the program. A few nurses from different sites had also offered clients the opportunity to speak to former clients who had been through the program to explain what NFP was about, but most clients refused this opportunity.

One nurse shared, “I typically will, like, do phone calls, send a letter, one time, I’ll - You know, I call it drive-by, where I’ll stop and actually knock at the house.”

Another nurse shared, “Well, we send them the - We have three letters that we’ll send out. You know, the first letter is just kind of like, ‘Hey, we -’ you know, ‘Please call us. We need to make an appointment.’ And then, also just texting and calling and be like, you know, ‘Do you want to still be in the program? We need to make an appointment. We need to keep an appointment.’ And then, if they just don’t respond, or if they say, ‘No, I want to be done.’ And, with her, she just stopped responding.”

Another nurse from a different site stated, And, she called and she was upset. I guess she called my supervisor, if I recall correctly. And, didn’t want me coming out, and we talked about it and processed. And, there was something that happened in between our visits and DHS came out. And, that one ended up going to a different nurse. And, we processed that and, ‘Well, maybe a different nurse would work.’ And, having the flexibility - And, that seemed to work out for her.”

Another retention strategy that was discussed was the use of clients’ medical information. A few nurses and one nurse supervisor across multiple sites discussed that it was a common procedure for them to access clients’ medical information from health service organizations with which they were affiliated. These nurses and the nurse supervisor shared that access to client information allowed them to check on the status of the mother and baby after the delivery, communicate with the client’s provider about any concerns a nurse had about the baby, and “run-in” to clients at their next appointment when nurses had a hard time getting a hold of a client. One nurse emphasized that access to medical records was particularly useful because she had been unsuccessful in hearing back from providers when she attempted to directly contact clients’ doctors.

One nurse explained, “So, I was able to flag—because our, the [name of health service organization removed] with the Health Department and [name of health service organization removed] —our - If our clients see [name of health service organization removed], go to [name of health service organization removed], we have access to their medical records. And, I was able to flag the doctor and tell him that I was worried about this baby’s creeping.

A nurse supervisor stated, “I don’t think so - And of course the couple cases that we have aren’t [name of health service organization removed] moms. I mean, maybe that’s why they’re so difficult. Because if they’re in [name of health service organization removed], we have a pretty good control of it. We know what’s happening.”

A nurse shared, “And then, if I-- One of the advantages, when they are referred from the clinic, is that if I can’t get a hold of them because phone numbers change a lot, I can look

up to see when their next appointment is and maybe meet them there at their prenatal appointment and...”

Another nurse stated, “Um, sometimes, you reach out to their doctors in email, but I haven’t had very good success. People don’t reach back, in general. Um, I just - I’ll usually ask the clients to give me as much information as I can get, but - Most, most of them are in the [name of health service organization removed] system, which is immensely helpful. (*laughs*)”

The Nurse-client Relationship

Strong nurse-client relationships were seen as positive and aiding in reaching client goals by most nurses across most sites. In fact, almost all nurses across many sites described valuing the relationship they had with clients and ensured that the service provided was client-centered by developing a positive relationship with each client. Due to the frequency of nurse visits to client homes and the bond between client and nurse that usually began when a client was pregnant, the nurse-client relationship grew naturally over time. A few nurses from some sites described enjoying the connection they built with clients as part of their work. Many of the nurses in these sites expressed that it was easier to do their job when there were strong connections with clients. However, a challenging relationship with the client was considered detrimental for the success of a client’s participation in the program. Many nurses across most sites explained that these relationships were especially difficult to maintain especially after an NFP nurse made reports of suspected child abuse or neglect to CPS.

One nurse said, “I came from [redacted]. I was working in labor and delivery and postpartum quite a bit (*laughs*) for five years straight on that. Before that, I’ve had a lot of other experiences here and there. I enjoy this program immensely. I love my clients. And, it hasn’t been until recently that I’ve really come across a couple that are dealing with DHS (*laughs*), with the Child Protective Services.”

Another nurse in reference to the NFP program stated, “For me, that was a perfect fit. I loved it. I retired in [redacted] of [year redacted]. And it was a perfect fit because I loved doing home visits. I really loved the psychosocial aspect, and I really like working with new moms and their babies, and I didn’t have to give immunizations anymore (*laughing*). So I really enjoyed it. And it’s just really a good way to establish rapport with families, and I learned a lot from the families. I felt like what I learned from certain families, I could take to other families.”

Developing and Maintaining the Relationship

Several nurses across multiple sites described that the initial relationship building process required a lot of listening and meeting clients where they were at in every way, including the physical location and state of mind. A couple of nurses from different sites explained that how they were received by a client sometimes depended on whether the referral was initiated by the client or by other agencies that were concerned with the client’s behavior and safety of the child. Some nurses from several sites shared that when the client initiated participation and joined NFP, the relationship with the NFP nurse was most likely to be positive. In contrast, building a relationship with clients who were referred by other agencies such as CPS was described as

difficult by a few nurses from different sites. Indeed, one nurse described extreme discomfort in building her relationship with a client who was referred to her by Social Services that she eventually terminated from the program.

One nurse said, “So building relationships. So it take a while, some take longer than others before you feel that click, that moment where you know that you have them hooked. You know what I mean. Does that make sense? Um -it takes, some can take longer than others. Some you have the first 10 minutes you walk into their house. But some mamas have some real trust issues and some real kind of boundary issues and attachment disorders that they have grown up with and are trying to work through and are probably not even aware of. So it can be baby steps with quite a few, too. But a lot of mine I have maintained well, for over a year over now, probably about half, I would guess. I am in the process of rebuilding my caseload right now for which I am going to get in trouble because I have too many. But I have some I can and would like to go to an alternate schedule so that would be okay.”

Another nurse said, “Umm, one other time a referral I had was working with Social Services but she was a client that - one of the only clients that actually, because of my discomfort with the situation, that we declined in the program or she was mentally ill. So I actually talked to Social Services about her because they referred to me and, after I had already seen the client, and we declined the client because or you know I was afraid. It was one of those issues.”

Other areas related to building the nurse-client relationship shared by several nurses in various sites revolved around the nurse’s background and culture as well as the client’s availability and occupation status. Some nurses from a couple of sites who spoke Spanish or were of Hispanic background mentioned their ability to connect with Spanish-speaking clients and to build stronger relationships because of the language and cultural similarities they shared. A nurse who was a former graduate of the program described having a unique appreciation and understanding of the program and that sharing her story to clients on her visits had helped them overcome their obstacles. In this case, the nurse explained that her personal background allowed her clients to connect better with their nurse home visitor. Client occupation and their availability to meet with NFP nurses were additional factors that impacted relationship building in some sites. In some sites, some nurses explained that some clients worked two jobs and did not have time to meet while other clients had the time but were afraid they would be fired or flagged at their job if what was happening in their home was relayed back to their employers. Understanding and navigating these unique dynamics had helped some nurses in different sites strengthen their relationship with their clients. In such cases, some nurses explained that they had met clients at alternative locations like restaurants and coffee shops to accommodate to their client’s schedule and needs.

One nurse said, “And then, I start getting more into, just taking them in a little bit more and talking about culture, my culture, how I used to - You know, my family was and stuff. And then, they can understand, you know, that we’re all pretty much the same, you know...Like I said, with my Hispanic clients, it’s pretty easy for me.”

Another nurse who participated in the program herself described, “I’m very laid back and I’m very friendly with my clients and I will share things from my personal life if I think it

is therapeutic with them and so... But you know that's kind of, that's what you want you want to build a relationship. It is a partnership; you want to make them feel whatever. You want them to feel like you guys are friends and then they can tell you anything."

Another nurse stated, "And, I have somebody who's kind of working two jobs, and but she just didn't feel like she's able to make it happen, and I was like - I just kind of kept after her, you know, like a little bit like, you know - Because she is - She's a little chaotic. And, she's like somebody that could use a, use a step up. And so, I just keep in touch with her. And, I say things like, 'How are you doing?' You know? And then, I kept doing it and not a lot of response. And then, finally she texted me and she's like, 'I miss you so much.' *(laughs)* 'When can we get together?' You know?"

Across multiple sites, many nurses shared other strategies in the maintenance of relationships with their clients. Most nurses believed that transparency, openness, honesty, flexibility, consistency, and a genuine interest in learning about their clients' lives were effective strategies for developing and maintaining strong relationships with clients. Beyond making home visits, some nurses from a few sites described that to build stronger relationships with their clients, they had accompanied their clients to the doctor, therapist or other essential appointments where the client appreciated having a nurse's knowledge and company and the nurse was able to ensure the client understood what was communicated.

One nurse stated, " And, I think a lot of that is just, you know, continuing to develop a relationship with people because then, they feel, you know, confident that you're there to help them, and – so- I think it's just the consistency. You know, the consistency of I'm reaching out and making sure you make your - you know, come to - go to the appointments. And then, encouraging them when they're strong, you know, and pointing it out to them. I think that helps them."

Another nurse shared, "But, what I've found is that if I'm able to say, 'Hey, I'm just wondering where you're at. I know you're probably busy. When you have time, let's get together.' And, I don't push and say, 'Hey, when do you want to schedule next?' that they tend to come back more frequently than if I keep at it over and over again."

Another nurse said, "Anyway, she came over for her WIC appointment, and I was with her at that..."

Barriers to Maintaining the Relationship

There existed challenges to maintaining the relationship with clients as shared by many nurses from most sites. Such challenges related to the nurse's role as a mandatory reporter, age of the client, and perceptions of the NFP program by the client's family and friends. In almost every site where some nurses had made mandatory reports to CPS on their clients, these nurses expressed having felt conflict between wanting to protect the nurse-client relationship while upholding their mandatory reporting responsibilities. Many nurses from several sites also described that the relationship they had with clients sometimes suffered due to the requirements of being a mandatory reporter. These nurses explained noticing fear from clients related to nurses reporting them to CPS. Levels of success in retaining a client post-CPS report varied across and within sites; this variance also existed among individual nurses where some of their clients were more receptive to being reported than others. Several nurses shared experiences where upon

reporting to CPS their client either dropped out of the program, moved to another county or state, or disappeared (in the sense that they were no longer reachable) often regardless of whether or not action was taken by CPS. Other nurses in some sites expressed that collaborative efforts with CPS and other providers, as well as transparency with the client prior to reporting, were important factors that impacted whether or not a client chose to stay involved with NFP. Thus, the level of success in maintaining the nurse-client relationship subsequently impacted the nurse's caseload and the nurse's willingness to make a future report.

One nurse regarding mentioning CPS to a client stated, "She dropped out of the program after [name removed] and [name removed] went to see her and it is done now, which is really unfortunate because she was one that was greatly benefiting from this program. Yeah, never heard back. But I got my message across and that was the important part I felt like so I'm hoping that, you know, that case crashed and burned and then nothing happened with her because she is really high anxiety and I knew that and so I never should have probably mentioned DHS to begin with. I knew, she was like, prone to be anxious and it's my fault I have learned a lot of lessons from that experience. A lot."

Another nurse stated, "Yes. So, if there is a - Exactly. It's just to clarify the situation. Explain the rules. They kind of know now, so a lot of people are learning about that. And so, when there has been cases when they are - And, they're afraid, though, so there's a fear that if I might find out, which I haven't, but they wouldn't - They don't talk about it anymore. "

Another nurse stated, "It's kind of my role. Should I lose this connection to report and lose them and the possibility of do I work with them and set the goals that will help them in the long run?"

In addition to mandatory reporting being a barrier towards building or maintaining the nurse-client relationship, some nurses in various sites explained that some teen clients and/or those with a history of abuse or neglect when they were a child were more difficult to engage with. In some sites, teen clients tended to express that they knew all the information there was to know and dropped out of the program. A few nurses from a couple of sites described having a hard time with teen clients because they often did not open up to the nurse, thus creating difficulties in building the relationship. Some nurse-client relationships were disrupted due to the client's, her family members', partner's or friend's lack of knowledge or trust in the NFP program resulting in discouragement to participate. Additional difficulty in building relationships came from extended family members where some nurses from different sites explained having experienced unwelcoming behavior and misperceptions of NFP (that they were associated with CPS) from FOCs, mothers or mother-in-laws, and extended family members making it difficult for nurses to continue visiting their clients. Some nurses in several sites, however, described that once trust and a relationship was built with the client, because of the progress that the client and baby showed, family members usually came around to accepting participation in the program. Finally, a nurse from one site discussed declining a client after speaking with her supervisor because they were worried for the nurse's personal safety. This was a difficult relationship for the nurse because she felt threatened at the home visit.

One nurse said, “And, I don’t know if it’s because now you know everything about them. The abuse they, you know, received while they were children. Neglect. The parents are in prison or on jail or on drugs or whatever. They seem to be the ones that will within a short period of time say that they, they don’t want to be in the program anymore or they’re too busy or this, that, and the other - I do. Currently - Currently - You know, I’d have to really look at my list. That particular client who chose to drop out. I met her in foster care.”

Another nurse described, “I had a client just last week who said, ‘You know, my sister said’ – that she should get out of the Nurse Family Partnership because we’re undercover for Social Services and she’s gonna get - And, I have no concerns whatsoever about this mom. But, her sister had a situation—not with the NFP—but - Or, somewhere down the line. I don’t know the exact details, but I’ve been seeing her for, oh, maybe going on a year. And still, this is coming up. You know? You know, the idea that Social Services takes away kids.”

Another nurse said, “Well, it’s been a few years back. So - she just, she was - you know - I don’t have that training so I couldn’t give you a diagnosis or anything but it was pretty obvious mental illness and saying things that didn’t make sense and she kept asking me, ‘Are you scared? Are you scared to be here right now? Are you worried about your safety?’ And then she wouldn’t let me out the door. I had really a hard time getting out the door. So, at the time, we met with, I met with and talked to my supervisor and we had a lot of meetings about it and then my supervisor went up and above and agreed that I should not see the client. So then, of course, I think somebody else - she was- somehow, I got engaged with Social Service about her so she was, she was in the system and she ended up getting her baby taken away. I just heard that, so I never did see her. That was the only time that’s ever happened or that I didn’t feel comfortable seeing a client.”

Client Visits

Many nurses and some supervisors among all sites shared about their client visits related to initial enrollment, ongoing NFP curriculum-related visits, safety issues on visits, and location of visits, as well as client strengths observed during home visits. Several nurses from different sites also shared about actual and planned client visits and items that they had discussed during these visits.

Initial Client Enrollment Visit

Some nurses from various sites discussed that they had visited clients for initial enrollment purposes. Several nurses from different sites explained the importance of having face-to-face meetings with a potential client because that they had a better chance of enrolling clients in this way. One nurse expressed that she had enrolled every potential client she had ever gone out to visit. On the other hand, another nurse from a different site shared that after her initial visit with a client who had enrolled into the program, she cancelled on the nurse and declined further participation in the program. This type of situation was not uncommon as described by some nurses across multiple sites that initial enrollment did not always guarantee client participation in the program. In addition to enrolling clients, as previously described, almost all nurses from different sites shared that they had explained to the clients about their mandatory reporter duties

in their initial enrolment visits and made it clear to their clients that if they suspected child abuse or neglect on their visits they were required by law to make a CPS report.

One nurse stated, “Every person I’ve gone out to see signs up for the program.”

Another nurse shared, “I - Because I had a new client, I just met with her once. And then, you know, she signed the consents and everything. And then, after that first visit, we scheduled our next visit, but she canceled, and she said, ‘I really have enough support from my family, and I don’t feel like I will need this program.’ But, I don’t know for sure why she declined the program after that first visit.”

Another nurse explained, “I pretty much read off the consent. I forget what it says word by word, but you know, just that nurses are mandated reporters, and if I suspect any child abuse or neglect, I will have to report that. But, I will also let you know that I have or am making that phone call.”

Ongoing NFP Curriculum-related Visits

Almost all nurses across many sites discussed having conducted ongoing visits as part of the NFP curriculum. These visits occurred during the client’s pregnancy and/or after the baby had borne. Several nurses from different sites discussed their encounters while making regular visits that ranged from experiencing different types of client demeanor to approaching postpartum depression or violence in the home. Many of these nurses described what their interactions with their clients looked like on such visits as well as how they adapted when the client’s mother, boyfriend or husband were involved in the visits, especially when the client’s family was controlling or taking over the visit. Most of the education delivered to clients was related to: maternal health, child health and development, parenting skills, social support/networks, and developing life goals (e.g. going back to school, getting a job). In addition to delivering the NFP curriculum at home visits, multiple nurses from various sites explained that they had needed to engage with clients of different communication styles on their visits. For example, one nurse shared about a client who was very shy, had lacked engagement at visits, and perhaps felt pressured to participate in the program despite the nurse’s emphasis on the voluntary nature of the NFP program. This same nurse also discussed about another client who had been very engaged and had communicated information or her life during and outside of home visits with the nurse.

One nurse said, “It was good. It was actually really good to kind of catch up on her last six to eight weeks of her life, and Baby had been born and Baby was in NICU for a little while. Went home on oxygen, you know, I’m just kind of hearing about her struggles, but also her successes in figuring out those things, even for herself. So, that was - It was good.”

Another nurse shared, “We talk about everything, about them, baby, their goals, what’s going on in the home, their work, their school, their friends, their family, all that contributing stuff, so.”

Another nurse shared, “And so, with one of them, I don’t know that she was ever super engaged ever. I don’t know if she felt like she had to sign up for the program or what.

You know, and I usually give them a lot of outs like, ‘Hey, you can think about it. I’ll call you in a week.’ You know, and they’re like, ‘Oh, no. I’ll sign up.’ And, you’re like, ‘Alright.’ You know, she’s a very, very shy girl and would rarely say a whole lot at our visits.”

The same nurse also discussed another client and explained, “My other client, she was always really engaged during the visits. You know, and would text me to a certain extent outside of visits and just be like, ‘Hey, you know, this is happening,’ or stuff like that. ”

Safety on Home Visits

Several nurses and a few supervisors from different sites discussed about safety issues that had been observed and discussed during their home visits. Such safety issues were generally related to violence observed (e.g. IPV including verbal abuse) or intimidation perpetrated by the FOC as experienced on a home visit. In one situation, a nurse described having seen a violent situation in the home while visiting her client and having reported the incident to CPS. She was unaware that the police had been involved due to the report and upon a subsequent visit, observed the FOC being verbally abusive to her client which made the nurse feel unsafe. Similarly, another nurse discussed her discomfort with CPS after reporting her client on suspicion of child abuse and neglect because CPS had not kept her identity anonymous, thereby placing her in an uncomfortable and potentially unsafe situation when she made subsequent visits to the client. A nurse supervisor from a different site described an experience where she felt intimidated by an FOC who had yelled at her during a client visit in their home.

One nurse discussed, “And then, my other girl that I sent the card to, she did contact me, and we set up a visit time, went to confirm that visit time, and she said, ‘No, I’m sorry. I have to cancel. Can we do Friday?’ Today. And, I still haven’t heard back from her when I said, ‘Yeah, I could do Friday afternoon. Does that work? Does that work? Does that work?’ Um - Yeah. And, she’s kind of far out there. She’s not one that I just tend to want to drop by because I know there’s been intimate partner violence. She’s thinking he like slashed her tires at one point. He had even been calling me, trying to get to her - So, I just don’t feel comfortable going out there unannounced.”

Another nurse shared, “One - Well, there’s been a couple. One bad one was I made a report, due to a violent incident that happened in a house when I was there, and so I made a report like right after the house. And, apparently, I was told that the caseworkers didn’t go out yet, and I had to go back in a couple days, but they sent the cops right after I was there. And so, then I was put in a dangerous situation because the family knew I was the one who reported it wasn’t necessarily a safe environment. And, it was – I - I went out there not thinking anything had happened yet, because I was told the caseworkers hadn’t went out, but they kind of left out the important factor that they had sent the police, and so I walked in alone to basically an unsafe house. So, that one was not a good one. And, that’s just a lack of communication.”

Another nurse explained, “Yeah. So they, but they didn’t report my name, but they, two instances, they said, ok, this last case, they said, ‘Well, the person that reported said that you weren’t feeding the baby enough and said that you were very stubborn.’ So they gave them hints, in two different cases, gave the clients hints to who it was, and the client

basically knew it was me. Now, luckily, I was able to keep those relationships, but it was very uncomfortable for two visits after that.”

A nurse supervisor reflecting on a visit she had made as a nurse home visitor said, “Initially, when I wanted to report with that client, I wanted to report because the father, who was supposed to be taking care of the child, came in on one of our home visit meetings where I was in the room with the client, and his mother, and he came up the stairs, and he was yelling at me, saying, ‘You’re talking shit.’ And, he was very intimidating and standing up, and I was sitting on the floor. And, I was nervous. And, I was intimidated in a way, but I just remained calm, and I kind of had to talk my way through it. And then, get out of the house.”

Visits Involving CPS

Among several sites, a few nurses explained about formal and informal communications with CPS workers that occurred on home visits with their clients. Informal communications with CPS on visits included learning from a client that a CPS caseworker had visited, receiving written notes or caseworker business cards from the client, and meeting a caseworker who was out on an assessment by chance. More formal communications with CPS at home visits were related to scheduled joint visits made with the caseworker or visits that occurred at a CPS location (such as the crisis center, group home, or family services center). These interactions will be further explored in the CPS and NFP section of the findings.

One nurse said, “It’s terrible. Alright, so, he - I mean, that guy, she - I went to my like third visit—second or third visit—and, she hands me his card and says, ‘This man wanted you to call him.’ And, I’m like, ‘Okay’ - I had no idea what was going on, but I’m like, ‘Okay. Sure, can do.’ And, it was - I don’t know - It was the Department of Human Services.”

Another nurse explained, “Um, I had two times that I had clients referred. The first time, my client’s baby was about a year old, and I went to go visit with her, and I didn’t know that she had been referred. And, about halfway through our visit, she let me know that a caseworker had shown up. And, she told me about what the caseworker had asked her and talked to her about.”

Another nurse shared, “And, but she went to the [CPS crisis center name removed] because she had been - Very chaotic home life, and then she was put into a group home during the pregnancy because she and her aunt, who was the caregiver, would fight constantly... And so, she did much better - I visited, did all my visits at the group home, and she did really well there.”

Other Reasons for Visiting

Several nurses from different sites indicated that they had dropped by a client’s home at various times for different reasons, including when they could not get a hold of their client by phone or email. However, a couple of nurses from different sites explained that they did not make unannounced visits at their clients’ homes that had a history of IPV. Unscheduled visits were usually conducted with established clients with whom nurses had built a rapport and mostly resulted in continued regular visits with the nurse after the unscheduled visit. For example, one

nurse described having been unable to get a hold of her client for about a month and finally dropping in at her client's home, reconnecting, and continuing to make visits for some time before the client ultimately terminated her participation in the program. This example showed the variation in frequency that nurses conducted visits and how relationships with the clients ebbed and flowed.

One nurse said, "After the baby was born, I couldn't get a hold of her for about a month. And so, I just kind of dropped in on her one day. And, we then resumed our visits for a while after that, and then, like, about eight months old, she started canceling appointments and not showing up, and so - We had to just take her out."

Another nurse discussed, "And then, my other girl that I sent the card to, she did contact me, and we set up a visit time, went to confirm that visit time, and she said, 'No, I'm sorry. I have to cancel. Can we do Friday?' Today. And, I still haven't heard back from her when I said, 'Yeah, I could do Friday afternoon. Does that work? Does that work? Does that work?' Um - Yeah. And, she's kind of far out there. She's not one that I just tend to want to drop by because I know there's been intimate partner violence. She's thinking he like slashed her tires at one point. He had even been calling me, trying to get to her - So, I just don't feel comfortable going out there unannounced."

Alternative visits

Among most nurses in many sites, home visits generally occurred in the client's home. However, several nurses from different sites discussed conducting visits with their clients in alternate locations depending on what had been convenient for their client as well as had been safer for the nurses and/or clients. These locations included: client relatives' homes, local restaurants, the nurse's vehicle, libraries, parks, group homes, in jail when the client had been incarcerated, and at DHS family centers. One nurse explained that she had met with a client in her car by a nearby gas station and conducted a visitation due to her discomfort being in the home after having heard about an argument between the FOC and client. This flexibility in location of visits was often described as advantageous by several nurses in a few sites, especially when working with clients with higher risks including: current or history of IPV victimization, distrust of the government or system, substance use in the household (usually marijuana), and involvement with CPS. One nurse specifically praised the flexibility of the NFP program because of her ability to provide visits in prison to a client who was incarcerated and then at the client's place of employment after she was released.

One nurse shared, "And so, she did much better - I visited, did all my visits at the group home and she did really well there."

Another nurse stated, "And so, also the ability to be able to go different places with the client is really helpful because I've had several that have been in domestic violence situations, and their partner may be stalking them, or they may be really afraid of him coming home early or things like that, and we can meet in neutral places like the laundromat or like McDonald's or somewhere like that, and it's much more safe for them."

Another nurse stated, “And being able to kind of continue - there was one mom that was in jail for about three months. And, it was nice because I was able to coordinate with her. And, I met with her in jail a couple times. And, then she was on a work release situation. So, I was able to meet with her at her place of employment.”

Other adjustments to home visits were sometimes made as expressed by multiple nurses across several sites. A couple of nurses from different sites discussed altering their visitation pattern, whether it be not dropping by unannounced (which they had sometimes done previously) or visiting clients at alternate locations, to ensure client safety as well as their own safety. Some nurses from different sites had also adjusted their meeting times to when their clients had finished work or school, making evening visits rather than daytime visits. These examples showed the flexibility and adaptive nature of nurse home visiting to clients’ needs during visits.

One nurse shared, “So, I was able to meet with her at her place of employment. And, we really were able to negotiate how to do that. And, that meant more evening visits, rather than daytime visits with her, so able to negotiate with the supervisor’s help on how we can make this work for this client.”

Client Strengths

Several nurses from multiple sites shared client strengths that they had observed in their interactions with their clients. Some strengths discussed by nurses included having resources, a desire to self-improve, a desire to be self-sufficient, appropriate interactions with care of the baby, and family support.

Education and Work

Several nurses from different sites perceived a client’s return to school, work and/or both as a client’s strength and step in a positive direction towards self-sufficiency. Even though some clients were too busy due to work and/or school and were thus unable to find time to meet as often as desired with their nurses, several nurses from different sites felt that their client’s involvement with school and/or work was a sign of progress in their client’s life. Several of these nurses from different sites described such progress made by their clients in spite of their client’s existing challenges such as teenage pregnancy and considered the nurse’s involvement as successful.

One nurse said, “Yeah. She’s one that’s definitely always on my radar. You know, she has since enrolled back in high school. She had dropped out, so she is now at [school name removed]. The baby is going to the daycare there, so she’s definitely got some good supports going.”

Another nurse shared, “I—Yeah, I try to accommodate their schedule because I feel like a lot of times, it becomes—They get so busy. They’re working or they’re back in school, which is good. It’s success on our part.”

Client’s Care of and Interaction With Child

Several nurses and nurse supervisors from different sites described a client’s strength in adequately caring for and creating a positive environment for her child. Several nurses from

different sites also felt that if a client was taking good care of her child, then their role was to watch their client's progress while highlighting the client's strength in her maternal role. One nurse supervisor who worked with undocumented mothers shared that these clients tended to be attentive to her delivery of the curriculum and often followed through with what they needed for their babies mainly for two reasons: 1) because it was their culture to raise a child as a community, and 2) there was fear of being on the "radar" due to their documentation status that motivated them to adequately care for their children. In a couple of sites, a few nurses described other strengths among their clients to include being conscientious about child caring, showing love and affection for the child, and ongoing communication with the nurse on worries about supporting her baby and family.

One nurse stated, "So, you know, you see there's a lot of variables. And, it's an unfolding story. It's not going to be like an end and a beginning. It's going to be like a pay attention sort of thing. I feel like the mother's doing a great job. And, I feel like the baby's well cared for. And so, at this point, I don't feel like there's anything that really needs to be done more than watch."

One nurse supervisor said, "Um—Well, they—Most of my girls were undocumented, and I think, you know, they didn't want to be on the radar at all, for one thing. So, they listened intently to what I had to say, but yet they were—They're—They're very good caregivers, at least in my caseload. They were such good caregivers, and they—They, um, utilized whatever supports are out there if they don't have much family here and resources that I could connect them with. They seemed to believe in the idea, you know, it takes a village to raise a little one."

Another nurse shared, "But, she was worried because she doesn't have a lot of milk. Her baby's not this fat, chubby baby. I mean, he is gaining weight, but he's small. And, she's a very conscientious mother, super good mom. Like, she texts me about all kinds of things, worrying about the littlest thing. I mean, she's a very good mom."

Another nurse expressed, "I mean, I know that child's well-loved, well taken care of. And, that my client's usually pretty well-supported by her family, too, so it's actually a good scenario."

Acknowledgment of Risks and Desire to Improve

Several nurses from different sites shared about their interactions with clients who understood the gravity of their current situation as detrimental to their well-being and wanted to improve their situation. These changes were reflected around behavioral changes (such as quitting or reducing substance use) or in wanting to escape their current partner who was abusive. Indeed, one nurse from one site described her client's frustration with her own anger management issues and her desire to improve her behavior for the better. A different nurse from another site described her client's realization that she was in an unhealthy relationship with her partner and that she knew she needed to remove herself from such a situation but had not yet made a decision to do so. Such self-reflection, willingness to discuss safety plans with the nurse and management of their current situation, and wanting to improve were perceived as client strengths by several nurses from different sites.

One nurse said, “Well, that’s what I got out of her during that phone call last night was she doesn’t know how to deal with it other than to scream and yell. And, she really wants to know a better way to do that, which is excellent, it’s coming out. And, I told her we would talk about that at our next meeting. And, she was just—She was very upset last night when she called me, again, because of the fact that she feels like she’s screwed.”

Another nurse shared, “We did talk about, you know, having a safety plan in place because she’s talking about, ‘Well, if I leave him, you know, I know I could go live with my family. And, if I leave him, I know that’s he’s not going to be the dad who’s involved. He’s only gonna see the kids once a year.’ And, she thinks that the relationship is heading in that direction, but she was very clear about, ‘I know all the signs. You know, I know what healthy relationships look like, and I know that this relationship is unhealthy.’ So, she is very educated, but she’s just not ready to make that move yet.”

Consistency and Family Support

A few nurses from one site referred to consistency in a client’s life as a strength. Such consistencies included having a stable living situation over time, having consistent people as support, and overall stability or calmness or a lack of chaos in their lives. Having strong family support was also referenced as a client’s strength among several nurses and supervisors in multiple sites. Instances of family support were discussed in situations where there were family members present in the client’s life (including sisters, grandmothers, a supportive FOC and his family, etc.). Being present, providing support, and being family oriented were described by several nurses in different sites as characteristics related to strong family support.

One nurse said, “Yeah. I guess, for me, it sort of feels like a lack of stability. Like, or like you don’t have like—Like, when I think about the people that don’t have chaos, like my clients that don’t have chaos, they have consistent—They live in a consistent place. They have consistent people in their life. There’s a calmness about it.”

Another nurse shared, “And, he said, ‘I completely agree with you, you know. I was kind of surprised at how competent—’ I mean, she’s not smart, but she is competent. And, she’s—You know, she’s got—Her priorities are very clear for her, you know? And so, he said, ‘Yeah, I feel like they’re...’ You know, and this... She’s got sisters that really back her up and support...”

Another nurse said, “Mostly, there’s just—They’re very involved. You know, they’re very family-oriented and very supportive of their daughter. And so, it’s actually a very comforting situation for me to go into.”

Another nurse stated, “And, definitely, I’ve had clients, you know, over the years that have had, been in abusive situations. And, mostly, making sure that they understand what the resources are, what—And, fortunately, I’ve had the experience—They had a lot of strong family support.”

Another nurse described, “But I think, again, the dad is doing well with his child and he’s got a supportive family, too.”

Cultural Implications

In addition, several nurses from different sites spoke about culturally-based family structures and support for clients as a strength. Such cultural implications were related to clients from Hispanic and American Indian cultures that supported both client and baby in day-to-day activities.

Among most clients of Hispanic culture, some nurses and a nurse supervisor from different sites described that these mothers typically had more family that surrounded and supported the baby compared to non-Hispanic families. Family support among the American Indian culture was also described in terms of clients who lived on reservations with extended family members and a sense of communal support towards mothers that was apparent in their culture.

One nurse supervisor said, “We have a Hispanic population and that family kind of surrounds the baby.”

A nurse from a different site said, “And, a lot of them have a lot of support. You know, Hispanic culture has tons of support. They always have moms and grandmas and aunts that just babysit, you know?”

Another nurse explained, “You know, it’s—Because of, culturally, if there’s a concern, a lot of times I’ve seen maternal grandparents will step in...Just that they will get more support from family. And, a lot of times, with the girls that I work with that live in, on the reservation, they live with extended family.”

Father’s Presence

The presence of the FOC in the home such as involvement with raising of the child and support of the mother were described several times by different nurses and supervisors from multiple sites as a client’s strength. In these instances, several nurses further explained that some fathers had improved themselves through gaining employment, discontinued substance use, and supported their partner by taking the client to school, attending parenting classes with the client, and attending doctor’s appointments more frequently than what the nurses had witnessed prior. Another strength of the client was described by a few nurses from different sites when members of the FOC’s extended family were present and supportive of the client and baby.

One nurse said, “And, she says he’s doing great, and he’s getting counseling and he’s stopped drinking, and so there’s some good things there, but I just keep them a little bit closer, just...”

Another nurse explained, “The boyfriend was, you know, 18-plus. And, he came in on all the visits, usually about halfway through. He worked full-time. He was over helping out the family, hanging out with them a lot. He would take the girl to school. They would go to doctor’s appointments together. He was involved in the parenting classes with her...”

Another nurse spoke about father’s presence and said, “Then the father, too, he is from a different culture with this wonderful extended family but he’s also a prince. He’s really grown up—He’s the only male. He’s grown up with these older sisters. He knows how to take care of women, so he knows how to take care of this mom and pat her together, and he does it pretty well.”

Resilience and Overcoming Obstacles

Several nurses from different sites who highlighted client strengths in their practice also communicated what circumstances these clients had been in and how they had worked through their challenges to become strong mothers. Some of the circumstances described included: teen pregnancy, clients who were abused as adults and/or as children, mental health concerns, substance use, and violence in the home that could have negatively impacted the client and baby. Several nurses from different sites also highlighted client strengths in instances where the clients were overcoming such obstacles (i.e. teen pregnancy, history of abuse, and instability in the home due to drug use and/or violence), initiating engagement in community resources, recognizing risks for child abuse or neglect, and as result were thriving as an adult and mother by effectively caring for their child.

One nurse said, “So the mother moved out with her little boy, out of the house, and I found out that the grandmother had been on meth, that there had been a lot of domestic violence. I found out a lot through the grapevine, you know, the social workers and everything. The mother of the child, who was my client, she was amazing. She got a job. She finished school. There was a whole bunch of stuff that was really positive, and she was a very good mom, and her little boy was just amazing.”

Another nurse shared, “Okay, so –And, this is a client that I’m getting ready to graduate who I have a lot of faith in what she says. She was involved in foster care herself as a child. And so, this is coming from somebody who knows the system definitely. Her –Okay, so, my client has a sister who is on drugs. And, she has two children. And, somebody had contacted CPS. And, her sister lived with my client. And so, she was there the day that the CPS worker came to investigate. And, my client said that her sister was extremely intoxicated. Could barely talk. And, smelled of it. And, the CPS worker came in and didn’t acknowledge her drinking. She –My client said she was really disturbed because it was obvious that she wasn’t –She was not functioning well. And, that the caseworker told both of them that she didn’t see what was wrong about smoking weed and that she used to smoke weed.... Yeah. And, that she just looked around. Didn’t really look into any –You know, just kind of looked in the front room and that was it. Left. So, my client is concerned about her niece and her nephew. And, she said I just couldn’t believe that –I mean it was in your face and nothing was done.”

Another nurse from a different site said, “First one was mom about 40 and she was kind of a biker mom and, so, she was really kind of a Harley Davidson biker mom, a great lady. I really liked her so much, and she had a prenatal screen down at [redacted] and it came up positive for meth, so she was referred to Social Services and so the Social Services here picked her up and then they referred her to Nurse Family Partnership. And so I got to work with her and I really had a lot of respect and admiration for her. When she got her positive drug screen and knew the consequences, that she might lose her baby, she really worked with NFP and kept her appointments. She quit meth. She did her urine screens. She went to AA [Alcoholics Anonymous] for drugs and really worked at the program. She found a job.”

Another nurse stated, “So, she was 15 at the time and Social Services already knew her because she had a really abusive childhood from her mother. So her mom moved away

and she would live with her father some time and then stay with her mom sometimes, but her mom was never really able to parent well, so she would come back and stay with her father. So, when she was 15—Am I remembering this right? I think so. When she was 15, she got pregnant and she came into Public Health, so the gal that did Medicaid referred her to NFP, so I started seeing her. She was a very smart teenager, very smart. During our meetings, if she needed to contact a resource, like mental health, she would call right then and there and set up the appointment, which I thought was really great.”

Assessing Risk and Working With High Risk Clients

Although some nurses across most sites shared about their clients’ strengths, many nurses in multiple sites explained that, oftentimes, their scope of practice involved assessing and managing risks with their clients at home visits. Indeed, risk assessment amongst nurses within and across sites was quite similar. Many nurses from multiple sites did not have formal risk assessment tools but utilized various NFP-provided forms and questionnaires to assist their practice in assessing risks with their clients. Most nurses from various sites emphasized using nursing assessment and observation skills in their encounters with their clients and ultimately reverting to their nursing judgment whenever they encountered uncertainties. Some nurses from some sites shared their practice of focusing on strengths, reviewing records, or consulting with colleagues or the nurse supervisor as means to assess risk. Although many nurses shared similar assessment practices, there was not one standard method or tool for risk assessment that was used by all nurses in all sites. Finally, all nurses from all sites shared their experiences in working with clients with various risk factors, including: intimate partner violence (IPV), substance use, mental health, special medical needs, developmental delays or disabilities, unstable housing, social and physical environment, previous involvement with CPS, DHS, or law enforcement, and demographics (such as young age and low education).

How Nurses Assessed Risk

Most nurses across almost all sites and one nurse supervisor discussed the assessment tools they did or did not have available. Across multiple sites, many nurses expressed that they did not use formal risk assessment tools or that no tools currently existed of which they were aware. However, most of these nurses shared their reliance on the nursing process, nursing judgment, and clinical assessment skills by documenting their observations and concerns. One nurse shared that she utilized DAR (Data-Action-Response) notes, a focused charting method utilized to document patient assessments related to a specific problem. Many other nurses from different sites oftentimes spoke about a gut feeling or inkling that something was not quite right with their client. These feelings contributed to nurses not knowing when a situation was reportable to CPS or not.

One nurse stated, “We don’t have any. I know there’s been talk of that, that would be helpful, and you know, using those risk assessment tools, you know, on, you know, a certain timeframe.... I just – I don’t think we have that tool yet. And, if we do, I don’t know about it.”

Another nurse expressed, “Nothing that’s structured. Just kind of nursing judgment... In a way. We have a – like, a general nursing assessment, and it has, you know, alcohol,

drugs, tobacco use, home concerns, so we kind of document like a DAR note that way about what's going on, what we did, response from the family..."

Another nurse shared, "It's just that this most recent thing that I had with the mom who was turned in, there's something niggling at me there. And, I'm not sure I won't turn them in, you know, at this point. But, there's just something – I'd like to learn how to follow that, that niggling...But, when you're in the home, and you're seeing something and it's just like, 'Oh, that's really weird.' You know? Or, Mom is refusing to take the baby for well-child checkups. And, that's all it is. But, you know, that doesn't – you know, when do you report? And, not in the black and white sense, but like really getting into that – the gray areas of when to report."

At the same time, some nurses from many sites formally used assessment forms as recommended by the NFP NSO, with some that were required to be submitted to NFP's electronic data system - ETO. These forms included the Ages and Stages Questionnaire, Relationship Assessment Questionnaire (including questions on the client's relationship status), Health Habits form, Edinburgh Postnatal Depression Scale (screening for postnatal depression), Home Inventory, Life History, and other developmental evaluations, intake forms, or health assessments. One nurse shared that she has asked clients whether or not the results from the assessments aligned with their own perceptions of the issue, e.g. postnatal depression. Another nurse from a different site spoke about using a new assessment tool, DANCE, which had supported her assessment of bonding between the client and baby as well as emotional wellbeing. However, multiple nurses from different sites shared that they lacked specific assessment tools for detecting child abuse or neglect.

One nurse stated, "Well, we don't have any that do the risk for child abuse, but we do give the relationship assessment questionnaire periodically. And, you know, obviously, if there red flags in that, you'd be worried about the child, too, so."

Another nurse shared, "Oh, the resources. Okay. So, you know, I – you know, even – I used the Edinburgh, and then I usually ask them afterwards, you know, 'How is it that, you know – is this reflecting—the Edinburgh, you know, how you answered—is it really reflecting how you feel? How are you really feeling? How have you been emotionally? How has your health—emotional health—been?' You know, and then sometimes, it's, 'Oh, this is – this is, you know, it reflects it very accurately.' And, sometimes, they'll say, 'Oh, I kind of have been feeling down.' And then, I'll ask more questions."

Another nurse expressed, "I mean, you know. And, then we have a – we have this one, too, one of our new assessment tools called DANCE, um, and - it's an assessment tool - it's kind of more of a way to look as assessing that, too. You know, how they're bonding and that emotional wellbeing, how they're doing. And, sometimes, it just gives you a guide of like when you're assessing somebody in the home, and you're going, 'There's something just a little off, but I can't put my thumb on it.'"

In addition to formal assessment questionnaires, many nurses from various sites shared similar approaches to risk assessment. Many nurses preferred to focus on the client's strengths and her ability to parent (sometimes using a client's Strengths Form as documentation), rather than

worrying about the potential of the client in abusing the child. In fact, nurses from multiple sites found that leveraging existing strengths to address risks was well received by their clients. Some nurses from several sites preferred adopting a trusting approach in working with their clients toward achieving their goals as opposed to outwardly looking for signs or risks related to child abuse and neglect. By listening to the client's stories, experiences, and history, many nurses from multiple sites utilized motivational interviewing skills to probe and to understand the client's perspective and receive clarifications. By using open-ended questions, many nurses from most sites described being able to work with the client to seek solutions, but not necessarily behavior change. One example was when a nurse helped a client seek ways to use marijuana without impacting caregiving, such as locating a trusted alternative caregiving when she was high, rather than promoting the termination of substance use. These nurses worked to develop the relationship and trust with the client over time such that the client would divulge more information about her past and current lifestyle and behaviors. A couple of nurses from different sites had also shared personal experiences and history to engage with the client. For these nurses, the clients eventually became more comfortable with the nurse over time as the nurse-client relationship was built; they became more open in sharing their history and less fixated on maintaining a clean home, thus offering a more accurate environment for the nurse to assess. For most nurses from most sites, learning the clients' history was important so as to understand where they were at in their life and why they did the things that they did. One nurse shared that based on the severity of a situation, she had blatantly asked clients where a bruise came from in her assessment; while another nurse from a different site had specifically asked if a client had been kicked, slapped, or physically hurt by a partner.

One nurse shared, "Okay, um – I guess you're just – I feel like I'm kind of always like just listening, you know? And then, seeing if something feels like it's out of place, or you take the whole history into consideration. And then, if something doesn't feel right, I might run it by somebody else and ask what they think of that situation, if it doesn't feel – you know, like, I'll probably try to clarify it with the client and see what's kind of going on, but it's more of a fact finding thing, and then I kind of run it by my coworkers and say, 'What do you think of this?' And then, I haven't really had anything come up that seems really, you know, severe or anything - But, you know, there's always like little like red flags. You go, 'Okay. What's that about?' You know? And then, you just dive in a little deeper, so."

Another nurse recalled, "So, that's – what I'm trying to do is just kind of feel her out, get a sense of her past history. It took me a long time to find out that her dad had beat her and raped her several times. And, that's why he's in prison. But, it took a long time to get that out of her, and she was in tears when she said it. I'm just trying to get her to talk."

Another nurse stated, "He finally divulged it. I always had a suspicion that she – well, I point-out asked her, 'Where did these bruises come from and how?' - And then, she (*unintelligible*) other bruises that he had left. And, divulged more."

Moreover, nurse observations in the home were described as the fundamental method in assessing for risk. Many nurses from multiple sites emphasized their constant assessment when visiting with clients; they were assessing every time they entered the home, including medical, physical, mental, and environmental factors. Some topic areas assessed throughout the duration

of a client's involvement in NFP included: lifestyle choices (including decision-making and risk-taking background), substance use (such as alcohol and other drug use), plans or goals for completing school, living situation (including the home environment, cleanliness and neighborhood), relationships or family dynamics (such as dysfunctions or IPV), support systems, and family history – including the client's childhood as an indication of her future parenting, functioning level of the client (and its implications on appropriate teaching), and socioeconomic status (with relationship to access to transportation and doctor's appointments as well as ability to provide food and shelter).

One nurse explained, “Well, in this job, we do have a couple – you know, the questionnaires that we have them fill out every so often, but mostly just observation, you know, because we're there with the families so much, and they get so used to us being there that they are usually pretty much who they are in general, you know? Not every time and not every person, but it's a lot of just observation. And, talking. You know, you – you're surprised what people will divulge to you, you know, after they trust you, so. I would say that's mostly the – I mean, not the technical screenings, but a lot of just being there with the family.”

Another nurse shared, “You know what's nice about the Nurse Family Partnership that – you know, the whole program is set up where we are assessing, you know, as nurses. You know, we do it even though we don't even know, realize we're doing that. So, even a lot of the questionnaires that we – you know, some of the data forms, you know, can bring up information.”

Another nurse stated, “So those things that I'm gonna kind of look for, so that's temperament of the parents and what support, their support system, and their temperament, as well.”

In addition, many nurses from all sites shared various areas that they assessed for depending on the stage of their client: in pregnancy, in infancy, and in toddlerhood. In pregnancy, many nurses from different sites assessed the family as a whole in a holistic way, in addition to the areas assessed during a client's involvement in NFP. In infancy, nurses expressed that they observed interactions and bonding between the client and baby (including affect and mannerisms towards the baby), as well as caretaking, baby development, proper feeding, client's mood and temperament, and positioning of the baby. In toddlerhood, discipline and punishment (parenting style including temperament and patience), safety in the home (such as cords, toys, etc.), physical assessments of the child (especially weight), and appropriate bedding/dress were assessed. One nurse explained that physically weighing the baby helped facilitate relationship building between nurse and client because clients often enjoyed seeing their child's growth. Some nurses from several sites added that assessing the safety and risks for the client and baby was equally important.

One nurse shared, “At this point, it's kind of like – you eyeball it. You know? You look at the home environment. You look at how well they're taking care of the baby, you know? Is the baby developing correctly? Is the baby getting child care? Or, not child care, well-child care. So, like doctor's appointments. And then, you know, is my client – because she's 13 – is she getting these things? And, the school piece. That's huge, too.

Stuff like that. Um, what else do I assess? You know, I ask her every now and then if she feels safe in the home...”

Another nurse stated, “I weigh the baby, I think, a lot more than the other nurses do. We usually weigh for the first six weeks. But, I – I don’t weigh every baby every time, but especially if – sometimes, it’s hard when babies are underweight to – if you’re not having regular visits, sometimes it’s hard to get a feel for, ‘Okay, is the baby not gaining because there’s some neglect, or is the baby not gaining because you’re doing everything you can, and there’s just something going on physically with the baby?’ So, I do a lot more weights than other, I think, than the other nurses do. And, I’ve found it’s a really good way to sort of connect with the clients because they really like to say how big their baby’s getting.”

Another nurse stated, “Prenatal, I would say the babies are typically pretty well. Somebody’s got the baby covered. We don’t have moms leaving their baby very often that I can think of. Grandma’s got the baby or mom’s got the baby. So, again you have the child who’s at risk; they’re a child but the baby’s not. Does that make sense?”

Another method to assess client risk shared by some nurses in various sites was reviewing knowledge about the client through charting, for example attendance and adherence to doctor appointments, maintaining cleanliness in the home, history of substance use or mental illness, or reviewing growth charts. However, the knowledge was often compiled through experiences shared by the client that may include biased or incomplete information, making it difficult to truly assess the situation. In addition to reviewing charting and medical records, many nurses from different sites shared the importance of weighing information as it related to safety and caring of child. In a couple of sites, the organizational structure allowed nurses to access medical record system that flagged risks, including history of mental health, drug abuse, or involvement with CPS. In some other sites, nurses had gathered knowledge of the client’s history from the referral source.

One nurse shared, “So, you know, you see there’s lot of variables. And, it’s an unfolding story. It’s not going to be like an end and a beginning. It’s going to be like a pay attention sort of thing. I feel like the mother’s doing a great job. And, I feel like the baby’s well cared for. And so, at this point, I don’t feel like there’s anything that really needs to be done more than watch.”

Another nurse regarding a client involved with CPS recalled, “And, the only story I’m getting is from my client, which probably isn’t the most complete story...And then, going forth from that point, you know, again, it was mostly what I could get out of my client. And, really, she was not the most forthcoming and kind of spun it to, you know, make herself look better – as anyone would do – and, you know, I sort of didn’t really have any idea what was going on...”

Another nurse stated, “Um, so, and when you first get the referral, you don’t know a ton about the situation. If you can look up records in [county name removed] in the [NFP site name removed] system, which you know we do. Just to kind of get a background on what’s going on. You can see like - Or, maybe sometimes it’s written on the referral.

You know, this is what makes this client high-risk. Just knowing that. So, for example, a baby conceived by rape. Hey, there's high-risk, you know? (*laughs*) Extensive history of mental health issues, history of drug abuse, you know, our clients who are referred from [local youth shelter name removed], you know, history of homelessness. The client themselves has been involved in CPS. What else? I don't know. You know, stuff like that."

In addition to various methods of risk assessment, several nurses from different sites suggested that assessments were based on information in the present, not necessarily on the client's past history. Other nurses from some sites expressed that risk assessment varied case by case, as clients had different backgrounds or experiences; these nurses felt that understanding and interpreting each client's risks was case-specific and could not be generalized. Finally, a couple of nurses and nurse supervisors from various sites spoke about the importance of the cultural context when assessing risk. These nurses recalled cases they encountered that were related to the cultural context, such as coloring on the sacrum within the American Indian culture or male dominance in the Hispanic culture. It was importance for these nurses to examine risks within the appropriate context so as not to jump to conclusions about suspicions of child abuse or neglect.

One nurse shared, "I've gone back and forth on that because there are times when I think, you know, 'I want to deal with just what I see. And, to deal with, you know, just the moment and really focus on what's happening in front of me and your strengths and what – you know, what we might need to work on, and not have all of your history, not have it.' So, part of me likes that because I definitely, I think, feel more anxious when there's a lot of, you know, really serious risk factors, and I'm much more watchful, I think, and – which, I think changes the practice a little bit."

Another nurse explained, "It's like a constant understanding and a constant interpretation for each case that comes up or each new uncomfortable situation but, you know, it's really looking into it with that specific situation but it's harder, too, because it's not like a generalized thing, so, anyway."

One nurse supervisor shared, "And so, I remember one of our new nurse – the first time she weighed a baby, and the baby had – and so – and, I was with her on the visit – so, it was like – and then, she – we didn't say anything at the time, but then when we left, we had the discussion about those. Because that is something you see, and if you're not used to seeing babies of that, you know, ethnicity, you're – It's like, 'Whoa. There's a bruise on their sacrum,' you know."

Community Referrals and Other Resources

Almost all nurses from all sites recognized that red flags usually arose through observation in the home. To address these concerns, many nurses from multiple sites had participated in ongoing observation and assessments (keeping the client "under radar") or consulted with trusted team members. Through reviewing information with a more-experienced colleague, or processing the case with their supervisor during reflective supervision and case conferencing, many nurses from several sites found it helpful to consult with other professionals. Several nurse supervisors from different sites expressed that their nurses would discuss any concerns that arose within their caseload during reflective supervision. In these situations, the nurse supervisor reminded the

nurse of previous concerns about or situations regarding the client, thus creating a more complete story of the situation based on a series of circumstances. This cycle of discussion, clarification, and identification was described by some nurse supervisors as a helpful process for nurses in their practice of risk assessment. Furthermore, several nurse supervisors from multiple sites expressed having attended joint-visits with the nurse due to safety or risk concerns. In these sites, the nurse supervisor made her own assessments on what was happening in the home. Other collaborations with service providers who were involved with the client were also identified as a resource for nurses in risk assessment. For example, some nurses from several sites had communicated with the CPS caseworker involved, clinicians in the school-based health centers, and other pediatricians. Finally, when some nurses were truly uncertain of the next steps with regards to assessing risk and safety, they had called CPS and asked if the situation was reportable, or consulted with a known CPS worker to discuss the risks associated with the case. Regardless of whom the consultant was, these nurses usually received feedback and brainstormed strategies or resources to reduce risk in the home.

One nurse stated, “I just think it gets a little tough in the gray areas where it’s almost abuse and neglect but not quite. That – and, that’s when I ask for advice from, you know, my colleagues who probably know a little bit more about it than I do.”

With regards to receiving guidance from colleagues, one nurse recalled, “Like I had a client who, you know, like her baby was just born, and I was going in there twice a week just because she needed the extra time with me and wasn’t quite, you know, wasn’t back up to birth weight, and so, I was like, ‘I don’t know’ – And, you know, the nurses were like, you know, ‘She’s not two weeks old. Give her until she’s two weeks, you know, that’s not quite reportable yet.’ *(laughs)* You know, like – So, I guess it was just the nervousness of me being, you know.”

Another nurse reflecting on an experience with a CPS caseworker shared, “But, we didn’t want to step on their toes at all because sometimes they have their own policies and things, so between the caseworker and myself, we figured it out. And, you know, she was fine. But, they did end up calling a welfare check on her. So, yeah, I guess just kind of collaborating with people like that as well, that might be involved, whatever people are involved, I guess.”

In addition to utilizing NFP-related resources, many nurses in most sites had referred their clients to a range of community services, including: WIC, economic assistance, Medicaid, food banks, parenting classes, early childhood intervention (for language or developmental delays), behavioral or mental health resources, and substance abuse treatment, etc. In fact, some nurses in some sites felt that ongoing outreach to these organizations was part of their scope of work; so as to maintain organizational relationships that had facilitated effective referrals. Among several sites, a few nurses discussed approaches to referring their clients to resources. A few nurses from various sites had provided the information for their clients and then allowed them to follow up on the referral to build their self-efficacy. One nurse discussed having built a safety net for her client who received support through various venues, including having a therapist that came to her home and attending a school for pregnant teens where she was being supported by peers.

One nurse stated, “And then, I’ve also had contact with one of the food banks in town that I just happened to drive by when I was going out to our Unit Two training. So, I kind of made an appointment and met with their director over there, and she gave me a tour and everything. So, I brought some flyers back and told everybody about it here. She knows about our program”

Another nurse expressed, “The referrals - a lot of it’s based upon what we know about the client and the referral source. So, it could be everything from getting them actually on the assistance programs and helping them work through that, to trying to get them to like our food banks, or Salvation Army or our clothing places. Housing is the biggest challenges that we have, by far. We can work with our homeless shelters to get them housing, but a lot of it is based up on the client actually being willing to do it.”

Another nurse shared, “You’re not doing your job if you don’t go out there and do outreach. Because, if you’re going to sit here and wait for somebody to give you a referral, who knows? Then, probably we’ll never get them. So, I feel very, very comfortable with my jobs, knowing that I have actually a lot of really good outreach. I really do. I feel really good about that. And, I know we probably could use more.”

Another nurse said, “It really depends on what it is and if it’s service issues, then getting referrals, providing resources. We try to build self-efficacy in this program so kind of...for me, I do a lot of it as digging up the information and then allowing them to follow up on it. So a lot of it is referrals or resourcing out to something else, because there’s - we’re limited, kind of.”

High Risks

In general, most nurses from all sites shared similar risks associated with their clients that were considered greater in severity (low-acuity) and were correlated with child abuse or neglect outcomes. These higher risks included: current or a history of IPV, mental health, substance use, caregiving characteristics impacted by developmental disabilities or special medical needs, homelessness or unstable housing, complex family history or family system characteristics, being a young mom, having a low education, involvement with CPS and/or law enforcement, and statutory rape. Despite the existence of similar risks among clients across sites, different factors related to child abuse or neglect were of greater concern for different sites. For example, some nurses and nurse supervisors from several sites expressed that mental health and IPV were high priority areas for their nurses, while in a couple other sites substance use (including meth, heroine, and marijuana use) among their clients was more concerning. Overall, most nurses from all sites described that clients with higher risks tended to have a multitude of risk factors coupled with a lack of social support from their family members or friends.

One nurse shared, “So, for example, a baby conceived by rape. Hey, there’s high-risk, you know? – Extensive history of mental health issues, history of drug abuse, you know, our clients who are referred from [local youth shelter name removed], you know, history of homelessness. The client themselves has been involved in CPS. What else? I don’t know. You know, stuff like that.”

Another nurse explained, “It was. And, there were a lot of, you know, problem in the home that were, you know, her emotional disability diagnosis, her family – her brother had been removed from the home. I’m not sure what kind of trouble he was in. He was in a facility for a long time. And, she would never tell me what happened. Or, why she couldn’t go to school. But, the parents were – I mean, there were some issues, some severe issues. So, it was already more risky, I think.”

Another nurse stated, ‘But, the main problem with this client was she – well, she had no family support, number one, but when I would tell her to do things, ‘Take your baby to the doctor,’ she wouldn’t do it. So, I know she cared about her, loved her baby, but she wasn’t following through with taking the baby to the doctor, or – she wouldn’t do anything I told her to do.’”

Clients with Experience of IPV

Many NFP nurses and supervisors from several sites described variations in IPV incidence among clients and several gray areas surrounding IPV. There were within and across site variations in discussions that nurses had with their clients on IPV including when a client first experienced IPV, who the perpetrator was, how IPV impacted and still impacts clients’ lives, and actions clients took following the incidence of IPV. Some nurses from some sites described being physically present when their client experienced IPV (physical or emotional) while some nurses from other sites described hearing about IPV from the client or other sources such as a family member or CPS caseworker and had not witnessed the incident in-person. Several nurses from different sites explained that some of their clients had suffered physical or emotional violence from their partners, although some clients did not consider their experience as physical or emotional abuse. Several nurses from many sites also described that some clients had experienced IPV while pregnant.

One nurse said, “There’s too many. Examples like violence. Domestic violence. Most my clients, they don’t have the physical violence, but I have some emotional violence.”

Another nurse said, “Not to me. He was—He was being not necess—well, he was being verbally abusive to my client, and kind of stripping her down for stuff that he was just angry.”

Another nurse said, “She had, she had experience violence domestic with the boyfriend; father of the baby. Before when she was pregnant.”

Several nurses from different sites explained that their clients usually differed in how they shared information about IPV. A few nurses from different sites said that due to shame or fear of consequences to the IPV victim and perpetrator, some clients were hesitant to open up to nurses regarding their relationship status and experience of IPV. One nurse shared that she had found out her client was experiencing IPV a year after she had been in the NFP program, while another nurse explained that one client divulged IPV information voluntarily even before being asked. One nurse from a different site described that sharing her personal experience with IPV encouraged her client to share her IPV-related issues in the home, which was apparent because of the bruises her client regularly had on her face. In several sites, some nurses also expressed a

couple cases where the client denied that IPV was occurring despite observations made by the nurse including verbal attacks by the FOC and visible bruising.

One nurse said, “Or they’ll just come out and tell you before I even get a chance on the first thing, they’ll tell me they have kind of an abusive boyfriend, or...”

Another nurse shared, “And, I don’t remember her sharing - She actually shared about - When the child was about a year old. So, I had no idea she had the problems with her partner, issues, until about a year after she’s been in the program that she shared.”

Another nurse stated, “I suspect a lot of domestic violence in the homes that I visit. It’s hard to - It’s hard to get people to admit that is true for them. Yeah. But, you know, I had a gal who had a black eye every few weeks for—And, it would be this eye, and then this eye for the first little bit of the baby’s life. I’m—You know, when I finally talked to her about it, she said her makeup- It was her makeup. Yeah. That she just hadn’t cleaned it off well enough. I finally did. I finally said, you know, ‘I’m having a really difficult time with that because I’m remembering when I was a domestic violence victim and, you know, so it’s bringing some stuff up for me,’ and I just brought into my home base (*laughs*), you know? And, she finally acknowledged that there was some—‘He had “anger issues,” but she would never agree that he was being abusive.’”

A different nurse said, “Yeah. But, you know, I had a gal who had a black eye every few weeks for—And, it would be this eye, and then this eye for the first little bit of the baby’s life. I’m—You know, when I finally talked to her about it, she said her makeup - It was her makeup.”

A couple of nurses and a nurse supervisor from different sites also described cultural implications around defining and approaching IPV with their clients. One nurse described her understanding of IPV in the Spanish-speaking community: a controlling husband was considered a cultural role for men but could be considered emotional abuse from the nursing perspective; this dichotomy of perceptions created room for misinterpretation by the nurse. This nurse described the need for culturally specific discussion and education in such situations. A nurse supervisor from a different site explained that she had encountered challenges in some Hispanic families, where her client had been told by her husband that involving others in an IPV situation would result in her getting into trouble with the law and subsequent deportation.

One nurse said “And knowing what’s appropriate, like with the Spanish-speaking people from many different countries. [NFP nurse name removed] deals with very controlling, this is what the husband does and this is what the wife does and there is no crossover and he’s not going to take care of the baby and that becomes her work. And that could be misinterpreted as being too controlling and seeming emotionally abusive rather than this is the culture. This is how their culture is and giving them the support for how they can do that and how they can make it work and knowing that, you know, this is America. This is—Being able to share that this is what people see and this is how it is in your family and making that okay for them”

One nurse supervisor said, “Do they call automatically to CPS? What, um, how can we support—what should we expect, like? And, what should we be telling our moms if we suspect that there is abuse between the two going on? And, there is a call made, you know, what can Mom expect? A lot of moms—Well, in the Hispanic world, the husbands will tell them, ‘You’re the one going to jail because you’re the bad mom, and then you’re going to be sent back to Mexico.’ Well, that’s not necessarily true.”

IPV-related safety measures and issues with clients were described by several nurses from various sites. These nurses from different sites mentioned their knowledge about restraining orders to protect the client but that the client maintained contact with the FOC. In cases where a client had a restraining order on the FOC, several nurses from different sites communicated that they had needed to enforce with their client that continued contact with the FOC was unsafe behavior both for the client and the baby. Another nurse from a different site described a situation where her client had a restraining order against the FOC, but he had no restraining order against the baby so he was able to interact with the child while the grandmother was around. Several nurses from different sites had also developed safety plans with their client to ensure client and child safety in case of a future IPV incident. Other nurses from different sites had discussed with the client whether or not they needed to develop a safety plan.

One nurse said, “I had another—I guess I did have one this year. I had one that was—It was a domestic violence issue, and the incident—There was a police report. The boyfriend had—They were fighting over the car seat. And so, the mother called the police, and the police came, and they charged him with domestic violence. I don’t know if they charged him with child abuse, also. But, anyway, she had a restraining order, and when she told me about the incident, and she said—I think he was still contacting her, and I talked with her about, “That’s unsafe. You know, if he’s not able to comply, that’s unsafe behavior for you and the baby.”

Another nurse stated, “My understanding, from her, is that somehow, he has like an [redacted]-month probationary period, and he is not allowed to have contact with Mom, except by phone is fine. So, essentially, a restraining order, but there is nothing with a restraining order for him and the baby.”

Another nurse explained, “No, a transfer from a different nurse. It was a nurse that he or she left, so I took over her client. There was a known history of abuse with this particular client so we would address, we would talk about that. You know, talk about our relationship. Her concerns and you know, did she feel safe in the home? Do we need to make a plan? And I the other nurse had made a plan with her as well. But just reviewing that and we would also talk about just in general, safety concerns and also looking at the future as far as what she wants. I think there were a lot of issues like jealousy and things like that. For the most part, they were doing okay together. And then right before I graduated her from the program, the last visit she told me, I kicked him out.”

Approaching IPV With Clients

A couple of nurses from different sites described their approaches with clients with regards to IPV as well as how and when they educated them on the issue. These conversations ranged from understanding the situation and gathering information, to the impact IPV had on the client and/or

the child's development. One nurse described educating her client to realize that IPV had influences on not only herself, as the client, but also on her child. Another nurse from a different site said that once she knew IPV was occurring in the home, she addressed the concern instantly at the visit by educating the client about IPV and how detrimental it could be for the baby. Some nurses in several sites also shared that they had created safety plans with their clients as previously explained, identified close and trusted friends or family members, and identified the client's concerns and how to address them. Other nurses in some sites felt that NFP NSO-recommended assessments were helpful to open the dialogue with clients and to determine if other resources (e.g. domestic violence shelter) were needed. (Reporting the occurrence of IPV among clients to CPS will be further discussed in the Reporting Child Abuse or Neglect section.)

One nurse shared her approach, "So just kind of getting them to realize that, you know, it's not just about you. It's more to consider than that. But that was the only incident I had with domestic violence."

Another nurse shared, "Well, I try to get as much information about a situation that's being reported. You know, if I get to a client's house, and they tell me they had a fight with their significant other, the first thing I'm gonna ask is, "Well, where was the baby?" You know? And, try to determine, you know, is the—Is this parent even aware that that's detrimental to the baby, you know. And then, of course, educate them on that, but if it sounds like—I guess, it just sort of becomes a judgment issue, but if it's..."

Another nurse explained, "And I was like, 'Okay. You know, let's talk about a safety plan.' I was brand-new in my job, so I'm like, 'Oh, we need to find a way for you to be safe.'"

Clients with Mental Health Concerns

Mental health was considered a high priority area for many nurses across multiple sites. Almost all nurses from all sites shared their experiences in working with clients with mental health conditions, including depression, schizophrenia, suicidal or homicidal ideation (such as strangling the infant), post-traumatic stress disorder (PTSD) from IPV and/or involvement in the military, attachment disorder, generalized anxiety disorder, bipolar disorder, attention deficit hyperactivity disorder, and others. Most nurses from most sites recognized that mental illness often raised a red flag for them to be aware of due to increased risk to the child (e.g. lacking emotions, difficulty bonding, and possibly abandonment). Some nurses from a couple of sites specified that they knew their clients with mental health conditions were more likely to run into problems in the future with caretaking of the child (for example, appropriate dress for the weather), maintaining a clean and safe environment, and setting priorities. Although all sites described working with mental health clients, sites varied in their perception of mental health as a consistent challenge for nurses. In one site, many nurses felt confident and reassured with working with mental health clients due to supervisory support and effective reflective supervision. However, regardless of whom (the client, client's partner, or client's family member) suffered from mental illness, many nurses from most sites found it challenging to effectively minimize risks with their clients.

One nurse stated, "Especially, if they're telling me, yeah, exactly, they're telling me that they have like depression, or they're bipolar. Then that does kind of spark off some flags

for me to kind of be looking for it to make sure that they've, I guess in a sense, make sure that they have that support because I know that their risk is very much higher because of those mental health issues or illnesses that they have.”

Another nurse shared, “Mental health—is horrific. (*laughs*) That one, also, we're having a challenge with.”

Another nurse expressed, “...And, the ones that have the mental illnesses are sometimes the toughest, for sure. You know? (*sighs*) Because they can't – they can't set priorities as well, I don't think.”

As stated, many nurses from most sites provided specific examples of working with mental health clients. Among sites that described mental health as a challenge in their practice, many nurses shared that noncompliance with medications or parents failing to help their client comply with medications were difficult situations to manage. In one instance, one nurse shared that non-compliance to medication for the FOC led to outbreaks of violence (including yelling and agitation) and subsequently risk of harming the client and infant when the baby became distressed. Another area of mental health that was challenging for nurses was post-partum depression or a history of depression. Some nurses from several sites shared that depression coupled with a lack of support from the client's family, FOC, or friends (e.g. no one to help care for the baby when the client wanted to hurt herself or needed a break), or other medical needs such as disability or diabetes was even more difficult to address. Additional areas of concern related to depression included: suicidal attempts, effects of strong psychotropic drugs during pregnancy on the newborn (withdrawal symptoms, medical needs, etc.), desires to harm the infant (strangling the baby or calling the baby a demon), and irrational behavior towards the nurse (such as verbal threats or locking doors to a home thus preventing the nurse from leaving). Several other nurses in different sites also shared that working with bipolar clients was difficult depending on the mood of the client, and that diagnoses were not always clear (for example, one nurse only found out her client was diagnosed with bipolar disorder after the client's mom revealed it). Finally, clients with schizoaffective disorder or other disorders with paranoia characterizations were described by a couple nurses as less trusting, which made it difficult for nurses to develop relationships or even enroll the client into the program.

One nurse shared, “And so, I had one situation in which I was working with a 15 year old girl and who had psychiatric problems, had been suicidal, had been hospitalized a couple different times for that, and, you know, by that time her baby had been born and a big problem in her life was that she lived with her father and her step mother. And neither of her parents were willing to take responsibility for administering her medication correctly, or actually doing any of the follow up after her hospitalizations... And she began to act out, and I think that's when her suicide attempts, like, she made two of them.”

Another nurse recalled, “So, basically what happened with her situation is that she had a history of mental health issues. She – her and her boyfriend, who also has mental health issues – or, diagnosis, not issues, but diagnoses... They split up because, you know, of course, there was another girl involved. They split up. She was having some depressions. This baby at the time was five months old. Five, almost six months old. She was feeling very depressed. She has had suicide attempts in the past... She was feeling like hurting

herself, and she said, ‘Will you please just come stay with the baby? I just need to get out.’ Because at this point, she had no transportation. She – he left her. She’s in the house all day long, feeling depressed. She said, ‘Will you please come stay with the baby?’ She said, ‘I just need to get out and go for a walk. I need to do something.’ And he said, ‘No, I can’t.’

One nurse supervisor shared, “You know, the dad was agitated. He hadn’t been taking his medication for the schizophrenia. And they’d had a loud argument that left the baby distressed. You know, she shared all that with [nurse name removed].”

Another nurse explained, “And, you can only do so much, you know? I’ve had a few referrals – I had one referral that I was working on where I had talked with her and she seemed really, really interested in the program. And, then, the two times that I went to go sign her up, she wasn’t there. And then, after that second time, she just never called me back. But, she had schizoaffective disorder, and so I think it was, you know, that paranoia that, ‘Someone’s going to come check up on me.’”

Approaching Mental Health Risks

Some nurses from some sites shared strategies to address increased risks with clients as a result of suffering from mental health conditions. In general, regardless of the mental health diagnosis, many nurses across several sites suggested that these clients usually required more support and that they were more watchful or cautious when visiting these clients. One of the main strategies to address risk with mental health clients was through therapeutic communication, motivational interviewing and asking open-ended questions to assess stability, including understanding the client’s ability to cope or her coping mechanisms (e.g. learning to manage without medications). Several nurses from some sites also shared about meeting their clients where they were at in their stage of acknowledgement, while some nurses from other sites utilized Partners in Parenting Education (PIPE) lessons to engage with their clients, particularly those suffering from depression. These activities helped to engage the client in touching and bonding with the baby through experiential learning. Another strategy used by many nurses for various types of mental health illnesses was to develop a safety plan with the client (e.g. identifying an alternate caretaker, an alternative location – crib/bassinet/baby seat – to place the baby, teaching coping mechanisms – lying down on the bed, taking deep breaths, etc.). By establishing a strong safety plan where the baby had minimal risk and the client expressed love to or bonding with the baby, most nurses felt that risk in the home was lessened. In addition, most nurses from many sites often referred their clients to mental health providers for treatment or counseling after screenings that resulted in high scores. In fact, sometimes, a nurse or the client herself had called for a mental health appointment during a visit. Finally, several nurses from some sites had assisted their clients with more severe cases to be admitted into a psychiatric facility or hospital in-patient unit to receive treatment.

One nurse shared, “It was my first visit postpartum, transfer from another nurse, who had left. So first visit postpartum and first visit ever. In a situation like that I am purely relationship building... She made a comment about strangling the baby and I, well she started the whole conversation with, ‘I don’t know what [nurse name removed] told you about me, but I have a history of depression and’ – I don’t remember what else she said... and I was like, ‘Um – nope didn’t mention it and not on your chart.’ Wonderful, I mean.

I just said, 'No, she didn't mention it.' But looking in my head, I'm like, 'Oh, wonderful, fun surprises to get today on our first visit.' I said, 'Okay, well how are you doing? You know, how do you feel like you're doing?' We kind of talked through it. She said, 'Well I feel like I'm getting a little bit low.' And so we did a safety plan, 'When you feel you're getting low, what do you do? How do you cope? What are your coping mechanisms?'

Another nurse stated, "Or, we're working on just doing PIPEs and really letting the client kind of lead. Maybe they want to just verbalize about how they don't like DHS in their life."

Another nurse recalled, "She was a very smart teenager, very smart. During our meetings, if she needed to contact a resource, like mental health, she would call right then and there and set up the appointment, which I thought was really great."

A nurse supervisor shared, "We've also seen an increase in mental health issues in our clients. Mental health, diagnosed and undiagnosed mental health issues. And, someone who has an existing mental health issue is more likely to run into problems with a child. And so, they're much more cautious and observant. Well, they're always observant, but they're really sensitive to what could go wrong or what could happen to the child in that environment. And, we're always working on safety plans and assessing if the client is stable."

In addition to the strategies aforementioned, one site utilized a department-wide algorithm and a flowchart to determine steps to address their clients' mental health risks depending on the acuity level. The final step in this flow chart was completion of a crisis psychiatric evaluation by the local mental health service provider and/or a report to CPS if the baby was at risk. Several nurses from this site shared that they were required to stay with the client if she was suicidal or homicidal until additional help was obtained, either through screening on the crisis hotline or an in-person evaluation was made. Despite the availability of this algorithm, a couple of nurses from this site identified challenges when they attempted to counsel their client and notify her that an assessment needed to be conducted. For example, one client became upset with the nurse and yelled at her for hours before the mental health provider was able to come out to the home for assessment.

One nurse recalled using the depression algorithm, "So I went and was talking to her the next day and I told her about the client making that comment and she said, 'You have to go back. You have to go back and you have to do our, you know, our depression algorithm. You have to call DHS. You have to do these things.' ... And I was there for hours. And her mother yelled at me and said she is calling [Congressman name removed] and we're suing your program. And I mean like I was all that was evil for two hours in that person's house."

Collaborating with local service providers/counselors/therapists and CPS was considered a resource among some nurses from several sites when working with clients with mental health illness. These nurses had received diagnostic reports, learned about treatment plan and steps, and in sites with existing relationships with their mental health provider, directly scheduled appointments for their clients. Several nurses from one site also shared about utilizing a mental

health therapist who acted as a consultant for the nursing team by providing helpful recommendations during visits at monthly team case conferences. However, mental health was considered a gray area in nursing practice as expressed by many nurses in multiple sites, such that several nurses from different sites had reported to CPS either as a last resort to help their clients or because they were unsure if a mandatory report was warranted. These nurses had reported for: medication non-compliance resulting in risk to the client and/or child, suicidal attempts, and homicidal ideation (e.g. expressing a desire to strangle the baby or expressing comments of risk to baby, such as calling the baby a demon). These reports had resulted in a range of outcomes, including engagement with the local CPS prevention unit, no investigation by CPS, or removal of the child. Finally, one nurse shared that processing the case with her nurse supervisor was an important step in overcoming secondary trauma, especially after dealing with a mental health crisis.

One nurse shared her collaborative efforts with providers, "...And sometimes if the client allows the therapist, I've gotten some reports – they're just really simplistic reports – like this is what was diagnosed, these are the problems, if there is or there isn't any suicidal, homicidal ideation, this is what she's classified in the DSM-V, I guess it is now. I'm stuck on the IV."

Another nurse explained, "Or, if they're having an issue getting care, I can call the clinic and be like, 'Hey, this is the situation. Can we try and make an appointment for her?' I had – that actually happened with me with one of my clients who was experiencing postpartum depression and couldn't get an appointment for like three or four weeks. And, I was like, 'So, that's a problem. Let's – I think she needs some medication. Let's get this going.' And, so having that relationship is really, really helpful..."

Another nurse stated, "We also have [therapist name removed], who is our mental health therapist, and she comes up once a month... So, we all kind of, you know, hit hard on questions with her with any issues that we're having... So, you know, anybody that we are concerned about who might have a history of mental health disorders or postpartum depression... So, she really does help like when we do case studies she will sit in on them. And so, she kind of gives us her take on what she feels like is going on. So, that really helps, you know, kind of gives us some ideas of how to approach the – sometimes it's the significant other, you know, that we're concerned about..."

Another nurse explained how she handled secondary trauma from her mental health clients, "... And, processing that with the supervisor was really important. The – because the secondary trauma that we go through with some of that. And, knowing that I did the right thing at the right time, and that later, the client was able to thank me. At the time, she was not happy. She did not like me. She did not want that to happen."

General Substance Use

In addition to IPV and mental health, almost all nurses from all sites described their practice in working with clients who used both legal and illegal substances. In fact, substance use or abuse was considered a gray area for mandatory reporting among many nurses in most sites. Although many nurses recognized symptoms or mannerisms of using or abusing substances, such as canceling appointments, borrowing money from family, poor oral hygiene, weight loss, and

lacking attention to children, they felt that substance use or abuse was a major area of concern and challenge for their site. A couple of nurses from different sites mentioned that substance abuse coupled with IPV occurring in the home was of further concern. For example, one nurse described that her client's partner displayed obsessive behavior when he was using substances to the extent that he would make extreme requests to ensure the client was not having an affair.

One nurse shared, "I think drug use can be another one where you just – how much is a – you know, because a client, in the beginning, we work hard to let them know that they can trust us, all about the whole relationship, we're building trust. And, we really encourage them to be open with us about drug use and about domestic violence and about their health issues, and yet, I kind of always want to tell them, you know, 'Remember, anything you tell me can be used against you.' *(laughs)* I'm thinking that, but I don't – you know, I don't say that. But, those are where the gray areas I think really become tough."

Another nurse explained, "So, probably canceling appointments frequently, asking to borrow money from family and from you, really bad oral hygiene, sores, loss of weight, a lack of attention toward their children, towards hygiene in general. Of course, eyes, you know, fixed and – or not fixed, dilated or really pinpoint pupils. There's certain mannerisms that when people are on drugs that they do."

Another nurse stated, "I feel like substance abuse is a big one, and domestic violence is a big one. And then, probably neglect or medical neglect of the child."

Another nurse shared, "And, she had already told me about obsessive behavior on his part where like, for instance, you know, when he—especially when he was using—he would always suspect her of having an affair. And, at the time that this was occurring, they were actually living at her parents' house. And, like if he left the house and he would come back, he would examine her genitalia to see if she had had any sexual relations."

Moreover, some nurses from multiple sites shared that their clients had become more forthcoming with drug use over the years. For example, some clients had notified their nurse that they were doing well, had left a bad situation, or were admitted into a substance treatment program. In general, several nurses from different sites perceived clients to view pregnancy as a window of opportunity for change, such as quitting substance use during pregnancy. Furthermore, most nurses from all sites suggested that education was the best means to address substance use with their clients. Depending on the receptiveness of the client, some nurses from some sites described watching for cues by the client and that the client must initiate wanting to quit. General areas for education included explaining risks for pregnancy, risks for the child, smoking marijuana versus cigarettes, and the impact of second-hand smoking. Some nurses from several sites also expressed that they had, at times, felt personal danger or safety concerns related to substance use (e.g. the nurse was pregnant and exposed to second-hand marijuana smoke in the home). In these situations, the nurse had suggested meeting outdoors or at an alternative location.

One nurse explained, "And then she was very honest and forthcoming with me. She told me she had used, not recently but a couple months back. But she's like, 'You know, but I

did, when I did use, the baby wasn't with me.' And I, you know, I have a tendency to believe her so."

Another nurse shared, "You know? Is she going to be somebody who, if I start bringing information, she's going to be receptive to it? You know, start getting those cues? I've learned, over my practice, is that they're the ones that are going to have to be the ones that stop smoking. And so, if I start saying stuff, and she starts like, 'Oh, well, I've been a smoker. There's nothing wrong with smoking.' So, at that point, I usually just turn to the client and just say, 'Well, I'm just going to bring some information about what, you know, what secondhand smoke does your child and what you guys do with it is kind of your decision.' But, if she's more receptive then I kind of get some more information out of her, assess, you know, where is she at? Does – maybe she's willing to maybe smoke outside or, you know, change the quantity or something, so."

Another nurse explained, "It just depends. Like if it's something where I feel like my danger, if I feel danger or if I feel like I may get like a high, you know, sitting there (*laughs*) or whatever, then I'd be – I, I do. I'll say, 'Can we sit outside?' or, 'Can we meet at a different location?'... Um, yeah, I have where there's been several times where it's just like, 'Um, can we sit outside because – yeah, it smells like marijuana really bad in here,' so."

Many nurses within and across sites shared similar experiences in working with clients who used substances, such as alcohol, marijuana, methamphetamine, heroin, cocaine, and other drugs. Although the prevalence of drug use among clients and types of drugs used by clients varied across sites, almost all sites reported marijuana use as an area of concern. In general, most nurses from all sites shared that they have referred clients to treatment services, had clients admitted to hospitals (e.g. for overdosing), and had clients or clients' spouse or family reported to CPS, either by the nurse herself, another professional working in the home, or the client's mother/family. Reasons for reporting were usually related to drug use in the home potentially impacting child development and caring for the child while under the influence. In addition to reporting to CPS, several nurses from various sites shared that they had clients who were investigated by or involved with CPS due to substance use. In these cases, their clients had needed to participate in urine analyses. In such cases, several nurses from different sites shared that they usually emphasized the importance of adhering to urine analysis steps and timelines, but that clients were responsible for coordinating their own care. In some cases, a couple of nurses had followed up with the CPS caseworker to ensure that their client was responsive to CPS.

One nurse supervisor stated, "Well it's quite common to be, you know, for nurses to be concerned about the usage of marijuana in the homes. You know, especially now that it's legal. So it was bad enough when we had medical marijuana and they were, clients were doing their own grows and all of that."

One nurse shared, "I had one incident that I went out – she was in pregnancy, and I don't remember how long I was involved. And, there was marijuana smoke—and, it could have been other kind of smoke—coming from the back bedroom. And, I had told her – we had talked about other substance and things like that, and I had told her that this was

not a safe thing. That, you know, I would have to call, and how did she feel about that? It was fine at the time, but then she canceled me. And, they ended up moving from the area.”

Another nurse shared, “And just kind of get them to be the intermediary that, you know, okay the caseworkers coming out. A lot of times it may be unannounced and they don’t know when they’re coming and sometimes it means a drug test at the same time or some other kind of thing going on. So there, so sometimes, I’ve left a page, you know, ask social worker about this or have social worker call me and here’s my card to give them. So a lot of times that goes back to the client’s responsibility and that’s what I like about this program because it makes the client the person, who is kind of coordinating their own care.”

Finally, a major reason for concern with working with clients using substances for some nurses among several sites was the potential for substance-exposed infants. Many sites shared that their local hospitals will report to CPS regarding substance-exposed infants if they tested positive. These nurses also recognized that substance-exposed infants were considered a concern by CPS and that these infants were usually removed from the client’s home. Several nurses and nurse supervisors from different sites felt that working with substance-exposed infants was not necessarily the scope of NFP.

One nurse recalled, “Unfortunately, it started previous to this because, after the client had had the child, I was very concerned that the baby would be positive at birth. And, at the hospital, I talked with a, the nurse within the nursery. And, told them of my concerns, and they asked if they thought, you know, the baby should be tested, and I said, ‘Yes.’ And, they would contact the doctor. Unfortunately, the doctor did not feel that it was necessary to test the baby, so the baby went home...”

Another nurse shared, “First one was mom about 40 and she was kind of a biker mom and, so, she was really kind of a Harley Davidson biker mom, a great lady. I really liked her so much, and she had a prenatal screen down at [local hospital name removed] and it came up positive for meth, so she was referred to Social Services and so the Social Services here picked her up and then they referred her to Nurse-Family Partnership...”

A nurse supervisor stated, “...And, they were positive for drugs. And, they wanted to refer them immediately to us. And so – and, at the time, we were at capacity of clients. And, we were getting ready to expand and down a nurse and all this stuff was – it was like, ‘Oh –’ And, they weren’t really appropriate for NFP. But, they didn’t know what else to do with them, and it was like, you know – because they’d just heard about us, and it was like, you know, ‘Oh, let’s call them,’ you know?”

Alcohol Use

As stated, many nurses from most sites had experienced alcohol use among clients during or after pregnancy. Onset was usually attributed as a way to deal with trauma from childhood or related to family history (e.g. client’s mother was alcoholic). Most clients were sober during pregnancy, but some returned to drinking after giving birth sometimes due to a lack of support within the family. In addition, several nurses from various sites had worked with infants with

fetal alcohol syndrome; clients who drove under the influence and were arrested (followed by involvement with the court and/or incarceration); and clients who drank while breastfeeding, while caring for the child, or at a scheduled home visit. Some nurses from some sites further explained that most of their clients who engaged in alcohol use post-partum usually placed their child under the care of a trusted individual, but some clients had been intoxicated while caring for their child. In one site, a nurse shared that a client's mother was alcoholic and was incapable of providing shelter, food, basic needs, or preventative services to the point of neglecting the client, who was a minor, by spending all her money on alcohol. Such severe cases of alcoholism that impacted the care of a child were then usually reported to CPS.

One nurse recalled, "Um, I'm trying to think of, I had another client who was, um, over 18. I think she was 18. Turned 18 during her pregnancy, um, and prior to her pregnancy, she was in rehab for alcohol abuse... She was sober throughout her entire pregnancy... During the course of her pregnancy, she had shared with me that she had been sexually abused by an older sibling for six years. SO this is like from the time, um, she was like, I think, probably, I think she was in fourth grade, until she was in tenth grade. And her older brother had sexually abused her on repeated occasions. And that was part of what led to her alcohol addiction."

Another nurse shared, "And, she was a mom who, um – it was a substance abuse issue that she was arrested for driving under the influence, and alcohol was the issue. Father of the baby and his family took care of the baby while she was in jail, but, um, that one really wasn't a DHS situation. It was more the court. But, that's what we did in that situation is being able to juggle things to make it work for her..."

Marijuana Use

Among all substances, marijuana use was described as the main gray area for reporting to CPS amongst most nurses from most sites. This was mainly due to uncertainty around mandatory reporting with regards to new laws in Colorado related to the legalization of recreational marijuana. Many nurses from many sites shared that many clients or people living in the client's home used marijuana either medically or recreationally. Although sites differed in the prevalence of marijuana use among clients, most sites who observed a higher prevalence shared that it had become more apparent over the years, such that clients were more forthcoming now that marijuana use was legalized (for example, paraphernalia were now in the open rather than hidden).

One nurse expressed, "As far as just the mandatory reporting? I think scenarios. I mean, I think it's – I don't think this is a – I don't think it's a black and white issue. I mean, yes, there are times when it's like, 'Yes, this baby is potentially going' – it's those gray issues, like the baby sitting in a smoke-filled, you know, like marijuana smoke that you're like, 'Well, do I call or not?' It's those gray – especially now that, you know, we live in Colorado where it's going to be legal to smoke recreational marijuana – so, things like that. Like, how does this law, these new law changes affect if we call or do not call? Things like that."

Another nurse explained, “It’s prevalent. Especially – I don’t know – I mean – I don’t know if everywhere it’s prevalent but eight and a half years as a home visiting nurse. Now they’re leaving pipes out, versus me noticing a pipe hidden behind a book.”

Similar to alcohol use, some nurses from some sites shared that clients often quit or pared back their usage of marijuana during pregnancy. However, some clients from multiple sites regularly used marijuana post-partum, while breastfeeding, or while caring for the child. In addition to the client or a client’s household member using marijuana (smoking or ingesting), clients and their fetus/infant were exposed to marijuana in several ways: men using marijuana under the window of a client’s home, marijuana smoke or edibles in the home, growing marijuana in the home, or through working in a dispensary or marijuana-related positions such as trimming leaves for sale.

One nurse shared, “For instance, a frustration with moms in apartments knowing that their baby – maybe the window’s open, and there’s a group of men smoking marijuana under their window, and the smoke’s coming in. And, the police can’t do much... because it’s maybe in a public area, or it’s, um – even though they don’t have any in their home, they can’t do much. Now, if they were smoking in their home and the baby was there, then there could be ramifications, but having that frustration with moms is kind of interesting. Having people who are on medical marijuana becomes more of an issue, and really, sometimes they don’t quite understand that the baby is still a problem. If that baby’s in a home where there is smoke, and they’re breathing in the fumes, they’re in danger and we have to call...”

Another nurse stated, “But then she’s looking for a job. She works at this burger restaurant and then she’s looking for a part time job, and she’s so excited to tell me that she got a new job. I was just, like, ‘Oh, really. What job do you have?’ Like, she works in a medical dispensary. And I was just, like, ‘Oh, okay.’ And she was, like, ‘So what do you do?’ She trims marijuana.”

A nurse supervisor shared, “Well it’s quite common to be, you know, for nurses to be concerned about the usage of marijuana in the homes. You know, especially now that it’s legal. So it was bad enough when we had medical marijuana and they were, clients were doing their own grows and all of that... Own grows, their growing their own.”

Methamphetamine Use

Another substance used by some clients in some sites was methamphetamine (meth). Indeed, the prevalence of meth usage was higher in a couple of sites. In these sites, some nurses shared that meth use or a history of meth use occurred among clients, the FOC, or the client’s mother. Several nurses from various sites recognized symptoms of using meth and shared that they had worked with clients where someone in the household was using in front of the children, clients or the FOC were high at the home visit, or drug paraphernalia was visible in the home. Some nurses from multiple sites felt that it was most concerning when clients who used meth were the primary caretaker because they were unable to adequately care for a child under the influence; this scenario had resulted in a report to CPS. Interestingly, when their spouse or family member used meth, most clients recognized it as an issue and wanted to take action; for example, a client was concerned that the FOC was caring for the baby while high and refused to allow him to continue caretaking.

One nurse shared, “And, so what happened when she told me that, the time before I met with her, um, was in the presence of the baby and the father. And I had some suspicions about you know, where, what the father might possibly have been high on, just because of the way his eyes looked. And, actually, you know, I don’t really even know. The before that, when I had seen the father, he had all his teeth. And, then this time he didn’t have any teeth...”

Another nurse explained, “And, she was clearly very, very high and admitted to meth use. She wasn’t with the baby but had admitted to meth use and had admitted to using meth while the baby was around her so we felt we had to call and report that too so they could take action.”

Heroin, Cocaine, Narcotics, and Other Drug Use

Some additional substances or drugs used by clients, the FOC, or the client’s family member included: heroin, cocaine, narcotics, benzodiazepines, and bleach. In one site, some nurses shared that heroin was a major concern for their county, but their clients were not necessarily the individuals using the substance. In another site, several nurses explained that they had educated their clients about allowing the FOC to care for the child while using such substances may lead to liability for child neglect. In some other sites, some nurses shared that their clients had been addicted to painkillers (not always prescribed), while other nurses described situations where cocaine paraphernalia (e.g. a crack pipe) was visible in the home during a visit or family members who were primary caretakers were huffing bleach.

One nurse stated, “And, her situation was the father of the child abuses heroin so let her know a while ago that if she were to let her child go with the father of the child, knowing or suspecting that he’s using drugs, that she could be held liable for neglect. So she refused to let the child go and he got irate about it...”

Another nurse recalled, “One was a client who had mental health issues, and her sister was primarily taking care of the baby. And, when I went to go visit, the sister reported to me that the client had just been in the bathroom like huffing bleach. And then, when she came out, she was very irrational, grabbed the baby physically from her and locked herself back in the bathroom. And then, when she realized I was coming to visit, came out, threw the baby to the—this is, of course, you know, the sister’s version of the story—threw the baby back to her and left. So, I called to report that just because it seemed pretty credible, and I felt like that baby was potentially, could be harmed, so.”

Approaching Substance Use Risks With Clients

When approaching substance use concerns with their clients, many nurses across different sites expressed similar strategies to those that they used for addressing mental health risks. These strategies included using therapeutic communication, motivational interviewing, open-ended questioning, and to meet their clients where they were at. Oftentimes, through using these strategies, nurses in many sites had also used educational materials (in the form of PIPE or curriculum handouts) to support clients in recognizing their behavior and developing future goals. Indeed, some nurses from multiple sites recognized that telling their client what to do was not effective; but rather, opening the topic for discussion, understanding the reasons behind why

a client was using, or discussing the potential negative effects on the child, were helpful for nurses. Many nurses from multiple sites also shared specific strategies of reducing risk in the home regarding marijuana use. Many nurses from these sites attempted to understand why, when, and how clients were using marijuana, mainly through asking open ended questions. Some nurses approached marijuana use from the baby's perspective to educate clients, as well as the effects on brain and development and safety when caring for the baby while under the influence. A couple of nurses from different sites had worked with the client by discussing responsible use such that the nurse would not need to report to CPS for neglect. Many nurses from various sites encouraged quitting marijuana use by focusing on strengths (such as cutting back on usage), emphasizing implications on the health of the baby and client, or finding alternative ways to relax. Many of these nurses recognized that the client needed to take the initiative in making changes. One site shared that by using these strategies, some of their clients had switched to tetrahydrocannabinol (THC) oil or made changes to where they smoked to lessen the impact on their child. Ongoing assessment or monitoring over multiple visits was also often practiced by some nurses from some sites when marijuana use in the home (whether or not by the client) was not immediately impacting child development or health. Similar to mental health, several nurses from various sites shared that they had often utilized their nurse supervisor and colleagues as resources to brainstorm approaches for working with clients who were using substances. Almost all nurses from all sites expressed that they had referred clients to community services, such as substance abuse treatment facilities, or reported to CPS if the baby was in potential harm.

One nurse stated, "We've had some families who do switch to THC oil or make some changes to where they're smoking...because of what we can say to them. And, not be threatening that we're going to call DHS just because they're using medical marijuana. And, we are able to talk about responsibly using mar – the marijuana. When it looks like we're able to bring in information about the baby's brain and development issues and things to look at with the baby and safety issues if they're in a stupor when they're dealing with the baby. So, any kind of substances, it's been really positive..."

Another nurse shared, "Yeah, um, I actually have a client that she uses marijuana before she was pregnant. And now she really cut back a lot compared to using, like, three times a day to, like, once a week or less than once in two weeks. Um, since our program we focus on the positive, like, the strengths of the client. I really commend her for that for really cutting it down to that, like, just one to two in two weeks... But, I don't really, um, I can't make her stop. I'm not there to, like, go in her home and tell her, like, this is not really happening or this is not good. I always, like, discuss with her the negative effects of marijuana to her and her baby. And surprisingly she is, like, she stopped taking it. She stopped using marijuana."

Another nurse expressed, "But, definitely, I give them the most up-to-date, current information and, hopefully, support them. And, I had one client that was years ago, and mostly she had been smoking as a way of relaxing and kind of grew up in a family that did that. So it was kind of norm for her. And, really helping her try to, you know, find other areas to help her relax, whether – but it was quite the..."

Another nurse stated, "And then, he was smoking – smoking – I was like at, with the visit. And then, he went upstairs, and then there was definitely some pot being sm- you

know? And, it's like, 'Hmm' – you know? It's – so then, I was like, 'Should I ask?' So, I asked my coworkers, you know, 'Is that a problem? It wasn't in the room. He wasn't the caretaker. The mother was. And, it wasn't like around the baby.' So, they felt like it might be okay. It was sort of something to watch.”

Clients with Developmental Delays, Disabilities, and/or Medical Needs

Among most sites, most nurses had worked with clients and/or clients' FOC with varying levels of medical needs, delays or disabilities related to learning, development or cognition; impaired hearing or being deaf; or of a physical nature. A couple of nurses from different sites also shared that they had clients with brain-related disabilities including traumatic brain injuries from childhood resulting in delayed cognitive ability or a missing corpus callosum in the brain leading to concerns about the client's caretaking capabilities. Another nurse from one site was working with a HIV-positive client and was researching information on its impact during pregnancy, while some other nurses from other sites had clients with pregnancy complications.

One nurse shared, “A lot of gray areas actually. My last report was with one of my clients, where she would, she had her baby at 34 weeks, and the baby has heart defects, and um. And, I really like, I maybe had visited with her three times before, and she has a severe hearing disability.”

Another nurse explained, “And then you can prepare your visit, like, around certain topics that, you know, are the protocol for the program, but you know, you sincerely don't know what's going on. And she had a lot of, um, pregnancy complications, and so, again, a lot of my role with her was one of support.”

Many nurses from most sites had also worked with clients whose children were developmentally delayed or had special medical needs. Most frequently, nurses across multiple sites had worked with premature babies or babies with low birth weight who were being cared for in NICU. These premature babies usually required special medical needs, for example substance-exposed infants who were experiencing withdrawal symptoms and infants with heart defects or those requiring feeding tubes. Some nurses from different sites had also worked with clients' babies with cleft palate, physical deformities like tongue issues, torticollis (abnormal head/neck positioning), hydrocephalus, and other issues that required physical therapy or surgery. Language or developmental delays among premature babies was also common for some nurses in many sites. In a couple of sites, some nurses shared that some clients had babies with major surgery needs or respiratory issues, such as requiring regular suction on the nose, visits to the emergency room/department and ENT, or even hospitalization and intubation of the baby. In most cases, most nurses shared that their clients were attentive and caring for these babies to the best of their ability.

One nurse shared, “Her baby had had this respiratory issue going on. And, she was – she was high-risk for abuse. There was a lot of stuff going on. However, the baby – so the baby was having respiratory stuff going on with his little nose, and he was having a hard time breathing. But, every time I went over, she did exactly what I asked her to do. And so, the first time I went over, she was like, 'He's having trouble.' Or whatever. And, I said, 'You know what? He is.' And, I assess him and he was having, struggling with

breathing, having some trouble. And, I said, ‘You need to take him to the ER [emergency room] right now.’ And, she did. She took him to the ER.”

Another nurse recalled, “And so, I’ve had some preemies that have had some language delays...”

Another nurse explained, “Yeah, yes. Because the baby actually had exhibited withdrawal symptoms after he was born. There’s a couple of physical deformities, like the tongue – it isn’t a split tongue, but it starts to become a split tongue, so there’s an indentation in the tip of the tongue, it goes in and then, you know, like someone had cut it but you know, didn’t.”

Another nurse shared, “It was good. It was actually really good to kind of catch up on her last six to eight weeks of her life, and baby had been born. And baby was in NICU for a little while. Went home on oxygen, you know, I’m just kind of hearing about her struggles, but also her successes in figuring out those things, even for herself. So, that was – it was good.”

A number of nurses from a couple of sites shared that developmental disability was a major concern amongst their nurses, mainly due to these clients’ or clients’ FOC’s inability to grasp concepts taught by the nurse. Some nurses from some sites also felt that these clients tended to struggle with priorities and maintenance of life balance, such as maintaining a job while caring for the baby. Other clients had not been able to conduct addition, were not able to pay for bills, and were living based on government assistance for disability. A couple of nurses from different sites shared that hospital staff had erroneously assessed these developmentally-delayed clients as poor caretakers because of their lack of hygiene or lack of adherence to appointments. For clients with learning disabilities, some nurses from some sites were concerned with the client’s ability to read. Despite encouraging these clients to complete their General Educational Development credential (GED), most were unmotivated or disinterested in doing so.

One nurse explained, “The problem, the other problem is, is that the diagnosis that the client has is such that with – if you start to have a lot of people coming in, that can create agitation on the client’s part... Mm-hmm, and my concerns about Mom’s ability to grasp some concepts.”

Another nurse shared, “And, this client has significant developmental delays, and so does her husband. Well, what the family told me is that – well, yeah, I shouldn’t – I’m jumping ahead here. This is kind of confusing. But, anyway, so I just met the baby, the client. I was just told by [nurse name removed]. [Nurse name removed] had only met the family once herself. So, we didn’t have a good assessment of this situation. All we know is just – we were told that they have to have somebody work with them, both my client and her husband get disability. But, they can’t – they don’t – they’re not able to pay their own bills. They have to have – I don’t know. There’s a special word for it.”

Another nurse stated, “I’m just trying to think – let’s see, I know one of my girls brings up the concern for a potential gray area. She’s still pregnant, so – but, just her living conditions and her – she’s got some developmental delays that I’m still trying to figure

out, and so does the FOC. Still trying to, you know – I can imagine there’s going to be some gray areas with her case down the line.”

Approaching Developmental Delays

Several nurses across multiple sites also shared strategies to working with developmentally delayed clients. These strategies included: approaching the need to complete an assessment positively, ensuring not too many people were in the client’s home – thereby reducing potential opportunities to cause agitation for the client, and being more concrete when teaching concepts (e.g. modeling the way to feed by showing what the baby can eat and giving an opportunity for the client to practice during the home visit).

One nurse shared, “So, letting them know what, what’s available to them. And, helping them understand that, by asking a person to come into your home and evaluate the language and speech, that it – you know, if they see that there’s a need, that it just would help the child. You know, it’s a very positive experience, not a negative experience.”

Another nurse explained, “The problem, the other problem is, is that the diagnosis that the client has is such that with – if you start to have a lot of people coming in, that can create agitation on the client’s part.”

A nurse supervisor stated, “It’s like the one with, that’s the developmental delays. You know, I mean, I really had to say to those nurses, ‘You’re not – you’ve got to get really concrete. If you want her to give this baby finger food, put the baby in the high chair with her and say, “Let’s go through your kitchen and see what’s here that your baby can eat,” and show her. Show her what the baby can eat because they don’t, they can’t get it as an abstract concept. It’s got to be very concrete.’ And, when they did that, she did much better. And, she picked up on things better.”

Across several sites, some nurses shared that many of their developmentally delayed clients currently were involved or previously had some involvement with CPS, whether from the nurse reporting or someone else reporting. For the nurses who reported their developmentally delayed clients to CPS, many felt that they reached a point where they needed CPS’s expertise and help to coordinate services; when the mother was not capable of caring for the baby independently or the caregiver (such as the FOC) had other issues like mental health or disabilities. A couple of nurses had also reported their client’s parents to Adult Protective Services because they felt that their disabled client may have been taken advantage of.

One nurse explained, “This client was, had a developmental disability. And, she had twins. And, someone else – actually, it was a friend of theirs that was mad at them had made a referral to the Department of Human Services. So, I happened to be in the visit while DHS came to the house, to her mother’s house. And, he came in very...”

Another nurse stated, “Have I had to report anything? Um – let’s see – maybe Adult Protective Services. I’ve contacted them before for a patient of mine who wasn’t being well cared for and thought money was getting taken and things. And, she was disabled. But, I don’t think anything ever came of that, either.”

Family History and Social System Risk Factors

Some nurses across several sites also shared their perspectives on the lack of social support and family history as risks for their clients. Social and family support was expressed by some nurses across some sites as an important indicator of a client's strengths. Having social support was described by these nurses as allowing their clients to focus on her parenting such that there was no disruption or a need to be solving other problems in the home. When clients lacked social support, they needed to resort to community services (e.g. homeless shelters) and alternative care for their children (for example, when they did not have a trusted friend to watch their child).

One nurse shared, "Well, I like that because I like when there's good family support. It helps because then they're, you know, they can focus on their parenting more than when there is disruption and no support and more depression or – yeah. I find it, that it's positive if they have that family support there. Yeah."

Another nurse stated, "I guess that I'm just thinking because there's so much moving and there's lack of social supporters, it's probably that the bigger picture is our society. There's a portion of our society that has a lot of problems in child-rearing and there always have been."

Another nurse shared, "Whereas they may have a very thick family history and they see no hope for the family and there's a lot of generational problems and they have a lot more information than what I do. And, so sometimes there is kind of a sense that they don't want to move in the direction that I may, you know, present to them..."

In addition to lack of social support, some nurses from different sites shared that their clients' family history had an impact on their lives. Some clients had tumultuous relationships with their family or held resentment towards their family members due to past history. Other clients had alcoholic parents, incarcerated parents, experienced IPV in the home as a child, or had mothers who became pregnant as teenagers, thus influencing the client to become pregnant as a teen. A couple of nurses and nurse supervisors from different sites shared that their county had high proportions of generational poverty and a history of problems in child-rearing and lacking social support. Some other cases involved unstable and volatile family members usually due to mental illness while a couple of nurses shared that they had clients who had experienced rape and sexual or physical assault from family members as a child.

One nurse recalled, "In the discussion that we had, my client has a very poor childhood history. Father's in prison because of that, mother is in another state, but – so, there isn't family here that she can turn to..."

Another nurse shared, "So, that's – what I'm trying to do is just kind of feel her out, get a sense of her past history. It took me a long time to find out that her dad had beat her and raped her several times. And, that's why he's in prison. But, it took a long time to get that out of her, and she was in tears when she said it. I'm just trying to get her to talk."

Physical Environment and Housing Risk Factors

The physical and social environments as well as housing stability were additional risk factors assessed by most nurses in many sites. The physical environments that were concerning to some

nurses from some sites included lack of running water, electricity, or heat; inadequate supply of food in the home; unclean home (e.g. trash or feces on the floor); and a darkened environment (where the infant lacked stimulation). Related to the physical environment were also safety issues expressed by some nurses in different sites. These concerns involved having firearms in the home with open access to young infants, inadequate dressing of the child for the weather, inappropriate infant sleeping arrangement (e.g. lacking a bassinet or crib or co-sleeping with the infant), inappropriate use of car seats, lack of child proofing for unintentional injuries, and holding vicious dogs in the yard. In some situations, some nurses from some sites shared safety concerns that they had for themselves when conducting visits at their clients' homes due to drug involvement.

One nurse shared, "It – I actually was told I couldn't go into the home anymore by my supervisor. It was a very obvious drug house... I speculate just based on subjectiveness that it was probably a meth house... with some of the things that I was observing. And, my client was staying in her mother's home with her mother's boyfriend. And, my client was deaf. But, there was a lot of strange things going on. People showing up. There was a camera set up in the living room."

Another nurse stated, "...but, the doctor had said that she walked into the room. She was in the bed. The boyfriend was in the bed, and the baby was between them, and when the father was trying to get out of the bed, he nearly rolled over on top of the baby..."

Unstable housing, especially coupled with developmental disabilities or mental illnesses, was also highlighted as a risk factor among many nurses in multiple sites. These nurses shared that they had previously had clients who stayed at a court-ordered group home, bounced from friends' or relatives' apartment to apartment, couch surfed, were evicted or forced out of their friend's or parents' home, stayed at a short-term motel, accessed the homeless shelter, or were chronically homeless. The lack of stability in housing was characterized by frequent changing of locations and a lack of a permanent place to call home. In addition, homelessness or unstable housing was considered a major concern for nurses, especially regarding clients who had recently given birth to the child because of the added stress with a newborn infant. In some situations, the client had left the infant with a friend for several days while she was homeless, while other clients had taken the infant with them onto the streets. These actions were considered unsafe by some nurses. However, unstable housing was considered a gray area as shared by one nurse when the client was bouncing from home to home but the child was well cared for and had his/her physical needs met. A couple of nurses from different sites also recognized that homelessness was not necessarily a problem that they could find a solution or control for, but rather, educating the client and exploring alternative options or resources in the community was the best strategy to minimize risk.

One nurse shared, "It ended up that the [county name removed] nurse went out to see her and she had been – the roommate had put her out the night before after a violent disagreement. So, there's sometimes, just like I said at the beginning, we can't fix it. But if she could have stayed in the program with all of the issues – she had been homes and I don't know how many years she was homeless, but for a long time she had been..."

Another nurse recalled, “The process was – the client that I was seeing, she was bouncing from home to home... sometimes, she was living on the street. Sometimes, she was living on friends’ couches. Sometimes, she was living, um – who knows where she was living.”

Another nurse stated, “Well, I’ll just use that example of that mom who was bouncing from house to house. Okay, is that a gray area? Is that neglect? Is that, you know – she’s not – the baby’s being fed. The baby’s being – all of the physical needs are being met, but yet, she’s bouncing and bouncing and bouncing. Um, that’s a gray area.”

Approaching Environmental Health Risks

Some nurses from some sites shared their strategies to reduce risk in the home related to safety such as dirty environments and access to weapons. These nurses usually discussed with their clients the implications for the child (such as impact on a child learning to crawl) and ways to problem solve. In the case of a client’s home that was unclean and overflowing with trash, the nurse had physically assisted the client in washing the dishes and cleaning the home. Regarding gun safety, the nurse had discussed with the client about the importance of gun safety and gun-related accidental deaths for children.

One nurse stated, “And, you know, a lot of times – like, with her, for instance, you know – and, I helped her clean it up. I said, ‘You know’ – I said, ‘We’re going to clean this up right now because this isn’t okay. I’m not going to leave with this – you know, this is unsafe.’ And, and, you know, it was helpful. Never again did I go over there and the trash was overflowing. I mean, there’d be dishes and the house would be a little messy, but not the safety issue.”

Another nurse shared, “You know, they’re usually like, ‘Oh, I totally understand that.’ Um, and so I’ve never really had a problem with that. There’s been one instance where, um, an example that I often give is that one time I was making a home visit and there was a gun under the coffee table, and I have, I’m really anti-gun and I’m really, mostly because I’m so afraid of them and the violence that ensues. And so, I saw the gun, the baby was about five and a half months old, getting really, very close to crawling. And so, I talked, I was discussing that with my client and, you know, she was saying that it was her husband’s gun. And that she had asked him to put it away on several occasions and that he was being, just like, ‘Oh no, that’s, the baby needs not to be over there,’ and you know, more or less just blowing it off. And so I was like, ‘Wow, now how do I deal with this one?’ So, I talked with my supervisor during reflective supervision and at that time, you know, I kind of came to the conclusion of this is how I was gonna share it with my client. So the next visit, I shared with my client, ‘You know, I was glad the gun was no longer present.’ Um, you know, we, I discussed with her the incidence of gun-related deaths in children, and how the majority of them happen in accidents, basically, and that is actually, probably is the highest um, or the most reason for infant, infant children deaths are guns. But they’re, if in doubt, they just go under the whole umbrella of accidents.”

Several nurses and nurse supervisors from some sites explained that they had utilized other resources to assist their work in approaching environmental risk factors. These nurses explained that they had utilized CPS or DHS (such as TANF) as resources specially related to housing for

their clients. For example, a client with an open CPS case had needed stable housing with a new baby to ensure safety for the child and CPS helped to provide for this. Some nurses from one site had also consulted with CPS regarding whether or not a home environment was reportable for suspected child abuse or neglect. Some nurses from a couple of sites had attended several trainings related to environmental health led by their local CPS and prevention programs, such topics included the culture of gangs and what made a home livable by CPS standards.

One nurse supervisor explained, “I think, I think there’s been occasions when, if we go to – if we go to Child Protective Services, for example, one of the nurses had a client that had housing issues, a new baby, we were able to go there, that nurse went there and she was able to provide some support with housing just to get things changed so there was safety for her child...”

Another nurse shared, “My client was pregnant at the time. She got housing right before the baby was born. It was subsidized housing, like a sliding scale rate based on her income.”

Social Environmental Risk Factors

In addition to the physical environment, the social environment of a home has been concerning for many nurses in multiple sites. Examples of such concerns in the home included the client living in: an unsafe neighborhood with gang activity or violence; a house with violent individuals, with other women experiencing IPV, or with other individuals who were quick to discipline their children with force; or even in a drug house with excessive foot traffic. One nurse also explained that when her clients were placed in social environments where others were using substances, the client had picked up on these habits and looked up to them as role models; this was a concern for the nurse. Other nurses from different sites had also shared that another concerning social environment risk factor was when clients hosted or attended parties with substance use (such as marijuana and alcohol) with their infant present.

One nurse explained, “But it’s, they get put back into those same horrible environments where they’re sitting there smoking pot within the home, and that damages their brain. And continue using drug, and so they pick up on their role models. Their role models are drug users, stealers, to get the money.”

Another nurse shared, “It – I actually was told I couldn’t go into the home anymore by my supervisor. It was a very obvious drug house.”

Another nurse recalled, “Okay. I have reported a couple of times. Or, actually maybe just once. I had a client that had told me about a really abusive situation that her sister was in where her – the – her sister had three children, and they were being locked out of the house and lots of violence and lots of substance abuse. And, I felt like I needed to report, and so I did because my client was, didn’t want to report...”

Young Mom and Low Education as Risk Factors

Among many sites, many nurses shared that most of their clients were younger than 25 years old and were often teenagers. In some sites, some nurses had clients as young as 13 years old. Related to age, some nurses from most sites also explained that many of their clients had a low

education, often not having completed high school. Among some sites, a couple of nurses further elaborated that some clients were truant or dropped out of school, did not complete high school after giving birth, or were not able to attend school due to the client's mother not providing transportation.

One nurse shared, "You know, so she's a young mom. She was 17. She did not return to high school, so she, I think had like a 9th grade education. She had completed ninth grade, wasn't, wasn't very bright..."

Another nurse stated, "And I definitely can get a feel, I mean sometimes the risk factor that is obvious is like, maybe their age. Because a majority of our clients are younger, like younger 20s, maybe late teens, but that's not always necessarily the case."

Another nurse recalled, "...school authorities had reported her and also she almost got pulled to court for truancy for the child because she had her enrolled in just a standard traditional high school but she wasn't providing any type of transportation for the child to get to the school and she's doesn't have a driver's license. My client is 15 and so she couldn't get there by herself, so she wasn't going to school and she wasn't going to school for over a year, so."

Most nurses from most sites tended to view being a young mother and having a low education (e.g. not completing high school) as risk factors. These younger clients sometimes lacked basic knowledge about pregnancy and parenting, were uncontrollable by their parents, were often acting out (for example through substance use), and/or attempted suicide. Since these clients were minors, most relied on their parent for basic needs such as food and shelter. As such, coexisting risk factors including a complex family history, mental health, or being involved with an older FOC (e.g. some cases involved statutory rape) further enhanced the risk of being a young mother. To address these risk factors, several nurses from multiple sites explained that they had used simple explanations to educate clients about pregnancy, infancy, birth spacing, and appropriate caregiving, encouraged clients to continue their education by bringing in alternative school or GED resources, and assisted clients in establishing status as an emancipated minor.

One nurse stated, "I have one mom right now that is – she's 18 or 19. And, she is – she has her mother around, but not right – she lives with the FOC, and she knows very little – nothing – about babies, and so her, it's not a red flag, but it's like, 'Okay, so I don't know how much they yell. Is it just sometimes?' I really don't know..."

Another nurse explained, "She's a mom at 14. She is still baby, I mean she did not even understand how she got pregnant for crying out loud. Yeah, that was an interesting conversation..."

Another nurse shared, "And so, I had one situation in which I was working with a 15-year old girl and who had psychiatric problems, had been suicidal, had been hospitalized a couple different times for that. And, you know, by that time her baby had been born and a big problem in her life was that she lived with her father and her stepmother and neither of her parents were willing to take responsibility for administering her medication correctly, or actually doing any of the follow up after her hospitalizations."

Another nurse explained, "... You know, you can't necessarily talk to a 13-year old girl about life, the specifics of brain development in a two-month old and why they're doing the things they're doing. You know, like, you say things like, 'She probably still keeps her hands in closed fists.' (*laughs*) You know? 'She can – she's starting to lift her head up a little bit more when she's on her tummy.' You know? Stuff like that."

Despite viewing being a young mother as a risk factor, among a couple of sites, some nurses shared that they were comfortable with working with young clients. In these sites, the nurse supervisor had provided education, support, and guidance to nurses around adolescent development, such as reminding nurses what relationships were important to teenagers – their peers, while some nurses strived to understand the client's developmental stage so as to better engage her in the program and match ways of teaching concepts to her ability (concrete versus abstract).

One nurse supervisor shared, "And so, I do a lot of teaching about teenagers because 65% of our – well one-thirds of our clientele are teens. You know, they're 15 to 19 years old. And, emotionally, a lot of them are younger. And so, I do a lot of teaching about teenagers and adolescent behavior and adolescent stages of development that our clients are going through while they're to herd slash shepherd their little ones through their developmental stages."

One nurse stated, "She was young. And, maybe it was just her and her age. I try to look at that, too, 'Where is she at in her developmental stage? And, how can I do, what can I do to get her more engaged?'"

Previous Involvement with CPS or Law Enforcement

Another major risk factor among clients for many nurses across multiple sites was previous involvement with CPS, DHS, and/or the law enforcement. Across different sites, some nurses explained that their clients had been previously or were currently involved with CPS through several avenues, including: removal from their home as a young child; through foster care, youth in conflict, juvenile detention or truancy; or through previous reports, investigations, or open cases. With regards to involvement with law enforcement, some clients across several sites were involved through arrests for driving under the influence (DUIs) or neglect (for example, bringing an infant to a loud party with alcohol and drug use), running away from home, IPV-related issues, or the client's family member (parent or FOC) was incarcerated or had a criminal history.

One nurse shared, "I think there was just potential for neglect. I think – the client's like, 'I'm pretty sure that my mom called.' The client herself had a long history with DHS and had been removed from her home up in the mountains. And, I think she'd been in numerous foster homes, and when she was like 14 or 15, she'd been adopted by her mom, who was – the one who works at DHS..."

Another nurse recalled, "She, um, had bruises and such on her. I made a call, but somebody else had already made a call also. The cops had been called. They just told him to leave. And, that was it. At the time, the – I don't believe the cops had called CPS, but someone else besides myself did call CPS... I'm trying to remember now, but I think we had a good connection over phone, and in the beginning of the case, Dad was pretty

nervous. Apparently, he had spent some time in jail before that even Mom didn't know about."

In talking about the FOC, another nurse stated, "Mm-hmm. And, so, he finally went to jail for actually stabbing his cousin. So, that's the only reason that he's in jail right now."

Previous or current involvement with CPS was considered a major concern for many nurses in most sites based on the severity of the issue that brought the client into the system, while considering the client's strengths (such as a strong social network and desire for positive change). Most nurses who had prior clients who were previously involved with CPS (usually as a young child) described that these clients were often suspicious of the government and of people going into their homes, because of trauma associated with childhood neglect/abuse or the experience while in the CPS system. However, not all clients who were in the foster care system had negative experiences; in one case, a nurse shared that one client who was in foster care was supported by a great team, that included her foster care mother who was a mental health professional.

One nurse stated, "I think she was nine when she was removed from her home. And, it was a traumatic experience for her..."

Another nurse recalled, "...And then, people, you know, clients that have had previous experiences or have had family members with experiences with Social Services. And, I have to say, generally, it's negative. The impression is – I don't think I've ever heard a positive impression, honestly. And, that isn't – that doesn't necessarily mean one thing or another."

Another nurse shared, "I only know of one other case where the client was a foster child. And, she had her foster mother was a mental health clinician. And so, she had an amazing team that met with them at least once a month. But, I think most clients don't get that support, for sure."

There existed a range of interactions and collaborations between nurses and CPS workers when nurses had clients currently involved with CPS. In some sites, some nurses who had clients currently involved with CPS shared that they had positive interactions and collaborations with their client's caseworker. These interactions with CPS generally encompassed communication regarding updates on the client's progress and concerns that the caseworker had that were then addressed by the nurse at home visits. On the other hand, some nurses from the same and different sites shared that they were unable to contact or collaborate with the caseworker to better serve the client. In addition, visits with clients who were involved with CPS were made at various locations. Some nurses from several sites had made visits at the foster mother's home while others had conducted the visit at the department's visitation house, mediation house, or a group home. (Further details regarding strong and weak collaborations with CPS when serving mutual clients will be summarized in a later section.)

One nurse stated, "And in that case, I did not make the referral, but the child was already – the mother was already in foster care with the child, and so, when there was a concern, and they wanted specific information kind of passed along, they would get a hold of me

and go, you know, ‘We have some concerns about bonding. If you have any information about that, maybe you could, you know, pass that along.’ And so then, it gives me an idea of kind of what their concerns are. And, I – and, I could address it with the families.”

Another nurse shared, “Um, the same client when she had a CPS report last summer, I did make contact with the CPS worker. Well, I attempted to make contact, never got in touch with her, left me multiple messages. She never called me back so my experience with them is not, well the little experience, I haven’t had a lot, but the little experience I have had. They don’t really have a tendency to follow up...”

Another nurse stated, “...for instance, one baby was put in foster care and we met at the mediation house, the visitation house. So I never really saw the baby in the foster care home at all. It was always at the visitation house and the mom of the child was usually there, she came there. And um – so that um – was how and the social worker was able to coordinate that...”

Other Risk Factors

Some nurses from various sites shared additional risk factors among their clients that were concerning within their practice. These risks were not major concerns alone, but coupled with other factors, such as mental health and substance use, became areas that some nurses in different sites focused attention on when working with their clients. Such risks included: lacking an appropriate caretaker when the client was away or at work (for example, the boyfriend was quick to use force when the child misbehaved), temperament, attitudes, and mannerisms of the caretaker (be it the client or an alternative person), concerns with appropriately feeding and caring for the baby, and lacking affect or bonding with the infant. In a couple of sites, some nurses shared additional concerns when clients lacked prenatal care due to living in a remote area, did not adhere to physician appointments or NFP home visits, or (be it the client or the client’s guardian) refused referrals to other services such as mental health treatment.

One nurse recalled, “But, she said, ‘Oh, I’m gonna go back to work. And, I’m going to start working the night shift. And so, when the boyfriend or the husband comes home, he’s gonna watch the kids, the three kids until five, and then our two kids until I come home at eleven.’ And, I was like, ‘Oh, okay. Well that sounds exciting because you like to work.’ And, she’s like, ‘Well, yeah, but I’m worried because when the kids misbehave –’ and granted, they’re now 18 months and six months, – ‘when the kids misbehave, he likes to put them in their crib. And, then, if they cry, he’ll pop them.’ And, so she was really worried about what was going to happen when she went back to work like two weeks down the road.”

Another nurse shared, “Her boyfriend at the time lived up in [redacted]. And, they were living in a cabin. No prenatal care. Not at all until she came down from there. He wouldn’t take her to the hospital for several times, so she went from [hospital name removed] to [hospital name removed] to the mental health center for two weeks, so – that’s where we’re at on that. *(laughs)*”

Another nurse recalled, “So, I guess, if there was ever – like, I have referred her to mental health, to those kind of things, and it’s just been a situation where her mother doesn’t

believe that she needs help, and her mother will – I’ve referred to have her teeth – you know, she has cavities. The – my client still lives at home and her mother has canceled appointments, so – I mean, I – yeah, I have done the referrals. So, it’s a big case. It’s not only the three month-old baby that my client has, but it’s also her.”

Responding to Child Abuse/Neglect

In addition to risks associated with possible child abuse or neglect, some nurses across multiple sites had dealt with cases related to founded or suspected child abuse or neglect. Such cases usually involved sexual assault or statutory rape, medical neglect (including failure to thrive), general neglect, physical injuries, and IPV in the presence of the child.

Sexual Assault or Statutory Rape

Among several sites, some nurses shared that they had clients who were sexually assaulted as a child or teenager or were pregnant due to statutory rape. In these sites, sexual assault was usually committed by a relative. With statutory rape, some nurses had reported to CPS after they asked the client the age of the FOC and determined that the age differential fell under the definition. However, some nurses from other sites had not asked for this information from the client. Depending on the attitudes of the parents and the degree of support that the FOC was providing, many nurses from most sites generally did not report to CPS for statutory rape. However, a couple of nurses from different sites had reported to CPS strictly because of the age differential regardless of acceptance from the parents. In general, though, many nurses from several sites were unclear about the legal definition of statutory rape, including the age differential and minimum age of the victim, and wished to attend refresher trainings about this issue.

One nurse shared, “Definitely. Sometimes, or because you forget from time to time, or you know, one of the issues that we have, sometimes it comes up is when to report for. Which I have had this situation that I didn’t think of before where – I haven’t had to report it but if it’s been reported, where the dad is so many years older than the mom kind-of thing. So, I’ve had that actually, I think twice, over the years.”

Another nurse recalled a statutory rape case, “I said, ‘This is my client. She’s this age. The baby’s dad is this age.’ And then, they looked it up, and they said, ‘Oh yeah, there’s been a report made already,’ and that was that... And, she had told me that her parents had already made the report. She was 14 and the baby’s dad was 22. But, from what I understand is the police who had taken the initial report had told them as long as he’s, you know, supporting her and doing what he needs for her and the baby and the parents don’t have any issues, they were going to leave it alone. And, as far as I knew – she didn’t stay in the whole two years – but, as far as I knew, there were never any other issue. I think it was initial shock on the parents, and then, they were accepting of it after that.”

Another nurse suggested, “For the statutory rape, it’s like, ‘Okay, well, if they’re 16 and there’s a four-year gap –’ I mean, you forget those things, you know, after a couple years. So, just refreshers, you know, and not just specifically for the statutory rape, but just for general....”

There existed challenges in working with clients who were legally victims of statutory rape, mainly due to local variation in how the police and CPS dealt with such cases. In some sites, the police and CPS had not investigated a case further because they assessed that the FOC was supportive of the client. Within the same sites, however, CPS had investigated reports and placed warrants to arrest the FOC despite acceptance and support from both the FOC and family members. This inconsistency had made it challenging for nurses because they were unable to accurately provide information on the process and potential outcomes for their clients.

One nurse shared, “And then, when I went back – because I was on weekly visits – it was – the girl was 14... So, she had a – the 14 year old – had a very stable home. The grandma was sitting in on all the visits, very friendly, very nice... The boyfriend was, you know, 18-plus. And, he came in on all the visits, usually about halfway through. He worked full-time. He was over helping out the family, hanging out with them a lot. He would take the girl to school. They would go to doctor’s appointments together. He was involved in the parenting classes with her, so the only issue was the age... So, on my second visit, I went back, and I said, ‘Okay, this is what I’m going to have to do. And, anyone who’s a mandatory reporter is going to have to do this.’ And so, I explained how I’d have to report. And, I said, ‘When I report, I will report all these wonderful things that he’s doing because he’s super involved. He wants to be a great dad. This 14-year-old girl is more mature than most of my 20 year-olds.’ And, they were pretty understanding. I was thankful that the grandma was there because she was able to really kind of put it in perspective, too, and she understood that I had to report.”

She went on to say, “And then, I reported it to [county name removed] PD right after the visit I had with the client where I told them I was going to. And, they called me back right away and got all the pertinent information, and I was very clear about, ‘Look, he’s doing all sorts of really great things.’ And, even [county name removed] PD was like, ‘Oh, uh, well, he’s doing such a great job. It’s not up to me if they decide to prosecute.’ He’s like, ‘In this case, I hope they don’t. I wouldn’t think that they would because he’s doing so many good things,’ but, he’s like, ‘You’re right. You have to report it.’ ... Interesting. So, never heard, never heard. They got a voicemail from the DA [district attorney], but the grandma lost it on her phone, and they never called the DA back. Didn’t hear, didn’t hear, didn’t hear, didn’t hear. She had the baby. And, when I went to visit on that first visit, the baby had cleft lip and palate, so lots of medical issues going forward. The father of the baby was really involved. They had been taking the baby down to [hospital name removed]... And then, the visit after that where I was supposed to meet, she actually texted and said – well, she texted and said, ‘They have a warrant out for the boyfriend. They’re gonna come and pick him up.’ And, this was right after they’d had a baby with special health needs. And then, like two days later, she said, ‘I don’t have time for this program anymore.’ And, just dropped, which I’m sure it was because all this time they thought, ‘Oh, nothing’s gonna happen. Nothing’s gonna happen.’ And then, all of a sudden, like when she needed him most, they arrested him.”

Neglect

With regards to child neglect, some nurses from several sites had encountered cases related to medical neglect such as failure to thrive and general neglect where the environment was unfit for a child or the child was improperly dressed for the weather. Medical neglect of the infant was

described by some nurses from several sites as when the child needed special medical needs (such that the child was premature and had developmental needs) and the client was unable to adhere to such needs.

One nurse shared the main risks she encountered, “I feel like substance abuse is a big one, and domestic violence is a big one. And then, probably neglect or medical neglect of the child.”

Another nurse stated, “So that baby was born, the baby had a lot of medical problems, was hospitalized several months. Mom, um, just like really held back, did not really want to get involved, and a lot of that had to do with her own experience as a child. Because her mother basically was a meth addict throughout her whole childhood, was a prostitute, would leave her alone, I mean it was just, at one point that client actually confessed to me that there was nobody that she had in her life that she could trust, nobody. I know. And anyways, so, the baby came home, both parents reported each other for neglect, the relationship obviously soured, so they both reported each other for neglect. And it was really based, because of the demands that the baby had, in terms of medical needs.”

Failure to thrive was a more complex scenario and was especially concerning for some nurses in a couple of sites in particular. In these sites, several nurses had encountered multiple cases of possible failure to thrive, most of which had resulted in a report to CPS. In these situations, the nurse usually referred to the definition of failure to thrive as when the weight of the infant was two standard deviations below the mean for the age. Some nurses from these sites were hesitant to report failure to thrive cases to CPS for neglect because they felt that the lack of weight gain could have been attributed to other issues such as feeding or other medical problems. To address this issue, a nurse supervisor from one site had provided additional guidance and erred on the side of caution, suggesting that the nurse should report to CPS. In other sites, some nurses had consulted with more seasoned nurses and received advice on the case. However, in general, many nurses from several sites were uncertain as to when a possible failure to thrive situation warranted a report to CPS. In some sites, the hospital or physician had diagnosed clients’ infants with failure to thrive due to abuse or neglect and subsequently made a report to CPS.

One nurse explained, “Because for me in my most recent experience, I would like to see, ‘Okay, so, if baby drops 2 standard deviations and you think there is malnutrition or are there any other barriers, you know. Was baby sick? Were there barriers to food?’ You know, like it cannot be so black and white, but if it’s in a manual or there is an algorithm for it fits the mess, it fits the mess...”

Another nurse shared, “So, sometimes, when the baby is not really gaining enough weight the red flag is just, ‘Okay, this is, like, neglect.’ You know, but, um, there are some factors that could possibly contribute to it. For example, like um, problems with the GI of the baby...”

Another nurse stated, “That’s another gray area (*laughter*) and I know that you mentioned that before because I feel like some of those situations shouldn’t be reported but it is required to report if they’ve dropped two standard deviations on the growth chart, but sometimes the reasons why they’ve dropped aren’t documented or understood. It’s just –

and that's where the gray area is, because like the mother is interrupted with her child. They're doing things to help the child develop mentally. They're doing everything they're supposed to; the child's just not gaining weight, so I don't feel like that should have default back..."

A nurse supervisor stated, "There was another nurse, before the nurse I'm talking about, there was another nurse who also had a failure to thrive case. And the nurse supervisor and I met with her and talked with her about it. It was one that also ended up being reported, just concerning to me that at the point when the baby started you know significantly dropping, it was three months before the nurse brought it to the attention of the nurse supervisor, and then I found out about it."

Some nurses from a couple of sites had collaborated with the physician to determine whether or not a case was failure to thrive. However, there was often a lack of collaboration between the nurse and the hospital in most sites around communication of the infant's status and determining whether or not failure to thrive was an accurate diagnosis that warranted a report to CPS. In a couple of sites, some nurses felt that the hospital should have reported to CPS sooner regarding failure to thrive because they had a better understanding of the situation than the nurse. In addition, some nurses from several sites shared that there was inconsistency in how their nursing team defined failure to thrive versus how the physician diagnosed it; this led to miscommunication and, in one situation, ultimately resulted in an unwarranted report to CPS and the client dropped out of the NFP program.

One nurse shared, "And then, as far as sort of the hospital role comment, with a failure to thrive, you know, like again, I didn't know about that until about a week and a half afterwards. If – and, I was not able to assess that situation at all whatsoever. You know, I'm in the home, at that point, it would have been for an hour once a week. Which, you know, is often, but you miss a lot of stuff... You don't see everything. You only have – you can only go on what the client tells you, right? And, what you see during that one hour. And so, with the failure to thrive thing, I feel like, had there been, you know, cause for concern, that the hospital should have called at that point..."

Another nurse explained, "...I should say with some different medical doctors, there is some good collaboration, especially for instance, if you have an infant with failure to thrive. I have a couple that have a hard time gaining weight and there are a lot of physiological factors and it has nothing to do with the child, how much they eat – it's just they're anemic or they have a murmur or something like that. So, making sure and being collaborative with a physician and saying, 'Hey, I'm concerned about this.' And then they let me know their concerns, and that would be an example of good collaboration, usually with a lot of them, but there are some that don't have time for you but they are very willing to collaborate because they know that if you don't, then I'm required to report by law, so just making sure everything is good on their end and that they're aware so that there aren't any issues down the road..."

Beyond failure to thrive, environmental factors associated with neglect were also shared by several nurses within some sites. Neglect in these situations was attributed to: unsafe or dirty home environment, improper sleeping arrangements (e.g. co-sleeping), and improper dress for

the weather (i.e. the child wore limited clothing in cold weather while the client was properly dressed). These situations were usually addressed by nurses through education and modeling (such that the nurse helped the client clean the home), especially when the nurse was uncertain whether or not neglect was truly occurring. In some situations, though, the client was reported to CPS by neighbors, while in other cases the nurse had reported to CPS when other risk factors, including mental health, substance use, and a history of violence, co-existed in the home.

One nurse recalled, “So the only thing I ever did have was I got a client that was a postpartum client. So, we can get them up to a month postpartum, 30 days postpartum. And, and so, when I get her, she was – she had already had her baby like a few days. You know, the baby was a few days old. But, during my visits wither, she ended up getting – I don’t know. The baby must have been like a year old. No, not even a year. I think it was younger than that. But, anyway, she started (*unintelligible*) she got reported to Social Service because, for neglect. She had the baby at a party, and a fight turned up, and the baby was there with people drinking and stuff like that. So, the cops, when they go there, the police officers, they arrested her. And then, they got her for neglect and child abuse.”

Another nurse shared, “Um, yeah well, you know, someone said that the baby had, you know, fallen off the bed, you know, once. And then, she called me, you know, maybe a month later and said it had happened again. So, I didn’t know if that was like necessarily neglect or, you know, or what.”

Another nurse stated, “Yeah, there’s been a couple cases. One – it was a – Mom had a lot of mental health problems that she wasn’t getting treatment for. And, Dad also had a lot of mental health problems, and they were kind of unstable in a lot of aspect of their life, socially, financially – and, very, very little support from their families. So, they – it was a neglect, neglect issues that I was seeing, you know, a lot of, you know, Baby not dressed appropriately, home environment not really baby-proofed appropriately, some drug paraphernalia, some different things going on like that.”

Abuse

Finally, several nurses from various sites shared that they had encountered cases where the client received physical injuries as a result of IPV or other violence in the home in the presence of the child or, rarely, the infant being a victim of physical child abuse. Physical injuries to the infant as shared by these nurses included: bruising, injury to the nasal area, collapsed lung, and severe swelling or broken bones/fractures (e.g. broken rib, skull fracture, pelvic fracture through forcing into a car seat). Most injuries were caused by the FOC or an alternate caregiver, but in some cases, the client herself was responsible – usually due to negligence, not because of intentional injury. These instances were almost always reported to CPS by the NFP nurses who observed them or by hospital staff where the infant was admitted.

One nurse shared, “Of course, this felt very upsetting to me, too, but the baby had had a pelvic fracture from the dad pushing the little infant into a car seat or some kind of seat. So here are two Nurse Family Partnership nurses involved and a doula appearing in the family situation, and the dad was still abusive...”

Another nurse recalled, “I did have a family where I reported – of course, hindsight is 20/20. I wish I would have taken a picture of her bruise. She was a pregnant mom living with her mom and stepdad, and I felt like her stepdad was overstepping bounds of what is appropriate and safe, and I reported it.”

Another nurse stated, “And, I guess, he got frustrated, yanked on the baby’s arm and leg while he was – I mean this was – and, this was a – how old was she? Two months. Maybe not even two months. Seven, eight weeks. And, yanked on her ankle and arm in the crib and actually ended up fracturing both her ankle and her humerus. And so, you know, long story short, when my client got home and saw that she, the baby was crying, you know, took her to the ED immediately. Boyfriend didn’t admit to doing any of this at the beginning, but that first ED visit, I don’t believe CPS was called.”

Approaching Suspected Child Abuse/Neglect

Across many sites, most nurses shared about techniques and strategies they had used to help their clients with addressing concerns related to child abuse or neglect. When the issue was related to cleanliness and the environment, many nurses from several sites shared that they had used the opportunity to model proper cleaning with their clients during a home visit. When the issue was related to inadequate parenting or child care, similar to addressing other client risks, many nurses from multiple sites utilized PIPE lessons, curriculum handouts, and additional education prepared through the nurse’s research, to assist the client. In addition, some nurses expressed that they approached their clients in these situations with the client’s ability to parent and how they could strengthen the client’s competence and skills. Other nurses from several sites shared that they had helped a client to identify her needs and how to meet them based on the client’s capacity and energy to nurture her child. In other sites, some nurses emphasized maternal role, child development and growth, bonding with the baby, and appropriate touching and holding of the baby. Across other sites, some nurses suggested objectifying the situation, presenting information from the baby’s perspective, and phrasing issues in a helpful view as useful strategies to approach concerns of child abuse or neglect.

One nurse shared, “And, you know, a lot of times - like, with her, for instance, you know- and, I helped her clean it up. I said, you know - I said, ‘We’re going to clean this up right now because this isn’t okay. I’m not going to leave with this - you know this is unsafe.’ And, you know, it was helpful. Never again did I go over there and the trash was overflowing. I mean, there’d be dishes and the house would be a little messy, but not the safety issue.”

Another nurse stated, “You know, because a lot of times, you know, we may- we may have a concern, you know, during pregnancy of just, again, if you’ve been an nurse for a long time, and you’ve been doing this program, you know, that we see that they’ve not bonding with the unborn baby. And so, we try to facilitate that, you know, so that- so that they can have a good bonding with the child because, when they have a good bonding with the child, the chances of abuse and neglect go down. It’s really hard to hurt a child with the same hands that you’re hugging them with.”

Another nurse shared, “I approach them with their ability to parent. I look at it different. Go in with the ability to parent and their competency. They’re all competent, they have

the ability - I don't go in with the worry, 'Are they going to abuse the child?' So then, but then, when I see something, then you know, there's a little flag going up and - yeah just observe, and then probably what I would then if I - okay, with the patience thing, you know, the patience thing when they become toddlers and- yes. And, that's an issue."

Another nurse stated, "And, that we're all collaborating and, but moms that are struggling, I mean, we have a lot of our curriculum that we use. I think the relationship though, you know, I always go back to that. That's really what's important, and you know, helping her to identify her needs and meet her needs, so she has more capacity, more energy, literally, to be able to nurture her child."

Fatalities

Fatalities – the occurrences of death – were rarely discussed by any nurse across all sites. When fatalities within their scope of work were discussed by nurses, they were mentioned with regards to knowledge of child fatalities in their county – never of a client's child – and questioning whether or not NFP would have been able to prevent such an occurrence if the child was in the program. Reasons for child fatalities described by these nurses varied across sites, from co-sleeping to gun-safety to not knowing the specific factors that led to fatalities. One nurse further explained that she was aware of child fatalities in the state and that the majority of these cases involved children not known to DHS, such that they were young infants of first-time parents and could have benefited from participating in NFP.

One nurse shared, "Yeah. You know, because I see the problem. I mean, I really do. I mean, all these babies that have died, you know, under - you know, what if they would have had a nurse in there? What if they would have had someone in there to just, you know – would that have changed? I mean, I feel like the social workers can only do so much. We only have so many."

Another nurse stated, "Because the other problem with the year of all the fatalities was a lot of those kids were not known to DHS...Because they were under 1, they were children of first-time parents, and so, I think for us, we really have to have that on our radar, so that we can make sure that, um, you know, if we can touch anybody that can be referred to this, that that's probably the best of all worlds, because if they don't have to come into our system, that's a great thing."

Nurse Safety

Across multiple sites, several nurses described instances where they were concerned for their safety due to working with high-acuity clients. For example, reasons for safety concerns included: severe mental health complications (leading to threats to the nurse or to the client's baby), IPV or a violent individual in the household, gang involvement, violent dogs, involvement in criminal activity (e.g. drug trafficking), drug paraphernalia in the home or possible retribution after making a CPS report. In one site, a nurse felt unsafe while visiting a client's home due to a comment made by the FOC that she was unsure if it was a real threat or a joke. To address these concerns, some nurses in different sites had ensured that visits were always made announced, had rescheduled visits, asked the client to meet in alternative locations, suggested to the client to explore alternative living arrangements, or in severe cases, the nurse supervisor had not allowed

the nurse to continue home visits and declined further participation of the client. Interestingly, in several cases, some nurses from several sites shared that their clients were protective of their nurse; such that, one client had canceled visits when she knew drug dealers would be at the home, while in another situation, one nurse was able to receive gated parking while visiting her client in an unsafe neighborhood. Several nurses from a couple of sites had also instituted “safety buddies” such that a nurse had made a home visit with a colleague or nurse supervisor or had a colleague call after the visit to check on her status.

One nurse stated, “And she’s kind of far out there. She’s not one that I just tend to want to drop by because I know there’s been intimate partner violence. She’s thinking he like slashed her tires at point. He had even been calling me, trying to get to her- So, I just don’t feel comfortable going out there unannounced.”

Another nurse recalled, “Yes, there was, I think it’s been within the last four weeks, there was a murder, on [street name removed], right you know during daytime and the client’s apartment was just right there on that street. So the client and her partner were very anxious when the nurse came to visit because like, you know, they themselves are hyper-vigilant. And so then the nurse, she was really nervous about being there. And she parked on the street and she felt like there was someone who had followed her. You know she ended up getting in her vehicle and leaving. But she was able to work it out with the family that they gave her the passcode to be able to get into the parking, the locked parking.”

Another nurse stated, “Yeah, we all have a safety buddy so that we can call in and say, ‘You know, I’m walking into a really weird situations here. You know, would you call me in five minutes?’ Or, ‘Will you come with me because this one is really not okay?’ Or you know, something like that.”

Regarding uncertainty in whether or not a client’s FOC threat was genuine or a joke, another nurse said, “And, again, it was looking at my safety as well as her safety in a situation where I—I really wasn’t too sure. Was he just kind of saying something to be funny? Was he really like that? Was he capable of acting on what he—A threat, a semi-threatening statement?”

Reporting Child Abuse or Neglect

Across and within various sites, the incidence of reporting child abuse and neglect within the scope of work for an NFP nurse varied tremendously. Many nurses from multiple sites utilized similar approaches to discussing mandatory reporting with their clients and consistent ways to determine whether or not an incident or situation was reportable. There existed also similarities within and between sites in gray areas (confusion in what was deemed reportable), reported situations, and non-reported situations but there was variation in frequency to reporting.

Role as a Mandatory Reporter

All nurses in all sites recognized that as a registered nurse, they were mandatory reporters for child abuse and neglect. However, several nurses from different sites expressed confusion in what was deemed reportable, where one nurse expressed that she did not completely understand

what it meant to be a mandatory reporter; these were areas shared by nurses as possible topics for future education. At the same time, many nurses from multiple sites shared having conflicting feelings in their role as a mandatory reporter while maintaining the client-nurse relationship. The conflict laid in the nurse's desire to protect the child while feeling that making a report would betray the client's trust. Several nurses from various sites expressed that they did not enjoy calling CPS to report but would err on the side of caution and report. Indeed, one nurse emphasized that mandatory reporting was not a decision she took lightly because once reported, one could not revoke it. In addition, another nurse emphasized that if the hospital or clinic saw one of her clients (for example the baby was found to be injured or failing to thrive), it was the responsibility of the hospital to report, not hers. Another nurse from a different site emphasized a different point that she reported not because it was a mandatory responsibility as a nurse but that it was ethical in protecting a child. Finally, a nurse supervisor shared a perspective to which several nurses from other sites agreed: a nurse's role was to report and not to investigate.

One nurse in sharing topics for learning about mandatory reporting stated, "Okay. Um – Well, it – I would. I would like it to be comprehensive, not only what constitutes mandatory – which, I – You know, in my mind, I think I understand that, but maybe not, you know, since I have this situation that I feel is kind of like borderline. So, maybe I don't completely understand mandatory reporting."

Another nurse shared, "It's kind of my role. Should I lose this connection to report and lose them and the possibility or do I work with them and set the goals that will help them in the long run?"

Another nurse explained, "And so, you know, I sort of feel like, actually, had – I don't know, maybe, had we started like the CPS process there, maybe we could have avoided everything down the road. But again, that's not my responsibility to call there. That's the hospital, okay?"

Another nurse expressed, "Not just because I'm mandated, but because it's ethical. It's saving a baby's life. That's the way I look at it."

A nurse supervisor shared, "That I never found out. That was part of what I was taught in doing mandatory reporting, is that it's not our job to do the investigation piece. You know, sometimes I think nurses get caught up in, well, maybe it's not you know really something to be worried about and that's where you need to have someone where that is there job, to investigate."

Approaching Mandatory Reporting With Clients

Across and within sites, there existed many similarities in how nurses approached their mandatory reporting role with their clients. Almost all nurses in most sites first explained their role and responsibility as mandatory reporters upon enrolling the client when going through the consent. In fact, many nurses across most sites felt that it was important to let their clients know about their role in mandatory reporting at the beginning of the program. One nurse specifically stated that by discussing this with their clients at the beginning, she felt more "comfortable" when she had to report. In addition, some nurses from several sites shared that they utilized varying approaches to explain their mandatory reporter role to clients. Some nurses in some sites

expressed that sometimes they had to reiterate the fact that NFP was a voluntary program, NFP was not associated with the DSS or DHS in any way, and NFP nurses were there for the support and education of clients. In some sites, several nurses and nurse supervisors had tried to lighten the mood through using humor, so as to lessen the fear that some clients may associate with reports to CPS while others had stated that they told their clients they would always notify them if they had to make a report. Some nurses from several sites had also discussed their role by emphasizing the need to protect the child. Several other nurses from multiple sites also recognized that they had to continuously remind their clients that they were mandatory reporters, especially when clients began telling stories that were bordering a possible report to CPS.

One nurse stated, “Just right off the bat. We have built it into one of our consent forms. And, I go through it – You know, I don’t read it line by line, but I say, ‘I’m going to explain what each paragraph means, and then you tell me.’ And so, initially, we do the HIPAA. You know, ‘Everything we talk about is confidential,’ and then I say, ‘But, there’s one exception, and I’ll get to that.’ – And then, when we get to it, I say, you know, ‘This is by law. Anyone with a license, so not just me, but a paramedic, a fireman, a teacher, a doctor, anybody who’s got a license like that is a mandatory reporter. And, these are the things that we look for.’ And, I usually say, ‘Child abuse, neglect, domestic violence,’ so I always kind of jokingly say, ‘If you have a meth lab in the house,’ you know, anything like that to try to lighten the mood, but I do tell them right from the get-go that I have to.”

Another nurse stated, “Because I had said to her the same thing that I say to most people is like, ‘You need to know that I am a mandated reporter. That is not my goal. That is not my mission I am here to support and educate you. All I’m here to do is to life you up, you know?’ And, she was like, ‘No, you’re- you’re going to try to take my baby away if she has a cut or something, maybe you’ll like turn- you’re going to turn me into Human Services.’ ... And I said, ‘No, I mean, you - That’s not what we want to do. That’s not what any of us want to do.’ You know? And then, she went on, ‘I was going to be a good mother.’ But, what, what people were telling me is they thought that somebody had gotten, somebody in the motel or whatever had talked to her and thought, ‘Don’t - you don’t let people visit you.’ ... Yeah, you do your best to try to help her to reset, you know, but she was convinced of it.”

Another nurse in regards to telling a client she was a mandatory reporter stated, “And I’ve never gotten a negative response to that. I don’t think I’ve ever - I mean, I’ve lost clients after a couple of visits, but I don’t think it was related to that. I don’t think. But, I mean, ‘That’s my job. And, if you don’t like, it’s a voluntary program, and you can choose to be in it or not to be in it, but you need to know from the get-go.’”

Another nurse stated, “And, I usually say that, you know, child abuse, homicide – well homicide, suicide, and child abuse – from my LPC. And, I give the example of, you know, ‘If you-’ Just to lighten, I usually start with homicide. You know, ‘If you tell me, “I got a gun. As soon as you leave, I’m going out and I’m shooting them.”’ And, almost always, they laugh and say, ‘Oh, no.’ You know, it kind of lightens - and you know, I said, ‘Well, you know, I would have to call the police in that situation.’”

However, not all nurses from all sites explicitly explained what it meant to be a mandatory reporter to their clients. In fact, one nurse from one site specifically stated that she did not go through the consent form with her clients, but rather she allowed her clients to read the form and then asked if they had any questions.

One nurse shared, “No, I don’t like stirring up an issue that’s going to be an issue, you know? Like, they can read it all there. It says it right there on the paper. And then ask, ‘Do you have any questions?’ So, that’s how I – to sign and to read. They have to. They make sure they read everything they can read. Or, in Spanish, English, and they read. They take the time to read from 16 to 29. And, even the- nobody’s ever asked a question, and so, I don’t go through it, point by point. I just – read through it. And then, yeah.”

When facing a situation where a mandatory report to CPS was warranted, there existed variation among and within sites with how nurses approached it with their clients. Some nurses in some sites shared that they were almost always transparent with their clients either before or after the report was made, and that at times, they had even reported to CPS with the client present. These nurses approached this with clients by framing CPS involvement as beneficial to access resources, or that the report was needed to keep the baby and/or client safe. Other times, the same nurses and other nurses from some sites felt that due to safety concerns, potential damage to the nurse-client relationship, or fear that the client would flee the area, it was necessary to abstain from letting the client know about a report or even pretend that they were not aware a report was made.

One nurse stated, “She wasn’t happy about, but she also understood. Because I had told her - it was- the way I explained it to her, I said, ‘[Client name removed], this is your safety.’ I said, ‘I have to - because of [client’s partner’s name removed] diagnosis, you know, I have to be concerned that he could possibly hurt you or the baby.’ And I said, ‘That’s - when there’s a baby in the home,’ I said, ‘If there’s any concerns, we have to let them know.’”

Another nurse shared, “I think- I think that it would depend on where you’re at in your relationship with the client. If it is a new client, and you have no relationship with them, and you know that, by telling them you’re going to report that you’re going to lose them, I’m not sure how- I mean I’m going to have to take it on a case to case basis. I will tell you that, if I have tried to do the prevention, and I have tried to teach to areas of concern, and I have a very good relationship with them, then I probably would have that conversation with them that, you know, ‘These are my concerns. This is what we’ve tried to do, you know, to help with that. I’m not - this is reportable at this point.’ And, I think I will be- I think I would be more transparent with them.”

Determining When to Report

Across most sites, most nurses referred to their supervisors when they had encountered possible situations that warranted a report to CPS. Many nurses spoke about processing an incident or situation they encountered while on a visit with their supervisor during reflective supervision. During these sessions, the nurse supervisors usually raised questions on ethics, responsibilities, and safety. A couple of nurses from different sites expressed that they had called their supervisors immediately after a visit when they had serious concerns regarding an incident they

had just witnessed. Almost all nurse supervisors from all sites emphasized their role in guiding nurses towards making the decision to report or not; usually through motivational interviewing, asking questions, processing with the nurse, appreciating the difficulties, and ensuring that nurses understood their role as a mandatory reporter and the legal ramifications related to it. However, one site expressed challenges in determining when to report due to a difference of opinion between nurses and the nurse supervisor; where the nurses often felt that the nurse supervisor was overly conservative with her assessment and disagreed that it was reportable at the time. This difference in opinion usually pertained to possible failure to thrive situations. Despite these various methods of determining whether or not a nurse should report, one nurse felt that her colleagues tended to report when concerns were too severe for them to address and that they needed to be reporting to CPS sooner.

One nurse shared, “No. I would talk with [nurse supervisor name removed] first unless, like I said – I mean of course I’d probably end up having to call the police too if I was there and something was going on. But, yeah, I would absolutely – I would get in my car and call [nurse supervisor name removed] immediately.”

Another nurse stated, “The one with the pot smoke, the marijuana smoke, I knew that it wasn’t right. I knew I didn’t want to be there. And, finally, that’s – You know, she said to me, ‘You know, if you don’t feel like it’s right, then that means you should call.’ Because, you know, she said, ‘You know, can you go to sleep tonight if you don’t report? Can you feel like you’ve done your job?’ And, ‘No.’ The answer was no. I’m like, ‘Yeah, that was a great way to look at it.’ Like, can I feel like I’ve done everything that I could have? Because I really didn’t know the answer, and I thought, ‘At least, well, someone else should investigate this.’ Because maybe it isn’t an issue, and maybe the family will change, but – Yeah.”

Another nurse explained, “The two reports that I had to actually make, were, now, granted, you have to understand that my boss is very on the conservative side. She makes sure we follow very strict protocol with DHS, with reporting. Where we’ll report things that DHS doesn’t consider a priority.”

Another nurse stated, “And I think – I think we tend to wait until things are big to report... Yeah. I think we need to be reporting earlier.”

Some nurses from other sites shared about their utilization of colleagues’ knowledge and experiences through consultation to help determine whether or not a situation was reportable. This consultation was usually done in more informal settings. A couple of other nurses from various sites utilized motivational interviewing and assessment skills as well as their general knowledge of the family to determine whether an incident was reportable. Some nurses had consulted with the client’s physician to help gather a comprehensive picture of the client’s situation and background. In one site, several nurses discussed about a protocol they followed that addressed severe mental health concerns, including making a report to the police or CPS and ensuring that the client received a psychiatric assessment.

A nurse expressed, “Um, I have. I don’t know that it was mandatory, but after discussing it with some of my coworkers and my supervisor, we just felt that it would be the best

thing to do, just to see if, you know – We exhausted all of our other resources. We thought we'd see if they had any others. I've actually... I've called Child Protective Services twice.”

Another nurse explaining her site's protocol shared, “Like okay, and then I need you need to get a crisis psyche eval,’ and she is like, ‘What!’ and like back flips off of the deep end. Right. I mean she is just going nuts. And I said, ‘Your friend can drive you.’ She had a friend that was there. But I said, ‘But someone needs to stay and watch the baby per our office protocol. The baby can't go with you. So you know, start working it out. I'm going to go ahead and start calling DHS now. So maybe your mom can come and help.’ You know, trying to help problem solve, ‘Can the father of the child come home from work? Can someone come home from work?’ I can't leave her alone per our protocol until somebody gets there. Until she leaves and I hand them a business card and say call me after her psyche eval. So 2 hours later, an hour and a half later, the father of the child comes home and he was way cool, ‘I just understand that you're just trying to do your job. Now tell me exactly what happened.’ And I told him and he was, ‘Okay, that's cool. Like alright, come on, let's go.’”

Finally, in several sites, some nurses routinely utilized a specific CPS contact or the CPS hotline to assist in determining whether or not they needed to make a report. In several sites, these nurses had directly contacted a CPS worker to discuss hypotheticals, while in a couple of other sites it was more common for the nurse and nurse supervisor to call a CPS contact together. In these sites, having a CPS contact to discuss hypotheticals was considered a resource for the nurses. One site also utilized a case manager for pregnant women from a local nonprofit organization to help determine whether a situation was reportable or not. On the other hand, a nurse and her nurse supervisor from one site felt that additional guidance from the NFP NSO was necessary so that their team would be able to make such determinations internally, rather than consulting with a CPS worker.

One nurse shared, “So, the second time I made the suggestion that maybe we report it to the police that she's missing, but talk to DSS on that – They have a hotline that you can process if it was reportable or not... And so, we called the hotline to determine whether it should be reported. And, based on her history of frequent runaways and concerns with her care for the baby, we reported it and they considered it neglect.”

Another nurse explained how she utilized CPS as a resource, “Several times. And, boy, I'll have to really think, but I have – Each time, and I would say maybe two or three. I said several, and I can remember one off the bat, but I believe there were – There might have two, at most three. And, I've always reported this to one particular caseworker. And, I've always done it as a hypothetical, and he's questioned me, and we've, you know, gone through the details, and he – The conclusion has been it's not reportable, but continue, you know, and that's the way each of these three—and, again, I can't remember if it was two or three, but I remember one in particular. So, that's the way it's gone with me.”

Confidence in Reporting

There existed variation among and within sites with regards to a nurse's comfort and confidence in making a mandatory report. In some sites, many nurses expressed that they were comfortable in making future reports on their clients. A couple of nurses from different sites described that their comfort in reporting had increased over time as they had worked longer in the program; understanding that it was more important to maintain a child's safety than worry about damaging a relationship with the client. A couple of other nurses from other sites expressed that as a professional and with gaining more experiences in reporting, they had become comfortable in identifying when it was necessary to report to CPS versus when they may have just needed to provide additional support for prevention, as well as when to ask for help from their colleagues or supervisor. One nurse went on to describe that knowing when to report was a continued learning process.

One nurse shared, "I think I'm pretty comfortable with it. Calling and making the report, at first, was a little awkward until I said, 'This is my first time. I'm new to this,' and I felt so much better just letting them know that. And then, talking with Mom – I think it makes it easier just telling them at our first visit honestly, 'If I see or suspect anything that, you know, I will have to make a call.' So, just kind of laying the groundwork that, if you have to, we've talked about it. So, it's not a complete shock the first time they hear it."

Another nurse stated, "I think we all probably bat that back and forth, but if I'm really concerned about it, I would have no problem. Because I also know – I used to work pediatrics. It's only my responsibility to report if there's some concerns or issues. It's the Department of Social Services to look in and do their investigation to figure out what's actually going on in the home and what needs to be done as far as education and parenting classes and that sort of thing."

Another nurse shared, "No, I think, the longer I've been in the program, the longer I've been doing the program, I think the easier it gets to call. Because when you're like, 'It's just not right.' – I think, in the beginning, you're very scared you're gonna lose the client. And, 'They're not gonna like me anymore, and they're not gonna let me visit,' but I truly felt, at that point, like if I wasn't even gonna expose my unborn to that... Here's this, like, 10-month-old who's sitting there. I'm like, 'This is just not right. And, if it means I lose you as a client, then it just means I lose you as a client.' Because, then I did think, well, maybe that will drive home to her that, 'Gosh, this is important enough that [nurse name removed] felt like she had to call.' I don't know if it did."

A nurse supervisor expressed, "So, I think they're pretty good at it. It's not a comfortable thing to do, but they do understand that they're mandatory reporters for children that, when it comes to an adult situation, if they witness it, they have to report it. But, if it's just hearsay, if some – Say, their client is just saying, 'He's knocking me around,' that's not reportable by them, but they certainly encourage the client to call in and report that or call the police."

However, some nurses from the same sites and other sites expressed less confidence, usually because they did not feel confident in accurately assessing gray areas for reporting. In fact, a

couple of nurses from different sites felt that their understanding of mandatory reporting was unclear, especially around specific topic areas (such as drug use and IPV) as well as when making second or third reports on the same client was needed. Interestingly, uncertainty in to whom (for example, law enforcement versus CPS) and when to report also existed among some nurses who felt comfortable in reporting. However, those nurses who had never reported on their clients expressed greater anxiety than nurses who had previously reported in accurately determining when it was reportable as well as the reporting process itself.

One nurse expressed, “You know, in my mind, I think I understand that, but maybe not, you know, since I have this situation that I feel is kind of like borderline. So, maybe I don’t completely understand mandatory reporting.”

Another nurse expressing her uncertainty in reporting shared, “And, the thing that I, you know, because again I’m new to this. And, I definitely don’t feel like I know enough about reporting, but, you know, okay, so you make this report and then they don’t follow-up. And, then you continue to hear stories. Do you keep making reports? You know, so what is – What legally should you do? If you’ve already made one report.”

A couple of nurses from several sites, especially those with experience in reporting from previous positions, shared that they would have no hesitancy in reporting if they had severe concerns with their client; this confidence was attributed to understanding that their role was to report for concerns and that Social Services was responsible for actually investigating such claims. However, several other nurses from a couple of sites shared their hesitancy in future reporting due to prior negative experiences and a lack of response or an overreaction from CPS after making what they thought was an appropriate report. Indeed, after having a negative experience with CPS, one nurse and one nurse supervisor from the same site expressed that they planned to report only the specific incident and not other concerns or information about the family in future reports.

One nurse explained, “Because I sort of, you know, went at it with the premise of I was just – I was trying to get her support. I was not trying to get her in trouble. I was just trying to get her support. And, unfortunately, it led to that. So, it – You know, it was probably best for the baby, but it does make me sort of afraid to report things in the future, you know, because it’s definitely not my goal to have children taken away, you know?”

Another nurse shared, “I think with Social Services, when I have to report again, I will report a very specific information, and I will not go into all the other concerns that I had. I mean, if there is a reportable incident, I will report that incident versus—expanding on it - And, I think that’s what I learned from that.”

A nurse supervisor with regards to providing information in future reports continued, “On all the other concerns you have — that might not be reportable, but it adds to the picture for them... That sort of gives TMI, Too Much Information. Let them [caseworker] figure that out—when they get in the home.

Gray Areas to Reporting

Areas to reporting that nurses felt were uncertain or gray were similar within and across most sites. Most gray areas centered on incidences that nurses encountered on their visit or around stories that nurses heard about from their clients. As mentioned, substance use (such as marijuana, meth, and alcohol) as well as IPV - occurring during pregnancy, without the child present, or when the victim herself was still a child - were some key areas that some nurses and nurse supervisors expressed were difficult to determine whether or not it was reportable. Many nurses from several sites discussed uncertainty in knowing when to report for marijuana, especially with the new legalization laws. These nurses felt that their clients had become more forthcoming with sharing that they used or grew marijuana because it was now legal. However, oftentimes, these nurses were unsure at which point a report to CPS was warranted for using substances; for example, it was difficult to determine if a mother was able to provide a minimum of care, which would mean the mother was not neglecting the child. One nurse supervisor shared her uncertainty in when marijuana use was reportable by comparing marijuana use to drinking a glass of wine or smoking cigarettes during pregnancy; such that the latter scenarios did not warrant a report to CPS.

One nurse explained, “I don’t think this is a – I don’t think it’s a black and white issue. I mean, yes, there are times when it’s like, ‘Yes, this baby is potentially going’ – It’s those gray issues, like the baby sitting in a smoke-filled, you know, like marijuana smoke that you’re like, ‘Well, do I call or not?’ It’s those gray – especially now that, you know, we live in Colorado where it’s going to be legal to smoke recreational marijuana – So, things like that. Like, how does this law, these new law changes affect if we call or do not call? Things like that.”

Another nurse expressed, “Okay. So it would be more clearly around alcohol use and like growing marijuana in the home and what’s safe. How do I look to make sure that it’s safe? How do I educate the families to make sure that these things are okay? And on what – Should I be making a report around any of those things and when should I make a report? So that’s probably the biggest thing that I had done hypothetical questions on, in general. Pretty much all of my questions have been around that gray area of drug use, alcohol.”

One nurse supervisor stated, “Because of the legality. I mean, I don’t know... but, it – I mean, I, again, people can have a glass of wine while they’re pregnant. You know? And, they can smoke cigarettes (*laughing*) their whole pregnancy, and nobody says anything, you know.”

With IPV, several nurses and a couple of nurse supervisors from some sites explained lacking clarity about when to report to CPS, particularly around whether or not the child was present or if the child was placed in a risky situation. Several nurses from different sites also expressed not having enough information about reporting IPV when there was an unborn child involved and there were no additional children in the home. In addition to IPV, in some sites, some nurses were concerned with their client’s partner’s violent history (such as having an existing restraining order); this was considered as another gray area.

One nurse said, “you know, when you know that there’s known domestic violence in the house—You know, again, is that—Is that reportable? Is that not reportable as far as that if Baby’s around while the violence is happening? So, that’s—That’s a, you know, huge one. There’s just a lot of gray. There’s just a lot of gray areas. I mean, there really is.”

Another nurse said, “But, if the child’s not even home, or if she’s pregnant - Is that reportable? I don’t know. So, this is an area that I would like some instruction on because, you know, an unborn child is an unborn child, and it—You know, we don’t report marijuana usage or alcohol, so why are we going to report domestic violence? I—I—You know—Don’t know. So, it could—We could use some—I could use some info on that.”

Another nurse shared, “Oh, I guess that would be another gray area, actually – is intimate partner violence. You know, because there’s the whole, ‘Is it putting the baby at risk?’ Because then, yeah, that makes it a little more black and white. But, definitely a gray area with just being pregnant and things. I know I had posed a question to [nurse supervisor name removed] a while back – One of my girls was 16, maybe just 17 at the time, and was dealing with some intimate partner violence. So, I was like, ‘Is that domestic violence? Or, is that child abuse because she’s still a child?’”

Other gray areas for many nurses from multiple sites were usually related to possible neglect, including possible failure to thrive situations, clients with severe developmental disabilities, developmental delays with the child, the environment (such as uncleanliness, feces on the floor, vicious dogs in the yard), and severe mental health (with the possibility of causing harm to the child). In addition, multiple nurses from several sites raised the issue of when to report again if they, or someone else, had previously reported on the individual (be it the client or a family member). In several sites, statutory rape or age-related issues (significant age differences between the mother and FOC) were also considered gray areas for some nurses. For example, several nurses shared that if the parents of the client were aware of the age difference and accepting of it, they were uncertain whether or not they needed to make a report. In addition to gray areas on reporting on the client herself, some nurses expressed uncertainty in determining whether or not a situation was reportable when the child neglected was the client. These situations were related to an underage client including: being kicked out of the home, truancy due to the client’s parents not providing transportation to school, or inadequate provision of food, shelter, or clothing.

One nurse expressed, “Sure, I think there’s times where you kind of – You go – You know, something makes you uncomfortable. Some of it – I’m trying to think of an instance so I can – I think like weight issues are always, you know, to me kind of reflect consistency and, you know, or behaviors of the baby. You know, if the baby is looking really flat and not really, you know, those kinds of things. You worry, but you don’t really see anything. There’s nothing really obvious that you can report. And, those are things that you just kind of, you note and you kind of look for, but there’s not really a whole lot that you can report.”

Another nurse stated, “Yeah. I mean, I – You know, the one that’s come to mind was the case that I had reported first with the mom with mental health problems. There was a lot

of time where there was gray area. You know, and sometimes she'd make some comments, or the baby, you know, wouldn't be as well kept as maybe I thought the baby should be, but it wasn't real clear. You know, in those neglect cases, it's real hard to prove and real, you know, it's like, what – You know, what's allowable and what's not. And so, that definitely had a lot of gray areas”

Another nurse shared, “Then something gets done. But, if the parents are okay with it, the girl's okay with it, and there are no issues or noise made or a huge fussing and fighting, you know, they just go under the – the wire. It's like, okay. So yeah, we know how old they are and they know how old. And, they have been living there with them sometimes. It's like then we're, should we be reporting that she's only 16 and he's 19? - Yeah, those are good areas, and especially that age thing has always been a concern.”

Another nurse shared, “She's pregnant, 15, she's going to school full-time, can't really work very much and she's not working right now, so that's a gray area for me because I called to check and follow up, and they said they weren't going to follow up. And the other thing was this mother's been reported multiple times.”

Situations that were Reported

Despite several key topics that many nurses felt uncertain about regarding mandatory reporting, some nurses from multiple sites had reported to CPS. The situations in which they reported were usually related to neglect, but sometimes also abuse. With neglect, reported situations were different across sites and had included situations that involved a client who was a minor, the environment, the FOC, mental health, substance use, developmental disability, and failure to thrive. Some specific examples of instances where a nurse had reported were: a minor with frequent runaways while leaving the baby in the room; the environment being unsafe for a child (e.g. client was living in a drug house, house had little to no heat or electricity, sanitation concerns, and/or inadequate supply of food); the FOC taking the baby away, having a violent temperament or stalking the client; mental health issues (for the client or FOC) and concerns with regards to lacking adherence to medication, suicidal ideation, lacking bonding with the child; substance use (including alcohol, marijuana, and other drugs) affecting parenting and care for the child; cognitive delays while living in a chaotic environment; baby losing weight or not being fed appropriately; and clients not attending appointments for the baby.

One nurse recalled, “And then, in the little shack where she was staying at, was a one-room shack. And, he had – And, she also had care of his two kids from a prior relationship, and she herself was pregnant at the time. And, that was heated by a wood stove, and had a little bathroom stall attached to it somehow, and I just – I was pretty appalled at the situation. So, I called about that. And, they – they met as a team and decided that, you know, they were eating and they had a roof over their head and that, you know, even though they had to wear coats in the house, that it was okay.”

Another nurse shared, “You know, what – I know that, you know, it's clear that if we suspect that the parents, the parent is going to be influenced, the parenting – The parent's care is going to be, you know, influenced by the marijuana use, and we see that they're just really affected by it, then of course, we need to report right away.”

Another nurse explained, “Like when I was telling you about this earlier, like there might be these small signs that come up along the way that maybe I should have done more about and didn’t and then, all of a sudden, there’s this big situation that, you know, they were drinking alcohol and doing drugs in the home while caring for their child and they were not able to take care of her. So, and that was hearsay, but I still needed to report it and somebody did, so I ended up doing that.”

Although many nurses across many sites knew that blatant beating or visible injuries were reportable, most nurses had not encountered these situations with their clients. A couple of nurses from different sites had reported for bruising on a child (for example when a stepfather overstepped the boundaries of appropriate and safe disciplining). In another site, one nurse visited the emergency department with her client and baby; despite having no internal injuries, the nurse reported to CPS because the baby fell out of a 1.5 story window. Another nurse from a different site reported because her client told her that her partner tried to strangle the baby.

A nurse recalled, “I did have a family where I reported – of course, hindsight is 20/20. I wish I would have taken a picture of her bruise. She was a pregnant mom living with her mom and stepdad, and I felt like her stepdad was overstepping bounds of what is appropriate and safe, and I reported it... And I knew you can do that – take a picture, especially with your iPhone but I didn’t think of that... I reported the bruise, but it seemed like it took Social Services time to get in there to follow through and then, by that time, the bruise was gone and they – Of course, the family made light of the situation. Mom kind of – the pregnant mom I was working with started minimalizing it also, which is understandable since she was a teen, really understandable.”

Another nurse shared, “I had a baby that, an 18-month-old, that fell out of a one and a half story window. I went to the home and—for a visit—and, she said, ‘Oh, yeah. On Saturday night, you know, this thing happened. The baby fell out of a window.’ ... And, I said, ‘What does – Where.’ –You know, and I didn’t know at the time that she wasn’t there. She didn’t say that she wasn’t there. But, she said that the baby was fine. The little girl was fine, and they didn’t take her to the doctor. And, I said, ‘You have to take her to the doctor and make sure.’ I said, ‘That’s, you know, that’s – We have to do that.’ She didn’t have a ride, and at that time – Anyway, I transported her to—which we are not allowed to do anymore—but, I transported her to the clinic. The clinic wouldn’t see her. The doctor said, ‘If it’s more than one and half times the height of the baby, there may be internal injury.’ He said, ‘We can’t see, and so, she has to be seen at the ED.’ ... So, I took her to the ED in [city name removed]. And, the ED doctor there was very unfriendly who did an exam of the baby and said everything was okay, but she came out and really scolded the mother and me, too. And, she said that she filed a report. And so, I – I think I – I don’t remember if I had talked to my supervisor at the time, or if I just called and made a report. But, anyway, it was a weekend. It was Friday, I think, when I took her in. And then, so anyway, I made a report to the Department of Human Services, and they opened a case.”

There were other areas related to child abuse or neglect that some nurses from several sites had reported for, these included: substance use, mental health, and rough caretaking or disciplining. With regard to using substances (such as alcohol, bleach, and marijuana), some nurses were

physically present and witnessed the event or heard accounts from reliable sources; using substances was reported when the client could possibly or did harm the baby. Mental health concerns that warranted a report were usually homicidal ideation where the client wanted to strangle the baby. Rough caretaking or disciplining such as yelling, screaming, or spanking coupled with mental health diagnoses had also been reported to CPS. Additional reasons for reporting were shared by some nurses in a couple of sites, and related to assault and violence, including: statutory rape (where the age difference was obvious for reporting, due to the parents' birthdates on their babies' birth certificates), sexual abuse or inappropriate and violent behavior (sometimes from the client's father).

One nurse recalled a situation she reported on, "One was a client who had mental health issues, and her sister was primarily taking care of the baby. And, when I went to go visit, the sister reported to me that the client had just been in the bathroom like huffing bleach. And then, when she came out, she was very irrational, grabbed the baby physically from her and locked herself back in the bathroom. And then, when she realized I was coming to visit, came out, threw the baby to the—this is, of course, you know, the sister's version of the story—threw the baby back to her and left. So, I called to report that just because it seemed pretty credible, and I felt like that baby was potentially, could be harmed, so."

Another nurse explained, "I haven't a whole lot of where I've just been really suspicious of neglect. The times that I've had to report it was very obvious, like an age difference that was – They gave me the birthdates and it was obvious that the ages were such that I had to report. So, I haven't had any that were super gray. The two that I've had that were domestic violence type related were, definitely the women were wanting to talk to me a little bit about what's going on with the kiddos."

She also explained, "So, the first one was my very first client ever. And, because the baby hadn't been born yet, it wasn't technically a reportable event. But, I – He had taken – he had pushed her up against the bed at one point while she was pregnant. And, she's like, 'It didn't hurt or anything, but he pushed me up against the bed.' And then, he had taken her phone, and she had talked about how he goes through her phone. And, at one point, she said they got in an argument, and she was going to pick up the phone and call somebody, and he threw it against the wall. So, red flag to me there... She, at one point in time, like many months later, she left him, and we had a visit with her mom. But, I had reported during pregnancy just that there was some risk to the baby when the baby was born just to get a history started on the family themselves. So, I don't think I told her that I reported. That was more just, 'Let's just get a history going,' because I didn't think they were going to do anything because there was no baby in the house yet."

Reporting for IPV was described by some nurses in several sites. These nurses had reported even when the client was pregnant so as to set up a history of the family (despite knowing that CPS would likely not respond to the report since the child was not yet born) and/or when the child was present during an IPV incident. Indeed, several nurses from different sites indicated that they knew they had to report IPV if the child was present as a mandatory reporter. However, one nurse supervisor described not knowing if IPV was reportable unless you were present and witnessed the incident, highlighting a deficiency in knowledge about what was reportable in IPV

cases and when it was reportable. A few nurses from different sites also described reporting to law enforcement or the police became involved in an IPV case where the FOC was arrested and the child was subsequently removed from the home. In a couple of sites, several nurses explained that though the police became involved, the police did not report the incident to CPS and the nurse had to re-report the incident to CPS. Some nurses from a couple of sites had also reported not just their client's IPV situations but when they heard from their clients about instances of IPV among other people such as a relative. In most of these aforementioned reportable situations (for both neglect and abuse), there were usually multi-factorial concerns that led a nurse to report to CPS.

One nurse stated, "Um, we have domestic violence, definitely. And, actually, that situation we told you about, that's what was going on at the time when the child was put in danger, so yes. We have reported for domestic violence."

A nurse supervisor shared, "No. I don't think you have to report it— (*laughs*) I could be wrong. Unless you are there and you see it. But it is not a mandatory reporting thing that I know of."

Another nurse supervisor regarding a client recalled, "She, um, had bruises and such on her. I made a call, but somebody else had already made a call also. The cops had been called. They just told him to leave. And, that was it. At the time, the—I don't believe the cops had called CPS, but someone else besides myself did call CPS. They decided that, yes, they did need to go out. And, it was very nice because it happened to be a newer caseworker, and so he was learning the ropes of how to go talk to someone, how to interview someone, how to meet someone."

Another nurse said, "Okay. I have reported a couple of times. Or, actually maybe just once. I had a client that had told me about a really abusive situation that her sister was in where her—the—Her sister had three children, and they were being locked out of the house and lots of violence and lots of substance abuse. And, I felt like I needed to report, and so I did because my client was, didn't want to report. So, I did report that time. And then, I've been involved with clients that have had CPS involvement, but I didn't do the reporting."

Situations that were Not Reported

On the other hand, many nurses across multiple sites described situations that they determined to be not reportable. Such instances involved substance use, IPV, and the environment. For substance use, some nurses in several sites had not reported despite having known that the client used marijuana or having seen marijuana paraphernalia present in the home. One reason for not reporting was because the client was not breastfeeding. With regards to IPV, some nurses from different sites determined it was not reportable because the baby was not present, an apt safety plan was already in place, or the violence occurred while the client was pregnant. A few nurses from some sites also felt that if they were not present during the IPV incident, they did not need to report it, while one nurse from another site felt confused about when to report if she did not feel that someone was harmed in any way even though she knew of an IPV incident. For environmental concerns, several nurses from various sites chose not to report for situations including: lacking electricity, gas or propane, or lacking heat but clothing was adequate, as well

as gun safety; usually because they worked towards addressing these issues with their clients at the next visit.

One nurse explained, “So, there was a big gray area with her. And, we ended up not calling for her. I think she set up a good safety plan for herself, having him move out and making sure other people are around and knowing if he starts getting angry and things, that he needs to leave.”

One nurse shared, “Like, for instance, I had a family that had a baby. The baby was like, I don’t know, a year old. And, and was – and, she was my client. But, was in [city name removed] with pneumonia and stuff like that. So, when I went to go do her visit, well, they had shut off their water. They had shut off their electricity. They had no gas, no propane. So, that baby was in that cold house. And, yes, that’s neglect to me. But, it wasn’t – They weren’t having her without clothes, and it was a problem for the family. It wasn’t like – it was, you know... So, I had already seen them before and knew that there was nothing going on. So, that’s why I didn’t feel like I could call, you know, a caseworker and say, ‘You know, something’s going on here,’ or – I just took care of it that way. And, everything was fine. If I would’ve seen where, at some point, I saw neglect or abuse or I was really worried about that family for that reason, and then, all of a sudden, they had no heat and nothing like that. Yep, that would have been a problem for me. But, I already knew them, had already been with them for over a year. So, I kind of knew what they were like.”

In some other sites, current involvement with CPS, parenting style, adequacy of care, and cultural issues were considered not reportable by some nurses in several sites. For example, when a client – as a child – was already in the Child Welfare system (e.g. through foster care), rather than reporting to the CPS hotline, a nurse passed information and concerns to the caseworker already working with the client. The nurse then proceeded to work with the client on these concerns through education and working towards prevention. Parenting styles such as yelling, screaming, or spanking, but with no evidence of bruises were usually not reported to CPS by most NFP nurses in most sites. Some nurses across multiple sites described that if they observed the parent-child interaction to be positive (for example happy, playful, caring, loving, or praising) and there was prioritization of the child’s health by the client, they did not report to CPS. Inadequate care such as a child falling off the bed more than once over a period of time was not reported by one nurse because after triaging with the supervisor they determined not to report. Finally, cultural ceremonies or traditions, for example Buddhist families putting saffron on the child and shaving the baby’s head or utilizing cups for healing purposes that caused bruises, were assessed by another nurse from a different site and deemed non-reportable.

One nurse explained, “And, in that case, I did not make the referral, but the child was already – The mother was already in foster care with the child, and so, when there was a concern, and they wanted specific information kind of passed along, they would get a hold of me and go, you know, ‘We have some concerns about bonding. If you have any information about that, maybe you could, you know, pass that along.’ And so then, it gives me an idea of kind of what their concerns are. And, I – And, I could address it with the families... Leading – unless the child is in just imminent danger as of that moment we need to do something, if I am just seeing some red flags that I’m getting a little bit

concerned with, then I will actually start teaching to whatever concern that I have to help try to correct a concern before it needs to get to the reporting stage.”

Another nurse shared, “Well, I had one client that she – she would just yell a lot at her son. And, I know that she’s spanked him. But, I never saw any evidence, you know, any bruises on him. And then, I observed her interaction with him, and he was just happy and playful. And, she was loving to him and caressing and kissing and praising. So, you know, I really didn’t see that, you know, he was abused. It was just that this is her parenting style. She’s just, you know, tends to yell and spansks her son sometimes when he doesn’t listen. But, those are not reportable things, and – yeah.”

One nurse explained, “Or, for instance, I had one family that was Buddhist. And, it was really important for them to name their baby at one year of age. And, they put saffron on the baby and shaved the baby’s head. Some that – And, they – There was something – They were in a small apartment, and one of the neighbors called because they thought the baby was being abused or crying, but it was just part of their cultural ceremony process.”

Reporting Frequency

Within and across sites, there existed variation in whether or not a nurse had ever reported to CPS as an NFP nurse home visitor. In several sites, many nurses had not ever reported to CPS; these nurses had generally worked as an NFP nurse home visitor for several years and often had reported to CPS in previous positions (e.g. while working in the hospital or schools). At the same time, within the same sites, several nurses had reported multiple times to CPS both on their clients and on other people; ranging from once to upwards of ten times in their duration as an NFP nurse. Some nurses and the nurse supervisor from one site suggested that reporting to CPS had varied across the years, sometimes with three to four reports total from their site per year to about eight to ten reports per year. In addition, some nurses from some sites had only reported on other people – such as client’s family members or neighbors – when their client revealed information that warranted a report. In these situations, the nurse often encouraged their client to make the report herself, but usually resulted in making the report because the client was afraid to do so.

One nurse shared, “I’ve not made an actual report in this position. At my, a previous job, I’d done several reports... But, none in this county within this position.”

Another nurse expressed, “So, experiences that I personally had to report are not very many. I’ve had clients who have been involved with Child Protective Services. But, off the top of my head, I can think of only, I think, three clients in the last years where I actually made a call.”

A nurse supervisor explained, “And, we kind of hit this every once in a while. I would say – This last year, I think we saw an increase more in reporting than before. But, I would say probably ten – eight to ten reports a year are done by my team based on their observations or what they’ve been told.”

Another nurse stated, “So, I just talked to her. She actually said to me, ‘I’ve thought about reporting her, but I’m scared.’ And so, I talked to her about reporting and that she

can do it anonymously. But, she was horrified to make that call. And, I think she felt guilty. I think she felt guilty because it was a friend. And so, she started telling me more and that's when I said, 'Okay that's it I've gotta – I need to make the report because it was things like her baby.' – She was blowing marijuana smoke in the baby's face. She also had an older daughter that she witnessed her hitting her. Their house was filthy. There was a lack of food in the house. Just tons of issues. So, I told her, 'You know, I will report it. You don't have to worry about it, but it needs to be reported.'”

Reporting Process

With regards to the reporting process, most nurses across different sites expressed variation in their perceptions of the experience. In some sites, some nurses had positive experiences in reporting to CPS: they were asked comprehensive questions including strengths of the family and they felt that their concerns were heard. These nurses also shared that their report was usually taken by a live person (usually by phone after calling the hotline, or in person); a couple nurses and supervisors from various sites were surprised by this method and were appreciative of the opportunity to speak to a real person. In a couple of sites, some nurses had called only law enforcement (either due to the severity of the issue or because it was afterhours when the CPS hotline had already closed), or called law enforcement as well as CPS (because law enforcement did not relay the information to CPS).

One nurse recalled, “Um, let's see – I called – It was good. I think it was actually really good. And, I did just say, 'Hey, this is my first time calling, so if you could just kind of let me know what you need.' And, she was like, 'Oh, okay.' And, kind of made it a little easier for me because she knew I didn't know what to expect, so that was really nice. Just having easier communication that way... I got a person immediately... Oh – It was probably right around five, five-thirty. It was probably right after business hours. – I was surprised to have gotten a person so easily, so that was a pleasant surprise.”

A nurse supervisor expressed, “This – When I called recently, it was easy. And, she—the lady on the other line—was very – She was doing a lot of strength-based stuff and asking like positive kind of questions like, uh, 'What are your hopes for this family?' And, it really surprised me. And, I – You know, it almost choked me up because my hope was that that baby would have a chance. So, it was really a really great conversation with her, and she really made me feel at ease, even though the situation is not a good situation for that child. So, it was nice to have that human person on the other line and not just talking to something else.”

Another nurse shared, “So, when I called DHS, it was to determine, 'Do I report to you? Or, do I report to [county name removed] PD?' And, they said, 'Well, you can report to us, but you need to report to PD because they're the ones who will take action on it.' So, I did put a report in, and I did hear back like two days later that, 'Since you already called [county name removed] PD, we're not going to do anything with it, but we'll keep the information on file.'”

However, in some other sites, many nurses felt that the reporting process was somewhat disconcerting and had experienced negative encounters when reporting to CPS. These nurses had felt disrespected and undervalued when they had reported to CPS. From struggling to place a

report with a non-native English speaking screener to being questioned why she was even reporting, several nurses expressed that they had negative experiences while making a CPS report. Some of these nurses also shared that they felt the reporting process was too brief and with little follow through. In some sites, several nurses had called the hotline and were asked to leave a message. Although these nurses usually received a call back from CPS asking for more information, the nurses often perceived the interactions as negative due to the caseworkers' approach, such as being abrupt in the reporting process or resistant to documenting the report.

One nurse recalled, "It wasn't the best experience. So English was definitely not her first language and I was trying very hard to tell her about all of the strengths that this client had with her baby being the mom she has been fantastic, you know. Constantly continues to provide growth and development experiences through toys and books and a very appropriate mother across the board. I wanted that message to get conveyed and I don't know that it did. I gave the report."

Another nurse shared, "... So, I left my information and got a phone call back. And, the gal was very abrupt. Wanted more information than I had. So, I had the full name of the mom of this child. I had the names of the two children, and they were very unique names. I mean absolutely unique names. This gal was on housing, which she told me they couldn't look into anything with housing, which I get that, but the thing that really got to me was that this mom already was in the system with DSS because she took this six months baby out of the hospital without orders... So, they had her in their system. And, I told her this, but she indicated to me that really they couldn't do anything, that it really would be better for my client to be the one to call her, that they wanted to ask her questions. And, I told her she doesn't want to. And, I pretty much said I really don't know how you can't find this gal because I gave you her name, and there's gotta be some sort of way and being that she's in the system there has to be some way. She was very resistant to anything I said, and kind of gave me the impression that there's really not much we can do. That was my first interaction ever. That was the first report I've ever had to make, and it was pretty upsetting I'd have to say. I was pretty upset after I made the report because I was really worried about these kids."

Most nurses who had reported from several sites shared that they usually made the call to CPS privately, either in their vehicle after a visit or at their desk at their workplace. At the same time, a couple of nurses from different sites recalled needing time to prepare for a report, including gathering information and notes such as full names, addresses, and concerns. In one site, one nurse usually made her reports to CPS in person while in another site, a couple nurses expressed that in the past they had submitted paper reports to CPS by fax. In some sites, some nurses had reported to CPS with their supervisor present and during reflective supervision. Most reports to CPS were usually made within regular business hours.

One nurse stated, "No, because typically – I'm trying to think of when I've – Whenever I'm called, I'm in my car by myself. Like, I've left the situation..."

Another nurse recalling her reporting experience shared, "Actually, it was with [nurse supervisor name removed] in her office. And so, we made the phone call, and they just

asked basic information like, ‘What did you see?’ ... As far as making the report, it was okay. The process seemed to be very short and no follow through.”

A nurse supervisor recalled, “As, in the time that I was a nurse. In all the years I was a nurse, I’ve never worked with the Child Protection Team. Never reported. Since I’ve been supervisor, I’ve sat in twice, I think, the nurses called. And, as a support person.”

Transparency With the Client

Between and within sites, many nurses expressed variation in their transparency with clients when needing to make a mandatory report. In most sites, most nurses who had reported to CPS expressed that they had been transparent with their clients, depending on the situation. In some cases, if nurses felt that their safety was at risk, they did not tell their clients that they were reporting. These safety concerns included cases of IPV, other violence in the home, gang involvement, and severe mental health issues. Indeed, several nurses in several sites shared that in general, they aimed to be transparent with their clients; such that at enrollment, nurses explained their role as a mandatory reporter and emphasized that they would always share their concerns with the client prior to reporting. Several nurses from various sites shared that they had notified their client that they were about to make a report (or had made a report), reminding the client of the transparency they had promised during enrollment. In fact, a couple of nurses from different sites expressed that they had made reports to CPS with their clients present, and allowed their client to give her perspective on the report; or even encouraged the clients to make the report themselves. Having the client present while reporting was considered the ideal by these nurses, such that the client understood the goal was to protect the child and to support the family.

One nurse recalling a report where she was not transparent with the client stated, “It – I actually was told I couldn’t go into the home anymore by my supervisor. It was a very obvious drug house... The (*unintelligible*) apartments. So, I called in a report about concerns about the environment for my pregnant mom – at the apartment and the baby. And, I never heard from DSS. I called them and told them of my concern. So, I – I don’t think we ever get word back... We just make the call... You probably get a lot of answers. I With her, no, I did not. To be honest it was kind of a really frightening situation.”

Another nurse shared, “So, I guess now that’s another thing, too, that feeds my anxiety around it is if I see something that’s reportable, I do need to report this. I made the report. I talked to the client about it because it is open relationship and I wanted her to know that this was what I need to do in this situation. We talked about it in the beginning of the program. They signed a consent. I told them that if I know that – if I come in and I see a neglect situation or an abuse situation, it is mandatory to report her.”

Another nurse recalled, “So, I called her back and said, ‘[Client name removed], you just told me something that – You remember I said I had to report but when I report I know that there will be help there for you if you want it, and I want you to know that I’m really wanting to be there for you.’ I could just cry now, telling you about it - it was really hard. But it’s not like you can go into this with no feeling. I mean, recalling this, that was [redacted], so it’s long ago but it’s like it was yesterday. It’s so painful. So I

reported her ... [Client name removed] never talked to me again. She was furious with me. She always blamed me for having to put her in rehab. She did go to rehab ...and I'll leave that case just because there's nothing more to say about that except that, obviously, she didn't want to see me after that because, for her, it was betrayal. She was not taking responsibility for her own stuff. If she felt it was betrayal, it was not. It was looking out for her and her daughter."

Another nurse stated, "And, I – She wasn't sure if they had reported it to Department of Human Services. And so, I explained to her that if there was a domestic violence incident in front of the child, that that was reportable. And so, I asked her if she would mind if I did that there, or if she would like me to do it when I left. And, she said, 'There.' So, I called, and I would ask her questions while they were talking to me, and anyway, we made the report."

Other Areas Related to Reporting

In addition to determination of reporting, reporting frequency, and process, several other sites described other areas related to reporting. Some sites provided perspectives on why they felt that few mandatory reports to CPS were ever made by NFP nurses. One nurse supervisor perceived that women often dropped out of the program before it reached the point that a nurse would make a mandatory report, while a nurse from the same site suggested that sometimes those families who were at higher risk often did not enroll in the program, with the fear that nurses would report on them. Similarly, in another site, one nurse added that most of their clients were eager to learn and so had enrolled in NFP; those who chose not to enroll were likely afraid to become involved with a program where nurses – as mandatory reporters - visited the home. Finally, one nurse from a different site expressed her surprise that many nurses did not understand the severity of potential legal ramifications if they did not report.

A nurse supervisor shared, "Boy, I can't think of any but I am sure there are. And counties are different, but I can't think of any. We don't have a lot of calls into social service. I mean I think women drop out before things are if they're really difficult."

A nurse suggested, "So, and most of our clients – I hate to say this but – if they want to enroll with Nurse Family Partnership, they probably are eager to do the right thing. And, the ones that we – that elect not to enroll probably have reasons why they're afraid to be involved with something like this... So, I think that's why we probably don't do a lot of reporting too."

Another nurse stated, "That we can't – That we're mandated to protect you and to protect your baby. And, if we don't call, we're subject to penalties, too. A lot of – I'm surprised at how many people don't understand that we can be incarcerated or fined or both. So – Or, that our license is on the line."

Other Areas of Work

Across several sites, some nurses shared additional areas related to their scope of work. Several nurses from a couple of sites explained that they had attended staff meetings with their teams, one-on-one reflective supervision with their supervisor, CPT meetings, and meetings for the

Nurse Practice Council as part of their scope of work. In some sites, a few nurses expressed that they also sat on various community coalitions (e.g. Early Childhood Council) and task forces that addressed maternal child health issues.

One nurse in reference to Child Protection meetings stated, “That’s a regular occurrence, and I actually just came from one. So, they have to have a certain amount of people from different departments attending their team meetings to listen to the cases that have come in.”

Supervisory Resource

Across all sites, some nurses shared about having utilized their nurse supervisor as a resource for various situations within their scope of work. In most sites, many nurses explained that they had referred to their nurse supervisor for guidance and consultation on gray areas and potentially reportable situations to CPS. These gray areas were related to IPV, substance use (primarily marijuana), and other safety concerns like car seat safety and environmental health. Referring to the nurse supervisor for guidance had occurred in weekly reflective supervisions, on immediate phone calls after a visit, or in team meetings. Some nurses from several sites also explained that they had processed client cases with their supervisors to reflect on past experiences with the client as well as to receive guidance and advice on how to approach concerns in a future visit. A nurse supervisor from one site elaborated that she had assisted nurses in approaching risks with, delivering the education to, and engaging clients with developmental delays or teen clients. In several sites, some nurses explained that they had made a report to CPS on a client with their nurse supervisor present; these situations occurred during reflective supervisions when the nurse brought up concerns of suspected child abuse and neglect. Finally, in one site, a nurse supervisor and a nurse shared about overcoming conflict when they had disagreed on a gray area for reporting as it related to possible failure to thrive and discussed about approaches to handling such cases in the future.

One nurse shared, “But, I know I just - I mean, I talk with [nurse supervisor name removed] about pretty much any concern or question I have, and she gives the guidance and even sometimes she’ll mull things over and then call me back and give me advice one way or the other. And, that’s kind of how it went on [redacted] with this girl. In the morning, when we talked, she was kind of like, ‘Yeah, well, you know, talk to her the next time you see her,’ and then she thought about it more during the day and called me that afternoon and said, ‘Yeah, maybe we should call just- Just to be safe, to protect that baby,’ so. She’s my go-to.”

Another nurse stated, “Oh, I have great support. The greatest support is my team and our supervisors have been amazing. I don’t think there is anything more.”

Another nurse recalled, “I know- I remember it was when I was with my supervisor. I was with [nurse supervisor name removed] because we were in supervision. And, I was like, ‘Okay, so this is what’s going on. What do I do about it?’ And so, we called together. I know we had it on speakerphone. I believe it was - We called the hotline, and I think we got patched through to a live person. And then, we made the report-.”

Another nurse shared, “So anyway we had a conversation and [nurse supervisor name removed] told me I had to call DHS on her, and I said, ‘Can it wait until, I’m supposed to see her in [redacted] days, can I wait until then to monitor the baby?’ ‘No, she requested a different nurse.’ ‘Okay, that’s fine, you know. I’m happy that she chose to stay in the program but can I wait to call until I see the doctor’s note?’ ‘No, I saw the doctor’s note, you need to call now.’”

Scope of Work of Nurse Supervisors

Most NFP nurse supervisors across all sites shared their perspectives on their roles and responsibilities. Almost all nurse supervisors expressed their roles in training and orienting new nurses to their sites as well as in aiding nurses in building their caseloads. All nurse supervisors in all sites believed their main role was to support and guide nurses in their practice and implementation of the NFP program through reflective supervision, problem solving together, and ongoing education. In addition, several nurse supervisors across several sites spoke about their roles in facilitating CAB meetings as well as outreach in the community. Other areas of responsibilities shared by nurse supervisors included: administrative duties, addressing nurse safety, understanding nurse workload and their challenges, and resolving conflicts between nurse and client or between organizations.

Orienting New Staff

Across multiple sites, several nurse supervisors described one of their roles as to train and orient new nurses to their sites. These nurse supervisors described orientations, where they introduced the new nurse to their sites’ policies and procedures, as well as available resources in the community. In a couple of sites, several nurse supervisors suggested this role as a priority for them as they had several new nurses in the onboarding process due to site expansions. Some nurse supervisors from several sites also spoke about assisting their nurses in building their caseloads. In one site, this was seen as a challenge as there were several new nurses in the site who needed more referrals than they were receiving to build their caseloads.

One nurse supervisor stated, “But, I know how I orient new nurses, and I talk to them about resources available in the community and what to expect from those various resources.”

Another supervisor shared, “So as they’re gearing up, then I’m needing to make sure that they have an adequate number of referrals and then the position that I have. So, we’re going to need lots of referrals, you know, to keep them- yeah to keep them occupied and get them up to full caseload.”

Ongoing Education

Several nurse supervisors in multiple sites expressed their role in providing ongoing education for their nurse team. In one site, the nurse supervisor utilized her knowledge and experience in youth mental health to educate her nurses on addressing mental health risks with their clients as well as adolescent behaviors and stages of development. Other nurse supervisors from other

sites shared that they had connected with other nurse practitioners or trainers to deliver ongoing education for their nurses.

One nurse supervisor stated, “And so, I do a lot of teaching about teenagers because 65% of our - well, two-thirds of our clientele are teens. You know, they’re 15 to 19 years old. And, emotionally, a lot of them are younger. And so, I do a lot of teaching about teenagers and adolescent behavior and adolescent stages of development that our clients are going through while they’re to herd/shepherd their little ones through their developmental stages.”

Another supervisor shared, “Although my nurses, one of my new nurses, we went over to [community organization name removed], so we’re in the process of training a lot of new nurses on many things. So over time, we’ll all go see the [community organization name removed], meet with the nurse practitioner over there, talk to her about the types of things they do and what they see. And then review the policy with the staff.”

Support and Guidance

Across all sites, all nurse supervisors emphasized the importance of their role in encouraging, supporting, and guiding nurses towards program implementation according to program model elements with fidelity. Many nurse supervisors across most sites felt that especially through weekly one-on-one reflective supervisions, they were able to guide nurses towards effectively managing their caseloads through: problem solving with their nurses to accurately assess a client’s strengths and risks, determining if a report to CPS was warranted, and brainstorming next steps, such as deciding how to approach certain risks based on the status of the client. One nurse supervisor from one site specifically highlighted the importance of consistent reflective supervision as a key program model element based on research evidence. Another nurse supervisor from another site shared how she used reflective supervision, motivational interviewing skills, and a nonjudgmental attitude to help guide her nurses towards making a mandatory report to CPS.

One nurse supervisor shared, “What do I do besides a lot of emails and going to meetings? Providing a support system, I think, really, is, is needed and necessary. And a big part. I take it as a big part of my job for my nurses. Because they are out there in the field and working these hard - that hard world. And, they are dealing with chaos after chaos and crisis after crisis. You know. And I want them to be able to come here and have a safe sounding board to be able to debrief if you will.”

Another supervisor expressed, “In the Nurse Family Partnership, the role of supervisor is well-researched and evidence-based that says that, if you provide support to the nurses weekly, weekly sessions where you visit with the nurse - what’s it called? Supervisory something. Anyway, then you support the nurses and, if you support the nurses, then they can support the clients. So, we work we a team. We work on taking care of ourselves. We work on supporting each other and being very collaborative as a team.”

Another supervisor stated, “So, I just kind of problem solve with them and process it out with them as to what’s getting in their way of feeling okay about doing this? And, what

would help them feel better? You know, and my last resort is always to pull out the, ‘You’re the advocate for the child in this home. The child cannot speak, and so you have to advocate because this is a helpless child that is not going to get any support unless you bring it.’”

In addition to reflective supervision, many nurse supervisors from several sites suggested team meetings and case conferencing as helpful tools they used to assist their nurses in their practice. One nurse supervisor from one site expressed that she would select specific nurses to present on a difficult case during case conferencing, after she had already discussed the case with the nurse during individual reflective supervision; the purpose of case conferencing was for nurses to learn from each other’s experiences. Some nurse supervisors from several sites also stated that their nurses had often called them after making a visit where they encountered gray areas around mandatory reporting and were uncertain whether or not a report was necessary (e.g. cleanliness of the home or words stated by the client that were inappropriate or concerning). Overall, the underlying foundation of trust with their nurses was often mentioned as an important facilitator for accomplishing their scope of work for several nurse supervisors in multiple sites.

One nurse supervisor shared, “Well, since I meet with them once a week, they all know they have that opportunity if they want the privacy. So, there’s a lot of discussion that goes on in supervision. But, this is a very tight team that has a very high trust level with each other and are very, very supportive, so sometimes, they’ll bring it up in team meeting, too. And, you know, this kind of discussion gets going of, ‘Oh, that sounds like something you have to report. That’s so hard to do. I know I had to do it before, and’ - you know, I mean, they - it gets normalized for them in that setting. And so, I think that’s helpful to do both.”

Another supervisor expressed, “And sometimes, when we have had a case where I’ve work with a nurse, I’ll ask them to present it as a case conference, so that everybody can learn from what they’ve had to go through with it. And, there’s no - there’s really no judgment on this team of each other, which is really great. You know, and they just - they most likely will have talked to the other nurses as much as they could before they even bring it to me. So, they’re all aware of it. I mean, I find that out all the time where you know, they’ll bring it up in team meeting, ‘Oh, that’s the one you were talking about the other day, isn’t it?’ You know, but that’s how strong this team is.”

Another supervisor stated, “They would call and talk with me, we will review it or you know if I’m not here, maybe [nurse name removed] who is my senior nurse. I encourage them to call and ask, whenever they don’t know to call the hotline.”

CABs and Community Outreach

Across several sites, some nurse supervisors expressed that they had coordinated CAB meetings for their site. Some nurse supervisors from other sites currently sit or had previously sat on community coalitions or other committees where the emphasis was early childhood development and/or interventions. A couple of nurse supervisors from different sites also shared that they had also attended meetings with CPS supervisors and leadership, as well as participated in RED teams and shadowed caseworkers on their visits. In addition to attending meetings, some nurse

supervisors from some sites considered community outreach as an important part of their work to network with other community resources and work collaboratively together for families. Indeed, one nurse supervisor explained that it was important to lead the team towards improving interactions and collaboration with CPS, including coordinating meetings between nurses and CPS caseworkers to facilitate better collaboration in reporting and in working with mutual clients.

One nurse supervisor expressed, “Well, we have an Early Childhood Council here. She sits on that as I do. I’m the chairperson on one of the [community committee name removed], so I’m on that. And then, we have a [local initiative name removed] here - I’m trying to think.”

Another nurse supervisor shared, “Well now that I have gone through RED team stuff. In talking to them, I can add that to the table and helping them.”

Another nurse supervisor stated, “And, outreach, a big part of my position. I would say community outreach with other resources, whether it is physician’s offices to other home visiting groups, some other mom support groups, and other programs that we could work collaboratively with. Our Presumptive Eligibility site. I have done a lot of work with them in getting us on the same page and DHS is our new network tackling if you will.”

Another nurse supervisor stated, “I think a good collaboration not only has to include management, but it has to include the staff because, if you’re a staff member and you’re needing information, you have to channel then through your supervisor, through the other supervisor, and it just seems like it’s a process. So, it might be nice—and, we are working on that as management... So, we’re working on that. We’re trying to improve. We know that it’s an issue, and we’re trying to take steps to help.”

Understanding Nurse Workload and Burden

To better support nurses in their work, multiple nurse supervisors from several sites recognized the importance in understanding the realities and challenges that their nurses faced. Some nurse supervisors were previously nurse home visitors and were able to utilize their experiences to better relate with their nurses. Many nurse supervisors from several sites were knowledgeable about the tension nurses encountered when deciding whether or not to make a mandatory report, the successes achievable when nurses collaborated with prevention programs and community resources, and nurses’ negative perceptions of CPS. These nurse supervisors helped to facilitate attitudinal changes through exposing nurses to CPS programs, initiatives, and processes by organizing ongoing presentations and meetings with CPS workers. Multiple nurse supervisors from several sites understood the challenges of nurse home visiting and spoke about the issue of nurse safety as a great concern. Indeed, one nurse supervisor suggested that her nurses should follow their instinct in determining whether or not they should revisit a home.

One nurse supervisor shared, “And, you know, it’s really - it really has been a very nice collaboration when we’ve used it. Fortunately, we don’t have to use it frequently, but we know they’re there when we do need them. And, it has been such a weight off of the

shoulders of the nurses to know that somebody can come in and pick up some of those pieces where they can focus on the program more.”

The same supervisor stated, “But, I think the whole stigma is the hardest thing, even in the nurses’ minds. And there’s... there really is this whole shift in attitude with my team about reporting because, you know, if their intention is to get them to the prevention unit, they can tell them that. Where, if they don’t have a prevention unit, you can’t tell them, ‘Well, no. This is to keep you out of the system.’ You know? And so, that’s a really hard one because the- when you look at it from the outside, the focus feels like it’s different, even though it may not be. So.”

Another supervisor expressed, “And really, I think my awareness right now is going to safety with home visitors, so we have, you know, talked about follow your instincts. If you don’t feel comfortable, don’t go back into that home. I will not - So, I mean, right now, I know that I would encourage any staff member to kind of go with that if they feel that safety concern.”

Joint Visits

In addition to working with nurses through reflective supervision, case conferencing, and team meetings, several nurse supervisors from different sites shared that they had conducted joint visits with their nurses. Most of the time, these nurse supervisors utilized their joint visits to better assess a client’s risks or to provide a level of support and comfort for nurses who were worried for their safety, were unsure about whether or not they accurately assessed the situation, or desired to receive greater feedback from their supervisor.

One nurse supervisor shared, “So, I kind of went off-topic with that, but I will go whenever they ask me. If I’m hearing something that I think they’re not sure what they’re seeing, or they’re struggling with, I will suggest that I go with them. And, most of the time, they’re relieved when I say that because they’re struggling, you know, and you know, I’m pretty comfortable with asking questions of people as a - working in psych, you learn that, you know, you don’t get information unless you ask for it.”

Caseload

In several sites, some nurse supervisors held their own caseload, in addition to managing their nurses. In some of these sites, the nurse supervisor was recently promoted from a nurse home visitor position and was working on graduating her clients or transitioning them to other nurses. In one site, the nurse supervisor had always held a caseload. She felt that having her own caseload helped her to better relate to her nurses and thus, was able to provide better guidance and support.

One nurse supervisor stated, “Even when I was the supervisor for those [redacted] years. I always had a caseload [redacted] and, to be perfectly honest, I like it that way. I wouldn’t want to just supervise. I like having the clients. I think that you relate better to your nurse home visitor if you’re doing the job that you’re asking them to do.”

Another nurse supervisor stated, “I was a full-time nurse home visitor until I became the supervisor. I carried a caseload [redacted], I no longer have any clients that I see as supervisor.”

Other Areas of Work

Other areas of work were described by some nurse supervisors in several sites. A couple of nurse supervisors from two sites expressed their responsibilities in completing administrative duties, such as managing budgets, submitting progress reports, and reviewing ETO reports. One nurse supervisor also explained that she had managed nurse retention and turnover for her site, while another nurse supervisor from a different site shared that she had needed to refer to her department director for guidance on some client cases. Another nurse supervisor from yet another site also recalled that at nurse supervisory meetings, some supervisors had brought up reportable gray areas for discussion; showing that some nurse supervisors used other supervisors from other sites as a resource. In several sites, there were two nurse supervisors who managed the site. These nurse supervisors divvied their managing duties based on percent time (less percent time meant less nurses under their supervision). Usually the nurse supervisor who worked less than 1.0 FTE also managed another home visitation program offered at their implementing agency.

One nurse supervisor stated, “So then I do more the administrative part of it, with you know managing the budget, submitting reports, kind of thing. And reviewing, well both the nurse supervisor and I review our ETO reports, so.”

Another nurse supervisor shared, “So the way it works out is that I supervise [redacted] and the nurse supervisor has [redacted] nurses she supervises.”

Another nurse supervisor regarding nurse retention explained, “Like falling in love. Falling in love, and then having babies, you know, that kinda stuff. So, and I take that as a positive, cause we’ve identified what do we have control over, and the things that we’ve made changes to keep nurses, they’re not leaving for that reason...Until another nurse comes on, and then usually the way it, because we try to make sure that the other nurses, their workload isn’t too much. We don’t wanna lose them either. Because, like, I’ve seen that snowball effect where they’re like, ‘You know, I can’t keep up with this.’”

Another nurse supervisor shared, “No, this has come up at a supervisory meeting. People ask that question, ‘When is it, when is it reportable? Just because last night I say he hit me there’s no bruises, what do I do?’”

Challenges to Scope of Work

In one site, a nurse supervisor noted challenges she faced when working with her nurses to determine whether or not a CPS report was warranted. The nurse supervisor felt that her nurses should have presented the case to her sooner, so as to better address the risks in the client’s life and to provide the appropriate care needed for the client. The nurse supervisor resolved the conflict by speaking with the nurse where she reinforced the importance of bringing a high-risk case to her attention in a timely manner.

The nurse supervisor stated, “So I, you know, took a look at that and really it’s unfortunate that the nurse didn’t bring it to my attention, because, you know, we could have been doing case, case coordination. Yeah, so, and I’ve talked with the nurse about the importance of making sure that I know, so before it gets to this point.”

Nurse Home Visitor Perspective of the Supervisory Role

Areas related to the roles and responsibilities of the nurse supervisor were shared by some nurses in various sites. In general, many nurses from most sites explained that the nurse supervisor played an important role of providing support and guidance. In a couple of sites, several nurses explained that they had their nurse supervisor attend a joint visit with the client due to various concerns, including child safety and nurse safety; a nurse supervisor from one site reinforced this role. A couple of nurses from different sites also mentioned that their supervisor had or had not allowed them to visit certain clients with severe risks (such as living in a drug house), showing that nurse supervisors had the authority to determine whether or not a client could continue participation in NFP. Several nurses from a few sites explained that clients sometimes had direct interactions with their nurse supervisor, particularly in instances where the client had been unhappy with her nurse due to a report to CPS and/or the client had wanted to drop out of the program. Another nurse from a different site explained that she knew her nurse supervisor had been pressured by the state to ensure that nurses maintained their caseload.

One nurse supervisor explained, “And, you know, they always get the client’s permission before I come. And, they just will say, ‘My supervisor has to do supervisory visits, and she’d like to come out. Do you mind?’ Most of the time, they don’t.”

Another nurse stated, “It- I actually was told I couldn’t go into the home anymore by my supervisor. It was a very obvious drug house.”

Another nurse regarding client interactions with the nurse supervisor shared, “Talked to [nurse supervisor name removed], didn’t talk to me. That was what I had kind of gathered from what [nurse supervisor name removed] was telling that she had called and said that she no longer wanted to participate in the program and requested that nobody call her or nobody stop at her house anymore.”

Another nurse regarding client retention stated, “So, if there’s any angst for me, it’s that I have really good clients and they’ll move, or I have really good clients and something along the way shifts. And I must say, that after 10 years, I feel like instead of taking it so personally, I know it’s a lot of what’s going on with them. Not that my supervisor feels this, but she’s getting pressure from the state to make sure we keep our numbers up because it’s ... I know we’re a business. You know, it’s non-profit, but we’re a business and we have to be able to do the programming, get the numbers and show that we’re doing the work.”

Other supervisory-related interactions related to working with other partners were also shared by several nurses in different sites. In several sites, some nurses expressed that their nurse supervisor had participated in training and orientation, including coordinating speakers to present

at team meetings (e.g. a CPS representative), providing trainings to CPS on the NFP program, and bringing in various assessment tools for nurses to use. In some other sites, some nurses also mentioned that their nurse supervisor had participated in ongoing outreach with community partners; for example, some nurses in one site shared that their nurse supervisors were working with CPS supervisors to facilitate more interactions between NFP nurse and CPS caseworkers. In a couple of sites, some nurses suggested that their nurse supervisor needed to initiate collaboration with CPS at the supervisory level, and in one site in particular, a nurse explained that her supervisor and team had negative perceptions of CPS.

One nurse shared, “[Child Welfare trainer name removed], she came to one of our team meetings, probably a year and a half to two years ago. And, I think she’s a trainer. She’s the one who also did our mandatory reporter training down at [organization name removed] that we had talked about. And so, I think [nurse supervisor name removed] must have gotten in touch with her somehow and invited her down to a team meeting. So, we met her in a team meeting.”

Another nurse regarding interactions with CPS stated, “I think, though, that because of this, because we recently met and because my bosses are working so much with the bosses over there, that the ice feels like it’s breaking more.”

Another nurse shared, “Okay. [Nurse supervisor name removed] doesn’t hear this does she? Well, I think a couple of things. To be real honest, I know stereotypes for me about DSS. I see that. I see that in our office. And, I’ll be the first to say it. So, I think more awareness of our program over there would go a long way. And, collaboration with them, like, maybe get together so we learn what they do and they learn what we do. And, I know that’s going to happen.”

Scope of Work of CPS Workers

All CPS workers in various positions across all sites described their roles and responsibilities. Although most sites varied in their organizational structure, they usually had either generalist caseworkers who participated in all aspects of the Child Welfare process or unit caseworkers who played a specific role or specialized in working with a specific population, e.g. assessment or intake, permanency or ongoing, community liaison or trainer, and family advocates.

Role of Intake/Assessment Workers

Across several sites, most intake or assessment workers described that they became involved with a client upon being assigned a referral or report from their screener. Several intake caseworkers from several sites felt that they were the frontline responders to a report made to CPS deemed “screened-in”, where investigatory action was to be taken regarding the report. All intake caseworkers from all sites shared that they investigated reports of child abuse or neglect by using assessment skills to determine if a report was unfounded, inconclusive, or founded. Intake caseworkers were assigned a report to investigate with a certain response time that was determined based on the severity of the alleged incident. The three designated response times of 24 hours (usually a concern for imminent danger), five working days, or three calendar days was

the same for all sites. These caseworkers also assessed the level of risk as well as safety in the home, sometimes using assessment tools provided through TRAILS.

One intake worker shared, “So, we sort of go out on different responses, whether, depending on the need. It may be five day, which is five working days. It may be a three day, which is three calendar days, or it could be an immediate where you need to get out then and there, like that day, because there is significant concern that a child may be in imminent danger. So we do that.”

Another intake worker stated, “And then, if it’s screened in and we’ve given it a response time, I am given that information from whoever made that screening decision, and I then am - it’s my job at that point to construct an investigation.”

Several intake workers across multiple sites believed that their work was more fast-paced as compared to ongoing workers. In fact, many intake caseworkers from all sites described that they were usually allowed to investigate their referrals for 30 to 45 days, sometimes up to 60 days. During this period, intake caseworkers had conducted interviews with the alleged victim, alleged perpetrator, family members, and other collaterals such as NFP nurse home visitors or other service providers familiar with the family. Interviews had usually taken place in the home, or in schools or hospitals. In one site, an intake worker shared that the best practice was to first learn the child’s perspective of the allegation before the parents knew about it, so as to gather the truth before possible coercion or manipulation from the parents.

An intake worker in reference to beginning an investigation stated, “So, the typical pattern of that is to initiate it by making a face-to-face contact with the child. And, I have to sometimes find the means to do that. And so, you know, it’s school, childcare. If those settings don’t exist, sometimes, it’s in the home, you know, those kind of things.”

The same worker goes on to describe her process, “So, the first portion of the investigation is definitely making contact with that alleged victim, the child. And then, we start interviewing other siblings, parents, collaterals, you know, that type of thing, trying to gather as much information about the family – good, bad, indifferent – as we can. You know, we’re looking, we’re seeking to find strengths as we are to find their weaknesses or the wrongs that they’ve committed, so.”

Another caseworker shared, “I would say, in the majority of cases, yes, it would... it can hinder an investigation when the family, regardless of which member of the family or what role they’re playing, knows. And, typically, it’s because of information sharing, fleeing, changing stories, defensiveness- there is something to be said for the element of surprise when you’re doing an investigation, that people don’t have time to concoct a defense or a rationale or an alternative – in my opinion, I’m getting fresher, less critiqued information. I’m getting more off-the-cuff. I’m getting more honest responses.”

In addition to initial interviews with the family, many intake workers from several sites shared that they conducted follow-up home visits, phone calls, and/or developmental screenings to fully assess a family’s situation. Other areas necessary for a complete assessment were also described by some intake workers across several sites, including: history of substance use, criminal history,

previous involvement with CPS, other historical factors, environment (e.g. cleanliness of the home), and mental health. Interestingly, one intake worker from one site suggested that he assessed the family in the likes of a triage scenario.

One intake caseworker stated, “But, a lot of times, we want to know affect and demeanor and anything historically that they have – that information is really important to us doing an investigation because things of that nature play into child safety. Things like a history of drinking and DUIs, which we can find criminally, but you know, a history of - there’s a specific section in our investigations that sort of asks about those historical factors- And, what we know about them. So, gathering them is important to be able to come up with an accurate assessment of the current situation.”

Another intake caseworker shared, “We assess for drugs and alcohol and we really ensure that there’s, like, no severe discipline going on. On top of that, we may ask questions concerning mental health or depending on what the allegations are such as food, clothing, shelter around that area, which really gives us a holistic view of the child. Not all counties do that.”

Another intake caseworker stated, “Right, right. And, we all want to see families succeed, and we want to see kids be healthy and strong and stable. And, we know kids that receive routine medical examination thrive more than kids that don’t, so - I almost look at it as a triage scenario, you know?”

Upon completion of the investigation, based on the finding and assessment of risks and safety, intake caseworkers generally participated in similar activities across all sites. These workers had closed the assessment and referred the family to participate in voluntary community programs, worked with the family to agree to a voluntary case, or opened a case through filing for dependency and neglect (D&N) with the court, and then transferred the open cases to ongoing caseworkers. (D&N cases were opened when CPS was concerned about the welfare of the child and either removed the child from the home, or wanted to be able to supervise the child in the home through an ongoing case).

One intake worker shared, “We’re trying to give them resources. We may be sending them to our [local community organization name removed], which I can tell you a little more about what that is, or just giving them referrals to some of these places, you know, some of these other community programs that we have.”

Another worker stated, “And if there are or there’s questions whether or not there’s a lot of safety concerns, you can make referrals within the community, open up the case, you know, file a dependency and neglect petition in the courts-and order the parents to participate in a treatment plan or sometimes, you know, there is not truth to the allegations and then you can close your case with whatever the findings are, you know.”

Another caseworker expressed, “Typically we try to get, right after that second court hearing, we try to transfer the case. ’Cause really we’re only supposed to be investigation and then we’re supposed to transfer it on so that they can start treatment.”

Supervisors' Perception of the Intake Role

Across multiple sites, several supervisors shared their perspectives of the role of the intake caseworker. These supervisors suggested that the intake caseworker's role was to investigate reports of suspected or known maltreatment. By assessing for risks and safety, their intake caseworkers determined what course of action or intervention was needed based on the assessment. Indeed, one supervisor identified her intake caseworkers as the first line of involvement with families before passing them on to ongoing caseworkers. A couple of supervisors from different sites also emphasized that their intake caseworkers were mandated by law to complete an assessment within 60 days, with the preference to be completed within 30 days. These supervisors stated that the time needed to complete an assessment depended on several factors: severity of the allegation, receptivity of the family, and whether or not safety was a concern at the time of assessment. To initiate an investigation, one supervisor described their intake caseworkers as first having to conduct an interview with the child – the alleged victim – preferably in the school or hospital setting where the child was outside the realm of the alleged perpetrator. In addition to conducting an investigation, a couple of supervisors from different sites expressed that intake caseworkers completed additional tasks: they carried forward with filing court actions, was involved with the removal of children, set up services or made referrals to resources that would be beneficial for a family, and participated in court actions or case actions.

One supervisor stated, “So you have those 60 days. Now, usually, you don't need those 60 days. You can usually go in there and in the first week or two go, ‘Wow. We've got problems.’ Or, walk in there and just go, ‘Whoa, I just- I don't even know why I got this call, but I see no issues here.’”

Another supervisor shared, “It depends on where, they try to, the way we're doing it right now and there's changes to it but because of Differential Response. But right now they go to, if the child's in school or if the child's in the hospital, they try to, they have to see the child outside the alleged perpetrator. So usually try to avoid the home at first. They will end up going to the home eventually, but they try to see the child outside of that because you don't want to mess up the investigation or anything like that.”

Another supervisor stated, “And then, we would carry forward with filing court actions, if needed, removal of children, setting up services or making referrals to resources that would be beneficial for families or that could prevent interventions from us through, you know, court actions or case actions.”

Role of Ongoing Workers

In sites with intake workers, there usually existed ongoing or permanency workers who were involved with families after an assessment was completed and the family had an open formal case. An open case meant that the family was assigned to an ongoing caseworker, usually because safety issues arose where it was determined to be unsafe for a child. Several ongoing caseworkers from multiple sites stated that they often worked with their families for a longer duration than did intake workers, usually several months up to multiple years; and so, a longer term relationship was usually established between ongoing caseworkers and their families.

One intake caseworker recalled his relationships with his families when he was an ongoing worker, “But you see the same kid for five years, you become a pseudo-parental figure almost. And, you know the kid’s needs and so, to be able to know a group of therapists as well, to me, was helpful because, ‘This individual, he works real strong with males, and he doesn’t- he’s not super verbal and he’s not gonna sit- you know? Or, he’s got very good de-escalation skills, or she’s very nurturing, and that’s what he needs.’ And you know? So, it’s - you’re able to kind of match stuff up.”

Some ongoing workers from some sites described an initial part of their work as to conduct social histories with their families: gathering in-depth information on the family’s life. This facilitated the next steps for ongoing caseworkers, to implement, manage, and monitor services that were deemed necessary by the court, e.g. counseling, treatment for substance use, parenting classes, etc. The case and placement planning efforts along with service provision were described by many ongoing workers as their main responsibilities. Almost all ongoing caseworkers in most sites described their work as continued assessment of risks in the home and evaluation of the family’s progress towards achieving treatment goals; this was usually accomplished by making monthly visits in the home or at family resource/visitation centers. Ultimately, many ongoing caseworkers in several sites felt that their role was to maintain a child’s safety and to advocate for the child (e.g. through mitigating conflicts between parents and/or providers). In addition, some caseworkers from several sites discussed travel as an integral part of their work, from making monthly home visits, to accompanying their families to appointments, and even traveling to different states or countries for placement. Finally, several ongoing caseworkers from several sites shared their process for closing cases. Some ongoing caseworkers expressed that they worked collaboratively with service providers and the family to design a discharge plan or permanency placement, whether for foster care, residential treatment, adoption, or ideally reunification; other times, ongoing caseworkers had worked on allocation of parental responsibilities and/or provided resources for the family to allow for reunification of the child with the parents.

One intake caseworker who had previously worked as an ongoing worker described the process for cases, “It means that they’re assigned caseworker. And, they go through a very intensive information/fact finding, interviews with the family to get what’s called a social history. And, it is an excruciatingly in-depth look into that family’s life. Information gathering for, you know, finding out all those peripheral things that I try to touch on in the investigation, they go really balls to the wall and get this information... and then, we implement services that are necessary: counseling, treatment for substances, you know, that kind of thing.”

An ongoing caseworker shared, “I’m going to be watching their interaction. I’m going to be looking for any safety issues. I’m only required, as a caseworker, to see the client once a month.”

Another ongoing caseworker stated, “My role is to mitigate some... you know, mitigate conflicts with either parents or providers, group homes, to go check in with the kids. To recommend services, to recommend therapy, to fight for the kid for therapy. To fight with the kid against the therapist. You know, to change the modality. To fight with a parent behind what the kid’s needing and missing. Or, to fight with the kid behind what are the

parents' expectations. It's to keep a kid- and, my job is to help keep them safe. To, if they are in the home, how do I maintain them in the home safely?"

Supervisory Perspectives of the Ongoing Caseworker Role

Across multiple sites, several supervisors shared their perspectives of the ongoing caseworker role. Most supervisors in these sites suggested that ongoing casework involved ongoing assessment and case management. Ongoing assessment was accomplished through using various tools and included discussions on where the risk laid, and exploration of services to engage in to mitigate risks while strengthening protective factors. Case management included multiple tasks such as assisting families in accessing and truly utilizing services by making referrals to and follow up with service providers, establishing participation in treatment, hosting meetings with clients and other service providers to discuss progress on achieving treatment objectives, and safety planning (usually for families with founded cases), all the while maintaining paper record of their work for the purpose of court. Ultimately, most supervisors from several sites felt that ongoing caseworkers needed to develop effective ways to assist their families in achieving self-sufficiency and/or dependence on community resources, rather than a dependence on CPS.

One supervisor stated, "And then, you know, sometimes- sometimes we need and/or want a little follow-up. We just want to know that they got there and they got what they, what they were there for, for the purposes of the court, or just for the purposes of good recordkeeping, so we can know that, you know, they got what they needed."

Another supervisor expressed, "No, no, they're the case carrying case managers so they are the ones working and managing our cases - well, they're their cases so they are the ones working with the families, not directly, like they're not the therapists, but they are the case manager so they are the ones that are overseeing our cases that we have in the department."

Another supervisor shared, "But, if they're - if it's something that one of our families needs and the worker is clear about it, they'll just fill out the paperwork, or they'll help the family fill out the paperwork because the other piece of Child Welfare is that we really want to teach families to be dependent in their community. They can be interdependent on their community. They do not need to be dependent on a government entity, such as Child Welfare."

Another supervisor stated, "And, we oftentimes hold in person meetings with clients and other professionals as we're working a case to talk about how things are going and kind of assess on an ongoing basis, like, where that risk level is and what services are sort of being provided to sort of mitigate the risk and so there would be both."

Role of Generalists

In several sites, local human service departments hired generalists for their child protection work. In these sites, generalists described that they were responsible for screening, intake, ongoing, foster and/or adoption, adult protective services, and other financial or administrative duties; in general, generalists completed all tasks pertaining to the CPS process. Usually, generalists rotated in their responsibility for screening calls; such that a different worker was

responsible for the hotline each week. Most generalists from various sites explained that they worked in smaller, rural counties where they held multiple roles in their work. In several sites, a couple of supervisors and directors reinforced that their generalist caseworkers held multiple roles, such as child protection, adult protection, family engagement facilitation, foster care and adoption coordination; in fact, one supervisor felt that her workers were overworked and that it was challenging to be able to play multiple roles.

One generalist caseworker shared, “Generalists means that we do intake, we do ongoing, we might do adult protection. So, pretty much the whole umbrella of what Child Welfare serves, we would do - And, that even include legal stuff, you know, whereas larger departments, say [local county name removed], who will have a lot of stuff all separated out and specialized - we don’t have that luxury here, so.”

One CPS supervisor reflected on her worker’s duties, “So, we’re a small group, so there are four caseworkers but only two of them that are only Child Welfare. Well, actually, they’re not because they deal with all protection. So they have to do both, but then I have one that does case work. But she’s also the family engagement coordinator, so she does all of the family engagement meetings. And, then, I have somebody who does part-time case work, but he’s our foster care coordinator so he certifies all of our foster care homes. So, yeah, they’re really overworked.”

She continued to share, “They do. We’re generalists – that’s what they call a caseworker from a small county. They’re a generalist because they have to do their own adoptions; they have to do everything themselves, so that makes it a little difficult.”

Role of Screeners and Trainers

In several sites, usually the larger and more complex sites with multiple specialized units, there were screeners (sometimes called community liaisons) who were responsible for receiving reports of child abuse and neglect from the public. These screeners explained that they ran the hotline for their departments and determined whether a report was deemed “screened-in” (warranting an investigation) or “screened-out” (no investigation was warranted and/or community referrals were made). In some counties that practiced elements of DR, screened-in reports that were not warranted an immediate response were passed onto RED teams to determine their response time. In one site, several screeners explained that they also played the role of trainers for mandatory reporters in the community. One supervisor characterized the screeners in her county as people who received calls of suspected child maltreatment. In addition, when a report was not assigned and deemed as “screened out”, screeners were responsible for calling the mandatory reporter to notify him/her of the status: that it was not assigned or it was accepted for an assessment.

A caseworker expressed her knowledge of screeners in her site, “And those are [redacted], community liaison, community, I’m not exactly sure. But they also do all the intakes. So they are the first responders, the first connectors for our reporters. So they are the ones that are going out and doing those mandatory trainings, so that people know what to report, want what the perimeters are.”

An intake supervisor shared, “So, we have screeners and so we have Screening department. Those are the people that take all the calls, so when something’s not assigned and it’s screened out, then the screeners would be responsible for calling them back to let them know that it was not assigned or accepted for an assessment, so.”

The individual responsible for conducting mandatory reporting trainings varied across different sites. In one site, an intake caseworker shared that she facilitated mandatory reporting trainings for the community, while a Child Welfare trainer from another site explained that she was designated to lead mandatory reporting trainings for the community, coordinated ongoing trainings for CPS workers, and oversaw the completion of the Child Welfare Training Academy for new hires.

An intake worker shared, “And, jumping back to some, one of my job duties, actually, is that we as a department have taken it upon ourselves to extend a mandated reporter training to all mandated reporters in our community. And, one of my roles is to go out on site to those entities and train their frontline staff, who are the mandated reporters in what it means and what the process looks like.”

A Child Welfare trainer stated, “In my current position, I am responsible for training staff and that would be like ongoing training with staff. I also set up a lot of different raining by bringing training in for staff. Staff are required to have so many hours of training every year and so I help facilitate getting that accomplished for all our workers... When we have new workers, I oversee them while they are in the Child Welfare Training Academy, so that can keep me busy. I currently have like three workers in the Academy, so while they’re in the Academy, I also help oversee all their on-the-job trainee work sheets. I make sure everything gets completed and sent into the state so they can become certified to practice Child Welfare.”

Role of Lead Caseworkers

In a couple of sites, some units had lead caseworkers who had usually worked in the field for a longer period of time. These lead caseworkers explained that they usually worked more difficult, severe/serious, or sensitive cases (e.g. cases involving the media). They also required less supervision, mentored or supervised more entry-level caseworkers, sat on various department committees, and responded to the unit’s needs when the supervisor was unavailable.

One lead caseworker stated, “So the lead caseworkers, we function in various capacities. I currently, I’m a trainer, I mentor new caseworkers coming in out of the Academy. I am a member of several committees, one being the diversity committee that we have. I am, there’s a caseworker IV committee, we meet at least once a month to discuss lead worker issues. We basically step in when the supervisor is not available. We conduct meetings such as TDMs, TDMs, which are Team Decision Making meetings, family care meetings. I may accompany other workers in my unit to court. I may give them guidance and/or advice on referrals that they are getting with child protection issues, helping them to explore alternatives when it comes to placement with children, helping, guiding them in the directions for protocol under the child protection Colorado Children’s Code. The things that we can and can’t do, the things that we are required to do, being able to assess

risk and safety. I'm also a full time pager staff, which is the emergency response team after hours."

Role of Caseworkers from Other Units

In addition to the units discussed above, some sites had other specialized workers in their departments. One site had a unit of family advocates who assisted families in the intake and ongoing phases by connecting them to services. One family advocate explained that she aimed to be strengths-based with her clients but sometimes faced similar challenges to that of CPS caseworkers as she was associated with the department. Family advocates in this site became involved with families when the caseworker on the case determined additional services were needed to reduce risks in the home and to achieve tangible goals determined by the family and the family advocate. In several sites, CPS further divided their units based on age of the child, e.g. child ongoing, youth ongoing, teen unit, etc. In one site in particular, there existed a unit who worked with young children in intensive therapy as well as placed in expedited permanency. Most caseworkers from this unit explained that they worked primarily with children up to six years of age, often new-born infants who were substance-exposed. These caseworkers provided intensive treatment for medically fragile children through supervised visitations with parents (up to five hours of visits a week); with visits often conducted in the hospital, other care setting, or the home. As well, these caseworkers stated that they worked on creating a quick transition period for children to be placed permanently within a year, aiming for reunification but often adoption. In another site, there was a unit dedicated to working with military families, where caseworkers needed to understand the military's approach to criteria for child abuse and neglect which varied from the state's Children's Code. Most caseworkers in this unit described being cognizant of the military culture (e.g. protecting their own because they were good soldiers) and often attended boards where the military voted on a possible child abuse or neglect report and its subsequent treatment plans.

One family advocate shared, "So, any time there is an open assessment or an open investigation, if the intake worker feels like this family is up to working on the safety concerns, they ask for an in-home service provider, which is me, to come in and help the family assess- you're always assessing safety, but also work on tangible goals, like parenting skills or getting benefits increased or increasing community resources, like Nurse Family Partnership."

Another specialized caseworker shared, "It's to assist families with ameliorating the issues that brought them to us. Right now, it seems to be mostly drugs, a lot of drugs. Our unit is [redacted], so it's specific to children six years and younger, although at times we get older children, if we have a newborn or a two-year old with older siblings. It's Expedited Permanency Planning, meaning that six and under, within a year by federal mandate should have a permanent place. We always hope that's with the family, not always possible, but that's what we work towards. So we get to know the families, we help them dissect and see what they is most useful to them. And I believe in strengths base, but a lot of times people wouldn't be seeing us if they didn't think what they were doing was ok. So there's strength based but there's also, you're here because your baby was born positive for a number of drugs."

A military unit caseworker shared, “We attend those boards as well. We don’t get a vote but we get to say our little piece about what we found. Their criteria is different though so they vote a lot on risk. So was this child injured? No. But was there the potential that this child could have been injured? Yes. And so sometimes it meets their criteria but not ours. ’Cause for ours we have to actually show some effect on the kid.”

Role of Prevention Workers

A couple of sites had a prevention programs unit where case managers worked with families through referrals from the community or through screened-out reports from CPS. Many case managers from these sites saw themselves as social workers and therapists, who worked with at-risk families to provide education and support to help them maintain a stable, healthy family. Most case managers expressed using a family-systems model with a focus on support systems to address behavioral issues with the child, strengthen protective factors, and reduce risks in the home; to ultimately prevent penetration in the CPS system. Prevention workers also described that they were often involved in staffings, TDM or family engagement meetings, and RED teams. Occasionally, case managers in the prevention programs needed to refer their families back to CPS if they were unable to address their goals to prevent familial violence.

One prevention program case manager stated, “So we can be- that’s one thing that our program can do is we don’t have to- we don’t work with just the one client, we work with the family systems model, so we could work with everyone in the family – if there was an identified need and (*unintelligible*) resources, then we would be working with those family members as well to prevent any problems in the future.”

The same case manager continued, “Our role is to do more around what are the relationships in the family? What are the barriers to health in the family? You know, what do they need for safety and wellbeing? You know, do they need mental health services? Do they need, you know - we work with a lot of families that have a lot of conflict within the family- Being as that we’re trying to prevent familial violence and, you know, keep kids in school and keep kids to of the juvenile justice system and keep kids within their homes and not in foster care.”

Another case manager shared, “So basically then what I work on is whether the kiddo needs meds, what the diagnosis is, and so we set up goals, with each of the families, so that they are making progress and to see if I’m doing my job.”

Supervisory Perspectives of the Prevention Role

Within one site, a prevention programs manager and a Child Welfare administrator described the duties of the prevention program case managers. They both emphasized the voluntary nature of the program, along with the case managers’ specializations in various topics and backgrounds (for example, one case manager worked specifically with mental health cases while another had experience in the health department). In general, both senior CPS staff members from this site described prevention workers’ scope of practice as social work, attempting to meet the needs of at-risk families by working to meet measurable goals of the family. They described prevention case managers to work on various issues with their families including homelessness, developmental disabilities, and child’s behavioral issues (such as truancy, substance use, and

mental health). The roles of the prevention case manager were to address immediate needs of the family; advocate for the family in garnering services such as TANF, food stamps, and Medicaid; teach parenting skills; and encourage self-sufficiency among their clients. The approach was nonjudgmental with an emphasis on education to help families stay healthy and happy; similar to the approach that many NFP nurses embraced. The two senior staff members also stated that case managers did not perform unannounced visits but were family-driven in their work, such that they only worked with a family for the duration the family felt was needed for them to achieve their goals.

The prevention programs manager also shared that her case managers worked in a team approach to provide a multidisciplinary effect for their families. Her case managers supported one another through weekly staffings, where they introduced the cases, the issue, strengths and weaknesses identified through assessment, and goals. She also shared how case managers made assessments with their families, by asking basic questions including but not limited to demographics, housing situation, parenting ability, possible trauma or mental health conditions, stress in the home, DV history, and resiliency skills.

One administrator stated, “So then those caseworkers/case managers will go out and basically say, ‘I’m from Prevention. We had some concerns received, so how can we help you with those?’ And so, sometimes its diapers, you know, sometimes it’s real simple. It’s almost like Social Work 101, like back in the day when there was the goodness about all of that stuff. So, that’s what they really do. And work on homelessness issues. One of the Case Managers is specifically - She works with our shelter here, the homeless shelter, the [local shelter name removed], and works with families directly through that and trying to work on that homelessness piece, to get them into transitional housing or what the need is for that particular family.”

A prevention programs manager shared, “I mean, we try to give them as much information as possible so they’re empowered to make their own decisions but frame it in a way that we’ve educated them on how to make those decisions in a way that keeps a family healthy and happy; well, healthy and safe, happy sometimes, eh? (*laughter*). And that we’ve asked the questions about, ‘Do you need help with these issues? Do you have domestic violence in your family?’ Do we ask like that, of course not. But, you know, if we recognize it, then we introduce it and see if they want help. But, again, because it’s a voluntary program and because you’re really trying to establish a relationship with these families, I think it’s very important that they understand that we’re here to help them and not here to judge them, which is the biggest thing. But, also, so we’re not there to tell them how to parent a child.”

Role of the CPS System

Across a few sites, some caseworkers described what they perceived to be the role of CPS. Several caseworkers from a couple of sites believed that the mission of CPS had remained the same over the years – to intervene to protect children from harm – despite organizational and procedural changes. Some caseworkers from some sites believed that reunification was the main goal and that CPS’s role was to strengthen a family’s ability to protect their children. Other caseworkers from several sites felt that foster care as well as protective custody from CPS were

not always the best solutions for families. In fact, one caseworker from one site suggested that CPS were not good parents, while some caseworkers from other sites felt that foster care was not always suitable for children and was sometimes even detrimental for a child's growth and development.

One caseworker shared her perspectives on the CPS system, "It's to fight for the families, but then also at the same time, to protect the kid if the family is not workable – well, I'm not gonna say workable – but, if the family is not in the best interest of a child, we have to look at different permanency options. You know? The system as a parent is not a good parent. You know, but we've had those kids who we've had in the system since they were six, and they're gonna- we literally helped raise them, and they're emancipating at 18."

Another caseworker stated, "I think everybody thinks that Child Protection, it's like our- it's our number one job, like we are the first line of child protection. I know parents are supposed to protect their children, and then I feel like the community needs to have... and then, it's our job to come in when everything else kind of fails. I mean, sometimes we can come in and kind of try to hold things together or try to, you know, kind of be an oversight, but I really feel like it's best for children to live in a safe, stable place with their biological parents, so."

Another caseworker expressed, "It's just - it depends. I've not been having very good luck with my safety plans lately, but I always try. I - foster care is not the place for kids. It's really not."

Casework for CPS Workers

Although there existed variation in how different positions functioned in multiple CPS sites, there were also many similarities in how caseworkers functioned as well as elements of their scope of work, including caseload, case management, working with service providers, building a rapport with the family/client, attending meetings, conducting outreach with community organizations, and resources and supervision.

Caseload

Caseload varied greatly depending on caseworker position as well as by site. Indeed, caseloads often fluctuated depending on the number of reports coming into the department. Some intake workers from multiple sites did not classify their cases or assessments as part of their caseload while other intake workers from some counties did. In most counties, caseload usually referred to the number of open cases a caseworker held, with a case being a person or family involved with CPS with planned intervention goals and outcomes. Most caseloads seemed to vary between 15 and 25 clients for ongoing workers, while intake workers would manage 8-15 assessments per month. In one site, a specified unit had a cap for their caseload, such that caseworkers from this unit were not allowed to work with more than 12 clients at one time, due to the highly intensive and short term interventions planned for their target population (young children aged zero through five who were involved with CPS and required intensive therapy or treatment). In another site, most prevention program workers usually held a caseload between 10 and 15.

One intake caseworker stated, “Um, caseload is probably about 10 to 15 assessments per month that get assigned to me.”

Another intake caseworker shared, “Right now, it’s actually more manageable. It’s between 12 and 15. There was a time where I had 8 to 21 families.”

An intensive unit caseworker stated, “I think the cap of my caseload would be at about 12. Right now, I believe I am sitting at about nine.”

In a couple of counties, several senior level CPS supervisors expressed similar ranges for caseloads for their caseworkers. A couple of supervisors from different sites added that their workers’ caseloads usually fluctuated depending on the number of reports made to CPS as well as worker staffing at the time. For example, in one site, a unit supervisor shared that due to worker turnover, her caseworkers held a higher caseload than usual or a caseload of different composition (i.e. more infants when the unit was used to working with youth).

One supervisor stated, “On average, they carry- they get new referrals, or new assessments we call them, monthly, between 10 and up to 16. So, ideally, if they could carry between 8 and 12 a month, that would be an ideal situation, just given the amount of work that it takes and stuff, so. But, when it’s busier, yeah it could be 16 plus. I remember the days where there was 25, 26 in a month.”

Another supervisor expressed, “I think that’s about average, our workload right now is about 16. I think it’s at that level because of the other unit, the [redacted] unit, they’re down a few workers so we’re getting their overload.”

Case Management

Across multiple sites, many caseworkers regardless of position were involved in case management. Many caseworkers from most sites engaged with their families, made timely and appropriate referrals to other service providers, and worked with families to identify goals and plans to eliminate safety and reduce risk concerns in their homes.

One caseworker shared, “And we, so we develop a treatment plan with their input and also with things that we think might be helpful towards reunification and the stability of reunifications - So we meet with the family, we check on the child, either with kin or in their foster home, facilitate visitation, treatment, as many things as we can to help family get to where they need to be to have their children home. Or to keep them home.”

Almost all caseworkers from all sites identified interactions and relationships with various service providers in the community. Some of these providers were contracted or court-ordered, but others were voluntary programs available to families in need. Among several intake and ongoing workers in multiple counties, there existed a perception of great reliance on the knowledge of medical professionals who worked with their families to offer insight into family dynamics, parenting ability, and medical needs of the child. One supervisor from one site reinforced this notion of reliance on and collaboration with professionals, particularly those who had existing relationships with families. With the support of professionals already working with families, this supervisor felt that her caseworkers were able to develop non-adversarial

relationships with their families. This supervisor along with others from different counties expressed that their caseworkers often held in-person meetings in collaboration with their clients and other providers to discuss treatment plans and participation in services. For example, multiple caseworkers from several sites had invited NFP nurses to attend these meetings when they served mutual clients. In a couple of sites, a few caseworkers shared that they had tried to initiate NFP for their ongoing cases as a resource, but then realized their families were ineligible as they were not first-time parents. (Additional interactions and perceptions of NFP among CPS workers are addressed in the CPS-NFP section.)

One intake caseworker stated, “Oh yeah, oh for sure. We would depend a lot on that information, ’cause again, I’m not a medical professional. And, so, whenever it comes to kids with any sort of medical needs, or concerns, I would depend very heavily on any medical professionals that they were seeing regularly. So I would, I would think that, um, that would be one of the first calls I make after the family, if they had somebody involved already.”

One supervisor shared, “So, but you can, you know, you can provide all kinds of things that can help mitigate that and provide for safety for kids and lower the risk on a voluntary basis. If you have some buy in from the parents, and then it helps to have another professional saying, you know, ‘It’s ok, you can trust, you know, this work to help you’ and ‘This is going to be ok.’ You know, it doesn’t have to be an adversarial relationship. And often times other professionals who have relationships with clients can help open that door for us, and provide families with, you know, with things that they can’t, we could provide. And ultimately, help families to, to function better, and to actually avoid, you know, a higher level of interaction with us down the road.”

Across some sites, several caseworkers also expressed interactions they had with mandatory reporters. Several intake and ongoing caseworkers shared that they actively encouraged mandatory reporters to report when they were uncertain because it was CPS’s role to determine if a situation was a child protection issue or not.

One caseworker stated, “We’re the ones that decide whether it’s a child protection issue or not. So, I always actively encourage people. I’m like, ‘You’re not wasting anybody’s time. Call in to screening and just let them know what you know, and then it’s somebody even higher up than me that’s going to make that determination whether we even respond or not – so you shouldn’t even have to worry about it.’ I think most people hear that now, but I have heard that in the past. They’re like, ‘I didn’t know whether I should or not.’ And I always say, ‘Better safe than sorry. Let Child Welfare be the one to struggle with whether we need to go out or not. You should just make it. And we may tell you because we also call back, not us, but the screeners. If we don’t, if we’re not going to respond and we tell them, ‘It doesn’t meet the Children’s Code and that’s why, it’s for child abuse and neglect, so we won’t be going out.’”

Building the Client Relationship

In several sites, many caseworkers shared the need to build rapport with different types of families in their cases so as to provide necessary services. This relationship building process was

shared by most caseworkers across these sites as often challenging because many families perceived CPS negatively and feared that CPS would remove their children from the home. Because of the nature of their work, several CPS workers described it was difficult to provide the necessary services for their clients without having a relationship with the family. Prevention program workers were not immune to this challenge, as a couple prevention case managers explained that some clients had been adversarial in their initial interactions because they perceived the case managers as associated with CPS and DHS.

One caseworker described, “At first it’s kind of hard to establish that relationship because they think that you’re just being intrusive and that you’re there to ruin their life and take their kids away. But it seems like the more that you work with them, um, you just build that rapport and things progress forward. Sometimes you don’t ever get that though, like, sometimes you just don’t establish a good relationship and it’s really hard when you just constantly butt heads from A to Z.”

A prevention program case manager stated, “Well, when they first meet me they are very adversarial (*laughs*) because I am associated with DHS and Child Welfare.”

Some CPS workers from different sites explained that they usually appeared at a person’s home and stated why they were there but that this approach was abrupt and not suitable for initially building rapport with clients. These caseworkers often described resistance from clients where some families slammed their doors or refused to talk to them at all. Further challenges in building relationships with clients for CPS workers were mentioned by a couple of caseworkers in different sites. Such challenges were related to the limited number of times they could visit a home in a given period of time, thus creating a gap in the interaction with families, making them miss some important events that happened in the client’s home. To overcome these situations where clients were reluctant to be involved with CPS and/or caseworkers faced challenges in relationship-building, some caseworkers from some sites approached their clients in a more positive light. They highlighted the family’s strengths and focused on providing support and resources to the family, rather than using a punitive approach. Among some caseworkers across several sites, there existed a need to build rapport especially for ongoing caseworkers, family advocates, and prevention program case managers. Because these types of workers tended to work with clients for a longer period of time, many felt that approaching their families with a nonjudgmental and open attitude was more conducive to rapport-building. By developing a relationship with their cases, these caseworkers then truly understood a family’s needs and were able to effectively work with them to address such issues.

A prevention program case manager explained, “But I pretty much come in with an open mind. I give them the- they have the opportunity to decline services - However, I encourage the families, if they’ve got so many referrals I say, ‘We need to stop the referrals from coming, what can we help you to make some changes?’”

One caseworker said, “There’s times you have to go back more than once. Oh, I’ve had the door slammed in my face, definitely. But, you just keep reaching out. Mostly, what I do with people is I talk to them about their children. And, if I notice that there’s a lot of resistance—there’s always good things about our families. All parents love their children. All kids love their parents.”

An intake caseworker shared, “So, going into homes in general is always something that is kind of a humbling experience. Because you’re coming into the home and oftentimes you’re wearing the badge and it’s scary for families and it’s nerve racking for them and so I always try to make it where I can come in with kind of more of a humble heart and say, you know, ‘I’m here. I’m not here to accuse anyone of being a bad parent. I’m just here to assess the situation. Can I please come into your household and hear your story?’”

Another caseworker expressed, “I think they get really nervous just knowing that I’m coming out, and you know, I let them know that my position and my role is to be supportive of the family and kind of finding out what’s, you know, what discrepancies there are. And, hopefully that we can maintain the family together because that’s our goal.”

Some CPS workers in some sites also described family engagement meetings, where the family and anyone else who was involved with that family came together to discuss the family’s progress, as an opportunity to build the client relationship. The meetings were designed to strengthen the relationship between families and their providers, to help clients reach their goals, and to achieve better outcomes by using everyone at the table as a resource. One caseworker also shared that family engagement meetings allowed her clients to feel that they were the expert on their lives and that they were able to contribute to their service plan, while a caseworker from another site explained that family engagement allowed her clients to utilize their natural supports. Other caseworkers from some sites expressed valuing processes such as the DR model, which allowed them to better engage with the family because they thought it lessened the negative impact CPS had on families. In these sites, a couple caseworkers also explained that DR allowed them to engage the family through frontloading families with services and preventing subsequent removal of the child from the home.

One CPS worker said “And so, with the family we make them the experts, you know, to their life, and what feels right to them and what works for them and they essentially - We help guide them, come up with a plan for – to come up with a plan for their family. And then, we as the department determine, ‘Do we need to be involved to help that?’ Or, do they have enough natural resources and supports on their own to do that? And so, that will happen sometimes before a case would open.”

Another caseworker explained, “And, it’s actually in rule. I mean, so it’s part of our, um, state rule that you have to have family engagement, so it’s in rule now and what the timeframes are. And so, what happens is that we don’t have to have a case to do a family engagement. Oftentimes, when we’re at a point with a - Even with a family where we’re not really sure what we should do, we can have what we call a Team Decision Making, which is somewhat parallel to family engagement where we get together and we facilitate - And, again, we talk about the worries, what brought them, the family to our attention, what the strengths of the family are, what the services and supports are that they currently having going. And so, with that then we look at what’s left.”

Another caseworker said, “So it’s a little more, there’s, Differential Response is really kind of a way to lessen the impact that we have on families when we come in, it’s more what can we do to engage families, as we are supportive, we want to help with change

and make behavioral changes, it's not a, 'Did you do it, yes or no and if you did, ok, we fined you for it.' It's much more about we want to do some prevention, we want to. And so there will be High Risk Assessment workers and then there will be FAR which are Family Assessment Response."

Another caseworker shared, "And so, we're seeing a really, you know, big - I think the idea is to frontload the family with services and really try to get in there, if we can prevent a removal, you know, we will sometimes even be creative about how we cannot remove a child but still maintain the safety of the child within those family engagements by utilizing, again, their natural resources, their supports or can the department put something in place to help reduce and eliminate a removal?"

Many caseworkers from several sites expressed that they had made efforts to ensure that their clients depended on their community for resources and that they knew how to access it before the case was closed with DHS. In fact, even though most caseworkers from several sites expected clients to access different services on their own, sometimes they had personally taken clients to those services, advocated for their client to receive services, or taught clients how to become self-sufficient. In this way, some caseworkers in several sites were successful in maintaining rapport with their clients and were able to teach clients to learn how to take advantage of available community resources to support their families. These interactions with clients were expressed by several caseworkers across sites as strengthening existing relationships with their clients.

One caseworker stated, "We do a lot of advocacy for their TANF and their food stamps and their Medicaid, making sure that those things are in place. Most of them don't understand when they have to reapply. Then they come to us for food stamps and they don't understand why, even though they've gotten letter after letter, they're not reading them. They don't understand (*laughing*). So, you know, it's a lot of handholding in the beginning and then moving them from handholding to kind of like this, 'You can do it. You can do it.' And teaching them how to be self-sufficient, and then celebrating self-sufficiency. And when you're looking at someone who has been in this crisis mode for so long, you can't do it in three weeks. So, it's much more intensive as far as just being there in the beginning for them and then teaching them some sort of skills so they can become more self-sufficient."

Attending Various Meetings

In addition, many caseworkers regardless of their position participated in staffings, TDMs or family engagement meetings, RED teams, and unit or departmental meetings. Across most sites, most ongoing caseworkers spoke about hosting staffings for their cases; sometimes family advocates and prevention program case managers also participated in these meetings. Staffings were usually held to discuss service provision and a client's participation in services. Some intake workers from multiple sites also reported attending TDMs or family engagement meetings, mostly as a way to transition their families to ongoing caseworkers. Almost all caseworkers participated in RED teams, unit meetings (often weekly or monthly), and department wide meetings (usually quarterly). Some caseworkers from a few sites reported

participation in community coalition or committee meetings; while a few caseworkers from a couple of sites expressed having attended PRTs, case conferences, or CPT meetings.

One caseworker shared the process for RED teams in her site, “And we go through - there’s a process of one or - two, at least, you have to have two brains involved (*laughs*) to, you know, come to a conclusion. We try to get more. We try to have - so every call that comes in, we try to do this mini-staffing. It’s pretty quick. It takes 10 minutes usually to sort of just evaluate the content of the call and make a screening decision and document that conversation. And then, so that screening decision is made by us as a team, or some component of our team.”

Another caseworker stated, “We also now do family engagement meetings. When we have an ongoing case. And those are done every 90 days. And a lot of times, if the family wants their provider there, we do invite the provider so that we can all be at the same table every 90 days, see what’s going on, what’s been working, what hasn’t been working out, and what else maybe we can do that we haven’t tried yet.”

Outreach and Training

In addition to case management and meetings, almost all caseworkers from all counties spoke about the 40 hours of training they needed to complete per year to maintain certification. Some caseworkers from some sites felt that the training topics were useful and that offering of such trainings were easily available, while some caseworkers from other sites felt that after working in the department for so long, there needed to be new training topics and especially for those living in rural areas, there needed to be a greater availability of online trainings.

One caseworker shared, “And then, we go to 40 hours of training every year. You know, from anything to dealing with substance abuse to Child Welfare to ethics to, you know, all the trainings that we have available in the Training Academy. Interviewing kids, it’s a ton of training that we get- It all depends on when it’s available. Sometimes, we get trainings that come here, and we don’t have a choice about spreading it out. (*laughs*) So, yeah, it’s- it depends. Like, I’ve probably done 80 hours this year, when I would rather have done 40 next year and 40 this year.”

In addition, in some sites, several caseworkers participated in outreach efforts, mainly to familiarize themselves with available community resources. In other sites, a couple of caseworkers felt that it was necessary to develop relationships with and to work with community resources to support families. However, it was sometimes a challenge for these caseworkers to be aware of all available resources in a community as they may discontinue services at any time.

One caseworker stated, “Because I think the more natural supports we give to families, the better off it is. Because, you know, really, the last things we do want is to do that whole- you know, it’s a necessity sometimes to go to court, but if it isn’t and we can get those supports set up because they’re already existing in the community, I want to find those first.”

Another caseworker expressed, “For [local county name removed], services come and they go and so quite frequently, it’s you as a worker have to be the one to keep up on services and you have to try to remember and assess – you know, keep up in calling different people and so it’s very difficult to figure out what services are available. And, you know, it’s sad too because people come to DHS and they go, ‘You should know what kinds of services.’ And we do know some, but we don’t know everything. And, so our access, I feel like, can be limited by either not the trainings around it or just not an awareness of what different programs are that we can utilize.”

Client Visit

Many caseworkers and some supervisors among all sites shared about their client visits related to initial assessments, supervised visits, visits at CPS-related meetings such as TDMs or family engagement meetings, and collaborative visits with NFP nurses. While visiting, several caseworkers and supervisors from most sites described that they had learned about a client’s existing relationships with organizations such as NFP, discussed parenting strengths and shortcomings with the client, and made recommendations to help the client make long-term changes that allowed her to maintain custody or be reunified with her child.

Initial CPS Visit

Several caseworkers across different sites described making initial home visits to conduct assessments once they had received a report of child abuse or neglect. Assessment patterns were described consistently within and across multiple sites. (These patterns will be further explained in the Risk Assessment section.)

One caseworker said, “The first visit is just kind of feeling them out to see what their family life is like. I usually start by interviewing the children first, and just an overall view, trying to feel out whether or not the allegations are true. And then - Then I’ll meet with a parent, and I’ll go over my interview with them. And then, I’ll talk a little bit about their experience being a parent.”

Open Cases with the Mother or Child

Several caseworkers from different sites discussed their open cases with the mother or child and what had been expected of the client during their visit once the assessment was completed. On visits related to an open case, several caseworkers from different sites described making assessments of the client’s interactions with her baby and observing for any safety issues. In some other cases, several caseworkers from other sites explained about having open discussion at a visit regarding their concerns on the mother’s parenting, making recommendations for change, and providing messaging that if the client did not make changes, her children may be removed.

One caseworker said, “Well, I mean, it’s been nice because, like I said, given that I don’t have an open Child Welfare case on the baby, it’s been nice to get the information from [NFP nurse name removed] on what she’s seeing. So, even though I’m not open on the baby, when I do my home visits, of course, I’m going to go see [client name removed]. And, the baby’s there. I’m going to be watching their interaction. I’m going to be looking for any safety issues. I’m only required, as a caseworker, to see the client once a

month. With [NFP nurse name removed] out there a little bit more, if she were able to, you know, and not as my spy, but that she's a backup."

Another caseworker explained, "And, you know, 'And, I'm worried about, and to hear that they were actually worried about those things, too, let's me know that they're going on.' So, just sit down, went step by step what I wanted her to do and what she needed to do in order to keep her kids. And, what was going to happen if she didn't do those things, which was I remove her children."

Supervised Visits

A couple of caseworkers from different sites spoke about client supervised visits with professionals where the parent's custody rights had been removed and/or the parents had been granted visitation rights of their child. One caseworker described a supervised visit that her client had to attend where a family advocate had been present to ensure safety of the baby. This caseworker expressed that supervised visits started at the department and then transitioned to the home if the parent was adhering to the treatment plan, thus offering the potential of reunification. A couple of caseworkers from different sites also explained that an NFP nurse who served a mutual client had participated in these types of supervised visits.

One caseworker said, "Well, when the parent does not have custody of the child and she's seeing the child only supervised, a certain amount of time at the department by a family advocate. And, when the parent does well, and we extend her visits, we need really somebody who can safely supervise those visits, not in the department, but in the home, which is a more homelike environment. So, if the goal is reunification, and the parent is doing really well with their treatment plan."

Interactions with NFP on Visits

In addition to having NFP nurses participate in supervised visits, several caseworkers from different sites described collaborating with NFP nurses when working with mutual clients at home visits. In these instances, the caseworker had learned about their client's involvement in NFP while visiting the clients in their homes. Collaboration at home visits were described around meeting the NFP nurse at the client's home to discuss items including: how the nurse could support her client, improve the client's parenting skills, answer any questions that the client had, and move forward with the caseworker on similar goals. In one site, a CPS supervisor described making a couple of home visitations with the NFP nurse, where the nurse had already built a rapport in the home and was able to introduce the supervisor to the client, making it easier to engage with the client.

One caseworker stated, "I have collaborated with current FNP [NFP] nurses that are in the home on cases, so there have been a couple of times when I've been on an assessment, and the parents will tell me, 'We have an FNP [NFP] worker, or we have a nurse that comes out once a week.' And so then we kinda get to that and then I have the parents sign the release of information, and most times they're like, 'Yes, please talk to them, because they are here, and they know, they're there more consistently and they can speak into how we parent.' And so, so I have had two cases that I've worked with and collaborated with the nurse, that's the consistent visitor, and then tomorrow, in fact, I

have another assessment that came through and it's a revisit to that assessment, it's another referral."

One CPS supervisor shared, "We just scheduled the time and one of them, I only can recall two. One of them, the Nurse Family Partnership nurse met me there and the other one, we drove together. And so you know it was just a matter of, you know, going together. They had trusted this person so it was kind of like, you know, this is a person who works in Child Protection and then I explained myself and so it kind of worked out that way."

CPS Meetings

Several caseworkers and couple of supervisors from different sites described different types of meetings that they had with their clients which often involved other providers (such as mental health counselors, probation officers, and NFP nurses) who provided social support and/or services. The types of meetings conducted by caseworkers varied across sites but usually included caseworker staffings, co-teams, family-teams, and/or TDMs or family engagement meetings. Visiting with clients in these types of settings usually included various support systems as aforementioned and involved discussion of plans to ensure safety of the child, identification of risk factors, updates on client progress, and coordination of care.

One caseworker said, "So, if there's probation involved, and trying to sit down sometimes and having all of those, having their substance abuse counselor, their mental health counselor, their probation officer, myself, um, you know, if we have anything else and we're all sitting down together, having meetings every once in a while. You know, sitting down and saying, 'Ok, here it all is. You are sitting in a room with all of us if you have questions, but we're all on the same page. You're attending great over here but you're not doing it here, you know, how can we help you?'"

One supervisor shared, "It's gonna look different. Examples that we've had in our Team Decision Makings in the past: We've had teams that, you know, the parents are the only ones that show up. And then, we had one- We've had meetings where an entire AA group, of bikers (*laughs*), of 30 people came as support for this family. And, it was some of the best - It was one of the best meetings we had ever had because there was a support system there for the family, whether it's the pastor, their AA group, anything like that. Those are the most successful."

Another caseworker said, "They've been great. I mean, since then, I think that our caseworkers have been working more closely with the nurses. They've gone out to homes together. They share information. We have invited them, the nurses, to our staffings, so they can come to our co-teams, different things like that. They go to, like I said, the homes together now. It's just more of a group effort..."

Another supervisor explained, "Unfortunately, we had another case just recently that we're still struggling with. Mom and dad both have I.Q.'s of under 60, and we really struggled back and forth because she couldn't even figure out how to do four ounces. She didn't know how to measure. She just doesn't have the capacity to do it, and so then Nurse Family Partnership and [CPS worker name removed] had to get together and say,

‘What kind of plans can we put in place to protect this child who is living in this home?’ So, then we had a family-team meeting where the family comes in. We also invited the NFP representative, plus we were at the table, plus a guardian was there. And we really all just sat around then with the family and, as best we could, because the mother’s mom was there, come up with a plan, ‘How can we keep this baby in the home safely, and what are our options?’”

Client Strengths

Some caseworkers and supervisors from various sites described different types of client strengths that they had observed in their visits and encounters with their clients. A couple of strengths described by these CPS workers were similar to those explained by NFP nurses, including family and peer support. However, many of the client strengths shared by these caseworkers were different from NFP nurses. These strengths were client performance in taking care of themselves and their children, involvement of professional resources such as NFP, and participation in CPS programs that were strengths-based to support families.

Client Performance

Several caseworkers from different sites perceived there to be client strengths when a client was involved with the recommended resources and was fully engaged with receiving these resources. One caseworker explained that having cooperative parents and those who acknowledged what had happened to warrant a CPS involvement as important client strengths to making necessary changes in their lives. A couple of caseworkers from different sites further explained that a client’s ability to use recommended services and complete treatment plans was a strength. For example, one caseworker shared about a client who visited with a therapist for herself and her children, met with school representatives to form a safety plan for her children, and engaged in community resources after such recommendations were made by her caseworker. Another caseworker from a different site described clients who participated in several educational classes and were able to apply skills that they had learned from different classes. A couple of caseworkers from different sites also described that clients who had performed what was appropriate for their children’s safety and well-being often did not require an open case with CPS due to the client’s sufficient response in protecting the children. Other caseworkers from some sites explained that some clients had become stronger in their care of their child by appropriately disciplining more frequently than prior. Furthermore, a few caseworkers from different sites mentioned strengths in a client’s ability to access resources and not to completely depend on CPS. One caseworker in particular expressed that when the family had accessed resources without the constant support of CPS, they typically became stronger as a family and were able to learn their own coping mechanisms.

One caseworker described, “Mom’s been really on-board. She— We made a referral out to our [program name removed]. I made a referral to her for a therapist for herself and a separate therapist for the boys. She immediately engaged in all those services. She started meeting with the school, came up with like a homework plan through the therapist and, you know, really— Mom really engaged...she took things into the appropriate world, was being safe, you know, being protective of her children, so there was no need to open a case.”

Another caseworker explained, “She completed all her treatment and you know, she was successful as far as like, she met the requirements, not just that she completed, but she made you know, some of the changes, she was you know, being stronger with the care of kids, you know, disciplining them more than she was before.”

Another caseworker said, “And so the little little ones that we have, we’re more doing Nurturing Parenting or the Caring Moms or the fatherhood program, but in the sexual abuse we were doing more, um, behavioral or Love and Logic classes. [Local community program name removed] does a lot of those, but also so does Catholic Charities, um, and if they find another program that they really like, um, I’ve had some clients go through the YWCA, and that they’re not staying there, but they’ve gone through DD classes there, and just some other life skills classes that they’ve enjoyed. If they want to do that, I kind of let them pick and choose sometimes, and some clients, you will see, if they’re that motivated, they will not only attend the basics that we have asked in their treatment, but they will go and I will say, ‘You have all of these other options is you want to attend these classes’ and they will go above and beyond. And then they turn around and they use those skills, and that’s what we like to see, is that they’re utilizing the skills that they’re learning for these classes.”

Another caseworker stated, “Yeah, so if a family is able to do it on their own, I think that’s a lot better for them. If they don’t need us involved. If they can access the resources that they need without us then they’ll be stronger as a family. They learn their own coping mechanisms and are able to kind of figure things out for themselves and navigate the systems themselves without us having to say you’re doing it wrong. Let’s order you to do it the right way until you learn. Um, so I just think it is better for them if we don’t have to be there.”

Professional Service Involvement

Having NFP and other professional service involvement in client homes was considered a client strength by several CPS workers from different sites. Several caseworkers and some supervisors from different sites described NFP’s unique position of working with parents on parenting issues and offering services in the home as strengths to the family that mitigated circumstances of risk for abuse and alleviated caseworkers’ concerns. NFP involvement as a strength within the family was mentioned in instances where NFP nurses worked with medically fragile children and/or developmentally delayed mothers, empowered the client to be a good parent, and helped the client become self-sufficient and employable. Besides home visiting with clients, NFP nurses’ participation in extended visits, staffings, and court hearings were viewed as additional strengths for clients by several caseworkers and supervisors from different sites.

One caseworker stated, “So, helping them to understand to deal with the child’s problems. Also, I have, with my experience with this parent partner [NFP nurse], she has been empowering my parent also to be a good parent, by some taking care of herself, helping them to be self-sufficient, to be employable. And, all of these things that— A great program.”

Another caseworker said, “But, I got a DD [developmentally delayed] mom who was somewhat of a hoarder, but she had been working with a nurse because she was diabetic

and obese. And, it wasn't dirty, but there was definitely a lot of hoarding of food and a lot of poor nutrition, and I don't even remember the referral reason, but when I went out there, having the nurse in the home on a weekly basis helped alleviate a lot of concerns. And, just understand a lot of what the mom was operating out of was - Just, she was lower-functioning, so she was taking care of the child to the best of her ability. And, it's not up for me to judge people's parenting styles and living conditions. It's [up to] me to assess risk and safety, so."

Availability of other home-visiting or professional services, such as therapists who had made home visits to client's homes, was described as a strength in a couple of sites. Utilizing such services was especially important as expressed by a couple of caseworkers where there were rural clients in need of such services. One CPS supervisor described having referred clients to therapists that visited the home, which solved the transportation issue for most clients in rural areas and supported the family. A caseworker from another site stated the importance of having a professional in the home and how it mitigated the need to immediately investigate the case because the professional would assist the client overcome certain risks as well as report to CPS and/or the police if child abuse or neglect was suspected.

One CPS supervisor said, "I think— Like I said, I think that oftentimes, they're a support to the mom and the parents. But, it can also be that concrete stuff like being part of the safety plan to keep a child home if that's safe. If we can do that. I also do think having a nurse at the table, it brings a different perspective."

One caseworker said, "Yeah um if we know that there's somebody in the home with eyes on the family then we might not have to make as immediate as a response because it's a professional person, who we can trust to say, you know, they know to call the police if they need to, they know to call back to us if they need to, help the family through some of those things without us coming out there immediately."

Another caseworker stated, "And so, with that I am helping the family. They kind of start to say, okay we don't want this to happen. So, I think that gives them a lot of the forefront look. This is what might happen and this is why we're here. This is what's, you know — Who can you get to support you and things like that. We have a lot families who are here by themselves who don't have families. So, that's another good reason why we have this — the nurse and our community support systems for families."

Another CPS supervisor said, "Lots. (*laughter*) Lots of agencies. There are — um, we can refer them to a variety of therapists. There are therapists that go into the home. We like those because where we work is a rural area and there are lots of people who live in sort of, you know, far-flung houses that are hard to get to that maybe they don't have transportation and then having somebody going into the home would be, you know, a big — a big help and would help reduce the risk."

Support from Family and Peers

Several caseworkers and a few supervisors from different sites described client support from kin and peers (e.g. biker groups, friends, Alcoholics Anonymous [AA] groups) as a strength among their clients. These supportive individuals were considered a strength for clients because they

helped them to raise their children safely while the clients received the help that they needed. One CPS supervisor stated that when clients had community support from their peers, it was a strength for their clients that CPS appreciated and perceived that these clients to be most successful. Another CPS supervisor from another site explained that CPS was less concerned about a child's safety when the client received support from the family. Finally, another CPS supervisor discussed an example of a client strength where peers who served as large support groups attended family engagement meetings and were present to support the family.

One CPS supervisor said, "It's gonna look different. Examples that we've had in our Team Decision Makings in the past: We've had teams that, you know, the parents are the only ones that show up. And then, we had one— We've had meetings where an entire AA group, of bikers (*laughs*), of 30 people came as support for this family. And, it was some of the best— It was one of the best meetings we had ever had because there was a support system there for the family, whether it's the pastor, their AA group, anything like that. Those are the most successful."

One caseworker explained, "I'm trying to figure out who their supports are and what they need and getting all those people involved I think keeps kids at home, so you know, I do have some cases right now that kids— They're not living with their biological parents, but they're with kin while the parents get the help they need to keep their kids safe, but I don't have to take custody of them."

A different CPS supervisor said, "Are there, you know— With that older mom, or the kid's— The second mom, she had a family that was involved, so I wasn't as scared for her baby because I knew there were other eyes in there, not just [NFP nurse name redacted]. The mom that I said, 'We need that report now,' her family all lived in Arizona. She was here alone, had no support, no one looking on, in on that kid."

Risk Assessment

There existed many similarities among most caseworkers within and across most sites in their approaches to assessing risk and safety with their clients. Across most sites, there existed a systematic process to receiving a report on child abuse and neglect, assigning an appropriate response time to investigate the report, actual assessment of the report, and ongoing assessment for an open case.

Reporting Process

Across most sites, most caseworkers and supervisors described a similar process to receiving reports of suspected child abuse and neglect, although different types of caseworkers were assigned to this role in different sites. In general, many caseworkers from most sites shared that all reporters (mandatory or otherwise) were asked to provide first and last names of the alleged victim and perpetrator(s), home addresses, the alleged incident, and associated concerns with the family. With the implementation of enhanced screening in most sites, some caseworkers and supervisors from various sites shared that all reporters were now asked more in-depth questions, including occurrence of IPV in the home, child functioning, family strengths and supports, the reporter's perception of impact on the child, and the reporter's opinion of what should occur as next steps, for example requirement of CPS services, removal of the child from the home, or that

they reported due to their mandatory reporting responsibilities but no concrete actions needed to be taken. One supervisor added that enhanced screening had created greater uniformity in the types of questions asked of reporters, including mandatory reporters. Once CPS workers received information from the reporter, they then determined whether the report was screened-in for an investigation or screened-out with no response or with referrals to community services if deemed low to moderate risk.

One CPS supervisor shared, “So, what we have talked about is, so we have people answering our Child Protection Hotline, and so if it’s a screened-out referral, and it meets, you know, high-risk, moderate to high-risk that we’re not going to - Probably low to moderate even. If we feel like the family needs some help, our [CPS worker title removed], they will do the referral to NFP. Or, WIC, or, whatever is at the Health Department, and we - or Safe Care, whatever it is.”

Another supervisor shared, “No. The process is the same for everybody. We have recently moved to what is called enhanced screening, which is a more extensive in depth series of questions that we have and so it’s, um, because every situation is a little bit different. It’s not like a road book. You don’t have to ask exactly the same questions. But there is a lot of the uniformity with all reporting parties being asked mostly the same questions.”

One caseworker explained, “And, then the other questions we ask every caller about domestic violence. So, if they’re aware of any domestic violence in the home no matter what they’re calling about. And, then we ask about child functioning. And, then the strengths and supports. And, then we always ask the caller what they think should happen. Whether they think this child should be removed. Whether they think they just want this family to get some more support. Or, they just wanted to report it because they are a mandatory reporter. We want to know like what their opinion is of what we should do with the family.”

Types of Assessments

DR was planned for implementation in one site. Several caseworkers and supervisors from this site explained that DR involved assigning screened-in CPS reports to one of two tracks for assessment, (1) HRA for high-risk families with previous CPS involvement and cases involving sexual abuse, severe substance abuse, or serious bodily injury or; (2) FAR where workers were assigned to work with cases that were considered gray areas and those with minor to moderate infractions.

One caseworker explained, “And so, we’re getting ready to do like DR, and there’s just a different way of doing Child Welfare and so, I’m high-risk, so most of my caseload – when we move that way. It’s just [redacted] – will be sex abuse, serious bodily injury or our really high-risk families that nothing else has seemed to work with.

A supervisor shared, “Yeah, it is still the same process. Like a call is made into our hotline so then those are screened every morning. Then we would either decide to screen it out or assign it and then if we decided to assign it then we will have the two tracks. We would have the High Risk Assessment and then the FAR, so then we would be able to

decide from that some will go to high-risk if there is serious bodily injury...that's the biggest, you know, high level physical abuse, high level drug use, all sex abuse cases have to go to high-risk. But those ones where -that have a little bit more gray or kind of minor to moderate infractions, then we can go out as a - FAR worker can be assigned to those.”

In addition, in some counties, a couple of supervisors explained that designated workers were assigned to assess institutional investigations, which included abuse and neglect allegations within a foster home or an institutional setting (e.g. licensed or unlicensed daycare center, residential treatment facilities, etc.), while some other workers specifically investigated sexual abuse and/or fatality reports or cases. One supervisor also shared that allegations involving churches and schools were considered third party and were, thus, handled by law enforcement, unless the institution had a live-in function which were then handled by CPS.

One caseworker shared, “And, then I do any institutional investigations, which are abuse and neglect allegations within a foster home or a daycare setting... And, then any fatality investigations. So, a child that dies due to suspected abuse and neglect.”

One supervisor explained, “We do not investigate churches or schools. Those are third party and those are handled by law enforcement. The only school that we have an exception for that is if the school itself has a live-in function to it. So there are 2 of those here in [city name removed], one is the [school name removed] because they have facilities where students sleep there and the other one is [facility name removed] because they do some day treatment programs like schooling and things like that, but they also have sleep in facility for kids on mental health holds and things like that.”

Assessment Process

Once a report was screened-in for assessment, many caseworkers and supervisors from most sites shared site-specific processes for reviewing the report; this process was termed as the referral staffing process by several supervisors among multiple sites. Some sites utilized a supervisor review process where a supervisor reviewed the report immediately, determined if a child was in imminent danger, and then assigned a response time. Several other sites used a team approach towards deciding if an investigation (with appropriate response time) was necessary. In some of these sites, the approach was called RED team, which was generally used for reports that did not require immediate action. Some caseworkers and supervisors from some sites shared that RED teams, using criteria in Volume VII, determined what response time was appropriate for the report based on what constituted as a safety concern, as well as whether or not a specialized unit – in the sites that had them - was needed to conduct the investigation (e.g. sexual abuse investigation team, institutional safety assessment team, or military unit).

One caseworker stated, “... when the team of the people that decides whether or not we need to go out and investigate this, they have the historical perspective as well... And, then it is our job to enter it actually into our TRAILS system and - and then that piece of that referral is done.”

A supervisor shared, “So part of that assessing risk happens at RED team where we assess, ‘Yes, the child is highly at risk we’re going to right away’ or ‘No, the child is at

low risk so you can have five business days to respond.’ So part of that assessing the risk takes part at RED team when we evaluate all the details of the call. If a call comes in and it’s clearly an immed – of an immediate nature, the hotline worker knows to, um, bring it to a supervisor immediately.”

Another caseworker explained, “Um, we go through the agency history, the criminal history, try to find strengths and supports in the family, like if they’re already involved in services and things like that. Um, and the based on the criteria from Volume VII on how they need to be assigned, or what constitutes kind of the safety concern, that’s how we determine what they have to be assigned. So it’s kind of a long process. Um, and we just got through them one at a time and kind of determine if they need to be assigned or not.”

How Caseworkers Assessed for Risk and Safety

Upon assignment of response time, several caseworkers and supervisors from multiple sites explained that assessment workers had, by law, 30 to 60 days to make contact with the alleged victim and perpetrator, conduct an assessment (or investigation), and come up with a finding. Some caseworkers from some sites explained that the assessment involved observation in the home and information gathering on family risk factors and conditions, client strengths and resources, and with all persons involved including collaterals - people who could attest to parenting styles such as NFP nurses. Several caseworkers and supervisors across various sites also shared that a standard set of questions were often used by most caseworkers to assess risk and safety; while one caseworker emphasized that it was important to ask all questions related to possible impact on the child, not just questions related to the alleged incident. In general, several caseworkers in different sites explained that they often initiated the information gathering process through follow up with the reporter, especially if the reporter was a mandatory reporter because he/she usually had a strong understanding of the family dynamics and patterns. Many caseworkers from multiple sites shared that they were required to conduct interviews with the alleged victim, perpetrator, and other members of the household. A couple of caseworkers from different sites elaborated that questions for the child and location of questioning differed depending on his/her age. For example, school-aged children were often questioned at schools not the home. It was also common to communicate with collaterals to learn what these individuals perceived as red flags and to collect their opinions of whether or not the parent could adequately meet the child’s needs. Based on the information gathered, caseworkers with the consultation of supervisors then evaluated if the report met the Children’s Code definition of abuse and neglect and concluded with one of three findings: inconclusive, unfounded, or founded.

One caseworker explained, “And so, when I made - initially made contact with the family and we, you know, we do a full assessment about what’s going on and what kind of resources they have. You know, not just looking at the bad things, the abuse or neglect that may be going on, but also the strengths.”

Another caseworker shared, “And, this particular family said that they were working with Nurse Family Partnership and signed a release for me to talk with them. And so, I was really able to gather a lot of information from the Nurse Family Partnership nurse about what they have seen in the family and the concerns that they had and things like that. And, it actually in - in that particular case, it pushed me from - I had a lot of - Because

the kids were so little - The kid was so little - I did not have the kid really report anything, so I had mom and dad minimizing what was going on and - and things like. So, it actually worked talking with the Nursing Family Partnership it gave me information to actually open a case with us. Because they were reporting a lot of concerns that mom and dad were fessing up to basically.”

Another caseworker explained, “As far as like, you know, interviewing the victim. That’s your response time. And then, you interview all the people in the home and make an assessment if there is – if the allegations are true or not...And so, you take that information and use that as part of your assessment. And I think that it’s really important to talk to the reporter, especially if it’s mandated reporter because usually they are the ones that know the family pretty well.”

With regards to the information gathering process, a couple of caseworkers from different sites shared that it was important to begin the assessment with no judgment or assumptions of the allegations, to offer the family ownership so that they had the opportunity to offer their perspective of the story, and to use the opportunity as a way to develop relationships with the family with the ultimate goal of providing assistance and help. One prevention programs manager emphasized that her case managers often acknowledged that they were not there to tell the clients how to parent but were there to help and assist the family in achieving their goals.

One caseworker stated, “I think what I’ve learned over the years is you don’t go in there as um, like judgmental or you’re doing this, you’re doing that and assuming right away that what the allegation is, is absolutely true. You know, you go in there, I’ve learned to go in there as, and say, ‘You know what, I know, I know 99.9% of people love their children and want them to be safe.’... This is what I’m recognizing, based on maybe my interview with the children, you know, other things that I’ve done. And, um, this is what I’ve seen and if I’m seeing it incorrectly, then I give them the opportunity to tell me their, their side or their piece and say, ‘Ok, so then, this is what,’ I ask them, ‘What do you think needs to be worked on?’ You know, so I kinda give them some ownership.”

A prevention programs manager regarding the prevention programs stated, “But, again, because it’s a voluntary program and because you’re really trying to establish a relationship with these families, I think it’s very important that they understand that we’re here to help them and not here to judge them, which is the biggest thing. But, also, so we’re not there to tell them how to parent a child.”

Most caseworkers across all sites shared that they assessed for current safety concerns as well as risks, with the goal of maintaining the child’s safety and well-being while understanding that risk always existed. In fact, risk and safety were differentiated by almost all caseworkers and supervisors across all sites; safety was described as related to immediate harm or impact on the child while risk was the likelihood that maltreatment will occur in the future. Indeed, risk was not considered as criteria for assignment but rather CPS acted upon concerns for a child’s safety. To assess risk and safety, caseworkers considered many factors. Almost all caseworkers from all sites shared that they highly considered family and social history, which was assessed using TRAILS to gather information, including past CPS involvement and previous reports to CPS, criminal history, court involvement, and CBMS (Colorado Benefits Management System) to

gather information on supports within the family, including usage of Medicaid, Food Stamps, daycare, TANF, etc. Some caseworkers from some sites had also requested medical records on the child. In addition to history, most caseworkers also assessed for the social (such as support) and physical environment (e.g. cleanliness of the home, safety hazards in the home such as co-sleeping or inappropriate sleeping arrangements, inadequate heat and food, etc.). Other areas assessed by caseworkers included: age of the child (younger than six was considered higher risk); severity of the alleged incident; access to the alleged perpetrator; parent's cooperation (for example, running away, hiding, or if they lied about how the infant was injured); appropriate caregiving, bonding, and attachment; appropriate level of discipline (such as spanking and other physical discipline); level of functioning if the parent was developmentally delayed; and the history, occurrence, or co-occurrence of risk factors including substance use, mental health, sexual abuse, and IPV. A couple of caseworkers across various sites also explained that it was important to note the cultural context when assessing for risk and safety, such as assessing for whether or not the cultural practices of the family adhered to state laws and for the impact on the child. Some caseworkers from other sites shared that when assessing young children, they specifically assessed for physical factors including a healthy weight, developmental milestones met, attendance for doctor's appointments, and whether a failure to thrive diagnosis was organic due to medical reasons or inorganic as a result of neglect or abuse.

One caseworker shared, "Well, pretty common is that the level of, with discipline, you know we constantly talk with parents about appropriate discipline. What's good and what in their best interest, is it appropriate. You know, spanking versus non spanking. And so we, you know, we have those discussions with parents. And so far, my discussions with parents have been pretty non-confrontational, but I know that there are some parents that whole-heartedly believe that spanking and physical discipline is absolutely necessary and that it's not harming. So, you know, it's those levels of severity that you have to kind of look at."

Another caseworker explained, "And, then it's our job to look up all the history too. So, we look up all of their child protection history and document on the form so that when we're scr- when the team of the people that decides whether or not we need to go out and investigate this, they have the historical perspective as well. And, then we also look up criminal history for all the adults... And, then more than likely we have gotten three other calls since the first one came in and we work on the other ones, so."

Another caseworker shared, "Absolutely. So, when we go into people's homes, um, we typically look for a number of things. For one, we kind of look for the cleanliness of the house. We kind of look at the, um—I think our county is one of the only counties that actually screen children on all different levels. So, for instance, we ask them about is there any domestic violence and we have different questioning around that for kids depending on their age. We ask about sexual abuse. We ask if they are ever home alone... We assess for drugs and alcohol and we really ensure that there's, like, no severe discipline going on. On top of that we may ask questions concerning mental health or depending on what the allegations are such as food, clothing, shelter around that area, which really gives us a holistic view of the child. Not all counties do that."

Another caseworker stated, “You just look visually on the signs, baby is thriving, at a healthy weight, you know, getting them to that developmental milestone. You look yourself, ‘What are the parents doing.’ It’s a little different than when you actually, ‘Ok we’re bugging the room, talking to this kiddo, and how did they appear and they’re like, “Oh no, mommy beat up dad last night.”” You know, we’re not getting that, we’re getting you know, just the different signs from the baby.”

Overall, some caseworkers from some sites expressed that gathering a holistic view of the child was important to determine if the aforementioned risk factors had some sort of impact on the child. As stated, several caseworkers across different sites shared that to require CPS involvement, it was necessary to demonstrate imminent safety concerns for the child and not necessarily the prevalence of various risk factors. For example, illicit drugs did not necessarily equate to removal of the child from that household as long as the parent was able to find other avenues to support and care for the child in a protective sense. Another example provided by one caseworker was that lack of running water was not necessarily a safety issue, especially in rural areas, so long as the parents were able to provide water for bathing and drinking, e.g. through bottled water. Another caseworker from a different site further elaborated that their assessment was based on minimal standards for safety, such that situations she would not have wanted for her own grandchildren were not necessarily deemed as requiring CPS involvement.

One caseworker stated, “Some people in the community that feel, look, well, they don’t have running water or they don’t have - Well, you know, (*unintelligible*) we live in a rural area and sometimes they can’t get water, you know, or the well is down or whatever it is, you know. It happens but, you know, they go out and they buy bottled water. They’re able to bathe. They’re able to, you know, look for other avenues. I mean if you go to a third world country you’re not even going to have a roof. So, you know, it’s like - So, I guess it’s all a matter of perspective and how you see that. And, I think for me my bottom line is how well do you care for your child in a sense do you protect them. Those kind of things is what my thing is. You know, I don’t care if it’s, you know, if they - if they have five kids and they sleep in one bed, well I’m okay as long as they’re not sexually molesting each other, we’re good.”

Another caseworker explained, “So I would hope that we would both keep, you know, uppermost the safety and well-being of the child in mind... And, you know, we have, um, rather minimal standards for safety. You know, it’s not, perhaps the same thing that we might want for our grandchildren.”

In addition to adhering to state criteria for investigating child abuse and neglect, some caseworkers from one site shared that the military used a different process of assessing risk for their military families. These caseworkers explained that the military voted on a board for every report that was deemed as suspected child abuse and neglect and that voting was also used for approving the treatment plan – such that the military had ordered the soldier and family to participate in certain programs and services. The caseworkers stated that they had attended the boards and presented on their finding of the assessment but did not vote. Indeed, some cases may have met the military’s criteria for child abuse and neglect but not the state’s because the state required an impact on the child for the case to be founded.

One caseworker explained, “They, we look at our state’s criteria for child abuse and child neglect to make good determination all right this needs, this is a founded report. They vote on it at a board, every report that comes, not every report but the ones they deem possible child abuse/neglect. They vote on it as a board, um, and then there they can vote on a treatment plan as well for we want this person to do new parents support program or daddy boot camp or something like that. And they can order the soldier to do those things or family to do those things. So that’s helpful for us when somebody is ordered by their commander to do it then we don’t have to do it. Um...Um - we attend those boards as well. We don’t get a vote but we get to say our little piece about what we found. Their criteria is different though so they vote a lot on risk. So was this child injured? No. But was there the potential that this child could have been injured? Yes. And so sometimes it meets their criteria but not ours. Cause for ours we have to actually show some effect on the kid.”

Assessment for Prevention Workers

Assessment for prevention program workers was similar to the process for CPS caseworkers but differed in the way they engaged with clients such that prevention workers worked with clients with risks and not safety concerns. Several prevention program workers from one site shared about their assessment process with their clients. One worker explained that her program used a protective factors risk assessment and that, like CPS caseworkers, it was important to establish risk versus safety. Safety issues required CPS involvement, in such cases this prevention worker had made a report to CPS on the client, but in general most of her clients were high-risk and did not have safety concerns. Most prevention workers from this site shared similar factors assessed by CPS caseworkers, these included social history, physical environment (such as appropriate shelter, adequate heating, food, etc.), substance use, mental health, and IPV, as well as how these factors affected parenting.

A prevention worker stated, “It helps to establish risk versus protect, safety. The risk is different. We work with the high-risk clients. If there are any safety issues that’s Child Protection. That’s in a nutshell.”

The same prevention worker regarding tools that she used shared, “So do I have any assessments? Yeah, we use the protective factors risk assessment...through our agency.”

A prevention programs manager explained, “Other than the basic things – you know, the first questions we always ask are, ‘How’s your housing? How’s your food? How’s your heat?’ You know, those basic things to get through life, but then asking questions about, ‘Are there kids in the family?’”

Ongoing Assessment

In addition to assessing risk and safety as a response to a CPS report, several caseworkers across multiple sites shared their process of assessment for open cases. These caseworkers explained that they used similar strategies as assessment workers and considered similar factors as aforementioned. In addition, these workers had participated in ongoing communication with service providers, such as probation, parole, law enforcement, schools, medical staff, and mental health, to better understand the family’s progress in maintaining goals. Understanding what services were already being used by the client, such as NFP, was also important. Some

caseworkers in different sites suggested that having someone, such as an NFP nurse, who conducted periodic visits at the home mitigated a level of risk with the child. Indeed, NFP involvement was considered a strength for the family by many caseworkers across several sites. For children with special medical needs or those diagnosed with failure to thrive, some caseworkers among some sites relied on medical professionals who visited the children in their home and conducted weight checks or watched the parents feed because they provided helpful insight into the caregiving of the child. In a couple of sites, some caseworkers had brought in a public health nurse to assist in the physical assessment of the child. Finally, a couple of caseworkers from different sites shared additional areas of assessment that included monitoring of the child regardless of what setting they were in - the home, kinship, foster or group home - and determining whether or not the child's needs were met in these settings.

One caseworker shared, “So, in the center of our wheel is the child and the case manager and every provider, the family themselves, the parent - So, we're child-centered, family-focused. So, they're a spoke on our wheel. They provide us with information to feed to the case manager as they manage our Child Welfare case. And, if any one of those spokes is broke, we're not going to have the information we need to make good decisions. So, they're a valuable part of our team.”

One supervisor explained, “...often we – if we know that Nurse Family Partnership is in the home, well I'd like to know how many days they can go. I'd like to be able to call that worker and say, ‘How many days can you go- were you planning on going. Can you go more days a week?’ And that would give us an idea of whether the risk is being mitigated... We need to – we need that information from Nurse Family Partnership so that we know whether we need to open a case. Do we need to send another service in the home?”

Another supervisor explained, “She oversees [program name removed]. She's our - She's the liaison from the Health Department to our Child Welfare - specifically, our Child Protection Teams. She'll also go out and even educate a foster family if you have a child that's got placed on that's diabetic. So, but she supervises our Healthy—their [program name removed]. I think that's her main role. And, the HCP - I can't remember the name of that program, but –”

Placement and Service Planning

Across multiple sites, many caseworkers and supervisors shared about the process of placement and service planning for their clients. For different factors such as developmental delays and substance use, early childhood assessments and UAs respectively had been requested to assist in treatment planning. In addition, placement planning was described by some caseworkers in some sites to include open communication with parents, sometimes helping them to identify the appropriate support for the child (e.g. kinship care), with the ultimate goal of reunification with the family. A couple of workers from one site explained that they were involved in Expedited Permanency Planning where the child needed to be placed within a year of CPS involvement. Many caseworkers from other sites also described developing safety and case plans for their clients with services (whether court-ordered or voluntary) that would support the family and keep the child safe, and assisting in establishing the client into treatment. These plans were

usually made as a team effort by strategizing how best to handle each particular case involving a particular child.

One caseworker shared, “Um, I see that it’s kind of a slow process since we’re with children 3 and under, pretty much mandated to do an assessment and then refer, first to [organization name removed]. Sometimes that doesn’t work very well and sometimes I’ve asked my foster parents if they want to call another agency, like I’m ok with that. Because they might get the services more quickly. Sometimes I ask them to have their doctor write a prescription and have their doctor pick who that may be.”

A supervisor explained, “...cases involving children six and under, um, providing intensive in-home treatment to the family if the children are at home or if they were removed from the home, providing intensive hands-on parenting, um, teaching various things in order to — to reunify the children with the family. On the other hand, we’re also doing expedited permanency, which means the children have to be in a permanent home or we have to have a permanent plan for the children.”

As stated, case planning was often done in collaboration with team members including other DHS workers and medical staff members. Some sites used TDMs or family engagement meetings (by inviting people important to the family, including NFP nurses), or other interdisciplinary groups (involving probation officers and the court system) to assist in processing, brainstorming, and making decisions for placement, case planning and treatment or intervention. As well, the medical staff was often engaged to help develop discharge plans for the child. In some sites, a couple of supervisors expressed that these team-based meetings helped to determine if preventative services were more suitable for the family.

One caseworker stated, “So, I have a lot of experience dealing with medical staff. We even have had many staffings with our cases, collaboration with medical staff, coming up with a discharge plan for the patients, and if the child is not to be released to the family, then we make, you know, plans as to where the child should go and what will be the appropriate placement for the child, so that the placement can really meet this child’s needs if a parent can’t.”

A supervisor explained, “So, we decided that we wanted to have a family engagement meeting model that would address placement stability, long-term case planning and concurrent planning and a host of whatever issues are existing in that family’s case at the time. So, service provision, educational planning, medical issues, any- Whatever pertains.”

Another supervisor shared, “...so then Nurse Family Partnership and [case manager name removed] had to get together and say, ‘What kind of plans can we put in place to protect this child who is living in this home?’ So, then we had a family-team meeting where the family comes in. We also invited the NFP representative, plus we were at the table, plus a guardian was there. And we really all just sat around then with the family and, as best we could, because the mother’s mom was there, come up with a plan, ‘How can we keep this baby in the home safely, and what are our options?’”

Another caseworker stated, “What we have [redacted], which is an interdisciplinary group that meets every [redacted], and we work closely with the court system so that we can process and brainstorm planning for youth that come through.”

Clients With Substance Abuse

Substance abuse was considered as a high-risk among CPS clients by many caseworkers across many sites. Most caseworkers in most sites shared about the types of substances used by clients, strategies to working with substance abuse clients, resources available for these clients, and barriers as well as opportunities related to addressing substance abuse issues in their practice.

A broad range of substances were described as having been used or abused by clients by many caseworkers across multiple sites. Although sites differed in the prevalence rates of usage by substance, almost all caseworkers from all sites described that marijuana use was common. Other substances used by clients included: alcohol (as related to chronic use and alcoholism), methamphetamine, prescription drugs, opiates like heroin, and cocaine. In several counties, some caseworkers shared that clients abusing these types of substances had overdosed and resulted in subsequent hospitalizations that led to a CPS report. Multiple caseworkers and supervisors across several counties also shared that these substances were often comorbid with IPV and/or mental health.

One supervisor stated, “We have a lot of alcohol abuse up here, we have a lot meth use up here, um, some marijuana, um, and prescription drug use is really on the rise. Um, and I think that domestic violence also is a big issue for us. Oftentimes that goes hand in hand with the substance abuse and creates a pretty injurious environment for kids. Um, I think those are the two big ones that we see.”

A caseworker shared, “I think it has complicated but I still think, like, the biggest complicating drug is probably the prescription pills... But then you have the problem of some doctors that just — I mean, and that’s also hard because they have prescriptions. They just overtake their pills and the doctors just keep writing them or then they’ll go to a different doctor, you know, or to the emergency room because they’re on Medicaid, you know, or whatever, like, ‘I hurt my back’ so then they get another prescription and it’s just — it’s very sad. There’s a lot of, like, cocaine and heroin, too, but it just seems more so, like, the prescription.”

In addition to working with substance abuse clients, many caseworkers from multiple sites also explained that they had worked with substance-exposed infants. It was also through substance-exposed infants that CPS usually became involved with first-time mothers in several sites. When working with these substance-exposed infants, some caseworkers from some sites shared that the emphasis was usually placed on protection of the child, such that the legality of the drug used was often not important. These cases were usually referred by hospital staff in most sites, but one caseworker shared that marijuana-exposed infants were not usually reported to CPS in her county while other substances were reported and regarded differently as more severe. In a couple of counties, some supervisors shared that, in the past, hospitals had generated a red flag list of pregnant mothers who were at risk of giving birth to substance-exposed infants. CPS became immediately involved in these cases once the mother gave birth. However, this process was no longer possible due to concerns related to the Health Insurance Portability and Accountability

Act (HIPAA). A supervisor from another site shared that their county maintained a list of expectant mothers who were either reported on or currently had open cases.

One supervisor explained, “So we got contacted by the hospital because the child tested positive, so we went out and talked to, I believe it was THC but it could have been meth... I think they were the THC family, and so our perspective is a little different with that because of the law changes and that kind of stuff, so really what we care about is protection of the child at this point.”

Another supervisor shared, “It’s about whether you can use this substance and still effectively parent your child. And so, whether it’s legal or not doesn’t really matter in the big scheme.”

A caseworker stated, “It’s not that it is an illegal - It is an illegal substance, so we need to do this or that. We’re having to look at, go down to what is the level of safety? If there is no safety, what is the risk to the child? And, going from there: the age of the child, those types of things. Taking all the factors and looking at them as a whole, rather than, you know, it’d be if we had a heroin-exposed newborn. That’s - That’s completely different. Or, a cocaine-exposed newborn who’s going through withdrawals. That’s - Or, meth. That’s different.”

As stated, marijuana use, medically or recreationally, was common in many sites. Some caseworkers from some sites described that marijuana use had occurred in the presence of children, while caring for the child under the influence, and while driving under the influence. The latter two conditions were considered higher risk because of impaired judgment associated with marijuana usage while caring for a child. Some caseworkers in a couple of sites explained that clients were also growing their own marijuana in their homes. A couple of caseworkers from some sites had also dealt with parents who purchased marijuana for their children to use recreationally, while a few caseworkers from one site shared that children who were addicted to marijuana had been under CPS protection.

One prevention worker regarding marijuana legalization shared, “It’s caused a lot of trouble with Child Protection, because parents are now using it in front of the kids and there is not a whole lot we can do with it. So, it is, it makes the risk factors a lot higher if the parents are using and high taking care of their kids, then it’s high-risk.”

One prevention programs manager shared, “Okay, we’re talking about marijuana. I think part of it is - From what I’ve seen that I don’t understand is that they legalize marijuana and a lot of families, especially for their kids, think it’s okay now for their kids to have it because it’s legalized. I think to myself, ‘Okay, you’re buying your children marijuana for recreational purposes, not for medical purposes, but you wouldn’t buy them alcohol. So what’s the difference? You still have to be 21.’”

Approaching Substance Use

Many caseworkers and supervisors across multiple sites shared that the CPS approach to substance use had changed over the years. In the past, addiction to a drug be it alcohol or methamphetamine often resulted in automatic termination of parental rights and removal of the

child from the home. Presently, caseworkers were more likely to have examined social supports within the family and other services that addressed the safety of the child without removal while providing the basic needs for the child. Indeed, many caseworkers from most sites explained that substance use did not necessarily result in a removal of the child, but rather it was important to assess for impact on the child and the client's ability to parent.

One supervisor shared, "Yeah. So, um - I'm trying to think - So, in substance abuse cases where you might have a parent that's addicted to whatever drug. It might be alcohol, meth or whatever. Typically, you know, nine years ago, if you had somebody that was positive for meth, you automatically filed, and that child was removed from that parent. Well, now, we would look at, 'Okay, so what services or supports are available to that family? Do they have family? Church? Neighbors? Could these people come in and supervise the contact with the parent?' So, that parent still is there giving baths, feeding the kid, you know, doing - You know, reading bedtime stories, but under the supervision, so that we're addressing the safety of the child, but not the - We're not removing the mom, you know, the parent and the child."

A prevention programs manager shared, "And so, it's been - It's a lot of educating them, as well. The moment we start talking about it in the framework of alcohol, then a light kind of seems to go on, but a lot of them don't see it that way at all."

In approaching marijuana use, many caseworkers from several sites were encouraged by their judge to treat it as similar to alcohol: whether or not the parent was meeting the needs of the child. This approach was also prevalently discussed by several supervisors among several sites, that the context of how marijuana use impacted the parent's ability to care for the child, marijuana impacts on the child, and assessment of the child's safety were used to determine whether a report was founded or unfounded. In multiple sites, many caseworkers and supervisors recognized that marijuana was not a clear cut area for them to assess and that there existed conflicting guidelines to assess this area. In some sites, a couple of supervisors stated that infants who tested positive were automatically considered a founded case of child abuse/neglect, which required CPS involvement. This approach was not used by all sites.

One caseworker shared, "Well, it's pretty much statewide where we, you know, we require - We treat it like alcohol. So, if they use marijuana, we ask that they not use it around their children. We also ask that they not - And, that there be a sober adult within the home, just like, you know, if they were drinking alcohol, you know, that somebody is not intoxicated and can care for a child and deal with an emergency or whatever may come up, so - Yeah."

Another caseworker expressed, "We are so limited. It is the most gray area and quite frankly I think it was legalized too quickly because there's not good guidelines. You know, there's conflicting guidelines in the Children's Code versus what our state has and so it makes things very messy and complicated because—And there's no guideline for levels either. We go out and we assess that. If they are using in front of their child, that is illegal, and they can't be doing that. However, it's very limited in what we can do."

One supervisor stated, “Marijuana piece our judge still says, you know, under federal law it’s illegal so you shouldn’t be smoking it. But we don’t remove kids for it — what you would base it — what you would base it off of would be just like you — this is how I do it — alcohol is legal, marijuana is legal. Okay, so as long as they’re meeting the daily needs of their children and there’s no abuse or neglect going on at home that’s how we should view it, and... Just like if an alcoholic can’t maintain their home and they don’t get their kids to school and the house is filthy and whatnot, that’s when you go in to assess. So, you’re assessing the safety of the child.”

Another supervisor expressed, “So if the child tests positive for a substance, then that’s an automatic that they would call us. The marijuana thing has opened up a lot of different - weird doors for us. And, marijuana use during pregnancy clearly, to me is, like, alcohol use during pregnancy. And so, it’s very much, you know, not recommended. However, you have a significant amount of people that say ‘Well, it’s legal, so therefore, you know, I’m gonna use it.’ And the concern is, it’s really amount marijuana use, how is it impacting their parenting, but it’s also about how is it impacting the child. And so, and the development and all those other things. And so, I think that we have to have a different way of looking at those cases. We have a lot of people that think that because marijuana is legal, you know, that’s ok. But it’s like, are your children exposed? What does that look like? It looks different for a person who might be terminally ill- who’s taking edibles. If they still can parent, that’s not as big concern for me, the concern is when they’re stoned all the time and they can’t parent.”

In addition, many caseworkers across sites explained that most clients believed marijuana use was not harmful because it was now legalized. This perception had resulted in many caseworkers educating the parents in a similar framework to alcohol, such as educating on the physiological effects on the child, legal responsibility (e.g. someone in the home must not be intoxicated and could care for the child), effects of marijuana use while pregnant, and strategies to protect the child (e.g. smoke outside, do not breastfeed while using marijuana, etc.). In one site, a prevention programs manager shared that her case managers approached marijuana use with their families with education; they educated parents on the effects and physiological impact of marijuana use on the child as well as on their ability to parent. Some supervisors and caseworkers across several sites had also worked with NFP nurses around substance use issues with NFP clients. These situations usually involved consultation around whether or not mandatory reporting was necessary. Finally, several supervisors from various sites explained that ongoing discussion and site-specific policies were being developed to address marijuana legalization.

One supervisor explained, “And, so, we kind of educated them about using THC when you’re pregnant, the effect on children, exposure, that kind of stuff and talked to them about how they could protect the infant now that they’re going to be bringing him home. And it was a really low risk – they smoke outside, she’s not breastfeeding, like the actual exposure is pretty low, but it was obvious that this person needed some education and support about raising an infant...”

A Child Welfare manager stated, “So the recent situation, I received a call and the nurse had brought to her supervisor a concern that she thought that um, her, the mother who was like six months pregnant, was using, had relapsed and was using meth again. And

what would I recommend. Is that something that we would have them call in? Is that a mandatory reporting issue? And what I explained is, ‘You certainly can call it in, but there is no red flag anymore, and um, we definitely want to try and intervene with this mom before the baby is born, so, what’s the best way to do that?’”

Clients With Mental Health Concerns

Another area of concern amongst some caseworkers across most sites involved mental health illnesses. A range of mental health illnesses amongst clients were described, including: schizophrenia, postpartum depression or attachment disorder by the mother (including lacking bonding with the infant), and children with behavioral disorders, attention deficit hyperactivity disorder, reactive attachment disorder or trauma related to experiences of abuse or neglect (including growing up in a drug-abundant environment). Other issues related to clients with mental health illness included lack of adherence to doctor’s appointments and reluctance by the client in admitting that they had mental health illnesses. Several caseworkers across various sites also recognized that mental health was often associated with other complicating concerns such as substance use.

One caseworker shared, “Yeah. But, it’s like a mom that doesn’t understand attachment, doesn’t - It’s the one that I told you about that her first one was given away—and then, now she’s got this one-month-old. She doesn’t cuddle the baby. She doesn’t - She rarely holds the baby. I’m pretty sure she props the bottle.”

A prevention programs manager shared, “That one [program name removed] really looks at the kids who - when we get a referral for the behavior of the child that the parents don’t know how to deal with anymore, and they’re like, ‘Take my child.’ Or, ‘I can’t handle this anymore.’ Or, because of the child’s behavior, they’re the, a higher risk. You know, some of the kids with ADHD, ODD, mental health issues, or they’re just running away – you know, all of those issues and the parents are like, ‘I can’t do it anymore.’”

In approaching mental health with their clients, some caseworkers from a couple of sites suggested that the client’s mental stability and adherence to medication were assessed. Many caseworkers from most sites also described that collaboration with service providers allowed them to better understand the clients’ ability to meet the child’s needs and that providers had participated in staffing the case and developing a discharge plan that emphasized the best interests of the child with regards to placement. In most cases, several caseworkers suggested that mental health combined with other safety and risk concerns often resulted in removal of the child. Many other caseworkers across several sites also suggested that mental health issues were often not fully addressed when the client’s case was closed. Finally, one division manager shared her experience in assisting the county’s Health Department to develop an algorithm for serving mental health clients, including how to intervene and determine when additional help or assessment was needed.

A caseworker stated, “So, you know, just the visual of depending mental health, is mom stable, is she on her meds is she following through? So it just depends on the type of case.”

Another caseworker shared, “This is with older children, you know, if the child has behavioral problems and is mental health hold for 72 hours at [hospital name removed] or [hospital name removed], then we do outstaffings with medical staff to come up with a plan, discharge plan, where the child is going to go where the child’s needs will be met and what will be in the best interest of the child as far as placement goes.”

A Child Welfare manager explained, “Like, when we strategized with this whole algorithm, it was really about people who were threatening to hurt themselves, and so, what to do, how to intervene, how to, at what point would you call somebody else? At what point would you call the hospital? At what point would you, you know, if you were out at the home and the child was born, at what point would you call Social Services, at what point. And so we had, um, you know, kind of a whole strategic plan about, you know, what would we do with the nurses, and. And it was really all from the nurse perspective...”

Clients Experiencing IPV

In addition to substance abuse and mental health, IPV was expressed as another risk factor among clients for many caseworkers and supervisors from most sites. Many caseworkers and supervisors from several sites described the function of CPS in preventing familial violence and their role in conducting IPV assessments. One caseworker described the function of CPS as one that was trying to prevent familial violence and attempted to keep children in proper places such as schools and homes, while a supervisor from a different site described IPV and child abuse as public health issues, indicating the preventable aspects of IPV.

One caseworker said, “Being as that we’re trying to prevent familial violence and, you know, keep kids in school and keep kids out of the juvenile justice system and keep kids within their homes and not in foster care.”

One CPS supervisor said, “And I, personally, consider things like domestic violence and child abuse public health issues, so I think that’s part of it as well.”

Substance Use and IPV

A couple of CPS workers from different sites described the co-occurrence of substance use and DV among some clients in their counties. One caseworker described seeing alcohol use and violence in the home among clients she worked with, such that clients who abused alcohol tended to be involved in DV. A supervisor from a different site reinforced this perspective and expressed that alcohol and meth abuse coupled with IPV created an injurious environment for children.

One caseworker said, “And, once in a while a few meth users and things like that. So, more alcohol, which create the domestic violence, you know. So, for some reason domestic violence and alcohol you do see that pattern in there.”

A CPS supervisor from a different site stated, “We have a lot of alcohol abuse up here, we have a lot meth use up here, um, some marijuana, um, and prescription drug use is really on the rise. Um, and I think that domestic violence also is a big issue for us. Oftentimes that goes hand in hand with the substance abuse and creates a pretty injurious

environment for kids. Um, I think those are the two big ones that we see. And poverty, you know, definitely contributes to some degree, but sometimes it's hard to sort out just what's true poverty and what is neglect, um, so."

Socioecological Environment as a Risk Factor

Another area of risk related to child maltreatment shared by multiple caseworkers across several sites was the social, physical, and ecological environment. Risks related to the family/social environment were described by these caseworkers, including having a history of CPS involvement or termination, previous CPS reports, or criminal history; bringing children to environments (e.g. parties) with substance involvement; having dysfunctional relationships with the family or FOC, lacking social support or being in social isolation; or having inappropriate alternative caregivers (e.g. known drug users).

One caseworker recalled, "She had been here, went to a party, took off with a guy, left the infant with a known drug user that we had a case on before and have taken her children away. Left her in the care of this person, in the home; there was a drug raid. People were running out the windows, jumping out the windows, running down the street; they were throwing money out. They happened to, when they went in they happened to arrest two of them. They arrested all of them eventually. But the woman that was the caretaker of the child had her pockets full of drugs. She got arrested, and the mother left the child there. Now in that case we took custody cause the mother wasn't around, we didn't know where she was at, nobody knew where she was at. I don't even think they knew what the baby's name was. So she was just baby Doe for a while."

Another caseworker regarding safety issues explained, "We have the potential for it. Some of our families do have a lot of history with us [with CPS], which makes them high-risk."

Another caseworker stated, "I think sometimes being isolated could up the chance of abuse or neglect."

The physical environment also offered different risks to child maltreatment. Several caseworkers across different sites shared that inadequate housing for the child (such as homelessness or living in a drug-house), lack of home upkeep (e.g. unclean – dead bugs or mold in the home or hoarding), lack of heating (for example, child was laying on cold floors with no blankets), and inadequate provision of food and clothing for the child were risks in this domain.

A caseworker shared, "Dirty homes. Is it just clutter or is it filthy? If, I get all the dead bugs and the chronic lice and so, those are the issues that put kids in high-risk... I work – I had a hoarding home that, it was awful. So what I did is I worked with the family getting at least the kids' room cleaned up, and the upstairs cleaned up and what that looked like."

Another caseworker stated, "We had one family where kids weren't eating, and she didn't understand the free lunch program. She hadn't even signed them up for it, and so we stop then because we can't talk to her about the behavior of her children if her kids aren't eating."

For all aspects of the environment, some caseworkers, prevention program workers, and supervisors from multiple sites explained that living conditions were not judged in their assessments and that poverty did not necessarily mean parents were abusing or neglecting their child.

One caseworker shared, “Just she was lower functioning, so she was taking care of the child to the best of her ability. And, it’s not up for me to judge people’s parenting styles and living conditions. It’s up to me to assess risk and safety, so.”

A prevention programs manager expressed, “You know, just because you live in poverty, it doesn’t mean you’re maltreating your children, and I think that’s another thing that we have to overcome. I know some parents who live in poverty who take very good care of their children, so I think that’s the one thing that we need to overcome.”

Developmental Delays and Special Medical Needs

Among most sites, many caseworkers also described working with parents and/or children who had a spectrum of developmental delays or special medical needs. Developmental delays included Down syndrome, low IQ, delayed speech or motor skills while cognitive issues such as mild retardation were also prevalent within and across sites. Children with special medical needs ranged from premature infants or those hospitalized in the ICU for example for substance-exposure, to handicapped or medically fragile children - some had respiratory diseases requiring oxygen, others required gastrostomy tubes, and some were diagnosed with diabetes, colic, or lung development issues.

Some caseworkers across sites shared about safety and risk factors related to clients with developmental delays or special medical needs. Some developmentally delayed clients in various sites were disinterested in adhering to feeding schedules for their child or lacked consistency with bringing their child to doctor visits; when cases had risen to this level, the child’s safety became a concern warranting CPS involvement. Several caseworkers in different sites also shared that developmentally delayed clients often required information to be explained in a more concrete and straightforward manner or repeated over multiple visits, while another caseworker from a different site expressed her concern for young clients not understanding how to care for medically fragile children because they lacked the necessary coping skills. In another site, one caseworker recalled a developmentally delayed client who did not even realize she was pregnant until the baby was born. In some sites, some caseworkers explained that developmentally delayed clients caring for medically fragile children were at even higher risks because these parents did not fully understand the diagnoses and the associated care required to provide for their child’s needs. Finally, several caseworkers and supervisors across several sites recognized that developmental delays were unchangeable, unlike substance abuse, and that these clients were often not mistreating their children, but rather lacked the knowledge and capability to care for their child adequately.

One caseworker explained, “Um, a pretty straight forward feeding plan, with a certain amount of formula and things like that. . . maybe it’s a cognitive issue, or maybe they just really don’t care, like, they’re just not interested in following those, um feeding schedules, or, no interest in making it consistently to their doctor’s appointments. At that

point, it becomes pretty dangerous for us to not become involved if we have to. And so, once it rises to the level where it's really becoming a safety issue for this kid, I think we have really no choice but to become legally involved."

Another caseworker shared, "So, I think the scary thing for us is that people are given a child and don't really know what they're doing. It's like we always say about, you have to have a license to drive, but no license to have a child. And so, people just really didn't realize that these children were fragile, that they didn't really know how to take care of them, they didn't know, you know, that one shake or one, you know, um angry moment could create such a terrible, you know, situation."

Another caseworker stated, "Like I said, most of our clients have cognitive limitations. Sometimes, it's hard for them. Just for one doctor's visit to get all of the information that the doctor wants to relate in regards to the child's medical diagnoses and follow up care..."

A supervisor shared, "Unfortunately, we had another case just recently that we're struggling with. Mom and Dad both have IQs of under 60, and we really struggled back and forth because she couldn't even figure out how to do four ounces. She didn't know how to measure. She just doesn't have the capacity to do it... Yeah, and I think it's been interesting because with those two particular cases, again, there's no evidence of any maltreatment. It's the risk of maltreatment but not based on anything other than their IQ, which is really hard because we can't change their IQ. It's not like a mother who's doing a drug or a poverty issue or anything like that. I think those two cases are interesting because you can't change their IQ. You can only put certain safeguards in place to do the best you can."

Low Education and Young Parents

Beyond substance use, mental health, and developmental delays, some caseworkers across most sites expressed that having a lower education and being young were additional risk factors. Especially coupled with the aforementioned risk areas, being young and less educated were often described by some caseworkers as risky because the parents simply lacked knowledge in how to properly care for a child, had lower tolerance towards managing their anger and frustration with the child, or simply lacked confidence in their abilities and skillsets. Several caseworkers in various sites also shared that there were multiple avenues that they encountered young teenagers: through those currently involved in the CPS system as a child (including foster care), through youth in conflict such as those who acted out or ran away, or through probation including those who had criminal involvement. In several sites, some caseworkers explained that they had also worked with young teen parents, many of whom were in foster care, or teenagers who were on the path towards getting pregnant at a young age. In the cases with pregnant adolescents, a couple of caseworkers from various sites explained that support from the family for the pregnancy was assessed as a strength. A supervisor from one site also explained that young parents who lacked knowledge in child caring did not necessarily become involved with CPS but were often referred to community or public health department programs, such as NFP if they were first-time mothers.

A caseworker explained, "Or, they don't understand. Sometimes, they don't understand. Just the clientele we're working with are lower education... I just recently made some more referrals. Um - it kind of goes in cycles, so for a hike, we'll have some teen parents come in."

A prevention manager shared, "Actually it's usually, usually youths that are 10 to 18 and are usually in trouble with the law, they have court cases, or are delinquent kids - but they also, some of them, you know, have little kids or have babies, not a ton. But maybe so it probably doesn't apply to them as much, but they're part of Child Welfare as well."

The same manager expressed, "One of the things that we want to start working on more is pregnant parenting teens because of the fact that it's a high-risk population for, not only child abuse, but other issues. And, also, on the other hand, we try to make sure all of the kids we're working with have their immunization and then report back to them."

Another caseworker stated, "But then, the teenagers that are usually involved with Child Welfare that are, like, 14 or 15, like, I think of, I have a child in my caseload now that's 14 who looks like he's about 20 and goes out with older girls, like, he has a girlfriend now that's 24, which is not good. But, my girls - I mean they get pregnant, like... But then I can see cases like that or I, like, have a girl that's 15, like, that disappears for days with boys too."

Another Child Welfare manager explained, "Um, we will make referrals to them if we have like a young family that just kind of seems clueless. But, really doesn't need our intervention. We'll make referrals, you know, we had - and, to this date, I get confused about the different nurse programs."

A couple of caseworkers from one site shared their areas of assessment for cases involving pregnant teenagers or teenaged mothers. One caseworker explained that she had assessed if the guardian of the teenager was ensuring that the pregnant teenager was attending her doctor's appointments. This assessment was necessary because the teenager lacked transportation and was underage; thus, she relied on her guardian to adequately care for her unborn child. The same caseworker also explained that the teenager had an open case but once born, her child may or may not become involved with CPS. Therefore, ongoing monitoring and communication with medical providers was necessary for this caseworker to accurately assess for the teenager's child's safety. In a couple of sites, some supervisors also shared about various programs designed for youth (aged 10 through 17) to assist them and their parents in accessing community resources.

One caseworker shared, "But, just more of the - you know, are the kids taking care of themselves? The guardian, if - you know, with the teen mom, it depends on what the circumstances is, is the guardian making sure the kid's getting to their appointments. You got a 14 year-old pregnant kid, she can't drive herself. And, she can't - technically, she's not supposed to sign for herself, so that you communicated or that the guardian is taking care of this pregnant youth that they have in their home."

The same caseworker stated, “The youth was already open for whatever reason on dependency and neglect case, so that’s one component. But, now you have a young teen, pregnant, on an open case.... So, not only do we have a guardian and a teen on a case, now we have a baby that we either automatically file one or just sit back and watch... Just watch, just monitor. Just communicate and monitor.”

Abuse and Neglect

In addition to assessing for and working with clients with various risk factors, many caseworkers from all sites shared about their experiences with actual cases of child abuse and neglect. Among all sites, abuse was usually categorized to be physical or sexual while neglect involved cases related to medical or educational aspects. Finally, some caseworkers across multiple sites recalled cases related to foster care, kinship care, and general custody under CPS.

Physical and Sexual Abuse

Physical and sexual abuse cases were explained by some caseworkers across various sites. These caseworkers described physical abuse cases to include bruising, burns, serious bodily injury resulting in broken bones, physical abuse in public (e.g. slamming a child’s head on a car), and being shot. In many physical abuse cases, some caseworkers across sites explained that the perpetrator was jailed and/or placed against protection orders so that he/she no longer had access to the child.

One caseworker recalled, “He got belligerent and violent. He dragged his seven-year-old child out of the car by his foot, so that his head slammed on the car, you know- Slammed on the car and then down on the ground, and dragged him up the front steps by his foot. Law enforcement was called. The reason he wanted is he was, ‘It’s my kid. You can take the other fucking kid, you know, and leave and blah, blah, blah,’ that kind of attitude, and he was plowed. Law enforcement was called. He was arrested. There was a protection order put in place.”

Another caseworker explained, “The other is that we had a sexual abuse case where a three-year-old made an outcry of sexual abuse. No criminal charges were filed because they didn’t get what they needed to make, take it criminally. We closed it founded based upon the outcry of the child and the evidence from interviewing the other child and Mom’s, you know, the information she could provide.”

Another caseworker shared, “In that situation, the child was harmed by Dad and he was in jail for harming this baby.”

Medical Neglect

Medical neglect was a common form of maltreatment expressed by many caseworkers across multiple sites. Medical neglect occurred in situations where the parent was unable to adequately care for a child with special medical needs, including not adhering to doctor’s appointments, diagnoses of failure to thrive due to maltreatment, and substance-exposed infants.

One caseworker explained, “Um, and if there’s concern, and then if there’s immediate concern, obviously, I mean I have taken custody on the spot at a hospital once a kid has been determined, like, seriously, failure to thrive.”

Another caseworker shared, “Um, they’re like, questioning, like the supervision of the child, um, not, like, age-related or that maybe the child is, like, failure to thrive or not making progress appropriately.”

Educational and Other Forms of Neglect

Some other forms of neglect were also shared by some caseworkers and supervisors among various sites. Educational neglect referred to children who were not attending school (truancy) whether by choice or because the parent was not taking the child to school. There were also instances of repeated severe neglect, exposure to IPV in the home, as well as environmental neglect such that the child was living in a dirty home, the parent was unable to adequately provide shelter and/or food for the child, or cases where the parent was beating up dogs in front of the child.

One supervisor explained, “Oh, I’m on – there’s a team that meets every Thursday morning for like three or four hours, and we go over juvenile delinquent cases or kids that in the community that might need some extra help, like truancy cases, different things like that. And, we staff those to see what services they need, or if they need to come out of the home, or if they should be committed.”

Another supervisor shared, “Well, there was just a referral where somebody was beating up the dogs in front of the kids, so of course – it’s (*laughs*) neglect if it’s really happening.”

A caseworker explained, “We don’t speed pass it, oh no, we have to address everything that’s going on. If I walk in, and there’s no, if it’s maybe it’s educational neglect, kids aren’t going to school. But I walk in, house is a disaster, there’s animal feces everywhere, we’re gonna address that, we’re not gonna walk away from it.”

CPS Custody

Among ongoing cases, some caseworkers across several sites shared about their client’s experiences under CPS custody including foster homes, kinship care, and group. Some caseworkers from some sites mentioned that children, often those who had suffered severe abuse and neglect and its associated trauma, had bounced from home to home repeatedly without ever getting adopted and that young teens in foster care or group homes had become pregnant. Other caseworkers amongst some sites explained that substance-exposed infants and medically fragile children had often been taken into CPS custody and placed into homes, where kinship care was the preferred placement but was not always possible.

One caseworker shared, “Because I was at the other end of adoption at times. I watched those kids that nobody wanted because they were so severely abused and neglected that they bounced foster homes repeatedly.”

Another caseworker explained, “No. I was just going to say, you know, with the medical fragile child, definitely it was really hard, you know. Eventually, the baby had to be placed out of the home... And so, eventually that child had to be placed out of the home. We tried to put services.”

Another caseworker stated, “Um, we ended up taking custody, I put her in a foster home for a few days until we could notify kin. Of course, then the mother surfaced, but she was in no shape to take that baby back, she was not drug free. And um, I don’t think she had any intentions of straightening up at that time, so at court, we ended up calling in the grandma. And grandma happened to live in another county, so the baby went with grandma...”

Fatality

Compared to NFP nurses, there was more discussion of child fatalities by CPS caseworkers and supervisors across sites. Most caseworkers and supervisors across various sites explained about their past and current positions as it related to investigating fatalities and near-fatalities. There was also greater knowledge and recognition of fatalities in their counties by caseworkers and supervisors across sites as compared to NFP nurses.

Fatalities and near-fatalities among children across sites were generally related to shaken baby syndrome, co-sleeping, or severe abuse. A couple of caseworkers and supervisors from one county further explained that there was a high number of fatalities in a recent year, with many of the children not being known to DHS, were related to the military, and were children of first-time mothers. Fatalities were also described by a couple of caseworkers from different sites to occur among CPS clients’ family members (such as the client’s mother or father) or among pregnant mothers who abused drugs.

One caseworker shared, “Yeah, I think, um, for example, like, I have one that was a pretty severe physical abuse. Um, and I removed the children, and placed them with kin, so with grandparents. Um, neither of the parents would really ever admit to the abuse, and they really couldn’t seem to understand how significant it was, even though it was, like, very significant. This kid probably could’ve died.”

One CPS administrator explained, “It’s really to determine if there is a consistent - Like [county name removed] two years ago, I want to say [redacted], had [redacted] deaths, kids dying because of co-sleeping. So, we actually started a co-sleeping thing because of all of that. With the health department and the coroner and some other people to the table...”

Another director stated, “Because if anybody can be, you know, have intervention at that level and not have to come to our level, I think that’s great. We had, in [redacted], we had 10 fatalities with kids at a very young age. And um, seven of the ten of those were related to the military. And a great deal of them were first-time children.”

Another caseworker shared, “I think it’s getting worse now, especially the prescription drug use, and now we’re seeing a lot of heroin coming into the county. We’ve had a lot of deaths with mothers that were pregnant and I wish there was a way we could intervene during the pregnancy part portion. Not wait ’til after they’re born and after they’re addicted.”

In addition, several caseworkers and supervisors across different sites explained that their scope of work involved investigation of fatality cases – usually collaborating with the law enforcement

- and those of near-fatality. One caseworker emphasized that fatalities were certainly an aspect of his work and that it was the reality for CPS workers in their everyday work. Several caseworkers and supervisors from various sites also emphasized that those who performed fatality investigations needed to have a greater level of experience in casework. One supervisor expressed that due to the age group (younger than six) her unit worked with, the possibility of a fatality led to greater turnover because of the associated responsibility. Finally, one administrator explained that the state had passed legislation related to each county creating a Fatality Review Group that investigated all child fatalities, as well as the formation of a task force to address co-sleeping fatalities in her county.

A caseworker shared, “And because I am a caseworker IV, we get more serious injuries, we get more serious cases, we get sensitive cases and they involve, um, that maybe media perhaps even a coworker. We get cases that have egregious injuries, uh, we get fatalities, we get things that are very complex...”

Another caseworker stated, “—the child fatality, but still, that’s the kind of stuff you have to deal with every day, so.”

An administrator explained, It’s the one that - The state has recently passed legislation in which every county has to come up with, and it’s through the Health Department, and it’s specifically for prevention actually – that they have to come up with a team and there are certain required parties on that team, and any child that dies, we have to staff that.”

She went on to state, “... had [redacted] deaths, kids dying because of co-sleeping. So, we actually started a co-sleeping thing because of all of that. With the health department and the coroner and some other people to the table, but [programs manager name removed] kind of headed that up and did that, so that’s just one example of how can we prevent these particular deaths? You know, if there are a bunch of SIDS, what’s going on with that? Are we seeing any connections between that? And those sorts of things.”

Reporting of Child Abuse

Across all sites, some CPS workers shared their experiences and knowledge of people who report to CPS, including mandatory reporters, the reporting process, and reasons for reporting. In addition, in most sites, there existed workers who were responsible for conducting mandatory reporter trainings for their community as well as those who had worked with mandatory reporters on hypothetical situations and consultations as part of their scope of work. Finally, a couple of CPS workers from various sites discussed their philosophies to mandatory reporting while others shared their perceptions of NFP nurses in their reporting duties as well as challenges to working with mandatory reporters.

Reporters

Some CPS workers across all sites shared their knowledge of people who had reported to CPS. These workers explained that people from the community as well as mandatory reporters, such as NFP nurses, social workers or medical staff from the hospital, and schools had reported in the past. In some sites, several caseworkers shared that NFP nurses who had reported had generally provided trusted, reliable, and comprehensive information on a family, while reporters from

schools usually provided less comprehensive information. A couple of caseworkers also suggested that despite having less knowledge, reporters from schools tended to be more forthcoming with sharing of information, while medical providers and victim advocate groups were usually more restrictive in what information they shared due to confidentiality and HIPAA concerns. Another difference within reporters was suggested by one caseworker; she felt that NFP nurses tended to be transparent with their clients upon making a report while school staff had reported and let the victim know, but not the parents (alleged perpetrators). Furthermore, in one site, several caseworkers spoke about a liaison initiative with their county's public school system where a Child Welfare liaison educated school staff on what was appropriate to report, which ultimately reduced the number of unnecessary reports to CPS. In another site, one prevention case manager expressed that she herself was a mandatory reporter because she worked with families and young children, and had on occasion reported her families back to CPS.

One caseworker stated, "Um, it can be, it can be a lot of different people, like, just like in the civilian side, we get schools and law enforcement calling in, um, therapists and people like that. We also have, um, the social work services, a lot of times they get report, that on [military location name removed], like, they'll get reports before us, because like they get MP blotters, so like the Military Police blotters, and can see that there was an incident, and so a lot times they'll make reports in to us, you know, um commanders, really anybody. It's not that much different, probably, from the civilian side of things out in the community as well."

Another caseworker expressed, "If it's a doctor that's reporting or something, sometimes they are very narrow in the information that they feel comfortable or permitted to give... Well, yeah. I mean, they'll be – they're willing to – sometimes they'll report that they saw something and that they had a concern, which is great that they're making that report. But, a lot of times, we want to know affect and demeanor and anything historically that they have... Schools are, tend to be fairly forthcoming with their broader picture when they're making a report. The other advocacy groups tend to also have less of a willingness to go beyond – like victims' advocates type people."

Another caseworker shared, "So, and the liaison is kind of educating the school staff on what is reportable, what is appropriate to report and what is not. So, by having that, it has reduced the number of the referrals that we got. (*laughs*)... That really helped to eliminate so many unnecessary referrals that come to the department that we ended up closing, you know, in the referral stage anyway."

A prevention case manager stated, "So if I suspect that the parents are actually using or it is a bogus referral that came in with them using, then I will work with the families regarding those issues and set up goals. If they are using and it is affecting their parenting then I have to make a referral back to Child Protection."

A couple of caseworkers from one site shared the distribution of types of reporters in their county. In this site, one caseworker expressed that the majority of reports were made by mandatory reporters including medical staff (social workers or nurses) from the hospital and schools, while another caseworker suggested that half of reports were custody-related – for

example, one parent reported on the other due to retaliation on the results of granted custody, about 25 percent were made by mandatory reporters, and the remaining 25 percent were related to a possible D&N case, where a complaint was filed to the court due to a child not being properly cared for by the parents. In another site, a supervisor discussed that approximately 20-25 percent of reports were usually screened-in (requiring action) due to a cause of concern. A Child Welfare manager from a different site explained that the reports were often made by phone, but some people had reported through fax, email, or in person; as well, the majority of reports were made during regular business hours.

One caseworker shared, “Through that, my experience dealing with child abuse cases, investigations – I have had a chance to deal with hospitals, with nurses, some of the reports – most of our reports come from mandatory reporters, who are, you know, schools, hospitals, and stuff.”

A supervisor stated, “So we take phone calls 24 hours a day, 7 days a week. The bulk of our calls come in during regular business hours, which is 8 to 5. We do have a number of calls that come in after the hours as well. But during, when we receive our report and we not only do we receive phone calls we also get faxed reports and we have an e-mail system that takes reports as well. It is called [email removed] and so people can e-mail reports to us as well and that number has increased significantly over the last couple of years.”

Another supervisor expressed, “You know, the number of calls we are getting are still up. In fact, we had a record this month. We took 70 calls and it was kind of concerning. We didn’t, maybe 20% to 25% of that is what we accepted which was kind of a cause for concern.”

Reporting and Screening Process

Across multiple sites, many caseworkers and supervisors shared their understanding of the reporting process. Many CPS workers stated that reporters would call the local hotline or a locally designated phone number and deliver their report. In a couple of sites, a couple of supervisors shared that people could report to an intake caseworker or supervisor directly in-person if they had an established relationship. Other supervisors from different sites shared that people could call 9-1-1 after hours to make a report, while for sites that ran a 24-hour hotline, people could make a report at any time. One director of Human Services shared his knowledge of the state’s development of one general reporting hotline that would send reports back to counties. A couple of caseworkers from different sites went on to describe that reporters offered their concerns of allegations of child abuse or neglect, listed the victim and alleged perpetrator’s names, addresses, and birthdates, along with other related information (including if other children lived in the home, if the children attended school, strengths of the family, substance use, DV, and mental health history). Upon receipt of the report, it was then determined to be screened-in (assigned to a worker with varying response times depending on the level of risk and danger for the child) or screened-out (usually with no action taken by CPS but some cases had been transferred onto community service providers).

One caseworker shared, “So, people call into the hotline, um, they make a report, and from there, um, it either goes—it’s usually they’re directly assigned to a worker if it’s,

like, an immediate—there’s imminent risk and danger for a child, that needs to be addressed instantaneously.”

Another caseworker explained, “An intake means that somebody will make a referral to us or a report to us with concerns of allegations of child abuse or neglect and, um, they usually list the victim, the alleged perpetrator, the other parent maybe if there’s other kids in the home, if they go to school. And then from there as an intake worker we’re assigned a response time.”

Several sites hired designated workers called screeners who responded to CPS reports through the hotline, while in other sites there were rotating caseworkers who were responsible for receiving the hotline calls. Some caseworkers and supervisors from different sites further elaborated the screening process in their site: the screener would conduct a background check on the family including criminal and Social Services histories; a supervisor or a team of Child Welfare workers (through the RED team) would meet to evaluate the collected information including reviewing the allegations, genogram, danger or harm, risk factors, and supporting networks; then the supervisor or RED team decided whether or not the report was accepted for further investigation.

One supervisor stated, “Okay, so we have one full time worker that it’s her full time job to take the hotline. She’s been doing that for 13 or 14 years, um, and when she is at lunch or something or wherever and other people have to, um, do that and they’ve also receive training in taking hotline calls.”

Another supervisor shared, “We rotate intake right now, so all the caseworkers have to do intake and they get it for a week.”

Another supervisor explained, “So when somebody calls in they make a report, the hotline worker then, um, does a little bit of background check. They look at the criminal history. They look at Social Services history, and then a team of people — we — RED team — we team — a team of people get together from Child Welfare and evaluate all of the information. We look at the genogram. We look at who’s in the family. We look at the actual allegations. We look at if the allegations meet the state statute for abuse and neglect, um, and then we make a decision on whether — whether it’s going to be accepted or not. But that’s made at a team level and we use scaling questions to, um, to gauge where people are on if they want to accept a referral or not.”

Some sites shared that mandatory reporters received a response from CPS regarding whether an investigation was accepted or not; this response was usually in the form of a phone call or formal letter with details that included whether the case was assigned or closed and associated findings. A Child Welfare manager from one site explained that mandatory reporters who had an ongoing relationship with the child usually received feedback or were instructed to call CPS within 24 hours to determine if an investigation was opened; however, reports by mandatory reporters did not receive any priority but the information was often considered highly credible.

One Child Welfare manager explained, “So the mandated reporting, the rules around mandated reporting include if the mandated reported has an ongoing relationship with the

child that they're on. We do contact them back and let them know or they're welcome to, they're instructed to call us back within 24 hours to determine whether or not an investigation happens. They don't get priority. They still, it still has to meet the Children's Code definition, but they are, we consider them to be highly credible informant because they're mandated reporters and they get specific parameters that they have to report. If they have a relationship with the family we are then able to share information with them. And what some of our ongoing services might be with the family."

Impact With Enhanced Screening

Enhanced screening was recently introduced and being implemented by most CPS sites. This new method to screening CPS reports involved more intensive questions about the family structure, social supports, and other relevant information. One supervisor suggested that enhanced screening might have implications on the length of calls when making a report (e.g. longer calls) while another supervisor from a different site felt that this method would impact school reporters more than nurses because school staff usually lacked a comprehensive understanding of the family and may not be able to answer many of the enhanced screening questions.

One supervisor explained, "Oh, it is, um, we've been doing enhanced screening for probably about six months... There are more questions. There are a lot more questions and follow up questions for – so instead of a caller calling — if they call and say, 'Oh, Billy has a black eye.' Instead of saying, 'Okay, thank you very much.' We ask a lot more questions. And there's also — it's not just questions about the incident but about the family as well. It's about what family — what supports the family has, how can the caller help, what do they think would help. Is there anything that they could do to assist the family. So, it's not just about the incident but it's about, um, the supports around the family as well. So the main difference is a lot more questions."

Another supervisor shared, "Okay. With NFP, I don't think it will affect it at all because, like I've said, we tease out every last detail before that report's even made. So, I don't think, as far as they go, that there is going to be any difference whatsoever because it was never a case of just calling to say, 'Hey, I'm concerned about a mom. I think she's using drugs.' ... It was very detailed, very – 'This is why I'm concerned. This is what I've seen. This is what's falling, you know, through the – you know, through this family's – you know, this is where they're struggling. This is where they're doing really well.' Um, so that's always been the referral process between us and NFP anyway. So, I don't think, as far as they go, that there will be a change at all. Now, the rest of the world, big difference... Um, because, you know, like when the school mandatory reporters call us, it's simply, 'The kid has a black eye.'"

Reasons for Reporting

Many caseworkers from several sites described reasons or risks for why people had reported to CPS. These reasons for reporting largely related to three categories: physical child abuse, child neglect, or petty reports. With regards to physical child abuse, reports for allegations included beating the child resulting in injuries, sexual abuse, and extreme violence towards the child leading to a law enforcement response. With neglect, most reports were multifaceted including

elements of mental health or developmental delay issues with the alleged perpetrated, missed medical appointments or removing medically fragile children out of the care of the hospital, lacking engagement with the child (e.g. not meeting developmental milestones), substance use (including substance-exposed infants), and unclean environments. There were some common reasons for unnecessary or petty reports to CPS across multiple sites, which included: child being inappropriately clothed for the weather, report on pregnant women (such that the only child present in the home was in-utero), or falsified reports as retaliation due to custody issues. A couple of caseworkers recalled reasons for why NFP nurses had reported, including: questioning the supervision of a child (resulting in neglect), failure to thrive or failing to make age-appropriate developmental progress, and DV.

A Child Welfare director regarding substance-exposed infants shared, “And so we don’t have a way of really being notified, unless the hospital’s social worker is pretty astute, and figures it out and then they call us... So if the child tests positive for a substance, then that’s an automatic that they would call us. The marijuana thing has opened up a lot of different... weird doors for us. And, um, marijuana use during pregnancy clearly, to me is um, like, alcohol use during pregnancy.”

One caseworker shared, “We get reports from people who are using the department for retaliation, um, custody, we don’t do custody... And a lot of times we’ll get calls where, the public is just not, they don’t have the information in regards to, um, what we’re, what we can do and what we get involved in. Sometimes, it’s just a matter of someone’s angry at another person and they’ll call us and make up a complete report.”

Challenges with Reporters

Prevalent across several sites was the challenge for caseworkers to work with medical providers and school staff who reported to CPS. One caseworker felt that medical professionals from one hospital often reported one incident but lacked communication with other hospitals that may have treated the child on past visits; these medical workers lacked a comprehensive story of the child when they reported. Several caseworkers and supervisors from different sites also felt that medical staff and school workers tended to over-report, for example reporting due to missed appointments or unexplained injuries, and wanted CPS to intervene when the issue was not considered serious by the department. In another site, one caseworker expressed that medical providers often took things personally because they were so involved with their clients.

One caseworker shared, “And, I’m not picking on the medical profession by any means, but not everything is reportable. Not everything is a child abuse or neglect or emergency. Or Volume VII. It’s sometimes okay. She missed two appointments. Or, three appointments. And, it’s not – you’re not the doctor. Okay, and that’s not okay and it’s not a problem, you know, aftercare up to however long they need their initial checks, vitally important. I understand... You are the nurse, however. She missed three medical appointments, but she didn’t miss any with you. It’s time to come take her baby. And, yeah, and so then that’s where sometimes I guess, the conflict comes down is medical sometimes wants us to jump in so fast to remove or to investigate or something. It’s like – it’s not quite that serious to me – you know?”

Other Areas of Work

Transferring Units

In several sites, a couple of caseworkers shared the benefits of having transferred from a different CPS unit to their current unit. Regardless of which position they were currently working, these caseworkers suggested that it was helpful to understand the work flow and process from their previous position. For example, it was described as helpful for intake workers to know what ongoing workers looked for with regards to family dynamics for a smoother transition towards an open case.

One intake caseworker suggested, “So, you know, I think that knowledge wise, I mean it’s much broader. So, I know what the ongoing caseworkers are looking for as an intake caseworker. So, it kind of helps our kind of putting things in the forefront so they’re not like scrambling- okay, so what do we do next. So, it’s good. It’s a good way to transition things.”

An ongoing caseworker shared, “So I have that background as doing initial, you know, investigations when I get the referrals and my initial contact in an investigation with a referral, which was helpful in my job as an ongoing, just to see how the case starts and how, you know, it gets, proceeds to the next level, and how the case ends. So, it’s kind of helpful to see how that worked from intake to ongoing.”

Voluntary Cases

In some sites, several caseworkers mentioned working voluntary cases, where families voluntarily accepted CPS involvement. These cases became voluntary cases with some ongoing CPS involvement, usually because CPS was unable to ensure safety solely through community resources. Some caseworkers suggested that voluntary cases were rare in their counties, but often these families were more willing to change and work on achieving their goals.

One caseworker suggested, “There’s the other kind that we can’t ensure safety through walking away and community organizations. And, those are the ones that will primarily – at least, at a minimum, become a voluntary case – so that we can keep some ongoing involvement.”

In several counties, some supervisors expressed that voluntary or non-court cases were preferred. In these cases, their intake caseworkers had not needed to file for a court case and had not needed to remove children from the home. These supervisors suggested that when families actively wanted services and sought help, their caseworkers felt that they were better able to work with the family because they were more willing to cooperate. One supervisor felt that voluntary cases allowed her intake caseworkers to seek natural services, support, and resources for the family, while keeping the family together and preventing legal action.

One supervisor shared, “And so, if there’s a need there, if the family can see that we can all work together, we offer lots of services on a voluntary basis, like without filing court cases, without removing kids. You know, we’re happy to go in , and we would much prefer to go in and open a voluntary case with a family and provide some services to

lower risk so that we don't have to come in with a, with a court order and, you know, I mean, at least half of our cases are voluntary.”

Skills Needed for CPS Work

A couple of senior level CPS workers from one site shared some important skills they felt caseworkers needed to succeed in their practice. These skills included: writing skills for court letters, presentation skills for testifying in court, engagement skills to facilitate a family in progressing in their plans, collaboration skills, diplomacy, and the flexibility to be able to work with people in various forms of crises.

One administrator shared, “You know, you have to have good writing skills in order to write good court letters. You have to be able to testify in court, so your presentation skills. And your family engagement skills have to be good in order to get the family to a point where, not only are they understanding what's going on, but you're engaging them to try to move them forward in that process, and what other supports do they need in order to be able to do that. So, you know, caseworkers you have to be a collaborator; you sometimes have to be a diplomat. I think it's a varying kind of position and ultimately the goal is to keep kids safe, to help them achieve whatever their goal is ultimately as kiddos.”

Supervisory Resources

Some caseworkers from all sites shared about how they had utilized their supervisors as resources in their scope of work. Across several sites, some caseworkers and a couple of supervisors explained the importance of supervisors being available for caseworkers in processing and discussing cases through informal channels like by phone or more formal venues such as scheduled staffings. Some caseworkers in different sites also shared about their supervisors being knowledgeable about and reminding caseworkers of resources available to their clients in the community, including NFP. Several other caseworkers from a couple of sites suggested that the support they received from their supervisors as well as the ability to share experiences in consultation with their supervisors were helpful in their practice, especially when there were serious allegations or injuries. These opportunities were helpful because they were not left on their own to make important decisions.

A caseworker shared, “It's pretty bad, you know, um, my supervisor is wonderful, she's always available by phone. But that's not a coworker, it's something different. Sometimes I'll seek somebody out and occasionally we run into other people at the visitation center. Our sort of core is our supervisor's room up here in this building, but I never hesitate to say, ‘I need help.’”

Another caseworker regarding community resources explained, “I remember when I made my first referral, but I can't even remember who suggested it to me to be honest with you. It may have been a supervisor... Yeah, what that was about. But, it may have been my supervisor that I was staffing a case with, and he said, ‘You know, she's a first-time mom,’ you know, ‘Do this.’”

Another caseworker shared, “If there is a serious allegation, serious injury, things like that, we always consult with our supervisor, our superiors, letting them know what's

going on. We never, we're never supposed to make decisions on our own without gathering as much information as possible.”

Scope of Work of CPS Senior-level Workers

The scope of work among various senior-level positions was discussed across all sites. As each site had a county administered Child Welfare system, there existed distinctions in how each county structured and organized their workers. However, generally, most sites had unit- or generalist-supervisors, and/or division administrators, as well as department directors. Almost all senior-level workers in Child Welfare were responsible for some level of supervision, with directors leading and managing larger numbers of workers than supervisors, as well as the hiring and management of personnel and overseeing service delivery to children and families through coordinated efforts. Overall, these senior-level decision makers also provided support and resources to their employees, regularly outreached in the community to collaborate with service and placement resources, provided training or consultation for community members (such as mandatory reporting for NFP), and participated in evaluation/performance monitoring activities. However, despite some similarities in job functioning, supervisors, administrators, and directors played varying roles in their scope of practice.

One deputy director shared, “And, um, I am currently the deputy director of children, youth and family services, so I oversee [redacted] managers that have all of the divisions, the intake division, the on-going division, of child protection and then I also oversee youth and family services and I have [redacted] managers there, and they each have about 50 staff.”

Another supervisor reflecting on her consulting role with NFP shared, “She feels free to bounce off her concerns with me to see if, if it's reached that level, or if it hasn't quite yet. Um, and I think that's helpful to both of us. Because I know that, if it's reached that level, I'm going to get that report. I know that. And so, when she's coming in to just bounce it off me and to tease it out of me, then you know, we can tease out the situation, then... to me, that's just as beneficial as making that mandatory report. Because sometimes, I will tell her stuff like, ‘Well, have you thought about this?’”

A prevention programs manager stated, “So I spent the first year really looking at putting programs in place, how do we evaluate our outcomes, what kind of indicators are we looking at, instituting some of the net protective factor things into their work. I mean, they were doing it, but it wasn't formal, so looking at things like the protective factor survey and other kinds of standard assessments and putting those in place. So, now, we're really in a period of evaluation – how this program put together the way it is and how that's affecting the outcomes and then tweaking it, of course, along the way.”

Roles and Responsibilities of Supervisors

In multiple sites, there existed unit supervisors who were responsible for managing their caseworkers who worked with a specialized population, such as intake, ongoing, or youth in conflict. In some other sites, usually those in smaller and more rural areas, there were generalist supervisors who managed all caseworkers within child protection and sometimes those within

adult protection. In general, most supervisors (regardless of being unit-specialized or a generalist) held similar roles and responsibilities within and across sites.

One unit supervisor stated, “Um, I’m current employed with [count name removed] Department of Social Services as a Child Welfare supervisor. I supervise the [specialized CPS unit names removed] Unit. I typically supervise [redacted] caseworkers and one case aide at any time.”

One generalist supervisor shared, “I have [redacted] caseworkers, and they’re generalist caseworkers, so they do, everything from intake to ongoing to adoptions. And they also do adult protective services – And, so I’m, I’m also a generalist, you know, I supervise all aspects of child protection.”

Almost all supervisors from all sites shared their role in working with caseworkers to ensure the safety of children, while adhering to federal and state guidelines. To do so, supervisors managed their workers, ranging from four to 15 workers in a unit, who in turn managed cases; monitored training of staff; monitored coverage in their unit and in the caseloads of workers; and assisted workers in difficult cases. Several supervisors from different sites mentioned their role in orienting new staff by ensuring the delivery of proper training and that caseworkers received the mandatory 40 hours of trainings per year. Indeed, one supervisor shared that she introduced the NFP program to all of her new caseworkers in their initial training. In assisting caseworkers on difficult cases, several supervisors from different sites described case conferencing with their workers, while one supervisor described having attended facilitator conferences or court mediations with their workers, along with the mediator, attorney, and parents to discuss the issues and to try to come to a conclusion.

One supervisor shared, “So basically just managing. Right now, we have 96 cases in our unit, so you know, overseeing that many at this point.”

Another supervisor stated, “So my role with, with the caseworkers is to, provide supervision, um oversight, to decisions that are made at all levels, from screening decision, like when we first get referrals in, um, do we accept it for an assessment, you know, investigate whatever the allegations are, um. So I’m involved in those front level decisions to decisions around do we open a case, do we, um, you know, request, uh, um file motions with the court to take custody of children.”

Another supervisor regarding training new staff expressed, “Since that time, I - I talk to all of my new workers about it. And, [NFP nurse name removed] comes into our office frequently. Um, and so everyone in our office knows her, um, they know what she does and that’s just something that is introduced to them very early into their training.”

Many supervisors from several sites also spoke about their roles in providing guidance, support, and resources for their workers. This was usually accomplished through individual supervision, unit meetings, or co-team meetings – which were group supervisions where workers could sign up to staff cases and receive guidance on decisions such as closing a case. Individual supervision was usually conducted over a scheduled time for caseworkers to meet with their superiors; sometimes for staffings – which were discussions between caseworkers and supervisors to

determine the direction of a case and potential services needed for the family. Some supervisors in some sites were more informal in their practice, where they encouraged caseworkers to ask questions at any time; while others scheduled individual weekly or monthly sessions to review cases with their workers. One supervisor mentioned that she was required to conduct 90-day reviews on the case, sometimes to prepare it for foster care review. In addition to reviewing cases and court reports, some supervisors from several sites were involved in attending court for hearings and/or attended joint home-visits with their caseworkers as support. Supervisors would monitor caseworkers in the court hearing or visit and note the progress being made.

One supervisor shared, “I provide weekly supervision to my workers. I review cases. I provide support, guidance, make sure that they are adhering to federal and state guidelines, keeping up with their work, making sure safety is always being respected with regard to the family. I will also assist workers with home visits and court if need be if they are unable to do so, and kind of as a backup on occasion.”

Another supervisor stated, “Um, I, uh, oversee all the information that goes into the state database, the trials database, and I review case files with the caseworkers – I review court reports that the caseworkers write to submit to court and approve those.”

Another supervisor shared, “So – Right now I have [redacted], uh, caseworkers under my supervision, so it’s just giving them the guidance, the support, reviewing cases, working with them, ensuring the safety of the children, conferencing with them, attending meetings, staffings, handling complaints, reviewing court reports, various stuff like that.”

Another area of work that permeated across sites and supervisory roles was participation in multiple types of meetings, including: family engagement or TDM meetings, PRT meetings, RED teams, and staff meetings. In family engagement meetings, many supervisors issued service authorizations for their caseworkers; while in PRT meetings, supervisors participated in permanency placement discussions. These two types of meetings were mostly implemented in counties that were granted the Title IV-E waiver to increase permanency for children. Multiple supervisors from different sites also shared their role in determining if reports to CPS warranted an investigation; this determination was either completed by the supervisor individually or in RED teams where multiple workers were involved in the process. In addition to participation in these team meetings, all supervisors from all sites spoke about conducting weekly or monthly unit meetings with their workers, to discuss cases, update workers on changes, allow caseworkers to staff a case, etc. Other meetings that supervisors frequently attended included quarterly division meetings, monthly joint-team meetings, supervisor meetings (where transfer of cases from intake to ongoing, changes with state guidelines, and upcoming audits were discussed), and service management team meetings (where they reviewed different contracted services for specific cases).

One supervisor in regards to team meetings shared, “Right now, we try to have it every week, just so we can keep connected and everybody’s, ‘Hey, we’re still here, you know, this is what’s going on.’ Sometimes it comes out to a little venting session and stuff like that. But I think it helps to know that you’re not alone and that you’re still together.”

Another supervisor stated, “And I think just the – we do a lot of information sharing. We go to staffings together. I mean, if we do a family engagement meeting, as a supervisor, I try to be there for all my workers.”

The same supervisor expressed, “But, as a supervisor, you know, we actually – intake and the permanency supervisors, we get together weekly to talk about the cases that are going to be transferred and to talk about, you know, the concerns and the needs and who the worker would be, and then, you know, if there’s any concerns or questions from our workers, then we as the supervisors will get together and share information with – and make decisions based on, you know, what we collectively think is important or best for the family, so yeah.”

Another supervisor regarding service authorizations shared, “So that should really streamline the process. It should make referrals and re-auths happening more timely and then also just the, you know, the auths used to like, I just sent them directly to our contract team and then there would be errors and stuff. And they’d get sent back. So now, hopefully, with just the supervisor sending them out after looking at them it should also clean up that process.”

Other areas of work for supervisors included outreach to service providers (e.g. attending community or committee meetings), conflict resolution (particularly in handling complaints from families who were angry that they had become involved with the CPS system), administrative duties (including reports to the state), billing and finances (ensuring that the billing was assigned to the appropriate service and that the client was a core services client), and ensuring accurate documentation in TRAILS.

One supervisor reflecting on working with contracted providers shared, “I think we have a good relationship with them overall, I mean we have certain supervisor or admins that are assigned to the groups to sort of review, talk about areas where we can improve on both ends. You know, what we want, what they want, what they’d like to see and stuff like that. So I actually with [local county name removed], I think we do pretty good with that.”

Another supervisor regarding improved communication with the community stated, “So, there were two real big complaints from providers in the community, and that was that our caseworkers weren’t communicating with them about referrals or about open cases. It was like, ‘You give me your information but I’m not going to help you.’ So we really changed the way we do work now. I feel that the way we respond to a family is so different from when I came on here – so I feel that’s really where we have changed it. Now we actually communicate with people and try to support them to support the families.”

Another supervisor on her role with finances expressed, “So for kids that we have in placement, I negotiate what we pay for those. I negotiate rates and pay providers who are, therapeutic providers who provide therapy and treatment for our clients. I negotiate subsidies with adoptive families, I don’t know, that’s...”

Specifically for generalist supervisors, managing the coverage of on-call (where every worker worked a rotating schedule for receiving CPS reports 24 hours a day), supervising other programs in DHS (e.g. Adult Protective Services, Colorado Works), and facilitating team approaches to decision making were considered some additional responsibilities. Indeed, several generalist supervisors from different sites suggested that using the team approach and collaborating was frequent while another supervisor actively utilized the state as a team member to help interpret state rules and regulations within Human Services.

One generalist supervisor stated, “Well, we have — I mean for a smaller community I think we have some, you know, pretty good resources. Most counties may see the state not as a team member. I actually — we use the state quite a bit. And, you know, if there’s something I’m not sure about it or having a hard time interpreting rule, I’ll just call the state, you know. We have a pretty good relationship and know the people and the different programs so we contact the state quite a bit.”

There were additional aspects of their work as explained by several supervisors in different sites. One supervisor agreed that although collaboration was encouraged in her team, she offered her case managers a level of autonomy in making decisions for their cases. Interestingly, in a couple of sites, some supervisors actually carried cases and performed occasional field work; although most of these supervisors carried very few cases and only when their unit was not fully staffed.

A prevention programs supervisor expressed, “And both of the community case managers, and well, the [prevention program name removed] managers, too – I give them a lot of autonomy to make decisions. They’re all really good at their jobs.

Another supervisor shared, “Uh, only, I do right now because I’m down a caseworker, so I’m carrying a couple of cases. Uh, typically I don’t carry cases though, when I’m fully staffed.”

Roles of Administrators

Among sites with Child Welfare administrators, managers, or deputy or division directors, these senior-level decision makers were responsible for managing a division of workers, including both supervisors and caseworkers; sometimes up to 100 caseworkers and five to six supervisors. This position was mostly present in larger counties where the Department of Child Welfare was split into several units, such as intake, ongoing, and foster care. Most administrators described their roles to primarily include the provision of leadership and direction to reporting employees (both caseworkers and supervisors), ensuring of accountability with their workers, and monitoring of appropriate implementation of plans and contracts.

One administrator explained, “So, ultimately, I feel like I’m continuously developing staff, developing my managers to be leaders, developing my supervisors to be leaders, so it’s a continuous... In a lot of ways, it’s similar – it’s just my clientele is a little different. So, I’m just working with people who have a need or a desire to want to work within Child Welfare, and I’m just helping develop them and move them along in that system. Or maybe they want to go work somewhere else after they’ve been here for a little while, right? – recognizing this is not the place for me, but that’s okay. Or I want to do

something different. So, I think it's always a challenge working with people. There's no magic line. There's no - you don't have this protocol or procedure thing of this is how you do it, so that's why I like it."

The same administrator shared, "Everybody's kind of streamlining processes and those sorts of things - that's a huge undertaking at times... So, lots of personnel stuff, having to deal with 'Why aren't you doing your job?' Or, 'You should be doing this.' It's kind of Parenting 101 sometimes (*laughing*), you know. But it's continuous holding people accountable to, 'This is the standard. This is my expectation. Why aren't you meeting it? How can we develop you as a person to get you to the point where you're really established in your position?'"

Another administrator stated, "I also am directly responsible for providing supervision to [redacted] Child Welfare supervisors. And so I meet with them regularly to staff cases, and give support and feedback on anything that involves, anywhere from dealing with personnel issues that they see as supervisors, to individual case information on how things are going within the case. And then also to kind of monitor programs, because each supervisor kind of, um, provides or is responsible for one or two programs that are specific to a need such as substance abuse treatment, they might oversee a substance abuse treatment contract. I also oversee [redacted] units that are considered core service programs, which is unique. Some counties contract out core services, our county does [redacted], we contract those services outside, and then we also have it internally."

In supervising units and overseeing processes, several administrators from different sites shared that they often provided support and feedback for their supervisors in regular meetings. As administrators were responsible for monitoring their units and core service programs (which were either contracted out or provided internally), they also assisted in the implementation of state-authorized changes (such as preparing for RED team and implementing DR). Many administrators had also helped their supervisors deal with individual cases or personnel issues.

One division director shared, "Yeah. And so, as we're moving forward with trying to create prevention programming, but then also, we want to implement Differential Response and a Family Assessment Response track, I am looking to build up services that are like front-end, short-term, you know, not court-ordered kind of services. So, I think it's because we - our practice has been more the deep end, long-term, court-involved - That - we just lean to that direction."

Several administrators in some sites were also involved with negotiating billing and other financial duties such as overseeing budgets in regards to appropriate spending of funds. Preparing for state audits and working with the state to improve outcomes in problem areas (such as reducing the number of days of out of home placement for children) were also described as functions of Child Welfare administrators. One administrator spoke about attending meetings with the state to provide input on different state initiatives and feedback on how it was being implemented at the local level.

One administrator stated, "I also oversee the budgets, uh that are prepared in regards to utilization of funding for um, services that we receive federal funding for... I think I

mentioned budgets for each program. Mainly anything to do with the financial aspects of Child Welfare, certain amounts of money and funds that are spent have to be approved by an administrator, we have to make sure that the spending is within the appropriate category in which the funding is provided for.”

She goes on to say, “And in addition to that, I spend a lot of time going to state meetings, just providing input to, uh, different programs on the state level, how they um, are being monitored and provided services in our community here in [local county name removed], I give feedback to the state department regarding those type of programs that, and are also known as initiatives, in which the state has, that they’re implementing, as an administrator it’s my primarily responsibility to report back how those initiatives are going. Some of them may be related to, um, programs that were developed as a result of the CFSR which is the Child and Family Service Review that the federal government does. And they have put a, our state on a performance improvement plan, and so I deal directly with state officials when they want to know what our progress is in meeting the goals of those performance improvement plans.”

Finally, many administrators from several sites had worked with the legal system, county officials and commissioners, city council members, and community organizations (such as NFP) to collaborate in providing better services for their families. Through outreach both internally (for example with family resource or service centers) and externally (such as with law enforcement and community organizations), several administrators described their role in finding and creating effective partnerships to make a caseworker’s job easier; sometimes by establishing an MOU. One administrator had been working on developing partnerships in his community, organizing opportunities for his caseworkers and providers to learn about their work and to develop relationships, while a deputy director from another site described her role in collaborating with NFP through consulting and delivering mandatory reporter trainings.

One administrator stated, “Mostly in my position, mostly what I do is a I do a lot of meetings. I do a lot of, going out into the community and meeting folks and looking for potential collaborations, and a lot of just oversight of our overall intake assessment process over the hotline for calls coming in, and so most of the time, we have very competent staff and so most of the time, the day-to-day work of, of the actual Child Welfare practice out in [local county name removed] – they are taking care of them and my job is to find effective partnerships to make their jobs easier and to help them be better.”

Another administrator shared, “So, yeah, what we’ve done is we’ve worked with our country attorney’s office. We got a copy of [local county name removed] contract—they have a contract with some community agencies—and, we’ve created an MOU, basically cut and pasted that contract.”

A deputy director stated, “And then, like I said, we kind of, [CPS worker name removed] and I serve as, kind of, consultants if they have a question. And it’s funny, I got a call last week about, you know, the nurse thinks that the mother has relapsed, she’s pregnant, she’s six months pregnant, but she’s relapsed on meth, and so what should the nurse do?”

Roles of Directors

In general, most directors across most sites were responsible for the oversight of all program areas within their agency. Depending on the background of the director, some tended to emphasize their focus in one area over another; for example, one director with a background in finances tended to oversee the financial and eligibility departments within Human Services, while allowing her Child Welfare supervisor greater independence in dealing with child protection issues. In some sites, the director oversaw both Health and Human Services, while in other sites, the director was only responsible for managing Human or Social Services. In smaller sites without administrators or deputy directors, the Human Services director was responsible for supervising the Child Welfare supervisor. In these sites, the director was more hands-on with regards to child protection issues; although they did not typically supervise the casework unless the supervisor was unavailable.

One Health and Human Services director shared, “But, I don’t supervise the work... I don’t supervise the caseworker, the caseworker unless that supervisor is unavailable.”

Another director sharing her scope of work stated, “Everything. Obviously I oversee the entire agency. My strong background obviously is the financial and the eligibility side. I have a lot of involvement with Child Welfare now as the director that I never had before. And I basically just oversee all the program areas of the agency.”

Similar to supervisors and administrators, many directors from several sites also participated in regular meetings; including monthly meetings with their staff and/or service providers to CPTs, coalition or committee meetings, and meetings with the state about procedural changes to local meetings about new initiatives. One director shared that he helped to plan and facilitate annual staff retreats to encourage intra-agency collaboration, where all staff members from his agency convened, learned about the different departments and their programs, and discussed how to deal with stress, burnout, and resiliency.

One Health and Human Services director shared, “Well, part of it is that we have monthly meetings that the [specialized CPS unit] staff go to, and we invite other stakeholders, such as mental health, probation to attend these meetings communitywide, so that we can talk about the clients that we have in common. So, we may – we’ll have that at least once a month where they will collaborate and talk about a case, try to do a case study on the certain case, but also look at, ‘Why are we stuck with this kid and family?’ and, ‘How do we – what do we need to do to make it work better?’”

The same director stated, “In the past, we’ve had once a year staff retreats, and our focus was on, ‘We need to focus on how we, as each department in Public Health, Social Services and [specialized CPS unit], how we all interact and get to know each other better, so that we know what each other is doing.’ So, we – we even have these game show quizzes to talk about, you know, ‘What do you know about Public Health if you’re in [specialized CPS unit]?’ And, if you’re in Social Services, either in Eligibility or Child Welfare, what do you know about Public Health? And, what does Public Health know about you?’ And, we would break up in groups and do all these different things in the past of, ‘How do we get to know each other?’ If we’re going to collaborate, we need to

know what each other does and doesn't do. And, where they begin and end and what their limits to them are and that sort of thing.”

Another director expressed, “So, we share. We share. We collaborate. And, we also are supported by a Child Protection Team. So, that kind of stuff gets discussed and becomes known to new workers and new people that come in. Because we sometimes take things for granted. So, we have community connection through a Child Protection Team.

Some other areas of responsibilities described by directors included: improving work flow processes, dealing with employee related issues such as conflict resolution between supervisors, restructuring the department and its programs, and writing grants for various programs or initiatives (such as funding for the family resource center).

One Health and Human Services director reflecting on restructuring his department stated, “And so, that created an opportunity for me to combine the two units into one overhead unit. So, what I did was I made the position available so that the supervisor for Child Welfare is also the supervisor for [specialized CPS unit]. And so, it's one position for two entities. And, we divided up some of the other work with the other staff, so that they could take on some of that responsibilities that these two workers were doing. So, we divvied that out.”

Another director shared, “We do write quite a few grants out of our Family Resource Center but they're all so specific to certain needs. We're very fortunate to be a 1451 county. We just — [Child Welfare supervisor name removed] and I were just talking about this — we got an e-mail a while back about a grant and we did write for...”

Consultation for Mandatory Reporters

Several supervisors and directors from different sites shared that they had occasionally provided consultation for NFP nurses around mandatory reporting. Usually these consultations occurred by phone or in person, with the nurse and nurse supervisor describing a situation where they were uncertain whether a report to CPS was warranted or not. The consulting CPS worker had then offered strategies and advice, including possibly receiving an official CPS report. However, a supervisor from one site explained that this consulting opportunity was available in her county but that NFP did not utilize it while other mandatory reporters in the community did.

One Child Welfare director shared, “I also am sort of a consultant for them, when they have a problem, they call me or [CPS manager name removed], and just, when they wanna consult and just say, ‘I have this situation, what do you think I should do?’ and so, they don't get names, but they just say, ‘This is the, this is the situation, should I call this in? Should I- What do you think is my best approach?’ So I serve in that capacity.”

A supervisor stated, “The other thing that we do for other nurses, doctors, the hospital, schools is that we are an open line for them to call with the hypothetical that we talked about earlier – where it's not actually a report of child abuse but we can get them feedback on how to support families without us. Nurse Family Partnership does not use that, but all the providers in this community do.”

Caseworker Perspective of the Supervisory Role

Some caseworkers from all sites shared about the roles of supervisors and directors and how they had utilized them as resources in their scope of work, for example through case staffings. Several caseworkers from various sites also explained that supervisors sat on various teams, including RED teams and DATs, and had attended division meetings and led team meetings. In multiple sites, some caseworkers stated that their supervisors had played a role in orientation and ongoing training, by coordinating in-service presentations by community members such as NFP. Other responsibilities of the supervisor shared by some caseworkers in different sites included assigning cases to caseworkers, approving client services, assisting in decision making on treatment plans, and writing policies, for example regarding how to approach concerns regarding marijuana use. In a couple of sites, a few caseworkers were aware of their supervisor's interaction with NFP nurse supervisors to facilitate collaboration, while some caseworkers from other sites suggested the need for their supervisors to initiate such interactions. One CPS supervisor explained the importance of her director in allowing supervisors to build their own relationships with external partners, such as NFP.

A caseworker shared, "It's pretty bad, you know, um, my supervisor is wonderful, she's always available by phone. But that's not a coworker, it's something different. Sometimes I'll seek somebody out and occasionally we run into other people at the visitation center. Our sort of core is our supervisor's room up here in this building, but I never hesitate to say, 'I need help.'"

Another caseworker regarding community resources explained, "I remember when I made my first referral, but I can't even remember who suggested it to me to be honest with you. It may have been a supervisor... Yeah, what that was about. But, it may have been my supervisor that I was staffing a case with, and he said, 'You know, she's a first-time mom,' you know, 'Do this.'"

Another caseworker stated, "Actually, she's collected all kinds of information, I think she's probably in the stage where she's ready to write an official policy, however, all of us kind of are on the same pages. What, what we're looking for as far as, um, using marijuana and child abuse. Yeah, the safety, I think we're all on the same page there. But I've not seen the official written policy as of yet."

Another caseworker shared, "Most of the contact that they have is through my supervisor. I know we did a [redacted] campaign with the Nurse Family Partnership and, so we all just collaborated together regarding the [redacted], and what things we needed to do for, for getting that into the public because at that particular time we had a lot fatalities and so... I think [CPS supervisor name removed] is building a working relationship with them and so I think that is helpful."

One supervisor shared, "Um - The freedom. And, I think, you know, neither of us have supervisors who watch our every single move. They let us develop that relationship and let us run with it. And, it's only through that personal relationship that you can, you know, talk about those fears..."

Role of CPS

Across several sites, several senior-level Child Welfare workers described the role and functioning of CPS as a whole. These administrators and directors described a family-focused approach to build strengths in the family and keep families together. In addition to educating families to not become dependent on the CPS system, one administrator in particular highlighted her enthusiasm in CPS's cultural shift towards a preventative, trauma-informed, and less restrictive – almost voluntary – approach to assisting families. Similarly, a couple of supervisors and directors from different sites valued the philosophy of CPS workers as social workers with a role in prevention and to intervene when necessary to protect children. Another director shared that the role of CPS was to respect the liberties of families to raise their children safely.

One director expressed, “And, my philosophy was, ‘No, we’re social workers.’ And, we need to look at, how do we help families—even if there’s not abuse and neglect—or, but they’re red-flag kind of families that we know that are out there that we can really work at doing prevention work. And, that if we don’t do the prevention work, they may eventually become a Child Welfare open case, and we don’t want that. And, if we can work with kids and families prior to them becoming an open referral, we’re better off. The family’s better off. It’s easier to go from a lesser known crisis than going from a big crisis of abuse and neglect, and to make the changes and to be more of this open system of, ‘We’re here to help families,’ and not just do the old school of, ‘We’re going to just do investigations.’”

Another director shared, “So, our job is the... We are the government in terms of providing Child Protective Services. Our job is to treat the, the public respectfully. Our job is take information the public gives us— and to now run it through a thing called RED team and screen out or assign for assessments. And then, our job is to respect also the fundamental liberties of families to raise their kids as they can, as long as it’s not an unsafe way to raise a child... They are who raise kids. Not the government.”

An administrator stated, “Some of the other things that I’d like to say is that I’m looking forward to this trauma care, trauma informed system that the state department, there are several counties that are doing it now, and uh, developing a trauma care system and I’m looking forward to the day when that happens in [local county name removed], because I don’t feel that we’ve been as effective as we need in addressing the fact that when, uh, there is child abuse or neglect, there is some trauma to the family or to the child and we need to do a better job at recognizing that the system, and how we intrude upon people’s lives.”

Scope of Work for Other Partners

Among several sites, some community partners held positions including center and public health directors, public health nurses, program and council coordinators, and public service workers (e.g. juvenile defense and temporary assistance) and shared about their scope of work. Duties among these community partners varied by position and by program. Among directors of public

health from different sites, similar duties and responsibilities were shared. A center director and nurse clinician from the same organization shared similar areas of work while public health nurses, a program coordinator, and a temporary assistance worker expressed similar types of responsibilities in their scope of work.

Public Health Directors

Among several sites, the public health directors shared about similar areas in their scope of work, including oversight and supervision, program management, fiscal and grants management, administration, and participation in various meetings. These public health directors explained that they were heavily involved in overseeing various programs, sometimes introducing new programs, which were offered within their department. These programs addressed early childhood development, family planning and women's health, environmental health, communicable diseases, immunization, and emergency preparedness. Public health directors from these sites also managed staff conflicts and ensured that performance evaluations were completed. Attending various meetings was also described by these public health directors as a responsibility in their work, including all-staff meetings, coalition meetings, other community-wide partnership meetings including those with Human Services, and CPTs.

One public health director shared, "So I run, you know, I oversee all of our programs. I directly supervise the Nurse Family Partnership supervisor. And then we have all of our health department programs including Early Intervention, um, prenatal, plus we have nurse consultation for childcare centers and, um, Head Start and Early Head Start. We have WIC. We have environmental health under us, communicable disease, immunizations, um, emergency preparedness..."

Another public health director explained, "And, then, insuring that all of our contracts are renewed. We go after lots of grant money for our programs; we start new programs. And, then, we insure that [redacted] contract deliverables are met and that any recording and invoicing is done in a timely way. I manage any kind of staff conflicts and insure that performance evaluations yearly are done. I manage the budget for us, report monthly to the Commissioners at the Board of Health meetings, and I meet with them generally in [redacted] to do a budget overview and present our budget for the coming fiscal year."

She went on to state, "I'm involved in several local coalitions; usually those meet monthly, some quarterly for several of those. And then I'm involved in other community partnerships. We have a newly-formed health kind of coalition, so we've been the founding member of several coalitions, one of which was also the dental coalition and now we have a [redacted] health program that was a spinoff from that. And we have, as well, coalitions like Early Childhood – we weren't one of the founding members for that one... We attend that as well."

The public health directors from several sites described their role in the supervision of and/or interactions with NFP. In one site, a public health director expressed that she was heavily involved with NFP, which was a program offered under her department, and that she frequently utilized reflective supervision with other program supervisors. Two public health directors from

different sites explained that they sat on the NFP CAB, played a role in client recruitment for NFP, and had followed-up on referrals made to the NFP program.

One public health director expressed, “Oh, gosh, it’s all over the board. I, you know, since I was in NFP I really try to do reflective supervision with all of my staff. But the NFP supervisor, just because I felt that that was really valuable and important way of managing and supervising, so I do—I don’t meet with them all on a weekly basis but I certainly meet with them; some of them on a monthly basis or every other week depending on the program and staff person. But I have implemented that...I certainly feel that I’m more involved with NFP than my predecessor was just because she was never a part—she never went to the NFP training or anything like that.”

Another public health director regarding her role in NFP explained, “...and then we have some joint responsibilities; the joint responsibilities being we’re supposed to help with client recruitment, which we do, and then representation by us on the [site name removed] NFP, I guess it’s a coalition, I don’t know. We don’t call it that, it’s the governance committee.”

Center Director and Clinicians

In one site, a center director and nurse clinician expressed similar roles and responsibilities in their field of work. These clinicians were primarily involved in conducting and overseeing initial medical examinations for children involved with CPS through investigation. They also provided ongoing medical care and treatment for children involved with the CPS system, including foster children but kinship or other placements were not required to receive medical care with this center. They were involved with gathering family history and other information on the child, participated in ongoing communication with CPS workers and the police, and referred clients to community resources. The center director was also a trainer and consultant on various issues for the community, including substance-exposed newborns, child abuse, and neglect, while the nurse clinician had consulted with NFP on mental health issues.

A center director shared, “So, that’s what happens right now. Our medical team would do an evaluation. And then, we would relay it to the investigators. We would have a dialogue and a communication... Those kids, if they’re being placed in out of home placement or kin or whatever, I think we should see those kids medically. Right now, the department will only do that for kids... They only require that for kids that are in their custody. So, there might be a kid that’s a kinship placement, but that’s not in their custody, we wouldn’t necessarily be required to see those kids.”

She also explained, “Yeah, I’ve done lots of training, and I- it’s an area that I’m interested in...So, for example, the substance-exposed newborns that we did these convenings...”

Relating to consultations with NFP nurses, a nurse clinician shared, “Oh, it’s a handful of times. So, maybe every other month or something like that. It’s not a lot...some of it may be related to mental illness, you know, and again, part of my role here is, you know, this is adolescent psychiatric treatment center, so you know, I work a lot with that kind of

psych field and that, so- So, stuff about whatever that may, may border on a diagnosable mental illness. And again, the nurses and [NFP nurse supervisor name removed] are so skilled, you know, it's more of that just support. And, 'Yes, you guys are on the right track,' type of a thing."

Other Positions

Among several sites, some other community partners in various positions held similar job responsibilities. A couple of public health nurses from different sites, along with a program coordinator and financial assistance case manager shared similar roles in their scope of work. From care coordination and case management to making home visits for assessment and planning to referring clients to community resources, these community partners delivered direct services and education to their clients. These various workers from different sites developed relationships with their clients, took into account their clients' cultures within their practice, and collaborated with other community resources to serve their clients' needs.

A program coordinator explained, "What we do is a lot of creative problem-solving, and sometimes around the team, at the team meetings, you'll see the blending and granting of funding and services occur. And, then, it's also outcome-based. Every meeting that we have with the family, the family has to be present. We don't meet without the family there and also with the youths there if they're able to participate. And it is based on outcomes where the family's goals are achieved."

A financial assistance case manager shared, "I meet with them first for the assessment. That one takes an hour or longer. Um, then I meet with them to establish the individual responsibility contact and they have — I mean it is something we agree upon before it's ever typed out because I want them to feel — I want them to know that they are in control... And I'm — like I said, I'm not going to set them up to fail. We're going to do this to where they believe that they can do this activity or whatever we ask them to do in order to be in compliance with the [program name removed] guidelines."

A public health nurse stated, "That's all I do is home visits and education and follow-ups and, you know, brief checkups, weights, blood pressures, and stuff."

Although the service delivered by these community partners ranged from position to position, many of these workers adopted a strengths-based approach to working with their clients and had experience in referring their clients to NFP and/or working with NFP to serve mutual clients. One public health nurse shared that she served as a liaison between the health department and CPS and often played this role for NFP nurses who had a client involved with CPS. Another public health nurse from a different site explained that she had referred clients to NFP and had collaborated with the NFP nurse to ensure that they did not deliver duplicative services. A program coordinator from another site had interacted with NFP and other community providers to coordinate care for an NFP client.

One public health nurse explained, "With the NFP program, I kind of act as a liaison informally. A lot of the nurses have questions for me because, you know, they're trying to get in touch with a caseworker, or they want to know how the system works and

because I work with them on a more regular basis, I've kind of developed a relationship with the caseworkers that we can, I can pair them up and work together."

Another public health nurse shared, "And, sometimes if I know though that one of the Nurse Family Partnership nurse- you know- or the- the- the first-time prenatal is involved in the program and actively being contacted I will back off a little on my home visits and focus my time, you know, on other- on other women."

These community partners also had connections and had interacted with their local CPS. One public health nurse had made reports to CPS on her clients, while a financial assistance case manager from another site worked in the same unit as CPS and had consulted with caseworkers regarding prevention efforts for her clients. As stated, another public health nurse from a different site served as a liaison for CPS and assisted caseworkers regarding medical concerns with their clients.

A financial assistant case manager shared, "And when I'm establishing these [redacted] if I have any kind of a concern, I sit down with Child Welfare and we discuss it. And they give me a lot of input on to what they think would be preventative, um, to help those clients never get to their level."

A public health nurse stated, "On a day-to-day basis, I work a lot with their, what they call their assessment team now, so the intake when they get a referral of child protection concerns. If the case has any medical- Anything medically concerning in it, or the caseworker has questions about a medical concern, or the family is having trouble with medical care or finding specialists for their child."

Finally, a public service worker in juvenile defense and a council coordinator from different sites shared about their scope of work and interactions that they had with CPS and NFP. The public defender was involved in representing juvenile clients and had frequent interactions with CPS. She also sat on the NFP CAB and assisted nurses in accomplishing their committee goals. The council coordinator from a different site was responsible for facilitating organizational collaboration between multiple agencies - including CPS and NFP - to accomplish goals related to early childhood development. She was primarily involved with systems and infrastructure development within the community.

A public defender explained, "Well, primarily I'm assigned to a district court division which includes mostly felony charging for adults. I'm also, um, a lead attorney in the juvenile division in Pueblo and represent juvenile indigent clients who have been charged for crimes as well as adults who've been charged with mostly felonies."

Regarding her involvement in NFP CABs, she also shared, "Um, really just to sort of initially track kind of what's been going on with what goals they have and then, um, sort of as I get more experience hopefully help direct some of what at the least the [site name removed] Regional Board is looking to accomplish, um, with goals that they might set up or steering committees or, um, really just trying to make sure that their ultimate goal and purpose of providing help and support for families is the—is something that they're able to actualize in any way that I can facilitate that."

A council coordinator expressed, “We’re established in state statute to bring together community partners, including Nurse Family Partnership, to do comprehensive early childhood community assessment, establish strategic plans with priorities that are going to make sure all children start school ready to learn.”

Client Visit

Several community partners from different sites described their reasons for visiting clients and their experiences related to those visits as part of their scope of work. One public health nurse described visiting a home for behavioral health related reasons with children to conduct an assessment, provide brief interventions, and provide further services to the clients. These visits had usually occurred where the children lived and required more time with the clients than physical health assessment related visits. Another community partner discussed their clients having been visited by CPS caseworkers in their county and that these caseworkers oversaw the care of most of the clients that resided in the center. A couple other community partners including public health nurses explained that they had accompanied CPS caseworkers on visits to conduct health assessments or made joint visits to mutual clients. One public health nurse shared that one joint visit she had conducted with a CPS caseworker had almost jeopardized her relationship with the client because the caseworker removed the child from the home at the time of their visitation.

A center director said, “And so, those behavioral health visits are assessments, maybe brief interventions, and then we get them the services. We fully recognize—especially for mental health services—they should be where the kid lives. And, they should stay the same. And so, we may then refer them back to where- That community where that kid’s living. So, we’re not necessarily trying to provide them all there. Because those are maybe weekly visits, or every other week. That’s much more than physical health.”

A nurse clinician said, “So, every morning caseworkers come back here and will ask us to see kids, and we talk about the cases that they’re working on, and you know, we just get together. We just had the holiday get-together lunch with caseworkers and other people. And then, caseworkers are also kind of oversee the care of most of the youth that are here in residence at the [center name removed], too, so you know, I’ll call them and say, ‘Hey, I saw so-and-so,’ and you know, ‘Here’s what I found, you know, just to let you know.’”

A public health nurse said, “Anyway, he [a caseworker] asked me to accompany him, and I felt like it almost jeopardized my rapport. Because I had a really good relationship with this young mom, and I felt like then it was a little awkward to be going with him because they were, they were taking her children away.”

Client Strengths

Among a couple of sites, some partners from the community described strengths among their clients. Client strengths were explained about in instances where these community partners were able to successfully refer and enroll clients into programs such as NFP, clients had multiple resources in their lives, and clients were actively engaged in using these resources. One

community partner described that many of her clients had followed through with and participated in referrals to resources such as mental health and developmental screenings. Another community partner from a different site stated that job-readiness training had been provided in her county for clients to assist them in getting jobs and to become self-sufficient; such a resource was available and had been utilized by her clients.

One eligibility case manager stated, “And — and in— in, um, response to that a lot of our people are getting jobs elsewhere because once they’ve developed that resume they’ve got — they’ve got a good resume. They’ve got experience. They know how to deal with the public. They know how to be confident in themselves. Um, so we help them do that. We have a job readiness class that I facilitate every [redacted] morning at the [resource center name removed], and it’s a two-hour class and what we do is we help clients who have no work experience, have no resumes. We help them to understand the importance of a resume, the importance of presenting yourself to an employer, um, how to, um, professionally put together a resume so it’s not all chopped up and incoherent.”

A public health nurse explained, “Yeah. Yeah. I really like working with moms and babies too, so. And, yeah, I really have had good experiences in the referrals with - with the Nurse Family Partnership for. Well good and — we’ll probably get into that later, but the— It is a little frustrating that lots of the first prenatals that I encourage, you know, or refer to the program end up not participating. But, there have been several — quite a — several that have done the program and it’s been great. Yeah.”

A council coordinate stated, “And, we have a syst—part of that screening system is also [redacted] community agencies that do social and emotional screening and developmental screening that’s embedded and part of their regular work. They know how to help— They know what to do if somebody’s in the gray area. They know who to call. They know how to help the parent practice with the child to see if they catch up. They know who to refer when the kid needs extra services. And, we have almost a hundred percent referral follow-through rate in those agencies because they know Mom, and they’re right there and say, ‘Let’s call.’”

Risk Assessment Among Other Partners

Among several community members in various sites, risk assessment was explained generally within their scope of work. Some community members across sites also shared about their experiences in intervention or treatment planning, various risk factors for child maltreatment among their clients (such as substance abuse, mental health, history of abuse or CPS involvement, developmental delays and special medical needs, and being young parents), and resources available for these clients.

In assessing risk, several partners from different sites explained their process for their specific role in their organization. A couple of members from a local crisis center explained that they conducted physical assessments for children involved with CPS, including those in an investigation of abuse or neglect or those already in placement. Physical assessments involved assessing for bruising and injuries and were necessary to assess and screen for urgent medical and mental health concerns. Several public health nurses and department directors from various

sites also explained that they had assessed for risk and safety with their clients through physical assessments (measuring weight and height) and developmental assessments on achieving milestones. Screening for children's social and emotional progress, children's developmental milestones, and maternal depression were also implemented by one partner from a multi-county site. This individual went on to explain that four areas of focus were assessed: physical health, mental health, parent support, and early childhood care and learning.

A crisis center director explained, "And, we try to do - Within the first 72 hours of placement, to see them for their placement exam. Even if they're placed out of the [redacted] area, which can be problematic. And so, we try to work with people if they're way out of the [redacted] area, but as soon as they have to come in already for something, and we'll work with them. But, the idea of that exam is sort of an intake exam to make sure there's no abuse or neglect that wasn't noted, to make sure there's no urgent medical concerns, urgent mental health concerns, you know, anything like that. So, we don't do major screens at that point, but we do a full physical. You know, and obviously, if it's an older kid, and they're telling us suicidality or - you know, we would address that right then. So, dental, same thing. We just kind of - any urgent needs and abuse/neglect screen."

A public health nurse shared, "Yeah. Yeah. I sure, I sure do. I always try to do - Well on babies and stuff I have a portable scale and routinely try to check their, their height and weight if mom's willing. And, then like do a brief developmental assessment on babies, you know, on their miles- developmental milestones and a little anticipatory guidance for what she should be happening and then, you know, what to look for in a month or two. And, safety issues and nutrition."

A council coordinator stated, "Yes. And so, basically, we - if we're going to make sure all kids start school ready to learn, we probably need twice as many as we have. But, we've established common goals, and we're working together. A lot of what we do is on screening, early identification of children, making sure parents understand what kiddos need to achieve developmental and social and emotional milestones and that kiddos have it and that there's - We didn't really have any screening before our Council started, very little. But, every kid gets screened to make sure if they have some little area where they need extra practice to succeed, that that's identified early and they get it."

Sharing these assessment findings and collaborating with CPS caseworkers were described as additional elements of assessment for many community partners across various sites. In fact, these other partners were often involved in the treatment and intervention planning for their clients involved with CPS, to ensure that the families were able to build self-efficacy and succeed.

One program coordinator stated, "So that's how we try and figure out who can do what and who's going to do what before the next meeting and what the family will do, what [mental health organization name removed] will do, what the Department of Human Services will do to help the family. So, we try and figure out, when we put together the planning phase, like what the plan is going to look like and then who's going to do what.

It's to build success for the user and family that builds self-efficacy and ensuring success for the family.”

A public health director shared, “That’s what we’re responsible for. But they also have been very good to acknowledge that we bring, as a team, as a whole, collectively, bring possibly some added dimensions to their assessment that may have been missed. And so they hear us out and that kind of concerns of, ‘Oh, but we know’ - da, da, da, you know, whatever. And then they’re like, ‘Oh, we didn’t know that, we didn’t hear that from the family,’ or whoever they’ve interviewed, so.”

Risk Factors

As stated, some other partners across sites shared about risk factors for child maltreatment among their clients. Substance use was described by many partners as an issue of concern, including substance-exposed infants, drug-endangered children, and a history of and current substance abuse (including alcohol and marijuana). In addition, mental health illnesses were another area of concern for several partners in various sites. Mental health related concerns included: various mental diagnoses, impact of psychotropic use during pregnancy, adolescent psychiatry, and trauma associated with abuse. Previous CPS involvement or a history of physical or sexual abuse in the family was also expressed by some other partners as an additional red flag within their practice. Furthermore, developmental delays and special medical needs (such as gestational diabetes and pre-eclampsia) were concerning for some partners across sites because of possible failure-to-thrive scenarios and parents lacking the ability to adequately care for their child. Being a young mother, often co-existing with other aforementioned risks, was an additional concern for some partners. Youth in conflict or youth placed in foster care were generally the CPS departments in which various partners had interacted with the pregnant adolescent or youth mother population. Finally, other risks were mentioned by some partners in several sites, and included: lack of social support, involvement with multiple systems (e.g. CPS, mental health treatment, probation, etc.), inappropriate level of disciplining such as to the point of abuse, and other social-ecological factors.

One program coordinator shared, “Yeah, um, for instance, I have a client right now that she is expecting. She’s probably about four or five months old (*laughter*) — along. Anyway she’s four to five months along — probably more like four — and we’ve received some reports that a suspected abuse, drug abuse. So I’m really concerned about her. I’ve known this gal since she was little, and, um, there’s a pattern in her family of drug abuse, and, um, you know Child Welfare has been involved previously with her sisters and stuff.”

A psychiatric nurse explained, “Right, yeah. It just - it doesn’t happen that often, believe it or not. And, I think this may have to do more with the type of kid that typically comes here. It’s - they are all high-risk adolescents, but these may have more of the diagnosable mental illness, rather than - I don’t know how to say it. It’s...”

A public health director stated, “And so, you know—and we’re also dealing with families all the time who have a history of abuse themselves; they’ve been abused.”

Another public health nurse explained, “We’ve also had cases where a child who’s in

foster care is pregnant. So, a 15, 16, 17-year-old who is a child in the system but has become pregnant, and so that kind of is another unique way that a referral could be made to Nurse Family Partnership.”

Physical and Sexual Abuse

Some other partners in various sites also expressed about their experience with clients who had suffered from physical or sexual abuse. In the case of physical abuse, one nurse explained her role in investigating and assessing for abuse such as bruise patterns and failure to gain weight. With sexual abuse, a couple of other partners in different sites had encountered clients who were victims of inappropriate sexual touching and sexual assaults.

A nurse clinician explained, “It’s often on a case-by-case basis. So, ‘Hey, have you thought about this with this child?’ Or, ‘This bruising looks more like - is pattern bruising, and here’s why I think that.’ Or, you know, ‘I’m gonna draw some labs, you know, because, you know, we think that this thing is going on. And, here’s what happens in the body when, you know, we see this type of thing. So, pay attention to these things.’ You know? Or, you know, ‘Hey, you know, we noticed that this child’s not gaining a lot of weight. You know, can you ask the parents about this?’”

Reporting Child Abuse or Neglect

Other community partners including nurses, public health directors, and organization leaders provided information on reporting to child abuse and more specifically mandated reporting. A couple of community partners shared about their knowledge of the reporting process, how they worked with NFP in nurses’ practice of mandatory reporting, and their perceptions of NFP nurses as mandatory reporters.

A couple of community partners from different sites shared their knowledge of the reporting process to CPS. These individuals stated that screeners were responsible for entering a report into the CPS database system and that CPS supervisors identified a response time to the report based on the severity of allegations. One public health nurse, who was a mandatory reporter, described observing or learning about IPV incidence among her clients during her interactions on visits. For these cases, she usually contacted her client’s physician to facilitate assessment for the child and/or had reported IPV to CPS on the client’s behalf, but not the child’s. She stated that she had conducted reports to CPS usually by paper or in-person, with an occasional phone follow-up to answer additional questions from caseworkers.

A public defender stated, “... they were called screeners. And so somebody would screen the child abuse and neglect reports, enter them into the system, um, identify the urgency of the response time, um, make sure that somebody – a supervisor over me – would train them and then assign them to the case.”

A public health nurse shared, “Okay. We, well, we actually still just use a paper triplicate paper referral... and we usually just take it over and then a brief like phone follow-up to make sure they got it and to see if there are any questions...”

She also explained, “Sure. Well sometimes—I am trying to think of one. I haven’t had one recently but there have been issues, yes, where I do a home visit and I can see that the —that the home is, you know, not clean enough or not, not safe really for, for a child or the mother has actually verbalized, you know, her issues with domestic violence between herself and, and the father or another person. Where, if needed to report it to the [organization name removed]. Usually I report to a physician here in the clinic for a checkup follow-up with the child or —and we refer to then —to the [CPS organization name removed]...”

Other community partners from various sites expressed that they had worked with NFP nurses regarding mandatory reporting, through consultation or collaboration with CPS. One community nurse practitioner shared that she had consulted with NFP nurses to determine whether or not a situation was reportable and had suggested resources available through DHS. In another site, a public health director described situations where NFP nurses had attended mandatory reporter trainings held by CPS as well as consultations with the CPT to discuss cases.

A nurse practitioner regarding consultations with NFP shared, “If she – if—or one of her staff—is out in the community and one of their clients will disclose something, and they’re not sure if that needs to be reported or not, then she’ll call and we can discuss it and figure out if this is a reportable thing or not. You know, or if there’s any kind of resources that are available through the Department of Human Services that I know about, those types of things.”

A public health director stated, “... but certainly over the years we had Child Protection come and do trainings about what’s reportable and what’s not. The team, I think always felt comfortable talking—at least in [county name removed]—to folks about situations...”

SECTION III. CPS AND NFP

NFP Perceptions and Interactions With CPS

Within and across sites, NFP nurses had varied perceptions of CPS. Some nurses in some sites expressed a negative perception of the department as well as of interactions with CPS caseworkers; while other nurses from the same sites and other sites perceived CPS positively. Overall, most nurses and nurse supervisors from almost all sites believed that there were great inconsistencies with how CPS workers performed or conducted their scope of work.

Perception of CPS

As stated, there existed great variation among NFP nurses and nurse supervisors within and across sites on their perceptions of CPS. Several nurses and nurse supervisors in multiple sites expressed a community stigma on the department that they themselves admitted to having: CPS removed children, were punitive, and were not strengths-based. Some other nurses in several sites expressed their perceptions of inconsistencies in how CPS caseworkers investigated cases and in their determination of a child’s removal from the home. For example, several nurses from

one site perceived that CPS had clearer delineations of assessing child abuse/neglect for infants, but not for teenagers. In a couple other sites, some nurses even expressed that CPS as an entity was unknown or foreign to them.

One nurse shared, “Yeah. The only – I haven’t been doing this very long, and I feel like there’s kind of this stigmatism – I don’t want to say stigmatism. Maybe – bad blood between NFP and DHS.”

Another nurse in reference to CPS removing children before completing a full assessment was completed stated, “I can say it happens more than should... And, I’ve seen them leave babies when they shouldn’t have.”

Another nurse shared, “Right. And you’ll hear from other nurses also that, you know, it seems like the follow up is much clearly defined for infants. Like we’re reporting infants, but in terms of teens.”

Another nurse stated, “So, you know, looking – You know, ours is a very strength-based program, which I really appreciate. And, again, I’m – you know, I’m sounding very negative about Social Services. But they’re – I don’t... my experience has been they haven’t necessarily been that way, maybe in the past. I mean, maybe things are changing, and that would be really good I think. But, you know, we really look for the strengths and yeah, I guess that’s what I want to say.”

Another nurse shared, “You know, it feels to me like it’s a black hole over there. Over there. I think we even say ‘over there’ quite a bit.”

On the other hand, in many of the same sites, some nurses and nurse supervisors expressed having seen a change in how CPS functioned as compared to previous years. Many of these nurses felt that CPS workers had become more responsive to NFP, provided more follow up for mandatory reports, and became more strengths-based in their approach with clients. In addition, in one site, several nurses expressed a level of comfort and support from their local CPS department including perceptions that the caseworkers and supervisors were approachable and available.

One nurse stated, “Since I haven’t done it, I’ve heard from others that you report and, in the past, it’s been that they – they treat the nurses here the same as they would anybody else. And, that they may investigate and may not. But, we had a recent meeting with CPS in which they were much more willing to really listen to what we had to say.”

Another nurse shared, “Well, I think that it’s been probably a little better more recently than at the beginning. It seemed like, years ago, when we [were] first starting, if something came up where we felt we needed to call them, they were all about getting information from us, but not giving us any information and not letting us know what happened then. Whereas I feel like now, the last – Oh, the last couple of years, when I’ve had to call them, they’ve called me back to let me know.”

Another nurse expressed, “Which has really improved from what they used to do - including, like, can you list any of the strengths that the family has.”

Another nurse stated, “But after now, after all these years, we just had to develop a relationship and now I don’t feel any of that. I don’t feel any challenge at all that I can think of. If anything, I feel a great deal of respect and there’s just a lot of respect between us, you know?”

Another nurse expressed, “She is. She is approachable and you know, if she’s busy, then she’ll tell me that, ‘I’m going to come and see you, in whatever, five minutes.’ Or it – I, you know, I always felt respected.”

In fact, some nurses from a couple of sites expressed that CPS involvement for their client was positive and had resulted in favorable outcomes for both client and child. In these situations, the CPS caseworker usually held a similar philosophy to NFP, was strengths-based, and open with families. For example, when CPS was involved in one site, some clients were able to have guard rails or window screens installed in their homes. In another situation, an NFP nurse and a CPS caseworker worked together with the client to relinquish her rights due to severe mental health issues. Through the client’s involvement in CPS, the nurse was able to successfully transition the client through a difficult decision.

One nurse stated, “So, in that situation, it was really a blessing that she was hooked up with somebody from DHS who was in the home and kind of keeping tabs on things.”

Another nurse shared, “And the caseworker was very – I said, ‘You know, they need screens on their windows. They need –’ You know, she went and did a safety evaluation. And, anyway, they ended up buying and placing screens in the windows and doing some really helpful things. And, I think after that, I really saw them as being very helpful, and I think it loosened a little bit of reluctance, you know, to utilize that service,”

Another nurse expressed, “Yeah, not all of them. I mean, when I left I was working with a family and mom was an alcoholic and dad had been on drugs and he had quit drugs through a drug program through the courts. And Social Services – [CPS worker name removed] and I were working well together at that. And [CPS worker name removed] has a really open philosophy and positive outlook towards families, the same as NFP, and we were working together really well, too. But it’s just, you know, it just didn’t work out for the mom. So, so it is nice to have those success stories because not every case is going to be successful.”

Among several sites, some nurses and nurse supervisors provided their perceptions of how CPS specifically handled marijuana use. Several nurses from some sites understood that CPS suggested marijuana use to be treated similarly as alcohol, where reporting was necessary when the parent was impaired and caring for the child. Other nurses from a few sites recognized that CPS would not usually become involved if the plants being grown were separated from the child and the child had no access. In addition, many nurses from most sites believed that CPS would not even investigate a report for marijuana use.

One nurse stated, “I haven’t had that situation, but I know there are plenty of clients that use marijuana. Um – so that could, I can see that definitely being a potential if both parents are impaired that’s not a good, you know, that’s reportable. So how do you broach that who then says well, legal, you know. That kind of thing, it’d be nice to have a little bit more guidance on that since it’s such a gray area in a lot of senses and I feel like, I don’t know, this could just be a perception from Child Protective. But that’s not really a high priority for them because they deal with so much severe cases that you’re reporting a little marijuana use, they’re like, ‘Man. Why are you bothering?’ Well, ‘I’m bothering because I’m a mandated reporter and I don’t mean to waste your time.’ But sometimes we can get that impression that you’re wasting their time.”

There were other perceptions of CPS raised by NFP nurses from various sites including: CPS caseworkers as overburdened with heavy caseloads, caseworkers as incredibly busy, and high turnover occurring within CPS. In some sites, several nurses also perceived a distinction between NFP and CPS as separate entities, where communication occurred only when certain situations arose. More positive perceptions of CPS were also expressed by some NFP nurses in a variety of sites: CPS as ultimately aiming to reunite the family, CPS as a resource for families, and CPS as accessing similar resources to NFP.

One nurse shared, “I think their caseloads are probably very huge, um that’s kind of how I see it.”

Another nurse stated, “I guess in our area – I don’t guess. I know. In our county, they have a really high turnover, and we don’t. Yeah. And I think there is something to that for them.”

A nurse supervisor stated, “You know, it – Right now, I sort of see us as two separate entities who every now and then, chat if the situation, you know, arises. And, we can both make it happen.

Another nurse expressed, “Yeah, right. Because if the ultimate goal is to get that family back together in a positive way, then – And, I’m sure they’re accessing some of the, a lot of the same resources that we access, so – Yeah.”

Perceptions of CPS Organizational Culture

Many of the nurses and nurse supervisors across most sites discussed their perceptions of CPS as an organization that created barriers for clients. However, these perceptions varied across sites. Some nurses from these sites talked about how the clients feared CPS because of cultural and linguistic barriers while others perceived CPS sites to have different unstated standard protocols and that staff adopted the philosophy and underlying cultures of each site. A nurse from another site also discussed having had challenges with English not being the first language of the hotline receptionist and concerns for whether or not everything she reported, about the client’s strengths in particular, were being fully captured. Another nurse from the same site also had concerns about culture not having been taken into consideration by caseworkers when they conducted their assessments and thus having had incidents of cultural misunderstandings and suggested that standard procedures would help to handle gray areas. Finally, another nurse from another site discussed challenges with caseworkers who did not support certain parenting preferences such as

breastfeeding and strayed from the initial reason for having CPS intervene. However, a couple sites also indicated that community resources available in Spanish were beneficial resources for them.

A nurse stated, “Because, at the time she was new into the system here, so I think different places have different philosophies, different unstated M.O.s and I think, after another work system, you adopt their philosophy and their underlying culture at least.”

Another nurse recalled, “Uh-huh. The caseworker, in my opinion, does not like breastfeeding. She thinks it’s gross, whatever. So, has been on her about the breastfeeding. They were focusing on the breastfeeding at the visits and that she was doing it too long and that, um... What she had told me when I kind of met—because my client was telling me and I’m like, ‘They said what?’ And, she’s just like, ‘You know, that I can’t breastfeed her that long, and that I’m doing it for myself, for my own satisfaction, and all blah, blah, blah’ - And so, what my whole think was is I was kind of like, ‘Okay, that wasn’t the issue of why she got the baby taken away. It was a safety issue, but this is what we’re focusing on?’ So, the only reason the caseworker talked to me is because I was kind of advocating for the breastfeeding and saying, you know, ‘This is actually a really good thing,’ and so, she just said, ‘Well, she needs to be eating. We want her.’”

Perception of how CPS Viewed NFP

Many nurses and nurse supervisors across many sites perceived that CPS lacked knowledge about NFP, had an incomplete understanding of the NFP program, or lacked understanding on the role of the nurse home visitor. This lack of knowledge related to NFP’s service provisions, nurses’ qualifications and role as a nurse home visitor, the program curriculum, and nurses’ extent of knowledge about the clients. More specifically, some nurses believed that CPS did not know the frequency of nurse home visits with their clients. Several nurses from other sites also perceived CPS caseworkers to not always understand the nurse-client relationship or the meaning of NFP as a voluntary program. In fact, in several sites, many NFP nurses and nurse supervisors perceived that CPS believed they were able to mandate clients into the NFP program. Finally, many nurses and nurse supervisors across most sites felt that they could serve as an integral resource to CPS but were underutilized due to this lack of knowledge by CPS caseworkers and supervisors.

A nurse stated, “They probably don’t understand our role, just like we probably don’t understand their role, and also the things that we deal with, they probably don’t understand our program and what we’re doing, or even some of them don’t even know we’re in the same building (*laughing*), so I think that’s a lot of it. I’m not really sure they get burned out and, like I said, they have high turnover. I’m not really sure on their part.”

Another nurse from a different site stated, “Mm-hmm. I think their lack of knowledge of what we do. And then, and then going a step beyond that, whether they regard if it’s important or not.”

Another nurse stated, “They don’t understand what our role is what we do. Um... that’s my perception. They don’t know what NFP is and it’s like we are literally [co-located with] you. And we work for the county just like you do. And then, if they have heard of NFP, a lot of times I feel like they’re okay either letting something slide or not getting as involved as they might otherwise because oh, there’s a nurse in the home. That’s not our role.”

Another nurse shared, “Um, well number one is just the attitude of the CPS worker that we have to – I mean, they don’t understand. We have our – the premise, the premise of NFP is to establish a relationship with your client. And, now, it doesn’t always – Luckily, with [client name removed], it’s different. I can – I called CPS on her, and she understood. But, sometimes, when you have to call CPS, the client, they aren’t going to – they’re not going to be like that. You’re going to lose that client.”

Additionally, in several sites, some nurses perceived CPS to undervalue NFP nurses as professionals while other nurses in various sites felt that sometimes CPS distrusted their abilities to be mandatory reporters or treated them as laypeople when reporting. In fact, in a couple sites, several nurses expressed needing to explain the NFP program while reporting to provide greater merit for their report; which they perceived did not contribute to any change in how the report was received. On the other hand, some nurses from several sites perceived caseworkers to be understanding depending on the individual.

One nurse stated, “Because there are times when they actually, I’ve not had this experience, but when other nurses have gone up there, they’re just told to take a number and wait in line, where we’re really trying to advocate for our clients or, it’s not a very pleasant – and it’s not a very pleasant atmosphere up there at all.”

Another nurse recalled, “It was long ago when the marijuana issue was with the client, and they developed trainings on how to report marijuana that was ten years ago, and I felt like it was targeted at me because they thought I knew that the client was smoking marijuana or might be. And they thought I should have reported it earlier.”

Another nurse shared, “So I mean, when we’ve made reports, or when I’ve made reports up there, it’s like I’ve explained the program just to kind of give the report a little bit more weight, but that hasn’t really seemed to matter.”

Perception of Clients’ Perceptions of CPS

Among some sites, several nurses spoke about their perceptions of how their clients perceived CPS. Almost all of these nurses expressed that most clients were fearful of CPS, often due to cultural and language barriers. Some clients were fearful that CPS involvement would result in deportation while other clients who did not speak English did not always understand the purpose of CPS coming into their home – to assess for a child’s safety. Some other clients who had been involved with Social Services in the past tended to think everyone was from the department. In these situations, a nurse had tried to connect with the CPS caseworker to provide further information for the client, or explained to the client that NFP was not connected to CPS but that there may be occasional contact due to accessing resources and services or mandatory reporting.

One nurse shared, “Right, right. So there’s a lot of fear because, I guess, maybe cultural barriers – Cultural, language barriers. I know what the only thing I did was contact that CPS worker to get a little more insight on what they were checking for, and they just wanted to make sure that she was okay, that she wasn’t being abused.”

Another nurse stated, “Well, it’s my own opinion, but the couple of families that I have had to explain that to are very – have been very involved with DSS through foster care, and so, in my view they kind of have an idea that everybody is DSS.”

Knowledge of CPS

Beyond sharing their perceptions of CPS, many nurses and nurse supervisors from all sites explained their knowledge of the CPS system, including the reporting process, who reported to CPS, and prevention programs available within the department. Across positions and sites, most NFP nurses and nurse supervisors knew that they could call the CPS hotline or talk with their supervisor if they needed to make a report but had less knowledge about the criteria for reporting and what protocols followed reporting.

Reporting to CPS

Many nurses and nurse supervisors across all sites were aware of the hotline they could call to make a report and a few nurses across different sites believed that mandatory reports could be made anonymously. One nurse was aware that it was a misdemeanor if DHS did not protect the confidentiality of the reporter and another nurse and a nurse supervisor from a different site knew that reports may not be confidential if the case went to court and the reporter was asked to testify. Some nurses and nurse supervisors across most sites were also aware that CPS did not want them to make reports until after the baby was born and that marijuana use was a low priority for them. However, they were uncertain about how often they should make a report if they believed that there was a safety issue and CPS had not intervened previously.

A nurse stated, “Yeah. It is. And, the thing that I, you know, because again I’m new to this. And, I definitely don’t feel like I know enough about reporting, but, you know, okay, so you make this report and then they don’t follow-up. And, then you continue to hear stories. Do you keep making reports? You know, so what is - What legally should you do?”

The same nurse continued to say, “And, you know, if CPS doesn’t act on it, you just keep reporting until they do? You know, so, there’s - It just seems like there’s more - I guess, just more guidance with when to report, what to report, the whole process. You know, how DSS kind of leads through. Because I know they have tons of reports. I mean I’m - I know their job is horribly hard, but I would just like to know their process and how they screen through all of it. I really don’t have any knowledge to tell you the truth. I have absolutely no idea.”

Another nurse stated, “But, I also think that they - I think their perception is we’re protecting our clients maybe but, I don’t know. Or maybe we’re a threat. We talked about this at a staff meeting. It can be intimidating, although I think I’m like so not

intimidating. But, to know that we're registered nurses and that we go in the home and that we educate our patients, our clients."

What Protocols Followed Reporting

A few nurses and nurse supervisors across different sites had some understanding of the protocols that CPS followed after a report was made. They knew that someone received the calls, others decided if the case was going to be investigated, the case was assessed, and then a caseworker was assigned to an open case. However, the majority of nurses and supervisors across most sites were not familiar with what happened after a report was made. They did not know what CPS assessed, how decisions were made about if and to what extent CPS would get involved with a case, and when CPS decided to terminate parental rights.

A nurse supervisor stated, "I think the Department of Human Services, their intake team, they go out and they do an assessment to see if the case is going to be opened or not, if there's - If it's not, then they'll go ahead and close it. If it is, then they may stay with it a little bit, and then send it to a permanency worker. So we're learning - I'm learning the lingo. But, I - That's who we met with initially because that might be our first point of contact is somebody doing the intake or assessment, maybe of one of our clients or their families."

One nurse stated, "Like, I really don't understand their process of, after you do, after you do the report, and the intake is made, how decisions are made as to follow up, um and then also I think it would be really helpful to, um, I mean I understand that their caseloads can probably prevent them from ever trying to contact us in terms of our involvement I've had one situation where I didn't initiate the report, and I was at a home visit when the caseworker showed up, which was really very interesting, cause the client didn't know that, it made it awkward."

Another nurse shared, "My knowledge in this county as, you know, obviously, when the report is made, they're required by law to respond. But it just depends on the severity, I guess of the report. And I know that some reports have more precedent than others. It's pretty much, that's my knowledge for CPS."

Another nurse from a different site stated, "Well, I feel like I still don't know what their process is, so I would love to learn more about what they do and, you know, how many referrals they have to have before they open a case, you know, the teams: the assessment team, the ongoing or - I cannot remember what it's called. And then I think they have another team. I just feel like it's such a big process that I would really like to learn about that."

In addition to not knowing the general protocol that followed after a report was made, several nurses in multiple sites also felt that some cases were handled quite subjectively. Some nurses across multiple sites questioned why some families had their children removed while others who they perceived had greater safety concerns had children remain in the home. Some nurses across multiple sites were also unfamiliar with the terminology used by CPS which then impacted their level of understanding of CPS processes. Recognizing how this lack of knowledge impacted their

work, many nurses and nurse supervisors from multiple sites desired the opportunity to learn more about CPS' procedures and terminology.

A nurse stated, "It seems to me that their process is very subjective because it really depends on the caseworker that they have. Because I've seen - Like, my one case, they were getting like 10 reports all at the same time, and they left the kids, and this is a house where the kiddos had been removed multiple times already."

Another nurse from a different site stated, "Yeah. It is, and that's an area where, you know, I just feel like I don't quite understand because, you know, there are certain guidelines that I am quite sure are set in place. And, I just - It would be nice to know what those are. But, depending on if the family has an open case, if there's other children, they've got histories, I know that all plays into it also. But, usually, if it's like heroin, meth, they'll take custody. And, they usually give the mom visitation rights. Occasionally dad. Depending on his issues. And, that's about it. And, they'll bring a foster family in and they start helping with taking care of the baby. And, they're usually babies that are in the hospital for quite some time. So, you see the mom go through the court process, and the family, you know, the foster families. And, almost always we discharge to the foster family, but not in some cases. I mean I have seen, especially with the narcotics, it's a very gray area because if they have a prescription for narcotics it's - DSS really can't do anything."

A nurse supervisor stated, "Um - I guess it would be interesting to know what the process is when... From the time they get a referral on somebody - Like, they get a phone call, you know, that they think that this child's been, you know, being beaten. And then, what do they - What is the process? What do they do? Because I - I honestly don't know. I mean, I know what ends up happening, but I don't know what they do and how quickly they respond, and I know some things would probably - Like, I've heard them talk about a RED something or RED Zone, or RED some - (*laughs*) Anyway, so I mean, I know there's things that are more- Make it more of a priority than others, I'm sure."

The same supervisor continued to say, "The process and defining 'open case' and what that means and how long can it be open and- You know, kind- Like, stuff like that would be interesting to know."

Knowledge of Other People Reporting to CPS

Among all sites, many nurses described their knowledge of situations or cases where another individual reported on their client, client's partner, or client's family members. Other individuals who had reported on nurses' clients included: the emergency department or hospital, schools, the police, neighbors, clients' friends, or clients' family members. When the emergency room or hospital reported, some nurses in different sites explained that the situations were usually related to injuries on the infant, substance-exposure, or age differences that showed up on the birth certificate. Schools were described by these nurses as usually reporting for truancy, while the police usually, though not always, had reported to CPS after arresting a client or the client's partner (either for substance use or IPV).

One nurse stated, “It’s basically just blood vessels were popped. But that showed me that there was enough of a pressure incident so the baby needed to be seen. So I had her take the baby to the hospital. Well, when she went to the hospital, apparently her story had changed four times. So, they reported her to DHS per their protocol, hospital protocol, because just the story was a little bit different each time.”

Another nurse explained, “Then her baby was born in [redacted] and she was doing pretty good, and then in June or July she kind of subconsciously repeated what her mom did – her mom was an alcoholic and her mom was killed when she was drunk and walking down the road, and the mom I worked with repeated this history and she had her baby with her in a stroller and she was drunk and walking down the road from Target, so the cops were called and Social Services came in so [CPS caseworker name removed] and I worked together on, you know, how was the mom doing.”

Some nurses across several sites also shared their knowledge on why neighbors had reported on their clients. Neighbors who reported on the client usually called the police regarding IPV or violence in the home, drug use (e.g. meth) in the home, or an unclean environment that was unfit for a child. For clients’ friends or family who had reported, the situations were related to: the client running away, substance use (e.g. alcohol), custody issues, or statutory rape.

One nurse shared, “And, as far as – I had a poor client, she finally told me she was using meth. It was pretty sad, but. And, I think she had – someone – her neighbors had reported them for neglect or abuse or just because they were using in the house. But, I never knew it until she was leaving town, and you know. And, I asked her, you know, because I noticed all of a sudden she lost weight, but she was never under the influence when I would go there.”

Another nurse with regards to substance-exposed newborns stated, “Well, it’s nice because (*laughs*) we don’t have to do a lot. We don’t have – We’re not the ones that report it... It’s the hospital that’s going to report it. And, if it becomes a good wakeup call for the mom, and she really cares about her baby and wants to be a mom to that baby, then she’ll start making the steps necessary that she has to do to get her baby back. And, we – You know, we can continue working with her as long as she’s trying to make that happen.”

Another nurse recalled, “And that’s pretty much when I lost contact with her, except for a few brief conversations, and it was really sad, because at that time, um, because she had been drinking, mom called DHS on my client and they actually gave custody to her parents, including the mother, who, for years ignored the fact that her daughter was being sexually abused by a sibling.”

Another nurse shared, “So, I don’t even need to – You know, I mean, I had another client of mine – I didn’t call CPS, but, father of the baby, they’re in a custody battle. He called CPS on her.”

Knowledge of Prevention Programs

Although most nurses and nurse supervisors were fairly unfamiliar with general processes within CPS, those who worked within counties that had prevention programs and/or a Prevention Unit were more familiar with those aspects of CPS. These nurses and nurse supervisors were familiar with the prevention programs' philosophy, eligibility, population served, and services offered.

One nurse stated, "But, I know that they've gone into homes, that they really try to help the families with finding resources to help them keep the children and to provide a safer home for the children."

She later stated, "Yes. I'd have to get you a brochure. But, it's a program where they work mostly with families, but the primary client are the kids, and so a child between the age of - I think like five and 21, something like that. So, some of our clients will sometimes fall in there and have been involved. But, they're more of like a prevention-based case management kind of a program. And, they're a collaboration between DHS, the Health Department – because one of the women who is on the team actually has a seat here – somebody who comes from a church - So, I think they're a team of like four or five people, and they all have different specialties. And so, when they get referrals in, they determine, 'Okay, which specialty is really going to be most appropriate here?' And then, they divide it up that way. So it's more of like prevention, but it's kind of like a home visiting program, similar to ours, a lot of case management. But, in terms of how they work with [CPS supervisor's name removed], that might be interesting to know is, you know, what if they have a client they think needs to be set up with prevention? How do they go about actually getting them from [program name removed] into the prevention unit? Since they work right under [CPS supervisor's name removed]?"

A nurse supervisor stated, "And, then they have - I want to say three - They have a health module, a home safety module and a parenting module."

Contacts and Context

Some nurse supervisors from several sites were familiar with points of contact for CPS but many nurses from the same and different sites were unfamiliar with the caseworkers within their counties. Although several nurses from a couple sites had direct contacts at CPS whom they relied upon for guidance and feedback, many of the others were uncertain about where their CPS was located and who they could reach out to if they had any questions. However, many nurses across most sites were familiar with the negative reputation that CPS had in the community.

One nurse stated, "I feel like I don't even know who works across the hall from me. I don't even know who they are. I don't know their faces. I don't know their names. I don't know what team they're on. So, I feel like just- If it was like a monthly or quarterly meeting or something where we just got together and, 'This is the NFP team' and 'This is the Child Welfare Team,' and so we know who each other is. And then, just have an open communication with them where I felt like I could just call with a question. You know? It didn't necessarily have to be, 'I'm reporting,' but 'This is what I'm seeing, and what do you think about it?' Or, 'What do you think I should be doing or referring the client to?' So, just having more open communication with them."

Another nurse stated, “We discussed and talked to her about it, and had her tell us how she was feeling, which was mistrust with DHS. The people that she didn’t know, she said basically, ‘No, I don’t trust you because I don’t know you.’ The other people, she gave credit to, which was her old caseworker, her new caseworker, and the DHS caseworker.”

A nurse from another site stated, “Unfortunately, DHS has a very negative connotation, especially in the population that we work with because a lot of them have negative experiences. Whether it’s from their childhood, you know, themselves or a sibling or a friend. You know, already having those negative experiences that are really hard for us to, like no, no, no, they are trying to help. They’ve had all these negative experiences, to offset that so, so that we can be supportive of what their role is.”

Interactions With CPS

Within and across sites, there existed variation among NFP nurses and nurse supervisors in their interactions with CPS. In some sites, several nurses had limited to no interaction with CPS. In the same sites and other sites, other nurses had significant interaction with CPS, be that from the nurse making a mandatory report to the client being involved with CPS in some way (e.g. foster child, sexual abuse, or another individual reported on the client).

One nurse stated, “Okay. I have reported a couple of times. Or, actually maybe just once. I had a client that had told me about a really abusive situation that her sister was in where her – The – Her sister had three children, and they were being locked out of the house and lots of violence and lots of substance abuse. And, I felt like I needed to report, and so I did because my client was, didn’t want to report. So, I did report that time. And then, I’ve been involved with clients that have had CPS involvement but I didn’t do the reporting.”

Another nurse shared, “I’ve never had to report, but I have had clients that have been reported.”

Across most sites, most nurses and supervisors expressed inconsistencies in their interactions with CPS. Many nurses across most sites had experienced positive and negative interactions with CPS caseworkers; indeed, the experience was largely based upon the caseworker assigned to the case. In positive interactions, most nurses expressed that caseworkers had: provided appropriate follow up on the case, asked questions regarding strengths of the family, asked for input or information on the family, and took initiative to approach NFP. On the other hand, negative interactions experienced by many nurses in multiple sites included: lack of communication or follow up, a difference of opinion of safety issues, and abruptness or rudeness when communicating.

One nurse shared, “It’s all dependent upon the case and the caseworker I’ve dealt with. Unfortunately, I’ve had a lot of interaction with them in the past two years. And, some have been really good and helpful, and some have been really bad.”

Mandatory Reporting

As summarized in the Scope of Work section, the prevalence of mandatory reporting among nurses within and across sites varied significantly. In every site, some NFP nurses had never made a mandatory report while other nurses in the same site had reported to CPS. Among those sites where some nurses had made a mandatory report, most nurses expressed that they had made the report usually by phone, but sometimes in person. In most sites, most of the nurses who had reported to CPS expressed the experience to be fairly positive. Reasons for this characterization included: having a live person to refer to, ability to offer information on strengths of the client/family, and ability to share all information the nurse thought was relevant. On the other hand, in a couple of sites, many nurses who had reported to CPS expressed negative experiences while making their report. These negative experiences were due to: lack of professionalism (such as abrupt or rude reactions by the CPS worker), dismissal of the report (e.g. not acknowledging that a mandatory reporter was referring), and lack of personal engagement (e.g. caseworker seemed to be following a checklist rather than having a meaningful conversation).

One nurse recalled, “I was surprised to have gotten a person so easily, so that was a pleasant surprise.”

Another nurse stated, “To them. But, now, you know, you just pick up the phone and ask to speak with – Or, you actually don’t even have to ask to speak, you just – The menu directs you to somebody, and then someone answers the phone. Like this last occasion that I had just a couple of weeks ago. I think the menu directed me, and I talked to the person. And, they were – pleasant to deal with, you know.”

A different nurse stated, “That’s the dependent part of the caseworker. Some are really good and they understand, and some, you’re no different than a random person off the street.”

Another nurse shared, “The bad experiences I’ve had with them was one that I’ve had to report here recently. And this actually has happened twice to me, with another report now that I think about it. The two reports that I had to actually make, were, now granted, you have to understand that my boss is very on the conservative side. She makes sure we follow very strict protocol with DHS, with reporting. Where we’ll report things that DHS doesn’t consider a priority.”

Another nurse recalled, “No, not from the impression I got. I mean, I can’t say for sure, but it was one of those conversations that it kind of just felt like it was hurry up, make your report and let me move on. You know, ‘I’m too busy.’ So, it was – I can’t really say that she didn’t know about us, but, she didn’t seem very impressed.”

Among the sites where some nurses had reported to CPS, most nurses had received little to no follow up from CPS after making the report. In most situations, some nurses from several sites expressed the need to initiate the follow up process by calling CPS several days later. On the contrary, in a couple of sites, some nurses and supervisors acknowledged that at times, CPS had called back for more information, CPS had followed up by phone about the process, or they had received written notice from CPS about the status of the referral.

One nurse stated, “And, it was just a bad – Like, and it was all due to lack of communication. I could have been handled much differently, rather than me walking in thinking nothing had come of it, they didn’t know I was the one who reported, when in actuality they did because the cops were there within an hour of me being there.”

Another nurse shared, “Um, she’d ask me – She had told me what the referral was based on and asked me what I thought about what was reported, if it was a legitimate concern. And so, I kind of discussed with her what I had seen.”

One nurse supervisor explained regarding what her nurses received as follow-up, “What I hear back is, they’ll say no. That’s not something we can handle or that’s not reportable. We actually got a written document back on something we reported about two months ago.”

In addition to making reports to CPS, many nurses from several sites had interacted with CPS through consultation on hypothetical situations regarding mandatory reporting. In these situations, NFP nurses and/or nurse supervisors had contacted a point person in CPS to discuss by phone or in person about gray areas and whether or not they should make a report to CPS. Many nurses expressed these interactions as positive and helpful for their practice. It is important to note that not all nurses from one site nor had all sites interacted with CPS in this capacity.

A nurse supervisor stated, “And so, it’s really helpful to them to have someone as experienced as [CPS trainer name removed] that they can just dial directly and say, ‘Tell me what I should do. Here’s the scenario. What should I do?’ You know, because they feel more confident in what they’re doing after they’ve had that support. And, mine is pretty good, but I don’t work in that area, you know, so her credibility is really high. (*laughs*) And, between the two of us doing that, you know, or them calling [prevention programs manager name removed] or calling [case manager name removed], they - What I see in them is a higher level of confidence in what they’re doing when it comes to looking at whether they need to report or not.”

A nurse describing consulting with a caseworker shared, ““This is what’s happening.’ And they provide some sort of advice or whatnot.”

Mutual Clients with CPS

Beyond mandatory reporting, several nurses from multiple sites had interacted with CPS through serving mutual clients. These clients had been reported by the nurse, the hospital social worker, or a third party; or were already involved in CPS prior to NFP participation (e.g. through foster care or youth delinquency). In these sites where some nurses served mutual clients with CPS, the NFP nurses expressed inconsistent interactions with CPS often dependent on the specific caseworker assigned to the case. Some nurses from some sites shared that the CPS caseworker had initiated contact with the nurse; usually because the client notified the caseworker that she was in the NFP program. Other times, some nurses expressed that they found out that their client was involved with CPS when the caseworker coincidentally arrived at the home during the nurse’s home visit. In one site, several NFP nurses shared that caseworkers had called a designated NFP contact whenever CPS removed a child who was participating in NFP; so that nurses were aware that the client was no longer eligible for the program.

One nurse shared, “I’ve had CPS workers call me and ask me what I’m seeing in the home.”

Another nurse stated, “Mostly emails, a couple phone call. And, that’s about the extent of it. When they learn that they have a nurse, they would contact me. One of them was kind of long ago. I don’t remember if I contacted her first. But, it’s the – You know, it’s kind of the initial, ‘Hey, I’m here.’ You know, ‘What’s going on?’ And then, after that, there’s not a lot of contact.”

However, in most cases, many nurses across most sites expressed that they had initiated contact with the CPS caseworker regarding a mutual client, often by phone but sometimes through email or in person. These initial contacts usually involved: clarification of the case’s status, information sharing on the family by NFP, and a lack of information sharing by CPS. To facilitate information sharing, many nurses from all sites shared a signed release of information with the caseworker; but some nurses from several sites expressed that a signed release did not always result in a free flow of information from CPS to NFP.

One nurse shared, “Well, the client had the information from the CPS worker, but I cannot remember how – She had the information either in a letter or a business card, and then I contacted them just to get more – I just wanted them to be at ease to find out exactly what it is. Because, yeah, people get very scared. They make assumptions, negative ones, immediately. And then, so I just wanted to find out the situation. I think I contacted her – yeah.”

Another nurse stated, “I gave my card to a couple of the caseworkers who were involved with it, and got some cards from them. And then, never heard anything.”

Another nurse stated, “You know, and so, and so then it was hard because I did get a release, I think, from my client to speak to the social worker, but I never did. She never responded to any of my requests with that kind of information – Like, ‘Is [client’s name removed] doing what she’s supposed to be doing? You know, she’s telling me she’s doing all of the things, but I’m not really sure that she is.’ And, she didn’t...”

In addition to initial contact with CPS regarding mutual clients, several nurses from multiple sites spoke about ongoing interactions with CPS due to mutual clients. These ongoing interactions included: updating CPS on the client’s progress through phone or email communications; being invited to and/or attending TDM or family engagement meetings with the client, her caseworker, and her providers; attending court as a support for their client; participating in treatment planning; and conducting joint visits with CPS in the home.

One nurse recalled, “In that particular case, I was invited to the TDMs. I did go – And, I was invited by the family. They, the sister and the grandmother wanted me to be there, so that I could just say that they were participating in the program because they felt they – they were fearful they were going to lose custody of the baby. And, I think – I think it was only a few TDMs before they just decided that – before Mom voluntary signed over her rights to the grandmother.”

Another nurse stated, “Um – it depends on the meeting. I’ve been to – there’s been a couple where I’ve actually been able to be at like the team meetings and stuff, so it was a collaboration of all the resources. Those were lovely because then we actually knew who was all involved. And then, we could work together and not duplicate like a thousand different services.”

Another nurse shared, “Yeah, she’s responds to my emails. And then, she called me on Friday. She wanted to know about what was going...”

Training, Meetings, and Conferences

Across several sites, many nurses and nurse supervisor had also interacted with CPS through trainings, meetings, and conferences. In trainings, some NFP nurses expressed that CPS had mostly presented on mandatory reporting and marijuana. Several nurses from one site in particular felt that the training for when to report was inconsistent as different caseworkers did not offer the same threshold for when nurses should report.

One nurse shared, “Not to- I mean, there’s several, but most of the time, it’s with DHS or Child Protection where they’ve put on like a class or something. But, it seems to be – there still seems to be some differences of opinions between caseworkers and trainings – In like when to report, when not to report. How to handle the cases. That kind of thing.”

Another nurse stated, “Well like I said, last year, we went to that workshop that was a pretty good workshop, pretty detailed, that talked about the situations of when we should and when in doubt what to do. And so, I felt like that answered a lot of questions. I mean, that’s what addressed the whole situation of the legalization of smoking pot. And then, we’ve had them come in from time to time, so I think that has helped.”

Some nurses and nurse supervisors from a couple of sites had also interacted with CPS through meetings. These meetings were usually purposed for meet and greet, to apply faces to names, to learn about the CPS process, and for nurses to have questions answered about gray areas for mandatory reporting. In a couple of sites, a few nurse supervisors and nurses explained that they had attended RED teams or CPTs, and/or shadowed caseworkers to better understand their process. In some other sites, several nurses and nurse supervisors had interacted with CPS through conferences, community or coalition meetings (e.g. local NFP CABs or through the Early Childhood Council), and DHS Wrap-Around services (where all services providers collaborated to support a client). For example, one nurse supervisor had worked with CPS workers and other community stakeholders on joint maternal child health campaigns. In some sites where CPS and NFP were co-located, many NFP nurses expressed that they had informal interactions with CPS while passing in the hallway or at holiday parties.

One nurse stated, “Um, it was more just kind of a forum to ask questions about Child Protective Services. And, kind of their process, a little bit. And then, we’d ask about reportable situations.”

Another nurse shared, “I don’t know if it’s really necessarily been brought up. A couple of us had gone to that conference in Vail in [redacted] about substance use. And, we had talked – There was some stuff about that. And, I had talked to another NFP nurse from

[city name removed]. And then also, one of the caseworkers from CPS was there, and I kind of discussed it with her as well.”

A nurse supervisor stated, “Well, we have an Early Childhood Council here. She sits on that as I do. I’m the chairperson on one of the United Way committees, so I’m on that. And then, we have a [project name removed] here – I’m trying to think. It’s another – it has another name, too, but [project name removed] is a federal grant that came to [county name removed] from SAMHSA. And, the whole point of it is to look at and see about doing a more fluid handoff of services for families and kids, now zero to eight, and so I’ve been on that since the beginning. And, [Prevention Programs manager name removed] joined that when she came into DHS, so I see her for both of those meetings.”

Use of a Liaison

In one site, many nurses expressed that they occasionally utilized the designated public health nurse liaison for CPS to find out which caseworker was on their client’s case. This liaison had sometimes, but not always, been contacted by CPS prior to opening an assessment.

A nurse supervisor stated, “I think the only way they would know is if they contacted us. We do have [public health nurse name removed], who is kind of the liaison nurse between the health department and DHS, and sometimes they have contacted her prior to an assessment. I just talked to her today, though, and she says they have not been notifying her at all.”

Referrals from CPS

Referrals from CPS to the NFP program varied among and within sites. Most sites had received the occasional referral from CPS but this was described as uncommon. Moreover, some multi-county sites expressed that referrals from CPS came more frequently from one county as opposed to another; this may be due to a lack of relationship with some counties but a greater collaboration with other counties.

A nurse stated, “Because we usually don’t, most of our referrals come from WIC or either pregnancy center. We usually don’t get a lot of referrals from upstairs [meaning DHS] so.”

Another nurse explained, “Now, occasionally, we’ll get a referral, but that’s very, very infrequent.”

Another nurse stated, “In [county name removed]? Yes. Well, I don’t really have a whole lot of relationship. I know who the people are and occasionally they refer to us... And usually, in the times they have, it’s been people that really weren’t interested in the program.”

In some sites, some nurses and one nurse supervisor felt that CPS often referred inappropriate or ineligible clients to the NFP program. These included second or third-time mothers, mothers with severe mental health illnesses, and medically fragile infants. Some nurses from a few sites also expressed that CPS had tried to mandate NFP for families with open assessments or cases. In these situations, the NFP site had reeducated the CPS workers on NFP as a voluntary program.

One nurse stated, “[County name removed] is a little harder to work with because they want to change the design of the program. They want us to have second-time moms - like they referred me to a lot that decided they’ll get in like three months after the program. I’ve had a lot of referrals from [county name removed] that the mothers decided not to be in it. So...”

Another nurse shared, “Umm, one other time a referral I had was working with Social Services but she was a client that - one of the only clients that actually, because of my discomfort with the situation, that we declined in the program or she was mentally ill - So I actually talked to Social Services about her because they referred to me and, after I had already seen the client, and we declined the client because or you know I was afraid. It was one of those issues.”

Across several sites, some nurses also explained that oftentimes clients who were referred by CPS felt mandated to participate in the program, despite knowing that NFP was a voluntary program. When encountering such situations, many nurses in most sites had emphasized to these clients that NFP was a voluntary program that was beneficial for families and supported them in achieving their goals. Despite this emphasis, several nurses from different sites reported that some clients still felt reluctant to participate in NFP because it was CPS who made the referral.

A nurse reflected on how a potential client viewed her referral to NFP, “In the client’s eyes. I mean, if the referral’s coming from Child Protection, that’s kind of saying, ‘You have to do it, even though I’m not writing it in.’ And so, I was like, ‘You know, you can tell her to give me a call. Give her my number. Give her my call phone number,’ which I know she already has because I’ve answered some questions throughout, you know, the time and helped her with diapering situations later, after the baby was born. And so, as of today, I still have not heard from her. And, when and if she does call, I will also reiterate to her that Child Protection cannot order her to do this. If she - This is a voluntary program, and it’s...”

Another nurse shared, “The one [location name removed] client though. My original first. Just so you know, she was referred by DSS to me. I emphasized at length that it was a voluntary program. She enrolled, but, very hard to track - She was referred DSS - They encouraged her highly to participate. I don’t know why. They never shared. And, I could tell from the get go that maybe she felt like she should be in the program.”

CPS Prevention Programs

In several sites, many nurse supervisors and nurses expressed that they had interactions with CPS prevention programs including SafeCare. Some ongoing interactions with these prevention programs included meetings, co-trainings, email communications, progress updates and case conferencing on mutual clients, and consultation for hypothetical reporting cases.

One nurse supervisor stated, “You know, and having the prevention unit has been really helpful because to get them to the prevention unit, we have to go through CPS. And, so, they may then be able to go to a client and say, ‘There’s a unit that DHS has that will help you with some things, but I have to make a report to Child Protective Services to get you there. It doesn’t mean they’re going to come out here and look to take your child

away from you. They're going to kick this out and say you don't meet their criteria, but then, they'll push it onto the prevention unit, which is where we want to go.'"

NFP Perspectives on Collaboration Efforts Between NFP and CPS

Collaboration between NFP and CPS varied from site to site and within site as described by different NFP nurses and nurse supervisors from many sites. These variations were attributed to aspects of NFP requirements but also due to varying CPS responses to child abuse and neglect reports made by nurses. Most nurses from all sites described existing collaborations with CPS related to trainings and guidance from CPS, communication after a report was made, and other interactions when serving mutual clients. Although some nurses from several sites referenced such collaborations with their local CPS departments, other nurses from the same sites as well as other sites expressed challenges in collaboration. These challenges to collaboration included: a lack of communication initiated by CPS, not understanding the process of CPS, not having a formal protocol in place for collaboration between the two organizations, one-sided communication with CPS, a lack of professional respect for nurses by CPS workers, and lack of knowledge by CPS about NFP.

Across several sites, several nurses and nurse supervisors explained about collaboration efforts that had occurred between CPS and NFP. Indeed, strong collaboration was prevalent across these sites. Most of the collaboration efforts described by some nurses and nurse supervisors from these sites revolved around receiving guidance or training from CPS and interactions related to serving mutual clients. With regards to guidance and training from CPS, some nurses from several sites explained that they had received information on what was reportable, on differentiating gray areas, and on CPS functions and processes, as well as guidance on specific cases when they were unsure about making a report of child abuse or neglect and brainstormed next steps and strategies. Having working relationships with CPS and/or a point person within CPS to answer their questions and concerns related to mandatory reporting was described by several nurses and nurse supervisors in these sites as helpful and collaborative between the two organizations.

One nurse supervisor said, "And, I said, 'This sounds reportable, [nurse name removed]. If you think you want to run it past [prevention worker name removed] and see what she says, that's fine. But, I think this is really going to be reportable.' And, that's exactly what [prevention worker name removed] said, too, 'You've gotta make a report on this.' But, it was - It's another resource, even just as a sounding board. And, they're very open, they're very available that way, at least right now. We'll see what happens as they get really busy. But, it's been a nice support, I guess I would call it, to clarify some things."

The same supervisor also explained, "We have had representatives from CPS come to team meetings because the nurses at times—and, it dep—you know, I've had new members come into my team over the last few years. And, they always - The gray areas are really hard to differentiate what you do and what you don't do. So, we've had, several times, had folks come in to team meetings and talk with us about what parameters they're looking at. And, that's been helpful."

Another nurse supervisor from a different site said, “I do have, I’ve developed a relationship with the deputy director of CPS and then with the director of the Child Welfare side, I guess that’s what she’s called. She’s underneath the deputy director, so I’m not sure what her title is. But - Anyway, being able to email questions to her, as well as the deputy director and getting their responses. Calling and say, ‘Ok, I have this going on and this is what I’m feeling like I need to do, you know, is this something that’ you know, and they’re, ‘Yeah’ or, ‘You need to you go ahead and report.’ You know, that kinda thing.”

One nurse stated, “My own personal feeling, I don’t know, is that we have a good relationship with them because they do invite us if sometimes we’re just not sure should we report something or not, they welcome us to come and just ask them questions without revealing any names, just to kind of brainstorm.”

Collaborative interactions related to serving mutual clients were also described by some nurses and several nurse supervisors in these sites. Such interactions occurred when caseworkers initiated contact with a nurse after she made a report to CPS to ask additional questions and/or made timely responses to the nurse regarding the outcome after she made a report. Additionally, other collaborative interactions were related to working together to support mutual clients, including: conducting planned joint visitations with clients and actively participating in TDM or family engagement meetings. Having open communication and a strong understanding of one another’s roles were shared by several nurses in a couple of sites as facilitating these collaborative efforts with mutual clients.

One nurse explained, “But, definitely, I really appreciated my interaction with [CPS caseworker name removed] ... If you make a referral, that there should be some feedback. And, my understanding is that there is now, that they call you, and let you know at least if a case was taken on or not. Which [CPS caseworker name removed] did do.”

Another nurse stated, “I did have one client - And, I never actually filed the report, but I had one client that did have an open case with DHS...so I was involved in a couple of like family meetings. I talked to the caseworker a couple of times. When I did home visits, the caseworker was there once, and my client and the caseworker had developed a pretty good relationship.”

Another nurse said, “So, and I always - I always emphasize that to my clients, like I don’t - You know, I want to promote your relationship and help you to enjoy each other and, you know, be a unit. Yeah. So, that was a big case. And, it was really nice to have some direct contacts at Social Services. And, I guess I just created those by having the... One of the managers came and spoke to us at our meeting, and she had given me this navigator’s name, and then - Yeah, then - So, one phone number kind of leads to another, lead to another, and asking the right people the right questions, and that was before the prevention unit had started, but it was kind of pre-prevention, which I think I was telling you in our case, our open forum sort of.”

There were other instances when collaboration between NFP and CPS was described. Several

nurses and nurse supervisors from a couple of sites shared that they attended regular meetings with CPS workers and supervisors, were invited to CPS team meetings, attended presentations by CPS, and/or shadowed caseworkers on visits. In one site, several nurses and a nurse supervisor shared about collaborative experiences with their local CPS prevention programs, while some nurses in a couple of sites had engaged with supportive services offered through CPS for their clients. Another area of collaboration between CPS and NFP was explained by several nurses from a couple of sites as having their opinions valued as a mandatory reporter when they reported suspicions of child abuse or neglect. This collegial feeling between the nurse and reporter were expressed as positive and collaborative.

A nurse supervisor regarding shadowing caseworkers explained, “Uh, I would say that there were girls on the team that did do this. Uh, their eyes kind of opened up for what they do. The more experienced girls on our team, um, I felt like they were saying they... One in particular. And, her case load is very crisis oriented and chaotic. Not on her part. On the client’s part... And, so, she went out for several visits in a row with this gal.” Another nurse supervisor shared, “Currently, I think we really have good collaboration. We’re trying to bridge our two teams and trying to - In doing that, we had a meeting last week, and we brought together the intake workers and our NFP nurses. I think they learned a little bit more about us than we did about them at that meeting. They had a lot of questions for us, but we’re really trying to be a part of their rhythm and trying to find a way to be able to communicate a little bit better with them in a timely manner. Because I know we’ve had cases in the past, and it takes a little bit of time to get that communication started. I think, recently, it’s been a little better between our two teams.”

Stronger Collaboration

Training and Meetings

Several NFP nurses and nurse supervisors from different sites referenced new or improving collaboration with CPS recently than in prior years. They explained that these collaborative interactions were primarily initiated through invitations to attend CPS team meetings (such as with their intake team), family engagement meetings that involved mutual clients, or through trainings related to mandatory reporting and/or marijuana provided by CPS. Several nurse supervisors from different sites explained that providing a venue for nurses and caseworkers to meet face-to-face and to learn about one another’s roles had facilitated better and timely communication. A nurse supervisor from one site shared that coordinating bi-monthly meetings with CPS, that later transitioned to monthly meetings, had improved collaboration between the two organizations.

One nurse supervisor stated, “Yes and that question comes up about HIPAA. And that I say social service, it’s kind of a little more open, so while we might be circumspect about what we say. We might say, ‘I’m on this case, I’d like to talk to the social worker.’ And it’s worked, I would say over the last couple years, it’s working more.”

Another nurse supervisor stated, “How that started. Oooh. Ewwww. Gosh. I can’t remember when that started exactly, but we were doing, um, every other week and then now it is just a monthly visit that we are doing with DHS. In hopes to get the collaboration working.”

Another nurse supervisor said “Okay. Currently, I think we really have good collaboration. We’re trying to bridge our two teams and trying to - In doing that, we had a meeting last week, and we brought together the intake workers and our NFP nurses. I think they learned a little bit more about us than we did about them at that meeting. They had a lot of questions for us, but we’re really trying to be a part of their rhythm and trying to find a way to be able to communicate a little bit better with them in a timely manner. Because I know we’ve had cases in the past, and it takes a little bit of time to get that communication started. I think, recently, it’s been a little better between our two teams.”

Valued as Professionals

Another theme that was referenced as a positive factor towards stronger collaboration between NFP and CPS was when nurses felt valued as professionals and had their reports of child abuse or neglect taken seriously. Several nurses from various sites expressed that they were treated as professionals when they made a report to CPS. A couple of nurses from different sites also shared that they had received contact from a caseworker after a report was made (e.g. to gather additional information on the family or to share the outcome of the report) because the caseworkers valued their professional opinion as a nurse and mandatory reporter. In fact, one nurse supervisor specifically explained that their local CPS department valued their perspectives and had not ignored their reports because the caseworkers recognized the validity of the nurses’ concerns.

One nurse supervisor stated, “They don’t ignore what we say. They really don’t. Because they value the fact that we’re in there. We’re a trusted individual by these families, and we see things and hear things that not everybody does, you know. And, I mean, in our marketing with the doctors’ offices, our last one we did was over here a couple weeks ago, and they said the same thing. You know, ‘We want to have an open relationship with you guys to - If you see something with a client that you’re concerned about, call us. Let us know what it is,’ you know.”

Another nurse shared, “I think part of it is the Nurse Family Partnership name while it may not be known to everyone, they do know, ‘Oh there is a nurse calling.’ And interface back.”

Face-to-face Interactions

Having face-to-face introductions or ongoing interactions with CPS workers was referenced as another area of collaboration between NFP nurses and CPS caseworkers for some sites. Such face-to-face interactions included: meeting caseworker teams in an introductory Meet and Greet, receiving guidance in-person regarding hypothetical questions on gray area cases, making a CPS report in-person, and meeting in-person regarding a mutual client (such as to exchange signed consent forms or through staffings and family engagement meetings).

One nurse said, “And then, I presented her case when we - When Dr. Olds came up here in [month redacted]. And so, I had talked to her before Dr. Olds came up, and she came to that meeting. So, we had met. We went to this coffee place and met. So, I met her face-to-face a few - And so now, we just - When we have a concern about this case, we just - I call her or email her, and she’s really - she’s not very good about answering her phone, but email, she’s great. She gets right back to me.”

Another nurse stated, “Face-to-face. I would just go down to her office and say, ‘[Caseworker name removed], let’s –’ Social Services has had this quality that you can say to them, ‘What if I had this situation? What would you say?’”

Another nurse described, “I had one very good experience with them, where it was a fairly newer, I think she had only been with DHS for about [redacted] months, and I wish I could think of her name, but she was very good, she had me come to a staffing upstairs, totally involved me in the whole process, and these are ongoing clients that I still have to this day.”

Another nurse stated, “So anyway I called, I found out who the CPS worker was and I called her and told her who I was. She was very pleasant. And she told me, ‘Yeah, we can talk.’ She said, ‘You have the consent, I’ll just come downstairs.’ So she came downstairs to the second floor and met in one of the conference rooms and she was very informative... So I was really impressed like for her to be, she shared quite a bit with me. She gave me her professional opinion when she was there. Where she visited the client I had never been. The client, I usually meet her in town, but she met the client out like in [location name removed] or something, somewhere east, way east. The client never would let me come out and visit her there.”

In several sites, NFP and CPS were co-located in one building while in other sites NFP and CPS were located nearby; in both cases, face-to-face interactions were facilitated more easily than sites that were not co-located. Such interactions were informal including seeing one another in the hallways, weekly drop-in visits, attending building-wide holiday parties, and informal interactions in the community. However, co-location did not always facilitate stronger collaboration; for example, some nurses and nurse supervisors from several sites referenced little collaboration despite NFP and CPS working in the same building.

One nurse from a site where CPS and NFP were located explained, “We still maintain a very good relationship. I mean, we live in a small area. I mean, we see people at meetings. We see them out shopping. You see them at dinner.”

In another co-located site, a nurse shared, “So, you know, NFP caseloads kind of fluctuates, so when my caseload was low or lower, I had time to call people up or go trotting down the hall. That is the other nice thing about living in a smaller community is you just walk down the hall and say, ‘Hi. How’s it going?’ and so I had time to talk to people. “

Another nurse stated, “...whereas CPS is upstairs and they don’t see us on a regular basis. I think if maybe it went along the lines of CPS, too, is if we had more type of trainings together and they saw our faces more often, they would be more willing to work with us because it’s like our clients – they don’t really- they’re kind of leery of the program until they meet you and see your face, then they find out you’re not so bad or scary and they’re a lot more open.”

Collaborating With Mutual Clients

As stated, some nurses and nurse supervisors in several sites had expressed collaborative efforts between NFP and CPS when working with mutual clients. Such collaborative interactions included attending staffings, treatment planning meetings, family engagement meetings, and court hearings; conducting joint-visits with the client; having open communication; and working with CPS and other service providers to effectively provide Wrap-Around services for a client. In-person interactions regarding a mutual client were described by some nurses in multiple sites as collaborative when the nurse was able to share opinion on the family and receive the caseworker's perspective and other information on the case. Several nurses from a couple of sites shared about instances where they had exchanged information freely with caseworkers, communication was initiated by both sides, and both parties supported one other's work to effectively serve the client and protect the baby. A few nurses from different sites also mentioned having worked together successfully with caseworkers to locate kinship care for their client or return care of the child back to the mother whose child was temporarily removed due to IPV. The prevalence of these types of collaboration varied within and across sites.

One nurse recalled, "...because I was worried because there wasn't a crib for the baby. And, you know, they didn't have a crib, they didn't have a basinet, there was nothing. Right? And, I'm like - The baby was sleeping on the couch with the mom...and so, finally, I contacted - Because they - They told her they had ordered her a crib... Week after week, I would go, and there was still no crib... Anyway, I finally contacted the social, her social worker, who I've had a couple of contacts with...But, I wrote to her and said, 'I'm concerned because there's no crib for this baby,' and she said, 'Yeah, we're supposed to have a meeting this week, and I'll get - I'll push it,' or whatever. And then, next thing I knew, when I went, there was a crib."

Another nurse stated, "In other cases, sometimes it's nice if they're - you know, number one, we see what's happening, and they call and try and get information, which I've had happen. And, that was actually one of our best cases. Me and the caseworker worked really hard, and we were able to get the mom out of the environment."

One nurse supervisor said, "I think I had one—Maybe a couple years ago, where the child was taken temporarily out of the home because there was a domestic violence situation, and so both parents were taken to jail, so the baby was, had nowhere to go. They took the baby into custody. And then, they did put that baby in kinship care. By the time my client graduated, she had the baby back. So, she went through all the steps, and I really was able to communicate with—I don't know who the worker was at the time, but with that caseworker in finding the best way to take the steps, go through the plan to get the baby back to Mom."

Collaboration with CPS Prevention Programs

Some NFP nurses from one site described that they had worked closely with the prevention programs in their local CPS department. The collaborative interactions ranged from receiving guidance on when to make report to CPS and having the prevention program manager attend team meetings to consistent communication regarding mutual clients. Several nurses from this one site expressed their collaborations to also include consistent phone calls and in-person interactions to discuss progress made and services needed for their mutual clients. In fact, these nurses shared that the prevention programs were a resource for their clients. This NFP site

described a strong relationship with their local team of CPS prevention workers, where they were able to utilize prevention workers as liaisons to CPS caseworkers and as a sounding board to develop strategies to reduce risk among their clients and assist their clients towards achieving their goals.

One nurse supervisor recalled, “We’re here, and we’re interested in what you’re doing.’ And, ‘Oh, we could use some help with this, and could you come and talk to us about exactly what your unit will be providing and what kind of support they can give to our clients?’ And, that was the reason we invited her to team meetings, you know, ‘Where will she fit in? Where will this unit fit in with our clients? And, will they actually offer some support before things get to the point where they have to open a case at CPS?’ So, as it turned out, that was true.”

A nurse from the same site said, “And, it was really nice to have some direct contacts at Social Services. And, I guess I just created those by having the - One of the managers came and spoke to us at our meeting, and she had given me this navigator’s name, and then - Yeah, then - so, one phone number kind of leads to another, lead to another, and asking the right people the right questions, and that was before the prevention unit had started, but it was kind of pre-prevention, which I think I was telling you in our case, our open forum sort of.”

Weaker Collaboration

Many NFP nurses from different sites described collaboration with CPS as mixed depending on experiences they had in interacting with individual caseworkers. In fact, there had been some instances of interactions and a level of collaboration among CPS workers and NFP nurses in most sites. However, there existed variation in the consistency and level of collaboration among different sites and within one site in particular.

Minimal Interaction

Some nurses from several sites explained that they had no to minimal interaction with their local CPS department. In fact, several nurses from one site were unsure as to who worked for and where their CPS department was located. In another site, there existed varying levels of collaboration with CPS: one nurse described that she had a point person at CPS who she interacted and collaborated with regularly for her clients, whereas another nurse from the same site had never interacted with CPS in her tenure as an NFP nurse.

One nurse stated, “And, when I think about it, my contact with them has been pretty limited, other than with [CPS caseworker name removed].”

Another nurse regarding a lack of collaboration with CPS explained, “I think that it’s something that has been ongoing. And since I’ve been here other nurses have complained about the lack of collaboration between us and CPS and then the things that I’ve experienced. But other nurses have complained about it and I don’t think it’s getting any better... ’Cause from time to time we come up with different ones of us have different issues come up that where we have to report to CPS or CPS is automatically already involved so issues come up and so we just get with each other or share with at

staff meeting or with our supervisors about what our concerns. And always with collaborating.”

Lack of Communication

Some nurses from several sites referenced interfacing with CPS and that they had open communication, but others from the same sites described a lack of communication from their CPS department. In these situations, some nurses explained that there tended to be a one sidedness from CPS in that CPS often received information from NFP but NFP nurses were unable to obtain the information they desired, such as the status of a mandatory report. This lack of communication existed within and between sites regardless if a consent form was shared or not.

One nurse said, “The biggest issue I have is they want all the information we can give them, and then they give us nothing back. Like, there’s a lack of communication. Once they get the information they want, it’s really hard to figure out where the client is in the process. Whether they’re staffing the case, whether an assessment has been done, which caseworker actually has them- I had one client that was switched caseworkers probably 10 different times, and she couldn’t keep track of it. And, I couldn’t keep track of it. And, that became really difficult to find out information on where the status was.”

Another nurse shared, “I did, through a series of channels. My client works with the [developmental organization name removed], and so her caseworker and I have releases signed that we can talk back and forth, and then, found, talking with the caseworker, the caseworker had known who had referred and what the reason was.”

Another nurse described her interaction with CPS worker by saying, ““What are you’ - And, of course, we had a consent that we could talk from the client.”

Lack of Knowledge

Some nurses from some sites expressed another factor contributing to lack of collaboration with CPS. These nurses explained that they lacked knowledge on the CPS process and that not everyone in CPS knew about the NFP program and the role of the nurse home visitor. This lack of knowledge on the part of either organization was prevalent across multiple sites and also varied within site depending on the nurse.

One nurse explained, “But sometimes I feel like we are working against each other because it’s like, and I think that’s just because of lack of knowledge, or lack of knowledge of each other, what each other do. So I mean, of course, we know what they do hands down. But I think maybe they don’t know exactly what we do or all that we do. They just think that oh she’s just a nurse; she’s a nurse so she goes into the home. But what do we do in the home? You know, oh, yeah, they do education, but I don’t think they really maybe get a whole, full grip of what our purpose is in the home. What we teach and how we do teach safety and how we look for those triggers and look for different things that may put a certain family a higher risk than others. So I’m not sure they really get that whole concept. And then I think when we come to them to try to collaborate I think because of the type of work that they do is how they have to be a certain way, I think that maybe they have a hard time distinguishing from like general

public or versus this is my coworker and my colleague and we work together on this. Um, instead of and maybe just a certain way you have to treat public or have to talk to the public or tell them okay we can't, you know, divulge that information, it's very sensitive."

Variation in Interactions Within Multi-county NFP Sites

There also existed variations in multi-county NFP sites with regards to collaboration with different counties of CPS departments. One nurse from a multi-county NFP site who served two counties explained that she had great collaboration with one CPS county but not with the other. She expressed that she had received positive responses and interactions with one CPS county, while the other CPS department were unaware of NFP as a program. In another multi-county NFP site, a nurse perceived one CPS county as unwilling to collaborate while she had working relationships with some caseworkers from another CPS county due to serving mutual clients.

One nurse said, "Excellent, [county name removed] DHS was excellent. Very personable, made sure I was involved with every staffing that they had, invited me to the court hearings..."

The same nurse regarding a different CPS county said, "Yeah, and I don't know why. And a lot of them aren't even aware that we're here. So that's very frustrating to me. That they're not, because they do have, in their defense, they have a very high turnover, but I just think, because we have such an interaction with these clients, you know, we're in their home, that they would want more of a relationship with us, they would take advantage of [number redacted] nurses seeing their clients."

Another nurse shared, "They - when I've been involved in collaborating with the DHS people, they can see us as a team. And, we can kind of support each other a little bit more with what we have to do, with our different approaches. I felt supported in some things when I've had some of the DHS team members - once they kind of understand what we do - I went to a presentation for our district for the southwest, southeast area. And, there were some other Department of Human Services people there. And, it was really evident, they weren't real open to us working with them."

Lack of Professionalism

A few nurses from some sites also described poor collaboration in their experiences with CPS workers due to a lack of professionalism among caseworkers. Such experiences were related to a nurse reporting a client to CPS where they were not taken seriously by the caseworker. One NFP nurse recalled asking why her report to CPS had no action from CPS and the caseworker replied that it was because the report did not come from a physician. As well, some nurses from various sites expressed issues with regards to CPS being open to communicating with the nurse on a mutual client due to a lack of respect of the nursing profession. For example, one nurse felt frustrated that there was an automatic barrier to communication despite being a mandatory reporter, being a professional, and having a consent form from the client. In fact, several nurses from multiple sites expressed that they had been treated like laypersons when reporting and/or following-up with a report.

One nurse stated, “Whereas when you’re dealing with another professional, I think, you know, and I understand there are still parameters that you still need to go through. If you still need to get consent, that’s fine, but at least say to me, ‘Okay, sure no problem. You know I have to get this consent, but I don’t mind talking to you’ - and I feel that we don’t get that. It’s just an automatic barrier of okay, I need the consent and I can’t share that information with you. Or they don’t even ask for the consent. I can’t share that information. And to me personally it makes me feel like okay, well who am I, what, I mean?”

Another nurse stated “And, Social Services was called from [hospital name removed], and then I had the [county name removed] caseworker call me and say, ‘Tell me again why you referred this child.’ And, I told them and then - And, I listened to them for a while and I said, ‘You know,’ I said, ‘I’m just curious, you know, why you didn’t act on this, why you didn’t take my referral seriously.’ And, he said because I wasn’t the physician, and it didn’t come from a physician, and at that point, I don’t think they knew what Nurse Family Partnership did. And, I think at that point, we were talking about, you know, having some feedback about the referrals that we had given.”

NFP Perspectives of Barriers to Effective Collaboration

There existed several key barriers in collaboration between NFP and CPS that were commonly expressed across most nurses and nurse supervisors within and across sites. Lack of knowledge by NFP about the CPS process and lack of knowledge and understanding of the NFP program by CPS were described as main barriers to effective collaboration by almost all nurses in all sites. Communication issues, including miscommunication, lack of communication, lack of follow up after a mandatory report, and lack of sharing of information due to consent issues were also described as challenges by many nurses across most sites. Philosophical misalignment between NFP and CPS, individual caseworker attitudes, and negative perceptions (including stigma) of CPS were also expressed as other barriers to collaboration. Some nurses across sites described barriers related to mandatory reporting, including uncertainty as to when to make a mandatory report, perceived disrespect from CPS when making a mandatory report, and inconsistent CPS response to mandatory reports. Finally, barriers within CPS such as high turnover rates, burnout, and high caseloads were described by some nurses in several sites as additional barriers to collaboration.

Lack of Knowledge and Understanding

As previously explained, across most sites, many nurses and nurse supervisors shared the perspective that their local CPS department seemed to lack awareness, knowledge, and understanding of the NFP program and the role of an NFP nurse. Many nurses in multiple sites explained that when interacting with CPS caseworkers, they had often needed to explain about the program and their role as a nurse-home visitor. In some cases, the caseworker had not expressed a desire to learn about the NFP program. Even among sites where NFP nurses believed CPS were aware of the program, some nurses shared that the CPS workers still lacked an understanding that NFP was a voluntary (not court-mandated) program designed for first-time mothers. In some sites, some nurses explained that CPS had often tried to mandate NFP as a

service for their clients while in some other sites, several nurses shared that CPS had referred second and third time mothers to NFP. Finally, a couple of nurses across sites recalled instances that CPS had made referrals to NFP, including those living in foster care; in most of these cases, the client was not particularly interested in the program, was often difficult to reach, dropped out of the program shortly after enrolment, or were too high-risk for the nurse to visit (for example due to nurse safety).

One nurse shared, “And, back when I first met her, and I - you know, I went in. I’m like, ‘I’m from Nurse Family Partnership,’ and she’s like, ‘What’s that?’ She didn’t even know what it was, didn’t know who we were, what it was, what I do and has not tended to ask.”

Another nurse explained, “Well we talked about that a little bit at our staff meetings and I think, I think they really just need. I guess it’s just the exposure. I guess them just learning about us. You know, CPS you really don’t have to form, people know what CPS is. So they have a nationwide, everybody knows who they are and what they are. I think, I kinda feel like, you know, where our breakdown is that we don’t maybe they don’t know who we are or what we do. And even though we have people come down from CPS to talk to us about it, I don’t think they still get the full understanding of exactly what we do and our job is the same in the sense as their job. We’re working, we should be working together collaboratively um, to create safe environments to keep the baby in the home when it can be done.”

Another nurse stated, “The one [city name removed] client though. My original first. Just so you know, she was referred by DSS to me. I emphasized at length that it was a voluntary program. She enrolled, but, very hard to track. “

At the same time, many nurses across various sites expressed that they lacked knowledge and understanding of the CPS process and procedures, including processes that led to investigation of reports of child abuse and neglect and what information could be shared with nurses. This lack of understanding had created challenges for those NFP nurses who had reported to CPS or had clients involved with CPS. By not knowing the processes within CPS, these nurses were unable to accurately provide information for their clients on what steps were next and how best to prepare for them. In one site, some nurses further elaborated that they did not know who were a part of CPS and where their local CPS was located. This lack of knowledge was described as a barrier towards strengthening collaboration between NFP and CPS.

One nurse shared, “And just an open forum for questions because I know there are lot of nurses that have questions about, you know, with their processes and what they do and what would make their life easier with us reporting. You know, because sometimes we’re not entirely sure what they want from us.”

Another nurse explained, “But, but the big area now, a deficit, is just not knowing their, their whole procedure. Who works - you know, what - Even where they are located isn’t – you know, I always would like to know visually, you know, where that person, if you call and make a report...”

Another nurse stated, “I don’t know. I think that kind of understanding of what we’re doing and me having an understanding of what they can share and what they can’t share would be helpful. And then, too, after a report is made and a case is opened, then having a better understanding of why the case wasn’t opened and what the steps are in the future with that and what types of things they’ll be doing.”

Communication Challenges

In addition to general lack of knowledge of one another’s agencies and roles, many nurses and nurse supervisors from most sites explained another key barrier to effective collaboration to have been issues around communication. Various elements related to communication, including lack of communication, miscommunication, issues related to consent, and lack of follow-up after a mandatory report, were described by almost all nurses in all sites as a major barrier to collaboration.

Lack of reciprocal and timely communication as well as miscommunication with CPS were described by many nurses across most sites as problematic in their practice. Most nurses were frustrated in these situations because they did not have complete and accurate knowledge on their client’s case, including placement goals and timelines, which were necessary for the nurse to continue visits with the client. This lack of communication was often related to consent issues that arose when nurses approached caseworkers regarding mutual clients. Most nurses across many sites explained that caseworkers were often reluctant to divulge information on the client due to HIPAA and confidentiality concerns, despite the nurse explaining that she worked closely and in the home with the client. In some cases across several sites, a couple of nurses explained that the client was unwilling to share a release of information with all service providers; thus creating a challenge for the nurse to understand whether or not the client was receiving the care that they needed. In addition, in some sites, some nurses shared about difficulties in identifying, contacting, and/or meeting with the assigned caseworker to share a client’s signed consent. In some other cases, despite sharing signed consents, some nurses explained that some caseworkers were still unwilling to share specific details regarding the client’s case or investigation.

One nurse shared, “And, I have not had good communication with them at all. I don’t know what’s going on, I don’t know - they’ve had court dates. I mean, she hasn’t filled me in on what happened in court, or what we’re working toward, nothing.”

Another nurse explained, “So I called her. You know. And the saga begins. So I called her she said um she told me. Actually, we played phone tag for a while, but then when I finally got her. She told me, ‘Yes she had their case.’ So she asked me what questions and concerns I had. So I told her that I wanted to get an update to find out what’s going on. So she told me, well um what did she say to me. ‘You know, well, all I can tell you is the case, we are investigating the case.’ And she was very nonchalant about it, very, you know, ‘that’s all I can tell you.’ Then I identified myself and told her who I was and so she was well, ‘You know, I can’t tell you anymore information because it’s confidential. Blah, blah, blah,’ and so I had to say to her well, ‘Um, you know, it’s like I said before I’m a nurse and I work with the Nurse Family Partnership program downstairs on the second floor and I do have a consent release.’ ‘Oh, okay, well you know, if you could fax that to me.’ And I just found it frustrating.”

The same nurse continued, “You know, I feel as though we have consent to talk with Social Services regarding clients and especially ones that are already within the system, but it’s kind of unclear what information they can and cannot share – like location of the client, that I’m having a hard time getting a hold of, you know, like where they’re at. Even simple things like that have been a challenge, collaborating in that way, so, you know, that sort of information as a whole – what they want to share and what they don’t want to share, I think would be helpful. And not just location, but beyond that. What is the situation at home? What are they working on? Things like that, as well. What can they share with us? What can’t they share? It was interesting that they couldn’t even share location (*laughing*) with me.”

Another nurse shared, “And, but anyway, it was very interesting how dysfunctional it could all be when people are not communicating. And, it was much more - You know, we had lots of - And, like I said, we had so many people in there with her, that that actually made me feel okay. But, I didn’t think that she was getting the care that she needed because she didn’t want her, she didn’t want that information shared with everybody.”

Lack of communication was also related to follow-up after a nurse made a mandatory report to CPS regarding their client. Among nurses who had reported to CPS, most shared a frustration in receiving little to no information on the outcome of their report, for example if a caseworker was assigned to investigate the report or the report was screened-out. This lack of follow-up was especially unnerving for those nurses who made a report due to safety concerns such as drug-related activity, resulting in nurse safety concerns when they made a subsequent visit to the home with no knowledge that CPS had already responded. While in some other situations after making a report and not receiving follow-up, some nurses from one site had shown up at a visit to find out that the child was removed and the client was angry with the nurse.

One nurse stated, “She never called me back so my experience with them is not, well the little experience, I haven’t had a lot, but the little experience I have had. They don’t really have a tendency to -. Their follow-up is not that great. But that could still be you know, individualized as well. Overall, in general if I had to rate them I would say I don’t think they follow-up very well. And not only just with me but with clients as well.”

Another nurse explained, “I would love for just a phone call. You know, if I make a report and then, they open the case, somebody goes out. It would be really nice just to hear back from them. Hey, we opened it, these are our concerns. Do you agree? What do you think? Just hearing some feedback. A lot of times we make our report and then unless we’re calling the hotline to try and follow-up, we don’t hear anything else and we’re in the home, you know, and in some cases every week. “

A nurse supervisor shared, “A lot of times they would remove. We have no clue. We go to show up on the door, and the baby is removed. And, we are like, ‘What.’ And, they are mad at us... The client is mad at us because they feel we have had a hand in this.”

There were also times expressed by some nurses and nurse supervisors in various sites regarding miscommunication when serving mutual clients. One nurse explained that resources that were

promised by the caseworker were not offered week after week; this was frustrating for the nurse because the baby was co-sleeping with the client presenting a safety risk. Within the same site, another nurse explained that due to lack of communication with the caseworker, she had to rely on her client relaying information to her on the case which was at-times unreliable or incomplete; this challenge created frustrations for the nurse because she felt that she was not as supportive as she could have been had she been more knowledgeable about the case.

One nurse explained, “I’ve talked to the social worker at [crisis center name removed], but that’s because I was worried because there wasn’t a crib for the baby. And, you know, they didn’t have a crib, they didn’t have a basinet, there was nothing. Right? And, I’m like - the baby was sleeping on the couch with the mom. And, I was like, ‘This is not okay. We can’t have this. This is’ - you know, ‘She’s at high-risk,’ and so, finally, I contacted - Because they - They told her they had ordered her a crib. And—the [crisis center name removed] had—and, but there was no crib. Week after week, I would go, and there was still no crib.”

Another nurse shared, “Unfortunately, my client was, you know, not the most communicative about all of this. And, I found out that the baby was removed about a week and a half - a week or a week and a half later when my client texted me saying she was going to kill herself. (*laughs*) So - Well, that was a whole thing. So, I sort of feel like, you know, if the NFP were involved up front and, you know - Because, I missed the TDM [Team Decision Making]. And, the only story I’m getting is from my client, which probably isn’t the most complete story... But, I just, you know, I feel like I could have been more support or, you know, something, had I known what was going on.”

Philosophical Misalignment and Individual Attitudes

Beyond knowledge and communication barriers, there existed perceptions of system-level challenges for collaboration among some nurses and nurse supervisors in some sites. The perception of organizational or philosophical misalignment between NFP and CPS was expressed such that NFP was prevention-focused while CPS was intervention-focused. In addition, several nurses from different sites explained that NFP focused on the client’s strengths and desires, which conflicted with CPS’s punitive and investigatory approaches and the tendency to believe that there was no hope for the family. A couple of nurses from several sites also shared that they believed NFP’s goal to help clients build self-sufficiency and keep families together conflicted with CPS’s purpose of removing children from homes. One nurse also explained that she felt CPS lacked cultural competency in their approaches while the NFP program tried to understand their client’s culture and incorporate it into the curriculum.

One nurse shared, “And, I was kind of surprised, but we come in with a different view that’s more strength-based. They have a caseload that’s many, many people more than what they really should have. They’re stressed. They’re trying to accomplish certain goals within a certain timeline. And, we have a different point of view. We’re working at their strengths and then working on things a little bit longer than what they do. So, we have a different pace that we work with our clients on.”

Another nurse stated, “Barriers, number one, our communication is—as you’re heard—is pretty big to me. Number two, our goals. We are there to help the families work on their stuff to keep their children. I don’t know that that’s always the case with Child Protection. They’re saying that it is, but sometimes, it’s not.”

Another nurse stated, “And that was the other thing is that in those visits DHS didn’t seem to really take the culture into consideration. I had one child that the family, I can’t remember if they were from India or they were Buddhist from Thailand. Anyway, the child had some bruises that ended up being from healing. The cups, it was from the cups. And they, there were some acupuncture marks and they were called in because of this being abuse when really it wasn’t abuse and so the family really felt offended because it was a lack of respect for the culture. And with NFP, we’re so much more tuned into their culture and help me understand, ‘Tell me what this is about. Help me to know what’s going on.’”

In addition to organizational philosophies and missions, some nurses and a supervisor from various sites explained that individual caseworker attitudes created some challenges to effective collaboration. Such challenges arose when the caseworker had been abrupt, rude, or disrespectful when a nurse called to make a report to CPS or initiated interactions with CPS regarding a mutual client. One nurse shared that during a report to CPS, a caseworker questioned why she needed to make a report despite knowing that she was a nurse and a mandatory reporter. In another case in a different site, a nurse explained that the caseworker was against breastfeeding while the client was pro-breastfeeding; these contrasting attitudes towards breastfeeding made it difficult for the nurse to assist the client in achieving her goals when the caseworker did not allow visit time to be dedicated towards such activities. Another example of caseworker attitudes was shared by another nurse when she attended a conference where caseworkers seemed to express negative perceptions of NFP. In a couple of sites, some nurses were also uncertain about CPS perceptions of the NFP program and that caseworkers may have perceived NFP nurses to have been overly protective of their clients and as a potential threat to their work. Finally, a nurse supervisor perceived that some caseworkers tended to have similar backgrounds to the clients she served and had initially pursued a career in social work to help others but became cynical over time.

One nurse explained, “Uh-huh. The caseworker, in my opinion, does not like breastfeeding. She thinks it’s gross, whatever. So, has been on her [the client] about the breastfeeding. They were focusing on the breastfeeding at the visits and that she was doing it too long and that, um - What she had told me when I kind of met—because my client was telling me and I’m like, ‘They said what?’ And, she’s just like, ‘You know, that I can’t breastfeed her that long, and that I’m doing it for myself, for my own satisfaction, and all blah, blah, blah.’... You know, so we’ve talked a lot about that, but I’ve just been very frustrated just because she’s - she was very, you know, kind of rolling her eyes and stuff at me when I was trying to talk to her about breastfeeding.”

Another nurse shared, “I don’t know if there’s some kind of - and, I hate to say this - educational barrier. I think you’re going to meet [nurse name removed] later or somebody is. [Nurse name removed] and I went to a conference recently. And, I promise you when we stood up and said we were with NFP, most of that room in

attendance was DSS caseworkers, and we just felt like we were, honestly, and I don't - I mean I'm not that, a petty person but I felt like we were stared down. I didn't say anything to [nurse name removed]. She hit me and she said, 'Oh my goodness did you see them look at us?' So, maybe it's our fear of what they think of us. I don't know."

Another nurse stated, "I went to a presentation for our district for the [redacted] area. And, there were some other Department of Human Services people there. And, it was really evident, they weren't real open to us working with them."

A nurse supervisor shared, "Um - I don't know that I really know, other than the fact that I have some suspicions. And, I don't know that it would have anything to do with members of the Child Protective team, but when you look at some of the, the caseworkers that work for the Department of Social Services, I suspect that a lot of these people were where our clients were, and they pulled themselves up, and they went to school, and they got a job. And, maybe when they got the job, they wanted to help. But now, some times has passed, and they've gotten kind of cynical about the whole thing, and - and, they feel a little, you know, 'What is your problem?' And, it's not that they ever say that to the client..."

Stigma

Among most nurses in all sites, stigma and distrust associated with CPS was described as a common perception by clients as well as by members of the nursing team in several sites. Stigma was described as an additional challenge to collaboration between the two agencies by many nurses because of several reasons. First, some nurses from various sites expressed that clients' perception of CPS as an agency that removed children from the home and/or resulted in deportation or court involvement was a barrier because these clients were fearful and unwilling to engage in Social Services and if reported on, often led to damage to the nurse-client relationships and subsequently dropping out of the NFP program. Next, many clients who were fearful of Social Services tended to have had previous involvement with the system in the past, while some nurses from some site felt that they had betrayed their client by reporting her to CPS. Despite working hard to repair the nurse-client relationship and supporting the client involved with an open case, some nurses and nurse supervisors from various sites explained that NFP – as the voluntary program – was often dropped first because of the overwhelming requirements to participate in treatment as mandated by CPS. In addition, some nurses and nurse supervisors in several sites were weary of collaboration between CPS and NFP because of the potential that clients may perceive NFP and CPS as one organization or that NFP was a "secret service" provider to CPS and feared that they (NFP and CPS) would remove their children.

One nurse stated, "However, after that, she was really upset with the social worker that she was dealing with, she didn't trust her of course, you know, and that's a big thing with the DHS worker, where we have trust with the client, they of course don't trust the social worker, usually, in most cases."

Another nurse explained, "But, just in general, you know, I'm wondering - And again, you know, that has to be - I think, you know, if Social Services had a better collaborative reputation, where we weren't here to get you and take your kid away, but we're here to

help you learn parenting skills. And again, maybe there are things that are going that I'm not aware of, but I think if you polled most people on the street, you know, they would have a rather negative view in that collaborative piece and really - Yeah."

A nurse supervisor shared, "I don't know how to help with retention. We've got one client right now that, if we could get her back in the program and she could understand and she'd have a change to develop a relationship with the nurse, then that might have worked, too, actually. It might have worked. But she is so overwhelmed with all of the requirements of Social Services and her baby and all the nurses and everybody else in there, the one person she can get rid of was the Nurse Family Partnership nurse because it's a voluntary program, and that's what she said, 'You go. I'm done.' And she has that right. This is a voluntary program."

As well, some nurses and nurse supervisors from several sites explained their concerns around the potential change in the community's perception of NFP (from positive to negative) if they were too closely aligned with DHS because of the associated stigma. One nurse supervisor even expressed that interacting with CPS regarding mutual clients could be dangerous because of the potential in losing that client as a participant; while a nurse from another site shared that clients may no longer perceive NFP as their advocate if they were too closely aligned with DHS. Additionally, some nurses from one site shared that involvement with prevention programs first required a report to CPS which was then screened out; this process was challenging when clients had negative perceptions of the CPS system.

A nurse supervisor shared, "The risks, obviously, are them feeling that they - You know, that we're sort of a united front, and the client seeing it that way. That, you know, we are suddenly, you know, arm in arm with - You know, Social Services."

Another nurse supervisor in interacting with CPS explained, "Dangerous... Because you could lose your client. I mean, your client has developed a trust relationship with you, you report them to Social Services for whatever reason."

A nurse stated, "Um, as far as looking at it from our client's perspective is that, you know, the client typically looks at us as their advocate. So, if we collaborate with Child Welfare, maybe they might see us not so much as their advocate depending on how it's, you know, talked about or how it's displayed to the client."

Another nurse shared, "I know that - The only kind of bummer or downside if that, if you want to get them hooked up to the prevention unit, you kind of have to - you have to go through the Protective Services line, and then you have to say, 'Okay, but these would really be a good case for prevention,' and then [prevention programs manager name removed] said, 'Call me.' So then, you have to call [prevention programs manager name removed], and [prevention programs manager name removed] has to go down to the meeting and say, 'Oh, this is one for us,' and sort of take that case over."

In addition to client stigma towards CPS, a couple of nurses from different sites shared that they themselves, their nurse supervisor or other nurse home visitors from their site held the belief that

CPS only removed children and did not focus on client strengths. When the nurse supervisor held stereotypes and stigma of CPS, some nurses shared this was a specific barrier to effective collaboration because their leadership did not perceive interactions with CPS to be beneficial. In another site, a nurse supervisor was surprised by her nurses' personal beliefs and stigma towards collaborating with CPS. She shared about a joint meeting with caseworkers where nurses had an opportunity to interact with the caseworkers, but many were unwilling to ask questions.

One nurse shared, "Okay. [Nurse supervisor name removed] doesn't hear this does she? Well, I think a couple of things. To be real honest, I know stereotypes for me about DSS. I see that. I see that in our office. And, I'll be the first to say it."

A nurse supervisor explained, "Here is your opportunity and you are not asking any questions. So, we made this meeting happen and, yet, you are not doing anything about it.' And, the response, because we questioned that, the response came back as, 'They were not ready to accept us. It felt very - did you feel the tension in that room?' 'No, I didn't', and I am a feeler. Nope, sure didn't.' ...And, maybe one question was asked... I am just so surprised that it is from our team and not their team."

Challenges Around Mandatory Reporting and Treatment Planning

Among all sites, many nurses expressed that several challenges to collaborating with CPS revolved around mandatory reporting. From uncertainty in when to report to CPS to how CPS responded to reports, many nurses shared about their perspectives in these barriers to collaboration. Conflicting philosophies and uncertainty with when to make a mandatory report was expressed by many nurses across most sites as the greatest barriers in their practice of mandatory reporting. A couple of nurses from different sites shared about the conflict between maintaining their role as a mandatory reporter and keeping the child safe while upholding the relationship with the client and focusing on client strengths. Although all nurses recognized that they were mandatory reporters for suspected child abuse or neglect, many nurses from most sites also shared about situations when they were uncertain whether or not it was necessary to make a mandatory report and when they felt anxiety in accurately assessing safety and risk for child maltreatment. Among some nurses in various sites, there also existed a lack of comprehensive knowledge of the situation with the client that had created barriers to assess whether or not a situation was reportable; this was usually due to minimal hours spent with the client and only being able to assess for risk based on what information the client was willing to share. Several nurses in different sites also explained that they were unsure whether or not they should make uncertain reports anyway because they did not want to overburden CPS caseworkers with unnecessary reports. These issues related to mandatory reporting created barriers to collaborating with CPS.

A nurse shared, "And, the thing that I, you know, because again I'm new to this. And, I definitely don't feel like I know enough about reporting, but, you know, okay, so you make this report and then they don't follow-up. And, then you continue to hear stories. Do you keep making reports? You know, so what is - What legally should you do?"

Another nurse stated, "My job is to educate so that they don't need something like that. You know? So, it is kind of a little bit of a conflict, but you don't - you also don't want

to turn your eyes to something that's dangerous. So, um, you know – I think if they know that, you know, that's why you're there, and then you're able to clearly say, you know – You know, 'This is absolutely the last thing I would want to do.' You know? 'But, I feel like your child's in danger,' you know?"

The same nurse shared, "Right. And, we have a huge network of people in a hospital. You know? So, it's like, "Do you think this?" "Do you think that?" You know? And so, and they're kind of contained. So, you know, you can – But, in that, in a – Like, in home care, to be in someone's home and be a mandated reporter, I'd say, that emphasis I don't know really enough about. So, that's a barrier to being able to do it correctly and to be able to maybe – recognize maybe as many things as you could recognize, you know."

Another nurse explained, "They make me feel like - I think one of the things is my own liability, that I'm not picking up on certain things. Say, okay, with growing marijuana in the home, if I'm not asking certain questions and something were to happen, either the child were to ingest something or say they grow something that will catch fire, something like that, would I be responsible in some way for that? I know I would feel like I could have done more or should have done more, but would I really be responsible for that? And so that increases my anxiety around my own clients."

Inconsistent responses by CPS to mandatory reports were also described as a barrier for collaboration for some nurses in some sites. These nurses shared that their local CPS was inconsistent in their determination of when to investigate a report or to remove a child; resulting in some nurses being unable to accurately provide information on CPS processes for their clients. This inconsistency had also contributed to some nurses from some sites becoming less willing to make future reports to CPS. In one site, some nurses shared that they felt their local CPS acted upon reports for infants but not on those for teenagers who were not deemed as a priority. A nurse from another site perceived that CPS did not respond to emotional abuse while another nurse from a different site felt that her team's reports to CPS regarding failure to thrive were not taken seriously. In general, many nurses across sites found it disappointing and frustrating when CPS did not deem their client's situation as severe enough to receive CPS services.

One nurse explained, "It's like over kill in one situation and then another one you don't do anything when there is physical abuse."

A nurse supervisor shared, "And, my perception of how they responded to those phone calls is- I think it was, they were poorly responded to... It - Well, particularly for, you know, (*sighs*) When we have a client that is having problems, it's frustrating when we know that if they would work closer with us, that that interaction could be more meaningful for the outcome for the client and for that family because, supposedly, what you hear is everybody wants to reunite the family, if at all possible. And, I think my frustrations are seeing how, in one case, they seemed to be almost lenient when it's a case that I wouldn't have been as lenient."

Another nurse regarding past experiences impacting future reports stated, "You know, will they recheck with the client or will they just rely on me to make another report, because I'm less likely now to make another report since that past situation, and I'd tell

them that, too. But, anyway, it just made me uneasy with that.”

Another nurse shared, “Right. And you’ll hear from other nurses also that, you know, it seems like the follow up is much clearly defined for infants. Like we’re reporting infants, but in terms of teens, um...It doesn’t seem to be the priority.”

Another nurse stated, “But, I, you know, haven’t heard—and, again, maybe I’m not... Maybe I need to know more about this. But, usually, you know, the emotional abuse kind of thing. And, I don’t know if they’re moving in that direction. That, of course, is much more difficult to, you know, determine or maybe identify and the lines are maybe blurrier.”

Some other barriers to collaboration with CPS related to mandatory reporting were described by several nurses in various sites. As stated, some nurses felt disrespected when they had made a mandatory report to CPS. This lack of respect for the nursing profession contributed to some of these nurses feeling hesitant to make a future CPS report particularly when they were uncertain of its necessity. For example, one nurse had experienced language barriers when she made a CPS report, where she felt her message was not documented in the way she intended regarding the strengths of the client because the CPS caseworker did not speak English as a first language. Some nurses from a different site were on hold for a long period of time before being able to make their report. In a couple of sites, some nurses shared that they had to make a report to the police because it was afterhours at CPS; in many of these situations, the police did not relay the report to CPS so that the report was never documented in the CPS system. This miscommunication created challenges for the nurse who believed that CPS and/or the police would address the safety issue in their client’s home.

One nurse stated, “Well, it makes me feel scared for the children in this town. I feel concerned as a professional that I’m not going to be taken seriously, you know. Because I told them who I was, the program I worked with, and there really wasn’t that professional courtesy at all. I know that when a professional comes to me and talks to me it, you know, I definitely - It pricks my ears up and I’m like oh, you know, okay. Because I respect their opinion and their expertise and what they’re doing. And, I just didn’t get that at all from...”

Another nurse shared, “Frustrating, like yeah, okay. So, makes you not want to report. Not that I wouldn’t not report but, you know, the feelings that go along with the whole reporting process. It’s not a happy fun time to begin with.”

Another nurse explained, “It wasn’t the best experience. So English was definitely not her first language and I was trying very hard to tell her about all of the strengths that this client had with her baby being the mom she has been fantastic, you know. Constantly continues to provide growth and development experiences through toys and books and a very appropriate mother across the board. I wanted that message to get conveyed and I don’t know that it did. I gave the report.”

Another nurse shared, “And—to her—and then, she had told me after the, after she had. He finally got out of the house, she got him out of the house only because he went to jail

for another crime, that it was a few months after that incident—and, this is where I get frustrated—a few months after that incident that she had to call the cops in the middle of the night because she was in the living room trying to change the baby’s diaper. He was mad. He came and he got like a plastic Loaf n’ Jug cup and threw it at the baby’s face, and hit the baby in the face. She called the cops. They came. They charged him with endangerment of a child, but DSS was never contacted.”

Another challenge to mandatory reporting was related to confidentiality and anonymity. Several nurses from one site explained that their local CPS often provided hints to the client as to who made the report, which sometimes created challenges for the nurse to retain the relationship with the client. As a result, these nurses felt a level of distrust with CPS in situations when they did not reveal to the client that they had reported. In another site, one nurse explained that she had made a confidential report to CPS on her client who did not know she reported. When the case was brought to court, the reporter’s name – the nurse’s name - was revealed and the client declined further participation in the program. In yet another site, a couple of nurses shared about situations where CPS did not maintain anonymity in who reported, resulting in strained relationships between the nurse and client. These examples portrayed challenges in retaining client participation in the program after making a CPS report.

One nurse recalled, “Yeah. So they, but they didn’t report my name, but they, two instances, they said, ok, this last case, they said, ‘Well, the person that reported said that you weren’t feeding the baby enough and said that you were very stubborn.’ So they gave them hints, in two different cases, gave the clients hints to who it was, and the client basically knew it was me. Now, luckily, I was able to keep those relationships, but it was very uncomfortable for two visits after that.”

Another nurse stated, “One bad one was I made a report, due to a violent incident that happened in a house when I was there, and so I made a report like right after the house. And, apparently, I was told that the caseworkers didn’t go out yet, and I had to go back in a couple days, but they sent the cops right after I was there. And so, then I was put in a dangerous situation because the family knew I was the one who reported it wasn’t necessarily a safe environment. And, it was - I - I went out there not thinking anything had happened yet, because I was told the caseworkers hadn’t went out, but they kind of left out the important factor that they had sent the police, and so I walked in alone to basically an unsafe house. So, that one was not a good one. And, that’s just a lack of communication.”

Another nurse regarding client retention post-CPS report shared, “No, it wasn’t that long before Social Services went in but, by the time they went in, they didn’t really find a bruise, but they did tell the mom, the pregnant mom’s mother, where the report came from, I think. Yeah, I’m sure they did and so the mom called me up and said, ‘My daughter will no longer be in the program and you were totally wrong in your report and your assessment.’ So.”

Furthermore, related to client retention, many nurses across most sites who had reported their clients to CPS expressed difficulty in maintaining the nurse-client relationship after making the report. Several nurses from a couple sites expressed their tendency to be transparent with the

client when they had needed to report; but other nurses from the same and different sites stated that due to safety concerns they chose not to reveal to the client that they had reported to CPS. This challenge towards relationship maintenance with the client when needing to report was expressed as a potential barrier to collaborating with CPS when the nurse did not want to be associated with the department.

One nurse stated, “I think I’m, pretty comfortable with it. Calling and making the report, at first, was a little awkward until I said, ‘This is my first time. I’m new to this.’ And I felt so much better just letting them know that. And then, talking with Mom – I think it makes it easier just telling them at our first visit honestly, ‘If I see or suspect anything that, you know, I will have to make a call.’ So, just kind of laying the groundwork that, if you have to, we’ve talked about it. So, it’s not a complete shock the first time they hear it.”

Another nurse explained, “And, I also did not want her to know that I called. Now, I know some of my colleagues have not had a problem letting their clients know, but in this particular situation, I knew that if she found out that I had called, that that would be it. I would not be making any more visits. And, I felt that, for the sake of keeping her as a client, I didn’t want them to know, I didn’t want her to know that I gave the referral, and I told this to the DHS caseworker, and they understood. And, they actually knew her because of what her diagnosis was, she was not an unknown entity to them.”

Furthermore, among several sites, a couple of nurses explained that they had at times disagreed with aspects of a CPS treatment plan for mutual clients. One nurse shared that despite knowing that her client was likely not going to reunify with her children, the caseworker increased her visitation hours and offered her more responsibility; thus creating a falsified sense of possible reunification for the client. In another site, a nurse supervisor shared that some caseworkers had disagreed with safety plans set by nurses for their clients; while a nurse from a different site shared about her concerns for a client who was reunified with her child despite safety concerns with the FOC’s abusiveness that was not addressed by CPS.

One nurse shared, “And, it was always things around like visitation, increasing the hours or increasing the number of days that she had them. At the end, they even moved to overnights. I almost feel, too, like it was *(laughs)* like she was set up to - like, I - Because I knew all along she wasn’t get them. I’m like, ‘Why are they increasing the visits and giving her overnight, giving her more responsibility, when I just don’t see them giving her these twins.’”

A nurse supervisor stated, “You know, we are always there to make a safety plan with the girls. DHS feeling that that was not a safety plan. It is not what they would do for a safety plan.”

Another nurse explained, “Baby got to go back in the home because one of them did what they were supposed to, which was her, and she got custody, but he’s still in the home... And, I’m still worried about this baby...She actually got the baby back pretty quickly, which had nothing to do- I mean, that wasn’t my decision. I was a little like worried.”

Challenging Factors Within CPS

Other factors related to CPS structures and casework were discussed as barriers to collaboration for some nurses across several sites. These factors included: caseworkers overloaded with high caseloads resulting in lack of time to communicate with services providers (such as NFP nurses), high staff turnover leading to challenges for nurses and clients to navigate the CPS process with different caseworkers over the duration of case involvement, and the nature of CPS work – being tough - coupled with individual inability to cope with stress contributing to caseworker burnout, turnover, and negative attitudes towards community collaboration.

One nurse stated, “That they’re not, because they do have, in their defense, they have a very high turnover...”

Another nurse shared, “But I think you have a lot of them and I’m sure they’re stressed. That I’m just not - they’re under a lot of pressure. So I think that has a lot to do with it, too. But also depends on individual and how that person deals with or copes with stress. So I think it just depends on the person, the type of stress you put them under and then that’s what you get.”

Another nurse explained, “And, because the caseloads of the caseworkers are so much more large, it’s very difficult to get in touch with them. They usually call back, but because we’re out and about on visits, too, it’s sometimes difficult to get contact.”

There existed additional challenges within CPS shared about by some nurses across a few sites. In one site, some nurses explained that despite working under the same roof and in the same building as CPS, their name badge did not allow them access to the CPS side of the building. This physical barrier made it difficult for NFP nurses to collaborate with CPS. In several other sites, nurse supervisors shared that a lack of a common language when discussing risk and safety and mutual clients was a barrier to effective collaboration.

One nurse shared, “But, I also think that they - I think their perception is we’re protecting our clients maybe but, I don’t know. Or maybe we’re a threat. We talked about this at a staff meeting. It can be intimidating, although I think I’m like so not intimidating. But, to know that we’re registered nurses and that we go in the home and that we educate our patients, our clients.”

Another nurse stated, “You would think, the one thing that, you would think being in the same building, that we would have more communication, but we don’t. You know, we can’t, our badges don’t take us [redacted] to their area.”

A nurse supervisor explained, “Other than I’m here and we’re doing this. We don’t have a language of what can I do for you, what are you doing, that really fits the models. So then, you get into conversations that, well I can’t do that for your or nope, can’t do that. What can be really the roles?”

Other Various Barriers

Some additional barriers were shared by several nurses in different sites. Among nurses with significant experience in working with CPS, many explained that a great amount of time and coordination was needed to collaborate and work with caseworkers when serving a mutual client. One nurse explained that to facilitate collaboration with CPS, there would need to be a decrease in other job duties for the nurse due to time constraints. Several nurse supervisors from different sites also shared that there were few opportunities for CPS to refer to NFP, for example because they worked with different populations. In one site, although many nurses had attended mandatory reporting trainings, they expressed challenges especially when the CPS trainers provided conflicting opinions on when to report. For example, one nurse shared that different trainers provided different feedback on what was reportable for drug use among pregnant moms. One caseworker felt that as long as a safety plan was in place it was not necessary to report, while another caseworker told the nurses to report whenever a client was using a substance.

One nurse explained, “It is difficult. It does take more time. Calling back and forth, playing tag when you really have to talk to a social—caseworker—is really difficult. I know, for me, the big thing was, ‘Give me a time that I can call you.’ ... So, that’s probably the more difficult time. I think being able to juggle some of the other caseload to some of more stable families, to be able to see every three weeks or once a month while - during the time that we’re involved in that collaboration.”

Another nurse stated, “So, collaboration, part of it is just a time factor...It’s not - If you want to have more collaboration, then you need - Your job duties need to be decreased.”

Another nurse explained, “Not to – I mean, there’s several, but most of the time, it’s with DHS or Child Protection where they’ve put on like a class or something. But, it seems to be – there still seems to be some differences of opinions between caseworkers and trainings.”

She goes on to say, “Right. And, I’ll give you – here’s a pretty firm example. We had one training with like the drug use among our pregnant moms. Or, our moms that have babies. We have one saying, ‘As long as they have a safety plan, they can be using meth and going on benders, as long as that baby’s in a safe place being cared for, and they come back and it’s okay.’ Then, we have the people that are like, ‘If you know they’re using at all, including like marijuana, you need to report.’”

Furthermore, some nurses and nurse supervisors from a couple of sites explained that NFP had stronger collaboration with CPS in the past, but due to fewer interactions with CPS over time (such as no longer participating in CPTs or CPS no longer attending CABs) the previous collaboration had been lost. Finally, one nurse specifically detailed challenges when she was called as a witness for a trial involving her client; she was unable to bring her case notes to the trial to highlight specifics related to her client’s strengths and her role as the mandatory reporter on the case was revealed, which led to her client becoming angry and making it unsafe for the nurse to continue making visits.

A nurse shared about previous collaboration as compared to the present, “And we would help supervise some of those different activities and so we, seems like, if you have some of those kinds of things going on then it’s easier to get to know the people involved and

then pretty soon you start seeing them on the elevator or in the hallway and its get a little easier. And that's kind of been lost over time."

A nurse supervisor regarding previous collaboration explained, "Oh, we had her come to one of our advisory boards at the time. She, but you know she, didn't have much time."

Another nurse stated, "I had no notes with me. Everything had to be - so, of course, when they're asking, I had no specific dates because I didn't have my charting with me. And so...It was a - It was a hard process. And, like I said, I think, if my name would not have come out in that, I would have continued - She would have continued as my client..."

NFP Perspectives of Opportunities for Collaboration

There existed variability among and within NFP sites the desire to collaborate with local CPS. Almost all nurses and nurse supervisors from most NFP sites believed that collaboration efforts with CPS could be strengthened, but the level of collaboration considered appropriate and beneficial varied among nurse and nurse supervisors within the same site. Some nurses and nurse supervisors from several sites believed that a distinction between the NFP program and CPS was necessary. In fact, one site in particular did not want to be seen as associated with CPS, while another site believed that there could be a strong relationship between NFP and CPS but not necessarily a "marriage" due to fundamental philosophical differences; NFP focused on prevention while CPS was involved in intervention. However, one site believed that there was opportunity in referring families to services within CPS and DHS but distrust of the system hindered the potential of collaboration. Overall, many NFP sites were interested in strengthening collaborations with CPS but many sites had hesitation and concerns around maintaining organizational separation while working together to make families stronger and healthier.

One nurse supervisor suggested, "And getting management together. And, getting management to know each other's program. And, what it is they do. What it is we do. How we do it. How they do it. And, how can we possibly see something working together."

Another nurse supervisor stated, "And I really - You know, I'm - I'm really conscious of not pulling myself to align with Social Services. And so, I think that's really important for us as nurse home visitors. I don't want to be seen as like- Honestly, I don't even want to necessarily be seen as side by side with them. We're - We're in there to help empower them to be the best moms they can be. And, whatever anybody else's job is in there, that's them. You know?"

A nurse stated, "It's just a very - It's like two ends of the spectrum. And we go over safety. You know, our information is so incredible. So what we're trying to do is prevent the problems and they're coming in afterwards. So, I think there can be a good relationship. I don't know that there can be a marriage. It's kind of like two different kinds of purposes."

Within several sites, some nurses and several nurse supervisors believed that collaboration with CPS was absolutely needed for the betterment of children in their community; working together collaboratively with CPS created safer environments and kept children in the home. Despite relatively positive interactions with some caseworkers in one site, several nurses wished to have a stronger collaboration with the department as a whole so that interactions with all workers would be positive. In particular, some nurses in several sites felt that CPS managers and administrators needed to communicate and to implement a collaboration plan; while those in another site believed that management and staff in both agencies must engage to facilitate collaboration efforts.

A nurse shared, “For resources, Department of Social Services is also resources, not necessarily just child placement stuff. Resources as far as what’s best for the client. Because I think we could work better in the community, you know, not just have it being so segregated. We’re not trying to take from your position, you’re not trying to take from ours, but work together collaboratively and go, you know, for the betterment of the client.”

A nurse supervisor expressed, “I think - I think there’s really a lot of benefits in that we’re all there to – as long as the goal always is to help these families succeed. And, I think that that is their benefi - I mean their goal as well.”

Many nurse supervisors and nurses from multiple sites expressed that better appreciation by both parties on how each agency functioned and worked was needed. In addition, several nurses from two sites emphasized the need for mutual respect and greater recognition of the roles and responsibilities for workers from both organizations. Through understanding what each organization did and understanding how together NFP and CPS could support families, some nurses and nurse supervisors from several sites felt it possible to build relationships from the ground. Several nurse supervisors and nurses from different sites also believed that CPS needed greater respect for the nursing profession, for example to respect a nurses’ judgment when he/she made a mandatory report. A nurse supervisor from one site also suggested that co-location between CPS and NFP was an important factor to consider when thinking about building collaboration between the two organizations. Co-location was suggested as potentially facilitating increased interactions through formal and informal channels; as well as allow nurses to become familiar with the workers in CPS.

One nurse reflecting on past CPS interactions suggested, “Contact. I mean, having somebody to contact. Recognition of what each other does. The more I’ve learned about CPS and their processes, the better I’ve been able to help other clients like work through it. Having them understand what we do is a huge part of it. And, we’re still working on that. Very much so because I have to explain it every time.”

A nurse supervisor stated, “If there was mutual respect both ways and an understanding of, of what their role. What is their role? Who are these people? What kind of education do they have? What kind of training do they have to be on the Child Protection Team? Who are they exactly?”

Another nurse supervisor stated, “I think having Social Services and Nurse Family Partnership in the same location, in the same building, is important. I think running into and interacting with the people every day, having social events together.”

Education Opportunities

Education for NFP

Mandatory Reporting

Among the nurses and nurse supervisors who had participated in mandatory reporting training, several nurses from all sites and a couple of nurse supervisors from different sites expressed the need for additional training and education around mandatory reporting. Many nurses and a nurse supervisor from multiple sites voiced a general desire for additional training on mandatory reporting including what was or was not reportable and the responsibility that being a mandatory reporter entailed. These types of trainings were expressed by these nurses and the nurse supervisor as needing to be comprehensive and ongoing such as through refreshers and updates on reporting expectations as a result of legislative changes (e.g. legalization of recreational marijuana). One nurse supervisor elaborated that although nurses should have learned their mandatory reporting duties in nursing school, some NFP nurses could still benefit from continued education and refreshers on their responsibilities and accountability in their practice.

One nurse shared, “That was a great training. But no, I enjoyed going to that, but I really would love to, I think we should have more trainings on, you know, mandated reporting. Just kind of, I guess, giving us support in what we do. Keeping us up to date with laws of the state, what we’re supposed to do and just giving us that support in general.”

Another nurse stated, “I’m sure you understand what I mean – it gets foggy after a while, so there needs to be a formal training, I think, for all nurses, especially if you’re in a field like NFP where there is an obligation to report and there are already events that you’re going to report on at some point, so, yup.”

A nurse supervisor expressed, “If you’re a mandatory reporter. So, I know from working with nurses for all these years, that there’s some nurses that didn’t listen when they were in nursing school and don’t listen now when it comes to knowing what your Nurse Practice Act and knowing what it means that you’re licensed and you’re responsible and accountable for your practice, and all of that kind of stuff. So, I would imagine that there’s some nurses in NFP that, that could use that... That education and that dialogue and communication to learn as much as they can about, about the things like that we’re going to cover at the state meeting.”

For those who had not attended mandatory reporting training but recognized their role as mandatory reporters, these nurses and nurse supervisors from several sites expressed great interest in education opportunities for learning more about what was reportable as well as other topic areas. Some suggestions included: signs of child maltreatment in the home, risks for child maltreatment, mandatory reporting for the home visitor as compared to the clinical nurse, clarification on reporting for an underage mother and for pregnant clients, IPV and mental health as they related to mandatory reporting, the reporting process, county specific CPS functioning, and when to involve law enforcement.

One nurse stated, “Well, I think I said this in the very beginning of our, the first interview was that it’s different when you’re working in a hospital situation versus in a home. You know, it’s more - It’s more gray areas. And, I hate to say like I know that mandatory reporting should be black and white. Like, ‘If they do this, this and this and this,’ but it’s not. And so, you know, I would really like to know more about how that looks being from a perspective of a home visitor. Some education would be great. You know, what - What we see versus, you know, how does that relate to black and white mandatory reporting?”

Another nurse shared, “Yeah. So, you know, there’s not a whole lot of guidance with that at all. So, some of the main things are what things are reportable. And, with some of our teenage clients, you know, if their families are kicking them out of the home, is that not reportable too? Because they’re still children.”

One nurse supervisor expressed, “But, if the child’s not even home, or if she’s pregnant - Is that reportable? I don’t know. So, this is an area that I would like some instruction on because, you know, an unborn child is an unborn child, and it - You know, we don’t report marijuana usage or alcohol, so why are we going to report domestic violence? I – I - You know - Don’t know. So, it could - We could use some - I could use some info on that.”

Another nurse shared, “And there was supposed to be a conference call with Dr. Olds about more training for the nurses for mental health evaluation and things like that because I, you know, I’m fairly fresh out of nursing school. I hadn’t really had a lot of mental health training, just my mental health rotation which is a substantial amount. Right.”

A number of nurses from a few sites also stated that they wanted training on how to handle gray areas where it was not a clear sign of abuse or neglect. Some examples of what nurses from different sites considered to be gray areas included clients refusing to take their child to well-child visits, underage clients being kicked out of their homes, allegations of other children in the same home being abused or neglected by their mothers (not the client), and improper use of car seats. A few nurses and a supervisor from different sites also expressed the desire to learn more about the step-by-step process for how to report, including who to call and what to expect. Other topic areas that several nurses from different sites suggested included: maintenance of the client-nurse relationship after reporting, how to work with families in the CPS system, clarification on reporting for marijuana with regards to neglect, and clarification on the definition of child sexual assault or statutory rape.

One nurse explained, “But, when you’re in the home, and you’re seeing something and it’s just like - ‘Oh, that’s really weird.’ You know? Or, Mom is refusing to take the baby for well-child checkups. And, that’s all it is. But, you know, that doesn’t - You know, when do you report? And, not in the black and white sense, but like really getting into that... the gray areas of when to report.”

Another nurse stated, “The drug stuff would be nice too. Especially the marijuana. Yes, you smell it and you don’t know whose using. What do you do? Do you report it because a child lives in the house and you can actively smell it? Is that illegal? You know, is that something we need to be reporting as neglect. Yeah, those are good areas, and especially that age thing has always been a concern.”

One nurse supervisor shared, “It think it’s just in time, a lot of the training has to be just in time. So, when my whole boat came in, we did [instructor’s name removed] and talked about the policy. I haven’t talked to all my nurses about the policy yet, we’re not, they’re not in those positions. Things came up with one where the child was in a home where she thought the other children were being beaten by the mother of the son - do we call on that? We don’t really know.”

Another nurse said, “It’s just that - Yeah, I think I just want a training, a really good one that, an intensive one that would just like, lay out like, ok, this is what you’re gonna do, like a step by step kinda thing, because it’s just very vague. I know that we’re mandatory reporters and all that, but it’s just, how does it work, when, where do you call. What are we gonna expect and all that.”

Child Welfare

Many nurses from all sites and a couple of nurse supervisors from different sites shared about their desires to learn more about many aspects of the structure, practices, and practices of local Child Welfare departments. A few nurses from some sites and a supervisor were particularly interested in learning more about the reporting process such as where to call, what was worth reporting, how much evidence was needed for a report, what to expect during the reporting process (such as the duration of the call), and how caseworkers followed up with mandatory reporters on their report. Some nurses from different sites also had more specific questions around whether or not nurses could call someone at Child Welfare for a consult without making a report, if nurses should continue to call and report on something if they felt that a child was at risk or unsafe even if the initial report did not result in an investigation or open case, and when Child Welfare should be called versus when the police should be called, specifically with sexual assault cases.

One nurse stated, “Right. I think some kind of like - What would be considered a high-risk, you know? And, what number do you call when you need to do that?”

Another nurse wondered, “Who, who gets - Who’s answering the phone and, um, is it like triage nursing or what? You know, it’s just they take information, and then they pass it on to somebody else and what’s the protocol there? So, that would really help me understand...”

A nurse supervisor shared, “What I hear back is, they’ll say no. That’s not something we can handle or that’s not reportable. We actually got a written document back on something we reported about two months ago. I think staff would say they’d like a little more about when should you report. What would make it worth reporting. Thanks for calling, however. And maybe a place just to run things by more, then have to call the hotline. We don’t want to tie them up with things that we’re just kind of questioning.”

The same supervisor continued, “The other training is, although this isn’t pretty specific, if we were in a home and someone says, my child last night was sexually assaulted by the whatever. We would send them immediately to the ER. I don’t know what people do...But, obviously you would have to call the police first and that was the point. A lot of the doctors were like doing the exams and didn’t know just to call, or call the police. Or what would you do? Would you call the hotline or call the police? Right, so that’s a good question too. When you are told something has happened, which of course you can’t substantiate.”

Another nurse questioned, “And, you know, if CPS doesn’t act on it, you just keep reporting until they do? You know, so, there’s- It just seems like there’s more - I guess, just more guidance with when to report, what to report, the whole process.”

Many nurses from all sites and a nurse supervisor voiced that they wanted to better understand general Child Welfare procedures. Areas of interest included how they screened a report, how they determined whether or not to open a case (including how many reports led to an open case), how they assessed risk, what they considered to be high-risk, how they categorized clients by risk, and the differences between investigations, open cases, and Safe Care. A number of nurses from multiple sites were also interested in learning more about the various teams within Child Welfare, how they communicated (i.e., how a caseworker for Safe Care would learn if a case was opened on one of their clients), and how long each phase (e.g., investigation, open cases) could last. Other nurses in some sites were interested in learning about ongoing cases; including the process when caseworkers changed on a case (e.g. transferring from assessment to ongoing), services or resources provided to clients with open cases, what to expect when their client had an open case, and the client-caseworker relationship. A few nurses also commented that they felt that learning more about CPS and their overall process and procedures (including the assessment phase) would also help improve collaborations between Child Welfare and NFP. Several nurses from one site elaborated that it was helpful to learn the assessment process so that they could be prepared to provide information for their clients. A few nurses from this site emphasized that understanding the assessment process would not affect a nurse’s reporting practice.

One nurse supervisor stated, “Um - I guess it would be interesting to know what the process is when - From the time they get a referral on somebody- Like, they get a phone call, you know, that they think that this child’s been, you know, being beaten. And then, what do they - What is the process? What do they do? Because I - I honestly don’t know.”

Another nurse explained, “But, but the big area now, a deficit, is just not knowing their, their whole procedure. Who works- You know, what - Even where they are located isn’t - You know, I always would like to know visually, you know, where that person, if you call and make a report ...But, also, you know, when Child Welfare - I’d like to know, when they go in, how - How - You know, our nursing assessment might be different than their assessment. So, what are they looking for? What’s - What’s little red flags? I mean, I think, you know, there were little red flags for me that kind of popped up, so that’s why I’m having my concerns...And so, what would they do? And, what did they look at when they go into a home? And, what’s their process? And, do they have like a checklist? Do they have a questionnaire?”

Another nurse supervisor expressed, “And so, I think because we have this other SafeCare component, I think it’s going to be really important that there’s some clarification, and there was some discussion on this because, you know, the system itself is probably not going to be totally up to the date, up to the minute current. So, how are those SafeCare workers going to know if there is an open case. And, how - You know, people are very transient, too, our population just moves from county to county. And so, how is that all going to catch up with each other?”

A nurse supervisor and a couple of nurses from different sites were also interested in learning more about how Child Welfare worked with their clients. Topics of interest included whether or not Child Welfare used a strengths-based approach with clients, clarification on how they handled cases involving undocumented immigrants, how they addressed emotional abuse and marijuana, how caseworkers triaged or made decisions regarding clients, and what resources they provided to clients whether the case was closed or opened.

In regards to the need for additional training, one nurse supervisor commented, “I think some of the issues that come up around the undocumented because that’s another world. No. You know, like if you call the police because you’re in danger, intimate partner violence, no they don’t deport you. He might get deported though because now he’s got a record, so those kinds of things, that’s changing rapidly.”

One nurse shared, “And, you know, I don’t know what kind of training they get, you know, are they able to look at clients’ strengths? And, I’m sure, but I just don’t know that. It would be interesting to learn, maybe, about that. Really, how do they assess - Are they only looking at the problem, at the crisis? And, or they have time and are able to look at the strengths of the family? I don’t know.”

Another nurse stated, “A very comprehensive - And then, once that report is done, then what? What resources do they give them? What follow-through is...”

In addition, numerous nurses from most sites and a nurse supervisor from one site described the type of training and education they wanted and believed would help improve collaborations between Child Welfare and NFP. Many nurses and a supervisor from multiple sites stated that they desired opportunities to generally network through attending each other’s regular (monthly, bimonthly, or quarterly) meetings or formally scheduling biannual education sessions where the two groups could interact. They expressed that in addition to learning more about each other’s work, getting acquainted with each other’s staff would improve their abilities to work together. A few nurses from different sites voiced an interest in learning more about what client information caseworkers could share with nurses, the types of support (such as self-care) and/or training caseworkers received in carrying out their work, and what caseworkers would like the role of nurses to be in order to be most helpful in supporting their work.

One nurse shared, “I would like for us to, at least in our area, even though they have a high turnover, I’d like for us to know at least some familiar faces and the names. So, maybe even some more socialization for us. Maybe some co-training, so that we know what they’re looking for, and they know what we’re doing.”

Another nurse stated, “You know, I feel as though we have consent to talk with Social Services regarding clients and especially ones that are already within the system, but it’s kind of unclear what information they can and cannot share – like location of the client, that I’m having a hard time getting a hold of, you know, like where they’re at. Even simple things like that have been a challenge, collaborating in that way, so, you know, that sort of information as a whole – what they want to share and what they don’t want to share, I think would be helpful. And not just location, but beyond that. What is the situation at home? What are they working on? Things like that, as well. What can they share with us? What can’t they share?”

Another nurse stated, “And just an open forum for questions because I know there are lot of nurses that have questions about, you know, with their processes and what they do and what would make their life easier with us reporting. You know, because sometimes we’re not entirely sure what they want from us. So that’d be nice to hear.”

A few nurses from different sites described a couple of preferences for learning styles for better understanding Child Welfare. These strategies included one-on-one sessions with caseworkers as well as shadowing opportunities. One-on-one sessions were preferred for asking specific questions and informal consultations whereas shadowing was proposed as a way to truly observe and understand how Child Welfare functioned and what day-to-day activities took place.

One nurse stated, “And then, like I said, just - I really would just like to pick one of - One person’s brain over there and just kind of get to know how their processes go, and ask little dumb questions, you know, like, ‘Well, what if this happens?’ and, ‘What if this happens?’ You know?”

Another nurse said, “And so, I think we get pretty good training, but we could always use more specific. Because this is in a huge auditorium of people. But, if we can do some one-on-one it would be great too in regards to what do we do. And, really what happens to it once we do? Once we report it, if there were something, what really happens?”

Another nurse stated, “I would love to have a DHS contact to call because not all, because they know what’s going on. That their job is to decide if it would be a case that would be open, you know, it’s my job to CYA, and make sure that nobody gets harmed... I would love to have a DHS contact to call and say, ‘hey, this is what’s going on, what do you think?’”

In describing the type of caseworkers to shadow, another nurse shared, “I would probably - I would probably be interested in doing all of them, but - The long-term and the assessment team. And, I think mostly for me, though, I’m more curious how, like, how do they determine which reports are they going to pursue and which ones they’re not and that kind of stuff.”

While expressing an interest in shadowing caseworkers, another nurse stated, “Yeah, just to see what they do. It’s kind of a big mystery to me.”

Education for CPS

Several nurses and a nurse supervisor from most sites shared their perceptions about areas where they felt Child Welfare needed greater education and training. Many nurses and a nurse supervisor from different sites felt that Child Welfare needed additional training and education about NFP to become more aware of the program. Specifically, they felt that Child Welfare generally did not understand NFP's role in the community, who implemented the program, how nurse home visitors worked with clients and the nurse-client relationship, nurse home visitors' boundaries, roles and responsibilities, and program elements such as NFP as a voluntary program needed to be emphasized. A couple of nurses from different sites also expressed that they felt that some caseworkers needed to be reminded that they could not disclose who reported a client to CPS. Several nurses from one site suggested that a greater awareness of NFP could be facilitated through sending an NFP representative, perhaps a nurse supervisor, to present on the NFP program once or twice a year to CPS workers at various unit meetings or through job shadowing so that caseworkers could experience what nurses encountered on day-to-day. These types of interactions were expressed as helping to keep NFP in the minds of CPS workers so that they knew NFP was an available resource in their communities.

One nurse shared, "At that point in time, you know, I had one experience in those meetings where the woman who was her caseworker when she was a child tried to tell me, 'Well, you know, even if she's not feeling good, and she cancels the visit, you still need to be in that home and weighing that baby.' And, I was like, 'Well, this program is voluntary,' so I had to, again, reeducate..."

One nurse supervisor stated, "And, they [potential clients] weren't really appropriate for NFP. But, they [Child Welfare] didn't know what else to do with them, and it was like, you know - Because they'd just heard about us, and it was like, you know, 'Oh, let's call them,' you know? And so, we had to do a little more reeducating on what the program is really for, you know. And, yes, we can take them after they have their babies, but - You know, we're not in there. We're not going to police them. You know, we're not."

Another nurse explained, "Very awkward and uncomfortable, I mean, completely, the family was just very upset with me. And so I think what DHS should've said, professionally, because they're going past the little line here, on anonymity, that's actually a misdemeanor, if they're not keeping it anonymous, that's a misdemeanor on the DHS person's fault with them in Colorado. The nurses, cause other nurses have had the same complaint. So I think that DHS needs to be reminded, their reaction to the client should be what mine was. It really doesn't matter who reported you, everyone's just concerned about the baby, so let's focus on that. That's where I took, but I thought in all professionalism, they should have done that same thing instead of giving them hints to who it was."

Another nurse shared, "Talk to them about what we do, give them more information about what services our program offer...And then vice versa, they come with us and see what we do, what we encounter, what we experience so that way we can both see hand in hand what each other do and maybe would give us a better appreciation of what our jobs are. I just thought about that."

Networking Opportunities

Among all NFP sites, almost all nurses and nurse supervisors expressed the desire to know who worked in CPS; so that nurses were able to be able to put a face to a name. Whether or not NFP nurses could attend a CPS staff meeting or CPS representatives could present to NFP, an open forum for questions and answers was described as an opportunity for NFP and CPS to network. Other nurses from several sites suggested routine conversations and meetings so that nurses could establish a personal connection with workers. In another site, a few nurses suggested regular presentations from NFP to CPS caseworker orientations; co-attendance at community-wide events and resource parties (e.g. include organizations like CPS, Maternal Child Health, WIC, Food Stamps, or Medicaid); scheduled workshops between CPS, NFP and other home visitation programs; CPS representation on CABs; and co-attendance at larger community-wide meetings. Several nurses from one site also expressed that informal and casual events may be more beneficial so that nurses and caseworkers felt more relaxed. Joint visits, shadowing (to spend a day with a caseworker), and attending RED team meetings were additional opportunities suggested by several nurses across multiple NFP sites. The purpose of these activities would be to learn how CPS caseworkers assessed cases and handled cases, as well as the general CPS process.

One nurse stated, “Um, no, I just think the idea of having opportunities to meet face to face, and also, um, to meet maybe on a regular basis at whatever new orientation they do for employees would be a good idea. And not just necessarily for case workers, but for, um, all new employees up there.”

Another nurse suggested, “I think we should have an event. I think that would like a mixer, you know, like come see about our program. Like honestly, a resource party would be really cool to have. Invite WIC, invite DHS, invite Maternal Child Health, invite Food Stamp folks and Medicaid, all of those kind of program, but in particular just NFP and DHS coming together in a relaxed environment where like maybe we each have like slideshow presentations going at either end of the building and we can, either end of the room and we can kind of mingle and trickle over and they can stand there and see some of our outcome and you know, just brief information. And then maybe like, I would say 10-20 minutes tops for presentation on like processes, people, and contacts and you know, who would be the best to answer questions and then a QA and call it a day.”

Some nurses in several sites also suggested the opportunity for NFP and CPS to participate in joint trainings of mutually-relevant topics. Topics brainstormed by these nurses included: drug abuse and its impact on families, violence in the home and its impact on the child, changes about the law, motivational interviewing, strengths building with families, and therapeutic communication. Ongoing interaction between NFP and CPS through meetings, joint-trainings, joint-visits, and community events, quarterly, semi-annually, or annually was welcomed by both nurses and nurse supervisors in many sites.

One nurse supervisor expressed, “Setting up with CPS if they, you know when we can, some way for us to interact ourselves so at least that they know we are here. They get that message from their top also but if we’re all doing the same piece. I think something on

drug abuse would be good and how that can impact and I think the issue of violence in the home and how that impacts.”

A nurse stated, “Um, I think just collaborating, like, if there’s any change. Like, maybe biannually or maybe just annually getting together with them and, you know, what’s changed in their process? What’s changed in our process? Um, you know, I think what, a lot of times, what happens is that we forget or new people come in – and you forget, you know, who the resource are. Or you forget - And so, you have to be reminder, you know, like, ‘Oh, don’t you remember? I have this available in the community’ - It’s always nice to have reminders.”

Other Opportunities to Improve Collaboration Efforts

Reporting Child Abuse and Neglect

Many nurses and nurse supervisors in almost all sites expressed the need to have at least one contact person within their local CPS department. A direct contact at CPS was expressed as beneficial for discussing hypothetical situations and could guide nurses to navigate through gray situations when a report of suspected child abuse or neglect to CPS was unclear. In particular, one nurse supervisor believed that every NFP site needed to have an internal contact at CPS to ask about hypothetical scenarios when nurses were unsure about making a mandatory report. However, another nurse supervisor from a different site felt that mandatory reporting guidance would be helpful coming from the NFP NSO as she preferred to discuss gray areas with her nurses, rather than with a CPS contact. Several nurses and nurse supervisors from another site believed that ongoing communication with CPS about mandatory reporting (for example through annual training refreshers) was important to maintain relationships.

One nurse supervisor stated, “You know, so that, I think, is probably really important that every site have somebody they can contact internally in DHS or CPS to say, ‘Hey, what do I do with this? Should I report this? Should I not? You know, where is this reportable?’ Because those were the questions that came up when we had the rep come over here. ‘What exactly is reportable?’ Because the guidelines are, you know, any kind of type of abuse or neglect. Well, how do you define that? And, there’s a legal definition of it, but when you’re looking at a family, and it’s gray, what do you do with that?”

A nurse suggested, “But, it would be nice to have another resource that we could - Let’s say, we get mandatory training, so both of us had a little bit more knowledge, and so then we go, and I meet with her once a week in our weekly supervision. And, we can call up somebody from Child Welfare and just say, ‘Here. Here is the situation. Um, what’s - what should we do?’”

Another nurse supervisor stated, “Like when you said the mandated reporting, you know, kind of guidance that sounds like it’s coming down the road, I think, is really going to be helpful. Because it would be nice to make those decisions on my own and decide – or, with our team, you know, like to bounce it off the other nurses, ‘What do you think?’ kind of thing. And, I would just be less likely to bounce it off a caseworker. I’d rather bounce it off ourselves and know whether it’s really reportable or not, you know.”

Another nurse reflecting on what interactions had been helpful suggested, “Well, I mean I think just ongoing like we do here – having them come in periodically and talk about reporting and - is helpful.”

In addition to education and guidance on mandatory reporting, some nurses from every site suggested opportunities in improved interactions with CPS during a report and after a report was made. Many nurses and nurse supervisors from most sites discussed the need to receive feedback and follow up from CPS once a nurse had made a report. This feedback was important for some nurses to plan their next visit with the reported client accordingly (e.g. for safety measures). Additionally, several nurses from multiple sites wanted to know whether an assessment was or is taking place and what they could expect to happen next. A few nurses from one site also suggested that an automated system for mandatory reporters should be set up to facilitate a quicker report. Other nurses from another site emphasized the need for CPS caseworkers to respect the nursing profession especially when nurses were calling to report on a client; there needed to be a level of professional recognition and support. Several nurses from one site also expressed that CPS caseworkers must maintain professionalism and keep reports anonymous. For example, caseworkers should not tell clients that their nurse reported on them because these situations were challenging for nurses in maintaining their nurse-client relationship.

Upon reflecting on past reports to CPS, one nurse suggested, “I would love for just a phone call. You know, if I make a report and then, they open the case, somebody goes out. It would be really nice just to hear back from them. ‘Hey, we opened it, these are our concerns. Do you agree? What do you think?’ Just hearing some feedback. A lot of times we make our report and then unless we’re calling the hotline to try and follow-up, we don’t hear anything else and we’re in the home, you know, and in some cases every week. Like, you know, how can we partner to, what are you looking to do, what are you mowing forward with, how can we support that.”

Another nurse stated, “Um - I don’t think anything that I haven’t shared already. Mainly just really wanting some two-way communication between us and CPS. And, maybe like DHS in general, you know, just so everybody knows what’s going on. Because I do think it would make everyone’s job easier. You know, when you’re only operating on a partial story, it’s a little bit hard to do any more than you’re already doing or, you know, be the most effective. So, yeah, some - Like the two-way communication, or just some, you know, reaching out from CPS to us, that back door. Something like that. I don’t know.”

Another nurse stated, “Very awkward and uncomfortable, I mean, completely, the family was just very upset with me. And so I think what DHS should’ve said, professionally, because they’re going past the little line here, on anonymity, that’s actually a misdemeanor, if they’re not keeping it anonymous, that’s a misdemeanor on the DHS person’s fault with them in Colorado. The nurses, cause other nurses have had the same complaint. So I think that DHS needs to be reminded, their reaction to the client should be what mine was. It really doesn’t matter who reported you, everyone’s just concerned about the baby, so let’s focus on that. That’s where I took, but I thought in all professionalism, they should have done that same thing instead of giving them hints to who it was.”

With Mutual Clients

Many nurses and nurse superiors from every site also provided suggestions to improve current CPS interactions when working with mutual clients. As explained, one of the greatest challenges to overcome among most nurses in all sites was communication and sharing of records or information with respect to HIPAA laws. Information that nurses felt was pertinent to receive included: caseworker on the case, when CPS was going out to assess, stage in assessment, other service providers involved, if a child was removed, concerns and issues, and details of the treatment plan (or inclusion while creating the treatment plan). Most nurses in multiple sites felt that there needed to be a two-way communication with CPS; where nurses had reported on strengths and progress made by a client but wished there was reciprocity from CPS. Most nurses from many sites wanted CPS to provide more open communication and to be more prompt in communicating. Some nurse supervisors in most sites held the same beliefs that CPS needed to be more consistent in providing feedback to nurses on mutual clients. Indeed, some nurses and nurse supervisors from several sites had suggestions in improving these interactions. One site offered the idea of developing internal agreements, like MOUs, between local agencies to facilitate an easier process for better communication. Furthermore, when working with mutual clients, many nurses from most sites suggested an opportunity in attending staffings or family engagement meetings, Skype meetings with different providers, consistent phone or email communication, and role clarification with the caseworker. Finally, one nurse from one site saw potential in CPS referring to NFP.

One nurse shared, “When, once the client’s been contacted. Because like if... Depending on the situation. Like, the one, it’s a safety issue. If they know you’re the one referring, then you have now put yourself in a very confrontational situation. And, going out unaware is not good - If they take the baby, I would love to know. Because that’s happened, where we show up and Baby’s gone. And, we didn’t know. And, that - I mean, so in those cases, I think the earlier, the better just for our safety and being aware of what we’re walking into.”

Another nurse stated, “I would love to be able to sit down with them and to, to have a - To write up a game plan for this client. You know? What is - what’s their goal? What’s our goal? How can we both, um, utilize the best of our resources in order for this patient, this client to obtain these goals? How are we going to communicate between, in the process? You know, what’s that communication going to be like? Knowing, and having the client know that we’re communicating.”

Changes for CPS to Consider

Among several sites, a few nurses expressed multiple areas that CPS should consider with regards to quality improvement. Almost all nurses from all sites felt that CPS needed to understand the benefit of working with NFP when serving mutual clients; to utilize the information NFP nurses were able to gather through being the eyes and ears in the home. These nurses believed that CPS needed to understand the different perspectives that a nurse may bring to a team approach. Some nurses and nurse supervisors from two sites consistently expressed that the fundamental philosophies within CPS needed adjustment: CPS should change how they functioned and should not be removing children and that CPS needed to learn to have better relationships with their clients. In addition, a nurse from one site suggested that CPS should have

a medical professional (e.g. a nurse) on staff to assist their caseworkers in making decisions around medical issues like failure to thrive.

One nurse stated, “But I think it’s just mainly the main thing is communication. Oh, and then maybe their supervisors maybe thinking about how we can do an internal since we’re under the Health Department. And I know we’re considered Health Department and they’re county and we’re in the process of switching all that over to everybody being county. But maybe have some type of agreement where we know that we’re inter-county/Health Department, whatever you want to call it. But since we are colleagues and we’re working for the same main goal there doesn’t have to be so many um, um, um, so much red tape in a sense for us to talk.”

Another nurse stated, “And, if we had a genuine collaboration, that would be nice, I suppose. But, I see the direction coming much more—and I’ll just say this again very frankly—that perhaps... I’m gonna be a little tentative here - That Social Services could learn something from the Nurse Family Partnership, for example, since that’s what we’re talking about in how we approach the relationship with clients. And, you know, I think the learning coming from that direction would be much more beneficial.”

With regards to education and caliber, several nurses from several sites believed that CPS caseworkers needed better training and more education. Specifically, CPS caseworkers need to perform better during assessments (such as questioning other people involved with the family like NFP). Some nurses from these sites also believed that during assessment, CPS should ask all first-time mothers if they were involved with NFP.

A nurse suggested, “Increasing the staff to the Department of Social Services, training as to, I think they’re getting some individuals in there who are not as educated.”

Another nurse stated, “And, number two, a better assessment could have been done because they - Everything - They walked in there taking everything that was being said at face value. And, some of it was, but some of it wasn’t. And, they - I just think a better assessment could have been done and asking other people who were involved with the family.”

Opportunity for Changes Within NFP

Within several sites, some nurses held a different perspective in opportunity for collaboration. Rather than focusing on how CPS could improve their functioning, some nurses provided feedback on how NFP as an organization and nurses as individuals could strengthen collaboration efforts. At the organizational level, nurses and nurses supervisors from several sites suggested the need for NFP to learn the CPS language and/or to develop the same language to use with CPS when reporting. Several nurse supervisors emphasized that currently NFP and CPS used different languages, in assessing risks as well as strengths. These nurse supervisors believed that in addition to a learning process, there needed to be greater NFP NSO guidance towards collaborating with and working alongside CPS workers. At the individual level, some nurses from several sites suggested the following: to not get offended personally by how CPS caseworkers reacted, to take the initiative in sharing information regarding mutual clients and show signed releases, and to learn to perceive CPS as supportive of families and focused on child

safety. Other nurses from one site felt that NFP could look at their existing processes to determine a better approach in notifying CPS that they served a mutual client or a method to notify CPS when they had enrolled a client referred by them.

One nurse supervisor suggested, “I think something that would help us is to develop a - a way we could communicate with Department of Human Services because it seems like, right now, we have different languages. And so, how are we risking our clients? What’s their rating compared to Department of Human Services? And, what do they feel would be reportable?”

A nurse stated, “I think we need to look at, you know, maybe we need to find out how, once we enroll a client, how do we flag them, or how do we let them know that they’re a part of our program?”

On Community Perceptions

Overcoming stereotypes of CPS within the NFP office and in the community was another opportunity expressed by many nurses and nurse supervisors among most sites. Several nurses from a couple sites admitted that within their own site, there existed stereotypes of CPS; some of these nurses felt it necessary to first overcome these stereotypes and stigma before collaboration could be initiated. In addition, across many sites, there existed the perception that community stigma of CPS needed to change. Several nurses from a couple sites expressed that NFP may help to break down this stigma by reassuring clients that CPS was there to support families and to reunify children with parents; in fact, these nurses suggested that NFP association with CPS may improve CPS’ reputation in the community.

A nurse stated, “Well, I think a couple of things. To be real honest, I know stereotypes for me about DSS. I see that. I see that in our office. And, I’ll be the first to say it. So, I think more awareness of our program over there would go a long way. And, collaboration with them, like, maybe get together so we learn what they do and they learn what we do. And, I know that’s going to happen.”

A nurse supervisor stated, “That’s something that - I don’t know if that is true everywhere, but I don’t know that when people think CPS they think of that. They think more of, ‘They’re there to remove the children.’ And, that’s a stigma, I think, that has to change. I don’t believe that that’s what they really want to do. I think that maybe the resources have been limited where, sometimes, they just don’t have anything - Especially in some of the lesser counties. But, getting over the stigma in the nurse’s brain first, so they can help the clients get over the stigma and be okay.”

On Prevention Initiatives

Some nurses and nurse supervisors from several sites expressed interest in collaborating with CPS at the prevention level. Several nurses and the nurse supervisor from one site expressed the desire to refer clients to prevention programs without the need to first report to CPS. In addition, continued education with CPS workers was suggested to reinforce that prevention programs (including NFP) was a resource for their families. Several nurses and the nurse supervisor from this site also expressed the need for more prevention opportunities. Other nurses from a couple

other sites felt the need for prevention programs in the community and within CPS to function better together and to facilitate a better referral process for the various programs.

A nurse stated, “Maybe just more of - Like we talked about, like we don’t know the exact process, or we do, but it’s kind of like you have to do three different things to get it set up. So, maybe as their prevention unit grows, just better access in terms of not having to go kind of roundabout. But, that may never change. They may want to have everything logged in through CPS.”

CPS Perceptions of and Interactions With NFP

Similar to those of CPS by NFP nurses and nurse supervisors, perceptions of and interactions with NFP among CPS caseworkers and supervisors varied across and within sites. Among all sites, many caseworkers and supervisors perceived NFP as a quality resource for families who qualified. Many caseworkers perceived nurses to bring a level of professionalism, medical knowledge, and trust to their relationships with their clients. Among most sites, many caseworkers and supervisors had limited interactions with NFP but within a couple of sites, some caseworkers and supervisors had consistent and ongoing interactions with NFP; interactions that were described by some CPS workers as a working relationship. These interactions included trainings on mandatory reporting, communication about a mutual client, attendance at meetings and community events, and making referrals to NFP. Other sites, usually those that were served by a multi-county NFP site, showed variance in the frequency and quality of their interactions with NFP, where some counties expressed consistent and frequent interactions while other counties expressed no contact with their assigned NFP nurse(s).

Perceptions of NFP

Perceptions of NFP as a Program

Across all sites, many caseworkers and supervisors perceived the NFP program as positive and a beneficial resource for families who qualified. Many caseworkers from most sites perceived NFP as a great resource for parents to learn skills that were applicable for future children and a resource that was not related to Child Welfare. As well, some caseworkers from one site felt that NFP was beneficial because they conducted home visits and spent more time with clients than at a doctor’s visit. Other caseworkers from another site felt that NFP was beneficial to clients due to the fact that the program included medical and developmental elements. Some caseworkers from another site perceived NFP positively as their involvement increased the level of safety in the home.

A CPS Family Advocate stated, “So, it is something that is substantial in their life and ongoing, where they can learn these skills, so then when they have more children, they have these skillsets. They have this knowledge, and they also have a person that they can call and refer to without, you know, without that fear, again – and I know I keep saying that, and it’s unfortunate, but it’s true – of [county name removed] Human Services.”

A caseworker stated, “Yeah, so um, you know and just – I mean, she takes her to the doctor’s appointments, which is great, but the doctors – They just don’t spend the time. You know, I think it’s different when you have somebody coming to your house.”

Another caseworker expressed, “What I like about Nurse [Family] Partnership, too, it’s the medical and developmental aspect. It’s just that they’ve combined the two, which is really nice.”

If NFP was involved with a client, many caseworkers and supervisors from several sites felt that NFP became the eyes and ears in the home, which often assuaged the concerns or worries a caseworker had about the family. Additionally, several caseworkers from another site perceived that when NFP was involved, the response from CPS was not as immediate because a professional who was trusted to report to the police or to CPS was already helping the family through concerns.

One CPS supervisor stated, “And then, we also know that if we get out, there’s some other eyes still in the home. So, it lessens our worry, I guess, than if there was nothing.”

Another caseworker shared, “It’s always really nice when they’re already involved because it is another set of eyes in there.”

Another caseworker stated, “Yeah, yes. It can give us the assurance that there is some reasonable expectation of safety, and if that changes, there are eyes in that home to observe it and see it and report it.”

Another caseworker stated, “Yeah if we know that there’s something in the home with eyes on the family then we might not have to make as immediate as a response, because it’s a professional person, who we can trust to say, you know, they know to call the police if they need to, they know to call back to us if they need to, help the family through some of those things without us coming out there immediately.”

With regards to NFP’s targeted population, perceptions varied across sites. Many CPS caseworkers and supervisors across most sites often felt that mutual clients between NFP and CPS were uncommon due to the limited eligibility criteria of NFP. Indeed, one supervisor from one site believed that if NFP was involved, CPS would ideally not see the same clients. There were also varying views of whether clients first engaged with CPS or with NFP, with some caseworkers and CPS supervisors who felt that clients would be in NFP first and then NFP nurses would make a report to CPS, while other caseworkers and CPS supervisors from different sites felt that CPS would refer families to NFP after receiving a report from a third party. Those with the latter perception also often believed that having a family involved with NFP would mitigate concerns for child abuse, thus making it implausible for clients to first engage with NFP and later with CPS. On the other hand, some caseworkers from one site felt that NFP worked with the same population as CPS and that the two agencies should be able to work together to prevent further issues.

A supervisor stated, “Probably not as widely used as we may be presuming it is. Although I think our customer base probably has some intersections with it, but they probably intersect less than we think they do.”

A supervisor from another site stated, “It would be a nurse accompanying a caseworker. A caseworker wouldn’t accompany a nurse unless we have a case. Well, they wouldn’t have NFP if they have a case.”

A caseworker from another site noted, “If somebody makes it to us first, and they haven’t made it to them, which typically is not the case. You know, if somebody makes it to us, they’ve typically had some contact – already with NFP.”

Another caseworker stated, “You know I think they have an idea, I think that they work with the same clients, they work with the same population, and so they know that there are going to be some really hard cases, and then there are going to be some that are wonderful to work with, where you feel like, ‘Oh my gosh, we just avoided years of dysfunction by having this in place.’”

Perceptions around NFP staffing and turnover also existed across different sites. In one site, some caseworkers perceived the NFP program to be highly staffed with many nurses; while caseworkers and supervisors from another site felt that NFP in their counties were understaffed. At the same time, supervisors from another site perceived turnover to be an issue for NFP serving their county. In addition, other perceptions surrounding the NFP program and its functioning were expressed. Several caseworkers and supervisors from one site perceived NFP as better than CPS at engaging with families, in the way that nurses presented information and assessed situations differently than CPS caseworkers. In respect to perceptions regarding the NFP CABs, an administrator from one site expressed that the CAB had been helpful in receiving reports but did not necessarily offer helpful information for her and her department’s practice.

One caseworker explained, “Yeah. Because it seems – there’s a lot of them, from what I’ve noticed – Well, when they all came to our meeting. I mean, we couldn’t all fit in that room”

A supervisor shared, “And, it’s been good, you know? It’s, they have fewer nurses than they have had in the past, and so I don’t always think it’s as easy to collaborate when your program gets cut a lot, but we do think that this is a really worthwhile program.”

Another supervisor stated, “I think because of their staffing. I think when they have enough nurses they come up here. You know, if their staffing of something has been cut.”

A few caseworkers across different sites shared their perceptions of NFP as it related to culture. One caseworker felt that working together with NFP nurses could be powerful because people from impoverished countries or people who were struggling had often allowed doctors and nurses into places (such as the home) that caseworkers could not go. A CPS supervisor from a different site also wanted to know the language capacity and cultural competency, acceptance, and sensitivity of NFP nurses.

A caseworker stated, “Because even when you look at globally, you see humanitarian relief and stuff, you always see doctors and nurses. And, I think that’s one thing that breaks down a lot of barriers, culturally, you know, people from impoverished countries or people that are struggling, they’ll let the doctors and nurses in. You know? So, you can get in places sometimes where we can’t.”

Perceptions of NFP Nurses

Many caseworkers and supervisors from several sites perceived NFP nurses as beneficial, competent, caring, knowledgeable about medical-related issues, and thorough in their work; NFP nurses were able to work with families and refer mothers to appropriate services. Of those caseworkers who were knowledgeable about the NFP program, several from a couple sites perceived NFP nurses as providers of education for mothers in their program. This education was described by these caseworkers as including pregnancy expectations, expectations for feeding, nutrition, hands-on parenting techniques, self-sufficiency, and developmental goals. Additionally, other caseworkers from one site felt that NFP nurses shared very credible information about their clients, with regards to what they observed, heard or saw; this information had been helpful for decision-making for CPS caseworkers. In another site, some caseworkers felt that NFP nurses were really interested in learning the CPS language and process.

One caseworker stated, “So that was some – we had to work through it. But, honestly, I mean we’ve been just kind of passing ships and trying to connect. She sounds very, you know, awesome in working with the family and trying to get services in for mom, which is great.”

Another caseworker shared, “I think that overall, for me, when I know that I have a registered nurse going in, that is a relief for Child Welfare I think. That’s as good as having, almost as good as having a kid at the doctor every other week.”

Another caseworker stated, “Yeah, yes. It can give us the assurance that there is some reasonable expectation of safety, and if that changes, there are eyes in that home to observe it and see it and report it.”

Another caseworker expressed, “And I have found that here, I think they’re very thorough, and I think maybe the fact that I used to do that job, and that type of work, I see the extreme value of it, and including as many people just around parents as possible could be beneficial. So.”

Another caseworker shared, “They have very credible information to share about what they’re observing, hearing, you know, seeing of, of that information. So, yeah, it can be very helpful information in decision making.”

Another caseworker stated, “They wanted to understand our language and our terms and our acronyms. I felt like that they really did want to understand.”

Furthermore, some caseworkers from other sites felt that people with a specific personality characteristic became nurses (e.g. wanting to help others) and that nurses were supposed to care

for the wellbeing of children and their parents. Finally, in a multi-county NFP site, one administrator offered perceptions around the county's assigned NFP nurse. This administrator perceived the nurse as isolated from the county's departments of health and Human Services despite being located in the same building.

One caseworker stated, "And, I think it's a personality characteristic of people that go into certain fields, and you know, it's a trait that I think is inherent to be able to do that work."

Another caseworker expressed, "And I would think collaboration with Nurse Family Partnership would be the, of children, the safety, and wellbeing of. Isn't that what nurses do? It's the well-being of children and parents."

A CPS administrator regarding an NFP nurse stated, "And so, she's kind of isolated and does her own thing and leaves and takes – They won't send her clients. I asked – We had some problems with the space because, even though we came into a new building, we had all this space, the Public Health area didn't have as much, and they were kind of crowded out. And so, we didn't have – And, we have some new grants that we needed some new people on board, and it was right around the time when we heard that there was going to be this change with NFP becoming more under Child Welfare Department."

As Mandatory Reporters

CPS perceptions of NFP nurses' ability to maintain mandatory reporter responsibilities varied across sites. Many supervisors from a couple of sites greatly valued the professional opinion of NFP nurses when they reported on their clients. Several caseworkers from different sites also valued the NFP perspective as it came from mandatory reporters and felt that NFP nurses provided reliable and credible information on their families as collateral for assessments. One supervisor believed that the NFP nurses in her county usually reported strong cases that required action and that nurses should continue to report these cases while a caseworker from another site affirmed this perspective by suggesting that nurses need to not make "bogus" reports - reports that did not meet substantiation or the level of severity for CPS to intervene. On the contrary, some caseworkers from another site lacked knowledge on whether or not NFP nurses were aware of and upholding their responsibilities of being a mandatory reporter; to the point that some caseworkers found this worrisome.

One supervisor stated, "And so, we as a department know that. And so, we know if we're getting a report from one of the nurses, we need to take it seriously. There's something going on here.

Another supervisor shared, "Because you can't respond to everything. So, you know that when she's coming in, we need to pay attention and, and for whatever reason, she is concerned enough that she's come in. And so, I think that that's probably one of the most important things that all of the nurses need to know is to, to not make these weak reports. You know?"

Another supervisor stated, "I think, to me, it's just very simple. It's - I cannot respect them if I don't know what their job is because I'm going to start thinking they're not

doing their job.”

Another caseworker stated, “I think Child Welfare was a little worried. They wanted to make sure that NFP knew what it meant to be a mandatory reporter.”

Additional perceptions of nurses arose among various CPS workers in several sites. In a couple of other sites, several caseworkers and supervisors shared about the relationship that NFP nurses had with their clients, that they perceived these nurses to greatly value the nurse-client relationship, and the importance of building strong relationships with clients in the NFP program. Several caseworkers also explained the conflict that nurses sometimes felt between betraying that trust with their client while maintaining their role as mandatory reporters; that emphasis on maintaining the nurse-client relationships created a competing priority with mandatory reporting. A couple supervisors and caseworkers from these sites recognized this reluctance and hesitance among NFP nurses to report. In fact, a supervisor found it worrisome that an NFP nurse had perhaps waited too long to report in one instance, while a screener from a different site worried that nurses may convince themselves that it was not abuse or neglect to maintain the nurse-client relationship. An administrator from one site perceived that sometimes NFP nurses struggled with situations when CPS had to intervene. For example, she shared that some nurses questioned whether or not they had performed to their best ability to keep a child safe or to help a client. In addition, several caseworkers from one site felt that NFP nurses were not working with clients with concerns that warranted CPS involvement. Other CPS workers from the same site and some from another site perceived NFP nurses were uncomfortable in contacting or reporting to CPS, even though they were working with high-risk clients who could have penetrated the Child Welfare system.

One caseworker explained “NFP nurses. When they go into the home. And, I feel as though they, the last thing that they want to do, and they will find any and every mechanism to not have to report if they don’t have to...Because of that relationship, that they want to – because of the fear and the — sometimes the reality — that, once a report is made, that that relationship is devastated. So, I feel as though, on some level, there is a lot of reluctance from people that have those kinds of relationships with their clients to make reports.”

One supervisor shared, “...having discussions about issues that she’s seeing is that that relationship that she’s building with that client is pretty important.”

Another supervisor expressed, “Well I, I always, um, felt like she was reluctant to call us, like she, um, and this isn’t just her, we get this from lots people who work with clients, I mean the schools, I mean other people who make referrals to us, who are mandatory reporters who are nervous about doing that because it impacts their relationship with their client. And she was no different than that, in terms of my interaction with her. It felt like there were times when, um, she would make a referral and we would think, ‘Why did you wait so long?’ Or we would find out, we would get a referral from another source and find out she was involved and wonder why she hadn’t called us.”

A CPS administrator stated, “But, and then, the nurses of course really struggle with something does happen and CPS has to intervene, then sometimes they’re like trying to

figure out, is there something that I could've done differently, or was there something, and, you know, what I try to say is, 'Everything that you do is, is in an effort to keep this baby home, and so you can't look at it like that, because people are responsible for their behavior.'"

Philosophies to Mandatory Reporting

Many CPS caseworkers and supervisors from several sites shared similar philosophies to mandatory reporting. These workers felt that nurses and mandatory reporters should always err on the side of caution and report to CPS if they had any doubt in suspected child abuse or neglect. Many workers from different sites were also receptive to receiving calls from NFP to determine if a situation was reportable or if a family could receive prevention services. Finally, one supervisor suggested that nurses needed to understand that they should make appropriate reports to CPS to earn the respect of the agency so that they will respond timely to their reports.

One supervisor shared, "Well, a nurse is always a mandatory reporter, so we don't ever want you to ever feel like you can't report it. So, when in doubt or when you think you should report it, that's always a base. But, if there is a time where you ever want to talk about some things like, 'What can we do as far as service-wise?' Maybe you don't- NFP doesn't have the resources or the wherewithal to do something and it is kind of learning toward a Child Welfare kind of thing, but it's not- it doesn't kind of reach that threshold. Certainly we could talk about what agencies- like, maybe this is an opportunity for Safe Care to take the next step."

Another supervisor explained, "So, I think that you know, I guess we'd rather see people over report than under report in general, because if we know about something, you know, well for starters we can put it in our system and then if something else comes in that's similar but maybe has more information we can see, well, this is not the first time, maybe there's a pattern with this family... So, but, you know, what happens is, if you wait and wait and wait, and then, you know, until something really becomes serious before you report it, then we have to respond, like it might mean we have to do something more than what we would've had to initially. And again, if we can intervene at a lower level and maybe provide some services to a family we can avoid, um, further incidents of abuse or neglect, but also having to perhaps remove a kid or do something that's more drastic."

Another supervisor stated, "And so, I think that that's probably one of the most important things that all of the nurses need to know is to, to not make these weak reports. You know?... Because you're going to gain the respect of CPS agency and when you call, they're going to respond."

Perceptions of NFP Clients

Several caseworkers from various sites shared their perceptions of clients enrolled in the NFP program. Some caseworkers from several sites felt that NFP clients were not only comfortable with their nurses, but felt supported by them and saw the NFP as a positive resource. These caseworkers perceived NFP clients as connected to their NFP nurse and that a rapport was developed between client and nurse; to the extent that it would not normally be the case between clients and caseworkers. Several caseworkers from another site expressed interest in shadowing

NFP nurses on their visits, but were uncertain as to how the mothers would receive it, due to stigma associated with CPS.

One family advocate stated, “And, I know that the mom in this case really was able to connect with her and have a rapport with her. And, just because she didn’t work for the department. So, there wasn’t that over – I mean, I know clients really get kind of scared with the department is that, when I come in as an in-home service provider, ‘Hey, I’m here to help, but I still work for the department.’ So, we’re still – There’s still the thought in their mind of, you know, ‘Is she, is this going to end in a removal?’”

Another CPS caseworker expressed, “I wish I had time to shadow them. But, I don’t know how their families would feel about it, honestly.”

Perceptions of Other CPS Workers’ Knowledge of NFP

Several caseworkers and supervisors from various sites provided their perspectives of others’ knowledge of NFP. Most CPS workers across many sites shared that few of their colleagues (whether they be other caseworkers or supervisors) knew about the NFP program or its eligibility and had limited interactions with NFP. Some caseworkers in a couple of sites felt that ongoing caseworkers, especially, had limited interaction with NFP. Among some sites where some CPS workers expressed that their colleagues lacked interaction with NFP, other workers expressed knowledge that their supervisors had engaged with NFP. Other sites also expressed knowledge of interactions between CPS and NFP. Most caseworkers from one site were aware of ongoing interactions to build a working relationship, especially between the CPS prevention programs and NFP. In another site, some caseworkers believed that their coworkers had interacted with NFP but they themselves had not.

One CPS administrator shared, “Some people knew. Some people didn’t. Didn’t know the criteria. So, I mean, we really started from scratch, I mean, we had a lot of assumptions, I think.”

A caseworker stated, “And I kind of feel that maybe some of, you know, some of our supervisors didn’t really know what they could. They know now, but I, you know.”

A family advocate stated, “I don’t think many ongoing cases have Nurse Family Partnership in them. At least, I don’t hear them, I don’t hear that from my colleagues of saying, ‘Oh, we have a visit today and Nurse Whoever is coming from Nurse Family Partnership.’”

A supervisor shared, “I know [CPS supervisor names removed], who were the assessment supervisors before the changes have had some standing meetings with Nurse Family Partnership, but I have not been involved in those – So they were like getting information and bringing it back to all the leadership team.”

Another caseworker stated, “Gosh, it was a long time ago. I think that – And this may or may not be true. Maybe it’s one of the times that they called me that made me think of it, but I think they work with our Prevention Unit more often, like with our community case

managers that go out and work, hopefully keeping families out of our Child Welfare system.”

Knowledge of NFP

Similar to perceptions of NFP, the level of knowledge of NFP varied among CPS caseworkers and supervisors within and across sites. Knowledge of NFP (or the lack thereof) tended to be disclosed within the context of eligibility and enrollment, services, and existing interactions with NFP as well as challenges with such interaction. However, knowledge of NFP did not vary significantly by site or position as variations in knowledge existed within and across site.

A few caseworkers and CPS supervisors across multiple sites had learned about NFP through direct interactions with an NFP nurse as a result of serving mutual clients. However, across a few sites, some caseworkers and CPS supervisors who were familiar with NFP had learned about NFP through this research study and often demonstrated some hesitancy in their responses. Knowledge of NFP such as eligibility requirements and the length of the program were often demonstrated by reiterating what the interviewer had shared just moments earlier in the interview.

One caseworker stated, “Um, that’s interesting, ’cause I didn’t know they were here. Until right now. So they’re on the second floor? Really?”

A CPS supervisor from another site stated, “Well I only recently learned about it, through you, and it just sounds like such a good cause.”

Eligibility and Enrollment

Many caseworkers and supervisors across all sites acknowledged that they lacked knowledge around the various eligibility requirements for NFP. Although some caseworkers and supervisors across most sites were familiar with the criteria that clients had to be first-time mothers and identified this as a significant barrier to the program’s potential reach, others were less familiar with this requirement.

A CPS supervisor stated, “Well, to be honest, I never really knew about – I knew that we were part of Pueblo’s Nurse Family Partnership and we could access that service – but we really don’t access it a lot. Um, we don’t really deal with so many first-time mothers as we do the second-, third-, fourth-time mothers. And it’s my understanding that Nurse Family Partnership is for first-time mothers.”

A caseworker shared, “Cause it has to be their first child, correct? And now, from what I understand, so I would want to know what the referral guidelines would be. Um, is uh, so like, if the child is three months old, we can still make that referral, correct? No? They can’t take that referral?”

A caseworker from another site stated, “Um I didn’t realize until probably in the last week or so that the project only relates to first-time parents and you have to do it within a certain time frame. I thought this is great! Let’s just throw them in everywhere and I haven’t had an opportunity to yet since that family that I had in my caseload, but I’ve

been thinking about them knowing that they're there next time we see a baby let's try to get them in and I've talked to a couple of my coworkers, 'Hey, try this.' And that's where now I'm learning that, this time frame, has to be first-time parents. All the rules."

Some caseworkers and supervisors from multiple sites were also unsure about the duration of the program. Many knew that mothers had to be enrolled in the program by 30 days after the child's birth but only a few knew that mothers could enroll during pregnancy. Many caseworkers and supervisors from several sites were also incorrect about the length of the program, although a few caseworkers across different sites were aware that the program went until two years postpartum.

A supervisor noted, "But it's, I'm not sure whether she can do stuff before the child is born or whether it's only after the child is born. But I think it's maybe up to like three years?"

A caseworker stated, "Um, I think that, I know that there's an age range. I know that they generally like to work with the kids, I want to say it's, it's 1 to, from birth to three months or it's either birth to one year or birth to three months. It's small kid, it's our most vulnerable population."

Another supervisor stated, "And, it follows them through the age of two. It may not be as intense as they get older, but you know, they still check in with them."

A few supervisors across multiple sites also had conflicting views of whether or not mothers could stay involved with NFP after having their child removed as well as whether or not mothers had to be involved with Child Welfare in order to enroll in NFP. Some caseworkers and CPS supervisors from the same and different sites also acknowledged their general lack of knowledge around eligibility and enrollment and the need for them to learn more.

A supervisor stated, "So really I think it's just that criteria piece and I think we could probably work pretty well, um – I think we just need to educate ourselves more on it as well; so- I don't think a lot of people – I don't even know all the criteria. I know bits and pieces. Because once I heard oh first child and I was okay."

Another supervisor from a different site stated, "No. We were just talking about that today, actually. I did- Because I didn't really know what the qualifications were and when you could refer and how can you refer, so no, I don't think we do, actually. I mean, the little information we were getting was, you know, just from working recently with some of them and- So, yeah, I don't- I don't think we do. Yeah."

The same supervisor continued to say, "And so, I guess that would be the question is if a child is removed, does the service from the Nurse Family Partnership discontinue? Like do they stop? I mean, you know, because then the par- the baby is no longer with the parent or the mother. So, that's a question I don't know. I mean, I don't know if that would be something that they could continue still meeting with the mother while we're looking at reunification and still meeting with the baby elsewhere. That's a good

question. Because, obviously, if the baby's removed, I don't know that we could share much if they're not involved."

Most sites also held an inconsistent knowledge of the referral process; where some caseworkers understood the steps to refer while other caseworkers were unaware of whom to contact. Some caseworkers from different sites understood that there was a NFP referral form which could be faxed or emailed to a contact listed on the form. Other caseworkers from the same and different sites were aware that there was a formalized referral process but did not know who the contact person was for their county or did not know the contact information of the NFP site at all. Additionally, some caseworkers from various sites had misinformation on the referral process; they did not think that a referral form existed (e.g. other community agencies had referral forms specifically designed for CPS to use but NFP did not).

One caseworker stated, "The way- How we do it is we just fill out a form. It's a handwritten form and we scan it and e-mail it to the head nurse and say here's a referral for you."

A supervisor had a differing knowledge base and recalled, "I mean, I wouldn't even know how to contact her if I wanted to make a referral."

Another caseworker stated, "But there's no official, like, form for us. You know, we always usually have forms for referral of services whether it's kinship or any kind of services."

Three sites seemed to have a more consistent knowledge of the referral process; where referrals to NFP were commonplace. In fact, in these sites, several caseworkers and supervisors had a contact person within NFP to make the referral. These CPS workers were aware that they could call or email their point person, or simply walk over to the NFP site and provide a referral in person. Some caseworkers and supervisors from these sites were also knowledgeable about the referral details that usually included a name and phone number of the referred client. Alternatively, several caseworkers from some sites had provided a family with NFP's program information and phone number; where the family then self-referred to NFP. In several sites, many of the caseworkers and supervisors who were aware of the NFP referral process stated that their colleagues may not be as knowledgeable about the process and that they may benefit from attending a training about NFP.

A CPS prevention programs manager stated, "But [NFP name removed] and I have a really good relationship and so if she has a question, she picks up the phone, and if I think that one of our families would benefit from NFP, it's one of the first things we think of and to do some sort of joint case management work on. I think we're lucky in the fact that we have a good relationship with the people over there, and they feel that they can pick up the phone."

Another caseworker reflecting on how he approaches referrals to CPS with his clients recalled, "Usually, we tell them they need to contact, and then, we give them the number. We may also be the ones that might initiate that, too."

Another CPS supervisor stated, “I know that we need to, I know that I certainly need to learn more in regards to the referral process and what they need from us. I know [CPS name removed], who is our administrator who has worked pretty closely with Nurse Family Partnership in the past so I have scheduled now meetings. I think they have either monthly or maybe quarterly meetings where everybody is getting together to figure that stuff out.”

NFP Referral Sources

Knowledge regarding NFP referral sources among CPS workers varied within site and across site. Most sites had an inconsistent knowledge, where some caseworkers knew that physicians, hospitals, and clinics made referrals to NFP while other caseworkers from the same and different sites had no knowledge. Of those caseworkers who were aware of NFP’s referral sources, many tended to be knowledgeable about the referral process. Some caseworkers and supervisors from other sites had a solid understanding of NFP’s referral sources to include TANF, Medicaid, WIC, food stamps, and family service centers. These sites also consistently referred to NFP when they had clients who were eligible.

A caseworker stated, “In our community, the referral process is pretty broad from our practitioners, our doctors and family practitioners at that level of pregnancy, if they see any need, they’re making that referral pretty rapidly. So, I feel as though the number of people that have been contacted is pretty high, I think.”

A supervisor questioned where NFP received referrals, “Yeah. What happened to the relat - Is - well, does Public Health still make referrals to your program?”

Another caseworker shared her knowledge in NFP’s referral sources, “I would probably say still the food stamps, Medicaid technicians over the family service center, which is kind of a little north of us, but still. I believe they’re the ones that, and that’s where I learned about the program. They’re the ones that have a better chance.”

Across most sites, many caseworkers and supervisors believed that when agencies other than CPS referred to NFP, both clients and NFP nurses were more accepting of the referral. For example, a Social Services director from one site explained that eligibility staff (such as TANF or Medicaid) had more successfully referred clients to NFP than CPS caseworkers.

A caseworker stated, “Mm, I think if, I think if you’re referred from somebody other than us, although I think we can make referrals, but if it comes from the doctor, or even the family themselves having an interest, you know, then there’s less hesitancy. And I think that that’s helpful. And I think that happens. I think that a lot of the things that y’all are probably involved in, we have no involvement in, you know? They’re young moms and struggling and doctor or whoever, nurse practitioner thought it was a good idea.”

A Social Services director recalled, “We had a little bit more success with our TANF program, referring to Nurse Family Partnership because they can come on our program before the baby’s born. I don’t think it’s limited now. As soon as they figure out they’re pregnant they can be on. We’ve had more success with those clients because they’re a little more voluntary. “

Knowledge of NFP Services

Scope of Work

A few caseworkers and supervisors across a couple sites explained that they thought the primary role of NFP nurses was to provide medical services to clients. Such services were perceived to include weighing the baby and assisting with medically fragile babies. However, a few other caseworkers and supervisors across many sites were knowledgeable about NFP nurses teaching parenting skills, checking on the welfare of the child, assessing children's development, using a structured curriculum, teaching mothers how to meet their child's needs, and providing hands-on parenting help. Nevertheless, many caseworkers and supervisors within and across most sites were not familiar with the role of NFP nurses and desired opportunities to learn more about their scope of work.

A caseworker stated, "My understanding of it – and this might be faulty because it's not, I haven't had official training on it in my capacity. So, my understanding is that, um, at times they can go out to homes and assess for medically fragile children. They kind of offer some services. I also know that, um, they offer services such as with the drug-exposed baby, like, going out and weighing the baby and making sure that the baby's okay. Um, and that's really all I know. It's very limited."

A supervisor stated, "Up to two, ok, so. And I don't know, I don't have a lot of specifics about what she provides, other than, um, probably some, like parenting ed kinda stuff around newborns, toddlers, I guess, since it goes up to two. And uh, some support. And probably information around post-partum depression, I think we've talked with her about that in the past, health, given the fact that she's a nurse, and again, these are probably more assumptions on my part than actually direct knowledge. And issues around health and feeding and nutrition and all the things that new moms need to know about babies. And my sense is that she tends to work with younger moms, just because it's, I think it's first-time moms only, so."

Another caseworker noted, "Um, they currently go into homes. The work with young parents, first-time parents. Hopefully they like to get started before they, their delivery date and then they work with them for two years after the delivery date. That's pretty much all I know. They teach them you know how to bond with their baby, and that sort of thing, is what I understand."

Another supervisor shared, "I'm not quite sure what the objective of NFP is."

Another supervisor from a different site stated, "I mean, it would be helpful to know the qualifications, but also when we come across families that have that service, what is it that they do? So, just getting in there and talking about their curriculum and what they do and how they work with families and how often they're in there and what the scope of, you know, they can do. That would be extremely beneficial."

Frequency of Visits

Almost all of the caseworkers and supervisors who were familiar with NFP knew that the nurses provided their services through home visits. However, they were uncertain about the frequency of the visits. Many did not know how often the visits occurred while others had a misperception

of the frequency of the visits with some who believed that the visits occurred multiple times a week while others thought they were just once a month.

A supervisor stated, “Well, we’ve met with some people from Pueblo who were part of the Nurse Family Partnership in the past and so I know it’s a nurse, um, that goes to the home – I think it’s once a month – and meets with a parent, first-time mom or pregnant mom. And just teaches them how to be a parent, answer questions, that type of thing.”

A caseworker stated, “Right, first-time moms and it’s a partnership between the nurse and the family and, um, I understand you go in the home, I you know read a little bit about it. Like once, or how often I don’t know. But and that is up to two years of age, right?”

Knowledge of CPS Interactions With NFP

Caseworkers and supervisors had varying knowledge about existing interactions CPS had with NFP as well as challenges with such interactions.

Mandatory Reporting

Many caseworkers and supervisors across all sites were knowledgeable that NFP nurses were mandatory reporters and that the nurses were often hesitant to make a report because they desired to maintain their relationships with their clients. A few caseworkers across a few sites were also aware that nurses had clients drop out of NFP after learning that a nurse had reported them and that nurses sometimes informed their clients that they were going to make a report.

A supervisor stated, “They want to feel like they can trust her and tell her everything, and when she has to make that report and then it’s outed, that relationship is lost.”

Another supervisor stated, “You know, I think, for me, the biggest deal is that we don’t ever receive reports from the NFP nurses that are weak. If they come to us, there is a concern, and we know we need to take it seriously. And so, they may have been concerned for quite a while, but they never report them to us until they have no more choice.”

A caseworker from another site stated, “They have a close relationship with their families. NFP nurses. When they go into the home. And, I feel as though they, the last thing that they want to do, and they will find any and every mechanism to not have to report if they don’t have to. Because of that relationship, that they want to... Because of the fear and the – sometimes the reality – that, once a report is made, that that relationship is devastated. So, I feel as though, on some level, there is a lot of reluctance from people that have those kinds of relationships with their clients to make reports.”

Practices, Procedures, and Structures

Many caseworkers and supervisors from multiple sites were unaware of the structural elements of NFP such as the length of its existence, how it was funded, the agency it worked under, and who typically referred to them, but only because they were unfamiliar with NFP in general. Those who were more familiar with NFP tended to also be more familiar with the specific aspects of the program. Knowledge of NFP practices and procedures also varied within and

across sites. Some caseworkers acknowledged that nurses had restrictions on what they could share because of confidentiality and that it was challenging for NFP to partner with an agency that was not always welcomed into the home of clients. However, less was known about how NFP assessed safety.

A supervisor stated, “I guess the question was, at what point do, you know, they look at safety and say, ‘Okay, we need you know, C-, Child Protective Services in here,’ versus, ‘Okay, this is what we have, and we need to maybe step up our contact or increase, you know, certain, you know, services that we’re providing in order to address the risk that we’re seeing.’”

A caseworker from another site asked, “So, how long has [NFP] been around?” She later also asked, “Because, who pays for this? Well, I mean, we’re not Medicaid.”

A supervisor from another site stated, “I’m thinking it would be great if we were able to give more information, like what exactly it would do, what would be an appropriate referral, how make the referrals, you know, the whole process and that part. I think it would be a great idea.”

Physical Interactions With NFP

Initial Interactions

Across most sites, a few caseworkers and supervisors had interactions with NFP. However, there existed variations in the level of interaction with NFP in multi-county NFP sites. In several multi-county NFP sites, some caseworkers from one county shared that they had interacted with NFP while other supervisors and caseworkers from other counties shared that there was no interaction at all. In addition, across most sites, many caseworkers and supervisors who had interacted with NFP expressed that their initial interactions were often a result of the NFP nurse making a report on their client. In some other sites, several caseworkers and supervisors first learned about NFP through other means, including at a resource fair, NFP outreach (e.g. presentation), previous work background, social workers at the hospital, transition into another position (e.g. supervisor), or from the need to locate a resource for first-time moms. In one site, some supervisors could not recall when they first heard about the program but knew it had been available in their community for a long time.

One family advocate stated, “I actually Googled Nurse Family Partnership. I was looking to see – I had a brand-new mom who was going to need services. She was, she doing well, but she was going to need services past an assessment time, which is 30 to 60 days. But it didn’t really meet the level to open a case for that family, but I wanted to see if there was something out there that could really beef up her skillset, and have her have a tie in the community that wasn’t [county name removed] Human Services.”

One supervisor recalled, “I think she probably made us aware of it through maybe – I don’t remember exactly for sure. I just know that, you know, our usual way of getting information is through her coming in and saying, you know – You know, ‘This is the program’ – I don’t know exactly when it started here but I know it’s been quite a while.”

Another supervisor stated, “So I don’t really remember a time without it.”

Regarding Mutual Clients

CPS interactions with NFP when serving mutual clients varied within and across sites. Some sites shared many mutual clients with NFP where many of its caseworkers had consistent and ongoing interaction with NFP nurses; to the extent that some level of collaboration existed in these sites. Among other sites, some caseworkers had interactions with NFP nurses due to serving mutual clients but other caseworkers had limited or no interaction with NFP at all.

One caseworker reflecting on past clients recognized her first interaction with NFP, “And, this is my first case – and I’ve been at the county 5 years, and I’ve had four pregnant moms.”

Another caseworker stated, “You know, I really don’t know. Again, I haven’t had much interaction with the Nurse Family Partnership.”

Another caseworker shared, “But not, really it’s infrequent and it’s really when they contact us – At least that’s what I would say. But, I’m like, the only person who’s, like, ‘No way.’ But everyone’s, like, ‘Yes, of course we know them. We work with them all the time.’”

A supervisor stated, “I, so I know, [NFP nurse name removed], who is the nurse who is assigned to this area, and we’ve had some contact with her. Not recently, I don’t think, I think it’s been at least a couple of years since we’ve had any real direct contact with her. There have at times been clients that we have both had involvement with at the same time, although that’s pretty rare. She has made referrals to us in the past, again, I don’t think, not in the last couple, I didn’t even know until recently that she was still around, because we just haven’t had any contact with her in the last several years.”

With sites where CPS caseworkers had mutual clients with NFP, interactions included: gathering NFP’s perspective on the family (e.g. safety and risk factors, strengths, familial background); sharing of a caseworker’s plan for assessment; occasional check-ins by phone, email or in person; inviting NFP nurses to case staffings or family engagement meetings to discuss progress, goals, or placement plans; and joint visits to the client’s home. Despite having positive interactions with some NFP nurses, a couple of supervisors from one site felt that separation between CPS and NFP to an extent was necessary; such that one supervisor had tried not to conduct joint visits with NFP.

One caseworker stated, “You know, safety. Risk. But, it just helps us trying to get at that other perspective because we could probably be like, ‘Oh, no. This baby is not going home.’ And clearly, there’s other parts to that case, but just that piece, that the nurse has helped us understand or give that perspective has been good.”

Another caseworker stated, “So, it’s only – I’m not going to say ‘big’ case stuff, but I don’t monthly check in with her. It’s if there’s going to be some – A change in the case, then I will notify [NFP nurse name removed]. Or, if there was a – And, after initially, first couple missed appointments, [NFP nurse name removed] was in communication

with me, 'Hey, heads up. [Client name removed] missed this.' And then, I would get on the phone and call her aunt. And say, 'I got another call from the nurse.'"

A supervisor recalled, "We just scheduled the time and one of them, I only can recall two. One of them, the Nurse Family Partnership nurse met me there and the one, we drove together. And so you know it was just a matter of, you know, going together. They had trusted this person so it was kind of like, you know, this is a person who works in Child Protection and then I explained myself and so it kind of worked out that way."

Another supervisor shared, "But, I did. I do remember having some contact with the nurse that was involved with the family. They were able to give some feedback about, you know, what they've seen and just the family composition, the strengths that they had seen in this particular mom, some of the needs and the struggles that they'd seen over the course of their work with this mom, so it gave us a bigger picture in enable – in allowing us to go forward with the case planning and treatment planning for this mom."

Another supervisor regarding joint visits stated, "But, we try not to do that. It's happened a few times, but we try not to. We try and keep it separate."

The individual who initiated interactions in sites where CPS caseworkers had interactions with NFP nurses for mutual clients varied. In several sites, the interaction was often initiated by the nurse through a phone call, while in other sites sometimes the client had notified the caseworker that a nurse was involved in the home. In the latter cases, through gathering this information, some caseworkers had then called the NFP nurse and initiated the contact. In one site in particular, some supervisors recalled an instance where the NFP nurse was a witness for a court case with a mutual client. This case was difficult for both CPS and NFP as the family refused NFP participation after they realized the nurse had made a CPS report.

A caseworker stated, "I'm supposed to – I mean, because like I've got response times, so it's either immediately, you know, 72 hours, or 5 business days. And so, sometimes they'll make a referral, and they want to know who it went to. And, they'll say, 'It's five working days.' I probably haven't even looked at it yet, and so they'll. My guess is they call the hotline and find out who was assigned and then they call me. I think – I'm assuming that's what happens because I haven't called them, so – I would have eventually, but they usually reach out to me first."

A supervisor stated, "That they had reached out to us to, you know, let us know that they were involved and a resource and a service that could be looped upon and used, you know, to help with reunification and a service provided. I – that's what I think I remember, so yeah."

Another caseworker recalled, "But it's worked out the parents have just told me that they're in there."

Another caseworker shared, "She will attest to the fact that we are really good parents basically. And so, I get them to sign the release and I think then I communicated at first with the Nurse Family Partnership via email. We are all employees of the same agency,

and so they are all in our email. And so, I connected with her and said, ‘Hey, I have this open assessment on this family and I would like some additional information.’ And then – and then – and then – after a – a few emails then we had a phone conversation as well.”

Another supervisor stated, “And you know – And, just like we knew was going to happen, they pulled the service, you know. The family didn’t want it anymore, which is why it’s so important to us to keep that protected – But, that’s why we weren’t able to is because she was a witness and had to testify and...”

Having a contact person within NFP was shared by some CPS caseworkers in various sites. In one site, some caseworkers had a contact person at NFP whom they called to find out which nurse was working with their mutual client. In another site, some caseworkers expressed that they were to call NFP if they removed a child under the age of 5, to see if the child was involved with the program. Different caseworkers from another site had different contacts within NFP with whom they had interactions.

A caseworker stated, “I mean, we were always supposed to call them if we removed a child under the age of five, just to see if they were involved with Nurse Family Partnership, but that was just like a – on a list of things you check off.”

Use of Liaisons

Several CPS workers from two sites expressed the use of liaisons to facilitate interactions with NFP. One site had a designated nurse liaison from the public health department who also worked for DHS. Some caseworkers from this site had used the nurse liaison to find out which NFP nurse was involved with their mutual client. In another site, a case manager was employed by DHS and placed at the local public health department. This case manager had helped several CPS caseworkers identify which NFP nurse was involved with their mutual client, as well as connected the two agencies when referrals were made.

A prevention program case manager stated, “And, usually, I kind of talk to them over there and find out who’s going to get it and – Yeah. Let them know that I’m working with the family, you know, also. And then it’s kind of the same thing in reverse if they want to make a referral to us. And, they’ll fill it out, send it over, and then I’ll let them know which case manager is going to take the case. Because it may not be me, it might be some other case manager who might be better suited to that particular case. And then I’ll kind of make sure that they’re both connected.”

NFP Reporting Child Abuse and Neglect

Some caseworkers in several sites expressed that they had interactions with NFP nurses when nurses made a report to CPS. Some reasons for why NFP nurses had reported to CPS included: inappropriate supervision of the child, failure to thrive, impact of marijuana use on caring for the child, etc. A few caseworkers from several sites expressed that when an NFP nurse reported, they had received all information the nurse would tell them. This information usually included: family demographics, family or friend support, safety concerns, substance abuse background, DV background, homelessness, legal involvement, etc.

In one site in particular, a supervisor expressed that NFP nurses had made CPS reports to a specific contact within CPS; this contact had an established relationship with NFP through ongoing interactions over the years. Similarly, in some other sites, some supervisors and caseworkers shared that NFP nurses had called for consultation to ask about potential gray areas. Usually, these consultations occurred by phone or in person, did not involve the names of clients, and involved the nurse and/or nurse supervisor asking about hypotheticals. Most of the time, these consultations became an actual report to CPS.

A supervisor shared, “Oh, she makes it through me, but that’s just because we have this long-term relationship but – that, that’s just – Yeah. So, she makes it through me. Not that she couldn’t make it through anyone else.”

One caseworker in receiving reports from an NFP nurse stated, “You know, so, any and all information that the nurse can give us, we take.”

Another supervisor stated, “She feels free to bounce off her concerns with me to see if, if it’s reached that level, or if it hasn’t quite yet. And I think that that’s helpful to both of us. Because I know that, if it’s reached that level, I’m going to get that report. I know that. And so, when she’s coming into just bounce it off me and to tease it out of me, then you know, we can tease out the situation, then – To me, that’s just as beneficial as making that mandatory report. Because sometimes, I will tell her stuff like, ‘Well, have you thought about this?’ ‘Well, no, gosh, I hadn’t.’”

A prevention program case manager shared, “Sometimes, they’re unsure as to whether or not it’s an appropriate Child Protection referral – And so, along with that, I really do a lot of educating them on what type of information they need to pass along, you know, when they make the referral.”

Furthermore, in one site, a supervisor expressed concern on the abilities of NFP nurses to recognize signs of child abuse or neglect. This supervisor had interactions with an NFP nurse due to serving a mutual client where the nurse did not assess risk with the client at the level that CPS did. On the other hand, in other sites, several supervisors shared their confidence in NFP nurses’ abilities to make a mandatory report when necessary.

One supervisor stated, “Well, I think that, we opened a case on this family for a period of time and I, I think it just, I don’t remember any other specific interactions with her around that, but I think it just sort of made us worried, you know, that she was maybe seeing things that she wasn’t looking at the risk level the same way that we would. And, you know, maybe that’s not fair, I mean maybe it’s too, the same expectation that she would see it the same way we do is not a fair expectation, because she’s not a Child Welfare worker.”

Another supervisor expressed, “But, I have no doubt, if she needs to make a report, she will make the report. I mean, that will still happen, it’s just – It’s, it’s – You know, she’s gun-shy.”

An administrator shared, “I think we look at – I mean, even – I mean they’re mandatory reporters. So, if they’re trained on mandatory reporting. I think we feel really confident that they’ll... if they suspect any child abuse, they’re going to call us.”

Training

Some caseworkers and supervisors from several sites recalled their interactions with NFP nurses through training opportunities; whether they were CPS trainings for NFP or NFP presentations to CPS on the program. In some sites, these trainings occurred annually. Training topics shared by some CPS workers and supervisors from several sites included: CPS organizational structure, mandatory reporting responsibilities, the reporting process, marijuana and its impact on mandatory reporting, gray areas, and resources such as prevention programs.

One caseworker stated, “Recent. Yes. And, it went well. It was actually – because the Nurse Family Partnership is part of the health department, and so, there were other health department people there as well but pretty much the entire Nurse Family Partnership staff was there. And, it went well. They – they specifically requested the training due to the new marijuana laws in Colorado and how that affects child protection. And so, I spent a lot of time on that and they had a lot of really good questions about what... some of the stuff that they have seen and should this be reported and things like that. And so, we had a good open discussion about that.

Another CPS worker recalled, “So I can’t remember if she presented or just came to that. I’d need to go back and look. And I can do that if you need me to tell you. It seems like maybe some word came out about it and then they asked me to train, or maybe I went to train and then it seems like we were already working with them before or that. It seems like maybe they just sort of advertised it. I don’t know how long this, they’ve been...”

A prevention program case manager stated, “And I know they presented at one point, but I was not there at that one. So it’s just a matter of sharing the information that other workers get.”

An administrator stated, “The nurses have, at, sometimes asked me to come and train, come and train about mandatory reporting, come and talk to them just about what other programs we have, what others agencies.”

Other Meetings and Events

In several sites, some caseworkers and supervisors also expressed interactions with NFP nurses through other channels. In some sites, CPS held initial meetings with NFP to build relationships, educate CPS on the NFP program, and educate NFP on the CPS process. Some sites also had ongoing interactions with NFP through email communication and outreach, shadowing workers, physically visiting the NFP or CPS site, attending one another’s team meetings, NFP attendance at RED teams, or visiting at community resource fairs. In some other sites, several supervisors and administrators interacted with NFP through community meetings like the Early Childhood Council and NFP’s local CAB.

One administrator stated, “Yeah, I believe that was the initial one that they just wanted to just meet. I do – The NFP, my understanding is they did talk about their program to

educate the case managers because, even when we started this collaboration, started on our first meetings, we had to stop and go, “Well, what is NFP?”

One caseworker recalled, “You know, not that I can recall them coming here, but I did participate in a, a fair, one year. I forgot what it’s called but it was at the mall. And they were there, and it was great, because I had, at the time I had a client that was utilizing the service and I was looking for, I had told her she that she needed to come to the fair, because she needed some things, and I knew that they would be there.”

A supervisor shared, “There’s been – she’s been the constant person. And, I think there’s been other people that have been involved, but you know, it’s just – it’s been a really nice working relationship because she can come in here into the office and, you know, talk about a client she may have concerns about.”

Another supervisor stated, “[Social Services director name removed] at that level does. She sits on whatever meeting that they have and she’s the one that, a lot the one that’s bringing information and she may have been the one they brought, here is the new form.”

Referrals to NFP

Some caseworkers from several sites reported their interactions with NFP through their referrals to the program, with the number of referrals from CPS to the NFP program varying within and across sites. Many caseworkers and supervisors from most sites believed that referrals to NFP had occurred at some point in the past. Indeed, some sites referred to NFP more frequently than others; usually those who referred more frequently were familiar with NFP’s referral process and program. Several caseworkers and supervisors from other sites believed that referrals to NFP were infrequent due to NFP’s program eligibility (first-time mothers) and enrolment period (preferably during pregnancy but up to 30 days postpartum). In fact, almost all sites expressed that they seldom worked with first-time mothers. Even when first-time mothers were involved with CPS, it was often past 30 days postpartum. In addition, due to the work requirements of intake workers to complete assessments within 90 days, some caseworkers explained that they were not always able to assess whether or not NFP would be beneficial for a family until the enrolment period had already passed.

A supervisor expressed, “You know, we’re just totally open to whenever we do have a client that fits the criteria for that program that we wouldn’t hesitate in making a referral.”

A Social Services director stated, “We don’t have a lot of those referrals too much. ’Cause usually they’re second time moms. I mean our contact. They’re not the first-time moms usually so that’s kind of. And I always think that’s kind of hard because we could have some moms who could really benefit from it but they have other kids so I mean that’s kind of been our issue.”

Another Social Services director reflected on her department’s experiences with referring to NFP, “But our intake, I don’t know if I’m supposed to tell if it works well but our intakes struggle a little bit because of the timing and you know, it seems like when they get one they would try to refer.”

Reasons for referral to NFP also differed across sites. In some sites, several caseworkers and supervisors explained that they automatically referred first-time mothers involved with the CPS system; these were sites that were familiar with the referral process and the NFP program. In other sites, some caseworkers had only referred medically fragile children, drug-exposed infants, developmentally delayed mothers, young mothers, or mothers lacking support systems to the NFP program. Some intake workers from various sites who had referred to NFP usually referred cases with medically fragile children, drug-exposed infants, or young mothers. Occasionally, ongoing workers from site sites had made referrals to NFP; these referrals tended to be adolescents in the CPS system who had become pregnant.

A family advocate stated, “So, every client - I try to refer every single client that is a first-time mom. Just every single time. And, I have had some who, clients who haven’t followed through with the program, and then I’ve also had some times where they’ve been full and not taking any clients. So, but I always just try to get it out there, so that they have a resource.”

A supervisor recalled why her workers may refer to NFP, “Um, we will make referrals to them if we have like a young family that just kind of seems clueless. But, really doesn’t need our intervention. We’ll make referrals, you know, we had...”

Another supervisor reflected on cases when her workers referred to NFP, “And the child, I believe, had some lung development issues, so it was a high-risk baby that would benefit from having some services.”

A caseworker shared instances for when she referred to NFP, “And they will let us know if there’s a support system. And sometimes it’s a first-time mom, sometimes there’s a, there’s no support system, or sometimes you have, maybe parents who simply don’t know. And so, for whatever reason there’s a child protection issue coming in, we’ll initiate, I’ll initiate Nurse Family Partnership, cause I’ll just call them and say, ‘Hey, uh, I have a family that could benefit from you guys service, can you go out and make contact?’”

A Social Services director expressed, “If they, well, we have experienced, is that when we’ve had a baby born to a first-time mom and maybe they’re drug, I’ve seen a majority of them are probably drug exposed, mostly a lot of THC. Whatever the drug is. If they are a first-time mom, we will try to refer them to the Nurse Family Partnership. But, so, that’s how, one avenue. If we have an ongoing like a child in foster care who’s pregnant, we’ve had actually more success with that. When they’re in placement or in a home, if a kid that we’re working with is pregnant and has a baby, that seems to work well.”

Referral follow-up

Across some sites, several caseworkers and supervisors expressed that referrals had been made in the past but follow up on a client’s enrolment was rare. Referrals by CPS screening or intake units usually involved families who did not warrant an assessment or case. In these instances, CPS had no involvement with the family and was unable to follow up on the family’s participation in NFP. Other situations had involved an intake worker making a referral to NFP and not hearing back from NFP regarding whether or not the referral was accepted. Other times,

some caseworkers from several sites were notified that their clients were not accepted into NFP due to: client ineligibility (not a first-time mother or the enrollment period was over), nurses were at caseload and could not take on more clients, or nurses felt that the client was forced to participate in the voluntary program. In another site, a CPS worker had consistently and successfully referred her clients to NFP every time she worked with a first-time mother.

A caseworker shared, “So it would be very useful to know... Well first of all I’d like to know, ‘Yes, we received your referral and yes it meets the timeline and we will be looking at it.’ Or, ‘Yes, we received your referral and we will be going out tomorrow or something.’ But we don’t — we never hear back. We have to call them and say, ‘Did you accept it?’ and they don’t call us back very well either.”

Another caseworker stated, “I don’t think I heard back from them, actually. I just sent it in. And, I don’t think I did hear back.”

Several caseworkers and supervisors from a couple sites expressed that NFP was hesitant, reluctant and even refusing to receive a CPS referral or a referral that had an open CPS case. In some sites, several caseworkers described situations where they had made referrals to NFP but the nurses either never notified them regarding whether or not the client enrolled or waited too long to follow up with a client such that the 30 day postpartum enrolment deadline had passed and the client was no longer eligible; these situations were frustrating for caseworkers. In one site, some caseworkers believed that NFP had never accepted any of their referrals, despite the fact that the clients were eligible and appropriate for the program. In a couple sites, several caseworkers and supervisors also expressed that clients had not wanted to participate in NFP despite the caseworker suggesting the program as a voluntary resource.

A caseworker reflected on past referrals to NFP, “And, like I say, there’s another incident where we’ve made the referral within the first 30 days, it was about 20 days, and they held onto it and we didn’t hear from them for two weeks, then they said, ‘No, it’s too late now.’ But we’ve made the referral within, before the baby was 30 days old.”

A supervisor recalled interactions with NFP, “Very limited. I know about Nurse Family Partnership and what it’s supposed to do, but we, as a county, since I’ve been here, have never collaborated on a case. We tried once, and she refused the referral because she said we were forcing the client to go, and the caseworker explained that it was a voluntary case, that we have treatment plan goals and their program would help them with that goal. And so they reached out to get in the program. It wasn’t like, ‘You have to go do this.’ It was, ‘This is something that will help you with this goal.’ And she fought with us to the point where they didn’t qualify because it passed the number of days that the client could get in.”

A Social Services director shared, “But our intake, I don’t know if I’m supposed to tell if it works well but our intakes struggle a little bit because of the timing and you know, it seems like when they get one they would try to refer. A lot of resistance from the client not wanting that program. Some do like it.”

A CPS Prevention Programs worker stated, “The barriers lie within the clients because they have to agree - They have to want to participate in the services.”

CPS Perspectives of Collaboration Efforts With NFP

Collaborative efforts between CPS and NFP varied from site to site and within site as referenced by different caseworkers and supervisors. Some CPS workers from various sites described not having had any prior interactions with NFP whereas others from the same and different sites described continuous interactions and interfacing when it came to serving their mutual clients. These variations were attributed to different aspects of CPS processes but also NFP program requirements. In most cases, among caseworkers and supervisors who had collaborated with NFP in some capacity, many CPS workers mentioned the value of NFP’s work and the positive impact they had on their mutual clients and their families.

Varying Levels of Collaboration

As stated, there existed variations in the level of collaboration within and across all sites. Some CPS workers in several sites reported collaborations with NFP through regular ongoing interactions in the form of consultation and trainings as well as through open discussions of cases with mutual clients – though serving mutual clients was considered rare. At the same time, some CPS workers from the same and different sites explained that they had minimal to no interaction with NFP to the extent that some caseworkers and supervisors were unaware that NFP was available in their respective community and that collaboration between the two agencies was lacking. Many of the caseworkers who expressed little to no collaboration with NFP attributed the cause as a lack of knowledge and awareness of the NFP program.

One caseworker with regards to strong collaboration said, “We usually sit down face-to-face and have a conversation about what their concerns are. And, what the strengths are and what - What it will look like moving forward. The NFP nurses typically want to know the how, where, when and what of what we’re going to do moving forward, so that they have some ability to impart that information to the family.”

Another caseworker described her limited interactions by saying, “I would love to have more. Honestly we have not had a lot of training yet, emphasis on it. The only time I really have any interaction with them specifically is if there is a medically fragile child or if there is, like, a drug-exposed baby. And typically they contact us in the sense of they’re either going out to the home or their - But honestly the collaboration, I feel like, is very lacking.”

Another supervisor explained, “Well, I believe we have a good working relationship with them when we are jointly involved with families. Whether that’s us reporting to them or um - them reporting to us and then becoming involved. It’s good to, I think they have a pretty good understanding of how to contact us and coordinate with us and things like that. So I think it’s a good collaboration, but like I said it’s not a large number.”

To highlight the variations of collaboration within sites, several supervisors and caseworkers from one site had different perceptions of collaboration with NFP. In this site, a CPS supervisor described not knowing if caseworkers in her site had interacted with clients who had NFP involvement; she perceived that there did not exist any alliances between CPS and NFP in her site. In contrast, several caseworkers from the same site discussed their collaborative interactions with NFP nurses where they had worked closely together to support their mutual clients. One caseworker further explained that it was helpful to understand what one another were providing for their mutual client and to receive occasional updates from the nurse on their mutual client's progress.

One supervisor said, "But, we don't have those alliances. And, we can't - we don't have that relationship, so we couldn't share information anyway."

She went on to state, "Yeah. Totally happenstance. I've never experienced that, either, as a worker or with any of my staff reporting to me that they had a nurse home visitor from your particular program that they were collaborating with in any way. Certainly, we have medically fragile children who have nurse visitors, but they are more from the medical side coming out to support that child in a very focused way."

One caseworker from the same site shared, "Well, the initial - It was helpful inasmuch that, once I'd identified who she was - Or, we met each other, and you know, to try to get on the same page of what she could offer [client name removed] and what the department was doing, but beyond that, it was just updates. She would call and give me an update that she had went out. It was not so much that I had to, honestly, you know, reach out to her, it was great that she was able just to keep me updated."

Several caseworkers and supervisors that served multi-county NFP sites described varying levels of collaboration. A couple of CPS workers from a multi-county site described having minimal knowledge about NFP but had worked with other organizations that were similar to NFP. In contrast, another caseworker from the same multi-county site but a different county described collaborating with their NFP nurse regularly when serving mutual clients, including weekly communications and sharing the client's strengths. Similarly, some caseworkers from another multi-county site described a lack of collaboration with NFP due to challenging interactions with a nurse who openly spoke in the community about her disinterest in working with CPS, while another caseworker from the same multi-county site but a different county described that she had experienced face-to-face interactions with NFP nurses and that the nurses had discussed their concerns with her and other colleagues within CPS.

One Social Services director from a multi-county NFP site stated, "So, that's who she reports to. So, there's a real big disconnect between what [NFP nurse name removed] does and what we're doing here in our county... There's not a lot that goes on there, not a lot of interaction, not a lot... So, [NFP nurse name removed] kind of stays to herself and does her own thing. And, there's been some - And, she's not a team player... And, basically, they - She kind of can come across angry, and so they basically stay away from her."

A caseworker said, “We did weekly communication if there was any concerns, then the nurse would call and let me know. Of course, you know, we had already exchanged information, we’ve already had done the authorization for release of information. The nurse was looked at in the home as a strength. Especially for the mother, she really enjoyed and looked forward to the nurse coming in and asking her a lot of questions and it was helping her a lot.”

Another caseworker shared, “Um, I — I have minimal knowledge. And I’m not sure if this even, um, if this even coincides with one another. We work with a — we, and — and I actually refer a lot of my clients to [community service name removed]. They work with [developmental organization name removed] and they work — um, they have nurses that go into the home and provide nursing services, occupational services. Um, obviously those can be through other agencies like [developmental organization name removed], they — you know, they assess the kids and that sort of thing. So I’m not sure if it’s the same thing. It doesn’t sound like it may be with the same even funded source. I don’t know. Um, but I do work a lot — and I do ask anyone who goes into the home — whether they be nurses, occupational therapists, whomever those service provider is that I keep in contact with them and they keep in contact with me. If they observe anything concerning, nonconcerning. I mean, tell me — I love to hear great news, positives. So, I’m not sure if this is the same thing as Nurse Partnership. It doesn’t appear that it could be.”

Another caseworker said, “Typically my unit’s very involved and I can even tell you just with home healthcare right now maybe not through the Nurse Family Partnership, um, where a child’s got a nurse going out daily. We get releases signed by the family and we are out there communicating. Typically the nurses we rely on heavily. I don’t even know we’re out in the home often because the families tend to act more real around them than they do us, um, and they have her cell phone number so they’ll call if there’s a concern. That kind of stuff. So, typically just getting a release of information is important then we have a lot of contact; so.”

Other perceptions of collaboration between NFP and CPS were expressed by several caseworkers and supervisors in various sites. Of the caseworkers and supervisors who perceived strong collaboration with NFP to exist in their site, many expressed that serving mutual clients had created opportunities for the two agencies to work jointly with families. A couple of caseworkers from different sites also explained that collaboration with NFP was important in their work. In another site, a supervisor explained that collaboration dynamics between NFP and CPS had changed over time, such that initial collaboration was not as strong as it was more recently.

One caseworker regarding collaborative interactions said, “I have had an experience working with Parent Partnership [Nurse Family Partnership] program before. They provide hands-on, you know, parenting help, assisting them the first time, and also the parents, young parents’ needs, specifically, young parents. And, collaboration is very important with them.”

A supervisor said, “It was probably not a good collaboration at the beginning.”

Mutual Clients

As explained previously, some caseworkers and supervisors had collaborated with NFP due to serving mutual clients and viewed the collaboration as positively impacted CPS's image in the community and families' perceptions of CPS. In most sites, some caseworkers utilized NFP nurses as a source of information on their mutual clients and facilitated a team approach towards service provision. Gathering information from NFP nurses was described as a form of collaboration for caseworkers who conducted investigations or assessments as well as those who held ongoing cases. One caseworker described receiving information on a client's baby from an NFP nurse who conducted visits more frequently than the caseworker; this caseworker perceived the nurse to be a second set of eyes and ears in the home, who was able to continuously assess for the client and child's safety. In several other sites, some intake caseworkers explained that they had utilized NFP nurses as collaterals to gather information on the client to assist their investigation. Furthermore, using NFP nurses as a source of information was particularly referenced a few times in two sites in instances when caseworkers had an open case with the mother but not with the child, so that interfacing with NFP helped them gain more information about both mother and child as the case progressed.

One caseworker said, "...just to learn exactly what they're doing, I think it's a great way to team. I mean, as I said before, we're kinda working through this general thought process that we're the bad people that come into their lives, and so, I think that enforcing that partnership with them can only be beneficial. When you've got those supports, and we work together, and you know, you can call me, you can call her, those kinds of things."

Another caseworker shared, "Well, I mean, it's been nice because, like I said, given that I don't have an open Child Welfare case on the baby, it's been nice to get the information from [NFP nurse name removed] on what she's seeing. So, even though I'm not open on the baby, when I do my home visits, of course, I'm going to go see [client name removed]. And, the baby's there. I'm going to be watching their interaction. I'm going to be looking for any safety issues. I'm only required, as a caseworker, to see the client once a month. With [NFP nurse name removed] out there a little bit more, if she were able to, you know, and not as my spy, but that she's a backup."

Another caseworker stated, "I can remember one investigation that I did while I was doing investigations that Nurse Family Partnership was very involved in my investigation process. I don't remember all of the details of what the concerns were. I think it was drug use. And so, when I made - initially made contact with the family and we, you know, we do a full assessment about what's going on and what kind of resources they have. You know, not just looking at the bad things, the abuse or neglect that may be going on, but also the strengths. And, this particular family said that they were working with Nurse Family Partnership and signed a release for me to talk with them. And so, I was really able to gather a lot of information from the Nurse Family Partnership nurse about what they have seen in the family and the concerns that they had and things like that. And, it actually in - in that particular case, it pushed me from - I had a lot of - Because the kids were so little - The kid was so little - I did not have the kid really report anything, so I had mom and dad minimizing what was going on and - and things like.

So, it actually worked talking with the Nursing Family Partnership it gave me information to actually open a case with us. Because they were reporting a lot of concerns that mom and dad were fessing up to basically. And, so it was really nice. I think without that extra set of eyes we may have closed that case and that child may have been continued to, you know, have been subjected to neglect. So, it was nice to have that additional piece of information and - and - and be able to give the services to the family that they needed.”

With regards to collaboration with mutual clients, almost all sites discussed that they required a release of information to facilitate open discussion on the client’s case and treatment plan with NFP nurses. Most caseworkers from different sites were able to obtain consent from NFP nurses, either submitted by the nurses who had their client sign the form or directly from clients themselves. This exchange of consent forms was seen as an important factor in facilitating collaboration by multiple caseworkers across several sites, resulting in improved interactions and an open flow of information between the NFP nurse and CPS caseworker.

One caseworker said, “We did weekly communication if there was any concerns, then the nurse would call and let me know. Of course, you know, we had already exchanged information, we’ve already had done the authorization for release of information.”

Another supervisor stated, “But, for my interactions, it was more of information gathering and sharing. We had releases signed, of course, so that we could share information about progress. And, again, the global assessment of, you know, what - You know, where that particular mother was at within, you know, the program that they were working and stuff. So - And so, my contact was really only, I think, a few contacts before we moved it on. But, if I remember, on the back end, there was some more, you know, actual joint information sharing in person and stuff, so yeah.”

Another supervisor shared, “Typically my unit’s very involved and I can even tell you just with home healthcare right now maybe not through the Nurse Family Partnership, um, where a child’s got a nurse going out daily. We get releases signed by the family and we are out there communicating. Typically the nurses we rely on heavily. I don’t even know we’re out in the home often because the families tend to act more real around them than they do us, um, and they have her cell phone number so they’ll call if there’s a concern. That kind of stuff. So, typically just getting a release of information is important then we have a lot of contact; so.”

A supervisor stated, “So, that she’s never been thrown under the bus. Ever. We keep it very general and seek releases, so that then we can gain that information that we already knew. Um - Which works.”

Other collaborative interactions between NFP and CPS as they related to mutual clients were expressed by several caseworkers and supervisors in a few sites. These CPS workers had conducted joint visits with the NFP nurse and/or invited NFP nurses to team meetings (e.g. TDMs, family engagement meetings or staffings) along with other service providers for discussions and decision making for mutual clients. Having good communication on the progress

being made by the client and NFP presence at various meetings were described by several CPS workers in different sites as beneficial for the client.

One supervisor shared, “That experience was just good collaboration with Nurse Family Partnership. It involved good communication, it involved inviting Nurse Family Partnership to our staffing so like our case consults, or if cases are stuck, kind of where should we go from here kind of thing. So just real good collaboration and communication with NFP and the nurse continued to, you know, be present at our meetings, work with the family, give me feedback on, you know, how things are going with her work in the family. It’s, it was really positive.”

Moreover, several supervisors from one site explained about a unique collaboration they had with their local NFP site as it related to mutual clients. One supervisor explained that she had utilized various techniques to engage with clients who were reported by their NFP nurse. She described seeking general consents to releases to gather information on the client so that the client did not suspect her nurse of making the report. This supervisor recognized the importance of maintaining the nurse-client relationship in the NFP program and had a working relationship with the NFP nurses in her county. In another site, a prevention programs manager shared about collaboration efforts between NFP and the prevention programs in her county. This manager explained that her case managers and the NFP nurses had established working relationships through other partnering for other campaigns in the community. She expressed that collaborative interactions between NFP and CPS prevention programs included: referring clients to NFP whenever eligible, ability to reach one another when an issue arose or when they served a mutual client, and partnering on community-wide prevention efforts; such communications and interactions whether by phone or in person were necessary to maintain working relationships and had helped both case managers and nurses to support their mutual clients.

A supervisor stated, “So, that she’s never been thrown under the bus. Ever. We keep it very general and seek releases, so that then we can gain that information that we already knew. Um - Which works.”

A prevention programs manager from a different site stated, “Yeah, the social workers at the hospital reported. The first one, the family that’s now kind of successful, as successful as I think we can hope for, [prevention worker name removed] went in because they were afraid to send the baby home. The baby also had some health issues and they were afraid that the parents wouldn’t understand some of the health issues. And, so, [prevention worker name removed] went in. Well, because of the work that she and NFP had done, when the second case came up, they just picked up the phone automatically and called [prevention worker name removed] because they had this established relationship, because it’s all about relationships, and then [prevention worker name removed] picks up the phone and called NFP. And, so, in any of those cases, we call.”

The same manager said, “Well, I think that it’s almost a given now that whenever we have a mother with a very young child, it’s automatically a phone call to NFP, saying, ‘I think we have a good referral for you.’ I also think that, when we’re looking at prevention from a level one primary thing, when we’re talking about safe sleep or we’re

talking about leaving kids in cars in hot weather and things like that, I think that's one level of collaboration because we have our finger on the heartbeat of kind of what's going on in the community. But I also think that there's really no limit to the collaboration efforts, as long as people keep communicating and, again, there's no ego in the game."

Training and Consultation

Some caseworkers and supervisors from several sites referenced collaborative interactions with NFP nurses through conducting mandatory reporter trainings and consultations as well as participation in educational opportunities they had to learn about NFP. Mandatory reporter trainings that were conducted with NFP nurses were described by some supervisors and a Child Welfare trainer among several counties to include: the definition of mandatory reporting, the definition of child abuse and neglect, the law, signs of child abuse/neglect, and scenario-based examples.

One deputy director said, "So, I've also done some training for the nurses, and, um, on mandatory reporting. I also am sort of a consultant for them, when they have a problem, they call me or [CPS manager name removed], and just, when they wanna consult and just say, 'I have this situation, what do you think I should do?' and so, they don't get names, but they just say, 'This is the, this is the situation, should I call this in? Should I - What do you think is my best approach?'"

A Child Welfare trainer shared, "And - So, yeah, I think that was it. And then I went, like I said I think it was with our health department... I mean, it was at the Health Department, so I went up there and had training and I think it was good. And I think we had good dialogue because I know that after, I had people, I have had calls from people who worked for Nurse Family Partnership. Because one of the things I throw out in my training is that they, 'You can always call me if you have a question; however, if you think enough to call, I'm probably going to tell you to report it. Like, if you thought enough to think, "Oh, something maybe funky may be going on.'" But I always throw that out like, 'If you have a question about something, if you're not sure what to do, you can certainly call me and run it by me if you want.' So I've had several people do that in the past."

A couple of caseworkers and a couple of supervisors from different sites also spoke extensively about having provided one-on-one consultation to NFP nurses and other community members who were seeking additional education on assessing risk and safety while trying to determine whether or not to make a report to Child Welfare. These workers shared that they typically received calls or emails from NFP after they had provided a training and distributed their contact information. They shared that most calls were regarding a question about whether or not to report. The caller would describe the hypothetical situation and often ask the caseworker or supervisor for feedback. In one site, a supervisor explained that she had consulted with an NFP nurse with regards to safety concerns in the home as a result of IPV. This supervisor strategized with the nurse ways to proceed to allow the nurse to feel comfortable in the residence after an IPV-related incident.

One caseworker shared, “I don’t remember specifically, but I think that I’ve had one nurse call me just to ask hey this is what’s going on. I know when I had the training we had a lot of that open discussion...And, I think it has been since the training that one of the nurses called and said hey this is what’s going on what do you think I should do. Should I report it or not?”

Another caseworker explained, “I mean, it was at the Health Department, so I went up there and had training and I think it was good. And I think we had good dialogue because I know that after, I had people, I have had calls from people who worked for Nurse Family Partnership. Because one of the things I throw out in my training is that they, ‘You can always call me if you have a question; however, if you think enough to call, I’m probably going to tell you to report it. Like, if you thought enough to think, “Oh, something maybe funky may be going on.”’ But I always throw that out, like if you have a question about something, if you’re not sure what to do, you can certainly call me and run it by me if you want, so I’ve had several people do that in the past.”

A deputy director stated, “So, I’ve also done some training for the nurses, and, um, on mandatory reporting. I also am sort of a consultant for them, when they have a problem, they call me or [other supervisor’s name removed], and just, when they wanna consult and just say ‘I have this situation, what do you think I should do?’ and so, they don’t get names, but they just say ‘This is the, this is the situation, should I call this in? Should I- What do you think is my best approach?’ So I serve in that capacity

A supervisor said, “... or, um, if there’s domestic violence, sometimes I’ve been called about, um, the nurse kinda feeling unsafe in the residence, and how to strategize about that. Um, what to do, how would, you know, how could the nurse feel comfortable being safe in the environment, um.”

In addition, multiple caseworkers and supervisors from some sites described formal educational opportunities such as trainings, receiving presentations during their regular meetings (e.g., unit or division meetings), and collaborative meetings where they had jointly discussed how referrals to NFP could be integrated into the work flow of CPS. A caseworker and supervisor from different sites also shared about informal educational opportunities they had encountered such as nurses sharing about their work when they had stopped by the caseworker’s office or ran into the caseworker at a client’s home or through conversations with colleagues. These were some examples of collaborative opportunities related to informal and formal education about the NFP as explained by several caseworkers and supervisors across multiple sites.

A supervisor shared, “In our collaborative meeting, we took time to really kind of process-map what a referral from Child Welfare looks like and where could you implement - You know, where would you start pulling in that- The NFP service referral, we process-mapped the assessment.”

One caseworker stated, “And I know that they were invited to present to our quarterly meeting. We have a mandatory quarterly meeting...And I know they presented at one point, but I was not there at that one.”

Another caseworker explained, “I went out to the house and the nurse was there since she was from Nurse Family Partnership. So that’s where I kind of learned a little bit of it...I thought this is great! Let’s just throw them in everywhere and I haven’t had an opportunity to yet since that family that I had in my caseload, but I’ve been thinking about them knowing that they’re there next time we see a baby let’s try to get them in and I’ve talked to a couple of my coworkers, ‘hey try this.’ And that’s where now I’m learning that, this time frame, has to be first-time parents. All the rules...”

Barriers to Collaboration

Many CPS caseworkers and supervisors across most sites expressed similar barriers to effective collaboration. Many caseworkers and supervisors from many sites shared that they lacked awareness and knowledge of the NFP program, including incorrect knowledge and confusion with other programs, and had little to no contact with NFP. In addition, the greatest challenge to collaboration between CPS and NFP described by most caseworkers and supervisors across all sites was NFP’s strict program eligibility (first-time mothers) and short enrolment period (up to 30 days postpartum). Some additional challenges related to the NFP program were also shared by some caseworkers in some sites; these included the voluntary nature of the program and nurses’ refusal to accept a CPS referral (e.g. due to stigma of CPS, waitlists, or without reason). Among several sites, some caseworkers also explained that NFP lacked knowledge in CPS functions and caseworker roles, as well as a displayed reluctance and perhaps a lack of knowledge in mandatory reporting. With regards to mutual clients, some caseworkers in some sites explained that confidentiality and communication challenges existed including time, scheduling, busy caseloads, and nurse turnover. Finally, preconceived notions and stigma associated with CPS as well as families not wanting to participate in NFP were shared as additional challenges to collaboration by many caseworkers and supervisors in most sites.

Lack of Knowledge and Interactions

One main barrier to collaboration between CPS and NFP was described by many caseworkers and supervisors across many sites as their lack of awareness, knowledge, and interactions with the NFP program. As previously explained, many caseworkers and supervisors across most sites shared about having little to no knowledge of the NFP program, including the role of nurse home visitors, program eligibility, program duration, and referral processes, and some were not aware that NFP was available in and serving their county. Several caseworkers and family advocates from different sites explained that NFP was not widely known in their county and as such was not used as effectively as it should be. Among sites with some caseworkers and supervisors who had heard of NFP, there existed some confusion between NFP and other health-related or home-visiting programs such as SafeCare. A couple of caseworkers and supervisors from various sites also explained that they had heard about NFP but once they learned that it was only for first-time mothers, they lost their interest in learning about the program or infrequently used this service.

One caseworker stated, “Um, I think one good thing to have would be to know who’s there. I don’t even know who’s our nurse in this community for that.”

Another caseworker shared, “But I honestly, with DHS, we don’t even know the first step. I wouldn’t know the first step of how to contact them—or how to even utilize the services. It’s one of those things that’s totally off our radar.”

Another caseworker explained, “See, that’s what I’m saying, like we need to, I’m thinking they’re somewhere across town or something... Yes, you can. So you can go down and recommend. See, that’s what I’m saying, the educational. I bet so many of us don’t know they’re downstairs... That’s a huge disconnect, like, like, like, what? I can go downstairs and say, ‘Hey guys, I’ve got a family, you guys.’”

A supervisor regarding confusion of NFP with other programs stated, “Um, we will make referrals to them if we have like a young family that just kind of seems clueless. But, really doesn’t need our intervention. We’ll make referrals, you know, we had - And, to this date, I get confused about the different nurse programs.”

Another supervisor shared, “I think we just need to educate ourselves more on it as well; so - I don’t think a lot of people — I don’t even know all the criteria. I know bits and pieces. Because once I heard, ‘Oh first child’ and I was, ‘Okay’...”

Some caseworkers and supervisors in a couple of sites expressed that they had received little to no contact from NFP nurses. In one county in particular, workers perceived that the designated NFP nurse for their county was unwilling to collaborate with CPS, based on her vocalizations to other providers to not work with CPS, reluctance and/or refusal to accept a referral from CPS, and delaying the enrollment period for a CPS referral such that the client was no longer eligible. Several supervisors and caseworkers in some other sites further explained that there was no relationship with the NFP program, that no liaison for working with NFP existed, or that their department lacked an individual who could update available community resources to include NFP.

One supervisor shared, “I’ve never experienced that, either, as a worker or with any of my staff reporting to me that they had a nurse home visitor from your particular program that they were collaborating with in any way... But, we don’t have those alliances. And, we can’t – we don’t have that relationship, so we couldn’t share information anyway.”

Another manager stated, “So, I – the entire time I’ve worked in Child Protection and have been in like a supervisory or management role, I have never experienced any partnership with Nurse Family Partnership program in our agency.”

Another supervisor explained, “...so the information we’re getting is from our Nurse Family Partnership person who does not want to work with Child Welfare. She is very clear about that and is public about that... She has told other providers in the community that they shouldn’t want to work with Child Welfare and she tries to avoid it all costs.”

She went on to share, “...but it was obvious that this person needed some education and support about raising an infant, so we told her about Nurse Family Partnership and she said she knew about it. So, [caseworker name removed] was the caseworker at the time. He was like, ‘Great. Well I’ll call in the referral so that she knows that you’re going to

reach out to her.’ So he did, and that’s when [NFP nurse name removed] said, ‘I can’t take that client because you’re forcing them to come.’ And so [caseworker name removed] educated her about what force means and, ‘We’re not forcing them. We’re offering this as a service, like this is a pretty low risk family. I don’t even think we’re going to have an open case, but we would like them to have resources when we’re out of their life. They need help. I don’t think they realize how hard it is to have an infant.’ ... So the client reached out to her and she never followed up with [caseworker name removed] again. So [caseworker name removed] called again and said, ‘You know, are you going to get engaged with this family?’ And she was like, ‘Well, they called but I haven’t met with them.’ And [caseworker name removed] was like, ‘Well, isn’t there a deadline for them to get into your program?’ And she’s like, ‘Yeah.’ And he goes, ‘Well, I would hope that you meet with them before that deadline.’ And she didn’t and so, then, the family said that when she did finally call them back, it was past the deadline and they couldn’t get in.”

A department director from the same county shared, “And, there’s been no interaction or collaboration with the Child Welfare staff. And so, it’s - And, it’s been pretty negative. And so, it’s been difficult.”

NFP Program-related Challenges

Beyond lacking knowledge or interactions with the NFP, the main challenge to collaboration as related to the NFP program model was program eligibility (being a first-time mother). Almost all caseworkers and supervisors from all sites explained that the greatest barrier to collaboration was this strict criterion for participation in the program. The reason that program eligibility was a barrier was that many caseworkers from many sites shared that they seldom worked with first-time mothers, were never involved with pregnant mothers (unless a child was already present in the home – which would make the prospective client ineligible for NFP), and therefore had few common clients with NFP. Several supervisors and the director from one site explained that they had greater success enrolling children in foster care who were pregnant (be it in placement or in home) to NFP than those who were referred through intake. These higher-level CPS workers shared that clients referred to NFP through intake tended to be resistant to participating in the program and that the timing for referral had not always been appropriate. The inability to enroll the majority of their clients into NFP – a service that was perceived as beneficial – was frustrating and even perceived as an ineffective program by some caseworkers across multiple sites.

One Child Welfare manager explained, “The difficulty that we have with Nurse Family Partnership and Child Protection is because their limitations of what they work with is first-time parents and the child if they have to generally they like to be involved with the family before the child is born, but the law in the state of Colorado says that a child is not a child until it breathes its first breath of air meaning that child abuse does not happen until that day that they’re born so there is not anything that we can do with families prior to that first breath of air. The only exception of that would be if a woman is pregnant and she has other children but then that would put them out for Nurse Family Partnership.”

Another supervisor shared, “This was the point that was brought up with Nurse Family Partnership. It’s not just us. And what we get is, ‘That’s the model. Evidence based. This is how it works best and with first kids.’ You know, I’ve even seen people say what’s if it’s the first child mother’s been allowed to raise? You know, the baby was taken from her at birth. Nope. If she gave birth and this is her second birth, live birth, I think. They won’t take it.”

A caseworker stated, “No, I think the only one would be sometimes availability. You know, uh, I don’t think we’ve needed it a whole lot because we don’t always, and being a smaller community, we don’t always have a lot of uh, people, having babies or just having had babies.”

Another caseworker shared, “I know that it exists and we’ve had some training on it. I also know that it is only, is available for first-time moms, which is a huge barrier and I think makes it quite ineffective. I have quite a few moms that I think will benefit from it but are now ineligible because they have already had a child... And that’s something that we gripe about all the time.”

Related to program enrollment, some caseworkers from some sites explained that timely referrals and lack of referral follow up were additional challenges they had faced with regards to collaboration with NFP. In the state of Colorado, referrals to NFP could be made up to 30 days postpartum. However, some caseworkers across multiple sites explained that they often did not become involved with a family until the infant was older than 30 days and/or it took time for the intake worker to determine whether or not a referral to NFP would be beneficial for the family because they did not want to overwhelm clients with too many services. Even among cases where the first-born infant was less than 30 days old, several caseworkers among different sites shared that their referrals to NFP were not accepted due to various issues. These issues related to nurse unavailability, delay of enrolment until the infant was no longer eligible, or lack of referral follow up such that the caseworker did not know if the family ever enrolled in the NFP program. These instances were frustrating for the CPS caseworkers who had made the referrals because they felt that the eligible family would have benefitted from participating in NFP but were not given the opportunity to do so, possibly due to their involvement with CPS.

A caseworker shared, “I wish, yeah and I wish it could because I think that’s the hard part in our role is that we might not get to a baby within the first 30 days. Um if we do we may get legally involved if it’s something that significant. It’s just hard to tell that quickly for us as intake workers... Otherwise again it’s we don’t just go out there and say, ‘Hey I’m [caseworker name removed] with DHS let me give you all these referrals. First, we have to do part of our investigation and see if they would even benefit from something like that. And so depending on how long it takes us to find a family, they don’t answer their door or their phone, we can’t give them that referral.”

One supervisor explained, “I know about Nurse Family Partnership and what it’s supposed to do, but we, as a county, since I’ve been here, have never collaborated on a case. We tried once, and she refused the referral because she said we were forcing the client to go, and the caseworker explained that it was a voluntary case, that we have treatment plan goals and their program would help them with that goal. And so they

reached out to get in the program. It wasn't like, 'You have to go do this.' It was, 'This is something that will help you with this goal.' And she fought with us to the point where they didn't qualify because it passed the number of days that the client could get in... So we have been referring to our other program that helps women in postpartum up to a year, so we've just been referring to that program and then, if that program sees that she qualifies for Nurse Family Partnership because it's under Public Health, then they can get her into Nurse Family Partnership. But typically, if they're an open Child Welfare case, she won't work with them."

Another supervisor recalled, "We have made referrals to Nurse Family Partnership before within the specified time of 30 days of the child's birth, and they have not been accepted and we were told they were too busy. And then we were told later that that was not true. So that's our main frustration is that they're not accepting everything that we're sending in time, we've sent things in time and then held onto it just for say five days, which made it then later than the 30 days."

She goes on to share, "Um, I don't think there is much of a relationship. We make referrals to them and then we don't hear from them again... So it would be very useful to know - Well first of all I'd like to know, 'Yes, we received your referral and yes it meets the timeline and we will be looking at it.' Or, 'Yes, we received your referral and we will be going out tomorrow or something.' But we don't — we never hear back. We have to call them and say, 'Did you accept it?' and they don't call us back very well either... I hear that — I hear that from caseworkers all the time. They've left messages, 'Hey, are you going to go out and see Susie Smith? I made a referral. Can you call me back?' And they don't hear anything."

Other challenges to collaboration related to the NFP program structure and processes were also expressed by several caseworkers and supervisors across various sites. Some caseworkers from several sites questioned how court-ordered clients would be able to participate in a voluntary program like NFP; one caseworker elaborated that voluntary engagement in programs for CPS clients was very difficult to facilitate. Some caseworkers and supervisors in multiple sites had also experienced waiting lists due nurses' inability to take on new clients and perceived that NFP lacked funding or that there was high nurse turnover. Furthermore, one supervisor shared that if NFP functioned as a preventive program, CPS should not be serving the same clients, thereby limiting the opportunities to collaborate. Another supervisor from this site explained that common clients between CPS and NFP were probably more limited than expected.

A caseworker shared, "But we get involved not voluntarily though. We get involved because obviously there's a safety concern ... But definitely this nursing program sounds very beneficial, um, to the community here in [county name removed] and if mothers would take advantage of that, obviously it's voluntary. When you say voluntary — by the way, I think, 'Voluntary oh, great.' You know, it's hard for us to get people to voluntarily engage..."

One deputy director shared, "It's, uh, they have fewer nurses than they have had in the past, and so I don't always think it's as easy to collaborate when your program gets cut a lot..."

Another supervisor explained, “I know turnover is a big thing and that’s the hard part when it’s always someone different. You know, you get a card from someone and then that person leaves so then you don’t know who to contact or - you know, it’d be nice having one contact person where — I think that’s what works with a lot of our resources here is we know who to call and we know who to talk to. So — and I know that’s hard in the bigger counties. They tend to have turnover.”

Another supervisor stated, “And, if they’re - You know, if the objective—and, I’m not quite sure what the objective of NFP is currently—is really in the line of prevention, then we shouldn’t see those people.”

Another supervisor expressed, “I think it’s not as - Probably not as widely used as we may be presuming it is. Although I think our customer base probably has some intersection with it, but they probably intersect less than we think they do.”

There existed several other challenges for multi-county NFP sites. In one site, some directors and supervisors were frustrated that there lacked oversight and accountability of the designated NFP nurse in their county since the NFP site was housed out of another county. In another multi-county site, some supervisors expressed that the NFP nurses had forgotten about their county as a source of potential referrals for the program.

One Social Services director explained, “So, that’s who she reports to. So, there’s a real big disconnect between what [NFP nurse name removed] does and what we’re doing here in our county. So, [public health director name removed] provides oversight, semi-supervision, but it’s kind of – there’s not a lot that goes on there, not a lot of interaction, not a lot - there’s not a lot of accountability to [public health director name removed]. It’s mainly to [county name removed]. So, [NFP nurse name removed] kind of stays to herself and does her own thing... Well, I don’t know. I mean, um, I think having the structure where [NFP nurse name removed] is under the direct supervision and accountability with [county name removed] is not a good system. It doesn’t work. I think having the structure where she is more under the county system and maybe under public health nurses and that, it’s like, ‘Hey, you’re part of us. You’re part of the county.’ So, there’s this kind of like she’s really under [county name removed], and that she reports to them, and so she kind of gives this sense of, you know, ‘I don’t really have to talk to you guys.’ “

Another supervisor shared, “They’re great in-home providers and we say, ‘Good we need you to see somebody in [location name removed].’ And they go well, you know, maybe not. So they forget about us and you know...”

NFP Nurses as a Challenge

Beyond programmatic challenges to collaboration, some caseworkers among some sites shared additional barriers that related to NFP nurses such as their knowledge, perceptions, individual attitudes, and job functions. Among some caseworkers in several sites, there existed a perception that many NFP nurses lacked knowledge of CPS processes and caseworker roles. For instance, a couple of caseworkers from different sites explained that some NFP nurses had disagreed with

decisions to investigate, open a case, and/or treatment plans for clients because of differing perspectives in what warranted a CPS response and/or involvement. In one case where the nurse had opposing views from the caseworker on the severity of safety and risks, a supervisor felt that because of how a case was handled, the NFP nurse had become more reluctant in making future mandatory reports. In another example, a caseworker shared that opposing views created conflict because she was unable to immediately make a decision on the case. She also suggested that there could be potential challenges if a nurse did not fully understand the caseworker's role and tried to take over developing the treatment plan for the client. Another caseworker from a different site also explained that disagreement on a service plan could be potentially detrimental to the client because of a disruption in service delivery. Finally another caseworker shared that some nurses had gotten frustrated when CPS did not address their concerns, usually in situations where the nurse did not recognize that CPS only addressed safety and not issues related to risk.

A Child Welfare manager shared, "You know, I think there's one case where she was involved, you know, I kinda heard from the worker, the supervisors that Nurse Family Partnership at the very beginning that particular nurse may not, may not have understood the seriousness of our concerns and you know, with advocating-"

Another manager stated, "...but I also recognize that there are a lot of people in the medical field, nurses, who don't understand what Child Welfare does, and there's a lot of concern there, they don't feel that our department, Department of Social Services responds in the manner which they think that we should in working with children and families. And I don't think they realize why and how we respond to needs when they call us."

One caseworker explained, "And then, also, with the nurses understanding we are the caseworker, not the – we are the caseworker, not the guardian ad litem, not the judge. We are the caseworker. Our badges are somewhat powerful, but not as powerful as you want us to be. We can't always jump on a decision because there – like, I said on this case, two attorneys and a judge and a whole bunch of other people on one case. But I can see potential, the problem is, 'You're the nurse. You cannot direct my treatment plan. You can't run my case. You can tell me, 'Well, I don't think she should be at home with her whatever, his ever' - Well, thank you for your opinion, but unless you see a safety issue, or they're in immediate risk, thank you for the heads up. I'll address with it everybody, but you are not the caseworker.'"

Another caseworker shared, "...I don't know if this would come up but it could come up — maybe just not agreeing on what sort of services should be provided to parents or just not having that dialog or, um- Obviously as a caseworker, you see safety first, but you see other things and sometimes when we have, um — I want to say it's always positive but it's not when we have other agencies going into the home. They may disagree and it can cause a conflict or some sort of, um, large disagreement on a higher scale. But, I don't know, that could be something that potentially could, um, disrupt services or at least not — it not be a good, um, I trying to think of words — at least it not be a good experience for the families. I don't know if that's something that would come up."

A couple of caseworkers and a supervisor from different sites explained about other perceptions that they believed NFP nurses had about CPS that inhibited collaboration. One caseworker thought that NFP nurses perceived CPS to be a “black box” where no information was shared, while a supervisor from another site felt that NFP did not perceive nor effectively utilize CPS as a resource.

A supervisor about using CPS as a resource shared, “But that’s something that we’ve been working on, so it would be awesome if she felt comfortable using that now because a lot of the nurses and doctors are now using that, and really all we want to do is support the families so their children aren’t abused and neglected.”

In addition, some caseworkers and supervisors across several sites explained about their perceptions of challenges in collaborating with NFP nurses as it related to their mandatory reporting responsibilities. Some caseworkers and supervisors explained that they seldom interacted with NFP nurses because NFP nurses made infrequent reports to CPS and tended to be reluctant in making a mandatory report about their client with fear that a report would damage the nurse-client relationship. In fact, a couple of caseworkers from various sites perceived that some NFP nurses had self-blamed for not being able to uphold their prevention role when they needed to report a client to CPS.

A caseworker explained, “I don’t remember getting a whole lot of reports from Nurse Family Partnership from, about child abuse or neglect unless they do more down in [location name removed]. ’Cause I don’t think they’re up here a whole lot.”

Another caseworker stated, “Because of that relationship, that they want to - because of the fear and the—sometimes the reality—that, once a report is made, that that relationship is devastated. So, I feel as though, on some level, there is a lot of reluctance from people that have those kinds of relationships with their clients to make reports.”

Another caseworker shared, “But, and then, the nurses of course really struggle with something does happen and CPS has to intervene, then sometimes they’re like trying to figure out, is there something that I coulda done differently, or was there something, and, um, you know, what I try to say is, ‘Everything that you do is, is in an effort to keep this baby home, and so you can’t look at it like that, because people are responsible for their behavior.’”

A couple of caseworkers and supervisors in some sites also expressed concern that NFP nurses were not adequately upholding their responsibilities as mandatory reporters, such that they waited too long to report and/or did not assess safety and risk at the same level as CPS. In one site, one supervisor explained that due to a nurse’s experience as a witness in a jury trial, she had become more reluctant in making mandatory reports. In this case, the nurse’s identity as the mandatory reporter for the trial case was revealed, the nurse was placed in a difficult position, and the client subsequently declined further participation in the NFP program. This supervisor explained that she understood how difficult situations could become for nurses when they needed to report, negatively impacting their relationship with their clients.

One supervisor shared, “Well I, I always, um, felt like she was reluctant to call us, like she, um, and this isn’t just her, we get this from lots people who work with clients, I mean the schools, I mean other people who make referrals to us, who are mandatory reporters who are nervous about doing that because it impacts their relationship with their client. And she was no different than that, in terms of my interaction with her. It felt like there were times when, um, she would make a referral and we would think, ‘Why did you wait so long?’ Or we would find out, we would get a referral from another source and find out she was involved and wonder why she hadn’t called us. And so, and I think that there was some conflict between the case workers and her at times around those types of things, which probably made her more reluctant to call, you know.”

Another supervisor shared, “But, you know, in this last one, jury trial - well, you’ve got to reveal your reporter, and unfortunately, couldn’t keep her out of it and- (*laughs*) So, that was tough. And now, she’s kind of scared to make reports. Because she lost those clients because of it and... And so, as part of that jury trial, um, you know, ‘How long have you known about this family?’ came out. And, ‘Who contacted you initially on this family?’ So, at that point, we had to disclose... Um - And then, (*laughs*) - So, that made it very, very uncomfortable. And, she was in the courtroom. She saw that. And then, they started saying untruths about [NFP nurse name removed]. These people were testifying to stuff that just wasn’t true. And - because they were upset at her. And - and so, that whole relationship just fell apart. You could see it before your eyes. It was sad. It’s never been rebuilt. It won’t be. Um...But, I have no doubt, if she needs to make a report, she will make the report. I mean, that will still happen, it’s just - it’s, it - You know, she’s gun-shy. She’s trigger-shy. And, I don’t blame her. You know, it was ugly. And, she got clo—right in the middle of it.”

In addition, several caseworkers and supervisors from some sites explained that NFP nurse’s level of transparency with clients when reporting was a barrier to collaboration. A caseworker from one site felt that transparency with clients was sometimes detrimental to her investigation because the element of surprise was sometimes needed, while a supervisor from a different site suggested that she preferred NFP nurses to be transparent with their client but understood the need to maintain the nurse-client relationship.

Regarding nurses transparency with clients on making a mandated report, one caseworker explained, “I think that I - there are certain scenarios where that can be very detrimental to an investigation. But, a lot of times, I think that’s the reporting party’s prerogative. Schools will- I know that’s slightly different, but you know, obviously, the NFP nurse tends to have the relationship with the parents... They’re typically letting the parents know that they’ve making that report whereas schools will let the victim know that they’re making the report and not necessarily the parents, so.”

Another supervisor shared, “So, I prefer that, but I also know why it can’t always happen that way.”

Mutual Clients

Some caseworkers from some sites shared about challenges related to collaborating with NFP nurses when working with mutual clients. These challenges were mostly related to confidentiality, communication, and time or scheduling. With the issue of confidentiality, some caseworkers across different sites explained that HIPAA and other laws prohibited them from sharing specific case information and details with other providers. Even when a consent form from the client was signed and shared, some caseworkers and supervisors from several sites explained that they were unsure about what information was shareable or not. In some cases, a couple of supervisors and caseworkers from different sites explained that a mutual client had revoked permission to share information with other providers. Several supervisors and managers from a couple of sites also shared that they were unable to make referrals to NFP when a pregnant woman was reported but screened-out due to confidentiality concerns.

One supervisor shared, “That way, yes. But I know Nurse Family Partnership is much easier, kind of, but I don’t know that there are, what barriers there would be. Confidentiality is always a barrier. Can I give this information or can I not? I know that was something that we talked about before. How much information can you share without a release of information so.”

Another caseworker explained, “And so that’s difficult to coordinate. And there was some confusion at the beginning about what, like, how much I could tell her, you know, versus not. And then she has a release.”

Another caseworker stated, “Well, it’s just - You know, part of the same things, I know some of them are bound by confidentiality on both sides...And, protected health information on both sides is what we can and cannot share, but nurse - You know, from both ends, understanding there’s only so much information we can give each other, but let’s share that information. I’m not gonna - I don’t need her medical - Well, I can get her medical history if I wanted it. I’m a caseworker. But, if there’s something you see, please let me - You know, that’s - They’re mandatory reporters. I understand that.”

A Child Welfare manager shared, “It would be nice to be able to contact NFP with names and information regarding those families that they could reach out to, but because of confidentiality we cannot do that. And so that’s probably one of the biggest concerns that I might have regarding catching those families that we do know about before the child is born, but we can’t do much with a referral or anything else until that time.”

Challenges related to communication were usually expressed around ineffective, lack of, or miscommunication. Some caseworkers from some sites explained that nurses and caseworkers were often in the field and unable to timely respond to phone calls; this lack of availability whether by the nurse or by the caseworker was perceived by CPS workers to be a challenge. In addition, scheduling issues due to time constraints, conflicting appointments (such as cases requiring immediate responses or court time), or busy caseloads contributed to more communication challenges because caseworkers were unable to effectively interact with nurses. Several caseworkers from various sites admitted that they were often difficult to get a hold of and were stuck in their world of individual casework. A couple supervisors and managers from

various sites explained that individual caseworker attitudes as they related to willingness to communicate with NFP nurses on mutual client updates were another barrier. One caseworker explained that she preferred frequent contact with her client's service providers but that other caseworkers only wanted major updates regarding the client's progress. Another communication-related challenge was expressed by a couple of caseworkers in some sites that the client may not be effectively communicating with the caseworker and/or nurse, for example the client may not tell the nurse that she had an open case with CPS. Some supervisors from one site also shared that due to lack of communication, they had not received updated contact information for NFP which had resulted in referrals being made to the wrong fax number.

One caseworker shared, "Well I, you know, I, the tough part is that with the busyness of this job, the constant pace and high caseloads, I mean, I think it can vary from day to day (*laughing*). Y-you can have a really crazy day and have no time for anything outside of what I have to do..."

Another caseworker expressed, "But just communication could be a barrier and also could be — it could be a barrier if it's not used appropriately and it could obviously be something that could make this whole experience productive and work well. So it just depends how — I think communication is huge."

Another caseworker stated, "Mm-hmm. And so she's—she's the one—who, you know, she's got a lot of knowledge on it. It's been a hard and difficult to, like, coordinate schedules because she's constantly going out and visiting and we're constantly going out."

A supervisor shared, "I don't see any barriers other than if case workers were not inviting NFP workers to like meetings and not keeping them in the loop and then vice versa if NFP wasn't, I mean really the only barrier I would see is if the communication wasn't effective."

In a couple of sites, some caseworkers and supervisors explained that another barrier to collaboration with NFP revolved around knowing when a client being investigated by CPS had already been participating in NFP. Not knowing when a client had been involved with NFP was a barrier for several reasons. Because many caseworkers perceived participation in NFP as a strength and that nurses tended to have a good knowledge of the client's risks, when they did not know the client had been involved with NFP they were unable to accurately assess the safety and risks for the case or to appropriately refer the client to community resources.

One caseworker explained, "I think the only problem is that initially, how do we find out that they are in there, 'cause sometimes there's a gap in that knowledge that they're already in there and they're working. And so it's, that's where I would love to have a little more information, is if we could find a way to, when that referral comes through. So."

A supervisor regarding the value of the nurse perspective shared, "I think it'll be better because things are missed now, and they see everything, like I said. So, if they [caseworkers] get a referral, and it looks like NFP's involved, then they can contact them right away and say, 'This is the referral we got,' that kind of thing."

Stigma and Preconceived Notions

In addition to organizational and individual behavioral challenges, several caseworkers and supervisors across different sites explained about stigma and preconceived notions as additional barriers to collaboration. These caseworkers and supervisors from several sites shared that their county's health department had at times wanted separation from Human Services due to stigma associated with CPS. Some other caseworkers from some sites also explained that community members, clients, and even NFP nurses had preconceived notions of CPS as an entity that removed children from homes, or that CPS had in the past not been collaborative with community members such as not involving community partners to their meetings. In such instances where NFP nurses and/or their clients perceived CPS negatively, some caseworkers and supervisors explained that NFP may not want to collaborate with an agency that was not as well-received in the community with concern that clients would decline participation in NFP and/or view NFP as the enemy.

One prevention case manager explained, "And the second challenge is probably more, which I think would work out, is that people come in with preconceived notions of what each agency does, and that's a challenge to begin with, but I think if you know, the more time that's spent collaborating, the more of those dissolve and go."

A director stated, "There's also this thing with the stigma around Child Welfare that [NFP nurse name removed] keeps holding onto, that we've talked to her about, tried to make some inroads about, you know, 'We're not bad people here. Caseworkers aren't bad people,' but she still perpetuates that kind of stigma of, 'Child Welfare is just taking kids away. None of my clients want to be associated with Child Welfare,' and we get that from another entity in the community, and it's really come down to their own personal issues..."

Another supervisor shared, "And, um, the only thing that would worry me is say that the nurse goes with Child Protection, some families don't like Child Protection, so maybe they wouldn't be as nice to the nurse as they would be otherwise. But, I don't think that's happened yet. But, that would be my only worry."

Another supervisor stated, "...because I think part of what the issue was- was that agencies were butting heads- I think they had good intent when they started it, but they didn't think through the details. And then, it kind of - One of the things that was really clear to me is that the Health Department didn't want to be attached to Child Welfare. They didn't want - they weren't willing to have the Department of Human Services on the release ultimately, and it fell completely apart."

Finally, a couple of caseworkers from a couple of sites shared that clients may have negative preconceived notions about the NFP program or did not understand the role of NFP nurses, leading to an unwillingness to participating in the program. These perceptions were expressed to be a barrier for collaboration when CPS workers wanted to refer clients to NFP, because NFP was a voluntary program and clients needed to be willing to participate as compared to other CPS services that were mandatory.

One caseworker explained, “And, what’s really sad I think for a lot of the nurses that do go out to the homes is the fact that some of the families really don’t understand what their role is, even though you try to explain it to the families. And, the families think, ‘Oh yeah, you know, go ahead.’ You can do this and you can do that and try to order them around to do stuff.”

A prevention case manager shared, “The barriers lie within the clients because they have to agree - they have to want to participate in the services.”

Other Barriers to Collaboration

Some additional challenges arose for a few CPS workers in various sites. Among some caseworkers and supervisors from these sites, there existed a perspective that if a community program or resource (such as NFP) was not regularly utilized or particularly relevant for the majority of their clients, many caseworkers often forgot that it was even available. A couple of caseworkers from one site also expressed that sometimes there existed too many resources to keep track of, continuously learn about, and recall as available for clients.

A prevention case manager regarding caseworkers forgetting about resources shared, “They kind of need a booster because there’s so much available, it’s easy to lose sight. You know of zone in on what you’re using at the time, and then six months later, you kind of forget what other programs have to offer the families.”

Another caseworker explained, “I think one of the reasons, for me, is that there’s actually probably more than one reason. One reason is sometimes I just forget it’s out there, to be honest.”

In another site, a manager explained that there was previously strong collaboration between CPS and NFP but once the NFP nurse supervisor left the program, collaboration slowly deteriorated. In comparison, a supervisor from another site shared that previous collaboration with NFP was challenging and territorial but had improved over time. Several higher-level managers from another site explained that individual caseworker attitudes may inhibit collaboration with NFP simply because some caseworkers were unwilling to collaborate with NFP and/or only referred to specific service providers. Indeed, a manager of prevention programs shared that ego could play a factor in preventing collaboration if a caseworker or nurse was overly protective of their own client.

A division director shared, “So — so given that, um, some of the barriers that I see is that we’re also set in our ways a lot of times. And so some of the workers that don’t refer just don’t refer and don’t think about it. Some — because we have our favorites.”

A prevention programs manager explained, “But I also think that there’s really no limit to the collaboration efforts, as long as people keep communicating and, again, there’s no ego in the game. I’ve worked in agencies where there’s, ‘This is my client.’ Or, ‘That’s your client.’”

Some additional challenges were also expressed by various supervisors in different sites. One supervisor perceived that information regarding the NFP program did not necessarily filter down to the caseworker or supervisor levels, while a program manager from a different site explained that the size of the county may inhibit collaborative efforts with NFP, such that collaboration with larger counties with more workers and more CPS reports would be more challenging. Finally, a director from a multi-county site explained that although he was aware of the NFP program, neither him nor NFP nurses had initiated collaborative efforts especially due to other priorities and responsibilities for his county.

A supervisor explained, “And [director name removed] may get that information at the regular meeting that she goes to. I’m sure they report out who they’re serving. It just may not filter down to our level...”

A prevention programs manager shared, “I think size of the county has a lot to do with it. I think that this might be more difficult when you’re looking at a size, county like [large county name removed] or [large county name removed], where there’s just so many people and so many referrals coming in all the time.”

A director stated, “And, I think that that’s both of our responsibilities and, unfortunately, I – you know, I just haven’t heard from anybody, but you know, that’s on me too. I haven’t reached out and I know that they exist as well. It’s just – there’s other front-burner issues that are priorities for our caseworkers.”

No Barriers to Collaboration

Several caseworkers from one site did not perceive there to be any barriers to collaborating with NFP. In fact, these caseworkers felt that they wanted to learn about as many services as possible to better coordinate services to benefit their clients.

One caseworker stated, “If it’s there and available, and I mean, a nurse is a medical professional, you know? They’re - They’ve seen it all. I mean, they’re - They’re like social workers, you know, they have a lot of characteristics, you know, a lot of job duties we have, you know? So, yeah, I don’t know why there would be barriers.”

Another caseworker shared, “I honestly don’t see any barriers working with the nurse practitioners [Nurse Family Partnership].”

CPS Perspectives of Opportunities for Collaboration

Among most caseworkers and supervisors in all CPS sites, the belief that opportunity to collaborate with NFP or to strengthen existing collaboration efforts was prevalent. Opportunities suggested by CPS workers included establishing a relationship with NFP as a whole through education and ongoing contact, clarification of information, increased referrals to NFP, troubleshooting or consultation in broader areas than sites currently have, and programmatic changes for NFP.

Benefits of NFP

Almost all caseworkers and supervisors from all sites viewed NFP as an opportunity to be a second set of eyes in the home as well as support in the home; especially for pregnant or parenting teens and young moms in general. The majority of CPS caseworkers in multiple sites saw NFP as playing a helpful role in educating parents on child needs and medical diagnoses, as well as appropriate care. It was suggested that parents were able to have their questions answered by NFP nurses without feeling intimidated to ask CPS caseworkers. Many caseworkers from various sites also expressed NFP as beneficial for assessing whether or not a family was adhering to a child's medical needs for failure to thrive cases; to the extent that NFP nurses often provided a different perspective on a family which was beneficial for caseworkers. Within several sites, many caseworkers suggested that NFP nurses could educate caseworkers on a variety of medical information and provide guidance on items including medical diagnoses such as failure to thrive and premature infants, appropriate care, appropriate child development, immunization recommendations, and drug effects during pregnancy. Several caseworkers and supervisors from one site consistently expressed that NFP provided the healthcare piece to the table, which was helpful especially for the less seasoned workers so that they had resources to educate families on basic parenting skills.

One CPS supervisor stated, "Yeah, absolutely. I mean, I feel like for me and my assessment it was just another collaboration, another like set of eyes on our case and someone that is really out there in the field meeting with families, checking the babies' wellness, educating families, you know. Yeah, absolutely. Another, if you will for lack of a better word, just another set of eyes to help us you know, make sure that the families are getting the resources they need and the tools and the training and the support. So, yeah, absolutely."

A family advocate stated, "It's somebody coming in who is really focused from a medical perspective whereas- So, it's something that parents can feel like asking questions, and they're not going to be judged when they ask those questions. And, it's okay not to know. They're very - They put it out there that, 'Hey, you don't know this. You're a first-time parent. Let's work on this.'"

Another supervisor expressed optimism about the perspectives NFP may bring to CPS, "Kind of, when you think about multidisciplinary teams, oftentimes in Child Welfare, we don't have a medical community member present, so I think they can bring that perspective, too. And, that's really valuable. And, I think that's where we started to see the value in that when we had a nurse that was part-time, and then, when she left, reaching across - Reaching all the way across the hallway."

Another supervisor shared examples of where NFP could be beneficial, "So - educating, you know, helping workers teach families basic things for, because specifically right now, I supervise a home-base unit, so I have a team of people who go out, can go out to the homes 1-2 times a week. And, they help parents with basic skills. So, if I have a worker who may be less seasoned than others, they can also partner with a nurse and kind of know, you know, 'Yeah, I could talk to them about that. That's not outside of something that I can talk with them about.'"

Across several sites, some caseworkers believed that NFP was beneficial for their families because the resource remained even after CPS was no longer involved. A family's participation in other community resources was often funded through CPS core funding; such that after a CPS case closure, participation in these resources ended. Since NFP was externally funded, many caseworkers recognized that families could continue their involvement with NFP after they closed the case; this was perceived as positive. In other sites, several caseworkers and supervisors perceived NFP as having the potential to be a community-based agency rather than a full service entity that they could work with consistently. Accordingly, NFP could play a significant role in prevention. In fact, a couple sites expressed the desire to partner with NFP on more primary and secondary prevention efforts; so that families requiring a lower level of intervention would not penetrate the CPS system. These perspectives were usually provided by supervisors across several sites, but some caseworkers also shared this perspective.

One caseworker shared the benefits of working with NFP, "So, even once we're gone, I see the benefit of the nurses remaining and just continue to monitor for that - Well, really, the next two years for this client because the baby's only three months old."

A supervisor expressed her desire to work with parents at an early intervention level, "And, um, we would love to partner with people to, um, provide things that families need at a much lower level before it rises to the level of risk that we have to do something a lot more drastic- but if we knew about what the resources were through Nurse Family Partnership, we might, could hook somebody up with that."

Education and training

Education for CPS

Numerous caseworkers and supervisors from most sites explained that they wanted additional education and training from NFP including a general overview of the program, how to make referrals, and about medical conditions related to their clients. Many caseworkers and supervisors from multiple sites also felt that joint trainings could serve as a way to strengthen collaborations between Child Welfare and NFP.

Several caseworkers and supervisors from most sites discussed their desire for additional education and training regarding NFP. They were consistently interested in receiving a general overview of the program including the services it offered, eligibility requirements, length of the program, the curriculum, and how to make referrals. Many caseworkers and supervisors from multiple sites felt that the best way to learn this information was to have representatives from NFP come and present to their staff at their unit or division meetings (such as the intake/assessment or family engagement teams). In general, quarterly presentations were suggested to teach new workers about NFP while annual presentations were suggested as a refresher for the department as a whole. Indeed, it was suggested by some caseworkers and supervisors from multiple sites that the education be delivered as a training in-house or during a lunch and learn. The purposes of the presentation were suggested to facilitate relationship building between nurse and caseworker, as well as applying faces to names. Several CPS workers from one site also emphasized that it was important to highlight NFP as an ongoing community resource in these presentations.

One caseworker stated, “And, also, we can maybe have a group of nurses giving us presentations here at the department and just say, ‘If you have families that are in need of services, we’re available.’ And, to just maybe come up with a referral form, how that can be when we need a referral, maybe a checklist of things if the child is a newborn, preemie, has special needs or what the special needs are and if they qualify maybe to get a nurse practitioner to work with them, or the parent is willingly cooperating with the nurse practitioner so we can talk to our clients and say, ‘Hey, there is a program that can assist you to be a better parent. And, do you want to work with them?’”

A supervisor explained, “To begin with, it’d just be a general overview of the program. You know, the pamphlet, you know, information to just gauge that. The contact, the contact information and referral process. Is it even appropriate for us to refer? You know, those types of things. And then, I think, just some relationship building in terms of being able to faces with names.”

Another caseworker said, “Um, I think if we had some training out here that would be good because then like I was all about it after I had my experience, I was telling all my coworkers about it. And now knowing the things that I do about the timelines and first-time parents and that thing that I think that is an important piece for people to know that I wouldn’t have known otherwise. So making sure that people know that that is available out there, I think is good.”

A manager shared, “I think just probably more knowledge, I mean, I cause I had heard of the name, you know, when I knew that this is what it was coming from, I had like a little idea, you know, nurses going down, working. But I think just more information, this is what’s available, you know, this is how you do it, if you’d like to refer somebody to this program, or this is actually how they get referred, is it through the doctor, you know, all of these type of stuff would definitely help us a lot.”

In addition to receiving presentations, a few supervisors from a couple of sites also shared that it would be helpful to receive NFP pamphlets, brochures or laminated informational sheets as well as program referral forms. Several caseworkers from one site expressed that such marketing tools would be especially useful for educating the Teen and Infant Units, since these units would have greater exposure to the same clientele as NFP. Some caseworkers in various sites were also interested in learning additional details related to the NFP program and the scope of work for nurse home visitors; such topics included: how many clients a nurse could take, how NFP nurses worked with families, and language capacity and cultural competency of the program. Several supervisors from another site believed that their intake unit in particular needed to be educated to view NFP as a positive resource, rather than a resource that they could not access; this perception needed to change to strengthen current collaboration.

A family advocate also suggested, “I mean, I definitely think if we had training available in-house, that was something that maybe we could - It’d be like a lunch-and-learn type training where it was something that people didn’t have to commit to—I know that sounds terrible, but it’s true - so, something that could be like an hour long where we could gather some information. Also, having information available. Maybe like flyers or cards, just some physical thing, so that it is around, so if somebody doesn’t know about,

they can just say, 'Here you go. This is this.' Because I know I've like emailed people the website, but other than that, you know, that's all I have."

One supervisor stated, "I'm sure they report out who they're serving. It just may not filter down to our level and you know, maybe we need to do a better job so that we see them as a positive resource not a resource we can't access cause I think that's probably the feeling out at intake, we can't access."

A few caseworkers from different sites shared about their desire to gain additional education from NFP nurses specifically regarding medical condition and care applicable to their clients. Some topics described by these caseworkers included assessing normal physical and cognitive development, identifying failure to thrive, which medical appointments and follow-ups (e.g., well child visits) were necessary, training caseworkers and children's caretakers to properly care for a child on a feeding tube, and the desired interactions and bonding between a mother and her child.

One caseworker shared, "Um, but if we had someone that I could say 'Alright, this nurse, this nurse or this nurse' three people that may be seeing one of my kids, and then I can talk with them, cause it changes so quickly and these babies, it's just, their health conditions can change so fast, and to have someone to talk to, it's hard to talk with the pediatrician, I go to a lot of doctor appointments with the babies on my caseload, and a lot of it, not that I don't trust the foster parent or the grandparent or whoever has it, but I need to hear what's going on, um, so I know what are we looking at. Is it more medically fragile if I have a parent who was not maintain a healthy child, how are they gonna maintain a medically fragile child unless I put some resources. I would also, and I don't know if it's a service that um they would offer, but I think it would be nice to have actual nurses that I could say 'You know what, I need a foster parent, I need a daycare provider, I need mom, I need whoever trained on G tube feedings' or trained on how to help a child who's having an asthma attack. Or whatever. Cause right now I go and I search for different people in the community. Who can do this training?"

Another caseworker stated, "I think just being very specific and sharing the information, what does a failure to thrive kid look like? What's the typical weight? What does a kid who comes home with a tube, a feeding tube, what does that look like, what does the care look like? When we go out and assess what's normal and what's not, you know, um, for our sick kids, for our kids who are using oxygen, for our kids who are, some of us need to be aware of, um, the normal development. What ages or milestones should kids be meeting at certain, you know, when we see them? If we see them, should they be sitting up at this age?...Should they be able to have the motor control, you know, with their head, um. What neglect looks like when they go out, you know, when they're reporting it to us. If I go out and I see a kid that has the flat in the back of their head because they're being left in the car seat or in, they're lying down, just left unattended for so long, um, what the interaction between mom and baby looks like...just a general, when they should be going back to the doctor, what the immunizations look like, what happens when the parents don't follow through with the immunizations. What happens when the parents aren't following their recommendations, what's the, you know, the outcome? Is this detrimental to the child's health and welfare."

Another caseworker explained, “Also, educate us as child protection workers as to what are the diagnoses? What is the appropriate care? What is the most important things in this, you know - Can this mom really do this? Or, you know, be present for medical follow-up appointment and kind of relate that, explain that to the parent or to the kinship provider and to us.”

Several supervisors and a few caseworkers from multiple sites discussed their perceptions that additional training would help improve collaborations between Child Welfare and NFP. They felt that it would be helpful to have ongoing quarterly, biannual, or annual trainings where Child Welfare and NFP could share about their programs, provide updates on their services and approach, and exchange any other relevant information. Multiple supervisors and caseworkers shared that this would help them stay informed about each other, remind them about NFP as a potential community resource, and to become familiar with each other’s personnel. Even among sites that were knowledgeable about the NFP program, several caseworkers and supervisors suggested that ongoing training about NFP would be beneficial due to the nature of caseworkers’ jobs; it was challenging to remember and use all community resources unless they were consistently used or were prominent in the community. A few supervisors and caseworkers from different sites also shared that they thought it would be helpful for Child Welfare and NFP to hold joint trainings on topics (such as assessing risk, community resources, and marijuana) that were relevant to caseworkers as well as nurses. Additionally, when asked specifically about the potential usefulness of regional trainings for NFP and Child Welfare, a couple of caseworkers and a couple of supervisors from different sites shared varying responses. Some were very enthusiastic about the idea and desired to participate, whereas some others were concerned about the time commitment and usefulness, though they stated they would likely still attend.

One supervisor shared, “Yeah. And as far as — you had another part in your question like what and how could we collaborate more. And that’s exchange information. They could come and present at — we have, um, unit meetings. We have, um, meetings where both, um, CPS units are, um, attend called the joint team. They could present at the joint team so that everybody would be aware of them again. Remind people of, you know, when to use them. That would be useful.”

A manager stated, “I think just understanding more of their program, maybe the goals of - I know the Public Health stuff because I interact with them more, but I think our line workers don’t know that as much because they don’t see them necessarily all the time. We have them part of a lot of different committees we have and meetings that we have to have that are mandated. But they don’t interact with them firsthand so much so I think some team building and some crossover education of what they do and don’t do...I just think just educating and doing more things together would be helpful.”

In regards to regional training, one caseworker replied, “Oh, absolutely... That’d be great.”

However, a supervisor shared, “Um, yes. Okay, having said that - (laughter) You know, it’s a time commitment, um, and that’s always juggling time and commitments. But, yes, I would do that. That’s part of my job and I would — I would want to take part in that.”

Education for NFP

In addition to educating CPS on the NFP program, a few caseworkers and supervisors from multiple sites shared their perceptions about the additional education and training needs of NFP nurses. Some caseworkers and supervisors from several sites suggested that NFP nurses needed to understand the CPS process and recognize who the CPS caseworkers were in their counties. In addition, many CPS workers from most sites suggested that NFP nurses as mandatory reporters needed to learn: when it was appropriate to report, understanding the role of a mandatory reporter, and recognizing that mandatory reports did not necessarily result in immediate action. In addition, other topics for NFP nurses to be educated in were suggested, including how to make a report to provide the necessary information that a caseworker needed when assessing a family, what assessment/intake workers assessed for in their investigations, CPS agency operations and protocol, as well as caseworker limitations. Some caseworkers from other sites emphasized the importance for NFP to understand CPS worker's roles and responsibilities; especially in why CPS may respond to certain calls in certain ways.

A caseworker shared, "Well, I think in the meetings, one thing is that idea of giving more information about how we operate and how they operate. We all make assumptions about, you know, 'They're not doing their job.' Or you know, 'This is what they do.' And it's like, 'Well, actually' - You know, so I think you'd come together like that, that sort of some of the myths dissolve and maybe some, more of the reality sets in on things like you know- what the protocol is, as well as what our limitations are; what we can and can't do, which includes any agency. It's amazing the assumptions we make that are it's like, 'Well, that's not true.'"

One Child Welfare manager shared, "...doing a conversation about, 'Here's what mandating reporting is, here's what child abuse and neglect can be defined as.' And then basic question and answer to be able to answer questions. Most often what medical professionals like Nurse Family Partnerships- most of their questions are around condition of the home, 'What should I look for is good, not good?' things like that. Um and so really just open up the conversation about you know, 'Here are some things that you can look for.'"

As previously explained, a few caseworkers and supervisors from various sites believed that nurses were often hesitant to make a report due to the risk of negatively impacting their relationship with the client. For this reason, one caseworker and one supervisor from different sites felt that nurses needed additional education and training on signs of abuse and neglect (including safety hazards) so that nurses would be more confident in making the decision to report, as well as additional training on how to discuss the situation with clients when deciding to make a report. A different caseworker and supervisor from different sites also shared that nurses could use additional education and training related to substance use such as how marijuana impacted a fetus or child and how to recognize drug paraphernalia and safety hazards around making drugs, such as meth. A couple caseworkers from one site also suggested that learning could be achieved through shadowing a CPS worker.

One caseworker stated, "I think more training would be good. Because I think sometimes they will Again, I don't know this for a fact, but I worry that sometimes they, because they are afraid of breaking the relationship, maybe they'll convince themselves this isn't

really abuse and neglect or it's not really high enough to call. And, if they have that more specific training, you know, that question or that opportunity to kind of convince yourself I shouldn't call won't be there. And, maybe us just helping or someone helping them with the conversation of telling the family that they have to report."

A supervisor said, "...now we need a whole big educational push on how does marijuana affect your children? You know, your fetus, your baby being around that second-hand smoke, all of that type thing."

Another caseworker suggested topics for NFP nurses to be familiar with, "But just safe, um, it's probably really important that they're trained to notice, um, sometimes, um, some of the drug paraphernalia, or, um, if, have a little bit of background on making drugs, like meth, things like that. Um, safety hazards, just things that they probably should report."

Relationships With NFP

Building Relationships

Some caseworkers and supervisors from several sites believed that to facilitate a relationship building opportunity with NFP, CPS supervisors and administration should have greater exposure and interactions with NFP; so that information could then be shared with frontline caseworkers. In particular, several caseworkers from one site suggested that the department needed to address the lack of awareness of NFP among their workers. Some caseworkers from another site provided somewhat different perspectives. These caseworkers believed that leadership alone supporting collaboration was not effective, but that caseworkers needed to commit as well. In addition, a couple of supervisors from another site believed that administration should allow freedom for nurses and caseworkers to develop their own relationships.

A Human Services director stated, "So, I think a lot of that is meeting with each other, getting to know each other and communicating really with each other. And, for the Child Welfare Department to really get to know NFP and what's really going on in NFP and how we can make it really work well together."

Another Human Services director stated, "So there's always trainings out there. There's always things to do and things to check off, and so, if the information sharing can fit into something normally that we do - I think we have referral numbers. If we do a meet and greet, than that would suffice for now."

A caseworker stated, "So, really, it's the powers that be communicating to - a way to then get the caseworkers that information."

A supervisor expressed, "The freedom. And, I think, you know, neither of us have supervisors who watch our every single move. They let us develop that relationship and let us run with it. And, it's only through that personal relationship that you can, you know, talk about those fears like the jury trial. Or, you can, you know, laugh about past referrals and where they ended up, or you know, all of that stuff that keeps that

relationship strong. So, that when things are critical, both of you can buckle down and do your job and respect each other's roles.”

Maintaining Relationships

Several CPS workers from some sites suggested that continued education, ongoing interaction, and experiencing the benefits of NFP would promote greater awareness such that CPS would continue to view NFP as a resource for families. Consistent information sharing and knowing that NFP was a resource would reinforce the program's visibility in the minds of caseworkers. Ongoing interactions suggested by some caseworkers in multiple sites included attending community meetings or training events to share ideas and resources. Ongoing communication could also occur through quarterly emails to remind CPS workers that NFP was an available resource for their families who qualify. Several caseworkers from one site particularly emphasized that periodic communication needed to occur every year so that caseworkers and supervisors were both aware that the program was still offered in their counties.

A supervisor suggested, “Yeah, I think, you know, we're just learning about it, it's relatively real new and yeah, just more workers interacting and seeing the benefits to working with Nurse Family Partnership will increase kind of our awareness and using that resource. Oh yeah, I would say ongoing efforts seem to be made to just make sure they stay aware of this service.”

Another supervisor stated, “And you know, the fact that I didn't even know that she was still around, and I don't know what that should look like, but I guess I'm just, it would be nice to, uh, have some, not go two or three years not hearing from somebody in the community who's providing services for people who we could potentially refer.”

Most CPS workers from all sites emphasized the need to know who they were interacting with within NFP. Preferably, a contact person within NFP was suggested as helpful to see if the services were appropriate for a family (e.g. providing an opportunity to throw out ideas or ask questions). In addition, several caseworkers from one site emphasized that CPS workers needed to trust NFP nurses in what they did. To facilitate this, a couple of caseworkers from this site suggested shadowing NFP nurses or attending a visit to see how families interacted with NFP nurses, what was really covered from the curriculum within a home visit, and interactions specifically in high-risk homes.

One caseworker shared, “So yeah, I think they get what we do. I do, I think so, but again, I've had great relationships with. I have that longevity in trust, in what their skills and knowledge are, and I have an understanding of what they do, because I worked closely with them prior. Someone else who has no idea what they maybe do in the family would be, would have a different perspective, but from what I can see, I think it's a good, I think it's good.”

In several sites, multiple caseworkers also mentioned that they had wished they learned about the program prior to their involvement in the research interviews; they saw great potential in the program and would have liked to refer their first-time moms to the program. These caseworkers believed that consistent and ongoing interactions with NFP would ensure that caseworkers continued to learn and remember NFP as a resource.

A caseworker reflecting on learning about NFP as a resource stated, “With babies? Absolutely. And I wish, I mean thinking back on it now, honestly Nurse—because I didn’t really know much about when I first started working with everybody and working here. Yeah, and nobody actually talked about that, like, that would be a good option. But I think it would have been a great option for some first-time moms.”

There existed additional perspectives from supervisors and administrators in several sites. One supervisor in a particular site believed that a relationship with NFP would strength CPS’ relationship with the court and garner another level of support especially when working with medically fragile children. An administrator from another site strongly believed that all CPS agencies needed to understand that NFP could not be court-ordered. The voluntary element of the NFP program was an important feature that several CPS workers from this site wanted to emphasize. Several supervisors from this site also believed that no NFP site should feel bullied to accept a CPS case due to court mandates. Finally, several supervisors and directors from a multi-county site believed that NFP nurses needed to change their perspective of Child Welfare and that the stigma they associated with Child Welfare needed to be overcome.

One supervisor stated, “So, I certainly see it in that way. I think that a relationship between your programs and us will strengthen our relationship with the court. It would just garner another level of support, and especially, when we’ve medically fragile children, that we can say, ‘Oh, well, yeah. We have these people here, and it’s not a case that we should keep open because they can have this arm, and they’re - They have these services and these people, hands-on teaching them about how to care for their kid’s medical issues,’ particularly around, you know, diabetes and, you know, infant reflex kinds of feeding problems, which is what we see a lot of.”

A Social Services director stated, “And, we also know - the protocol of NFP is it is not court-ordered. It can never be court-ordered. It can only be voluntary. So, we’re very aware of that. And, that’s probably something agencies need to be really well aware of—because we’re so used to being bullies and throwing our weight around and saying, ‘You’ve got to do this.’ And, NFP has got to, obviously, not do that.”

Another Human Services director stated, “There’s also this thing with the stigma around Child Welfare that [name removed] keeps holding onto, that we’ve talked to her about, tried to make some inroads about, you know, ‘We’re not bad people here. Caseworkers aren’t bad people,’ but she still perpetuates that kind of stigma of, ‘Child Welfare is just taking kids away. None of my clients want to be associated with Child Welfare,’ and we get that from another entity in the community, and it’s really come down to their own personal issues because, when we talk to Mental Health and other people that are dealing with some of the same clients, they’re saying, ‘We’re not hearing that. Our clients aren’t really - they realize that you’ve got to do a job.’ Yeah, there may be a few that are pissed because of decisions that have been made, but it’s not that prevalent. But, there’s a couple people that are perpetuating that stigma. And, we know that that stigma will always be there, but it doesn’t have to be as strong.”

Opportunities When Serving Mutual Clients

When serving mutual clients with NFP, many caseworkers from all CPS sites reinforced the need to share information openly to help identify the needs of the client. Among many caseworkers, it was believed to be important for neither side to overreact when working together, to be professional, and to perform their work duties responsibly. As well, several caseworkers from multiple sites suggested a more streamlined release form to share information. For example, some workers from one site believed that NFP needed to be aware of what the investigation founded. Other caseworkers from other sites believed that NFP nurses should designate time to communicate with CPS when serving mutual clients. Some caseworkers and a couple of supervisors from several sites believed that it was important to learn about a nurse's concerns with the family and what the nurse would like CPS to address. It was believed that the more information a CPS caseworker could gather the better; this belief was prevalent across multiple positions in several sites.

A supervisor stated, “Yeah, I know who they are. Yeah. We can talk freely now.’ You know? And, that’s the best way to have that information sharing is when we know who we’re talking to.”

A caseworker expressed opportunities in working together with NFP, “Yeah, if we’re gonna work together with the family, um, I think I would probably talk to the nurse, what would be best for her. Um, email or written reports or phone communication or maybe even all of the communication. Um, but I would definitely encourage that cause I am a real strong communicator with all the people that are working with the family. ’Cause if you’re not all on the same page and you’re not measuring that progress together, we’re not helping that family support the goal. So, and to be quite honest with you, sometimes unless all the resources that are working with the family communicate with each other, sometimes some of the parties don’t get the true and correct information.”

Across and within sites, some caseworkers and supervisors expressed various preferences for communication regarding mutual clients with NFP. Some caseworkers wished to receive quarterly reports on how the family was doing, how parents were responding to NFP involvement, what parents were doing with meeting the needs of their children, and how NFP was addressing concerns. In this sense, NFP should be supporting treatment plan goals and sharing insight into a family. Other caseworkers from the same and different sites preferred monthly contact, whether by email or phone. It was described by these caseworkers that some CPS workers were flexible and would adapt to whatever method worked best for the nurse: face-to-face, email, or phone.

One caseworker suggested, “Well, I would see them maybe collaborate in terms of, you know, I would initially tell them my concerns, and then they would report, probably, back to me after each—maybe not after each—but, you know, quarterly or something in terms of how things are going at the home, how the parents are responding to them being involved, and what the parents are basically doing around their daily care activities of a child. So, that’s sort of the information I would expect to be hearing about.”

A supervisor stated, “Okay. Well, I — I just think consistent communication is important, you know. I guess it depends on the family’s needs, you know. How high-risk are they? How often the nurse is going in to see the family and, you know, at least monthly, you know. I would say at least if the nurse saw the client once a month, you know, an e-mail or telephone call saying this family is doing great or, you know, these are my concerns. That type of thing; so.”

Moreover, several administrators and supervisors from multiple sites suggested creating a broad MOU with NFP. Suggestions for what to include in the MOU were individual confidentiality statements that would be signed by each nurse. A couple of caseworkers and supervisors from several sites also suggested that sharing of NFP case notes or documentation would be helpful to CPS workers. A couple of supervisors from one site believed that such reports from NFP could potentially be submitted to court.

An administrator offered suggestions to overcome confidentiality barriers, “And so, it’s real clear on, ‘Here’s the confidentiality law’—several laws are listed. You know, ‘You know you have to follow confidentiality,’ and just try to be real clear. So, a broader MOU, so in this example with NFP, [name removed], the Director of the Health Department would sign it as the agency with our director. And then, attached is an individual confidentiality statement that each nurse would sign. Because what we know is, contracts and MOUs at agency level don’t get down to staff level. And so, we’re trying to cover both steps.”

In another site, some caseworkers and supervisors believed that if NFP had a strong relationship with the client, the nurse could help CPS to truly assess the family’s situation; the nurse and caseworker could even collaborate to provide services that only CPS had resources for. Such situations could potentially be in the form of a voluntary case. In another site, several workers expressed the desire to understand why a family was involved with NFP, what interactions an NFP nurse had with the client (e.g. number of visits, duration of involvement), client’s engagement, nurse’s assessment of the family, etc. This information was described as helpful for CPS to strategize and incorporate into the treatment plan or case plan.

A supervisor expressed opportunity in utilizing NFP’s relationships with their clients, “And it’s just, I can see with the Nurse Family Partnership, these folks have relationships with these families, there’s some trust there already. And, like we talked about earlier, this piece about how they feel like making a referral to us can jeopardize that, but I also think that, um, if they have a good relationship with the parent, it can help us to kind of get in, to really assess what’s happening, and maybe offer some services in collaboration with this. ’Cause we have resources that they don’t.”

Among some sites, several caseworkers and supervisors suggested that NFP nurses be involved in family engagement meetings or TDMs, staffings, co-teams or group supervisions; meet with CPS and the family to deliver a team approach; and possibly incorporate joint visitations. Including NFP in these types of meetings with the family was considered important by these CPS workers in various sites, so that all services providers could discuss the needs of the family and work together to address them; as well as offer the venue for open communication between providers and with the family so as not to duplicate services. In addition, multiple caseworkers

and supervisors from several sites suggested that if NFP did not make the referral, whoever made the referral needed to notify CPS that NFP was involved. The ability for CPS workers to know of mutual clients was needed when NFP was already involved in the home. It was also suggested by some caseworkers in different sites that intake/assessment workers could ask the family if they were involved with NFP every time he/she encountered a first-time mother as part of a standard procedure.

One caseworker stated, “I mean I think it would be obviously important that they be at any family engagement or treatment team meeting. I always like kind of doubling up on visits so if that would be service that would involve, like going out you know, going out with them and sort of seeing what kind of work they do like that and then just any sort of, I mean, if it’s health department related. I mean we’re in the same building.”

Another caseworker stated, “So, I guess the only thing I would say is that it probably would be helpful if we did know who they were working with, so that when, if they come through, or if we get that call, cause sometimes we get calls on people and it’s not from the nurse, it’s from another person that’s witnessing something outside of what the nurse would know about. So, our referrals, they may not know about a referral coming in, that’s very often. So, I like the idea that I wish we could have a clean and free flow of information.”

A few caseworkers from several sites also believed that NFP needed to feel more comfortable in contacting CPS, whether to talk about potential gray areas or to make a referral (a report to CPS). In fact, a couple of caseworkers site believed that face-to-face contact with NFP would encourage NFP nurses to refer, to ask questions, and to trust who they were speaking with.

A CPS prevention programs worker stated, “Because I think when they have that, I think that the referral process goes better. They’re more likely to make referrals, or when they have questions, they’re more likely to do something with the information if they kind of trust who they’re turning the information in to.”

CPS Referrals to NFP

Among all sites, many caseworkers and supervisors shared opportunities in referring to NFP. However, several caseworkers and a couple supervisors from one site believed that due to confidentiality concerns, CPS was unable to provide NFP with referral names or information. Many CPS workers in most sites believed that first and foremost a referral to NFP needed to be timely due to the program’s strict enrolment timeline. Some caseworkers from one site even suggested automatic referrals to NFP if the first-time mom lacked parenting skills or was caring for a child with medical issues; this was suggested as possibly built into the assessment process when intake workers interviewed parents. A caseworker from another site suggested designating a CPS supervisor to be in charge of making NFP referrals for her county.

A supervisor shared, “It would be nice to be able to contact NFP with names and information regarding those families that they could reach out to, but because of confidentiality we cannot do that. And so that’s probably one of the biggest concerns that I might have regarding catching those families that we do know about before the child is born, but we can’t do much with a referral or anything else until that time.”

With regards to the referral process, several suggestions arose from some caseworkers and supervisors among different sites. Several CPS workers from one site suggested that referral forms could potentially be added to the department's online system where other community organizations hosted their referral forms. The referral form could also show that CPS was already involved with a client being referred; this communication was described as highly necessary by several caseworkers in this site. Within this site, one worker also suggested that it would be helpful to meet with the NFP nurse prior to he/she meeting the client so as to discuss goals and concerns. An administrator from another site expressed the desire to track referrals to NFP to receive a feedback loop to see if these referrals reentered the CPS system. Among several sites, some caseworkers and a couple supervisors particularly suggested better communication from NFP nurses when a referral was made. Caseworkers wanted to know whether a referral was accepted or not; if not, why it was not accepted. This information was necessary for caseworkers to determine whether other services may be needed, if a case needed to be opened, etc.

A family advocate reflecting on other resources in the community stated, "I don't know. I don't know if this is even - If I'm like overshooting here, but we have like - We have like our online thing called [name removed]. And, sometimes, you can go there and you can get like the [name removed] referral on there. So, maybe that'd be something more on our part where we could like put the referral sheet on, on that, so that when people are looking up resources, it's in one place for us, which - Sorry, that's more us than you guys, but just brainstorming on how that would make it easier for people to access the information that way. Because there's a couple of things on there that are just community resources."

Another CPS worker stated, "So it would be very useful to know - well first of all I'd like to know, 'Yes, we received your referral and yes it meets the timeline and we will be looking at it.' Or, 'Yes, we received your referral and we will be going out tomorrow or something.' But we don't — we never hear back. We have to call them and say, 'Did you accept it?' and they don't call us back very well either."

Areas of Programmatic Improvement for NFP

Many caseworkers and supervisors from almost all sites suggested for NFP to broaden their criterion for program participants. In fact, several caseworkers from one site suggested looking into whether or not parents who terminated their rights and then participated in the program had similar effects to first-time mothers. Similarly, many caseworkers and supervisors from almost all sites wanted to see NFP be eligible for second- or third-time mothers. For second- or third-time mothers to participate in NFP, some caseworkers believed that these moms should really want the program; several caseworkers from one site also suggested that perhaps a case by case basis could be instituted for the program. In addition to broadening program eligibility, some caseworkers from multiple sites suggested greater flexibility with the NFP enrolment timeline; for example, extending the enrolment period to past 30 days postpartum. By broadening the program criterion and creating a more flexible referral timeline, most caseworkers from multiple sites believed that this change would improve the reach of the program and allow for further collaboration between NFP and CPS.

One prevention program worker stated, “Not really. I mean I would like to see them take maybe a second child if they didn’t run through the first, with the first child -because there is a reason why they have the referral. So I’m thinking that- I think that would be helpful.”

A caseworker stated, “Yeah, I don’t know. That’s a, you know, a big question - I would be really interested to find out if there is, you know, I understand it’s an evidence based practice, if the research includes parents that have been terminated on or off and it that is not included in there. I would really think that it would be a very important, it is a very, it’s a big missing piece.”

Another caseworker reflecting on previous referrals to NFP stated, “So, I wish there was more flexibility around that timeframe. Like, I have a client right now who basically did that, drag their feet, didn’t get involved, and now, their child’s three months old. And so, it’s beyond the time period where we can get them involved. I think it’s just within that first month.”

NFP Reporting to CPS

With regards to reporting to CPS, a few caseworkers from one site believed that putting in place a similar relationship to that with the school district would be helpful. Social workers were suggested to be placed to help with the reporting procedure and allow for nurses to have someone to run scenarios by, to determine if they were reportable or not. Almost all caseworkers across all sites emphasized that a mandatory reporter should always call if they were concerned. A few caseworkers and supervisors from a couple sites suggested a formal contact or direct relationship with someone within CPS for NFP nurses to call and converse regarding gray areas related to suspected child maltreatment. In fact, some caseworkers and supervisors from one CPS department of a multi-county site expressed that workers were available to provide feedback on hypothetical situations to mandatory reporters in the community but the NFP nurse had never utilized the service. These supervisors suggested this consultation service as an opportunity that NFP nurses should utilize.

A supervisor stated, “[Local public schools district name removed] social work director put, has three people, three social workers who act as the catalyst for them to run things by. If - and then, they also have a standard reporting procedure now. And so, I could see something - Like, with our hotline, which is staffed by social workers that - you know, setting up some type of relationship that, if nurses have - if nurses have a concern, to be able to call and say, run something by - Run something by somebody and to determine if it’s something they need to report. If it’s something they need to do.”

Another supervisor shared, “The other thing that we do for other nurses, doctors, the hospital, schools is that we are an open line for them to call with the hypothetical that we talked about earlier – where it’s not actually a report of child abuse but we can get them feedback on how to support families with us. Nurse Family Partnership does not use that, but all the providers in this community do.”

Another factor to NFP nurses reporting on child abuse and neglect was raised by a supervisor in one county. The supervisor emphasized that NFP nurses should not make weak reports because making strong reports would gain the respect of the CPS agency; so that when a nurse did call, CPS would respond. The supervisor also emphasized the importance for NFP nurses to report both strengths and concerns when referring to CPS. Finally, a caseworker from one site suggested that NFP should consider not notifying the client that her nurse was making a report; this lack of transparency suggested by the caseworker was explained as necessary to lead to a more successful investigation.

One supervisor stated, “Because you can’t respond to everything. So, you know that when she’s coming in, we need to pay attention and, and for whatever reason, she is concerned enough that she’s come in. And so, I think that that’s probably one of the most important things that all of the nurses need to know is to, to not make these weak reports. You know? Because you’re going to gain the respect of CPS agency and when you call, they’re going to respond.”

A caseworker reflecting on NFP nurses disclosing a CPS report to their clients stated, “I would say - Better may not be the right word, but it can lead to a more successful investigation if they don’t know.”

Multi-county NFP Sites

In those NFP sites that served multiple counties, the associating CPS departments tended to want greater accountability among the NFP nurses placed in their counties but “directed” from another. Several directors and supervisors from these counties wished to have greater input in the NFP nurse hiring process and a desire to better incorporate these nurses into their county systems. A couple of supervisors from another CPS department served by a multi-county NFP site believed that its county held the potential to be a standalone site and that more NFP nurses needed to be hired to serve their area. Some caseworkers and supervisors from these sites also suggested that the specific nurses serving their areas should meet with their county’s caseworkers face-to-face to facilitate better collaboration and interactions.

A Human Services director stated, “Well, I don’t know. I mean, um, I think having the structure where [name removed] is under the direct supervision and accountability with [county name removed] is not a good system. It doesn’t work. I think having the structure where she is more under the county system and maybe under public health nurses and that, it’s like, ‘Hey, you’re part of us. You’re part of the county.’”

Another supervisor shared, “I don’t know how the funding for this works and, you know, may be [county name removed] doesn’t have enough numbers, but I don’t know why we can’t stand alone.”

Other Agencies

In one site, several supervisors expressed opportunities in gaining clarity about the Tribal CPS process; these supervisors believed that NFP could learn from this opportunity as well. The Tribal CPS process was unknown or confusing to almost all of the caseworkers and supervisors

in this site. These workers expressed the need to engage with the tribe when working with tribal families. Several prevention program workers from another site suggested that monthly staffings should occur with the various prevention programs and NFP. In another site, some caseworkers and supervisors suggested involving NFP in monthly case conferencing with the Family Resource Center or inviting NFP to sit on the CPT meetings. A few supervisors and directors from several other sites suggested that economic assistance staff and eligibility staff should be included in presentations and meetings with NFP.

One Social Services director stated, “We have a good relationship with Tribal Social Services. Um, they can call us. We’ll talk about stuff. Right now, they’re without a director, so I’m not for sure where we are with that. So, there’s no animosity. There’s sometimes confusion.”

On learning about potential meetings between NFP and CPS, another Social Services director shared, “Well, that’d be great because I could send probably the eligibility supervisor to that also.”

Other Organizations’ Perceptions and Knowledge of CPS and NFP

Knowledge of Interactions

A few participants from organizations outside of NFP and CPS across a few different sites shared their perceptions of what CPS and NFP knew about each other’s organizations. All of them believed that it was important for NFP and CPS to learn more about each other. One community partner in particular noted that this was an opportunistic time for CPS to work more collaboratively with NFP because the local CPS was moving into DR. Another community partner also noted that NFP nurses were not always aware of caseworkers becoming involved with their clients and that leaders of CPS and NFP were working on improving their knowledge of each other’s services but that this knowledge needed to be filtered down to the caseworkers and nurses, respectively.

In regards to what a particular NFP nurse could do better, a public health director stated, “I think embracing the whole mission of DHHS and educating NFP nurses on their particular mission. You know, maybe they aren’t up to speed on the purpose and the mission of DHHS in this point in time.”

The same public health director continued to say, “Well, I think it’s because she just didn’t want to be aligned with DHHS and she was unhappy to be - Knowing that all of these new things were coming down the pike, you know?”

A staff of a public health department stated, “I think that the caseworkers are usually really excited to have a resource and somebody who wants to work with the family and they want the best interest of the client, so I think they’re willing to refer if their client meets the criteria of NFP. A lot of the caseworkers didn’t - I wouldn’t say didn’t know about NFP, but maybe weren’t as familiar with NFP.”

The same staff member continued to share, “In other cases, Child Protection has become involved, and the Nurse Family Partnership nurse has not always been aware of the referral. And, in one way or another, either through the client later or maybe even six months down the road, they find out that the client has a caseworker. And, I think, in those times, it’s really important for the Nurse Family Partnership nurse to be involved if the client wants, and I think most of the clients are pretty willing because it’s so strength-based and they know the family and they’ve been going out there every two weeks, and they have things that they can contribute to the case that is helpful for the client.”

The public health staff also stated, “I think the leadership here is doing a really great job of, like I said, having those joint meeting and for the leadership and management to be aware of the programs that are out there and kind of continually reminding their workers to talk to their clients and see what, who they’re involved with, whether it’s NFP or somebody else.”

In reflecting on Child Welfare’s recent shift towards DR, a DHS staff member outside of CPS commented, “And so, Nurse Family Partnership is in a prime position to help. You know, and so, if they’re got a pregnant teen, or you know, a young mom who hasn’t had good role modeling in the past for parenting, you know, to stick with them, you know, over the course of, you know, two, three years, you know, and offer that support and education regarding effective parenting and stuff. So, I think there’s a lot of opportunity there. How it kind of plays out, you know, there’s always hurdles and stuff. But, I think there’s great - A great collaborative model could be built with NFP.”

Perceptions of Interactions

Among many community partners across some sites, there were mixed perceptions of how CPS and NFP functioned together and interacted. One public health director perceived NFP and CPS interactions in her county to had been limited and sometimes tense; while another public health director in a different county but the same multi-county NFP site attended biweekly CPTs and had sometimes provided the NFP perspective in these meetings. In another county, a public health nurse perceived CPS and NFP interactions to be positive especially between leadership teams.

One public health director stated, “Well, I think it’s because she [referring to the NFP nurse] just didn’t want to be aligned with DHHS and she was unhappy to be – knowing that all of these new things were coming down the pike, you know?”

Another public health director shared, “I do go to the Child Protection Team every other week. So I participate on that. I go to a lot of meetings as you can imagine (*laughter*) both internally with the county as well as, you know, with many community partners outside of the county.”

A public health nurse stated, “I think the leadership here is doing a really great job of, like I said, having those joint meetings and for the leadership and management to be aware of the programs that are out there and kind of continually reminding their workers

to talk to their clients and see what, who they're involved with, whether it's NFP or somebody else."

Perceptions of NFP Nurses as Mandatory Reporters

A couple of public health directors from different sites shared their perceptions of NFP nurses as mandatory reporters. One public health director felt that NFP nurses should have been educated on opportunities in collaborating with CPS and their philosophy towards child reunification with the family. Another public health director showed awareness of NFP nurses' transparency with their clients when making a report. She also suggested that NFP nurses needed to be able to report but should recognize that reporting was not the entirety of their job.

One public health director shared, "You know, I just think it's more education than anything for the NFP nurses, maybe [NFP nurse name removed] in particular. You know, I think that she's had the training in the past on mandatory... But I think, you know, it's just education and also then collaborating with your local HHS people so that you start to feel comfortable with the work that they do and know that they're out there promoting parenting skills and helping parents. It's not like they are out to pull babies out of houses where they don't think they're being taken care of. I mean, the push is to keep babies in their homes if they can be safely monitored and the children can thrive... So I think embracing the whole mission of DHHS and educating NFP nurses on their particular mission. You know, maybe they aren't up to speed on the purpose and the mission of DHHS in this point in time."

Another public health director stated, "You know, certainly they need to be prudent and they need to be able to report and, you know, report when they need to be reporting but, um, there's a very few percentage of our families that get to the point of being reported. And so it's really important that the nurses don't feel that that is what their job is."

Perceptions of NFP Referral Process

Most community partners in most sites expressed knowledge in NFP's referral sources. NFP referral sources shared by these community partners included: Medicaid, Public Health, and physician offices. Some community partners among several sites were referral sources themselves; with some sharing successful referrals while others sharing frustration with clients who did not end up participating in the program or with referrals that were not accepted. Among some sites, several community partners were also aware that CPS had referred to NFP in their area; and believed it was positive especially when a screener referred a family to NFP for preventive reasons. Other reasons for CPS referring to NFP were described by a couple of community partners in various sites, including foster care children who became pregnant, first-time pregnant women with no child in the home, and drug-exposed infants.

A public health director reflected on challenges when referring to NFP, "NFP, I think, will have troubles with, you know, because if - I mean already, when we do a referral, and it doesn't get accepted, we're calling them, 'What do you mean they don't get accepted? I've already talked to that momma and she's gonna do it, and what did y'all say to them?' And then we're kinda like all over, because, because we know our people. And we're like, 'What happened? What was the disconnect?' And I don't think they're

used to the referring agency calling them and saying, - ‘Why didn’t you accept them,’ yeah. ‘What shot ’em out?’ Because we did our leg work already.”

A public health nurse liaison shared her perspectives on CPS referrals to NFP, “Mm-hmm, yes. I would say pretty often. And, one way, they - The people who answer the phones for the hotline, the [position name redacted], they - If they get a call about a pregnant mom, and there’s no children in the home, they can’t technically open a case because there’s not a child in the home. And, if there was concerns, they can refer that family to NFP. So, I think that’s been a really good preventative measure that - It’s a good way for them to get involved with a nurse before...”

Perceptions of Collaboration

As previously explained, perceptions of collaborative interactions among some community partners in different sites varies within and between sites. Among some community partners in various sites who had worked with both CPS and NFP in various capacities, several partners had sensed some tension in interactions and collaboration between the two agencies, especially in sites where collaboration was lacking. In other sites, several community partners from other agencies provided information that their collaboration with both agencies was positive and worked well for all parties involved. Having a third party that worked as a liaison for the two agencies was reported as a facilitator for collaboration by a public health nurse in one site.

One public health director stated, “So I don’t think there’s been a lot of engagement on [NFP nurse name removed] part with DHHS and, you know, I only know that because of what [CPS supervisor name removed] and [director name removed] tell me. You know, [NFP nurse name removed] hasn’t really ever said, although she didn’t hide the fact that she was really unhappy to be moved up by Child Welfare. I don’t think that she wants to have a lot of interaction, but I don’t know that for sure, but the fact that she didn’t want to be moved close to them, I thought was problematic going forward, knowing how the programs were going to be more interfaced.”

A liaison who worked for the county health department said, “Sometimes, in those cases, the Nurse Family Partnership nurse will come to me and say, ‘You know, I reported this. I was wondering if there was a caseworker. How do I find out? How do I get involved?’ And so, in those circumstances, I can talk to the nurse about who to talk to and how to find out the caseworker and to get involved with some of the meetings, the staffings that they have.”

Perceptions of Barriers to CPS-NFP Collaboration

Among some sites, some community partners shared about their perceptions of barriers with regards to interactions between CPS and NFP. Factors within CPS; stigma from the community, clients, and/or individual nurses; NFP program elements such as eligibility and enrolment period; and mutual client challenges were expressed as major barriers for NFP and CPS to collaborate.

Factors Within CPS

Some public health nurses from different sites explained that factors within CPS hindered collaborative efforts with NFP. First, one nurse clinician shared that caseworker turnover and burnout, CPS leadership change, and lack of time due to busy caseloads were some barriers to effective collaboration. Another public health nurse from a different county explained that CPS caseworkers lacked knowledge of and familiarity with the NFP program, mainly because there was an abundance of resources and it was difficult to keep track of each program and population served.

One nurse clinician explained, “You know, there’s ups and downs, you know, at least in the [redacted] years that I’ve been here, there’s been a lot of change in leadership in the Child Welfare division. And, that certainly trickles down to the workers, you know, on the ground. And, you know, and some of that’s unfortunate, you know. And then, also, there’s a lot of turnover in caseworkers, and I absolutely understand that. This is a super tough job, you know, they’re overworked and underpaid, you know.”

Another public health nurse shared, “A lot of the caseworkers didn’t - I wouldn’t say didn’t know about NFP, but maybe weren’t as familiar with NFP... Just maybe lack of knowing what’s out there all the time. It’s really hard to know every program and who they serve. And, I struggle with that, just trying to keep on top of what the resources are and who to refer to at times.”

Stigma

Across some sites, several community partners shared that stigma associated with CPS was evident among the community, potential clients, and NFP nurses. A public health director explained that the NFP nursing team had previous experiences with CPS, while another public health director from another county (but within the same NFP multi-county site) shared that their designated NFP nurse held negative views towards CPS and expressed resistance to collaboration. An economic assistance worker from another site also explained that a challenge towards CPS collaborating with NFP was related to successfully referring and convincing clients to participate in the NFP program. In another county that was smaller and rural, a public health director explained that community members perceived other larger counties as the government and were reluctant to allow NFP nurses – based out of the larger county - to visit their homes.

A public health director shared, “But certainly some members of the team, you know did have the stigma or have had experiences before coming to NFP that weren’t great and so, you know that takes a lot of time do break down those types of barriers.”

Another public health director stated, “You know, [nurse name removed] hasn’t really ever said, although she didn’t hide the fact that she was really unhappy to be moved up by Child Welfare. I don’t think that she wants to have a lot of interaction, but I don’t know that for sure, but the fact that she didn’t want to be moved close to them, I thought was problematic going forward, knowing how the programs were going to be more interfaced.”

An economic assistance worker explained, “The cooperation of the clients is the biggest thing. Because a lot of them are, like — like this one gal that I have in my head that I

think she needs these programs — I think she’s, um, so comfortable with the way her lifestyle is. I don’t know that she’s capable of putting the baby first and that’s sad. But, um, I don’t know. I think that’s the biggest thing is convincing the client that this is something that’s only going to make their lives better.”

Another public health director stated, “You know, I think there are issues around, in rural Colorado, people, many people, not all, but there are many people that perceive [county name removed] as big government, big situations, whatever, and that it’s not that, oh it’s just the old nurses that work in [smaller county name removed]. And they’re our kind of friends, and they’ll keep things confidential, or that, you know, there’s just a different, you know, we’re just a number to them. So anyways, you wonder if that’s part of it.”

NFP Program Elements

Among different sites, a couple of community partners explained that elements of the NFP program hindered collaboration with CPS. Such elements were the strict eligibility of the program (serving first-time mothers), the short enrolment period (up to 30 days postpartum), and the rigidity of the curriculum or schedule (e.g. not working Saturdays or after hours). These community partners believed that broadening the eligibility of the program would offer greater opportunity for collaboration with CPS and expansion of the population served.

One public health director shared, “...we’re very well aware of Dr. Olds’ projects, you know, have been for years, you know, and desired it, desired expansions of it, wish it wasn’t quite so defined, but. So narrow with, just being Medicaid, just being first-time babies, just those kinda things. I know it’s just evidence-based and I understand all that, just wish it could be bigger.”

A public defender explained, “Um, so, and then the thing that’s hard sometimes about the Nurse Family Partnership thing is the window of opportunity. I think they’re a little too narrow sometimes.”

Other Barriers to Collaboration

Several miscellaneous barriers were also expressed by some partners in various sites. With regards to mutual clients, several challenges were shared. One public health nurse explained that it was challenging for NFP and CPS to effectively collaborate when one agency was unaware that they served a mutual client with the other agency, whether or not it was because the client did not disclose involvement. Such instances were especially challenging when the child was removed and NFP was unaware of CPS involvement and the nurse attempted subsequent visits. A public health director from the same site also shared that clients had dropped out of the NFP program after the nurse made a report to CPS; while a council coordinator from this site expressed that some clients may refuse signing shared releases of information thus creating challenges for CPS and NFP to share information on the mutual client.

A public health nurse explained, “I think if they don’t know that each other is working with the same client. I’ve seen that be a barrier. I know at times Child Protection has had a removal of a child from a home, and then the Nurse Family Partnership nurse doesn’t know, and they go to the home and the child’s gone. And, that seems like that’s

kind of a gap in systems. So, if the client's not disclosing that immediately, that can be a barrier.”

A council coordinator shared, “Yeah. I mean, maybe there's protocols for signing releases. I don't know if that would get in the way. If a family says, ‘We don't work with anybody’ - Sometimes, they say that.”

In several counties, some public health directors also explained that better collaboration existed in one county but not with other counties within an NFP multi-county site. Another public health director in a different multi-county site explained that their county lacked the number of clientele for NFP despite being funded for more and that the designated NFP nurses for their county were not integrated into their local health department.

A public health director regarding stronger collaboration in one county versus others shared, “Um, with child protection specifically, you mean? Yes, I would say that's accurate.”

Another public health director stated, “So, and we had done initially, back when we were going for it, we had done some data sets, and 12 is probably, 12, 15 is probably pretty realistic for what we should have. But, except for a brief moment, I don't think we've ever been up to 12 in [county name removed]. And I think right now we're at 4, you know, and that's just not acceptable to me.”

The same public health director explained, “Just coming into our health department a little bit and getting to be a part of us a little bit so that we can kinda, in theory, act like they're part of [county name removed]. And, you know, would that increase a perception of, you know, they're one of us kinda deal.”

Perceptions of Opportunities to CPS-NFP Collaboration

As mentioned previously, many community partners from various sites believed that collaboration between NFP and CPS was needed and could be strengthened. Almost all community partners believed that the collaboration between the two agencies would be beneficial, especially for pregnant teenagers so that at-risk clients would receive a great resource and needed support. Several partners in various sites believed that a referral protocol for CPS to NFP needed to be developed, especially to establish a collaboration where target teenagers who were pregnant were immediately identified and connected with resources. As well, it was suggested by several community partners that NFP should be contacted by CPS early on with expectant mothers. Another partner believed that collaboration with NFP and Eligibility programs (i.e. Colorado Works) could be beneficial; to increase referrals to NFP while ensuring families were receiving services. Additionally, several partners from different sites suggested strategies to facilitate stronger collaboration with NFP and CPS. These strategies included getting opinion leaders on board, ensuring outside accountability, appropriate messaging for collaboration (to the community and to clients), sharing success stories, and networking opportunities. Indeed, there needed to be ways for NFP and CPS to build trust with one another and to increase agency approachability.

A public health director stated, “So I think just networking and knowing what everybody else has to offer is going to be the benefit of having a Nurse Family Partnership nurse close to Child Welfare so they can communicate more freely and easily and, you know, just be integrated.”

Another community partner shared, “And, if you want Nurse Family Partnership and Child Protective Services to work well together, then I think Child Protective Services needs to be, have a clear idea of what they need to do, be monitored from an outside entity, and Nurse Family Partnership as well. And, have some specific criteria that allows for that. Because, when you try to do within the community, the politics of power get in the way.”

The same community partner stated, “Yeah, it’s just establishing protocols for referral and work. And, and really identifying how to message things with a potential client so that they’re not just, ‘I don’t want to work with you. You’re gonna take my child away.’”

A public defender expressed, “It would be a really outstanding collaboration if that target group of kids who are having kids could be set up to have some of these resources.”

In addition, among some sites, some community partners believed that there needed to be more integration between Health and Human Services in their counties. Open communication, releases of information, mutual understanding of family-centered philosophies, definition of organizational roles, and continued professional feedback were suggested by these community partners as necessary to build and maintain collaborative relationships. These partners further elaborated that both CPS and NFP needed to consider shadowing or joint visit opportunities for their workers, so that frontline staff could learn the work and roles of the other agency. It was suggested that both agencies should also continue training their staff in motivational interviewing and building strengths within their clients and families.

A public health nurse suggested, “So, that they know when they’re talking to a client, and they say, ‘Nurse Family Partnership,’ what that really looks like. And, what the nurses do on a visit, and how often they see them and what the program consists of and vice versa. The nurses to know what it’s like to be an assessment caseworker and knock on a door of someone who’s not very happy to see you and, you know, try to use engagement techniques and talk to the family straightforward about the concerns that there are. And also, find out what their strengths are - And, I think that’s just really valuable to, for everyone to see it from each other.”

A program coordinator stated, “The whole idea that it’s family-centered, so I think that getting away from the politics or power and power circles or the just coming together with a clear understanding that we’re here to meet the needs and help our families succeed and be successful. I think that basic understanding, and being able to understand that as a person. You know, it’s really easy to say family voice and choice collaboration. It’s easy to say those words but to really act them and do them is difficult, so we all have to realize that this is not easy, you know? It may not always go a specific way, but the whole idea of compromise and building on the strengths of the family – family voice and

choice – everybody around the table needs to understand that in order for collaboration to be successful.”

Areas for CPS to Consider

Several community partners in different sites offered opportunities for CPS to consider for strengthening relationships with NFP. First, CPS needed to perceive NFP as beneficial for their families and should present the program as a positive resource. Secondly, CPS should be knowledgeable about the nurses working in their counties and meet with them on a regular basis. Finally, CPS should develop a better system to recognize whether or not a family was already involved with NFP before penetrating the Child Welfare system.

A public health director stated, “And, you know, and I think part of that can be helped from the Child Protection Team side as well. I mean if in terms of if they’re having meetings with the family asking the family if they want to continue—or encourage them to continue—to have NFP and can we come to those meetings, you know, to help put a plan in place and be part of that. Um, and, you know, I think even when those things happen the client might just fire us anyway. But we’ve had clients fire us for a little bit and then realize, you know, that it was—it was—it was done out of, um, you know, out of necessity and caring and, you know, we’ve reconnect with them. But not always. We don’t always.”

Educational Opportunities for CPS

A few community partners among various sites also shared about opportunities for CPS to consider with regards to education and training. One of the community partners felt that Child Welfare caseworkers could benefit from additional education and training on things to consider when assessing a child for medical needs and questions they should ask clients and medical providers to better assess for child neglect. Another community partner also shared that she thought additional cross training among nurses and caseworkers could help improve collaboration between NFP and Child Welfare.

In regards to education and training opportunities for caseworkers, a nurse practitioner and program manager of a crisis center shared, “It’s oftentimes just supporting them, doing one-on-one education, but you know, kind of being lighthearted with them, you know... So, ‘Hey, have you thought about this with this child?’ Or, ‘This bruising looks more like- Is pattern bruising, and here’s why I think that.’ Or, you know, ‘I’m gonna draw some labs, you know, because, you know, we think that this thing is going on. And, here’s what happens in the body when, you know, we see this type of thing. So, pay attention to these things.’ You know? Or, you know, ‘Hey, you know, we noticed that this child’s not gaining a lot of weight. You know, can you ask the parents about this?’ Or, it’s something along the lines of, you know, ‘Hey, Mom told me that she is taking this kid to the doctor all the time, you know, at a [organization name removed] clinic, but there’s nothing in the [organization name removed] record. And so, maybe you should ask her these kinds of questions.’ So, it’s a lot of that informal education.”

In regards to improving collaboration between NFP and Child Welfare, a public health director said, “So, you know, just knowing each other and knowing what your services are and what the benefits are between an NFP program versus this Early Childhood

program for this baby. If NFP could have been involved from the get-go, this whole second big group meeting where there were more problems may not have even happened... So I think just networking and knowing what everybody else has to offer is going to be the benefit of having a Nurse Family Partnership nurse close to Child Welfare so they can communicate more freely and easily and, you know, just be integrated... they mentioned at the NFP governance meeting on [redacted] that there would be regional gatherings now until the end of June – it would be about a half a day - the point being to bring together HHS staff, the NFP staff and discuss referral processes, share program information, and we were supposed to let someone know if we needed that. And I didn't know if you knew who we should alert to let them know that it would be great to have a regional training.”

Areas for NFP to Consider

On the other hand, a couple of community partners from different sites also provided feedback for NFP to consider. These partners believed that NFP nurses should take the initiative when reporting to CPS that they were involved in the home and would like to receive updates on the case. Furthermore, NFP nurses should develop contacts in CPS to be able to ask hypothetical situations or potentially sit on CPTs to develop a better CPS knowledge base. A couple of community partners also expressed opportunities for additional education and training for NFP nurses. It was suggested that NFP as an organization should provide training for nurses in various capacities, including: understanding that their personal beliefs and experiences with CPS may impact their practice and education, as well as other programs or services that could be utilized as resources for NFP clients. Additionally, these community partners suggested that NFP nurses needed more education on the CPS process, mandatory reporting duties, and the purpose and mission of Child Welfare (i.e. to help families and promote skills). Another community partner stated that NFP nurse supervisors should be provided with trainings on how to respond to secondary trauma, recognize when nurses may need additional support, and how to effectively build partnerships in the community.

One public health director expressed, “You know, I just think it's more education that anything for the NFP nurses, maybe [nurse name removed] in particular. You know, I think that she's had the training in the past on mandatory reporting and she's been a counselor in the past for most of her nursing career. Previous to that, she worked in OB a little bit. But I think, you know, it's just education and also then collaborating with your local HHS people so that you start to feel comfortable with the work that they do and know that they're out there promoting parenting skills and helping parents. It's not like they are out to pull babies out of houses where they don't think they're being taken care of. I mean, the push is to keep babies in their homes if they can be safely monitored and the children can thrive. Because I think there's plenty of data that shows that children don't do as well in Foster Care so I think embracing the whole mission of DHHS and educating NFP nurses on their particular mission. You know, maybe they aren't up to speed on the purpose and the mission of DHHS in this point in time.”

Another public health director suggested, “I think that the supervisors also need to have, um, training in understanding. You know, if they're not familiar with building those relationships. You know, we're so fortunate here to be co-housed and we have, like, meetings together. I don't know that that's happening everywhere else.”

Yet another public health director shared, “So, and then the supervisor, I think, might need training in how to respond to secondary trauma, um, and how to identify when a nurse might need more than what the supervisor can provide.”

SECTION IV. OTHER AREAS OF WORK

Education and Training for NFP

All nurses and nurse supervisors from all sites described a variety of education and training opportunities that they had available to them including mandatory reporter training during nursing school and other education and training opportunities through the NFP program. Such professional development opportunities were described as important aspects of their scope of work, where nurses had been able to self-improve and reflect on their practice. More recent education and training that nurses and nurse supervisors had available to them varied across sites and included topics such as mandatory reporting, assessing risk and abuse, substance use, and IPV. Given the variation in available education and training across sites, these same topics were discussed in regards to needs for additional education and training.

Prior Training and Education on Mandatory Reporting

Multiple nurses from different sites and a few nurse supervisors from some sites shared that they had been informed that they were mandatory reporters during nursing school. However, many of the nurses and some nurse supervisors from multiple sites consistently stated that only a general overview of what was reportable was presented, that they were not extensive trainings, and that it was unrealistic to expect students to fully comprehend what it meant to be a mandatory reporter without having lived it in real practice, given the amount of time that had passed since nursing school, and because some people may not have paid attention in class. A couple of nurses from one site also shared that they had received some training on child abuse and being a mandatory reporter through positions they had prior to being an NFP nurse.

One nurse supervisor said, “It was - It was not a training per se. It was, you know, ‘Child abuse and neglect, you’re required to report-’ kind of - You know, just that typical...”

One nurse shared, “Basically, just - I mean, in school you learn what reportable events are and that you are a mandatory reporter in the Century Codes. There are some guidelines that you have to follow, that you should be aware of. I can’t remember what the Century Code is here...I mean, it is a very gray area, and there’s an assumption, I think, though that we learn those things so we should know those things, but if you haven’t practiced or had to do it...”

Another nurse explained, “I mean, in general, like in nursing school. As a [field of work removed] we, you know, there was definitely a discussion around child abuse and being a mandatory reporter but ongoing training or anything like that or looking for more specifics beyond, if someone were to come to the door and they agreed and they’re the only there taking care of their child or, you know, the obvious situations of abuse and

neglect like I wouldn't know, and it's another gray area, that middle ground, that you fall into with reporting.”

Existing Trainings and Education

All nurses and nurse supervisors from all sites discussed a variety of training and educational opportunities that had been available to them from various entities around a variety of topics including assessing risk, mandatory reporting, IPV, and substance use.

Assessing Risk

Existing education and training around assessing risk varied greatly across sites. At one site, most of the nurses and the nurse supervisor described a variety of trainings and educational opportunities that they had available to them such as trainings on recognizing child abuse, sessions presented by law enforcement, statewide conferences focused on child abuse and neglect, motivational interviewing trainings to assess relationships, trainings on home visit safety, online modules, child abuse and neglect as core elements of new hire trainings, a handbook, and resources through the intranet. One nurse from this site also shared about upcoming trainings on suicide, child abuse and neglect, sexual abuse of children, injuries and patterns of abuse, case studies, abusive head trauma, and Sudden Unexpected Infant Death. A nurse from a different site also described participating in a DANCE training, and a nurse supervisor from another site explained that they recently had a one-hour training on assessing risk which was good as a refresher but could have gone more in-depth.

One nurse shared, “I think it was for, I think it was for the state of Colorado. So it was people from different counties. So it was our county and NFP from different counties. And then, um, not sure, I think it may have been other home visitation programs as well and then it was law enforcement. And they were like, I think, the law enforcement was focusing on child abuse so by educating the offices on how to investigate, things like that. So it was really, that was informative. I enjoyed that because we had breakout sessions where we can do different things. I enjoyed that. And then I enjoyed also the more um, um, law enforcement stuff that they exposed us to as well. That was pretty cool as well.”

Another nurse stated, “Just, I've had quite a few trainings on child abuse reporting and all that. I mean, not the reporting itself, just the trainings on recognizing child abuse and what to do. So I'm very comfortable with that.”

Another nurse said, “No, this was before NFP. But with NFP, the thing that's been really helpful has been doing the statewide conferences because there's always been a focus on child safety or abuse/neglect. Promoting the relationships, dealing with the motivational interviewing to fine tune.”

Mandatory Reporter Training

Several nurses and nurse supervisors from all sites shared about their experiences with mandatory reporter training during their time with NFP. There existed variation within and between sites in nurses and nurse supervisors having attended trainings for mandatory reporting while working in NFP. Many nurses and nurse supervisors from multiple sites discussed having had someone such as a Child Welfare representative provide a training at their site, while some

nurses and supervisors from a few other sites talked about having attended trainings at partner organizations or having attended statewide trainings. Within the same site however, some nurses had attended mandatory reporting training at least once in the time they had worked with NFP while other nurses had not attended any mandatory reporting trainings at all. A few nurses and nurse supervisors from different sites also explained that nurses received mandatory reporter training on the first day of their job or during their orientation but the frequency of ongoing mandatory reporter training varied across sites; some nurses and supervisors from a few sites stated that they occurred every 1-2 years and some nurses from other sites shared that they had not had mandatory reporter training in “a long time”. Length of the training also varied across sites; some nurses in a couple of sites had attended day-long conferences while other nurses from the same and different sites only attended a one-hour orientation that covered aspects of mandatory reporting. A number of nurses and nurse supervisors from multiple sites also consistently shared that the content of mandatory reporter trainings included expectations regarding role as a mandatory reporter, what to look for, what was reportable, and who to contact. Additional topics that several nurses and nurse supervisors from various sites had learned included clarifications on reporting for marijuana use and the role of law enforcement in child maltreatment. A nurse and nurse supervisor from different sites also said that the trainings explained that investigating was not their responsibility.

One nurse stated, “We have had representatives from CPS come to team meetings because the nurses at times—and, it dep—you know, I’ve had new members come into my team over the last few years. And, they always - The gray areas are really hard to differentiate what you do and what you don’t do. So, we’ve had, several times, had folks come in to team meetings and talk with us about what parameters they’re looking at. And, that’s been helpful.”

Another nurse reflected, “Um - Well, I feel like it’s kind of a constant thing that we remind ourselves, so I mean, I feel like I was trained when I first got this job in, you know, real - You know, what is mandatory reporting, what does it look like, you know, what has to be happening for you to report like domestic violence is a reason to report. Of course, any signs of physical abuse or neglect, all of that.”

Another nurse explained, “So, we’ve, we’ve had some trainings, I think, on a regular basis where they will come once a year or every other year and really talk about what’s reportable, when to report, any updates - Like, yesterday, we met with a caseworker, and she gave updates about marijuana situation and when we should report and shouldn’t. And, I think we - My own personal feeling, I don’t know, is that we have a good relationship with them because they do invite us if sometimes we’re just not sure should we report something or not, they welcome us to come and just ask them questions without revealing any names, just to kind of brainstorm.”

One nurse supervisor shared, “Yes, we do. Once they’re hired on with the county, that - The first - Gosh, I think it’s the first day, they get an hour of mandatory reporting, but it’s only an hour.”

In addition to previous trainings, some nurses from several sites acknowledged future trainings and education on mandatory reporting and maintaining child safety that their team planned on

attending. There existed also some disconnect between nurse supervisors and nurses in a couple of sites: many nurses described having never attended a mandatory reporter training while the nurse supervisor believed that all her staff had received such training. This disconnect may be related to differing definitions of what was considered a training, orientation, or presentation. One nurse supervisor shared that although she had organized mandatory reporter training for her staff in the past, since some nurses were in different stages with their clients, not every nurse had been trained.

One nurse explained, “It’s not really, no, that’s gonna occur at our state workshop, we’re gonna discuss mandatory training, or mandatory reporting and some different aspects around that. This one, like it’s an organization like keep children safe or something like that, where we’re gonna talk about child abuse and neglect.”

Another example of the disconnect between nurses and nurse supervisors was when one nurse stated, “I had - (*laughs*) So, I don’t know if it’s just my poor memory, but I don’t remember - Other than, you know, something - A blurb somewhere that just said I - Because I’ve always known I was a mandatory reporter since I became a nurse. Although I don’t honestly remember receiving any sort of training, so.”

The nurse supervisor from the same site shared, “Over the years we attended [physician name removed] at [local county name removed], Drug Endangered Children, but not something every – and we also well actually we have a yearly mandatory training on these issues that every single staff does. It is a, they’re web-based training.”

Another nurse supervisor explained, “So everybody, I think the thing that we have to remember is that everybody is moving, coming and going so if you ask every staff, have I talked to them about mandatory reporting, no they don’t have, they just have prenatal kids - So we are all in different stages. And we could have a training today and hire two new nurses tomorrow.”

IPV-related Trainings

Training and education related to IPV varied across sites with two sites that seemed to have had extensive training on IPV whereas the other sites had minimal or no discussion about existing trainings related to IPV. Many nurses from a couple of sites shared about the training and educational opportunities currently available to nurses related to IPV. Such opportunities were more focused on practice and included trainings and workshops on assessing for DV and healthy relationships, mandatory reporting requirements related to IPV, developing a safety plan, the impact on the client and baby (including traumatic impact on the child’s development), and how to support clients who were experiencing IPV. These types of education were usually provided by representatives from the local women’s shelter or advocacy groups. A couple supervisors from two other sites discussed their training around IPV which focused more on policies such as state laws related to DV, what to do when something could not be substantiated, and who to contact to make a report. One nurse in particular explained that she had been certified in lethality assessment for IPV and had been able to conduct such assessments with her clients. In general, the frequency and availability of IPV-related trainings varied from site to site with some nurses from several sites indicating that they only participated in IPV education as a new nurse home visitor while others received ongoing training once or twice a year.

One nurse explained, “Well, like we just in [redacted] had a [event name removed] where we had a speaker from [women’s shelter name removed], which is the women’s shelter. And had her come in and talk about healthy relationships. How we can assist our clients in developing a safety plan or identifying what a healthy relationships looks like and kind of building on some of those skills. A lot of us deal with a lot of domestic violence. How do we best support our clients in that? Things like that.”

Another nurse said, “I know that we have a lot - Like, we do a lot of domestic violence training. We do a lot of, you know, dealing with a- We’ve done trainings on, you know, dealing with somebody that’s maybe come from an abusive situations themselves and how you deal with that kind of brain, and - So, we’ve done a lot of that.”

One nurse supervisor shared, “Um - Well, we’re going to be going to a domestic violence academy. It’s a two-day thing in April. I had gone last year. It was fantastic. And, learning the laws of Colorado...”

Another nurse said, “I have been certified in a lethality assessment for domestic abuse, so it allowed me, with that client, to really do that assessment, to know what she was dealing with.”

Substance Use Trainings

Numerous nurses and nurse supervisors from most sites described a variety of trainings and educational opportunities that they had received related to substance use, primarily marijuana. Such opportunities typically included trainings, workshops, and conferences that nurses attended on what is or is not reportable with marijuana, new trends such as edibles (marijuana-laced), and the risks to children. Some nurses from a couple of sites also talked about having had someone from a partner organization (such as a physician) or a Child Welfare representative attend one of their team meetings to talk about marijuana and the legality of usage around children. A few nurses and a nurse supervisor from a couple of sites also described trainings that they had attended around general drug use, drug-endangered children, and fetal alcohol syndrome. Several nurses from one site also explained that they had been educated on the importance of teaching safety with marijuana use similar to secondhand smoke.

One nurse stated, “Well, we went to a workshop probably about a year or so ago that, where they addressed it there. And, basically, they say that the drug use needs to be out of sight and reach of the children.”

Another nurse explained, “And, she yesterday mentioned that, you know, marijuana products are in, can be so concealed, you know, in cookies and chips and drinks and so on that even she says she doesn’t really know how those products look, so you- We were kind of brainstorming and maybe, you know, it would help to do like a- To go to those stores and familiarize, familiarize ourselves with what the products are and how they look, so that then we can identify, if we see something in the home, and is this child playing and maybe tasting some of that.”

One nurse supervisor shared, “You know the staff went to the drug endangered one. I think that was really helpful. Because it just helped, bring home all the different things

that could be happening. And we did go to a Drug Endangered Child one about marijuana at [redacted] Police Station.”

Another nurse expressed, “So, it’s all about safety, you know, it’s legal now, so you know, it’s if – only if you see it out in the open when we go in for our visits and the baby’s, you know, able to get it. If they’re smoking in the house, and then she went over the law, like, when they have the license to have it, or that’s a medical thing that they have, a license to have it in the home. However, they have to have it into a certain room. It’s got to be vented. And, that’s – it’s got to be where it’s signed off by somebody that actually checks to make sure everything is legal where some people can smoke it, but they’re not – some of the homes aren’t vented or, you know, the babies are there or whatever, so.”

Other Trainings and Education

Several nurses from most sites described a variety of other types of trainings that they had available to them. Such trainings included topics like Bridges Out of Poverty, motivational interviewing, Psychological First Aid, People in the Midst of Trauma, identifying dangerous homes, self-defense, how to recognize gangs, law enforcement, strengths-based approaches to working with clients, family dynamics, and family counseling. Topics of these other trainings described by the nurses varied within and across sites. The lengths of these trainings also varied from a couple hours for one session to ongoing courses over several weeks. However, most of the nurses across several sites described the training opportunities to have been helpful in improving the services they could provide to their clients.

One nurse reflected, “Oh, under the trainings, I guess we also had - We regularly have trainings on how to go into dangerous homes, self-defense courses, how to recognize drug-endangered families, how to recognize gangs.”

Another nurse shared, “We have- We’ve gone through extensive motivational interviewing. And, the Bridges Out of Poverty series. Working with People in the Midst of Trauma, that has helped, actually, because there are all these centering activities that you can do. Even though it seems like it’s out there, you know, it’s - A lot of my clients are in the middle of trauma. What did they call that? Psychological First-Aid, I think they called that.”

Another nurse said, “There’ve been some training through the Department of Human Services on family dynamics and family counseling kind of things and working through those. But at [organization name removed] the counselors would do periodic in-services for that. It was real nice to be able to be work with some other health professionals that kind of looked at things from a different point of view sometimes.”

Learning on the Job

Similar to the informal one-on-one education, a few nurses and nurse supervisors from some sites explained that some education and training also occurred “on the job” in a “learn as you go” manner. Such learnings were described to include how to engage in case conferences, learning about cultural factors related to assessing risk, and working with hospital staff. A couple of

nurses from different sites also discussed incidents where they had to learn what was reportable and how to report in real time.

One nurse supervisor shared, “So, as far as training, I think a lot of it is learning as you go. And, using our case conferencing and one-on-one’s, you know, to support new nurses through the process, so...”

In reflecting on mandatory reporter trainings, one nurse stated, “And I think it’s been quite a while since they had them. So, but other than that, I just had on-the-job training - this is how you report, these are the forms that you fill out, that’s basically it.”

Another nurse shared, “So, we did the education, then when I came back to work, I was just very upset and talked to my boss, and I just said, again, ‘What’s reportable? What’s not?’ So, we did consult one of the doctors that was here, and he just said, you know, ‘Again, all the information that I’ve read and the way that the law is and stuff that the best thing is to just educate like you would cigarette smoke, but...’”

Lack of Training and Education

Perceptions about whether or not nurses and nurse supervisors lacked training and education varied across sites and by topic. Several nurses and nurse supervisors from some sites stated that they lacked training and education relevant to their work with clients, particularly around identifying risk and mandatory reporting. A few nurses from different sites also described how the lack of training or education impacts their work.

Identifying Risk

A few nurses and nurse supervisors from a couple of sites stated that they lacked training in assessing and identifying risk. A couple of nurses from different sites spoke about the differences between assessing risk in hospital environments versus in a home and that they had not received any training or education specific to assessing risk through home visitation programs. A nurse supervisor from one of the sites also stated that her site lacked knowledge around assessing failure to thrive.

One nurse explained, “Yeah. Because I’ve not been educated. I’d say the huge barrier is that I have not been really educated in what - I mean, you know, all the years in the hospital and stuff like that...”

When asked about being trained in assessing risk, another nurse stated, “No. We - I mean, when we - I have not had any trainings, no.”

One nurse supervisor shared, “So I think that there’s a lack of knowledge, especially when it comes to failure to thrive.”

Mandatory Reporting Training

A number of nurses from most sites stated that they lacked training around mandatory reporting. Many nurses from a few sites generally stated that they had never received any mandatory reporter training. Multiple nurses from one site shared that they were unable to attend when the

mandatory reporter training was offered for their site. In a couple of sites, some nurses shared that during the onboarding process with their agency, they were given a manual or a quick presentation on their site's policy with mandatory reporting. However, some of these nurses admitted not having thoroughly read through the manual, or recognized that the presentation was not helpful for their practice. For example, nurses were told they were mandatory reporters but did not fully understand the process of reporting. Indeed, one nurse from one site felt that she had sufficient training in recognizing signs of child maltreatment, but lacked education in the process of mandatory reporting. A couple of nurses from a different site explained that they had requested to their supervisor to receive mandatory reporter training but had not yet been provided with any training.

While reflecting on the mandatory reporter training that was available for her site, one nurse shared, "There was one - I want to say with [presenter name removed], but I was sick with the flu, so I didn't get to go to that, unfortunately."

Another nurse from the same site stated, "I have not. I know that the group went early this year, but I was on maternity leave, so I have not."

A nurse supervisor said, "Uh, it's - I don't ever recall getting a specific education on mandated - Being a mandated reporter. It goes along with being a nurse, but—[redacted] But, I mean, it goes along with being a nurse, but there was never—in the [redacted], going on [redacted] now, years—I've never received any mandated reporter training as an NFP nurse. No."

Another nurse shared, "No, not really. I mean when I started I was given the Colorado Mandatory Reporter manual, which is pretty thick and to be quite honest, I'm not going to sit and read the whole thing."

A nurse from a different site explained, "Just, I've had quite a few trainings on child abuse reporting and all that. I mean, not the reporting itself, just the trainings on recognizing child abuse and what to do. So I'm very comfortable with that. The reporting I would like, and we were telling our manager, which apparently came after this last year, they started putting it into our orientation... But the rest of us who have been up here... for two or more years haven't had the formal training on, although now my supervisor, since this last report, she gave me the protocol of everything you fill out, so I feel a little bit better about it... I would like one more training on it."

Another nurse from the same site shared, "Those was the ones that I really—um, and this is what I told my supervisor when you're still on the orientation phase—is that I want to be, like, you know, I wanted training on the DHS reporting because it's very important."

Opportunities for Future Trainings and Education

Every nurse and nurse supervisor from all sites discussed their needs and desires for additional training and education around a variety of topics including assessing risk, substance use, IPV, and mental health. A number of nurses and nurse supervisors from a few sites also described

their preferred learning style such as group size, in-person versus web-based, and frequency of trainings and education.

General Training and Education Needs

Several nurses and nurse supervisors from all sites described general training and education needs that they had around a variety of areas. A few nurses and nurse supervisors from some sites spoke broadly that they desired trainings that were specific to home visitation programs given their unique circumstances of working in people's homes and often being alone in such situations. Specific topics that nurses and nurse supervisors wanted to develop their skills and knowledge around varied greatly within and across sites. A number of nurses and nurse supervisors from different sites discussed wanting to learn more about issues related to fathers including how to educate mothers on the rights of the father to see the child, addressing issues with child support or restraining orders, and how the involvement (or lack of involvement) of fathers impacted children. Some other topics that nurses and nurse supervisors wanted additional training and education around included benchmarks for child development, the impact of violence in the home on the child, preventing child abuse, building client strengths, available community resources, motivational interviewing, how to maintain client relationships, and potential legal ramifications for the actions nurses took (or failed to take) when interacting with clients.

One nurse explained, "Yes. (*laughs*) I would like to see training, number one, specific for our role. Because a lot of the trainings that they do are not nurses going into the home."

Another nurse shared, "...if I'm seeing that this baby is - 'Your baby's not being taken care of,' and you know, 'I need to report it.' You know, and, 'I hope it doesn't mess up our relationship, but I have to do it.' How else can I do it? Or, what can we do? How, as a nurse, you know, to try to keep our relationships and yet - Maybe more training on that, some tips on that, what do - What do other nurses do in a situation like that?"

Another nurse said, "You know, partners are very important in, you know, families in a child's life, the fathers. And, I really like to try to involve partners during visits, but sometimes, you know, they're either working or they think it's more for the moms and so on. So, maybe some training that, you know, where we could just learn about, more about, you know, what research is out there about the fathers' involvement and how that affects the child's life. And, you know, we know a little bit. Of course, we know about that, but - And, really maybe if we could get some tools. How can we involve fathers more? And, maybe some more facilitators for fathers. We have a few, but even more, so that they would know that they're welcome to participate at every visit, that we want them to participate at every visit."

One nurse supervisor stated, "I think something on drug abuse would be good and how that can impact and I think the issue of violence in the home and how that impacts. Even though those might not be mandatory reporting, there's no violence at the time, what the risk can be for the child. And a bunch of drunken, brawling men in your home and the child's in the middle of it. They can get hurt. Those would be my ideas."

Assessing Risk and Neglect

A few nurses and a nurse supervisor from some sites described their need for additional training and education on assessing risk and neglect. Some nurses from different sites and a supervisor stated that they wanted additional training on knowing what the “red flags” were for in-home assessments and on assessing concerns that included gray areas such as defining neglect or minimum of care and addressing failure to thrive.

One nurse stated, “And, I would say some of it - Some is blatant. Like, we know when we’re going to report. Some of the neglect issues can be challenging because, I’ve been trained, it’s minimum of care. Well, what’s minimum of care? And then, I would say our drug issues, especially in this state with our changing laws are going to be huge in what’s coming.”

Another nurse said, “Prevention and just - Yeah. I guess, yeah, that would be part of it is just kind of assessing the risk and what to watch for.”

A nurse supervisor explained, “I know we definitely need more training on failure to thrive.”

In addition to education on assessing risk, some nurses and nurse supervisors shared opportunities around the development of tools to assist them in this practice. A decision tree with information on risks and subsequent actions or resources needed to address the risks was suggested by several nurses from one site. Other nurses from another site proposed that five basic assessment areas should be developed for nurses to focus on when entering a home. Other recommendations included the development of risk assessment tools that could be used during certain timeframes with the client, e.g. admission, after baby is born, etc. Some nurses from various sites expressed knowledge that a risk assessment tool was in the process of being developed.

One nurse stated, “And, I know [supervisor name removed] and I and a few people have talked about kind of like having a decision tree along the lines of, you know, ‘Is this person – what kind of risk is this person at? Or, this baby at?’ And, knowing when do we call? Or, when should we kind of keep it more on our radar? Or, is it – you know, just – you know, keep it in the back of our head more? Yeah, or is there other resources that we could get involved with her situation?...”

Another nurse regarding risk assessment tools shared, “We don’t have any. I know there’s been talk of that, that would be helpful, and you know, using those risk assessment tools, you know, on, you know, a certain timeframe. Like, you know, when we do their admission time, or like maybe after Baby’s born and having those set times, but also knowing that we could use them at any other time if we needed to...”

Another nurse stated, “I think maybe – it would be nice from like Nurse-Family Partnership to include that in somewhere in the education. What you do in those situations to kind of be guided because it feels like, from site to site, it may vary. And so, a lot of times, we’re just kind of relying on that gut instinct or seeing the signs of – obviously, if you see the signs of – physical signs, you can report that a little bit easier.

But, it would be nice to have some education, I think, from Nurse-Family Partnership. And, I think we're trying to work on that with the risk assessment. Yeah."

Substance Use Trainings

Despite many sites having attended trainings on marijuana, several nurses and a nurse supervisor from most sites discussed the need for additional training and education related to substance use, particularly marijuana. Many nurses from multiple sites wanted to learn more about where it was legal or illegal to smoke and whether or not such policies differed when a child was present. A few nurses from different sites also wanted to learn whether or not they should report marijuana use when they could smell it in the home where the baby was present but they were unsure who was smoking. Other areas for additional education and training desired by some nurses and a supervisor from a few sites included the impact of marijuana use on babies as well as what mothers could do when they did not smoke, but marijuana smoke permeated into their home either through a window or vent. Several nurses and nurse supervisors across multiple sites shared that these issues were particularly pertinent given the new laws in Colorado and that they wanted ongoing (typically annual) trainings that provided them with updates on the changing policies.

One nurse stated, "...I think, because we are mandatory reporters, probably it would be good for us to go once a year, just to get, you know, like the thing with marijuana. Because we don't even know like now - Because if there is marijuana in the home, since it's legal, I know that it needs to stay away from the kids, but you know, I don't think they've even figured that out yet, to be honest, but - But, I mean, that's an example of with the laws change - I mean, I think it would be really good for us. And, it doesn't - It could even be an hour refresher. It doesn't have to be a big thing, but if there's any changes in the laws, or just reminding us the things we need to do. That would be good."

Another nurse explained, "But some of them will say, well this particular one will say 'Well, we go outside and smoke on the patio, so the baby doesn't smell it.' Well, the mother, the grandmother of the baby, the client's mother said 'Oh no, they open the door, and I smell it and the baby smells it.' So I'm kinda curious as to the legality of that, are you allowed to smoke marijuana while your child is in the home? Cause I tend to say, to tell them no, it's just like being, you're impaired."

Another nurse stated, "So, if something changes—like legalizing marijuana here in Colorado—that, again, would change - You know, maybe we need some more education then. Um - So, maybe once a year, maybe every other year. Once you're in the Nurse Family Partnership program, when you first get started, having some mandatory training and then maybe annually or - I don't know. At least once a year, probably."

Another nurse said, "The drug stuff would be nice too. Especially the marijuana. Yes, you smell it and you don't know whose using. What do you do? Do you report it because a child lives in the house and you can actively smell it? Is that illegal? You know, is that something we need to be reporting as neglect."

IPV-related Trainings

A couple nurse supervisors and a nurse from different sites described their need for additional trainings and education around IPV. Topics of interest included the impact of IPV on a child's development, whether or not to report when a client shared a story about past IPV without current visible marks (and if there was a cut off for reporting past events – i.e., within a few days, weeks, months, years), what was considered statutory rape (including age of the client and the age difference between the FOC and client), and whether or not to report IPV when it occurred when the child was not present or when the mother was pregnant without any other children present in the home.

One nurse supervisor stated, “And then the issue of how does it impact - the child's brain and development. Because our moms, I just want them to have a dad and I want to stay with him. They don't think about what that amount of stress and violence is doing to the child's growth and development. And how to talk to moms about that.”

One nurse shared, “You know, but then you have people saying, ‘Oh, but the kids weren't there. They were like asleep in the other room. They didn't know anything.’ And, it's like, ‘Well, do I still call on that’ Sometimes having those things clarified - Or, also the whole sexual predator kind of thing, you know, when you have a client who's pregnant, she's what? 13, 14 years old. How old is the baby's father? You know, kind of getting a review on that every now and then, what, what - What says - What denotes that sexual abuse has happened kind of thing.”

Another supervisor said, “But, if the child's not even home, or if she's pregnant - Is that reportable? I don't know. So, this is an area that I would like some instruction on because, you know, an unborn child is an unborn child, and it - You know, we don't report marijuana usage or alcohol, so why are we going to report domestic violence? I - I - You know - Don't know. So, it could - We could use some - I could use some info on that.”

Mental Health Trainings

A couple of nurses from different sites shared about their desire for additional education and training around mental health, especially for new nurses with limited experience in handling mental health clients outside of the nursing school rotation. These nurses shared that they lacked training in diagnosing or recognizing signs of specific mental illnesses. Indeed, one nurse described a situation where she was unable to make a diagnosis but it had been apparent to her that her client suffered from a mental health condition that could have jeopardized the nurse's safety. Another nurse from a different site explained that she had taken it upon herself to research and read about mental health to further her own professional development since such opportunities had not been made available to her. She also shared that she desired mental health training specific to maternal and child health and that such considerations were being discussed with one of the lead administrators of the NFP program. With regards to mental health's relevance to mandatory reporting, a few nurses from several sites expressed a desire for further training, not just for recognizing symptoms of a specific mental illness but how mental health related to their role in mandatory reporting.

One nurse stated, “Well, it’s been a few years back. So- She just, she was- you know - I don’t have that training so I couldn’t give you a diagnosis or anything but it was pretty obvious mental illness and saying things that didn’t make sense and she kept asking me. ‘Are you scared? Are you scared to be here right now? Are you worried about your safety?’”

Another nurse shared, “We did one like postpartum webinar, but that was more mental health stuff, but it was postpartum OCD, which was weird cause it should be like postpartum severe anxiety was more how those symptoms manifested but it was called OCD and I feel like that could have been helpful for some of the mental health stuff that runs very closely with that, very close parallels with the mandatory reporting. But I don’t think we’ve had anything and I would love some. I am always reading research articles, books, whatever I can to further my own professional development.”

The same nurse went on to say, “So anyway that was just horrific and there was supposed to be a conference call with Dr. Olds about more training for the nurses for mental health evaluation and things like that because I, you know, I’m fairly fresh out of nursing school. I hadn’t really had a lot of mental health training, just my mental health rotation which is a substantial amount... You know, so and it not specific to maternal/child health or yeah, you know, so.”

Frequency of Trainings

Multiple nurses from most sites and a few nurse supervisors from different sites described the frequency of trainings that they would like to receive. Most nurses and nurse supervisors within and across sites consistently stated that they would like annual trainings for the various topics described such as assessing risk, IPV, and substance use.

One nurse said, “I guess what I want to say about that is I think, because we are mandatory reporters, probably it would be good for us to go once a year, just to get, you know, like the thing with marijuana.”

Another nurse shared, “Um - I think training would be really good for us. And, I feel like it might have to be - The training might have to happen several times, not just a one-time training. Because I know I had training at some point, but I’m like, ‘Oh - How much do I remember from that?’ So, maybe consistent training, like once a year or something.”

Another nurse stated, “But, I think, you know, if we knew that, twice a year, we, we would be getting together with them and hearing what was the latest and the greatest, or what- Are there changes in the law? You know, that kind of thing.”

Preferred Learning Style

Moreover, a number of nurses and a couple of supervisors from a few sites described their preferred learning styles for future trainings and education. Many nurses and a couple of nurse supervisors from some sites shared that they generally liked in-person sessions where they could ask questions and dialogue with others. Although some of these nurses from different sites liked large groups and conference settings, many nurses and one nurse supervisor expressed preferring small group or regional sessions. Some nurses and a nurse supervisor across different sites stated

that they would like these sessions to provide opportunities to cover case scenarios and to discuss best practices and lessons learned.

One nurse shared, “You know, I mean, I think conferences are great. Things- I don’t know if- I was trying to think of like the size of the training. I think it’s better when it’s a smaller group, smaller setting. I don’t know if would be something to come to each clinic, or something that you start at each clinic, each site. Something that you start maybe at the state and then you finish or follow up, you know, at each site. That way there’s a chance to talk. Because I think, once you’re in a conference, it’s great, you’re getting all this information, but it’s - What if you have questions? Who do you ask? That sort of thing.”

One nurse supervisor said, “But it’s very much let’s learn from each other, and even bad cases and good cases. What did you do to make this really work?”

Another nurse expressed, “I like interactive or face-to-face.”

Another nurse supervisor stated, “I do much better like - I learn better if I actually do (*laughs*) like hands-on kind of stuff. That’s just my - I like that a lot better, so.”

A couple of nurse supervisors and a nurse from a few different sites shared that they would like future training and educational opportunities to be made available through webinars. Similar to the in-person sessions, the supervisors and nurse suggested that the webinars be interactive and include case scenarios, pictures, and various self-learning modules. Although the two nurse supervisors preferred in-person sessions, they provided two reasons for also wanting webinars. One was to have a consistent and readily available training tool that could be administered at any time without hiring a trainer or coordinating schedules among nurses. The second reason was to avoid the time and financial challenges that came with traveling to Denver where most large trainings and educational opportunities were typically offered. However, it was also brought up that the webinars may need to be tailored to each county to align with any unique public and organizational policies that may exist.

One nurse supervisor stated, “I would like to see, maybe a webinar or something you could use so that as staff come in, it’s always available, that’s kind of general. That we can talk about our specific counties, because different counties are different.”

The same supervisor continued to state, “I’m sure most of the supervisors would come up with that but, I think the webinars. I just keep coming back to that, with pictures, I just, interactive, I think that’s kind of, it’s a, it’s a beginning start...Because if I, if I bring up 4 more, it’s like you can’t, one-on-one training is not always as easy. And they have some time before they have the national training. How you can develop more self-learning modules? More - scenarios. I think scenarios is really important.”

Another nurse supervisor explained, “Well, one side of me says I like the classroom better, but the other side that has to travel to Denver says, ‘No. I prefer web.’”

One nurse said, “Right. Um, online, like the webinars are great. You know, especially if there’s not a lot of change, and you know, they just kind of refresh, you know, some stuff.”

Education and Training for CPS

Similar to NFP nurses and nurse supervisors, some caseworkers and supervisors from all sites described a variety of education and training opportunities that had been available to them. These education and training opportunities included extensive new hire trainings as well as ongoing training requirements to maintain certification. Education and training opportunities and topics varied across sites and included general job responsibilities and community resources including NFP. Many caseworkers and supervisors from different sites also indicated an interest in further education and training around these same topics. In addition, multiple caseworkers and supervisors from different sites described education and training that they offered to community members including topics such as mandatory reporting, assessing risk, and the role of Child Welfare.

Existing Training and Education

Numerous caseworkers and supervisors from all sites described various education and training opportunities that existed. Several caseworkers and supervisors across most sites, as previously explained in the Organizational Structure section, consistently described having a training requirement of 40 ongoing hours each year as well as education and training opportunities regarding their general job responsibilities. However, education and training opportunities around specific topics such as substance use, IPV, mental health, and community resources varied across sites. The structure of education and trainings across sites typically included webinars, in-person trainings and presentations, as well as informal “on-the-job” learning opportunities.

Requirement

As previously summarized in the CPS Organizational Structure section, several caseworkers and supervisors across most sites consistently shared about the existing training requirement for CPS workers. They stated that caseworkers were required to participate in at least 40 hours of ongoing training a year to maintain their certification. Many caseworkers and supervisors across multiple sites shared that these training hours could include any topic relevant to one’s work responsibilities including mandatory reporting, child abuse and neglect, interviewing techniques, substance abuse, ethics, and poverty. A few caseworkers and supervisors from some sites also described that the trainings could occur at their site, at the Training Academy, through webinars, or through partnering organizations. One supervisor also explained that caseworkers were required to track their own hours for the state audit.

One caseworker stated, “And then, we go to 40 hours of training every year. You know, from anything to dealing with substance abuse to Child Welfare to ethics to, you know, all the trainings that we have available in the Training Academy. Interviewing kids- It’s a ton of training that we get.”

Another caseworker explained, “Well right now we need 40 hours a year, which I think is very reasonable. . . I’ve taken some outside things, which they have approved. Like I took something with the health department, um, it was about early childhood and different things that they may or may not consider to be training but they’re things that help me. Probably the best training I ever had was, um, about poverty. It was really very. . . It was from the state, and there was a workbook.”

A supervisor said, “Yeah, in fact, I have to have 40 hours of training each year. I think it’s - Yeah, I think it’s 40. And, right now, I’m sitting probably at about 12, and all of them are webinars.”

An administrator shared, “Yeah. So we do that and then every worker has to do at least 40 hours of ongoing training per year. . . So that’s signing up for different classes through the state, or it could be different classes that the community is offering. And then they are responsible to keep track of their training. . . and that would be part of a state audit when they come in to look at employee files. They’re going to look at the training and make sure that workers are getting 40 hours.”

General Job Responsibilities

Several caseworkers and supervisors across a few sites discussed existing education and trainings on general job responsibilities; one of the sites had numerous caseworkers and supervisors who shared extensively about such education and training opportunities. A few caseworkers and a couple of supervisors from different sites described the initial training that caseworkers went through upon hire. The structure of this training was described to have changed in recent years where caseworkers previously attended an intensive training four days a week for the first few weeks but was later modified so that caseworkers instead attended a few days of training each month over the course of several months. In both formats, caseworkers underwent over a hundred hours of training, received an on-the-job handbook, and were required to complete homework that included shadowing other caseworkers. Many caseworkers stated that the new hire trainings occurred at the CDHS Training Academy and typically consisted of the core programs, intake and ongoing procedures, TRAILS, current research around inequities in the rates of out-of-home placements of children, assessing risk and safety, and how to develop treatment plans.

One administrator shared, “Okay, so it’s. The Academy is through the state of Colorado and the workers go for about seven weeks of training, some of it say, not all of the weeks are in the classroom but say they have five weeks in the classroom and two weeks is doing computer based studies. After they complete their Academy they come back with on-the-job training, workbooks that they shadow people, learn that way, and then they’re going to bring it back to their supervisor and have different discussions, whatever the OJT prompts but. Then there’s that additional, you know- put what you’ve learned into practice.”

A caseworker explained, “So, um the training for new caseworkers has kind of changed over the course of years, um for a while it was called the core program, and caseworkers were going once a month for four or five months and for like a week, and uh, they were holding caseloads at that time. Um, and so they were getting the information, um, which

is basically the same information, almost, that we, when I started we got. Um, me and two of the other caseworkers were the very first, when they did the new worker training, um, we were the very first, uh, caseworkers to go through that program. The first class. And that class changed from once a month, for a week for several months to eight straight weeks up in Denver, coming back down for like a day or two, uh, like, and it would randomly change each week, but.”

Another caseworker stated, “You just kinda walk through it, and, some, I mean the actual manual that you get or whatever, the training book has been very helpful, and I’ve pulled that out a lot of times as well as like, they have a little cheat sheet for TRAILS, and so I have that up on the wall so I can get to where I’m doing.”

Another caseworker shared, “Um, let me see, topics, um. The orphan train, how DS, how protective services um does, uh, the very first child who was removed from home was removed by humane society, which was pretty cool I thought. Um, racial inequality in um, out of home placement for children. That was interesting, not 25 slides of interesting. Um, really not giving, giving states, not giving any actually hands on or even book learning that you would need for what the Department of Human Services is mandated that the caseworkers do. How do you do a treatment plan, how do you assess safety, how do assess risk? That’s kind of like an on the job training thing, and it should, the mods would be better utilized that way.”

A few supervisors from a couple of sites shared about other trainings on general job responsibilities including the reporting process to Child Welfare. Training on the reporting process included how to take calls through the reporting hotline as well as how to interact with the alleged perpetrator and answer commonly asked questions. One key aspect that was emphasized by an administrator was that caseworkers were trained not to disclose the identity of the reporting party.

One supervisor shared, “Okay, so we have one full time worker that it’s her full time job to take the hotline. She’s been doing that for [redacted] years, um, and when she is at lunch or something or wherever and other people have to, um, do that and they’ve also receive training in taking hotline calls.”

An administrator explained, “In fact, we do not tell them what the allegation was. We provide demographic information only. And their training covers when the people say, ‘well where did you get my name?’ ‘Why are you calling me?’ Their training covers that you know, there was a concern and they don’t want the allegations, the case manager, it’s a case management model, to play into what, when she works with the family.”

Another supervisor stated, “But we do — yeah, get lots of training in, um, not just child abuse and neglect but in also these initiatives that are being rolled out.”

Discussions around hands-on training varied across sites. A few caseworkers from one site shared that they had obtained various “on the job” education and training opportunities. These caseworkers explained that they had learned new skills and techniques through client interactions, shadowing, and conversing with colleagues in an ongoing process.

One caseworker described, “I think what I’ve learned over the years is you don’t go in there as um, like judgmental or you’re doing this, you’re doing that and assuming right away that what the allegation is, is absolutely true. You know, you go in there, I’ve learned to go in there as, and say ‘You know what, I know, I know 99.9% of people love their children and want them to be safe.’”

Another caseworker explained, “Pretty much I just use the risk assessment with the safety assessment, which is another CDHS tool, but the safety assessment helps me identify just really the big safety concerns that sit in that particular environment. So I use those two together. And a lot of it is just kinda, just skills that I picked up and things that I looked for.”

Another caseworker stated, “And so I think I’m still even probably the newest worker in my unit and so I’ve been able to gain and learn from the other gals in my unit has just been, it’s structured me into what I am now as a caseworker. It’s just, you learn every day, there’s never a dull moment... Some families need you to tell them hey your jacking up, you know, need to not do that no more. Some families need a pat on the back. You know some egos you have to massage and some you have to be just you know, be straight up with. And so you kind of learn a lot of that. You just learn as you go... I learned as I’ve gone on.”

Assessing Risk, Early Intervention, and Mandatory Reporting Trainings

A few caseworkers and a supervisor from multiple sites shared about existing trainings related to assessing risk, early intervention, and mandatory reporting. A few caseworkers from multiple sites shared that they had received education on assessing risk such as the signs of safety, risk and protective factors, and poverty. A caseworker and a supervisor from different sites also described having been provided trainings on mandatory reporting and the caseworker also discussed having participated in a training for improving early intervention and prevention. In addition, one caseworker emphasized the extensive training that was offered around interviewing techniques for assessing risk and safety. She shared that she had received training on motivational interviewing and latency interviewing that included role playing with adults acting like children, reviewing video recordings of her own practice sessions, as well as receiving feedback from others.

One administrator shared, “That, and then just through training with [trainer name removed] on the signs of safety and partnering, partnering for safety, just really a (*phone ringing*) a huge shift in the caseworker not being the expert on the family that the family is the expert on the family and the kids.”

When asked if they had a standard risk assessment tool, one caseworker replied, “Yes we do. It’s through our protective factors training that we’re, that I need to revamp on - and go into more depth with.”

Another caseworker shared, “Well, you know, we do go through the core training when we become case managers, and so we kinda have a refresher that way. But every year, staff are mandated to go to mandated reporting training, it’s like a refresher every year... So, those yearly mandated reporting trainings are through our agency, so.”

Another caseworker explained, “Um, some of the very good trainings that I have received that, um, I’ve taken away with is, um, the, um, the, um, motivational interviewing, um, also the latency interview of children, um, and that’s really for the sexual abuse. And so there was two different interviewing classes, just motivational interviewing on just your clients on how to motivate ’em but interview and get all the information that you need. The latency interview was really to get a lot of the background and what, to work with little kids and to not just sit there and be like, ‘So, what happened?’...actually at the end after everything that we learned, they had an actor come in and they video recorded us...And the actor was the child. And we knew what the situation was, but then the actor was in complete character as the child, and you really had to, you know, even though you’re staring at an adult male or adult female...And so you’re really, um, that was nice because then you could watch it on video and you could see what you did and didn’t do and how, um, and then after we did that, then the next day we kind of reviewed everybody’s videos...So that’s the nice part is that that’s the feedback and the visuals, cause some of us work visually.”

A small number of caseworkers from a couple of sites shared about trainings that had been offered related to behavioral health and IPV. Trainings on behavioral health topics included substance abuse, mental health, medications, and drug-exposed children. A couple of caseworkers from different sites also described learning about different medical conditions and the corresponding medical care that would be appropriate for their clients. Both caseworkers described having gathered this information from NFP nurses who were involved with their clients.

In describing trainings that had been useful, one caseworker explained, “Well, I mean, anything to do with, you know, substance abuse dynamics, abuse and neglect dynamics, mental health, things, you know, to do with medication, you know, pretty much anything that has to do with people’s psyche, people’s, you know, I guess, you know, resources in terms of avoiding abuse and neglect, any of that kind of stuff is helpful. It all applies to our clients.”

Another caseworker stated, “And typically it covers everything from, you know, drug-exposed kids or drug abuse, to dealing with parents with mental health illness.”

Another caseworker shared, “[Organization name removed] is a big one that we, um, refer families to. So, it’s a community-based program. They are awesome. They’ve got lots of trainings here all the time.”

Upon reflecting on the NFP nurses, another caseworker stated, "I think they’re being very, very helpful, even educating us about medical stuff, the child’s needs and, like I said, if there are special needs with a child, it’s very helpful to the parent, very helpful for us...Also, educate us as child protection workers as to what are the diagnoses? What is the appropriate care? What is the most important things in this, you know - Can this mom really do this?"

Differential Response Training

Educational and training opportunities for DR varied across sites. A few caseworkers and a supervisor from a couple of sites shared that they had received training on elements of DR. They stated that trainings had been offered around the general concept and specifically for certain roles or tasks. One caseworker stated that the training for FAR positions included topics such as general procedures and paperwork as well as the assessment process, and another caseworker from a different site explained that training for enhanced screening including how to ask the right questions. A supervisor and caseworker from another site described trainings that they had attended on RED teams which covered the approach, structure, and procedures.

One caseworker explained, “So right now, we have immediate, five days and three days. And so they are in training us, they are giving us that are going into the FAR positions, three and, I think, five day. I just got my first one, my first five day...and sort of learning that because of learning the paper trails and how to sort of just be familiar with the assessment because a lot of the family engagement is, the Family Assessment Response. Sorry. Is assessment; it is just a lower risk.”

Another caseworker stated, “... the roll out is [month redacted]. So I know they’re — they’re starting to train them — I went to the training myself — starting to train workers in how to ask the right questions. And, you know, perhaps before we weren’t.”

An administrator shared, “And, uh, [another supervisor’s name removed] may have talked about the fact that our county is not considered a Differential Response county, which some counties are, which means there’s varying ways that they can respond to, um, a case, and um, we are, um, currently undergoing training on RED teams and trying to develop a RED team approach, where there’s a formalized structure tool that will guide us through asking the questions that the caller brings to us to make a determination whether or not this is a family that we’re gonna work with, that we have the ability to serve and work with, or a family that we don’t feel we need to be involved in.”

Community Resources

Discussions about education and training on community resources to keep caseworkers informed about new initiatives, programs, and interventions varied across sites. Multiple caseworkers and a couple of supervisors from a few sites shared about trainings that they had available to them about other organizations and programs available in the community as resources for their clients. Such organizations typically included mental health providers, substance abuse therapists, domestic violence shelters, and transitional housing. A few caseworkers and a couple of supervisors from different sites described having received information about community resources through formal trainings and in-house presentations including sessions where various organizations and agencies gathered together and each presented about their own services and programs. Some other caseworkers from a couple of sites shared about more informal educational opportunities such as receiving worksheets or handouts, approaching information booths set up by different organizations and agencies, and participating in interagency collaborative meetings where participants educated each other about available services.

In describing the list of community resources newly hired caseworkers receive, one caseworker stated, “They’re kind of specific – the categories they look at. So like

[organization name removed] is one, and that's for not only therapy but also substance abuse things. I always put on [organization name removed], which is our local domestic violence shelter. [Organization name removed], although it seems like I haven't put that one on there lately, but they do transitional housing, or I guess its [organization name removed], I guess is what it's called here in [redacted]."

Another caseworker explained, "Which is why there's a collaboration in our, for our team of different agencies, and that's the reason so that we can educate each other on what's available."

Another caseworker explained, "That's what usually happens [location name removed] every couple months. They have their own table and they set up their booth and they have an explanation of their services and then they can also get in contact with [training coordinator name removed]. She's the training person who can be in charge of how to get a training set up, what to do for that as well."

One manager shared, "We've had it where they come and they present, you know, certain agencies present to our old divisions, so maybe we get more of an understand of what they do other than to see a referral, here you go."

An administrator shared, "And then we're actually just starting a new initiative where we are going to be doing quarterly trainings with people and that wasn't occurring before. So, just kind of rotating in and out of a different curriculum that'll happen quarterly. Sometimes we'll do new initiatives, say, just even like, new programs, and interventions regarding, like, domestic violence. And then new workers come on and then they are never caught up to like that model or practice that we, you know, that we practice here, and so we're going to start doing that differently and just making sure that we identify models and practices that we want to make sure new workers are getting, just being up to speed on, and even the ongoing experienced workers will then test out in these competencies."

Structure of Education and Training

Multiple caseworkers and a CPS supervisor from many sites described the varying structures of the educational and training opportunities that had been made available to them. Although some caseworkers and a supervisor from different sites described having participated in webinars, most caseworkers and supervisors from multiple sites who talked about training structures discussed having attended trainings in-person. Training locations varied from those held at local DHS offices, at regional training sites, and in Denver. A caseworker and supervisor from different sites shared that in-person trainings can be challenging for rural communities because attending trainings in Denver from remote sites required a lot of travel time for caseworkers and bringing a trainer to their local office had often been challenging to trainers. Lengths of trainings also varied across sites from an hour to several days.

One caseworker described, "And what's nice is we now have a regional training site in [redacted], that's the newest, we don't have to go over to the Front Range any time we want to do a training. So that really helps..."

A supervisor shared, “We don’t have the real opportunity to do many trainings here in [redacted]...So, um, traveling here is - Is really kind of a hardship to trainers. And so, we do have some trainings that go to [redacted], which is about 50 miles from here.”

Another supervisor explained, “Yeah, in fact, I have to have 40 hours of training each year. I think it’s - Yeah, I think it’s 40. And, right now, I’m sitting probably at about 12, and all of them are webinars...they’re usually an hour, hour and a half and, you know, are - Have some pretty good information, and I can just sit at my own desk and get the training credit for it.

Another caseworker said, “They’re rarely online. They’re mostly in person. Usually, like three to four-day trainings...Long trainings...A lot of them have become much longer than they need to be.”

Need for Future Education and Training

Several caseworkers and supervisors from all sites described areas where they desired additional education and training. Most caseworkers and supervisors from all sites discussed additional education and training needs related to their general job responsibilities such as family engagement, assessing risk and safety, and community resources. Overall, several caseworkers and supervisors from many sites shared that they preferred in-person trainings and educational opportunities that were engaging and spanning over a few hours rather than days due to their busy work schedules.

Job Responsibilities

Numerous caseworkers and supervisors from all sites shared about their need for education and training around various aspects of their job responsibilities. However, the specific areas that caseworkers and supervisors mentioned varied within and across sites. A couple of supervisors and a couple of caseworkers from a few sites described having a desire for additional education and training around general work responsibilities such as family engagement, DR, and legal terminology, processes, and regulations. One caseworker also discussed the desire to have a certain proportion of the required 40 hours of ongoing training be devoted to self-care since caseworkers often got burnt out.

One supervisor shared, “And, I have been pushing for family engagement for a few years. There is resistance by my caseworkers to do that. With our new supervisor, [name removed], she’s been more involved in that. And then, we got - And, I’ve been asking them to get more trainings around that, but also we got involved with the Differential Response program, which encourages that.”

A caseworker stated, “Well I think one of the big things, that I know they offer for ongoing training, and I just went to that with, the legal preparation for caseworkers, I really, I understand it used to be part of the academy, I really think it needs to be back in there...they should really include that, because there was things that I didn’t understand, and not having a social work background or not learning this before, you know, I have attorneys blah-blah, they’re saying all these things to me and I’m like, ‘I don’t even know what the basic words that your saying, and I don’t know what my time lines are.’”

Another caseworker said, “I think we should be mandated if we’ve got 40 hours, to do maybe 15 hours of self-care. Um, because we get burned out.”

A few caseworkers and a couple of supervisors from multiple sites described needing additional education and training related to working with clients such as assessing risk and safety, substance use, and prevention strategies. More specifically, they were interested in learning more around recognizing trauma and the effects of substance use (particularly marijuana usage) on children. One caseworker also mentioned not knowing much about Child Welfare’s transition to include prevention and thus wanting additional education around it.

One caseworker stated, “But yeah, I think I would prefer somebody expert coming over and training us on what to look for, you know, and you know, for trauma, what are the signs of trauma? I mean I think it’s always good to have a refresher, because what causes trauma changes with the changing of our world, so, you know, getting an update on what’s the new thing that could be looking for is always good.”

A supervisor shared, “And, basically, I’ve been trying to advocate for some new trainings because...we’re basically - Most of the workers here have been here for 10 years plus...And, we’ve been there and done that, and we’d like to have some, some new trainings...I think that, um - Areas of, you know, trauma seems to be a catchword right now...a lot of services in the state. So, I think we need, um - A little bit more trauma training...I think we always need training around, you know, drug and alcohol effects on children...Especially with the new laws around the marijuana usage, the recreational usage...How is that going to affect kids?...Um, with the secondhand smoke and things of that nature that, you know, um-.”

A Social Services director explained, “The marijuana issue would be great just because it’s so new to us...any information we could get on that would be great because I think there’s just a lot of, you know, gray areas that we’re unsure of.”

Another caseworker shared, “Preventions - I think there needs to be more specific things to Preventions because that’s going to be state-mandated which is the area of PA3 which I don’t know what that is. It is not quite Child Protection but it’s what we are doing.”

A few caseworkers from different sites also discussed their desire to receive additional education and training around community resources. They described wanting improved education around services and programs offered by the Health Department and other agencies as well as new initiatives being rolled out in the community, including their expectations for the role of caseworkers.

One caseworker explained, “I think there could be more. Um - I think as a whole that there’s not very good education around what the Health Department offers the community...I think for CPS workers, I think it’s a challenge because of the nature of their job. I think it’s a challenge for them to really be aware of all the different agencies and what the services are that are available for their clients. So, I think ongoing - I think once a year it would be—and, maybe they do this, and I don’t know—but, I think it

would be good for them to have, you know, a brief training on what, what each agency does.”

Another caseworker shared, “Um, maybe, you know with all these initiatives, maybe more trainings for the initiatives... What’s what, what’s being asked of you, um, that could probably work.”

Structure of Additional Education and Training

Numerous caseworkers and a supervisor from many sites described about their desired structures for future education and training. Many caseworkers across multiple sites preferred in-person trainings and presentations that were engaging. A few caseworkers from different sites also noted that despite the requirement to obtain 40 trainings hours a year, it was sometimes challenging to take time away from their other responsibilities and thus they preferred sessions that were optional, held at their facility and/or in conjunction with existing meetings (e.g., division meetings), and over the lunch hour or only for a few hours rather than trainings that spanned over several days. A caseworker and supervisor from different sites also suggested informal sessions that created opportunities for peer-to-peer learning by engaging in dialogues with colleagues and being able to ask questions to one another. The supervisor also shared that shadowing could be problematic due to challenges with confidentiality.

One caseworker stated, “I mean, I definitely think if we had training available in-house, that was something that maybe we could - It’d be like a lunch-and-learn type training where it was something that people didn’t have to commit to—I know that sounds terrible, but it’s true.”

Another caseworker shared, “Um, I think because of just a caseworker’s schedule and how hard it is to take time away to have, um, training, especially like day long trainings, or you know, two day trainings, I think, I think the subject is great, but I think maybe they need to provide more sessions throughout the year, so that caseworkers have more of a variety to actually be able to go in, and you know, sign up for training. You know, there’s more varied days and times. But the subject area I think is great.”

Another caseworker said, “Well, I mean, we have all staff meetings. We had one this morning. People came and talked to us today. Um we have division meetings so just intake workers if you don’t want the entire building to hear about it but just like intake workers. We have those once a month. So stuff like that.”

A supervisor reflected, “Well, shadowing brings problems because of issues with confidentiality and yeah, I’m not sure that would work for us. But, yeah, I think some cross training so that they have some idea... about what we do.”

Education and Training that CPS Offers

Several caseworkers and supervisors from most sites described the types of education and training that CPS offered to external stakeholders. Some caseworkers from multiple sites discussed who at their respective sites were designated to provide education and training to external stakeholders which varied across sites. Many caseworkers and supervisors from many

sites shared about the education and training they offered to general community members including the approach and role of Child Welfare and how they could help address abuse and neglect. Several caseworkers and supervisors from most sites also shared about mandatory reporter trainings that they offered and a couple of caseworkers and a couple of supervisors explained that they had also provided one-on-one consultation to community stakeholders.

Designated Educator/Trainer

A few caseworkers and supervisors from multiple sites shared about the designated individuals at their sites who were responsible for providing education and training to external stakeholders. These positions varied across sites, as previously explained in the Scope of Work section for CPS caseworkers. At one site, it was the responsibility of their screeners to provide education and training to external stakeholders while at another site, there was one specific staff member who was solely responsible for providing internal and external trainings. A couple of other sites again differed where providing external education and training fell within the job responsibilities of one supervisor at one site whereas another site had a supervisor and caseworker who worked together to provide such education and trainings. Workers engaged in outreach and community liaising, who worked intake or investigation, or were supervisors or directors tended to be responsible for conducting trainings in the community.

One caseworker explained, "...we're really kind of pulling together to do some more community response and outreach to help our community supporters, our community partners with this is what we do, this is what we look for. So I do know that they do some mandatory training sessions. And those are, we have our intake team that kind of handles a lot of that outreach. So those are some of the areas, those people in particular would be our outreach, going out and saying, 'This is the services we have, the programs we have.'"

Another caseworker explained, "And, jumping back to some, one of my job duties, actually, is that we as a department have taken it upon ourselves to extend a mandated reporter training to all mandated reporters in our community. And, one of my roles is to go out on site to those entities and train their frontline staff, who are the mandated reporters in what it means and what the process looks like."

When asked who provides external trainings and education, one supervisor responded, "I do that. I take one of my caseworkers and myself and we go do it together."

Education and Training for the General Community

Many caseworkers and supervisors from multiple sites shared about the education and training that they provided about Child Welfare such as its general approach and role in the community, the new transition to DR, and what communities could do to help address child abuse and neglect. A few caseworkers and supervisors from some sites explained that an overview of Child Welfare often included who to call for the audience's specific county, what people could expect when they made a report, what caseworkers looked for in their assessments, and that the role of Child Welfare was not to remove children from their homes. A couple of supervisors from one site also shared their knowledge that CDHS was in the process of developing an online training for mandatory reporters, designed for medical professionals, school staff, and law enforcement, while some supervisors from a couple sites spoke about new initiatives that were to provide

training and education to other organizations and victims of IPV, giving them an opportunity to access services.

One Social Services director said, “And so, you know, we have some staff here who go out and do community presentations. Or, they help do like trainings to other professionals around, ‘If you have to call us, here’s what you can expect. Here’s what may or may not happen. Here’s what you’re entitled to know, what you’re not.’ And, but how to navigate that, just understanding that and, you know, building some relationships and contact points here, just so people would know who to call, rather than just a shot in the dark when you call a random number over there.”

Another director explained, “And, what we’ve tried to do is reach out to these different groups and say, ‘Look, we’re really trying to be more social workers, not just, you know, that’s why we got involved with the Differential Response program, so that we could be more of an advocate and social workers to work with families and help families.’”

One caseworker stated, “The part that I like about the [title removed], is the training our community...and helping be responsible for our children and what they can do to help lower the risk for child abuse and neglect. And, what the warning signs area and, you know, what they can do to support our families.”

Another director expressed, “The state is working on an online mandatory reporting training that would be available to anyone. And, they’re breaking that out into like categories of reporters. So, there would be one module that’s for medical, one that’s for school and one that’s for like law enforcement. And, that is going to be pushed out through the Training Academy, which you know, is now under contract with the Kempe Center. And so, the last I knew, they were doing like final revisions on that.”

Mandatory Reporter Training

Several caseworkers and supervisors across most sites discussed whether or not they offered mandatory reporter training to external stakeholders. However, responses varied within and across sites. A few supervisors from a couple of different sites shared that they did not offer mandatory reporter trainings. One of these supervisors explained that the reason why they did not offer mandatory reporter trainings was because there were liabilities that went with it and thus, most mandatory reporting entities utilized their own trainings. However, a couple of caseworkers at one of these sites shared that they had recently provided mandatory reporter training, therefore, contradicting the supervisor from that site.

One Social Services director stated, “Well, usually, most of the mandatory reporting entities have their own mandatory reporting training because there’s a liability that goes along with that.”

Another director shared, “No, we don’t do any...That might be — I — well, as far as us actually doing the training, no.”

However, a caseworker from the same site stated, “Um, we do, actually, um the last year not so, not so good at it. But most of the years that I’ve been with this agency we go out

to the schools and um, they kinda get to meet us, we talked about mandating, mandated reporting and things like that. So, um, most of the years I've been here we've been really good about communicating that with all the agencies that surround us.”

Another caseworker from the same site explained, “I just did a training per request from our daycare provider that [redacted]. She is the head of the [agency name removed] here in [redacted] and she asked if I would do a training on child abuse to the rest of her members.”

Numerous caseworkers and supervisors from multiple other sites consistently shared that they offered mandatory reporter trainings to external stakeholders. Such education and trainings were described to include different types of abuse and neglect issues, related laws, how to make a report, what to expect in the reporting process, what occurs after a report is made, and the various components of Child Welfare such as intake and ongoing. Many caseworkers and supervisors explained that such trainings were offered to a variety of mandatory reporters including schools, medical and behavioral health providers, NFP, law enforcement, and other community organizations.

One caseworker stated, “I also do mandatory reporter trainings. So, I go out in the community and I train reporters and that includes Nurse Family Partnership or other-mandatory reporters on what abuse and neglect is and how to report and what happens when you report it... We go definitions of what abuse and neglect is and then we talk about what it looks like from the outside. Behavioral indicators of abuse and neglect. Physical indicators of abuse and neglect. And, we talk - We specifically talk about physical abuse, emotional abuse, sexual abuse, and then neglect and the different types of neglect and what that looks like. And then, I give examples through my own experience of things that I have investigated or things that have been reported that didn't need to be reported or, you know, concerns that we have had called in that the audience that I am working might deal with. And then - And then, we tell them how to report and what kind of information we are going to get - we are going to ask when they are reporting the information.”

In describing the type of information that is provided in mandatory reporter trainings, one supervisor said, “I mean, the statute, the different types of abuse, pic—I mean, they show pictures. What's the - What is required of a mandated reporter. And, you know, you don't have to know what happened. It only has to be suspected.”

Another caseworker explained, “I also go out in the community and provide training. It's not on a regular basis. I kind of do it as requested of the department, and so the main thing that I go out and train on is mandatory reporting. And it's not just about the mandatory reporting, but I also talk a little bit about what happens after somebody makes a report and kind of what the Child Welfare rules and regulations are. I always find that that's the most beneficial to people. Like, ‘What happens when I call? Then what?’”

When asked to whom they provided mandatory reporter trainings, another caseworker responded, “But, all of those entities—Parents as Teachers, our [program name

removed], our mental health people, our schools, the NFP, our benefits people, law enforcement—I go out and I routinely train them in being a mandated reporter.”

A couple of caseworkers from different sites described the typical structure of mandatory reporter trainings. They shared that the trainings could be adjusted to the length of time available to the requesting party but generally lasted 1.5 to 2 hours and included a presentation with scenarios as well as time for questions and answer. One of the caseworkers also explained that the trainings could take place at any location such as the Child Welfare office, university, police academy, hotel conference room, or daycare center.

One caseworker shared, “I mean I do like 1 ½ to 2 hours, depending on people what works best for them...And it seems like, there’s always seems like there’s scenarios anytime I go out. Or someone will say, ‘I have this family and here’s the situation and what do you do or not do?’ Or kind of thoughts about that. So it’s like that, I could be making that up. But I’m sure that happens in almost every training I do – someone has something to say like, ‘Well what about this?’ And I really like it to be a dialogue because I think that gets you thinking better than me just saying like, ‘If it’s this, you report it. If it’s not, don’t report it.’ Or you know, like, let’s kind of talk about the nuances because it’s not black and white.”

Another caseworker explained, “The presentation is typically about an hour and a half of information and then we usually leave it open for 30 minutes of conversation of questions and stuff like that. There are some groups that will tell us we only have an hour, and, so, we will have to work with that and shorten it and try to get as much information in that hour as possible. But, for a really good presentation it is about an hour and a half to two hours.”

The same caseworker went on to state, “We do them here at the office. I have gone to our university here in town and trained students there. I go to the police academy and train the people going through the police academy. We have had it at a third - like at a hotel and invited a bunch of medical personnel to it. It just - it just depends on what’s - We can go anywhere. I have gone to daycares and just done a little training in their back room.”

One-on-one Consultation

A caseworker and supervisor from different sites shared that in addition to calling individual workers directly, community members could call the hotline for one-on-one consulting. They stated that one does not need to make a report when calling the hotline and that the individuals who answered the hotline were trained on talking through hypothetical situations and providing feedback regarding how the caller could best support the family.

One caseworker shared, “We always tell them, you know, call the hotline even it’s not - even if you’re not reporting. That we’re there to help you out with that too, so. It’s our job to educate, so.”

A supervisor explained, “The other thing that we do for other nurses, doctors, the hospital, schools is that we are an open line for them to call with the hypothetical that we talked about earlier - where it’s not actually a report of child abuse but we can get them

feedback on how to support families without us. Nurse Family Partnership does not use that, but all the providers in this community do.”

Education and Training for Other Partners

Multiple community partners from different sites shared about varying education and training opportunities. A few community partners from some sites shared about education and training opportunities that they had received around their own scope of work while a couple of community partners from different sites shared about education and training opportunities that they knew were available to NFP nurse and CPS caseworkers. A few community partners from multiple sites also described their perceptions of additional education and training that could be beneficial for NFP, CPS, and other community organizations.

Scope of Work

A few community partners from different sites discussed education and training opportunities as they related to their scope of work. A couple of community partners from different sites shared about trainings that they had conducted including topics such as substance-exposed newborns, abuse and neglect, and assessments and screenings. Such trainings were offered to caseworkers as well as physicians. A community partner from another site also described education and training opportunities that had been available to her including Child Protection trainings, nurse trainings, public health trainings, and learning informally from colleagues.

A director of a crisis center shared, “Yeah, I’ve done lots of training, and I- It’s an area that I’m interested in...So, for example, the substance-exposed newborns that we did these convenings, eight convenings around the state, [redacted] got a little bit of grant money and was able to pay for some of my time...So, I have done a fair amount of training around that, a fair amount of training around abuse and neglect. I feel really, really strongly that this project around, you know, basically developing this network, that first- You know, that- Developing those people that have knowledge around abuse and neglect, it starts with face-to-face training...I used to do a training for our caseworkers, probably every six months”

A program coordinator stated, “And, to give you an example, physicians’ offices are usually the place you embed developmental screenings. We didn’t have any really doing standardized screenings regularly with all their, at well-child exams birth to five. We worked, we set up a referral path. We worked with physicians. We trained them. They have it embedded. They bill for it. It’s now part of their regular work. We can end tomorrow. That system is in place.”

A health department staff member serving children with special needs said, “I have a whole file cabinet full of trainings. (*laughs*) I think Child Protection does a good job of bringing people in about drug-endangered children and offering conferences. There’s nursing trainings that are hosted in the state and public health trainings, I think. A combination. I can’t specifically name each one, but all of them have just helped a lot.

And, working with the clients, you learn so much about yourself and new ways to try things and learning from the other nurses, I think, it is really helpful.”

Existing Trainings for CPS and NFP

A couple of community partners from different sites shared about the education and training opportunities currently available to their local NFP nurses and Child Welfare caseworkers. One community partner shared that their local NFP nurses received training on motivational interviewing as a strategy for better engaging families in developing their parenting skills. This training was offered by a local mental health provider. Another community partner from a different site explained that their local Child Welfare caseworkers had a variety of education and training opportunities at their all-staff meetings on a variety of topics. They also had an annual retreat for Health and Human Services employees where staff were able to learn about each other’s programs and other services available in the community.

A health department staff member serving children with special needs explained, “I think motivational interviewing or what they call family engagement, it is the way that they talk to the clients to - I think that the change has to come from the clients, and then, if we can get on their side and kind of team with them about how to be a better parent and the resources in the community and what to do when they need help and find people in their lives that can help them out when they’ve going through a difficult time. I think all of those types of skills when they’re working with those people is valuable, who they can call if they have a question. And, I think both programs kind of do that already, but it never hurts to keep up on those skills. And also, like I said before, just learning about what each other does and...I’ve seen our local mental health program, which is now- It was [former organization name redacted] and then [organization name redacted]. They had a therapist who came over and did some training at the Health Department, which I thought was really nice. And, I’ve seen different trainers come in and offer those kinds of things, skills.”

A public health director stated, “It’s an all-staff meeting. Those are always on the [redacted] of the month or every other month...And sometimes we’ve had some really interesting training that has happened. [Mental health provider name removed] has come over and given some training...And then we have a mandatory retreat almost every year. We didn’t have one this year, but we generally have a mandatory retreat through the HHS.”

Opportunities for Additional Education and Training

A few community partners from different sites discussed additional education and training opportunities that they felt would be beneficial to other organizations and programs. One community partner felt that social workers from regional care collaborative organizations should be trained on how to best serve children who had experienced abuse or neglect since all children in foster care were required to be designated to a resource social worker in this model of care. Similarly, another partner from a different site believed that additional crossover training should occur with law enforcement and medical providers to ensure that they were familiar with the work of NFP and the best approaches for preventing or addressing child abuse and neglect.

A director of a crisis center stated, “To me, I think what makes probably the most sense is with the RCCOs [Regional Care Collaborative Organizations], you know, they have the PCMHs, the patient-centered medical homes, is almost defining of those homes. Because now, the RCCOs are required to - All the kids in foster care are required to be designated to a RCCO. But, my problem is, is not everybody in a RCCO knows how to take care of these kids, or frankly, wants to... So, let’s find out who those folks are. Let’s give them additional skills and training and support, access to the right information.”

A public defender said, “That person would be creating that programing, ensuring the training across maybe the law enforcement crossover and the medical community crossover... and then that’s where the Nurse Family Partnership would come back and kind of facilitate those trainings and provide maybe one or two nurses who could be available to come and meet people and sit down and talk about what it would look like.”

Cultural Implications for NFP Nurses

In addition to education opportunities within their scope of work, various types of culture were described to have impacted the work of NFP nurses and nurse supervisors among many sites, including clients’ culture and community culture.

Clients’ Culture

Some nurses and nurse supervisors from most sites discussed the presence of cultural variations among their clients and how these variations had impacted service delivery. However, client demographics and capacities of nurses to adequately serve such clients varied by site. The majority of sites indicated having high rates of Hispanic and/or Spanish-speaking clients and some also had clients from Ethiopia, Eritrea, Burma, and Asia.

Sites with bilingual and bicultural (usually Spanish-speaking and/or Hispanic) nurses described ease in serving such clients due to cultural understandings and lack of communication barriers. These nurses shared that they had translated materials or adapted curriculum to fit the needs of their clients. However, some nurses from such sites still struggled with adapting the curriculum to fit cultural norms, considering potential cultural differences when conducting assessments (e.g., norms around physical affection, baby weight, family planning, discipline, and environment), and changing behaviors that had been passed down for generations (e.g., Machismo and IPV being normal). This was also true of sites where nurses were not bilingual and relied upon interpreters. Other cultural barriers expressed by some nurses across multiple sites included: hesitancy to become involved with NFP or make reports about IPV, etc. due to fear of deportation, concern for safety when there was a large age difference between the mother and FOC; clients not knowing the laws in the United States; variations in gender norms that could be perceived as inappropriate in the United States (e.g. Machismo in the Hispanic culture); misinterpretation of cultural practices (i.e. overreacting to an infant being bundled in warm weather); overstepping cultural boundaries (e.g. being the first person to make a child laugh); and balancing the delivery of education with what was absorbable by the client due to language barriers. However, some nurses across a couples sites also discussed their perception of Hispanic families as having stronger and wider support networks and greater family support, as well as

nurses being highly respected in the Hispanic culture, all of which served as valuable resources for the families and nurse-client relationships.

One nurse stated, “So, you have to be able to go back and forth as far as respecting that culture, and yet, trying to educate what you’re trying to educate on, right? So, it gets a little challenging sometimes just because I’m Hispanic, and so I know the culture. And so, I know that some of the things that we teach, it’s hard for them to understand it. And so, I understand it now just because I’ve been educated in it, and but if it was me at that time, I would probably be feeling the same way.”

Another nurse shared, “Um, well, examples like - For instance, breastfeeding, for instance. A lot of the Hispanic culture do breastfeeding. I mean, they’re, they accept the breastfeeding part, but they also think that formula is so much better. And so, they get caught between, ‘My mom and my grandma say I should breastfeed, but I think that the formula is so much better for my baby. They get fatter.’”

Another nurse explained, “We have a lot of support for - For instance, in many of my Hispanic families where Dad doesn’t do much with the baby. Or, I’ve had an Arabic mom where that - She is expected to do everything for her baby. And, understanding that cultural piece gives me ability to support that mom a little bit better.”

Another significant population for two sites was the military population, including clients who were enlisted, deployed, or were military dependents. Several nurses from a couple of sites indicated that military families differed from civilians in that they tended to be more stable and responsible with their appointments; were more open to learning; had higher rates of child abuse because of PTSD, depression, and aggression issues; and were more transient. However, these nurses also discussed that military clients had access to greater resources not available to civilians such as their own counseling centers. Unfortunately, due to greater stigma among the military around mental health, a number of nurses who served military clients expressed that these clients preferred to seek services away from the base.

One nurse stated, “You know it’s really not much different other than their acuity level is lower, they’re lower acuity clients for the most part, at least mine have been so far. Just because of the military, they’re a little bit more stable, they’re more responsible with their appointments.”

The same nurse explained, “Yes. And that’s the only other thing with military. Our instance of military of child abuse just working at [hospital name removed], which is the main hospital here for that, it’s a higher incidence of child abuse with military families, because of the PTSD aspect of it. Depression issues.”

Several nurses and the nurse supervisor from one site also described having many clients from a nearby Indian reservation. Some of the challenges described included building trust with the community, learning the cultural norms around post-pregnancy traditions (e.g., not allowing visitors during a certain period of time postpartum, keeping everything hot including bundling the baby despite being in warm weather), and understanding how to navigate the various systems for how to work with the Tribal Social Services, county Social Services, and reservation’s police.

One nurse stated, “You know, I - It’s also being very respectful of their culture. I have had - I have tried to learn their culture norms around having a baby, and how - How closely they follow those because we have some that will not allow us to come in after the baby is born for 40 days.”

The same nurse explained, “You know, and so you - You have to kind of respect their culture in what they do. And, I learned from another one of my - I was playing with the baby and the baby was getting ready to laugh, and she said, ‘If you make him laugh, you have to make the dinner.’ And, that was something I did not know. The first person who makes the baby laugh has to create dinner for the family—so I backed off immediately. I didn’t know the baby had not laughed yet. So now, when I have, when I work with a family that is from that culture, I always ask when the child is around the age of laughing, ‘So, who’s made the dinner?’ You know, and I try to, you know, just be culturally sensitive to their needs.”

A nurse supervisor explained, “And so, I remember one of our new nurse -The first time she weighed a baby, and the baby had - And so—and, I was with her on the visit—so, it was like - And then, she- We didn’t say anything at the time, but then when we left, we had the discussion about those. Because that is something you see, and if you’re not used to seeing babies of that, you know, ethnicity, you’re - It’s like, ‘Whoa. There’s a bruise on their sacrum,’ you know. (*laughs*)”

Regardless of whether cultural differences were due to variations in race, ethnicity, language, or military status, the majority of nurses from multiple sites discussed the importance of respecting the clients’ culture, not judging the family, intervening through education if there was a safety concern, and recognizing that culture varied by each individual. In fact, many nurses noted that these factors were integral to building relationships with their clients. In several sites, a number of nurses also felt that it was helpful to be of the same cultural heritage as their clients.

One nurse stated, “You know, make sure that they know that and- Because change is hard. Change is hard with culture. And, not that I want to take that culture away, but there are certain things, you know, that I see that we can educate on that maybe they don’t even know because they’ve been taught that way, and it’s come down to- It’s been taught by generation, generation, generation, and then with the evidence that we know, that’s a challenge for a nurse to go in and tell them, you know, ‘Well, you know, evidence shows’ - You know, and this and that. So, it’s - It’s a challenge.”

Another nurse stated, “So now, when I have, when I work with a family that is from that culture, I always ask when the child is around the age of laughing, ‘So, who’s made the dinner?’ You know, and I try to, you know, just be culturally sensitive to their needs.” Another nurse shared, “I was doing joint visits at this point, but she basically wanted to respect the cultural thing, but also was, you know, saying, ‘Okay, well, if the baby has lost weight.’ She told the mom, ‘Like we, you know, you either have to unbundle him’ - because it, like, that’s just what they believe.”

Community Culture

Many nurses and the nurse supervisor from one site discussed how being in a smaller community was beneficial because everybody knew everybody. However, these nurses also discussed the challenges due to more businesses having closed with the declining economy and lack of trust in government agencies. The nurse supervisor also discussed the impact of shifting causes and signs of trauma within the community.

One nurse shared, “A lot of – I don’t know what their - their workforce used to be but a lot of the – the economy has hit that town really hard like most small towns and obviously with businesses closed and lack of employment.”

A nurse supervisor stated, “...for trauma, what are the signs of trauma? I mean I think it’s always good to have a refresher, because what causes trauma changes with the changing of our world, so, you know, getting an update on what’s the new thing that could be looking for is always good.”

Cultural Implications for CPS Workers

Among some caseworkers and supervisors across multiple sites, various types of culture were described to have impacted their scope of work. Similar to cultural implications shared by NFP nurses, these cultural factors for CPS workers were related to clients’ culture and community culture. However, the approaches that caseworkers took to addressing these issues were different than NFP nurses and the impact on casework also varied.

Clients’ Culture

Compared to the NFP nurses and nurse supervisors, more caseworkers and supervisors across more sites discussed greater cultural diversity among their clients. Cultural factors mentioned included race, ethnicity, language, gang affiliation, discipline styles, poverty, geography (i.e. rural versus urban), and military affiliation. For all of these cultural aspects, caseworkers and supervisors discussed the importance of focusing on risk and safety, not making assumptions, taking them into consideration when conducting assessments, making sure that they all received the same service and the same message, considering how the same behaviors had varying impacts on a child due to cultural differences (e.g., impact of discipline styles), and discussing what was appropriate by age and law versus what was culturally appropriate. Many caseworkers and supervisors across several sites also recognized the vast fear their clients had that CPS was there to judge them and removed their children and discussed efforts to explain their purpose and the recent paradigm shift across Human Services to keep families together.

One caseworker noted, “So, that has been very tough, I would say. And culturally, you can have a very large range of what people feel is appropriate, what’s culturally appropriate for them is maybe not culturally appropriate by law, or, so, we do have to consider all of those things. And we do, you know, if it’s age appropriate, we rely on what is the child telling us. You know, a child could get spankings every week, and that’s just the way it is, but is there impact? If it’s just, ‘Well, no I know, when I get trouble,’

but the next child could be just you know, 'He's hurting me.' So, it's hard to decipher, because you may have impact on one child and not on the other."

Another caseworker stated, "Um - Well, I had one client that she- She would just yell a lot at her son. And, I know that she's spanked him. But, I never saw any evidence, you know, any bruises on him. And then, I observed her interaction with him, and he was just happy and playful. And, she was loving to him and caressing and kissing and praising. So, you know, I really didn't see that, you know, he was abused. It was just that this is her parenting style. She's just, you know, tends to yell and spans her son sometimes when he doesn't listen. But, those are not reportable things, and - Yeah."

Another caseworker stated, "My experience has been in a small county, so it's, stand up from your desk and go ask someone in child support in the next row, or go upstairs to public health you know. So it was much more team oriented, right you could really take care of a lot of teaming quickly. Whereas, similar, I think that is just not as common in a larger county."

Although many cultural groups were generally discussed by many caseworkers across most sites, the military population was discussed more extensively by one site in particular. Cultural aspects of the military population that were believed to impact service delivery included deployment, resource issues, lack of support systems among families who were reassigned, having a unique health insurance, the vulnerability of children due to the parents being younger, and the added stress on families when a parent was deployed to a violent situation. However, it was also mentioned by several caseworkers from this site that military families had access to many services such as mental health services and parenting programs through the military that were not available to civilians and such services had helped keep them out of the Child Welfare system.

A supervisor noted, "Well, I think the one big concern that we have with military families it's a challenge for them is what I've already told you and that is that most often families have some kind of a support system and we know that for safety of children a big support system is a huge um deterrent for abuse and neglect for children and so because the military does not always come with an automatic support system, a mom, a dad, and sister or brother, who live close by that can give you a break and things like that. Their inability to have that is an issue and that can be problematic for them. The issue is that the average age of an active duty member that is stationed at [location name removed], which is our largest military base and one of the largest military bases in the nation is very young. So they're in their early 20s, which means their children are at a much more vulnerable age and so they may not have the experience that they would with a parent, who may be a little bit older or has older children um and so that becomes an issue as well...And then you have the other issue of what generally would be a two-parent household but because of deployment you've got, whether it's a person in another state or in another country that person being removed then leaves that other parent as single parent responsibilities. Because that other person is so far away. And then, of course, there are stressors that are different for a military family that are not stressors for your normal civilian family."

She went on to explain, “So if my husband works at the local um computer company it’s very different than whether or not he’s getting shot at on a daily basis in a third world country and is he gonna make it home alive and things like that. So there’s a huge number of differences between military families and nonmilitary or civilian families and that’s the reason why we specifically created this military unit to help with some of those issues.”

A caseworker noted, “What I really like about [the military] is that they are offered, they have so many services at their feet that they can get without us having to be legally involved. So the Army or the Air Force can order a family to do something or to participate in a service or offer them a service that might not be available in the community um that they can utilize and they can do that on their own without us having to get involved and I think that’s really helpful for families. I don’t like us when we get legally involved here it’s important for the safety, but I don’t think it’s always beneficial to the family structure.”

Community Culture

Various community-wide cultural factors were also mentioned by some caseworkers and supervisors across a few sites, such as high rates of teen pregnancies and trending drug availability and use. A number of caseworkers from one county also discussed the challenges of communicating with non-English speakers who grew up in Denver or Colorado Springs where there were more multilingual people and services because such resources were less prevalent in their community. Another challenge described by several caseworkers and supervisors from one site was that small town politics impacted their work because the community was small and many people knew each other outside of their primary work.

One caseworker noted, “No. And so, eventually that child had to be placed out of the home. We tried to put services. We tried to do all this stuff because this particular mom wanted to order everyone around. And, it was like no we’re here to support you not do all of the work. In her mind for some odd reason it was like, well no you come here and you take care of the baby. No. So, you know, once again, you know, the barrier I think is the language barrier. And, hopefully that definitely will change somehow. It’s really hard, you know, when you have a majority of speaking families out here now that have grown in [local city name removed] as opposed to [metro city name removed] where everybody is, I feel, more multilingual than up here, so it’s pretty hard.”

A supervisor stated, “Mostly it’s like different trends. Like right now I know we’ve been getting a lot of the heroin, heroin exposed infants. And then for a while we had a lot of pill kind of popping. So it almost seems like they’re into one thing and then another and it kind of switches around, so. I think a majority of our, it varies, what’s expensive in the area, or price.”

Cultural Aspects for Other Partners

Several community partners from other organizations had similar experiences and perceptions related to cultural factors as NFP nurses and nurse supervisors as well as CPS caseworkers and supervisors. A public health nurse who worked closely with the local Indian reservation described the availability of some culturally appropriate services on the reservation but the limitation of resources overall and the transportation and financial barriers to accessing services off the reservation. In regards to interactions with caseworkers, she described that it was challenging to navigate when to involve Tribal Social Services versus the county Social Services and that caseworkers from the county did not always feel comfortable coming onto the reservation. She also described that some clients were more traditional than others with their cultural practices related to pregnancy and birth, and that she felt it was nice to have the local tribe represented on the NFP CAB.

A public health nurse stated, “It was, it was actually frankly a little bit awkward because I felt like the- it was a man from [county Social Services removed] came down to do a home visit in the home of this young mom and the child, her children. And, I don’t know if he wasn’t comfortable doing a home visit here on, on the reservation or - He was saying that he needed somebody to accompany him.”

In another site, a public health director from a rural community shared the belief that people in rural communities tended to fear big government and worked well collaboratively because they were not territorial, they knew the majority of the clients and partnering organizations, shared the desire to help kids, and because the rural context required collaboration to succeed.

A public health director stated, “You know, I think there are issues around, in rural Colorado, people, many people, not all, but there are many people that perceive [county name removed] as big government, big situations, whatever, and that it’s not that, oh it’s just the old nurses that work in [local county name removed]. And they’re our kind of friends, and they’ll keep things confidential, or that, you know, there’s just a different, you know, we’re just a number to them. So anyways, you wonder if that’s part of it.”

She continued to say, “Well, we’re not territorial, you know, we both have our roles and there’s too much for any of us to do, so I don’t wanna be in her world, she doesn’t want to be in my world. But in, like I said, in rural, it’s a little different, we all know that we’re just one spoke of the wheel, and it rolls better if we all do our fair share of contribution. So I think the very essence of rural necessitates collaboration if you want to get anywhere, so.”

Other Knowledge Among NFP Nurses

Numerous nurses and nurse supervisors from all sites shared about their knowledge related to various aspects of their work. A few nurses from a couple of sites divulged their lack of knowledge related to their scope of work and some nurses from most sites described their understanding of their community and clientele. Many nurses from multiple sites disclosed their knowledge about local organizations that offered assessments and screenings, particularly for

developmental screenings. Several nurses and supervisors across all sites also described their knowledge of various community organizations that provided many resources to their clients.

Knowledge Within Scope of Work

A few nurses from a couple of sites disclosed their lack of knowledge around various aspects of their scope of work, some of which varied within sites. One nurse shared her knowledge around best practices for breastfeeding but another nurse from the same site was unaware about the impact of mothers smoking marijuana while breastfeeding. A nurse from another site stated that she was unfamiliar with many references around labor and delivery terminology, location of services, and other aspects of labor and delivery and that she had to rely on a colleague to explain many of these things to her. Another nurse at the same site also disclosed that she was unsure about the exact language in the consent forms that she had used with clients in regards to whether or not she would inform the client before making a report to Child Welfare.

One nurse explained, “Well, the Academy of Pediatrics recommends exclusive breastfeeding—that means no bottles, no supplementary food, feedings—until six months and then after six months, you can introduce solid foods and then continue to breastfeed until 12 months. And then, from then on, as mother and baby desires.”

In discussing marijuana, the nurse went on to say, “You know, even though it might be legal, you know, and it’s still not legally federally, but um - It’s still not recommended to - You know, by the Academy. There’s also another governing – ABM - Oh, how could I forget? Breastfeeding... Medicine - America Breastfeeding Medicine... But, still, the guidelines are, you know, not to smoke and breastfeed or chew or whatever or eat the edibles or whatever else. *(laughs)*”

Again about marijuana, another nurse from the same site shared, “It’s a very sketchy research around that. Very sketchy. Like, most reports say undetermined whether it crosses the breast milk... If at all - If any a very small amount. And, then there’s the side that argues is it worth it because we really don’t know.”

Another nurse disclosed, “I pretty much read off the consent. I forget what it says word by word, but you know, just that nurses are mandated reporters, and if I suspect any child abuse or neglect, I will have to report that. But, I will also let you know that I have or am making that phone call... I think it says something along those lines.”

Another nurse stated, “You know, and labor and delivery and all these kind of things. And, again, I didn’t work in that system, you know? And so, sometimes, I ask [fellow NFP nurse name removed] to help me because she was a labor and delivery nurse. So, ‘Where is that-’ ‘What’s this mean?’ You know? And then, and then you just piece it together, and you go, ‘Oh, okay. Alright. Now I know.’ So, yeah.”

Knowledge of Community and Clientele

A few nurses from most sites shared about their knowledge of their community and clientele. Some nurses from different sites described their population demographics such as having

reduced rates of teen pregnancies, small population size, a workforce that was greatly impacted by the economy, or its greater proportion of high functioning and well-educated mothers.

One nurse shared, “So, I think they’ve done more birth control efforts through public health classes in the high school. And, there was some, there has been money for long-term birth control, you know so a lot more of the moms are getting the long-terms – the IUD’s [intra-uterine device] and the Implanon. There’s just not as many high school pregnancies, which is a good thing.”

Another nurse stated, “Maybe [population size redacted] people. Smaller community...A lot of - I don’t know what their - Their workforce used to be but a lot of the - The economy has hit that town really hard like most small towns and obviously with businesses closed and lack of employment.”

Knowledge of Community Assessments

Knowledge around community assessments varied greatly within and across sites. A few nurses from some sites discussed their knowledge of assessments for developmental delays that were offered in their community. A couple of nurses from different sites shared extensive knowledge about these organizations and services including the general process of the assessment, types of communication that occurred with the provider such as responses to referrals and updates to the nurse and client, cost and payment options, and the types of services that were available after the assessment such as physical therapy, speech therapy, occupational therapy, and evaluation.

Another nurse from a different site did not talk as extensively about the services but shared that their organization had a bilingual provider that was helpful for assessments.

One nurse stated, “And then, he was smoking - Smoking - I was like at, with the visit. And then, he went upstairs, and then there was definitely some pot being sm- You know? And, it’s like, ‘Hmm-’ You know? It’s - So then, I was like, ‘Should I ask?’ So, I asked my coworkers, you know, ‘Is that a problem?’ It wasn’t in the room. He wasn’t the caretaker. The mother was. And, it wasn’t like around the baby. So, they felt like it might be okay. It was sort of something to watch.”

Another nurse explained, “For children that we think have a delay, [program name removed] is a... Well, it’s Medicaid-reimbursed, but even if clients don’t have Medicaid, they will qualify, so it’s a resource for- They get a free assessment to assess the kids for a delay, which mostly for me, it’s been speech delay and a couple of- They needed physical therapy. They had delays, gross motor delays, so they would - They didn’t walk. They were delayed in their gross motor, yeah...So, at this point now, they’re doing what’s called ACT, an advanced assessment with a team, and so they get two assessments...So, once the baby qualifies, they’re in the program for six months, and then they come together and evaluate the child again...So, they do qualify six months at a time for those services until age three.”

Another nurse said, “[Organization name removed] is an organization that deals with developmentally delayed children or developmental disabilities of some sorts...I put a call in or a referral, and they call me. They get a hold of the client and meet with the client, and then they call me back and say, ‘Okay, this is what we see.’...And then, they

call me and kind of get some more information about the client and what's going on. And then, they go out and kind of do an evaluation. And then, at that point, you know, whether they have to get PT therapy or OT therapy or speech therapy or whatever the cases may be. Then they have a meeting, and then they figure out a game plan and then they call me back again and tell me what's going on.”

Knowledge and Utilization of Community Organizations and Resources

Several nurses and nurse supervisors from all sites shared about their knowledge and utilization of various community organizations and resources they had utilized. These resources included medical providers, parenting programs, mental health providers, housing programs, and various public services.

Parenting and Child-caring Resources

Several nurses and nurse supervisors from most sites were aware of various pregnancy and/or parenting programs that were available in their community. Many nurses and nurse supervisors from multiple sites were able to describe the programs in detail such as the eligibility requirements, cost of participation, and types of services. Most of these nurses and nurse supervisors across several sites were familiar with parenting programs that varied across sites but were typically community organizations that offered parenting classes, in-home services, and/or home-visiting programs. The programs described differed across sites based on age eligibility (e.g., up to age three versus up to age five), whether they were court mandated or voluntary, frequency of visits among home-visitation programs, whether or not they offered incentives, and their levels of affiliation with other groups (i.e., solely a parenting program versus a religious-based organization). Some parenting programs also offered additional services such as food, clothing, and supplies. Among a couple of sites, several nurses recognized that referring clients to various types of parenting programs depended on the specific needs of the client and/or whether or not the client was comfortable with having multiple people or services involved in her life. A nurse and a nurse supervisor from one site also described a parenting program that offered a class for fathers. Additionally, few nurses from a couple of sites described programs specific to pregnancy that offered services such as pregnancy tests, ultrasounds, and other routine medical exams.

One nurse shared, “There's one called [organization name removed], which does a lot of home visits like we do, but they also will go and pick families up and take them to their facility and feed them. And then, have parenting classes, and they have a fathers' class. And, it's for high-risk, a lot of it is high-risk people. And so, I've been - I've referred several of my families, especially with fathers in the home to that.”

A nurse supervisor explained, “Okay. Well, here at the Health Department that is not involved with NFP would be [program name removed], so it's [program name removed] is what it's called. And, they work with moms who like, number one, we - Like, our - When they turn two, we offer that if the parent still feels like they need some parenting program. Or, a mom who, for whatever reason, wants to drop out of our program, which doesn't usually happen, but if it did, we would offer, you know, that, if they wanted to do that because sometimes - Her classes are usually in the evenings, so for those moms who are single moms who work all day long or whatever, that might be - You know, but we

haven't really - That has not really happened that I'm aware of since [program coordinator name removed] been doing [program name removed]."

Another nurse shared, "Well, there's the [program name removed]...It's similar to NFP home visitation program, but any - You know, fam - The families, they don't have to - It doesn't have to be their first child, it can be their whatever, third, fourth child. And, the program is from zero to five...And, they visit once a month. So, families who maybe are having their second child, and so they don't qualify for us, then we'll refer that family to the [program name removed]- Or, sometimes, when the client graduates from our program, we'll refer them to [program name removed] if we see that there might be benefit, or the client wants to continue home visitation program...The Early Head Start, it's also - It's a home visitation program, and I think they visit maybe once a week, if I remember it correctly. And, it can be - It doesn't matter what number child it is. And, that program lasts until the child's 3rd year, and then the families who are in the program, in the Early Head Start, then, you know, if their income still qualifies them, then they automatically - The child can go through Head Start. At three, they can start going to preschool."

Another nurse said, "The [program name removed] is the [umbrella organization removed] one that is downtown. Usually the pregnancy center has [program name removed] or they have, it's very religious based, but they have a program that is kind of similar to ours, but they hand out baby bucks and you can actually if you do enough stuff with them while you're pregnant, you can get a brand new crib."

Another nurse stated, "...but it's a clinic in which clients can go, and we see, you know, they can actually get pregnancy testing done and then ultrasound to confirm the pregnancy. But then they also provide a variety of parenting classes and, um, they also are able to get maternity clothing and um, emergency supplies for their babies. And a lot of the classes that they offer are parenting classes, and so they pay them for attendance in what they call baby bucks...The baby bucks can be accumulated to purchase items like cribs or car seats, that kinda thing."

In addition to parenting programs, a nurse and a couple of nurse supervisors from different sites also described child care services in their community. A nurse and nurse supervisor from one site stated that a community organization provided respite care for up to 72 hours if mothers needed a break for any reason, including dealing with eviction, IPV, substance use, or general parenting stress. Mothers could leave their child overnight through that duration and were assured immediate access to a child care provider. Another nurse supervisor from a different site explained that they had a community organization that helped coordinate general child care services. Mothers could call the organization and receive a list of licensed child care providers in any desired location such as near her work or home.

A nurse explained, "Well, what they do, if we see a client where there's some risk situations, we can get them to register with the [organization name removed]. So, they may not ever need to use it, but if they do then their name is on file, they're registered, and they can take their baby there up to 72 hours, no questions asked for respite care. And that's come up with situations where clients have been evicted or they're dealing

with a partner, who is abusive or substance abuse and they need some extra help while they take care of themselves and get other things in place.”

Similarly, a nurse supervisor shared, “It was a place called [organization name removed]. And we often referred parents, telling them about ‘If you’re at your wits end, here’s a place that you can take your kids and they’ll be safe, they can stay there overnight.’ I can’t remember exactly how many days, it was like 72 hours that the children could stay there. But it was like a way that they had immediate access to someone who could help them if they were ready to, you know, lose it with their child. And then, that non-profit organization, it went away and I don’t know what the status is now, on the [organization name removed]. But that was really nice to be able to have the resource available for the clients.”

Another nurse supervisor stated, “[Organization name removed] is - It’s a regional kind of - And so, like, if you- If you had a child, and you were ready to get some child care, you can call [organization name removed] number, even if you live like out - Like, you know, in [county name removed]... And then, you can - You can tell them, ‘I would rather have childcare close to my work,’ or, ‘I’d rather have childcare close to my home, or -’ Or, whatever. And, you can kind of specify what you’re- Kind of what you’re looking for. And then, they’ll send you a computer readout that has the licensed daycare providers...”

In addition to parenting and child care programs, some nurses across many sites shared about their knowledge of the availability of local community organizations and programs (e.g. Early Intervention) that worked with developmentally delayed children or children with developmental disabilities. Many nurses from most sites frequently referred their clients to these organizations that specialized in early childhood development. Indeed, clients were generally referred due to the nurses’ concerns with the child’s growth and development because most organizations or outpatient hospital units assessed for speech/language and motor development. Several nurses from different sites shared that they had maintained working relationships with these agencies, such that the organization had called the nurse and reported on the assessment outcomes. In addition, in a couple of sites, some nurses shared that they had clients that had a Home Health worker visit several times a week until the baby was stabilized; these babies were usually born premature or required special medical needs. Some nurses from some sites also communicated frequently with their clients’ physicians (e.g. otolaryngologists or ENTs) on medical needs of the child as well as shared home visit observations. Finally, several nurses from one site utilized their county’s CPS prevention programs to assist their clients with developmental disabilities while some nurses from a couple other sites interfaced closely with the Health Care Program for Children with Special Needs (HCP).

One nurse shared, “[Organization name removed] is an organization that deals with developmentally delayed children or developmental disabilities of some sorts... And so, they’re very – you know, you put your, let’s say I say, ‘Okay, I think this child has some sort of delay or something physically wrong with them.’ I pull a call in or a referral, and they call me. They get a hold of the client and meet with the client, and then they call me back and say, ‘Okay. This is what we see...’”

Another nurse shared, “Which I thought was good. And then, I’m going to follow up with the doctor regarding the observation that I made with the feeding with my last visit. And, I may – you know, and I’ve been thinking about calling and just talking to [prevention programs manager name removed] about, you know, ‘Is this a case that where it would be reasonable to have the prevention unit involved?’”

A nurse supervisor explained, “However, in my work with that, we’re well connected to the Children with Special Healthcare Needs because I used to, I supervised it for years. So they interface with them more. So we’re, we’re interfacing in lots of different ways just because of the institution...”

Mental Health Resources

Numerous nurses and nurse supervisors from multiple sites described their knowledge around a variety of mental health services that were available in their community through different types of organizations including clinics, hospitals, private practices, and community-based organizations. Although the organizations varied across sites, knowledge among nurses and nurse supervisors typically included service provisions and payment options. Multiple nurses and nurse supervisors across many sites explained whether these organizations served children and/or adults, provided inpatient and/or outpatient care, if they offered home-visits or home checks, and the level of services ranging from counseling therapy and other outpatient behavioral therapy to intensive hospitalizations and other crisis services. Furthermore, some nurses from one site described that a local obstetrician had provided mental health prescriptions for their pregnant clients but that not all providers were willing to do so. In another site, the nurse supervisor shared that their site offered an inpatient unit for mental health clients but that hospitalization treatment was not available for all people; while a nurse from another site explained that there was only one mental health facility that served her area. A few nurses and nurse supervisors from some sites also explained that the mental health organizations they utilized accepted Medicaid, and a nurse and a couple of nurse supervisors from different sites were aware of organizations that offered a sliding scale for payments. However, one nurse from a different site shared that some service providers did not accept military insurance.

One nurse shared, “[Organization name removed] is another one, too, that’s pretty good. Not as good as [organization name removed], but definitely better than DSS. So, [first organization name removed] is - They provide a lot of the mental health...So, counseling, therapy, that kind of stuff. And so, if you call them and make a referral, there’s not as much communication.”

Another nurse shared, “There are, there’s [organization name removed], I think, behavioral health. Yeah, [organization name removed] is one for some more serious mental health. And then there’s [mental health hospital name removed], which is actually the mental health hospital here.”

Another nurse stated, “[Organization name removed] is the mental health. I was part of a horrible story with the first time that I had to call DHS. They only do Medicaid so when I called them she doesn’t have Medicaid, she had some kind of different military insurance than the military insurance that we have normally down here. Um - so they wouldn’t take it. I’m so like, so I have to refer her for a crisis psych eval like right now

so who would you recommend that I call, please tell me, because she is screaming. It was really funny. Anyway, I called [organization name removed] and they said they'd take her. Oh, [organization name removed] is the other psych eval. I refer a lot to [first organization name removed] because we have a lot of mental health mamas. I have a lot of PTSD, a lot of generalized anxiety."

Another nurse stated, "It's not free but they do have sliding scale and I think they take Medicaid. So a lot of my clients we refer all the time to them."

As explained, a number of nurses across multiple sites were knowledgeable about behavioral health therapy and services available in their local counties. Beyond being aware of these resources, some nurses from multiple sites shared about their experiences in engaging clients with these providers. In a couple of sites, several nurses shared that depending on the severity of their client's issues, some had been hospitalized (e.g. due to a psychotic break). One nurse expressed that she had created a safety net for her client's baby by using the client's friend as a resource to call on in situations where the client needed mental health assistance but was unable to receive it right away. In addition, some nurses within the same sites were better than others at successfully engaging their clients to receive mental health treatment. For these successful nurses, engaging their clients in treatment allowed them to work with the client on other goals, rather than working with them so intensely on mental health concerns.

One nurse shared, "Or, they have – they're hooked up with a counselor, so we aren't looking at their mental health issues as strongly and as intensely as we would otherwise. It frees us up to do some other things with them, so."

Another nurse explained, "But, for those cases that I've had to call and be involved in – and, for instance, maybe there's been a – for the one person who had the psychotic break, and was hospitalized, that was the right thing for her. That's where she ultimately got some help that she really needed."

Housing Resources

Many nurses and a nurse supervisor from multiple sites shared their knowledge about housing options for low income clients. A number of nurses from several sites described no-cost housing options such as homeless shelters, youth shelters, and safe houses for women who were experiencing IPV; however, one nurse noted that she did not believe a homeless shelter was available in her specific county. Some challenges with such organizations included youth shelters not allowing mothers to live there with their children and homeless shelters not allowing minors or for occupants to stay on the premises during the day (i.e., permitted to stay only at night). A couple of nurses from one site also explained their knowledge around low income or subsidized housing such as Section 8 housing available in their community. They explained that such housing options often required that the clients were actively searching for employment and typically had long waiting lists as well. One nurse also described an organization that offered payment assistance for families that needed immediate and short-term housing such as a couple of nights in a hotel during a transition but that the application process was burdensome. Another nurse from a different site had worked with a local organization that helped homeless individuals transition to self-sufficiency through a transitional housing program.

One nurse explained, “It’s our youngsters, and so our barrier with our teen homeless shelter, we can have our pregnant girls go there, but the minute they have their baby, they’re not allowed to be in that house...So, they can take teens, but a teen with a baby is a different situation...So, that’s kind of a barrier for our youngsters if they don’t have anywhere to go. And, our adult homeless shelter, there’s a lot of regulations that come on taking a minor in that they don’t want to touch them, basically, due to the law.”

Another nurse stated, “Housing is really tough because we - I - What happens with housing is we have low-income - I give them a low-income housing list, but there’s always waiting lists. And, I tell my clients, if they think they need a place, ‘You’ve got to send - You’ve gotta go apply right away because if you’re looking for a place today, that’s not gonna happen.’”

Another nurse shared, “We have a [homeless shelter name removed] but that’s for only... You can only stay there at night. You can’t really stay there during the day. And then, we have a transitional house for three months, but you have to be - Like, you have to be really kind of proving that you’re going to - You can’t just - You really have to work at getting a job. They don’t just take anybody...They won’t - Because they want to show their donors that these people are making...”

Another nurse shared, “Over at, I think, [organization name removed], they will give us diapers or help with clothes sometimes if we need to, and I’ve gone in there. And, they will also do kind of one-time assistance for families, like if they need to go into a hotel. If they have a plan, you know...but if they have a couple nights that they’ve going to be homeless or the - They will pitch in. But, it’s a big application process.”

Another nurse stated, “We have so many resources, which is wonderful about [city name removed]. The shelter, we have, not much in the shelter area, but there are shelters here for our women, our clients. We have [safe house name removed], which is kind of a big hotel apartment building and it’s a very safe place for our clients to go.”

Other Types of Community Organizations

A number of nurses and a nurse supervisor from most sites divulged their knowledge about other service organizations in their community such as medical providers, safe houses, IPV, substance use clinics, schools, law enforcement, and food banks. A few nurses and a supervisor from multiple sites described their knowledge about and utilization of medical providers including hospitals, pregnancy centers, school-based clinics, obstetrics clinics, and emergency rooms. Such knowledge included the number of school-based health centers in their service area, the need to fly small infants to Denver due to the limited capacities of the local NICU, the services offered through the local pregnancy center, and the emergency room procedures for staff to call DHS directly if they suspected abuse or neglect. Many nurses from most sites spoke about having referred their clients to needed medical care such as the emergency room (ER), physical therapists, and primary care physicians. A couple of nurses from different sites also discussed about their concerns with feeding of the client’s baby and that they had used the client’s physician to follow up and assess the situation. Many nurses from a few sites also shared about having referred their clients to physicians for general medical health. Indeed, one nurse specifically mentioned that she had referred a lot of her clients to private practice physicians.

One nurse explained, “Well, almost a year ago, my client had a baby born at 32 weeks down at [organization name removed]. Because we’re in [redacted], our NICU at [hospital name removed], the hospital here, doesn’t have the capabilities to take care of a small baby. So, when a woman goes into labor, I don’t know at what point, but at least more than let’s say - If she’s only 32 weeks gestation, which is what my client was, or 31 - They fly her down to Denver.”

Another nurse shared, “At that time. And, he did confess to hurting the baby. The mom was able to call me when the baby went to the ER. And, I said - And, it was really nice. I felt really validated that she called me because she was very upset, and I said, ‘Well, this is the process. This is what’s going to happen. You can call DHS, too. When I hang up from you, I will call them to let them know that you called me. And, this is what’s - When you’re at the ER, the ER people will call DHS. So, you’ll probably have a lot of people there. You’ll probably - Your baby will be in the hospital. They want to make sure the baby’s okay.’”

Another nurse stated, “But, mostly, my concern for her was getting her mental health under control and her physical health. And, getting her to go to a physician and stick with one physician because she uses the emergency room. Like, she goes to the emergency room every other day practically. So, I don’t know. I don’t know what other services could, she could use, but besides those two things. She needs something.”

Beyond medical services, several nurses explained about other local resources. One nurse described local resources for children to receive reading glasses as well as services for children with special needs. Other nurses from a few sites were aware of speech therapists in their community and had referred their clients to receive evaluation of the speech and language development of their children. Additionally, a couple of nurses from one site shared their knowledge around a women’s shelter and substance use clinics. One nurse explained that the local women’s shelter had more flexibility in their communication with clients because they did not have the same legal obligation to report everything to which NFP nurses were accountable. She had referred clients who had experienced elements of IPV to this organization that provided support for victims of assault. The other nurse from the same site described a fetal alcohol syndrome education organization that provided trainings throughout Colorado as well as a specific conference that was held within their city.

One nurse explained, “I just - So, most often, I do it with the 20-month ASQ [Ages & Stages Questionnaire]. And, the first part is communication, and they may have 20 or 30 points. If I’m really concerned earlier - So then, based on that, I just tell - I just wanted to let them know, there’s a program in the community, the Early Intervention Program, and I explain the program to them. And, sometimes, it’s earlier. You know, I always observe for language, and if I feel before 20 months, they just have not a word or - Then, I will - At 14 months is...”

Another nurse said, “Reading glasses. And so, you had to fill out an application, and mail it to them or drop it in their mailbox and then they were going to respond. Well, they never did. Ever. Never heard from them at all. Ever, ever. Now, what I do when I have a client that needs glasses is - Well, I had contacted - I had one client who had

actually been a former client of the HCP program here...HCP. It used to stand for Handicapped Children's Program. It now has a different meaning, but we... They use the same acronym...And so, she got glasses. Now, we have a thing - I guess there's a new agreement with - The county has an agreement with Lenscrafters out at [redacted] that we have a referral form that we fill out, and if the client calls and takes that in, they'll do the eye exam and give them the glasses for free."

Another nurse stated, "[Organization name removed] is our local abuse counselling center. They have shelters for women. [Organization name removed] does not have to report everything that we have to report. They can keep almost everything anonymous, as long as there's not a child, you know, at risk, or at immediate danger... Yeah, they have a little bit more, things that we have to report, they don't... Because they want to keep that relationship so confidential between the client and themselves. They want to be ultimately their person of trust."

A few nurses from different sites described their level of knowledge around schools, food banks, and law enforcement. One nurse explained that the local high school had increased its offerings of birth control and public health classes to students which had resulted in reduced teen pregnancies. Another nurse from a different site described a local food bank to which she referred clients. She had knowledge about the location of the food bank and was familiar with the director. Another nurse from a different site shared that she was unaware that law enforcement did not call DHS directly when they were dispatched through 9-1-1 for alleged child abuse or neglect.

One nurse stated, "So, I think they've done more birth control efforts through public health classes in the high school. And, there was some, there has been money for long-term birth control, you know so a lot more of the moms are getting the long-terms - the IUD's and the Implanon. There's just not as many high school pregnancies, which is a good thing."

Another nurse shared, "And then, I've also had contact with one of the food banks in town that I just happened to drive by when I was going to our [training name removed]. So, I kind of made an appointment and met with their director over there, and she gave me a tour and everything. So, I brought some flyers back and told everybody about it here...[food bank name removed]. It's like [street name removed] and [cross-street name removed]. I have the address somewhere. But, she was wonderful. I've referred some of my girls to go there, and some of my other girls, they already go to food banks that they know about..."

Another nurse explained, "Well, what happened, too, because it was after hours, I immediately told - That next day when I had to call 9-1-1, I - Did I talk to - I think I sent [CPS caseworker name removed] an email. I can't remember exactly how it went down. She said, '[Nurse name removed], they don't have a record of it.' Which makes me upset. Nine - I would have thought 9-1-1 would have called Department of Human Services. I had to call them again and talk to a caseworker the next morning and give them the whole spiel...9-1-1- If they get a call at night, they need to refer that because that's extra work for - You know what I mean?...And, I thought - Luckily, if I hadn't had

texted [CPS caseworker name removed] or whoever I did, I wouldn't - I thought it would've, the police would have... They would have communicated with them. But, I guess they don't."

Moreover, a few nurses from different sites shared their knowledge about other community organizations that provided resources to clients. These included thrift stores that offered diapers and clothes, a credit counseling center that provided support with bankruptcy paperwork, churches that offered budgeting classes and support for paying rent or utilities, and an entity that provided legal services and aid.

One nurse shared, "We have, you know, the thrift store will - Over at, I think, Salvation Army, they will give us diapers or help with clothes sometimes if we need to, and I've gone in there."

Another nurse stated, "[Credit counseling name removed] where they will actually, um, they have online seminars that you can participate in, as well as one to one, and they can help people when it comes to doing the paperwork for bankruptcy, because I had a few different situations where my clients are into that, kind of stuck with that situation."

The same nurse went on to say, "And so they will have some of the local churches will actually help with rent or utilities... And then, um, with, they have to agree to participate like in financial planning, not financial planning, but in budgeting... In that kind of thing, to take classes about that."

Another nurse explained, "...I call either legal services—I've helped a client with, who was transporting her child across the state, and her boyfriend was threatening - So, I... You know, legal services is another avenue... No, it's It's state, I think. It's legal aid."

High Fidelity Wrap-Around Services

A few nurses from a couple of sites shared their knowledge of Wrap-Around services that were offered at their site. These nurses understood that Wrap-Around meetings were coordinated to gather various service providers and support systems a client may have to collectively develop an individualized education plan. One nurse specifically described the Wrap-Around coordinator at their site and that accessing Wrap-Around services required that two professional providers refer the client for the service. Another nurse from a different site also explained that there were four phases to the new High Fidelity Wrap-Around approach and that gathering service providers and support systems to coordinate care was only the first of the four phases.

One nurse shared, "So, the Wrap-Around meetings would happen when it was necessary. Like, so we'd start off with having the people that she wanted into the Wrap-Around. They had to be people that are going to be able to support her in one way or another."

Another nurse stated, "[Coordinator name removed] is the coordinator, and she's excellent as well. And, it requires two professional referrals. So, clients who have multiple needs for connection with professional organizations. So, you know, if one of my clients, you know, needed financial help that maybe Social Services could provide help with, continuing their education, mental health services, job placement, I would ask

this person or someone else, someone at mental health, if they would be the second professional referral. We would turn that in to [coordinator name removed]. She would contact the client, interview them, and then we would arrange this kind of roundtable. And, it was wonderful.”

Another nurse said, “Oh, the Wrap program, right, so the Wrap Program, oh she would be great for it... They bring everybody together all in the same room and come up with basically an IEP... Individualized education plan and it’s totally voluntary. The client has to want to be in this program, but it gets everybody that is supporting this person, like even a WIC educator, you know or whoever, their caseworker and for food stamps. You know, it gets everybody together all at the same table. Everybody sits down and says what their piece of whatever is and most of the time everyone has kind of the same agenda. We want to help you to be self-sufficient. We want to help empower you to make these phone calls and set your own schedule and go do all of these appointments. You know what I mean, but getting them all on the same page.”

The same nurse went on to say, “Yep, so it was a really cool program to hear about and they kind of have to be, they are only the two of them that are doing it right now and they have to be able to be a bit more selective about the building of their caseload. Well, selective and slow because it is more intense in the first, there are four phases that go to it and the first one is like getting everybody together and you visit like once or twice a week for a few weeks so that everything is running smoothly and so then after that it kind of trickles off and they can kind of pickup some more.”

Public Assistance Services

Several nurses and a couple of nurse supervisors from most sites had knowledge about various public services that were available in their community. These services included presumptive eligibility, WIC, TANF, food stamps, Medicaid and Medicare, and public health nurses. Many nurses and nurse supervisors across multiple sites tended to be most knowledgeable about WIC and were aware about different aspects of the program such as their location, how it was funded, and service restriction such as not being eligible for a breast pump if the client stayed at home. A nurse and nurse supervisor from different sites were also aware of recent policy changes within WIC that required all staff to notify clients that they would report them to Child Welfare if they were smoking marijuana and breastfeeding. Knowledge shared around other public services was minimal and nurses across these sites tended to just mention their awareness that they were available. In one site however, a nurse explained that she had assisted her client in obtaining a birth certificate and a social security card (which was drastically different from her routine scope of work),

One nurse shared, “I know in a lot of other NFP sites, WIC is right in the building where you are, but that’s not the case here. It’s in a different building. The only way for our clients to get a hold of WIC, they have to leave a message. Nobody answers their phone. Well, you know, low-income people, it just doesn’t It’s not a good system for them.”

Another nurse explained, “I don’t know if you know how WIC works, but these - When they get their WIC checks, they meet with a WIC educator, okay? So, my client met this WIC educator person because she - You know, if you’re not - If you’re home with your

baby—which totally makes sense—you don’t get a pump. I get that. You know, you don’t need it.”

Another nurse stated, “And the new policy that WIC put out... That they’re requiring them to report for marijuana use, for if they’re, not necessarily I don’t think in pregnancy, but the way they see it is that if the baby may be tested at birth and if the, if the baby is positive and the mom has been smoking pot, then the hospital will refer - and for any, like for breastfeeding moms, they want them to report... I was just reading the statement yesterday. WIC, they’re telling WIC that they are mandated to report if a mom is breastfeeding and smoking marijuana, and so.”

Another nurse shared, “DSS has the TANF. They have of course food stamps and all the benefits. Medicaid, Medicare.”

Other Knowledge Among CPS Workers

Several caseworkers and supervisors from all sites shared about their knowledge of various factors related to their work. Numerous caseworkers and supervisors from all sites described their understanding related to their scope of work such as policies around caseload, health and health care, and their community and clientele. An abundance of caseworkers and supervisors from all sites also described their knowledge of community organizations that supported their clients including medical providers, mental health providers, parenting programs, substance abuse service providers, housing options, and domestic violence shelters. Many caseworkers and supervisors from most sites also disclosed their knowledge of prevention programs offered within their department, other public services, and community meetings.

Knowledge Within Scope of Work

Several caseworkers and supervisors from all sites described their level of knowledge around various aspects of their scope of work including Child Welfare practices, their community and clientele, and issues related to health and health care, including alcohol, tobacco, and other drugs (ATOD). A few caseworkers from different sites shared their knowledge around practices at other sites or disclosed lack of knowledge or uncertainty around some aspects of their own work. One caseworker explained that counties with greater populations tended to have more standardization around caseloads. Another caseworker from a different site was uncertain whether or not there were a set minimum or maximum number of cases that were required for caseworkers. Additionally, this same caseworker was unfamiliar with TDMs or family-engagement meetings. Other aspects of Child Welfare that a couple of other caseworkers from different sites lacked knowledge included: what certain acronyms stood for and the frequency at which assessment tools were updated, if ever.

In discussing caseloads, one caseworker stated, I don’t know that they have a limit. I don’t think there’s ever too few, because then it would be a matter of do we have too many workers? (*laughing*) I don’t know that we’ve ever gotten to that point. But, I don’t think I’ve ever heard a number to say, ‘You can’t go over this’. I think that they have gone over when we’ve been so low on numbers, for workers.

Another caseworker also talked about caseloads by explaining, “Um, it varies. You know, in the bigger counties, it’s more standardized.”

Another caseworker disclosed, “Oh, well, we - Depending if it’s department-funded, we have to get authorization within our agency, like I said, our MAP team. And, the MAP - I couldn’t even tell you what the acronym means anymore.”

Another caseworker shared, “...so do I have any assessments? Yeah, we use the protective factors risk assessment...I would like to think it’s updated every year...But I don’t know for sure.”

A couple of caseworkers and multiple supervisors from a few different sites shared about their level of knowledge around topics related to health and health care. One supervisor understood that an emergency room nurse was unable to divulge client information due to confidentiality and HIPAA laws. However, a caseworker and supervisor at a different site lacked knowledge around medical conditions that impacted clients. The caseworker explained that in situations where medical providers shared diagnoses that she was unfamiliar with, she would research them to increase her knowledge, which some clients lacked the ability to do. The supervisor disclosed uncertainty around what constituted failure to thrive and how to best serve clients experiencing such conditions. A couple of supervisors and a caseworker from a few sites also described their level of knowledge related to substance use such as policies and the impact on children. A caseworker and supervisor from different sites also shared their knowledge of policies related to marijuana. The caseworker stated that although counties followed state regulations, some counties were stricter than others. They disclosed uncertainty around laws related to infants born exposed to marijuana but shared that civil court cases had been opened in such circumstances for neglect and acknowledged familiarity with laws against having THC that was accessible to children in the home.

A caseworker shared, “Even if I go to the doctor’s office, and they give me names, that the child has this, this, this diagnosis. I’m like, ‘Okay, wait a minute. How do you spell that?’ (*laughs*) You know? But, at least I can come back and then do online research. Some of our clients do not have the ability to do that.”

A supervisor disclosed, “Just as we wonder, you know, ‘Well, what about this baby? Is this really failure to thrive? Is it organic or is it nonorganic?’... It’s, you know, water that we really shouldn’t be in because that’s not our profession, but you know, we’re trying to sort it out, so we can know which - Which, you know, which way, which path to send the family down.”

In regards to policies related to marijuana, another caseworker said, “I mean, it would - It can depend - I mean, I imagine all the counties are having to follow the state regs [regulations] on it...But, I imagine some counties have more of a strict, you know, anti-tolerance policy than others.”

In discussing policies related to infants born exposed to marijuana, a director stated, “I mean, we um, depending on it, there’s really, they don’t, I don’t know what the law is necessarily but when we interact we assess and see what their issues are and we’ve

opened court cases, civil court cases in the department, dependency and neglect action. They don't usually get criminally charged with anything."

The supervisor went on to explain, "I know they were trying to say that if kids are exposed to it in the home, what was that ruling? Some legislation that they were gonna make it against the law if you have THC in your house and kids have access to it. And they were concerned about that, but I don't think there's any criminal."

A few caseworkers and a couple of supervisors from a few sites described their knowledge around their community and clientele. Demographics that were shared included languages such as varying dialects of Spanish; communities with high rates of teen pregnancies, poverty, and Medicaid beneficiaries; and information about the military population such as its proportion to the general population in a particular geography, their average age, the impact of deployment, lack of support systems, and different benefit systems. One caseworker was also familiar with transportation challenges in the community due to limited public transit options.

One caseworker explained, "And, you have a lot of dialects in the Spanish community, so how does that work, you know. So, I think the awareness of dialects. Even though they're classified as one dialect there's a lot of dialects and they might not understand what the other one is saying."

One manager shared, "Because 10% of our population in [location name removed] is military, is attached to military. We have [quantity redacted] military bases in [location name removed]. So we have a huge military presence and so we understood some time ago that there was a need for us to respond to military investigations a little bit differently because of deployment issues, because of um resource issues. Obviously, families that come from that are reassigned to different locations don't always come with their support systems. They have a different type of benefit system to include Tricare benefits, services on base, things like that.

An administrator said, "In [county name removed] the statistics show that there is a high incidence of teen pregnancy in [county name removed] and that's, um, unique I think to some of the other counties...But in [county name removed] I think among the large counties we've got a high incidence of poverty here; high incidence of people on Medicaid. And so really it — it's hard finding resources for those teen parents to be able to become self-sufficient."

Another caseworker explained, "I believe the public transportation is available for out of town on, two days a week, [weekday redacted] and [weekday redacted], from [location name removed] to [location name removed]. So if you have an appointment that you have to get to a doctor appointment in [county name removed], it's got to be between those times."

Knowledge and Utilization of Community Organizations and Resources

A number of caseworkers and supervisors from all sites described their knowledge and utilization of various community organizations. These organizations included medical providers,

housing, mental health providers, parenting programs, ATOD service providers, IPV resources, prevention programs, and other public services. In addition to general presence in their community, knowledge about these organizations tended to encompass service provisions, location, cost and payment options, experiences with staff turnover, and/or eligibility requirements.

Medical Providers

A few caseworkers and a supervisor from multiple sites shared their knowledge about medical providers in their community. A couple of caseworkers and a supervisor from different sites spoke generally about the availability of medical services in their community including school-based health centers and hospitals, as well as the relocation of a medical provider that no longer serviced their site. Additionally, a few other caseworkers from different sites shared their understanding of medical practices such as confidentiality restrictions, requirements for ongoing documentation for clients, and the presence of social workers in hospitals. A couple of caseworkers from different sites also described service provisions of local medical providers including one with an organization that provided home health nursing for children with special medical needs and the transferring of clients from local hospitals to Children's Hospital due to resource and capacity limitations.

One caseworker stated, "If it's a doctor that's reporting or something, sometimes they are very narrow in the information that they feel comfortable or permitted to give... Sometimes they'll report that they saw something and that they had a concern, which is great that they're making that report. But, a lot of times, we want to know affect and demeanor and anything historically that they have... in terms of previous incidents that may be coming into question now, given this situation, they may be questioning previous stuff. And, sometimes, they're reluctant—given confidentiality—to share some of that information. And, that can be a barrier... I would say medical field probably holds the highest level of confidentiality.

Another caseworker shared, "We work closely with the social worker at the hospital, and the baby's in the, usually they'll transfer them to Children's Hospital, because we don't have a facility close by so they have to go to Denver or Aurora."

Another caseworker explained, "Well, they usually come in and they simply do the nursing. They don't, now the same agency may have an occupational therapist, speech therapist, all those pieces plug in, but the home health usually comes in for my babies, does weight check, um, does, like G tube checks, maybe changing out different things, oxygen level checks, um, what else, I have, I'm trying to think. Oh, I have a little one who has a lot of asthma and possible cystic fibrosis, so she checks him really regularly, checks his breathing, oxygen level, medication, reports it back to the doctors."

In describing what would be helpful to caseworkers that are required to take a case to court, another caseworker stated, "A report. Physical report, you know, your documentation, whatever it is you normally do as medical professionals, just your documentation."

In addition, medical providers were described by some caseworkers across multiple sites as resources for their clients in different ways, including for clients and/or children with cognitive limitations, developmental delays or other medical needs. In assessment, a couple of caseworkers across sites had brought in public health nurses to help them assess for cases with medical concerns or suspected failure to thrive. For open cases, some home-health nurses in some counties conducted weight checks, taught the parents how to appropriately care for a medically fragile child, for example a child who required oxygen, and helped with furthering self-sufficiency and self-care. Most medical providers were described as helpful as a resource for clients through regular check-ups, providing clients with information on their child's conditions, teaching clients what to look for and avoid for their child's needs, and in sharing accurate information on the family. For example, one caseworker had a home-health nurse reassure her that the diabetic child's numbers were acceptable and that the parent was maintaining her child's needs. Another caseworker from a different site explained that home-health or public health nurses had reported back to her if the home environment was dirty.

A supervisor shared, "Yeah and part of that is because they're part of our department, like we're Health and Human Services. And so, our director supervises the public health nurses. And we, oftentimes, when we get a referral that is related to any kind of medical concerns or like failure to thrive, or um, and particularly for really young kids, but even older kids, um, we'll take the nurses out with us, to talk to mom about, like, first of all, she knows a lot more about that kinda stuff than we do, and um, she can speak a different language to Mom, and she can have a different approach with Mom than Child Welfare does."

Another supervisor stated, "Um, so I – and then, the same vice versa. Caseworkers going with nurses. They can see a diabetic child that maybe the numbers aren't as bad as we think they are, and maybe Mom really is paying attention to the diabetic needs."

A caseworker explained, "You know, just the weight checks. And then, the kids have come with, I don't know, like a G2 or, if they have oxygen, you know, things like that. They, the nurse, they come in and they can tell them, 'This is the way it's supposed to be, this is not the way it's supposed to be.' The nurses, they'll often report back to us if there's a lot going on in the environment, you know, bed bugs, drugs..."

Resources for Alcohol, Tobacco, and Other Drugs

A few caseworkers and a couple of supervisors from a couple of different sites shared their knowledge about substance use resources in their communities. Such organizations included general substance abuse evaluation and treatment, an intensive in-patient treatment, and in-home therapy. One caseworker was familiar with specific programs offered by the substance abuse treatment center such as a thirty-day and a two-week intensive in-patient treatment programs. A couple of caseworkers from different sites were also knowledgeable about the cost of participation and whether or not the providers accepted Medicaid. Several caseworkers from multiple sites expressed that most treatment providers for ATOD were paid through core service dollars, although funding was sometimes limited for smaller and rural counties. One supervisor elaborated that Signal was an agency that CDHS contracted with to provide substance abuse treatment for several counties. Under Signal were a group of providers including family and individual therapists who conducted performance evaluations and subsequent treatment.

One caseworker shared, “So therefore, um, we do, um collaborate with uh, the substance abuse, um, treatment programs that are in [redacted], um, some benefit more for clients than others, so we try to, we have, uh, court contracts with specific providers, but if that is not working, or if the clients, or if they’ve been there before and the program will not let them back in, we will search out another one and pay for it. Um, so that they get those substance abuse, mental health we are able to, depending on whether or not the client, the mom, has Medicaid or not, they’re able to, sometimes, either just go with [organization name removed], which is our um, mental health that we have a court contract here with, or they’re able to, if they have Medicaid or Medicare, they’re able to use any of the therapists in town that they would like to use.”

Another caseworker explained, “Um, the resources that we do use are through [organization name removed], and that is substance abuse treatment, which in [redacted], [organization name removed] has, and [location name removed] is about 48 miles from here, so we have that option of sending them up there to do either a 2 week intensive in-patient treatment or a 30 day in-patient treatment for drug and alcohol abuse. And that’s male facilities and female facilities. Now the problem with that is the funding. It’s about 3 thousand dollars or more a month just to get them treatment.”

One administrator stated, “Um, really [organization name removed] as the behavioral health organization up here. We do a lot of work with them. We also do a lot of work with [organization name removed] for substance abuse and [organization name removed] Behavioral Health I think the same — I don’t know how exactly they’re corporate structure is but I know that they’re very similar.”

A supervisor explained, “Signal is sort of an overarching agency that the state contracts with to provide substance abuse treatment for um, several counties in this state. And I think there are some counties that have another agency, and then Signal has a group of providers underneath them that actually provide the direct services. So Signal is sort of the umbrella organization, um, that has the contract with the state for substance abuse treatment. And then they contract with people who actually do the work and we choose from those people who we work with, who we refer our clients to, to get evaluations for substance abuse, evaluations and then treatment.”

Resources for Mental Health and Developmental Disabilities

A number of caseworkers and supervisors from multiple sites described their knowledge of mental health and developmental disability service providers in their community. One site in particular had several caseworkers and supervisors who were familiar with these services. Many caseworkers and supervisors from some sites also spoke generally about the availability of mental health providers or were able to name the organizations or private practice therapists/counselors that provided these services. Whereas, some caseworkers and supervisors from a few sites were aware of greater details in the services offered such as crisis centers, residential treatment centers for youth, family therapy or multi-systemic therapy for children, and extended stay programs in psychiatric hospitals. Several caseworkers and supervisors from some sites explained that many of these services were contracted with the county and paid for through core services dollars and/or Medicaid. One supervisor also shared knowledge about changes to

Medicaid that was expected to increase the accessibility (through increased coverage) to mental health services.

One supervisor explained, “Yes, it is, and then they have a hospital there so, a psychiatric hospital, if people meet criteria, have extended stays there... There’s other like residential treatment centers that is a higher level of care for kids, it’s higher level care than foster care.”

The same supervisor explained, “Like RYS at [organization name removed], it’s Residential Youth Services, there is the ATU, which is the Alternative Treatment Unit at [organization name removed], that’s for pediatrics or adolescents that are in a mental health crisis. So yeah, there’s a lot of different services...”

A caseworker stated, “So, we’ve got, um, there’s a couple different organizations. We’ve got [organization name removed]. [Organization name removed] can often offer therapy for families and ensuring that they can get that additive support. We have [organization name removed]. [Organization name removed] really great in ensuring again that there can be some mental health treatment. Oftentimes there’s mental health issues going in the household and maybe they’re able to provide for the safety concerns or needs for their children but they—there’s that additive risk with the mental health. So, [organization name removed] can assist with that.”

Another caseworker stated, “Um, so that they get those substance abuse, mental health we are able to, depending on whether or not the client, the mom, has Medicaid or not, they’re able to, sometimes, either just go with [organization name removed], which is our um, mental health that we have a court contract here with, or they’re able to, if they have Medicaid or Medicare, they’re able to use any of the therapists in town that they would like to use.”

In discussing the cost of inpatient mental health treatment, another supervisor commented, “Yeah, but I’m thinking some of that will change now with Medicaid with the new Medicaid guidelines. I understand they’re going to start covering some of that.”

Among many sites, some caseworkers and supervisors shared about multiple resources that were available for their clients with medical delays or those caring for children with developmental delays or special medical needs. Many caseworkers from these sites made referrals to early childhood development services or agencies that performed developmental evaluations, screenings, and diagnoses or provided support to developmentally delayed children. There also existed a plethora of various programs, including those that taught mentally delayed parents how to care for their child or for parents to care for their medically fragile children, daycares that worked with children requiring special education, and NFP - which was described as a resource for some sites for their developmentally delayed clients who were first-time mothers. Indeed, NFP nurses were described by some caseworkers as helpful in assisting the developmentally delayed mother and educating on expectations, feeding and nutrition, and developmental goals for the infant.

One caseworker stated, “Well, they have different programs. It depends on the age of the child. And, you know, a lot of times we have some adults that are mentally delayed and sometimes they do have the children. So, children that, you know, really don’t have a lot of risk, but they can place them in this and it kind of helps to get services so they can help provide better services for the children or how to work with the children.”

Another caseworker explained, “...and then we can contract with [organization name removed], they’re our main provider here in town that will do supervised visitation. They’re also a CPA, a Child Placement Agency, and they will be foster parents to our kids. So, [placement worker name removed] provides those types of services, they provide behavioral specialists, or what do they call them now, it used to be day treatment, but basically someone that will go in and see kids in schools and like kids that have behavioral issues. So they provide a big spectrum services... Well, you know, there is [different organization name removed], which used to be known as [former organization name removed], and they act like my past employer that works with works that have developmental disabilities.”

Another caseworker shared, “The [organization name removed] is, um, they’re for the developmentally disabled... They work with families who have kids who have significant delay, kids who have perhaps Down Syndrome, kids who are born with some form of mild retardation... are special education population.”

Another caseworker explained, "With the baby. And it gave us opportunity for a nurse to come in, help mom, brand new mom with the baby. Expectations, feeding, nutrition, and the developmental goals with the child for about, probably 6 months to a year that we used their services."

Parenting Resources

Several caseworkers and a few supervisors from multiple sites disclosed their knowledge about various parenting programs in their community, not just those that were tailored for clients with developmental delays. The organizations and programs that were described tended to be site specific but offered similar services such as one-on-one parenting group parenting classes, child development education, discipline practice, and in-home parenting services. Some additional details of parenting programs were shared by several caseworkers to include: management of child’s behavior, anger management, and mentor programs for children displaying risky behaviors or those with mental health diagnoses. Many of these parenting programs were usually referred by caseworkers to clients who were teen parents in foster care or had open cases. Additionally, the costs associated with accessing parenting programs were explained by a supervisor and caseworker from different sites. The program described by the supervisor was free to participants whereas the program described by the caseworker had a cost but was covered by Child Welfare through their core services dollars. A few caseworkers from a couple of sites described specific programmatic aspects of these parenting services, such as the frequency of home visits and broader eligibility requirements than those for NFP (e.g., up to age five, does not have to be a first-time mom). Other programmatic information they shared included the types of curriculum used and incentives that were offered for participation. Moreover, some caseworkers from different sites were familiar with parenting programs or classes offered specifically for fathers including a dad’s group and courses offering legal advice for fathers who wanted to

obtain custody of their child. One caseworker was also familiar with respite care services that were available in the community for parents – of children with or without developmental disabilities – who needed temporary but immediate day care services.

One caseworker said, “[Program name removed] through [organization name removed], [organization name removed] is a huge non-profit. They do a lot of different stuff. One of the services that I use there, or recommend a lot is [program name removed], which is like a mom’s group, or dad’s group, and then a kind of an in-home case management which is focused on child development...And then, we also have home based services, which is a therapist does that and it kind of can be molded to whatever the family needs. I’ve used that before for child development, parenting, discipline practices, things like that, but it also is a therapy outlet and so I use that with one of my other families, who’s a voluntary family and it not only helped mom with like the parenting and disciplining piece, but also a therapeutic element for her.”

Another caseworker shared, “We have a program that is - I’m not going to use the word similar. The only similarity is that it captures a similar age range. That’s really the only similarity. But, it’s a community infant program. And, it’s birth to five. But, it doesn’t have - You know, and it’s an in-home worker. They aren’t nurses. They’re typically trained therapists, but they go in and interface in a similar manner with a similar age range of children, but there is no - There is no requirement of first-time moms. It goes up to five. So, it’s a broader category.”

Another caseworker explained, “Um, we have the [program name removed], which is awesome for fathers who really want to get advice about how to retain legal custody of their kiddos or maybe they want some good parenting classes.”

Another caseworker explained, “Yes, it’s actually through our family resource center, they contract with, uh, probably about 3, maybe 4 people in the community who do go through trainings and use a curriculum and stuff like that to do the in-home parenting and they use, there’s probably 3 different curriculums that they’ve used. Uh, there’s also a couple of parenting classes that we will refer to, a love and logic and then a nurturing parent that are actually classes that they go to rather than the in-home.”

Another caseworker shared, “We also have, we, I often tell families about [organization name removed]...[Organization name removed] is a respite day care...For children who have developmental disabilities. And we also have [organization name removed]. [Organization name removed] is a free daycare for parents who have small kids, like this population we’re referring to...When there is a day where mom just needs a break...When there is a day where mom just needs a break... We link them with [organization name removed], where they can take them and drop them off, It’s respite for our parents who get overwhelmed because they have so much on their plate.”

IPV-related Resources

A few caseworkers and a couple of supervisors from multiple sites disclosed their knowledge about local services for women who had experienced IPV. These services included peer support groups, shelters, therapy and counseling for the victims as well as their children, and legal

services such as support in obtaining restraining orders against the perpetrator. Unfortunately, several supervisors from one site described not having a shelter in the area but that clients were able to receive resources from neighboring counties. One caseworker also shared her understanding of IPV advocacy groups being less willing to disclose information about their clients when making a report due to confidentiality policies and their reluctance to violate the privacy of someone who was already in a vulnerable state.

One caseworker shared, “You know, ‘I’m putting you at the [organization name removed] because it’s a safe place. You can get services for your children. Your children won’t be scared. Your children can get counseling. You can have positive peer support with other women that have been in domestic violence relationships. And, you don’t have to worry about the people that are using methamphetamine coming to your trailer anymore, and-’. You know, so we were able to capture all of that on one page, so - And, it was the idea that this is temporary, so we can get you into a spot. And, they also help with housing sometimes at the [organization name removed].”

Another caseworker explained, “Schools are, tend to be fairly forthcoming with their broader picture when they’re making a report. The other advocacy groups tend to also have less of a willingness to go beyond - Like victims’ advocates type people.”

When asked why, the caseworker responded, “Confidentiality, again. Just - Just, I think they feel that they have—when they’ve got a victim that has bought into their program and their services and their safety net, they’re reluctant to violate any - I mean, they obviously will report when they have something that’s reportable, but when we start delving into historical information or, you know, ‘Do you know about substance abuse?’ or things like that, they get gun shy maybe.”

A supervisor stated, “...they, um, have a couple of groups, they have a group for victims and also a group for children living in um, domestic violence homes. They have, uh, individual, you know, they work with the victims comp piece, and so there can be therapeutic services, um, they help with restraining orders, um, I mean they do lots of things and we work with them very closely when we are working with victims.”

Military Resources

A couple of caseworkers from one site shared extensively about their knowledge related to military services and procedures. Both caseworkers described a parenting program offered through the military and were aware that it was open to children three and under. One of the caseworkers also knew that it was not restricted to first-time mothers and that the program included parenting classes for parents with children of different ages within the birth to age three range. These caseworkers also shared their knowledge around military-based social workers and related entities that addressed allegations of child abuse and neglect among military families. They were aware that military groups often had different regulations and approaches than county Child Welfare caseworkers, including different classifications for child abuse and neglect. In addition, a few caseworkers described how useful the military had been as a resource while working with their clients. The military had been helpful by linking their mutual clients to voluntary programs, responding quickly to CPS when they needed to get a hold of mutual clients, and communicating promptly overall.

One caseworker explained, “However, through them we get a lot of other referrals as far as like um their [program name removed], which is awesome. And they’re, a lot of them have been previous nurses and so they I think are very similar where they go into the home, work with parents, give them, tell development things and talk with them about safety and all that kind of good stuff. Theirs is a little bit easier because it’s kids 3 and under so that’s huge.”

The same caseworker went on to share, “Um - with [group name removed] in particular it’s that we have very similar roles but very different roles and so they try to investigate for the Army or the Air Force what’s going on. We have different criteria for child abuse, child neglect, the Army versus the state. Very different...They, we look at our state’s criteria for child abuse and child neglect to make good determination all right this needs, this is a founded report. They vote on it at a board, every report that comes, not every report but the ones they deem possible child abuse/neglect. They vote on it as a board um and then there they can vote on a treatment plan as well for we want this person to do [program name removed] or daddy boot camp or something like that...we attend those boards as well. We don’t get a vote but we get to say our little piece about what we found. Their criteria is different though so they vote a lot on risk. So was this child injured? No. But was there the potential that this child could have been injured? Yes. And so sometimes it meets their criteria but not ours. ’Cause for ours we have to actually show some effect on the kid.”

Another caseworker stated, “Yeah, so they have a program called the [program name removed]...Um, and they offer parenting classes for families that have kids of different ages. I think their limit is, I think they’ll work with a family as long as the youngest child is younger than 3. So, um...So it doesn’t have to be first-time, it’s, I think that’s the only requirement. I think it’s age 3. But they go in, like, especially when we have failure to thrive children, that’s when we use them the most often. If kids just need to be weighed consistently, they can go in and kind of watch how the parents are feeding, and kind of see if they have concerns with that, or if it really is a medical concern.”

The same caseworker continued, “And then we work closely with, like I said, like [base name removed] they’re, and [second base name removed] actually, they have social work services, and so they also have a lot of different services that are available to, um, service members. And so, um, they’re like sort of an addition set of eyes on the family that sort of monitoring progress and things like that, ’cause military has a little bit different regulations.”

Housing Resources

A few caseworkers and supervisors from multiple sites described their knowledge of local housing options for clients. Such options included group homes for children and youth, foster homes coordinated through child placement agencies, homeless shelters, low income housing, transitional housing, and previously mentioned safe houses for women who had experienced IPV. In addition to being aware of the availability of these services, one caseworker was also familiar with a low income housing unit that often had waiting lists and eligibility restrictions such that one must have been a county resident for a minimum amount of time.

One supervisor shared, "...there's one in [location name removed] that's called the [organization name removed]. There's a boys' group home here, there's a girls' group home here..."

Another supervisor stated, "Because, basically, all we have here is, um, our county foster homes. We have [organization name removed], which is a child placement agency that kind of specializes in maybe a little more difficult child..."

A caseworker explained, "We do have a housing, um, low income housing available here, and there is another set of apartments in [location name removed], except that it's, you know, they have to have a transportation, um, that is set up. But there's a lot, there's a huge waiting list... And they have their, their um, what do you call it, you have to meet their requirements, like you have to be a [county name removed] resident for at least a year or two years, I think a year. You have to live- Because we're starting to get a lot of people that are just moving in here because the new marijuana laws. So we have a lot of people coming from Pennsylvania, Florida."

Other Community Organizations

A few caseworkers and a supervisor from multiple sites shared their knowledge about other service providers in their community. These entities included legal agencies, schools, clothing banks, day care services, and food banks. Knowledge shared around food banks, day cares, and clothing banks tended to only include awareness about their existence but some more information was shared around schools and legal services. One caseworker noted that schools were often more forthcoming in the information they shared when making a report to Child Welfare. In regards to legal services, a supervisor and caseworker from different sites were aware that the court system could override other organizational and program decisions and individuals making a report to Child Welfare could remain anonymous even if a case went to court if the attorney made an effort to uphold non-immunity or the reporter's anonymity. Furthermore, a caseworker explained having utilized the court and other evaluators as a resource. This worker described a sexual abuse case that had involved the client filing a civil protection order against the FOC and using a parenting evaluator to decide on case outcomes, which ultimately allowed the caseworker to close the case.

A caseworker stated, "I mean, there's also just kind of hooking people up with basic needs care, so like finding food banks, finding different resources like [organization name removed] if they're in that area of town. Clothing banks where people can get free eyeglasses if they don't qualify for Medicaid, or if Medicaid services don't provide a certain thing."

Another caseworker shared, "Schools are, tend to be fairly forthcoming with their broader picture when they're making a report."

One supervisor shared, "But, at the same time, you're involved with the courts. You're involved in a program that advocates for abstinence while you are in the program. So, it is kind of a conflict. But, the court system does, you know, override everything else."

When asked what happens to the identity of the reporter after a case is subpoenaed, a caseworker explained, “At that point what would happen is our attorney would probably intervene on that point. Our attorney wouldn’t allow you to take the stand. They would refer back to our intake assessment I think is would happen. And if the attorney had any more specific questions they could handle that in the chambers of the judge because the non-immunity is a priority. That might be more of a lawyer question but that would be what you know, as a caseworker I would urge for that to happen. I know, you know, attorneys in the past you know, have honored the request of the people, who want remain anonymous. We have it all the time with foster parents.”

CPS Prevention Programs

A couple caseworkers from one site and several supervisors from most sites shared their knowledge about prevention programs that were or would be offered through their department. The two programs that were commonly referenced included SafeCare, Colorado Community Response, and general prevention units. A few supervisors from different sites shared their knowledge that a prevention program was going to be implemented at their site in the near future. A caseworker and a couple of supervisors from different sites were aware that their sites offered prevention services and were also familiar with specific aspects of the programs such as eligibility requirements and authorization to make referrals without client consent. Although one caseworker knew that only closed cases could be referred to SafeCare, a supervisor from another site was uncertain about whether this restriction was for SafeCare or for NFP and had to be reminded by the interviewer that this was a policy of SafeCare and not NFP. One supervisor also disclosed their awareness that the prevention services were voluntary.

A director explained, “It’s the program that’s rolling out in a number of eastern Colorado counties and in the metro area, and we were just allowed to make referrals to SafeCare without - Without receiving, without receiving consent from a family.”

A caseworker stated, “Well, Safe Care is the birth to five, and then we’ve also got the five to 17 age group, and that’s Community Response.”

A supervisor shared, “[Prevention program name removed] really deals - They used to deal only with kids who were 10 to 17. We’ve expanded that now from 5 to 17 and 5 to 19, as long as they’re still either in high school or trying to get their GED. They could actually go all the way down to birth but the Community Response team does a lot of those kids. So, we’re really concentrating- And that program is primarily teenagers, although anyone can apply for [prevention program name removed].”

Another caseworker explained, “Closed assessments can go to SafeCare, so - Just not closed cases, but so we can - Some of those younger ones, we can look at SafeCare.”

Another supervisor said, “Okay, so I was wrong. NFP - (*laughs*) NFP can be involved if we have an open case. It’s just SafeCare that can’t be involved. So, that’s why I was confused.”

Public Assistance Services

A couple of caseworkers and some supervisors from multiple sites were aware of public assistance services that were available at their counties. Such services included TANF, Medicaid, and food stamps. One caseworker also knew about a work force center that offered job skill trainings. Additionally, a caseworker and a couple of supervisors from different sites had further knowledge about TANF's strict eligibility requirements regarding income, citizenship, and hours spent working or job searching. One supervisor was also aware of the income restriction related to Medicaid.

A caseworker shared, "So I've referred to them. I've also referred to just general support services with food stamps, Medicaid and those types of things. TANF is another one that I kinda, I'm finding that sometimes clients are, they've already been there, done that, and then they don't like to have all the regulation with it, and do all the, you know, jumping through hoops for this and that. But sometimes it's a re-refer, you know, and if you are really in such dire straits, that's a great resource, and there's the work force center that's attached to that, and they've very yeah. So the job skill training, and things like that. So those are the main sources or the main places."

Another caseworker said, "Most of the time they're so busy that they'll just email back really quickly, so I'm just able to ask general questions. 'Hey, would this family, um, they're working, would they even qualify for daycare assistance? Would they qualify for, um, the food stamps, or truthfully Medicaid' cause most of our families, you know, it's the, it's the, we, I could definitely know whether or not they're gonna qualify for TANF or not, cause that is a very strict guideline...But I also explain to them, if you're willing to do the TANF, or if you'd like the TANF, you know, we know whether or not in Child Welfare they're getting child support, things like that. And I'm able to explain to them, like, child support you're getting this much money a month, TANF will take your child support so you'd only get this much. This is why you'd probably want to do this versus this, you know, and I'm able to kind of explain to them, to go through that whole process. And on TANF, they have to do so many work hours, or they have to be job seeking, and things along those lines."

A supervisor explained, "That particular program right now is funded through TANF funds. We're hoping to move it over to Child Welfare funds because right now it has TANF parameters on it, which means they can't make over \$75,000; they have to be U.S. citizens; all of these type of things."

In regards to eligibility for Medicaid, a supervisor stated, "Hmm. And, that's 133% above poverty, right?"

Community Meetings

A caseworker and a few supervisors from some sites shared their knowledge about community meetings that were coordinated in their sites. These meetings typically brought together various service providers within a site and provided the opportunity to discuss client treatment plans, sign and exchange release forms, and inform one another about available services. Although participating organizations slightly varied across groups, entities such as law enforcement,

mental health providers, schools, substance use service providers, placement agencies, domestic violence shelters, public health programs, and parenting programs were often included.

A caseworker explained, “I think they are calling it [group name removed] these days and that is kind of a community group that discusses when there’s out-of-home assessment ordered from the court. They help decide if foster care placement needs to occur, so it’s usually for like [organization name removed], and we also have, we just started a safety management team.”

A supervisor shared, “It’s a pretty good group. There’s usually about 20 people there. Um, I chair the meeting and, you know, um - Depending on - It’s a [redacted] in the morning meeting, so depending on, you know, what people have got going on, it’s - Once you sign a release, um, and a confidentiality statement, you know, it’s usually one representative from each agency, say, probation, Social Services, mental health, the Health Department, law enforcement, our drug and alcohol agency – Um - The tribe’s also involved in that - So—the school system are big players in it.”

A director stated, “It was funded by the state...And, the state has set up rules and statutes about who needs to be involved in the program. So, that’s why they came to be, although we invite, certainly, anybody that wants to join. The mandatory stakeholders are Department of Human Services, Public Health, probation, juvenile probation, the court system, school districts, law enforcement...Oh, the managed service organizations which is the MSOs responsible for substance abuse treatment in regions, behavioral health organizations are also on the table, the Division of Youth Corrections participates as well. I think those are all the mandatory folks that it’s also in statute. And then, we also have [resource center name removed] is involved. And, they’re in [location name removed], which is in [redacted] on the other side...[organization name removed], which is our domestic violence shelter, is also involved. The Boys and Girls Club is involved in the program...*(unintelligible)* and the special - Yeah, there’s a lot of people that are involved. So, basically, we get, you know, 10-12 folks every month involved in this meeting. It would be the - They would be the natural place to start.”

Other Knowledge Among Other Partners

A number of community partners from most sites shared their knowledge about other organizations as well as their community and clientele. Several community partners from different sites were well informed about Child Welfare and NFP including their roles, services, structures, and approaches. A few community partners from some sites also knew about pregnancy and parenting programs outside of NFP. Additionally, a couple of community partners from different sites disclosed their knowledge about their community and clientele while a few community partners from some sites also described various community organizations and programs that were available to clients.

Child Welfare

Several community partners from most sites described their knowledge about Child Welfare. A number of community partners from most sites described their knowledge about various structural aspects of Child Welfare. A couple of people from different sites were aware of Child Welfare's transition towards DR while another community partner knew about prevention programs being offered under Child Welfare such as SafeCare. Some other community partners from different sites also disclosed having knowledge around aspects including staff turnover; various positions such as investigators, supervisors, and administrators; collaborative approaches such as the CPT, Daily Assessment Team, and family engagement meetings; assessment tools available to caseworkers; their location; and the scope of work of caseworkers including hours of operation and frequency of visits with clients.

A nurse practitioner and program manager shared, "They are implementing a whole different model of how they respond to cases with the Differential Response. And, you know, I think - I think it could - It certainly poses some challenges. At the same time, it poses a lot of opportunities because one of the goals of Differential Response is to work more with community agencies and community partners, and so, to - If there's a case that, previously, they would say, 'Yes, this is absolutely child abuse,' now they're thinking, 'Well, you know, maybe - Maybe it's more a matter of a lack of resources. They need some more help with stuff.'"

A crisis center director stated, "I think the problem is you have a large amount of overturn of caseworkers. And, it's a learning process every time...And, like I said, I think we've - Since I've been there, there's been one, two, three, four or five different directors in the [redacted] years I've been there. And, lots of different changes in the adminstra—you know, the administrators and supervisor levels."

A case coordinator explained, "When I first started to kind of get accustomed to what they do, I went to daily meetings called DAT, which is Daily Assessment Team, and SURF which is a review team, and I would listen in to some of the cases to kind of get an idea of what was going on. If I'm working with a family now, I'll go to a meeting regarding that family to kind of give my insight and input. But, they are also starting like family engagement meetings more often. So, sometimes, I'll attend those. And then, once a week, I attend the Child Protection Team, CPT, every [weekday redacted] and email and phone calls usually daily."

A public health director said, "Yeah, those are, yeah. Those are the ones that are bigger. And, you know, it's meeting them where they are, and kinda, you know, you don't not stay true to the curriculum and all, but you also have to kinda make sure that you are willing to meet them after, of course, that's another piece of their program, you know, they can't go very late or something, you know, they're pretty strict down there, and here we were like 'They don't care, if you wanna meet them on Saturday, whatever, whatever you can do to, and works in your hours, you know, just do it, that's great.' And so, that worked well, because then they could go ahead and meet them at 6 o'clock at night or whatever. You know, just come into work late, we don't care. Get the job done and meet the needs of the families. So it's a little stricter, their world."

One community partner spoke extensively about Child Welfare's procedures. She shared her knowledge regarding processes that included receiving reports, RED team meetings to determine if a case should be opened, and conducting an investigation once an intake caseworker was assigned. The community partner was also aware that during an investigation, Child Welfare caseworkers often coordinated interviews with law enforcement detectives in order to minimize the number of times a child would have to be interviewed. Another community partner from a different site was familiar with the procedures of the Tribal Social Services and shared that despite having non-tribal members living on the reservation, the Tribal Social Services could only intervene if the alleged issue involved a tribal member.

A crisis center director explained, "Well, so for example, when they now do the RED team. And, they get a call in and they determine if they're even going to investigate or not."

The direct went on to state, "Oftentimes, if the kid needs to be interviewed, the detective and the caseworker might interview. Or, one might interview with the other person in a room listening to the interview, so they're not being interviewed multiple times. And, we have interpreters that come to [crisis center name removed]."

A public health nurse shared, "I think, I know what it was. If - see it gets tricky with the population here in that the [name redacted] Social Services can only intervene in issues related to tribal members...And, even though some people are living here on tribal land, if they are members of another tribe that was the deal. Then the [name redacted] Social Services got involved."

Multiple community partners from different sites described their knowledge of Child Welfare's role in the community. They understood that Child Welfare was responsible for ensuring the safety of children. A couple of community partners from different sites disclosed their awareness that Child Welfare was often stigmatized and viewed as a negative entity that removed children from their homes. Another community partner from another site also believed that an additional role of Child Welfare was to provide trainings on mandatory reporting. In yet another site, one community partner expressed that being involved with CPS in itself was a resource for their clients because of the ability to then be connected to contracted services; thus Child Welfare's role was to connect clients to resources in the community.

A director of a crisis center stated, "So, they're just gathering information. On the civil side, on the Child Welfare side, their role really is to figure out if there's some safety and protection issues and whether the child is safe to be in that home or not, and what that plan might look at."

In talking about the work of Child Welfare caseworkers, a public health director explained, "But, in their world, we don't have privilege, and shouldn't, to know what the rest of the story is. And so it's a trust thing. And most of the time we do pretty well trust that they're doing what's best for the, you know, they want the child to be healthy, safe environment too."

Another public health director shared, “And so I didn’t come in thinking that they’re the bad people, you know, to split families apart or, um, it’s so often the stigma that comes along with child protection. Um, and so I don’t know, you know, I don’t think consciously we, you know as a team talked about that, um, but certainly over the years we had child protection come and do trainings about what’s reportable and what’s not.”

A public service manager said, “I want to help people and I want people to understand that DSS isn’t this horrible monster sitting there waiting to take your kids. Because that’s what people think, you know, and other people out there think that everybody on — that gets benefits is just a moocher, it’s so not true.”

Pregnancy Services and In-home Nurse Providers

Several community partners from most sites were familiar with NFP and knowledgeable about various aspects of the program. Many community partners from multiple sites were familiar with NFP’s services for clients including parenting support, depression screenings, education on health and safety issues, and generally advocating for clients. Across some sites, a few community partners also shared their knowledge about NFP program eligibility requirements, referral procedures, and that it was an evidence-based program. Additionally, a few community partners from different sites knew that NFP nurses were required to hold a certain number of cases that varied for different counties that they served. A couple of community partners from different sites described an NFP nurse or nurse supervisor by name and were familiar with the details of their work, including their experience, approach, and hours. However, one community partner also disclosed that she was not familiar with NFP prior to their initial meeting with the research team and that she was still uncertain about whether NFP services were available during pregnancy or solely after the child was born.

A crisis center director stated, “My guess is that, largely, that the belief was that, that NFP was prescriptive enough that it was - First-time moms, right? And, um - I think that there’s - There wasn’t an effort to sort of engage sort of higher-risk people up front. Right? It was an effort to basically be truly primary prevention. Is that right? Or, I’m misunderstanding?...And, those nurses are so skilled, you know, and have been at it for a while. You know, and [NFP nurse supervisor name removed] also has a lot of skill and experience, and you know, she’s usually right on, so - You know, and so I give a lot of support to [NFP nurse supervisor name removed], and you know, she’s already - 99% of the time already has the answer anyway...”

A maternal child health nurse shared, “And so, I refer any prenatal who is pregnant with her first child. I always give them information about the Nurse Family Partnership program and encourage their participation...And so, every one of them that is pregnant in her first pregnancy, I - I am talking to, you know, about...And, briefly explain and the back of the brochure has the - has the address and phone number for the [location name removed] program. And, I always make sure that they have it. And, then often - And, if - I usually ask the patient if they want to contact the program themselves or if they would prefer that I contact on their behalf and give their address and phone number to whoever and - Anyway, it’s maybe about 50/50 will say, you know, for me to do it and lots of them recently anyway have been doing some self-referrals ...”

A council coordinator said, “Well, she’s a regular member of our Council, so she comes to the meetings. She’s an active member of our screening committee, so Nurse Family Partnership does screening, so they kind of knew what was involved with that. And, she was key to helping us understand and set up a system that includes referral and service, etcetera. She has used the tools. We’re also screening now for - Promoting screening for maternal depression. She’s done a lot of that with Nurse Family Partnership, understands those issues. She’s an advisor to us, both on health and mental health issues, when we write articles or we’re looking at issues.”

A public service manager disclosed, “Um, I don’t know how full their caseload is either and whether they do before the child is born or if it’s just after...Um, I’m sorry I didn’t know any more about it before today, but, um, it’s definitely something I will look at for my clients.”

A few community partners from some sites were also aware of other pregnancy and parenting programs available in their community. Such service providers included general public health nurses who also conducted case management, resource centers, and pregnancy centers. Programs offered by such organizations included prenatal care, parenting classes, and play groups. A couple of community partners from different sites were also aware that these parenting programs were not restricted to first-time mothers and that they offered child care services while the parents were participating in the parenting class.

A public health director said, “I don’t know, we’ve also, we’ve had the prenatal plus program in [location name removed] and we never had great numbers. I think the most we ever had on that was 20, 22, 23, so, you know, prenatal plus doesn’t have to be first-time babies and stuff.”

A public service manager stated, “We have the [resource center name removed] here in town and they offer a variety of classes. They offer, like, parenting class. They offer playgroup, which is fantastic. Those little kids love that especially if they’re an only child at home...Mom and dad even enjoy it. So we do use that a lot for [program name removed] we — we, um, we have them go once a week over to playgroup and they get, you know, they get their credit for — for doing that. There is also a nurturing parent class that is held twice a week. There’s two separate classes that are held twice a week and it’s, like, an eight-week class — excuse me — two hours in the evening. They provide daycare while — while the parents are in the meetings. They also feed them dinner...and they also have, like, some incentives. They give away free stuff and — and I think — I think our clients even get \$10 every time they go to the class.”

A care coordinator shared, “Yeah. We have a lot in the community. [Program name removed] and [organization name removed]. [Organization name removed] has a lot of parenting programs and moms’ groups and dads’ groups and they also do something similar to NFP as far as home visit and like on a regular basis through different curriculums, and they can offer that to families with multiple children.”

Knowledge of Community and Clientele

A couple of community partners from different sites shared their knowledge about their community and clientele. One community partner was aware that their county had the highest rate of teen pregnancies in the state, while another community partner from a different site shared that families involved with Child Welfare often had many health care needs.

A public defender stated, “Well, for example, [county name removed] has the highest teen pregnancy rate in the state...”

A crisis center director shared, “And so, a lot of families that touch the Child Welfare system have a lot of healthcare needs. Whether they actually open up an investigation or not.”

Knowledge of Other Community Services

Some community partners from a few sites shared extensively about various community programs and organizations with which they were familiar. These community partners were all aware of medical services available to their clients including work force centers, hospitals, safety net clinics, family practices, and general primary care providers. Additionally, a couple of these community partners from different sites were knowledgeable about cost and payment options for these medical providers. One of the community partners also shared that their geographic location limited the number of medical providers available in the community.

A council coordinator explained, “And, we have a syst—part of that screening system is also seven community agencies that do social and emotional screening and developmental screening that’s embedded and part of their regular work... They know who to refer when the kid needs extra services. And, we have almost a hundred percent referral follow-through rate in those agencies because they know Mom, and they’re right there and say, ‘Let’s call.’ Physicians have a lower rate because Mom can panic and, you know, ‘I’m on my own, and do I call? And, oh, my gosh...”

A crisis center director shared, “[Hospital name removed] is a safety net hospital who provides a lot of these services and has a city agreement to do [so].”

She later went on to say, “So, [city name removed] has a program called [program name removed] where they are based in a residency, a family practice residency program, and they have a social worker that’s a case manager. I think they’re being asked to see more and more kids that are not in the department’s custody. We certainly can. It’s ideal - Most of them are eligible for Medicaid anyway. I mean, being a safety net hospital, part of the reason we were able to sell [previous hospital name removed] on this is because they’re Medicaid.”

A public health director stated, “So, part of the necessity was because, you know, we just, we do have some primary care providers, we’re not total backwoods, but we’re small, and so, you know, there’s just not a lot of, you know, medical personnel...”

In addition, a few community partners from some sites shared their knowledge about a variety of other community programs and organizations. One community partner was very knowledgeable about different aspects of law enforcement including an MOU that existed between the district attorney's office and local police department, how and which detectives were assigned to cases of child abuse or neglect, and strategies that detectives had used to collaborate with caseworkers as a way to lessen the burden on children being interviewed. This same community partner was also familiar with school regulations and the difficulty of obtaining information about children such as their immunization records due to laws that stated that only parents could give consent to release such information.

A crisis center director explained, "In [redacted], there is a Memorandum of Understanding, okay? So, a multidisciplinary agreement and, right now, that MOU is between the district attorney's office, the police department and - And, part of the - I mean - Let me back up. [Location name removed] is very unique because we have a large community that has one DA's office, one police department jurisdiction—for the most part."

The crisis center director also shared, "So, the next business day at [redacted] a.m., they're supposed to show up. They have a piece of paper. When they show up, if there is a potential criminal allegation—so, a bruise - Anything that in the Children's Code that would constitute abuse. So, even a bruise, a mark, whatever. In [county name removed], that would get a detective assigned. If there's nothing that's a mark or anything that would not be chargeable, it may not get a detective. But, for the most part, if it's an order-in in [county name removed], there's going to be a detective assigned, for the most part. Human Services would be - Would also send an intake worker to investigate if there's any question of protection. Okay?...They have what's have what's called Missing and Exploited Persons Unit...So, they actually - They're the child abuse detectives, and they also do missing persons, so they might do an elderly person who's missing."

Furthermore, the crisis center director stated, "Like, for example, the schools. Good luck. We can't even - We can't even get records from the schools on their immunization records. It's been very frustrating. And, we've been trying to say, you know, the schools might have information that would be important for the kids that, you know, so we're working on trying... And, part of it is just sharing of information. And, honestly, if the department has custody—what I've been saying all along - And, I know the attorneys want to give the parents, don't want to take the parents' rights away, and I get that, but for the health and wellbeing of the child, there should be some things that if the parents won't release or can't...Because the law says it has to be the parent."

DHS services such as WIC and TANF, along with various intervention or treatment services including those for mental health, substance abuse, developmental delays, child care, and parenting were generally described as resources for clients by several community partners in various sites. A couple of community partners from one site knew of a mental health provider that collaborated with county programs and about various public services. Some of the public services they described included Wrap-Around services and other programs or organizations that participated in Wrap-Around meetings such as presumptive eligibility, food stamps, DV support, and youth programs.

A public health director said, “It’s previously called [organization name removed]. So it’s our regional mental health...provider...And they work closely with our county programs and they provide services.”

The public health director went on to share, “So some of those things do work and some of them don’t. In other counties they have Wrap-Around, which is another great—we don’t have that here in [county name removed]. But Wrap-Around services in [county name removed] and [county name removed], um, where a team of professionals comes together who’s connected with the client and it could be a variety of—whatever that individual client’s situation is—come together with the client and they meet on an ongoing basis until the client doesn’t need that support anymore and bring together resources for that—for that client and family.”

A community coordinator and facilitator explained, “And then, around the table might be DHS who will be talking to the family about eligibility and food stamps. And, then, [NFP nurse name removed] also makes sure that everybody is involved with WIC and maybe the [resource center name removed] or the [pregnancy center name removed], so she might be the liaison to those other resources we have in our community for families.”

She went on to continue describing potential members of the Wrap-Around team by sharing, “It could be the Department of Health, the Department of Human Services, West Central Mental Health, any other private mental health clinicians, schools - preschool, nursery schools, elementary, middle and high schools, alternative high schools - Probation, Diversion. I know I’m forgetting people. [Advocacy organization name removed], [domestic violence group name removed], Boys and Girls Club. I’m trying to think – we have several agencies that have been actively involved with families. Churches have also take an active role, sometimes referring families. Let’s see, I know I’m probably forgetting some major ones – [organization name removed], which is our organization that works with developmentally-challenged children and adults; The Nurse Family Partnership, of course; medical, which our doctors refer. So, we have a variety.”

Collaborations With Other Organizations Among NFP Nurses

Beyond being aware of and referring clients to various resources, several nurses and nurse supervisors from different sites discussed varying levels of collaboration with different organizations in their community. Some of these organizations included: Head Start, schools, primary care providers, food banks, therapists, GED programs, other NFP sites, WIC, and mental health facilities. Also, several of these nurses and nurse supervisors from different sites further described changing collaboration patterns with other organizations, whether improving or weakening during their time in NFP. As stated by different nurses from various sites, some of the reasons for weak collaboration with other organizations included: staff turnover for other organizations and nurse perception of a lack of interest in collaborating with NFP from some organizations. Many nurses from various sites attributed improved collaboration to factors such as: having built relationships overtime, frequent face-to-face interactions, having a contact person at other organizations, and having open lines of communication regarding services and/or when serving mutual clients.

Weak Collaboration

Several nurses from different sites spoke about weakening (strong collaboration that deteriorated over time) or weak collaboration with different organizations in their community. For instance, one nurse described having a good relationship with a school before the school nurse (who had been the main contact person for NFP) had left, that resulted in less collaboration than before due to her leave. In a couple of sites, some nurses described having weak collaboration with their local WIC. A nurse from one site stated having worked together with her supervisor to call WIC, which was unresponsive in previous attempts to assist the NFP client, but had turned around later and provided needed services for the client. Even though this instance had a positive outcome, a couple of nurses from this site described having a challenging relationship with WIC. Another nurse from a different site stated always receiving a cold shoulder from a local mental health provider that would not receive referrals from the NFP nurse. In these cases where collaboration was weak, many nurses from different sites described feeling frustrated (often because they were unable to adequately secure services for their clients).

One nurse expressed, “I have tried my hardest. This - I shouldn’t be talking like this, but she is - It’s her way or the highway, the person that runs WIC. I know in a lot of other NFP sites, WIC is right in the building where you are, but that’s not the case here. It’s in a different building. The only way for our clients to get a hold of WIC, they have to leave a message. Nobody answers their phone. Well, you know, low-income people, it just doesn’t - It’s not a good system for them.”

In reference to the local mental health provider, another nurse said, “And, they make it so that when you do a referral, basically - They won’t take referrals. They won’t - They won’t take me referring a client. The client has to go in. You go in with the client, and you have to clear your entire schedule because it’s first come, first served starting at seven in the morning, and they’ll take you whenever they can up till noon. And, if they can’t get you in, then you don’t get in that day.”

Another nurse described, “So, again, I email that same person, and she finally gives me the appointment date because I said, ‘I want to make sure that she shows up. She’s telling me she doesn’t have one.’ But, there was times - I want to say there was like a two-week period that I wasn’t hearing anything back from this person at WIC. So, [nurse supervisor name removed] and I had to call kind of her higher-up, and I don’t know if they feel like we’re invading any of their territory or something, but we’re just trying to make sure that these clients are getting connected. And, sometimes, it’s as simple as a language barrier, that she didn’t understand. We’re not sure. But now, she’s hooked in, and she’s fine.”

Another nurse said, “But, some of our other nurses have more like with- We used to have a very close - Several years ago, we knew the nurse at [high school name removed] really well. And, we had direct - We had a lot of - We got referrals and we had - We had a close connection with the school nurse, and she left. And then, with - Yeah, and then, I don’t know, there were some changes, so I don’t know...”

Strong Collaboration

Several nurses and some nurse supervisors from different sites expressed strong collaboration with organizations in their community such as schools, law enforcement, therapists, food banks, and religious organizations. One nurse described receiving regular eligibility updates about her clients from an organization that provided speech therapy, and she at times attended therapy sessions with her client and baby to further build relationships with the therapist. Another nurse from a different site discussed having gone to a food bank to introduce NFP to them and provided posters as a recruiting method; this effort had created a relationship with a key contact person at the food bank. Another nurse from yet a different site described having a good working relationship with an organization that conducted Ages and Stages assessments for her clients and how comfortable she had felt due to the point person's demeanor and willingness to work well with her clients. A nurse supervisor from a different site described a strong collaboration with different organizations in her site, where her nurses had referred clients to different organizations and had received support (e.g. homeless shelter, low income housing, direct services for families) for those clients including from religious organizations. These strong collaborations existed in several sites and created avenues to serve NFP clients in many capacities.

One nurse said, "Yeah. Yeah, we ended up at a client's house together, so it was very nice. And, I trusted her. You know, I really - She really - She's - I trusted her with the client. You know, she was very - She's very energetic and happy and very to the point. You know, she doesn't hide anything, and she's not- She's very direct and friendly, and you know, 'Hey, I want to help you, and- You know, I want to keep you from being in the system,' and she told me the things that she told my client, that she was very, you know, 'I'm on your side.' And, I really like that. That made me much more comfortable referring folks to her than to somebody else."

Another nurse stated, "And then, I've also had contact with one of the food banks in town that I just happened to drive by when I was going to our [name of training removed]. So, I kind of made an appointment and met with their director over there, and she gave me a tour and everything. So, I brought some flyers back and told everybody about it here. She knows about our program, and we..."

A nurse supervisor stated, "Yeah. So, we - We do a lot of referring. The homeless shelter also is part of our community advisory board. We have a representative come, and she gives an update, and she visits with us. We have low-income housing. We have people come from [hospital name removed], different church organizations that support us and come in. We have a [organization name removed] locally here that provides some direct services to families."

Collaboration With Schools

A few nurses from different sites mentioned having good working collaborations with schools in their area. One nurse stated having great collaboration with the high school and that the school had referred clients to NFP. Another nurse from a different site spoke about assistance she had received from the school principal in increased accessibility for conducting visits by allowing her to meet with her clients in a private room at the school after hours.

One nurse said, “It is a good thing. But our caseloads look so different as far as age than it used to. We have an amazing relationship with the high school. I have, for a long time, you know, I’ve been there a long time and they know me, so it’s not that we missed any of the high school students or anything like that. They’re really on top of referring to us and that kind of thing.”

Another nurse from a different site stated, “Even the - I remember a couple times, even talking to the principal if there were - I don’t know what - Yeah, getting a conference room to meet the client, even after school for an hour, we could. So then, really, making it accessible for us to meet clients if we needed to.”

Collaboration With Law Enforcement

Working with clients had sometimes required reinforcements from law enforcement for a few nurses to serve their clients safely. One nurse and a nurse supervisor from different sites discussed collaboration with the local law enforcement where they had utilized their resources to receive information or had provided information to the police for the protection of clients. One nurse supervisor from another site said that she had contacted the sheriff’s office to see if the home they had been about to visit was safe or not, while a nurse from a different site described having collaborated with the district attorney regarding safety issues with the FOC and provided information for the district attorney to take necessary action, which was deportation of the FOC in this case. Indeed, collaboration with law enforcement was described as essential in providing safe working environments for these nurses as well as safe living environments for their clients.

One nurse supervisor said, “I’ve got - I can’t think of the specific title, but if we’ve got, let’s say a father that we’re concerned with, you know, he said that we can call him and see if, whether we should be going into the home with him there or not. Um, or an address that we’re not sure about. He can look that address up and say, ‘Yes, that’s an - That’s one that you don’t want to meet at the home,’ and that type of thing.”

A nurse from a different site said, “And so, I ended up - So, I talked to the DA about it, and he said, ‘Well, send me an email with the particulars, and we’ll look into it.’ So, I did. And, they went to make a - They sent whomever out to check on his work release site where he was supposed to be working, and something wasn’t proper, and they arrested him, and they deported him.”

Collaboration With Mental Health Providers

In addition to collaboration with schools and law enforcement, a few nurses from different sites described collaborating with their local mental health providers to support their mutual clients. One nurse described having referred her clients to a private therapist and having signed a consent form with the therapist to share information if there needed to be more conversations between the nurse and the therapist about their mutual client. Another nurse from a different site spoke about the strong collaboration they had with their local mental health provider, who cared for their Medicaid patients and worked well with NFP. Ability to communicate freely about the client with a mental health provider and having a provider that accepted Medicaid patients played a role in creating a strong collaboration between NFP nurses and mental health providers in these sites.

One nurse explained, “As far as Mental Health, there’s a private therapist and I refer to them and occasionally, if it’s someone who it seems like that it would be helpful for, we’ll get them to sign a consent so that we can talk.”

Another nurse from a different site shared, “Yes, definitely. For mental health we have [name of mental health provider removed], here, that takes Medicaid, most of our clients would go to [name of mental health provider removed], for therapy. And they do work really well with us.”

Referrals From Other Organizations

The number of referrals to NFP from different organizations differed by site even though NFP had a strong collaboration with those organizations as explained by a couple of nurses from different sites. One nurse described receiving many of her site’s referrals from their local public health department and having a relatively collaborative relationship with them, while another nurse from a different site described receiving no referrals from one organization even though they had generally good collaboration and she had made referrals for clients to utilize their service.

One nurse said, “But I’ve known her for years because she works there. And [nurse name removed], my partner up there, she used to work half time for Public Health, so I mean that was a great bridge. So we work pretty closely with them or you know when a client comes through.”

Another nurse from a different site shared, “[Organization name removed]. [Organization location name removed]. I have the address somewhere. But, she was wonderful. I’ve referred some of my girls to go there, and some of my other girls, they already go to food banks that they know about, so - Yeah, I haven’t gotten any referrals from them...”

Other Types of Collaborations

Among several sites, there were additional collaborations with various organizations as described by several nurses. One nurse described having collaborated with multiple players (including Xcel Energy, the client’s medical provider, and Social Services) to turn back on the heat in her client’s home that had been turned off due to a late payment. This was made possible because the nurse was able to communicate with the client’s doctor and voice her concern regarding lack of heat in the home, which then prompted the provider to write a note to Xcel to support reinstatement of heating services for the client. Another nurse from a different site described the importance of the Early Childhood Council in her county in bringing together several different agencies and connecting them together, which facilitated learning from one other at the meetings. A different nurse from another site spoke about the great collaboration she had experienced with the military. This nurse explained that she had referred her client to an Army Hospital so that she could receive the necessary counseling and help that she needed and that the response from the hospital had been fantastic where they communicated with the nurse at every step that took place.

One nurse said, “So, what I did was I worked on calling the doctor, getting a note to Xcel to turn on the heat again because they had a baby. I worked on Medicaid. I called Social Services, asked them if there’s anything they can do to, to get some help from LEAP. It

was an emergency. And, they'd had no idea that they were going through that. And, everything just fell together. And, everything just got turned on, got paid, got done. You know, before they had to leave the house."

Another nurse stated "So, I just thought of something I wanted to add that, in terms of collaborative models, the Early Childhood Council here in [county name removed] is a great place where all of the family - Anyone involved in children and families can be at the table at the same time and learn from each other and share with each other. It's just been a tremendous help in terms of connecting agencies."

Another nurse shared, "She ended up going for a treatment and before she left I gave her a hug and said, you know, I know that you are upset with me and angry with me right now for making you do this, but it is because I care about you and I care about your baby. And I hope that someday you'll realize that. And after the fact, she thanked me. It was a couple months down the road 'cause we kinda took a break, let her choose, actually that was the best collaboration. The Army Hospital, the social worker called me when she. I called the hospital saying sending somebody in with so and so. Her ride called me when they dropped her off. The receptionist called me to say that she had arrived and the counselor, social worker after they had evaluated her."

Contributors to Stronger Collaboration

A few nurses from different sites described what had worked well for them in building collaborations with other organizations that served their clients. These nurses described preferring face-to-face meetings at the client's home or joint home visits as a way to collaborate with other organizations that served mutual clients. One nurse described having had much success in connecting with other service providers through direct contact instead of via phone. Another nurse from a different site described that interacting with other organizations frequently, having nurse supervisors who had previously worked in the organization, having organization representatives sit on CABs, and ongoing outreach by the nurse supervisor as factors that had helped them develop good collaborative relationships with different organizations.

One nurse said "And those are ones that I've usually had to coordinate meeting at the client's house. Because I don't, I've not had much success with them calling me and talking on the phone, but I have had success finding out when they are going to be there and seeing if we couldn't do a joint visit."

Another nurse stated, "Yeah. There is. You know, I think, especially with [nurse supervisor name removed] and everybody being in the program so long, that they've developed good relationships. Usually with at least one person from those different organizations. And, they like, you know, some of them will sit on our advisory board or - So, you know, just being able to see them more than once a year helps I think with establishing that. And, like we have play groups at Catholic Charities. So, we're monthly - I mean we're pretty consistent that we see them."

Collaborations With Other Organizations Among CPS Workers

Several CPS caseworkers and supervisors from multiple sites described formal and informal collaborations with different types of community services that supported their clients. Some of these organizations provided services such as food, shelter, and clothing, while others provided medical health needs including mental health and behavioral therapy related services. Several caseworkers and supervisors from different sites discussed bringing together organizations that provided various services such as mental health providers, TANF, homeless and domestic violence shelters, therapists, and others that had been involved with their clients' cases into family engagement meetings to discuss client issues, which had created better environments for collaboration.

Varying Levels of Collaboration

Several caseworkers and supervisors from various sites described strong collaborations with different organizations in their community that were formal (such as contracted) as well as informal. On the other hand, a few other caseworkers from a couple of sites explained that collaborations with other organizations needed improvement. These varying levels of collaboration existed within most sites and the type of organization with stronger or weaker collaboration varied across different sites. A few supervisors from different sites described great collaboration with organizations such as TANF, employment services or job readiness programs, local mental health providers, schools, and shelters. Another supervisor from a different site shared about collaborating with an organization that provided motels for those who needed a shelter for a short period of time (as there was no homeless shelter in this site). Furthermore, this organization provided therapeutic services for victims of DV, offered mental health assistance, and assisted with restraining orders. Some caseworkers from a couple of sites described collaborations that were a work in progress or those that did not collaborate with CPS as much as they should. Indeed, one supervisor described the importance of having a contact person or two in each organization that helped her locate other personnel within the other organization if needed.

One caseworker described, "Um, you know, I think that we're pretty fortunate in [county name removed], I mean, we do have a lot of resources. I think they all don't collaborate together the way that they should. I think they stay, like, within their own little entity, you know, and everyone has their own, you know, organization that they work with, and a lot of times they don't do that collaboration with one another or real each other's role."

Another caseworker expressed, "Um through the Army we use, we work with Family Advocacy a lot. Um, our collaboration is okay on them, it's not great. It's a work in progress."

One supervisor said, "Well, I would say [prevention program name removed]; I would say [name of mental health provider removed]; I would say - We have a lot of different churches and different faith-based kinds of places. There are a lot of non-profits that we work with, the shelters – the [shelter name removed], we have the [transitional housing organization name removed]. We have really good working relationships with them. 2-1-1 or the United Way work pretty closely with them as far as resources. We actually

work really closely with our TANF people to really try to build on that inner strength of calling up someone.”

Another supervisor stated, “There’s usually, each agency that I named, there’s usually one or two people I know that I can contact that will be available or could help me find someone in their agency to be available to come to the table when we have to collaborate or work together on a certain cause.”

There were also instances of disagreement and conflict with other organizations in some sites. One caseworker shared that disagreements were imminent when collaborating with partners who provided services for children. Specifically, she discussed that she had not always agreed with a guardian ad litem about what was best for the child but had worked together to ensure that the child was placed in their home or in permanency.

One caseworker said, “We disagree on a case. I’m doing that right now with a guardian ad litem. We disagree on the recommendations for the case. It should never be a personal disagreement on, we’re working for the best interest of this child. And, you may not agree on where I want to place the child, or if I want to change the child, return the child home - That’s - We work that out. We take it to the judge and let the court - But, never forget that that should not be personalized. It should be, ‘We’re working to get this kid either home or permanency.’”

In addition, one site that served many clients in the military described varying levels of collaboration as expressed by a couple of caseworkers, mainly because there were many different military bases in this site. One caseworker described a collaboration with the military’s family advocacy program that was a work in progress, while another caseworker from the same site described working well with a different social work program at the military base where they had attended meetings together. These varying points of view about their collaboration with the military from these two caseworkers highlight the complexity of building partnerships with various groups within the same site.

One caseworker said, “Um through the Army we use, we work with Family Advocacy a lot. Um, our collaboration is okay on them, it’s not great. It’s a work in progress.”

Another caseworker said, “Uh, I, you know, we work with the social work program on [army base name removed], and so, they are really, like that’s one of their, part of their program, basically. It’s part of the social work program, so, we have like a memorandum of understanding with the military, and so, with the military bases here at least. And so we attend different meetings, different review boards and things like that, where they’re all present.”

Informal and Formal Services

Collaboration with informal (non-contracted) and formal services (contracted, for example with MOUs) were also described by some caseworkers and supervisors from multiple sites. Several caseworkers and supervisors from different sites discussed working with formal community services where the organizations had been required to communicate regularly with CPS

regarding their mutual clients and provide regular reports about the clients, including noncompliance with services. One caseworker shared about experiences where she had worked regularly with a contracted local mental health provider, while other caseworkers from a couple of sites spoke about informal services that they had found on their own to meet client needs.

One caseworker said, “And then, depending on what community partner we’ve contracted with, we meet - We all get together monthly with the caseworker, the family and the team, the guardian ad litem, the respondent attorneys, if they want, to meet once a month, all together in person. But, beyond that, you know, we’re communicating by phone or email any problems or concerns, getting monthly reports, including their information if it’s a court case, and our court - You know, and our court reports until such time that we’ve - Either services have ended because they, you know, they were effective or not effective, or we’re at case closure.”

Another caseworker stated, “I think just kind of regular communication. We work quite a bit; we contracted with [name removed], sorry it’s [mental health provider name removed]. It’s a huge, I think, gosh, they’ve got like 70 therapists.”

Another caseworker shared, “And then, of course, we have, you know, the understanding- And, we still - I think they’re still - I don’t know if - And, I - I don’t know how that works as far as if that’s like—for confidentiality—if, because they contact with us - And, I don’t - Permanency does more of that as far as on the other end of communicating with the providers and information sharing, but like, when we do any type of in-home services through our core providers, they actually provide us with monthly progress reports and notes and updates as to how the family is doing. And then, they will be a big part of the staffings and decision making, so...”

Another caseworker stated, “Um, things are made together. So some of those contracts are official, some are like, like yourself, the initiatives that are coming down, um, some of them we find by ourselves just trying to fit the family with the best possible match.”

Collaborating With Medical Staff

Several caseworkers and some supervisors from different sites described collaborating with medical staff for mutual clients. Types of collaboration with medical providers included jointly developing discharge plans for patients, connecting needed help for children with diabetes, communicating with hospitals about high-risk clients, and providing needed behavioral health services. One supervisor described having utilized medical staff to make assessments of risk and safety, while another supervisor from a different site had communicated regularly with their hospital regarding high-risk clients who could penetrate the CPS system (for example: CPS had communicated with the hospital to notify them when a high-risk client gave birth).

One caseworker said, “So, I have a lot of experience dealing with medical staff. We even have had many staffings with our cases, collaboration with medical staff, coming up with a discharge plan for the patients, and if the child is not to be released to the family, then we make, you know, plans as to where the child should go and what will be the appropriate placement for the child, so that the placement can really meet this child’s needs if a parent can’t.”

Another caseworker said, “I’m trying - You know, there’s been some in-home therapists that I’ve worked with closely over the years. And, I think that can be as valid and needed as community nursing.”

One supervisor stated, “And then, sometimes in the past, I know that we’ve had to utilize - We’ve had to utilize medical just to make sure we know what we’re talking about as we’re assessing risk and safety. And so, so I - Just from the introduction, I could see, moving ahead here, I can see how we can integrate more of those things into our meetings, but that’s basically what the structure of the meetings look like. And, it is a new process that we’re going to be- We’re still going to be making course corrections on as we develop it, but - But, we’re basing it on best practices from other counties in the state, so...”

Another supervisor from a different site stated, “Well, we used to have a list that the hospital would keep for us, and the hospital would have parents on a red flag list if there were problems. So, say I had a parent that has had 5 children and has been terminated every time, and then we find out they’re pregnant, so we would notify the hospital and say, ‘When this person gives birth, please notify us’...”

Collaborating With Schools

Some caseworkers and several supervisors from different sites also expressed instances where they had collaborated with school staff and parents. Such collaborations involved: meeting to brainstorm solutions for children with special needs, including those with behavioral problems; attending school staffings to connect schools, parents, and caseworkers; and jointly developing discharge plans. One supervisor stated having helped a school district build their own mandatory reporter training, while another supervisor from a different site had met with school representatives to strengthen collaborations. Another supervisor from yet a different site said that they had used DR concepts to engage with a school, by first identifying the school nurse as a liaison and then continuing to meet with school staff while they determined a process for mandatory reports from schools. One caseworker from another site expressed that the schools’ awareness of what to assess for with children regarding child abuse or neglect and how they were functioning in school made the collaboration with CPS strong.

One caseworker said, “Uh-huh, yeah. We work with them. They also participate in school staffings. They help us to kind of connect with the schools and have school staffings or sometimes will a parent say, ‘Okay, my child has been targeted by the school and because they are saying this and that, and my child’s behavior is not like that,’ or, ‘My child has been, is being blamed for other children’s, you know, behaviors.’ And so, we have school staffings and they also help us with, they come with us with the discharge of, you know, and find out what will be appropriate school that will meet this child’s special needs, if they have behavioral problems, if they have an IEP [individualized education program]. They participate in those, you know, meetings to see which school will be appropriate to this special needs for the child. So, that has been really helpful.”

One supervisor stated, “Mm-hmm. Like, [school district name removed] has their own, very comprehensive online mandatory reporter training. We helped them build that.”

Another supervisor from a different sites described, “So, we try to capture, even starting there, like what are we worried about with this collaboration? And, what has gone well? And, we identified that nurse liaison. And then, how do we - You know, what is our next steps? And so, we’ve just continued to meet, and that’s how we’ve gotten some of this process in of mapping referrals and all of that, so - What’s interesting is we’ve used some of those DR kind of concepts that we’ve learned on a lot of different - We used it for, yeah, that meeting.”

Another caseworker stated, “...and so, I think that the schools are very aware of what to look for with the children and how they’re doing in school. And so, I think that’s pretty nice that we have collaboration with the schools. Sometimes it could be a little too much but other times I think that it’s a good thing.”

Working With Law Enforcement

Many caseworkers and a couple of supervisors from different sites described having good collaborations with law enforcement. One caseworker described having called on the sheriff’s office for support regularly, while a couple of supervisors and a caseworker, all from different sites, described collaborating with law enforcement. Collaboration involved responding to law enforcement when they had questions regarding a case or whatever their need was. Another caseworker from a different site described having collaborated with her client’s probation officer to communicate about client progress and weaknesses.

One caseworker said, “Like, for me here, the Sheriff Department is right down there. When I first started, I wouldn’t think to call the Sheriff. Now I call the Sheriff’s all the time. ‘Hey, [Sherriff’s name removed], I need to pass something, run something by you.’ Or I’ll ask a favor that I would never think to ask somebody that I may have just met one or two times in a professional capacity at a meeting.”

Another caseworker said, “Yes, after hours. And we respond with, we collaborate with law enforcement, the hospitals, others agencies in the community that need, whatever the need is, we respond.”

Another caseworker stated, “So, if there’s probation involved, and trying to sit down sometimes and having all of those, having their substance abuse counselor, their mental health counselor, their probation officer, myself, um, you know, if we have anything else and we’re all sitting down together, having meetings every once in a while. You know, sitting down and saying ‘Ok, here it all is. You are sitting in a room with all of us if you have questions, but we’re all on the same page. You’re attending great over here but you’re not doing it here, you know, how can we help you?’”

Another supervisor expressed, “But we also have really good collaboration with our Sheriff’s Department and our local law enforcement also. We never have a problem if we need to, you know, they need to go out with us. They’re very, very good...”

Collaboration in CPS-related Meetings

Some caseworkers from multiple sites shared about their meetings that had brought together different organizations to the table to discuss client matters. Several caseworkers and a few

supervisors from several sites expressed that they had brought together clients, organizations that served them, and others involved in their client's case through family engagement meetings or TDMs and court mediations. A few caseworkers from different sites described family engagement meetings as a platform that brought together clients and different organizations, whether in person or by phone, creating an environment of collaboration to serve their mutual clients. One supervisor from another site explained that she had worked with a mediator when courts had issues with a case and brought together parents, attorneys and others involved in the case together for the mediation.

One caseworker said, "So all of those are family engagement. I think it's a great place for us initially to sit down. It takes, I used to say 'Ok, I got a case, I gotta call these parents and get 'em in before family voice conference to talk with them about their treatment'. The family engagement meeting allows that time, it's already set up, they talk, after the meeting I say 'Hey, can I talk with you for a minute? What do you think we should work on? We're gonna go into court for family voice conference and then they can give me that'. So, I don't like going to family voice conference and we're strangers. Sometimes I can't do anything about that, but-"

A supervisor said, "Usually the court having issues with the case, we try to sit it down, it's kinda similar to the mediation, where we'd have like a mediator and then we have the attorneys and the parents, all parties present."

Another worker stated, "We also incorporate family engagement models, so that we invite some of the same people to come to the table, so we may also include Social Service type of people that are the TANF Program managers that are working with the same clients, or a Child Support manger may come in working with the same families. And, we try to look at the whole picture, what we can do to help this family move forwards. And, those times, [name of youth program under Child Welfare removed] is involved, Child Welfare is involved, Probation, Mental Health or private practice therapists that are involved."

Collaboration Among Other Partners

Almost all community partners from different sites described having worked with other organizations in their community, including NFP and CPS, as well as WIC, education programs and health departments. Several community partners from multiple sites described existing and lack of collaborations in their areas. Many community partners across numerous sites described having known most of the other organizations in their community for a long time and working well with each other towards achieving common goals, for example through the Early Childhood Council. In fact, one nurse practitioner described having worked closely with CPS caseworkers and medical staff to ensure that the children in residence in their institution had been well supported. On the other hand, some other community partners from a couple of sites described not having had any collaboration with some agencies such as NFP in their area due to local NFP nurses' disinterest in collaboration or because NFP had not assigned a specific NFP nurse to their county (a smaller county in a multi-county site). For example, a public health director described

that an NFP nurse designated to her county had not worked well with other organizations in the community.

A public health director stated, “But, you know, I like [NFP nurse name removed]. We have a nice relationship, friendly relationship. We don’t hang out or anything but we’re about the same age, very close in age, a year apart. And we have the same views on a lot of things, and along that vein, I really like chatting up with her because we do have a lot in common in terms of life experiences and that sort of thing, but I just feel like in the last couple years, she hasn’t been a very good collaborator.”

One community nurse said, “I also pick up lots of brochures from the Health Department in [location name removed] and - or they drop them off for me sometimes if I tell them I’m running low. And, so they are available in the WIC office here in [county name removed]. And, I have also given a bunch of them to the education program here, and they have, you know, the people that come in and work on their GED or work on online courses and stuff here at the library in [county name removed]. They are available there.”

A nurse practitioner stated, “Also, kids that are in residence here, you know, it’s all right here. You know, and we work very closely with the caseworkers and the [crisis center name removed] staff also, the youth workers, to make sure that the kids are, you know, well taken care of and that they have that medical support there.”

Another public health director from a different site stated, “But, so I think that was not an issue of, you know, any coercion or anything like that, with them, wanting them to come up here. And now, with the current supervisor they have, she’s excellent. She’s very inclusive and very, you know, will work with us, you know, on any ideas we have. It’s just that they don’t, you know, I think in their expansion, they don’t have just one nurse assigned up here for [county name removed]. And I understand some of the thought process on that, is that, you know, when you only have one, then you only have one, and what if you liked that nurse, but you don’t? Then, so I appreciate having choice, and those kind of opportunities. But on the other hand, it’s not knowing that they’re going to see [hypothetical name removed]. [Hypothetical name removed] the one, and [hypothetical name removed] [is] out of here, you know. So we talked about them coming and working out of [county name removed] so there would be a little bit of visibility.”

SECTION V. OTHER CHALLENGES AND OPPORTUNITIES

Other Challenges for NFP

Beyond collaborating with other agencies, many nurses and nurse supervisors among all sites shared about challenges related to their scope of work including enrollment and retention of clients, nursing practice and approaches with clients of various risk factors (including mental health, substance use, developmental delays, environmental health, young mothers and low

education, and previous or current involvement with CPS), the NFP program and structure, and working with external community resources.

Enrollment and Retention

Among many nurses across most sites, there existed challenges related to enrolling clients in the NFP program. Some nurses from multiple sites shared that some clients were difficult to reach and were hesitant to participate in the NFP program due to previous involvement with the “system” and were fearful of a visitor coming into the home. In one site, several nurses and the nurse supervisor suggested that those with serious risk factors tended to decline participation in the NFP program. In another site, some nurses explained that they had struggled with receiving enough referrals for their nurses. These types of scenarios contributed to the challenges for some nurses in some sites to build their caseload to the NFP legislative-mandate of 25 clients for each full-time nurse home visitor in Colorado. Indeed, several nurses across multiple sites explained that it was emotionally frustrating for them when clients did not want to participate in the program and that they had learned to “let it go” over time and to not take it as personally. Another nurse from a different site explained that she disliked the cold call nature of enrollment where she felt like a salesman.

In recalling a previous interaction with a client, a nurse stated, “‘You’re gonna turn me into Human Services.’ And, I said, ‘No. I mean, you -That’s not what we want to do. That’s not what any of us wants to do.’ You know? And then, she went on, ‘I was gonna be a good mother.’ But, what, what people were telling me is they thought that somebody had gotten, somebody in the motel or whatever had talked to her and thought, ‘Don’t - You don’t let people come visit you.’ ...I tried my best to, to help her work through that and to say, you know, ‘Can we try to - Is there some other’ - I don’t know. She just was like completely shut down at that point, so.”

Another nurse expressed, “I know we’ve talked about stuff like that, and there’s this thought among us that those clients don’t sign up with us, the ones that truly have something terrible and horrible going on, or they know that they’re not going to be, you know, the perfect parent and may have some neglect and things. I think they don’t even return our phone calls. And, that’s just a hypothesis.”

Another nurse explained, “So, it may not be for everybody, so there will always be some clients that decide, ‘No. I don’t want to do it.’ And so, which - That’s a big frustration in the beginning, and it’s always something that we never like. We never get used to that totally. But, maybe, it’s easier to let it go and let it be what it is, so.”

Another nurse shared, “Exactly. That’s the hard part. I’m not the salesman. I don’t like calling people and being like, ‘Hey-.’”

Similar challenges were faced by some nurses across various sites with regards to maintaining their caseload and retaining their clients in the program. Several nurses in different sites spoke about clients who were difficult to reach (e.g. lacked access to a cell phone or changed numbers), were often transient (moving from county to county), continuously cancelled visits, or were simply too busy with school, a job, etc. to participate in the program. Some nurses across

multiple sites also explained that retaining clients who enrolled in late gestation or post-partum were usually more difficult than those who enrolled earlier in pregnancy, because they did not have as much time to build the relationship with the client. In some other cases, a few nurses in different sites had experienced clients who enrolled in pregnancy and then dropped the program after giving birth, with the belief that they had already learned everything that they could from NFP. One nurse also specified that her colleagues tended to take it personally when their clients had dropped out of the program.

One nurse explained, “I had a couple of my girls kind of just disappear. I can’t get a hold of them by phone or anything, so I couldn’t transfer them. I think there’s two of those.”

Another nurse stated, “When their phone gets turned off, and they’re moving from here to there. Um - Typically, I’ll try to call, text, try to contact them somehow. Let’s see - One of my girls, I was having a hard time, she kept canceling visits, and I couldn’t get a hold of her, whether it was by phone call or text, not returning messages.”

Another nurse explained, “Well, my caseload in this particular - At this particular site, we’ve been struggling with the caseload, and I don’t know exactly why, but we just - Somehow, it’s hard - It has been hard for pretty much every nurse, including myself, to maintain a full caseload. So, I don’t know exactly. I just can speculate.”

Another nurse shared, “So, with those two, it’s a little tough, I think, because I signed both of them up really late gestation. Like I said, I think they were both like 36, 37, 38 weeks. So, there’s not a lot of time to build a rapport before the baby comes. And that, you know, those several weeks right after you have the baby, it’s just sort of chaotic and, yeah, it can be a little bit hard to get in the home just because things are so crazy.”

In several sites, a couple of nurses expressed challenges regarding the transferring of clients, from their caseload to another NFP site or when a nurse had retired or left and a different nurse had received her clients. These nurses shared that they often had not received follow-up from the new site with regards to whether or not their client successfully transferred when they had moved to a new county. For nurses who had received a client from a retired nurse, some shared that it had sometimes been difficult to build the relationship with these clients because they had already had an existing relationship with the previous nurse.

A nurse shared, “No, I think it is a little different because, um - Well, for the one, I - I actually took on two clients when she left, and—two of her clients—and, it was more like - I mean, she’d been through the whole pregnancy with this other nurse. And then, I showed up like, you know, the week after the baby was born. And, you know, she’s at her very lowest, worst - You know, she isn’t sleeping because she’s up every hour with the baby. And so, she - Here she is, like, completely vulnerable, right? And, I’m like, ‘Hi. I’m your new nurse.’ You know? And, it’s like, ‘Oh —’ You know?”

Another nurse stated, “Yes. So, I currently have a girl - Yeah. So, kind of what happened is we had a nurse that resigned. And so, we got her - You know, we divvied up her girls. And so, I received one of her girls. So, when I called her to meet for the first time, and said, ‘Hey, you know, we’re going to meet now.’ She said, ‘Oh, I don’t know

if I want to be in the program anymore.’ And, I said, ‘Well, is it because switching nurses’ because sometimes girls do that. She goes, ‘Well, I don’t know. Can I think about it?’ And, I said, ‘Absolutely.’ I go, ‘Why don’t I call you back – you think about it. I’ll call you back in a few weeks and see how you’re feeling.’”

Relationship Challenges With the Client

Most nurses across all sites shared about their challenges with building and maintaining the relationship with clients over the span of their involvement in the NFP program. As stated, some nurses across various sites experienced differences in challenges related to clients who enrolled during pregnancy versus those who enrolled postpartum. In addition, building and maintaining the relationship was challenging when working with difficult clients, such as clients with difficult family members (e.g. family who were wary of participating in NFP), transient clients, those with difficult personalities that clashed with the nurse, younger (teenagers) or much older (30-something) clients, and those who suffered from mental illness and/or were developmentally delayed.

One nurse shared, “Yeah. It is. You know, it’s the family part that - the other people that sometimes it’s hard to build that trust with. And, definitely one case I don’t feel like I’ve ever built that trust. They’re always ...the family. They’re always fairly guarded with me, but they tend to not be around when I’m there. You know, they just kind of disappear, so, that’s okay.”

Another nurse explained, “And, it’s all about relationship. I mean, really, if you have that good relationship with that client, oh my gosh, it’s endless on what you can teach. And, if you don’t - Because sometimes personalities clash, which is kind of cool because I’ve had it happen to me where a client spoke both English and Spanish, and just didn’t hit - I mean, we just didn’t click, right?”

Several nurses across some sites explained that teenage clients were difficult to build relationships with because they tended to have priorities other than learning to care for their child, including texting on their phones during visits or hanging out with their friends. Some teenage clients often claimed to know everything already, for example a nurse recalled a case where one client claimed to know all the pregnancy information the nurse was providing because she had already learned it from her family members. Some nurses from several sites also explained that teen-aged clients were often difficult to build relationships with and had dropped out of the program because they were less trusting and open with the nurse, while a couple of nurses from another site shared that they found it difficult to relate to teenagers because of their age difference. In contrast, in one site, a nurse explained that an older client had been challenging to work with because she believed that she already knew many of the concepts the nurse was teaching her. With clients with mental illness or developmental delays, some nurses in various sites explained that these clients were sometimes distrusting of anyone who visited the home and perceived NFP to be related to DHS. Some developmentally delayed clients also lacked short-term memory or lacked the ability to understand who the nurse was, which led to challenges in building the nurse-client relationship.

One nurse shared, “But, for the most part, I mean, I feel like I have a great relationship with everyone. Some of them, I just struggle with a little bit. And, one being that really

young one because it just - She's so young, and I just am—always trying to figure out (*laughs*) how to get—through... And, not sound like I'm a parent, you know? I'm just like trying to talk to her, but there's always a lot of people there, and there's a lot of distraction, so that one's always a little challenging.”

Another nurse recalled, “Yeah, just – one time, I heard from a very young client that she knows everything that I – all the pregnancy information, she felt like there was nothing that she really learned because her mother and her sister said all the same things to her. And then, I asked her for one more appointment – that's when she said, ‘I don't think I want to continue’...”

Another nurse stated, “...and, in fact, some of the older moms have been some of my biggest challenges and I think they take the program because I'm an older mom and they know that and they think, ‘She knows what she's talking about.’”

Another nurse shared, “And had short term memory problems and things like that. So that was really tough afterwards.”

Another nurse with developmentally delayed clients explained, “A lot of times, you have to leave messages, and you don't get responses because you're just another person, you know, it's not somebody they know.”

In most sites, many nurses expressed about challenges related to maintaining the nurse-client relationship when they had to make a mandatory report to CPS. These nurses explained that although they had transparently explained at enrollment that they were mandatory reporters for suspected child abuse and neglect, many clients – over time – became overly comfortable with their nurse, perceived their nurse as a friend, and had often shared personal details that led to a nurse needing to make a mandatory report. Indeed, several nurses across sites shared that they often felt like they had betrayed their client by making a mandatory report. Many nurses in various sites also explained that making a mandatory report often damaged the nurse-client relationship, such that clients had become angry, moved away, and/or dropped out of the program as a result of the report

One nurse shared, “Yes. Sometimes, they'll share stories, and then – I think I've just had to say like, ‘Remember, what you share with me is –’ You know, ‘Remember that I'm a mandatory reporter. These are the things that I have to share if I see them happening.’ It hasn't happened for a while, though. But, I think they just get so comfortable in the relationship, and they see you so much as a friend, that you have to be really careful with keeping that boundary and reminding them, you know, and not letting it turn into a friendship where they can talk about, you know, the things they would talk about with their friends in terms of like, ‘Well, my sister's husband beat her, and you know, left the kid.’ Because it's like, even if I hear that, I have to report. Even if I'm so far removed, I still have to report what's going on.”

After making a report on a client, another nurse explained how it felt, “Very awkward and uncomfortable, I mean, completely, the family was just very upset with me.”

Practice-related Challenges

Across a number of sites, almost all nurses and some nurse supervisors expressed various challenges in relation to their scope of work and practice. From assessing for gray areas and mandatory reporting to nurse safety and overburden of work, many nurses across numerous sites explained about these areas that hindered their ability to adequately deliver the NFP program to their clients.

Gray Areas and Mandatory Reporting

Risk assessment and subsequent approaches to address gray areas were discussed in depth by many nurses and some nurse supervisors across all sites. As previously summarized in the Assessing Risk section, although most nurses explained that they used the nursing process to assess risk, a number of nurses from various sites explained that they lacked clarity in how to approach specific gray areas. Common gray areas described by nurses and nurse supervisors included: statutory rape as it related to age differences, marijuana use in the home, marijuana use while breastfeeding, other substance use, IPV (especially when the client was pregnant and/or underage), failure to thrive, severe mental health illnesses, and child safety (e.g. adequate car seats). In fact, because some nurses were unsure about what their response should have been to such gray areas, these nurses were then hesitant about their responsibility as a mandatory reporter. One nurse further explained that she lacked understanding on her responsibility as a mandatory reporter, which contributed to her anxiety in accurately assessing for risks.

One nurse explained, “I mean I have seen, especially with the narcotics, it’s a very gray area because if they have a prescription for narcotics it’s - DSS really can’t do anything.”

A nurse supervisor shared, “And, another aspect of the whole marijuana situation that we’re now having to deal with in Colorado with no prior proactive planning as to, you know, what are the - What are going to be the laws? What are going to be the protocols? And - And, if you have a family that’s constantly smoking all day long, you know, marijuana in their home, and - And, the baby is exposed to that all of the time, is there going to be - Is there anything wrong with that? What’s wrong with this picture?”

Another nurse stated, “- is intimate partner violence. You know, because there’s the whole, ‘Is it putting the baby at risk?’ Because then, yeah, that makes it a little more black and white. But, definitely a gray area with just being pregnant and things. I know I had posed a question to [nurse supervisor name removed] a while back - One of my girls was 16, maybe just 17 at the time, and was dealing with some intimate partner violence. So, I was like, ‘Is that domestic violence? Or, is that child abuse because she’s still a child?’”

Another nurse shared, “I guess knowing the laws and it would be a little better in knowing my responsibility around these laws a little bit better but that definitely is not my personality to pay attention to the specifics of that. There are so many and it’s so detailed that it’s really hard to know how to place that into the practice sometimes and so, you know, it’s just having that information or knowing it off the top of my head. And I know where I can go and look into it but, I don’t know, how each one interprets is different...Right, well, or when there’s so much- that you’re caring so much that you’re

trying to do in the home, that becomes the focus of your visit – just really what is going on in this home and really trying to do the work, not all of that and, too, it makes me feel uneasy, me especially since it's not my specialty. My specialty is a nurse, so anyway.”

Impact of Lacking Training and Education

A few nurses from different sites discussed how the lack of education and training in some areas had impacted their work. A couple of nurses across some sites shared that not knowing how to recognize signs of child abuse and neglect in the home care setting was a barrier in accurate risk assessment of the client's situation. One nurse shared that lack of knowledge around mandatory reporting and the general procedures of Child Welfare impacted her work with clients. In particular, she shared that knowing how to address gray areas was challenging because she was unsure how to weigh the potential impact on her relationship with the client without knowing how, if at all, Child Welfare would intervene, and thus the potential outcomes of her making a report. Another nurse from a different site also discussed the impact of not having had mandatory reporter training and that she had to consult her supervisor and receive assistance in making the report. A nurse from another site talked about the impact of lacking training and education in assessing risk and shared that she had often been uncertain about how to assess risk in a home visitation setting and had thus feared being legally liable for things of which she was unaware.

One nurse shared, “Just knowing that I should do it. (laughs) You know, because it's hard. Sometimes, you're afraid, you know, of losing the client or losing their trust. So, yeah, just having the more- Like, yeah, no, that is something that you definitely should have- Not the gray area- You know, like, some person you talk to- ‘Oh, well, yeah, you could report on it.’ And, the next person is like, ‘Oh, yeah, yeah. No, you should.’ You know? And, the next one goes, ‘Oh, I don't know. Maybe.’ So, just knowing for sure those kinds of little things...”

Another nurse stated, “I haven't had, no, actually we're getting ready to do that. I haven't had organized training, I've just been thrown, in fact I was kinda thrown into a little bit of a situation where I had to report, and I really didn't know what to do, so Mary, the manager was right there with me at the same time.”

Another nurse explained, “That's not my first thing, the inclination to look for things in the home that would indicate any abuse or neglect. If there's a bruise on the baby or something like that, you can ask about that, but otherwise, what else do you look for? I'm not quite sure. So, what would be my liability and what's my responsibility?”

Nurse Safety

In addition, maintaining nurse safety on home visits was shared by several nurses and nurse supervisors in a few sites as at times challenging. One nurse explained that she was uncomfortable with the demeanor and attitude of the FOC at a visit as she knew there had been violence in the home, while another nurse from a different site shared about an initial visit with a client with severe mental health illness. In such instances, the nurse left the visit without completing the intended visit plan, made future visits at an alternative locations, and/or the nurse supervisor for the site declined the client's further participation in the program. In another site, a nurse had felt uncomfortable making visits to a home (with known IPV) unannounced. Nurse safety was also a concern for nurses who had made a mandatory report to CPS regarding

violence or drug trafficking in the home, received no follow up on the report status, and made a subsequent visit to the home.

One nurse recalled, "And, I knew that I was not safe. I felt suddenly very much in danger, and I thought, 'This guy is going to flip out—' ...Because he's really pissed off at me. I can just tell. And, even though I'd only been there five or ten minutes, I said, 'You know what? I need to go.' And, I just gathered up my stuff and I said, 'Well, I'll see you later.' [Client name removed] was the name of the client. I said, '[Client name removed], I'll be giving you a call to set up another time to visit.' And, I left... And, that's - That is - That's the most unsafe I've ever felt."

Another nurse shared, "Well, it's been a few years back. So -She just, she was -you know - I don't have that training so I couldn't give you a diagnosis or anything but it was pretty obvious mental illness and saying things that didn't make sense and she kept asking me, 'Are you scared? Are you scared to be here right now? Are you worried about your safety?' ...Yeah. That's the only time in all the years, either this job or any job that I didn't feel safe."

Another nurse shared, "And, she's kind of far out there. She's not one that I just tend to want to drop by because I know there's been intimate partner violence. She's thinking he like slashed her tires at one point. He had even been calling me, trying to get to her...So, I just don't feel comfortable going out there unannounced."

Other Work-related Challenges

Beyond challenges in the practice of home visiting, some nurses and nurse supervisors in multiple sites also explained that there was overburden of work as it related to balancing paperwork with client visits, filling out too many forms, difficulty in maintaining caseload, and integration of new initiatives such as DANCE into practice. Several nurses and nurse supervisors in different sites also shared about the additional effort needed and secondary trauma experienced when working with difficult clients - especially those who required a report to CPS - and the associated burnout. A nurse supervisor from one site who held a caseload while balancing supervisory duties explained that she lacked time to attend additional community meetings, while another nurse supervisor from a different site shared about challenges with nurse attrition that negatively impacted caseload maintenance among the remaining nurses who took on clients from the nurses who had left.

One nurse explained, "If I sign up a mom, and we have a lot of attrition, it feels to me that people, and we all, like our team, takes it so personally. We have to keep affirming each other because if a person drops, it's because they have something that they don't want to show or can't do it - they're in work, they're in school. But it's very personal, because we are held to a high standard of keeping full time - 50 visits in a month, 25 visits if I'm a part-timer, and we have to have 25 clients all the time."

She also stated regarding clients who were reported to CPS, "They were the times that I felt like, 'I'm not sure this job is worth all the angst,' you know?"

Another nurse expressed, "But, if I'm supposed to be at 25, I want to be at 25. And, I want to do my visits. But, when you have a high-acuity case, it takes - You have to do a

lot of extra charting. You're calling people, you're doing extra work. I guess, as an - And now, with this DANCE - I don't even know how I'm going to fit DANCE in. That's another whole piece. I don't know if you're aware of that... It's another - They keep adding - They keep adding more paperwork and adding - They haven't taken away our caseload, taken away anything. They keep adding stuff to our job. I'm working much harder than I did when I started this job. Well, and part of is, I know, I'm a better nurse. I'm not - I mean, I have more - I know more, you know. But, I would say for nurse burnout—and, I know that there is issues in other sites—they're losing nurses. They need to reduce – Either - If they still want us to do all this stuff, they need to reduce our caseload. Or, say, reduce the amount of visits we need to see the clients.”

Another nurse regarding working with high-risk clients shared, “You know, and I know that. But, it's still tough. And, we have to process that, too. And, also, it's secondary trauma for us when we're in those situations. So, we - I've found that, usually if there's a difficult situation like that, I have canceled visits afterwards. I have just kind of walked the mall or just - I have time where I can go to the gym that I - I'm not real effective for another visit.”

A nurse supervisor explained, “Well, I - You know, we have our community advisory board. So, I'm on that...Once a year, we go to [redacted], but we go to the [redacted] meeting because we're requesting money for books for our clients, and actually, we're doing that in [redacted], too. But, I don't necessarily - I, personally, am not on other things. And, I - I don't know where I would put that anyway.... I mean, I don't - I mean, I - Between the supervisor role and carrying my own caseload, and then I also do [program name removed]...So, there's - There's nowhere to put it.”

Client-related Barriers

As explained, some nurses among various sites shared about barriers they had experienced when working with clients of various risk factors. Several nurses in different sites expressed that clients' lack of follow-up with and unwillingness to participate in referred services (such as mental health and substance use treatment) made it challenging to ensure their clients received the necessary treatment that they needed. For a couple of sites, when different nurses from the same site worked with different clients who were siblings, HIPAA and privacy boundaries were challenging to navigate. In these situations, it was also difficult for nurses when they utilized different approaches with their clients; such that one client preferred the working style of one nurse over another. In several other sites, other nurses expressed that recognizing a client's risks that could not be addressed by only NFP was difficult, because they were trained to embrace the preventive nature of the program. These nurses had tried to garner support and resources from the community, including mental health providers, housing shelters, or CPS, but had encountered barriers when these providers did not accept the client or did not assess the risks to be at the same level of severity as the nurses did and thus requiring attention. Some other barriers expressed by several nurses across sites related to clients' lack of transportation or lack of access to phones, lacking resources for foster parents, generational poverty, stigma with the “system”, and cultural elements such as living in rural areas and wanting privacy.

One nurse shared, “So, I make those referrals. I - Mental health, of course, you know, I’ve made quite a few mental health referrals over the years, which I would say, probably only 40% carry—or, maybe even 30% - follow through.”

Another nurse stated, “But, same kind of culture, same kind of social-economical levels. Maybe a little poorer. [County name removed] is one of the poorest counties in the state. Um - But, yeah, not very successful down there.”

Another nurse shared, “Rumor has it... We’ve been down there several years and it’s been really hard to get up the caseloads to [redacted]. I think we’re getting close. I’ve heard they’re very private and they really don’t trust people to come into their homes.— And, it’s been really hard for the nurses.”

Other cultural factors were sometimes expressed as a challenge among some nurses in different sites. In a couple of sites, a nurse and a nurse supervisor explained that working with undocumented or Spanish-speaking clients posed some barriers. For example when the nurse needed to make a mandatory report (including for IPV) and/or referred the client to other services in DHS such as income-assistance programs, the client was afraid of association with authorities and/or subsequent deportation. A nurse from the same site explained that some clients from other countries and of other cultures lacked understanding on the nurse home visitor role and were sometimes fearful of having such people visit their homes. In another site, a nurse explained that their site lacked a nurse who could speak Spanish such that they had needed to bring along an interpreter to visits. Another nurse in a different site shared that although she was Hispanic and knew the culture, she understood that behavior change in general was difficult and when coupled with culture, made it challenging for her to teach her clients. For clients with relation to the military – the client herself was in the military or was a dependent of someone in the military, several nurses from one site explained about the challenge when accessing mental health resources. Such clients with military relations sometimes had mental illnesses (e.g. PTSD) and were often reluctant to access mental health resources offered on the base due to associated stigma. In another site, one nurse explained that the homes in the tribal community lacked street names and had multiple addresses, making it difficult to locate clients; while another nurse from the same site shared about challenges in adapting cultural practices to the NFP curriculum. A couple nurses from this site also expressed challenges towards mandatory reporting with the tribal population because it involved a different process that was unclear to many of the nurses.

One nurse shared, “And then, they’ve – My - You know, she is, um, not a full citizen. And, um - Her parents are Spanish-speaking only, and she lives with them. And, I don’t know if there’s a little fear factor there going on, you know, of, um –”

Another nurse shared, “But, there’s not anybody here that specifically speaks Spanish—but, if we had a client that needs an interpreter, we have people available that can go along on visits with us, or we can get Spanish material and that kind of stuff, so.”

Another nurse explained, “So, it gets a little challenging sometimes just because I’m Hispanic, and so I know the culture. And so, I know that some of the things that we teach, it’s hard for them to understand it. And so, I understand it now just because I’ve been educated in it, and but if it was me at that time, I would probably be feeling the

same way... You know, make sure that they know that and - Because change is hard. Change is hard with culture. And, not that I want to take that culture away, but there are certain things, you know, that I see that we can educate on that maybe they don't even know because they've been taught that way, and it's come down to - It's been taught by generation, generation, generation, and then with the evidence that we know, that's a challenge for a nurse to go in and tell them, you know, 'Well, you know, evidence shows -' You know, and this and that. So, it's - It's a challenge."

Another nurse shared, "Yes, except for they also have, the military has their own counselling centers, so I would probably inquire if they had gone to see anyone there on base or if they would feel more comfortable. A lot of times they don't feel comfortable going on base... But, you know with therapy, like if they go to get mental health therapy, there's still that stigma, and it still does affect their job very much so. So a lot of them are less willing or open to go, you know, they're just trained that they just deal with it themselves."

Challenges With Clients With Mental Health Concerns

There existed barriers in accessing mental health resources as expressed by some nurses among several sites. In a couple of sites, several nurses expressed that some mental health clinics or service providers only accepted Medicaid, thus clients with alternate or no health insurance were unable to utilize such resource. Some nurses from a couple of sites also explained that they had limited service providers or counselors who offered treatment for mental health illnesses as PTSD or depression. Even in those sites with services available, challenges arose in one site with regards to providing the client with the appropriate care without removing the child from the home. In this site, one nurse shared that she was left without a resource because she could not guarantee that CPS would not remove the child once the client entered inpatient treatment; no other option was offered by the service provider. Finally, in multiple sites, some nurses expressed a lack of coordinated care with mental health providers, including having limited communication with these providers after making a referral and receiving little follow up. In another site, some nurses explained that mental health providers did not accept NFP referrals, but rather clients had to self-refer. Indeed, one nurse had brought a client to the provider directly to receive assistance and the worker was wary of having the nurse present during intake. Another nurse from the same site emphasized that if better relationships with their local mental health services existed, she would not have needed to report to CPS.

One nurse regarding the accessibility and barriers to mental health services expressed, "And, I've - I think they're easily accessible and I think sometimes maybe the barrier might be is when the client doesn't have insurance, doesn't have Medicaid, and they need services. And, sometimes, they might be hesitant to, to inquire just because they just can't see that they're gonna be able to afford to pay for the services."

Another nurse stated, "I had a mom who, she has several different diagnoses, she was doing what she was supposed to and seeing her psychiatrist regularly, trying to get appointments, which they weren't doing appointments at that time, it was a walk-in only basis, which is incredibly difficult for our clients. But, she was kind of losing it. And, it was likely due to the meds that she was on... She was not in a good spot when I saw her, and I called her, our mental health facility to try and work with her. Because I was like,

‘We need to get you in there. You can go inpatient. You can go with them. You can call DHS to try and get help,’ which she was absolutely not going to do. And so, I called her case—well, not her caseworker—but, I ended up talking to the nurse because her psychiatrist was out. And, there was nothing that they could do nor would do for days... Well, she was like – well, she won’t go inpatient because we have a history as well. And, I can’t deny it that if they go inpatient, CPS takes the baby.”

She goes on to say, “So, that’s a barrier when I’m asking for help, and I know that somebody needs help. All of her symptoms had been documented by them. The same ones that she was telling me and I was seeing. And, I was left without a resource.”

Another nurse explained, “So, I dragged her down to our local place. She agreed to meet me there the next day. And, I said, ‘I will be your support, and we’ll go through this whole service to find out what they can offer to you.’” And, I even called the person who was the head, who we knew, and when I got in there, I received the absolute cold shoulder because who am I? What kind of - Am I looking over their shoulder? What was - I mean, they were really concerned that a nurse was in the same room as the client going through the intake.”

Other challenges with working with clients with mental health illnesses involved the clients themselves. Many nurses from several sites found it difficult also to ensure that their clients followed through with attending appointments (for example, sometimes the client couldn’t be reached). A couple of nurses from one site shared that some clients had been reluctant to sign releases with the mental health provider especially when the client had a history of severe mental illness, while several nurses from a couple sites explained that clients with mental health illness tended to require greater effort and time to ensure the client was compliant with medications and therapy schedules. Other clients from different sites were described as hesitant to seek mental health services when they had no health insurance. Furthermore, some nurses within a couple of sites explained that over time they had seen more clients with undiagnosed or untreated mental health illnesses. Specifically in one site, a nurse shared that she had needed to decline the NFP program for one client because she felt unsafe around the client due to mental health concerns. Finally, in another site, one nurse recalled that she had made visits to mental health clients that became “crisis visits” where she needed to immediately address safety concerns rather than conduct the intended visit plan and curriculum.

One nurse shared, “I think most of it is just the release. I think it’s the client, the client has the right to say, you know – it’s the same with the mental health therapist, you know, some are ... Even with mental health therapists, you know, there’s a reluctance to, ‘Okay, I’ll go see them, but I don’t want a release to anybody else.’ So, that’s – some will, but a lot of them will not. And, depending on their previous experience.”

Another nurse regarding working with clients with mental illness expressed, “And so in order to get them in the door so that they will be compliant with medications and therapy schedules, she does, and that takes a lot of her time. And so it is hard for her to stay at 25 [caseload].”

Another nurse explained, “So, there have been lots of situations where we have some, a little bit more mental health problems that have been undiagnosed or untreated than I used to see before. I’ve noticed over time, we don’t have as many resources.”

Another nurse recalled an experience in declining a mental health client, “Um, one other time a referral I had was working with Social Services but she was a client that – one of the only clients that actually, because of my discomfort with the situation, that we declined in the program or she was mentally ill... it was pretty obvious mental illness and saying things that didn’t make sense and she kept asking me, ‘Are you scared? Are you scared to be here right now? Are you worried about your safety?’”

Another nurse shared, “Right or when you get to the visit – I mean, and I know they wouldn’t have probably the same flexibility – I get to the visit, and I have a topic already picked up, and it turns into what I call a ‘crisis visit’, where something is going on that I, ‘-This is just going to have to take a back burner for now, and let’s just talk about this, And then, next time I’ll just follow up with that.’”

Challenges With Substance Use Among Clients

In addition to challenges with mental health clients, there existed several barriers when working with substance use clients, including mandatory reporting for substance use and working with other providers. Some nurses from some sites expressed uncertainty in reporting for substance use, especially regarding marijuana. Newer NFP nurses across multiple sites were more anxious in this arena and shared that perhaps they were not asking the right questions with their clients. Among some sites, some nurses also shared mixed experiences in how CPS handled substance use after a report was made. Most sites recognized that marijuana was not usually acted upon by CPS but other drug use warranted a report to CPS. A couple of nurses from different sites shared that how CPS handled substance use had changed over the years, such that marijuana was previously a major concern but not currently. This change had created challenges for nurses who had reported on marijuana use but no CPS action was taken, leading to strained relationships between the nurse and client. The inconsistent way of handling legalized marijuana, including county/city laws, protocols, and CPS reaction, between and within sites had created challenges for many nurses and nurse supervisors.

One nurse shared, “I think one of the things is my own liability, that I’m not picking up on certain things. Say, okay, with growing marijuana in the home, if I’m not asking certain questions and something were to happen, either the child were to ingest something or say they grow something that will catch fire, something like that, would I be responsible in some way for that? I know I would feel like I could have done more or should have done more, but would I really be responsible for that? And so that increases my anxiety around my own clients.”

Another nurse explained, “But, in [county name removed] – and, I kind of saw this progression when I first started doing labor and delivery like in about [redacted], we would call at the time if we had the mom positive for pot, and DSS would get involved. Then, we kind of saw this progression that – again, this is my perspective – um, Mom was positive for pot ... no big deal. You know? Had the baby, no big deal. ‘Don’t call us.’ Definitely, all the other drugs: heroin, cocaine, whatever, then we even kind of

started seeing this progression of, you know, ‘She has – the mom has to be positive at the time of delivery.’ So, she could be positive for coke during her pregnancy.”

Another nurse shared, “...And, another person who apparently the father of this baby is doing everything including drugs and alcohol and everything and now he is okay to be with the baby. They give the baby to him. Just different scenarios that we hear over the years.”

One nurse supervisor shared, “So, that’s kind of like a catch-22 statement for these people. And, and another aspect of the whole marijuana situation that we’re now having to deal with in Colorado with no prior proactive planning as to, you know, what are the – what are going to be the laws? What are going to be the protocols? And – and if you have a family that’s constantly smoking all day long, you know, marijuana in their home and – and the baby is exposed to that all of the time, is there going to be – is there anything wrong with that? What’s wrong with this picture?”

Some other barriers for some nurses from various sites included the uncertainty in changes for mandatory reporting requirements and communication issues with service providers. As explained in a previous section, a couple of nurses from several sites shared knowledge of WIC educators as mandatory reporters being required to report for marijuana use amongst breastfeeding clients. This new requirement was worrisome for some NFP nurses because they felt that if they were held to the same policy, their reputation would be affected and that clients would not want to work with them anymore. In a couple other sites, some nurses had communication issues with substance treatment or service providers and physicians. For example, in one site, the nurse shared her concerns with hospital nurses about an infant possibly testing positive for substances. However, the physician did not feel it was necessary to test, leading to more serious complications for the infant months later. Finally, a nurse from one site shared about experiences with clients who would not admit to using substances even though she had seen them present in the home. This type of situation made it difficult for the nurse to make recommendations on next steps and treatment when the client was unwilling to acknowledge the issue.

One nurse shared, “And the new policy that WIC put out... That they’re requiring them to report for marijuana use, for if they’re, not necessarily I don’t think in pregnancy, but the way they see it is that if the baby may be tested at birth and if the, if the baby is positive and the mom has been smoking pot, then the hospital will refer – and for any, like for breastfeeding moms, they want them to report.”

Another nurse recalled, “Unfortunately, it started previous to this because, after the client had had the child, I was very concerned that the baby would be positive at birth. And, at the hospital, I talked with a, the nurse within the nursery. And, told them of my concerns, and they asked if they thought, you know, the baby should be tested, and I said, ‘Yes.’ And, they would contact the doctor. Unfortunately, the doctor did not feel that it was necessary to test the baby, so the baby went home...”

Challenges With Clients With Developmental Delays

Working with clients and/or children with developmental delays created several challenges for some nurses in a number of sites. Despite the fact that most clients wished to care for their child appropriately, some nurses from some sites shared that caring for medically fragile infants had led to frustration for the client when the baby's health was not improving. Furthermore, when developmentally delayed clients lacked a support system, neglect became easy because they did not always understand the impact of what they were doing to their child. It was also challenging for many nurses to work with these clients because it was difficult to get the client to do what she needed to do, for example ensuring that the baby was not neglected or recognizing that attending a party with the baby where consumption of alcohol was occurring was inappropriate. Many nurses from most sites recognized that these clients required greater support and education. However, one nurse shared that these clients were often nonresponsive because they tended to view her as a regular person, not a trained medical nurse. In these situations, it was necessary to leave more messages and identify more pathways to assist them. It was also challenging when the nurse was teaching concepts in an abstract way, not recognizing that clients with developmental delays needed more concrete ways of learning, as explained by a nurse supervisor in one case.

A nurse explained, "And, I know that she had some learning disabilities because she couldn't really read that well. So, trying to get her in – even suggesting it to – we suggested the GED. We tried to get her into that and she really wasn't interested. So, it was so many things. It was so challenging for us to try to get her to do whatever she needed to do."

Another nurse stated, "You know, again, it's the same, I think, both in the developmentally challenged and the mental health. You know, they just – they need a lot of support..."

A nurse supervisor stated, "So, all of those pieces, I think, fit into the pie that made it happen where we did more reporting this year. We've also seen more developmentally delayed parents in the last probably [redacted] months than we have before. And, I think that also is a contributing factor. They don't have a support system (*unintelligible*)... especially. And, neglect is really easy because they don't know, they just have a hard time really knowing what they're doing. And so, those are the challenging cases, the mental health and the developmentally delayed are the most challenging ones that we have..."

Challenges With Environmental Health

Across several sites, some nurses also shared about challenges in their practice with regards to housing or the environment. In these sites, several nurses had clients who were denied housing from the shelter because they did not meet the qualifications of being homeless; in one situation, the client needed a letter from her parents that they kicked her out of the home. It was also difficult for some nurses in one site when their client was unwilling to access homeless services, while in another site there were long waiting lists for transitional housing. Other barriers for some nurses in some sites included: difficulty to reach and visit with transient clients, uncertainty in reporting to CPS for environmental risks, and lacking training in how to work with clients living in chaotic homes (e.g. homes with ripped furniture and walls, violence, etc.).

One nurse shared, “So, they can take teens, but a teen with a baby is a different situation... So, that’s kind of a barrier for our youngsters if they don’t have anywhere to go. And, our adult homeless shelter, there’s a lot of regulations that come on taking a minor in that they don’t want to touch them, basically, due to the law.”

Another nurse stated, “So, she did all the paperwork and everything and so she came back to me and told me that they told her that um she would have to, cause she wasn’t, she never did meet the qualifications of being a homeless. But they told her that she would have to get a letter from her mother and stepfather stating that they were going to be putting her out of the house.”

Another nurse explained, “Well I need to call her cause we didn’t schedule a visit follow-up. Cause she’s kind of transient too. She’s not home. She’s like at a hotel. She’s trying to get her own place. So it’s kind of like, you know, I just have a contact information number and I have a hotel where she was staying or she could be staying somewhere else.”

One nurse supervisor shared, “But, I mean, the – just the filth and, you know, the dog feces that’s on the floor that, you know, the kid’s crawling in and, you know, that happens – I can’t – not just down there. I mean, I’ve had several clients that have had that situation. Pit bulls chewing on their dog bones right by the woodstove with the little kid crawling right next to them, climbing over the dog while he’s chewing on – I mean, like real bones, not like rawhide. I mean, we’re talking like animal bones. And, you know, I mean, dogs are dogs and, you know – things like that. You know, I mean, that’s a safety issue. It’s not abuse or neglect, but it’s a safety issue. Those are the gray areas that it’s not a mandated reporter thing, you know. “

Challenges with IPV

Across several sites, some nurses stated that clients who had experienced or were currently experiencing IPV were at-times challenging to work with. Several nurses from various sites shared that clients who had experienced IPV (or were experiencing IPV) required a delicate way of approaching the subject, especially with those who did not recognize their experience as IPV. Some nurses in other sites also explained that some clients who were extremely open about their lives (and specifically about experiencing IPV) at the beginning of the program tended to drop out faster.

One nurse stated, “Which is common. I mean, that’s common for a mom that’s in a domestic abuse situation, but it’s also really frustrating when you’re the one sitting there looking at it, and you’re feeling kind of nervous for the mom.”

Another nurse shared, “Because, I mean, I guess, I’m easy to talk to because they tell me everything. It’s like we’ve only met twice, and I find - And, I’ve found just from doing this program, if they tell you too much from the very beginning, they’re going to be your clients who are going to drop off the quickest.”

Challenges With Clients With Previous or Current CPS Involvement

While working with clients with previous CPS involvement, some nurses and nurse supervisors from several sites shared challenges in successfully engaging these clients in other DHS services, such as Medicaid or TANF. These clients were reluctant to engage with DHS due to their parent's involvement with CPS when they were children and its associated traumatic experiences. Some of these clients were also more hesitant to divulge information with the nurse, making it more difficult for nurses to build rapport, such that some had declined to continue the program after several visits.

Across many sites, several nurses also explained about challenges with working with high-acuity clients who were involved with CPS. Several nurses in multiple sites believed that their role, when a client was involved with CPS, was not to police the client, but to be their advocate; however this role was not always clearly understood by the CPS caseworker. Some nurses also expressed that they had needed to continuously reiterate to CPS that NFP was a voluntary program, that clients could not be forced to participate, that NFP could not be written into the treatment plan, and that nurse home visitors did not replace other treatment programs.

One nurse supervisor shared, "Also, our clients – in fact, a number of clients who, as children, were in the system because somehow DHS had gotten involved with their parents. And, those are the ones that are most adamant they don't want to have anything to do with Social Services. They won't apply for Medicaid. They won't apply for TANF. A lot of our moms don't want to go to CCAP [Child Care Assistance Program] because they make them go to court and file for child support..."

A nurse explained, "And, she was in the program until her baby was probably about six months and then she declined any further services. But, it does seem like the ones that I have picked up while they were in foster care, those are the ones who don't seem to complete the program. I've had another one years ago."

Another nurse on working with a client involved with CPS shared, "...but we don't - we're not to replace, you know - so, we had to explain to them that we can only go once a week. And, that's only for six weeks..."

NFP Program Challenges

There were also some programmatic challenges with NFP that several nurses and a few nurse supervisors from different sites expressed. With regards to the NFP education, some nurses and a couple of nurse supervisors shared about various challenges they had faced. Several nurses from different sites felt that the time needed to participate in initial education and training coupled with the pressure to quickly build a caseload was sometimes overwhelming, and one nurse even admitted that her charting may have suffered as result. The same nurse also shared that she (and her clients) had noticed inconsistencies with the NFP curriculum with regards to timing. Several nurse supervisors from different sites also explained that they did not like having to travel to Denver for trainings because of the travel time and that there lacked educational opportunities for nurses in their local county.

One nurse expressed, “I think, to be honest, I think it was disservice to me being a new grad in this field because I feel that my charting has quite possibly suffered because I built my caseload so fast and that is something that I have been asking for ongoing reviews and have gotten some.”

The same nurse shared, “I have found quite a few contradictions and inconsistency in time flows in our curriculum, like 5 maybe and that’s just things that I’ve noticed, things I’ve had clients point out to me as well that I’m like thank you so much for finding that. I’ll bring that to my supervisor’s attention.”

A nurse supervisor explained, “Well, one side of me says I like the classroom better, but the other side that has to travel to Denver says, ‘No. I prefer web.’ ...So, but if you’re talking about Denver - (*laughs*) I mean, I like going to Denver, but I don’t like going more than once a year.”

Another nurse supervisor shared, “The teaching - And, up here, it’s a little challenging. [City name removed] doesn’t have a lot to offer in the way of continuing ed. So, they go to Denver at times, which is always a challenge because we can’t stay overnight, you know, most of the time. It’s a long drive.”

As well, several nurses from one site shared about challenges with supervision where they had instances of disagreement with their supervisor on client cases. Some of these disagreements were related to incongruent perspectives on the definition of failure to thrive, as well as subsequent reports to CPS. Another challenge related to the NFP structure involved electronic medical record systems. In a couple of sites, some nurses explained that they did not have access to all of their client’s medical records which were sometimes a barrier when they needed to easily contact the physician with their concerns. A nurse supervisor from a different site shared about challenges with the organizational management when the department director needed to approve training vendors. Finally, a couple of nurses and a nurse supervisor from different sites shared about diminished funding for informal luncheons with community organizations and inability to pay for client services.

One nurse shared, “So anyway we had a conversation and [nurse supervisor name removed] told me I had to call DHS on her, and I said, ‘Can it wait until, I’m supposed to see her in 3 days, can I wait until then to monitor the baby?’ ‘No, she requested a different nurse.’ ‘Okay, that’s fine, you know. I’m happy that she chose to stay in the program but can I wait to call until I see the doctor’s note?’ ‘No, I saw the doctor’s note, you need to call now.’ And I’m like, ‘Okay-.’”

Another nurse explained, “[Affiliated clinic name removed], the Health Department and [affiliated clinic name removed], we can all get on the same computer. But, also through the hospital that the residents, you know, the new doctors, they have a clinic, it’s called [other clinic name removed], and the residents - But, we’re not on the same computer system with them. So, it’s harder to - We can’t check medical records and stuff.”

Another nurse shared, “So sometimes that. But, and we do a lot of outreach in the community. Or that - We kind of make that a regular part of our job and just chatting,

going in and chatting with people. We used to take people out to lunch but they cut our money... They don't give us money for that anymore, so [nurse name removed] and I still pay out of our own pocket."

A nurse supervisor stated, "But now they have a huge Spanish group and we have a dad in a group. But there's a cost involved and so where does that money come from? We can't pay for, you know, we don't really pay for services outside of the program so. Just looking at all those different pieces, and it's all combined together."

Challenges With Other Organizations

Among most sites, some nurses shared about experiences that were challenging when working with other organizations in the community. These challenges related to lack of access, referrals for clients, competing programs, and lack of collaborative efforts for mutual clients.

Challenges related to lack of access were mainly shared by some nurses in a couple of sites. The type of resource that nurses found challenging to access in their county ranged from site to site. In one site, several nurses explained that adequate mental health services (such as a 24-hour crisis line, safe havens, etc.) were unavailable in their county, while in a couple of other sites, some nurses shared that their county lacked public transportation or was rural and spread out with little resources available for clients. In a couple of other sites, some nurses stated that shelters in general were difficult to access due to long waiting lists or that housing for teenage clients with children was nonexistent in their county.

One nurse expressed, "So, there have been lots of situations where we have some, a little bit more mental health problems that have been undiagnosed or untreated than I used to see before. I've noticed over time, we don't have as many resources. For instance, locally we really don't have a good 24-hour crisis line... We have some numbers they can call, but they may not be 24-hour. We don't have a lot of - We used to have some programs where they would do a drive-by safety check on people that we concerned about."

Another nurse shared, "The lack of support in my areas – the supportive network and then even the spread-outness of the areas sometimes. There just aren't the resources, so it's very hard."

Another nurse stated, "Our transportation system in [county name removed] is really difficult. Yeah. And, we have a city bus, but it's really hard to get around the city, especially with a young child."

With referrals for clients to other resources, some nurses in various sites explained that they had encountered challenges with the referral process; such organizations included WIC, TANF, and Medicaid. Several nurses from various sites further explained that they sometimes did not receive follow-up from the organization on whether or not their client was enrolled and participating in the service. A couple of nurses from different sites also shared that some services required many forms to be filled out and/or resulted in denial of services after application, which was a challenge for some clients who were less motivated to apply for subsequent services.

One nurse explained, “So, counseling, therapy, that kind of stuff. And so, if you call them and make a referral, there’s not as much communication.”

Another nurse explained, “But, there was times - I want to say there was like a two-week period that I wasn’t hearing anything back from this person at WIC. So, [nurse supervisor name removed] and I had to call kind of her higher-up, and I don’t know if they feel like we’re invading any of their territory or something, but we’re just trying to make sure that these clients are getting connected.”

In a couple of sites, some nurses and a nurse supervisor expressed that there was competition with other programs in the community for clients. These nurses stated that other programs offered incentives such as diaper bags and that NFP was unable to offer such items to clients. In another site, a nurse supervisor shared about her concerns regarding SafeCare and its potential duplicity with what NFP provided. In several sites, some nurses explained that they had not received referrals to NFP from several entities in their county, such as WIC or individual practices.

One nurse stated, “But, part of that is because we have competing programs. They have a centering program that’s a group, like a group - I don’t know what you call that. Group-centered care? So, pregnant women go to a group. They get their blood pressures and urines done, and there’s like a topic that is very similar to what we might cover. And so, when we’re competing with that program, it’s difficult. Because they’re like, ‘Oh, I already do this at clinic. I already-’ Except that they are only a pregnancy program, and then there’s like just one postpartum visit.”

Another nurse shared, “And then, the other potential organization down there that could capture a lot of NFP potential women that could be part of Nurse Family Partnership is WIC. And, we have not gotten one single referral for WIC since I’ve been down in [county name removed], and that’s like been three years.”

Regarding SafeCare, a nurse supervisor stated, “I forget the names of it, but it’s like Parent-Child Interaction, I think it is, PCI. It’s what we do. And, I’m sitting there listening to this, and I’m like, ‘This feels like duplication a little bit here [with NFP].’”

Finally, across most sites some nurses and nurse supervisors explained about challenges with collaborating with various organizations and service providers. The organizations or service providers that were difficult to collaborate with were different across sites. Some nurses from various sites felt that other organizations had treated them like lay-persons, while in other situations the challenge was related to incongruent assessments of the client such that the nurse felt the client needed services but the provider did not. In one site, some nurses stated that they lacked collaboration with WIC and that workers from WIC were unresponsive and often rude in their interactions with NFP nurses. In several other sites, some nurses and nurse supervisors expressed that it was difficult to connect with physicians or that some physicians had dismissed the nurses’ opinion on medical cases involving failure to thrive, substance-exposure, or feeding problems. In another site, a nurse shared that the local developmental disability service was uncommunicative with her clients and when she initiated contact, the worker was rude, such that she no longer referred to this agency despite its ability to offer services in multiple languages.

Finally, another nurse shared that a housing provider had crossed boundaries by helping another individual gain custody of her client's child.

One nurse shared, "Well, then my client called me. And, she said, 'I can't get a hold of this woman. She is not returning my phone calls. Can you please call her for me?' I said, 'Sure. I'll call her.' So, I did. And, that caseworker called me back and chewed me out because who was I to intervene for the client, and I was not to be putting myself between her and the client. And, I said, 'Well, she asked me to call. She said she had been calling you and you weren't calling her back, and that's why I called.' ... And so, that has made me like not want to use them again."

Another nurse explained, "Yeah, yeah. For the most part. I think the thing I have trouble with is, you know, talking - Like, calling and talking to someone in the clinics. You know, it can be a little bit tough to find like the "inside" number sometimes. Because the number when you like you go on the website and stuff, it's the main number that patients contact, but - Well, that doesn't help me."

Another nurse shared, "So, this client went to [clinic name removed], so I flagged the doctor. Well, she didn't really - Even though- She didn't - Because we're peon nurses or whatever, she didn't take - You know, even though I'm not, but my colleague was a NICU nurse, knew this baby had trouble feeding. And, we had - I wrote it exactly as [nurse name removed] told me to do. You know, (*unintelligible*), all this kind of stuff. And, we flagged the doctor. The doctor didn't respond to us, but... And, we both were there, and we talked to the doctor. And, she was still trying to get this girl to - Well, the - She quit nursing because nursing wasn't gonna work. She, I think, bottle - They were trying to get her to continue to nurse. I don't remember the whole shebang. It was a [redacted] ago, but anyway, it ended up, when I - Because I still had access to EMR, she didn't believe me, but then down the road, I saw it in notes that the baby did have a feeding problem."

Other Challenges for CPS

Challenges encountered in their work were described among many CPS caseworkers and supervisors in all sites. Similar to those expressed by NFP nurses, many barriers for CPS workers were generally related to their scope of work, including casework practice, working with clients of various risk factors (such as mental health, substance use, environmental health, being a young mother, etc.), CPS organizational structure, community stigma, education/training, and working with other organizations.

Casework Challenges

Among most caseworkers in almost all sites, challenges in their casework practice were shared. Many caseworkers across multiple sites expressed that the intensity of their work coupled with the overburden of work led them to feeling overwhelmed, burned-out, overworked and emotionally-drained. Many caseworkers across a few sites also explained that they lacked time to perform all the work that they wanted to do and that scheduling had always been a challenge due

to immediate assignments and court dates. Indeed, one caseworker expressed challenges in quickly assessing a family's situation while assessing other families at the same time; this "juggling" of caseload did not allow for her to devote her attention to a specific family. In several sites, some caseworkers described their work as overwhelming when they needed to manage the opening of multiple court cases while continuing their investigations, or as emotionally tolling when they needed to terminate a case. At the same time, several caseworkers from different sites shared about a lack of supervision or support (e.g. the department lost their building and supervisors were unable to conduct supervision meetings). Some caseworkers and supervisors across other sites also explained about the associated turnover and issues with worker retention as a result of the overburden of work when existing workers needed to take on more cases from a leaving caseworker. In a couple sites where caseworkers were generalists – those who conducted intake and ongoing casework, some caseworkers and supervisors explained that it was challenging to balance multiple roles and have a strong knowledge of multiple areas.

One caseworker recalled regarding caseload, "The highest I have had is 21 cases, which is horrible unmanageable (*laughing*) -Yeah... (*laughter*) I was literally flying by the seat of pants so yeah."

Another caseworker explained, "We just always — it feels like turmoil. You know, it's just always... Yeah. Because we have a high turnover rate and I'm not sure it's because the work's so intense and, um, we provide — and intense in general just working with little ones that, you know..."

Another caseworker shared, "It's a very taxing job. It's a very stressful job. It's something that you quickly learn are you going to be able to cut it or you're not... But I think workers definitely do burn out. It's important for you to take a break to get away to leave your computer, to leave your case files at home, I mean leave them at the office, you know, don't take um home you know, because burnout is something you know. Just for example in our unit, you know, we've had a open slot in our unit for 2 to 3 years now because we can't retain a worker... You know, and so that hurts our caseloads, you know, get overflowed with that and things like that so it causes more stress for us, too."

Another caseworker about the intensity and emotional burden of casework stated, "Um, it depends. Sometimes, unfortunately, a termination takes heartbreak but not a lot of energy because you don't have a present parent. So it takes emotional toll, it takes a professional toll, but as far as the energy, sometimes, and always other times, very much so and it's heartbreaking when you get to that point. And you wanna make sure you've done everything you can, so that you can sleep at night too. You know, when it gets to that."

Another caseworker regarding the challenge of having multiple roles explained, "It is. You've gotta wear a lot of hats every day. It makes it difficult to be knowledgeable, to have a lot of knowledge about any particular one area. You have to have a general knowledge about everything. So."

In addition to the overburden of work, several other challenges in casework were described by some caseworkers and supervisors among some sites as they related to frustrations in the limitations to what CPS caseworkers could do. For example, several caseworkers shared they,

unfortunately, were unable to intervene or investigate first-time pregnant mothers – unless there was a child in the home – which was frustrating when they knew the infant would be born substance-exposed or IPV was occurring in the home. Other caseworkers from various sites also explained that they were only able to act on concerning safety issues, not merely on risk factors present in the home.

One caseworker explained, “Mm-hmm. So we’re very limited on how many people we can help, so we really try to help, of course, the worst case scenarios.”

Another caseworker regarding limitations to how they can assist a family shared, “...because some people would say, ‘Oh my gosh, I can’t believe that you would let those children return there.’ Well, in all reality, first of all it’s a whole lot better than it was whenever we found it, and there are no safety issues. And this is about the best that it’s gonna get, and mom and grandma have grown up this way and lived this way always, so what, you know, I can’t expect them to go and have this perfectly shining house, but, you know, as long as they’re willing to work on it, and keep going, then that’s the best they can ask from them, so.”

Another caseworker stated, “We have to address the safety, not the risk. So sometimes they get, you know, any, this is with all agencies, they get frustrated because maybe they think we should be doing more and we’re not.”

Challenges in Assessment

Another area of casework that was challenging related to various gray areas in assessment, including marijuana use, cultural-appropriateness in disciplining, and cases requiring medical knowledge, contributing to barriers in the decision making process of an investigation. Some caseworkers from various sites explained that there were conflicting guidelines regarding assessing risk and safety as related to marijuana in the Children’s Code versus what the state had legislated. In fact, one caseworker explained that there also lacked guidelines on the level of marijuana usage as it pertained to impact on parenting and on the child. There was general confusion among several caseworkers from these sites in how CPS should approach marijuana use, mainly because there was limited research and guidance on marijuana uses’ impact on parenting ability and/or on the safety of the child. Several caseworkers also shared that they were frustrated by the lack of clarity in THC levels and subsequent effects on parenting, an overall limit to what CPS could do, and lack of knowledge in the impact of marijuana edibles on children and while breastfeeding.

One caseworker explained, “So, it’s hard to balance, you know, the working with the family slash being basically the law of what’s okay and what’s not okay to do with your kids... It’s a hard role to be in.”

Another caseworker stated, “Yeah. Well, I mean, we are dealing with marijuana legalization, you know, and so, that can be a very gray area because the government is telling you one thing, and then we are still under federal law, and so we have to find a medium ground on what’s appropriate and what is not.”

Another caseworker shared, “It is the most gray area and quite frankly I think it was legalized too quickly because there’s not good guidelines. You know, there’s conflicting guidelines in the Children’s Code versus what our state has and so it makes things very messy and complicated because—And there’s no guideline for levels either... So a parent goes in to take a UA [urine analysis] and they may have a level of 5000, which is considered very high for us, but there’s no statewide level. There’s no—it’s just, it’s complicated.”

Several caseworkers across multiple sites explained the difficulty of assessment when looking at cultural appropriateness of disciplining, sometimes because of their reliance on the child’s perspective. One caseworker from one site stated that her assessment only looked at the family’s issues at one point in time and did not always accurately identify all the safety and risk issues for a family. Several other caseworkers from different sites also explained that an assessment was more challenging when the alleged victim was an infant and not a school-aged child, because they were unable to interview an infant who was unable to vocalize any issues. Another barrier in assessment was expressed by a couple of caseworkers in one site as related to a discrepancy in how the military and the state defined child abuse and neglect, leading to open cases for one agency but not the other.

A caseworker shared, “So, that has been very tough, I would say. And culturally, you can have a very large range of what people feel is appropriate, what’s culturally appropriate for them is maybe not culturally appropriate by law, or, so, we do have to consider all of those things. And we do, you know, if it’s age appropriate, we rely on what is the child telling us. You know, a child could get spankings every week, and that’s just the way it is, but is there impact? If it’s just, ‘Well, no I know, when I get trouble,’ but the next child could be just you know, ‘He’s hurting me.’ So, it’s hard to decipher, because you may have impact on one child and not on the other.

A supervisor shared, “Just a different knowledge. A set of knowledge and a different kind of experience. And, just a different view. Because, we can request these medical records, and they’re Greek for us.”

Another caseworker explained, “And we’re juggling our caseloads on that, too. So it’s not like a family is getting my undivided attention. So, we’re, we are taking -You know, I call it a snapshot, and this sounds terrible but it’s what we do sometimes – we take snapshots of families, and we all know what a snapshot is... Is it accurate all the time? No, sometimes it can make us look better; sometimes it can make us look worse.”

Another caseworker explained, “We have different criteria for child abuse, child neglect, the Army versus the state. Very different. Um and it’s just a matter of communication with them... Their criteria is different though so they vote a lot on risk. ‘So was this child injured?’ ‘No.’ ‘But was there the potential that this child could have been injured?’ ‘Yes.’ And so sometimes it meets their criteria but not ours. Cause for ours we have to actually show some effect on the kid.”

Relationship Challenges With Clients

Another practice-related challenge was the process of developing the relationship with clients. For some caseworkers in various sites, it was challenging to form a relationship with clients when they had negative perceptions of the Child Welfare system, such that CPS was there to take away their children. Due to this stigma associated with CPS and the determination in how caseworkers became engaged with families (based on alleged reports of child abuse or neglect), many caseworkers felt that their work was hindered when a family was uncooperative, rude, or even aggressive. Several caseworkers from different sites explained that some clients had slammed the door in their face, refused to answer questions in investigation, were reluctant to share information about their lives, and/or did not participate in mandated services and treatment. In multiple sites, some workers also expressed that interactions with clients were especially difficult when they had to remove a child from the home or take other drastic actions; while a couple of caseworkers from other sites shared that it was sometimes challenging not to take things personally when a client was uncooperative. One human service advocate also shared that some of her clients were reluctant to ask questions about medical-related issues as they were afraid that asking such questions would be perceived by CPS negatively.

One caseworker stated, “Cooperation of parents, the stigma of what Child Welfare means is certainly a barrier or something that can be difficult to overcome, confidentiality can always be a big one.”

Another caseworker explained, “But sometimes you get one that’s, it’s just very difficult. And it’s very hard to not take it personal.”

Another caseworker stated, “At first it’s kind of hard to establish that relationship because they think that you’re just being intrusive and that you’re there to ruin their life and take their kids away.”

A human service advocate shared, “The families are very scared of asking us questions about caring for their children. Medical questions because they’re afraid, if we see that they don’t know something, that that’s going to be a negative influence within their case, or within their assessment. And when you’re asking somebody who is not a person who’s affiliated with Denver Human Services those questions, you don’t have to feel embarrassed or, or you can feel like you can ask those questions. And get those needed questions answered. So that you can take care of your baby without feeling like, ‘I can’t say anything because I’m going to get in,’ I mean for lack of words, ‘trouble.’ Or it’s going to be looked at negatively because, ‘I didn’t know how to fix a bottle.’ So a lot of the times when we go in, things will just not happen. Because they are just, it’s not because they, they just don’t want to ask the questions.”

Other Casework-related Challenges

Other miscellaneous challenges related to casework were described by some caseworkers and supervisors across multiple sites. A caseworker from one site shared about safety concerns for female caseworkers when making visits to the home, such that he had on occasion accompanied his colleagues on such visits; while another caseworker from a different site explained that caseworkers were often entrenched in their casework and at times neglected to see the outside world to initiate interactions with other agencies. A supervisor from another site shared that

responding to crisis situations made treatment planning and focusing on strengths more difficult, while an administrator from yet another site felt that her caseworkers working with different families in different situations presented a daily challenge for them to overcome. Several caseworkers and supervisors from various sites also expressed that traveling to other cities to make visits with ongoing cases were challenging because of the travel time, while a supervisor suggested the weather in rural areas, e.g. snowy days, as a challenge for her caseworkers.

A caseworker stated, “There’s times when some of the gals in my unit will ask me maybe to go on a home visit with them if they don’t feel safe or if they need me to talk with a respondent dad because maybe they just feel like I can associate with him better.”

Another caseworker shared, “We’re - Yeah, we’re stuck in our job, in our own little world, and we don’t see outside. We’ll refer, but we’re not going to come to see you.

One supervisor explained, “...the TDM model, which is a reaction to a placement change, which then sort of forces you down the path of the meeting conversation being about that point in time and that particular crisis, or focused on the change of placement. And, it becomes more difficult to have ongoing planning and be strength-based if you are responding to a crisis.”

Another supervisor shared, “Nobody really wants to, you know, travel - Because I’m [redacted] hours away from Denver... But still, I mean, even going to [location name removed] is an hour over there and an hour back...And so, [location name removed] is approximately five hours from here.”

In addition, professionalism, confidentiality, and other challenges were raised by several caseworkers and supervisors in some sites. A caseworker from one site shared that maintaining an ongoing relationship with clients with open cases was difficult especially when the case was opened for a long duration of time, while another caseworker explained that foster care work was challenging to see the children who bounced from home to home and were never adopted. Some caseworkers across other sites also expressed that it had at times been difficult to maintain professionalism when working on ongoing cases, because they had become protective of the children while needing to balance their duty of holding clients accountable to their court orders. Finally, within one site, several supervisors and administrators discussed the challenge for their workers due to displacement from a stable work location. Their caseworkers needed to balance working their caseload at home while maintaining boundaries and confidentiality, in addition to managing a possible liability issue with the cases being transported and secured in personal vehicles. These supervisors also suggested that there could be additional challenges when their caseworkers begin working in one location again; because they must then adapt to working regular hours again as compared to greater flexibility that was possible when working remotely.

A caseworker shared, “It’s not, and sometimes it’s, you have to, there’s a fine line, I think between being, um, between, just making sure that you’re staying always professional, but maintaining that stance of, you know, you kinda, it feels like a threat, but you do kinda have to pull out those court orders of, ‘You may not agree with it, you may not be able to take accountability for it, but that fact is, you’re under court orders, and this is what you’re being court ordered to do. So you can hate me all day long, you can not want

to speak with me and we can speak through your lawyer if we have to, but the fact is, things aren't going to change until you begin following your court orders.' So, you have to kind of maintain that professionalism, um, and just kind of try to keep them accountable as much as possible, but it's not always easy...Um, so it's really hard to be able to draw that line of, 'It's not my family, like, this isn't my emergency and I have to maintain that professionalism.' So that can be just really difficult, 'cause, you start to feel really protective of these kids."

One supervisor stated, "So pretty much right now, the majority, especially you know, the caseworkers, I think on average, my workers have about 16 cases. So as a matter of, you know, they have cases at home, trying to balance home with the office. Not, you know, having things together and then of course it's all confidential."

Client-related Barriers

Barriers related to working with clients were also expressed by some caseworkers in several sites. Such barriers were usually related to working with clients with mental health illnesses, substance use, developmental delays, and cultural factors including those in the military.

Challenges With Clients With Mental Health Concerns

Among several sites, several caseworkers described specific barriers they had encountered when accessing mental health treatment for their clients. In one site, a supervisor suggested that mental health providers in their county often left to work in other areas. These moves had created instability for their clients in accessing these services and caused the clients to re-experience trauma. In another site, there existed disconnect between CPS caseworkers and mental health providers in their assessment of need for mental health treatment. For instance, the caseworker had referred the client for treatment but the provider assessed the client and determined that treatment was not necessary. This difference in professional opinion of requiring treatment was impacted by self-reporting on the part of the client. In another site, several caseworkers explained that there was a lack of immediate mental health services in their county and that psychiatric evaluations took too long to occur.

A supervisor explained, "Well, I think what's really been really, well, that it is a downfall in the community as far as not medically but in the psychological realm where you have so many different therapists that continuously revolve and go elsewhere. They don't stay very stable, and I think that that's just - It just harms our clients to repeat, you know, their trauma over and over again. I think that's what I don't like."

Another caseworker shared, "I think the biggest is, like with the mental health piece, because when we go in we make referral for a client and then a week later get a report, they don't need treatment...And our thing comes back like, 'What? Did you read the report?' You know, and on our end we're like, 'If anybody needs treatment, it's, you know, this lady.' That's our perspective and you're telling us 'no'."

Another caseworker stated, "[Mental health provider name removed] is great but the rift there is that sometimes we don't have enough mental health resources in our community to suit what we have going on. So, it's, like, psychiatric evals may take too much longer

— too long — and I think that goes on in all communities. We don't have a lot of available, like, immediate mental health that we need. So, those are pretty much it. The working relationships as far as, um, communication that's all pretty well good or *(laughter)* Anyway.”

Challenges With Substance Use Among Clients

In addition to mental health cases, there existed several challenges to addressing substance use or abuse among clients within CPS as explained by a number of caseworkers and supervisors from many sites. As previously summarized, many caseworkers and supervisors from these sites explained that there was a misalignment between Colorado's legalization of recreational marijuana and the Children's Code. There lacked guidelines on the level of THC that should be considered a cutoff for impairment and many caseworkers felt that there was great limitation in what they could do to enforce child safety for clients using marijuana. In many sites, some caseworkers shared the frustration that CPS was unable to act upon pregnant mothers who were using substances and reported to CPS, because there was no child present in the home. Finally, a challenge expressed by some caseworkers and supervisors in one site was that substance treatment for juveniles was lacking or nonexistent in their county, while in another site the administrator explained that limited funding was available to serve substance abuse families and that their county struggled with prioritizing the most severe cases for treatment.

A prevention programs manager explained, “Again, regardless of my personal feelings back and forth, it has really caused a disruption in the Child Welfare world because they didn't change the Children's Code. You know, the Children's Code still has parameters as far as investigating people with drugs so, just because it's considered a legal drug now, it still causes as much problems as it ever has, probably more so actually because now people are saying, ‘Well, it's legal. I can do whatever I want.’ No, you still can't drive with a child, you still can't do this, you still can't do that – just like alcohol.”

A caseworker shared, “Oh, our wish list, yeah. We need - Juvenile substance treatment is - It just doesn't exist. Not locally. And, that we really - And, when I say juvenile, I'm even talking about some of our young, first-time moms. You know, under the age of 20 or so. They still function in that world of being a juvenile. And, really, the treatment geared towards them is just not around. It just doesn't exist. You know, so anywhere from that 12-year-old that's got a, you know, pot habit and is drinking and blah-blah, all the way up to that 20-year-old who's got, you know, a 10-month-old baby. If there's substance use problems, we struggle with that service.”

A supervisor stated, “And so, um, you know, I think having or even knowing, like, there's times when we have had, like, teenage girls that we've had interaction with who are pregnant, or we get referrals on people who are pregnant, and we can't do anything about those, like, we can't take a referral on a mom who's pregnant and maybe using substances. We can't do anything about that until the baby is born.”

Challenges With Clients With Developmental Delays

Additional challenges arose for some caseworkers in several sites when working with clients with developmental delays. With clients with developmental delays, several caseworkers across different sites shared that it was at times challenging to work with such clients because they had

needed to explain instructions much more concretely and model the actions that the client needed to take.

A caseworker stated, “It’s, like, okay - But most of the time they come around and it’s easier I think with the younger kids. Like, I have a hard time with teenagers.”

One prevention programs supervisor shared, “Unfortunately, we had another case just recently that we’re still struggling with. Mom and dad both have I.Q.’s of under 60, and we really struggled back and forth because she couldn’t even figure out how to do four ounces. She didn’t know how to measure. She just doesn’t have the capacity to do it...”

Another caseworker explained, “Yeah. It’s our adolescent population that it – it’s tougher. Yeah, transitional living home or a group home for, you know, emancipation population would be really fabulous.”

Another caseworker shared, “We do have a housing, um, low income housing available here, and there is another set of apartments in [redacted], except that it’s, you know, they have to have a transportation, um, that is set up. But there’s a lot, there’s a huge waiting list.”

Challenges With Cultural Aspects

Among several sites, different cultural factors were expressed as additional challenges for some caseworkers. Some caseworkers in different sites expressed that some language barriers existed when the client did not speak English and there were not adequate interpreters available. In one site, several caseworkers and supervisors explained about challenges when working with clients with involvement in the military. A supervisor shared that some military families tended to have greater stressors in their life, less social support (as they were stationed away from their families), because of deployment were raising children as a single parent, and the associated barriers when working with military insurance. A caseworker from this site also explained about challenges when working with some military commanders who were unresponsive, uncooperative, and unsupportive of what caseworkers needed to do because they felt that the client was a good soldier.

A supervisor shared, “Well, I think the one big concern that we have with military families it’s a challenge for them is what I’ve already told you and that is that most often families have some kind of a support system and we know that for safety of children a big support system is a huge um deterrent for abuse and neglect for children and so because the military does not always come with an automatic support system, a mom, a dad, and sister or brother, who live close by that can give you a break and things like that. Their inability to have that is an issue and that can be problematic for them.”

A caseworker explained, “Um sometimes in the military they like to protect their own so commanders aren’t always the most responsive. They aren’t always the most cooperative or supportive of what we need to do because he’s a good soldier so that’s all that we care about. Um the Army and the Air Force can be difficult to, they preach to be very family centered, they really care about the family and they do up until when it interferes with somebody’s mission. So people get kicked out of the Army or the Air Force for having

something happen at home while they were deployed, they could get in trouble for that. And so that's, that can be kind of tricky. I don't like to contact commanders unless I absolutely have to. So if I have to serve somebody with court orders or I just can't reach them then I would take that route but otherwise..."

Supervisory Challenges

Challenges in performing their supervisory duties and responsibilities were described by multiple senior-level CPS workers in many sites. A main challenge for multiple sites was time management while upholding a multitude of responsibilities. For example, a couple of administrators felt that they were spread too thin and though they often delegated tasks to supervisors, supervisors themselves were often too busy to take on additional responsibilities. From attending various meetings to completing paperwork after hours, this difficulty to balance multiple roles was raised as a concern by supervisors and administrators alike. For smaller counties with generalist workers, several supervisors suggested that having to supervise child protection along with other programs were at times difficult to balance; while case-carrying supervisors felt that it was sometimes difficult to balance supervising and monitoring her own cases due to time constraints and traveling needed.

One supervisor shared, "So, when you maintain a big caseload, there's really not enough time for, you know, supervising and monitoring other cases when you've got your, you know, your plate full with your own families. So, I have tried to, over the years, you know, wheedle that down, so to speak. And, I think I've been pretty successful. Right now, I've - I just closed two cases a couple weeks ago, which were both in town cases—that didn't require a whole lot of traveling."

A generalist supervisor reflecting on overcoming challenges stated, "Just a good calendar first of all, um, and — and — to be honest I work a lot of after hours to get paperwork-type stuff done, you know. We're still trying to figure out how to get it done and, um, yeah it — I just have to take a lot home. Well, and I thought about that, it's really everything I'm required to do. All I need is more time; so - I don't know if anyone's figured that out yet. (*laughs*)"

Another challenge faced by many senior-level CPS workers across several sites was caseworker turnover; for example losing seasoned caseworkers to other units or to promotion into supervisory positions. Directly contributing to turnover, a couple of supervisors from one county suggested that the maintenance of worker morale and provision of support was difficult especially when the department lacked a permanent location for workers to convene. In these situations of displacement, there existed also a lack of privacy, communication, and support for caseworkers, which some supervisors attributed as the cause for worker turnover. There were additional challenges faced by supervisors and administrators, including working with different service providers, such as mental health, especially when self-reporting from the client did not meet the criteria of the provider for service. Finally, one administrator suggested that due to time constraints, it was sometimes difficult to assemble the appropriate players in the same place at the right time to discuss and resolve problems.

One supervisor shared, “We’ve been without a [redacted]. So it’s almost like we kinda learn to function a little bit in this dysfunction, where before we used to have a unit meeting like every other week if we had issues or things to discuss.”

Another supervisor stated, “We’ve been able to maintain our numbers, our compliance, which has been great, but it’s very wearing on the workers as well as individuals even just (*unintelligible*). And there’s a piece missing with communication and support I think because you can’t go back in an [redacted] and vent and unwind and ask for help – did she? – so, so, it’s been tough. I’ve had constant turnover over the past few months or so anyway in my unit. I’ve been the worst.”

One administrator shared, “So that’s an answer to your question about the barriers and the struggles and the complicated part of what I do, is trying to be in all the right places at the right time and...”

Challenges with CPS Organizational Structure

Among several sites, some caseworkers and supervisors shared about organizational barriers in their county. Several prevention program workers expressed that funding was a challenge for them, because they were unable to pay for certain services for clients and could not access core services dollars. For prevention workers, because the program was voluntary, it was also challenging to enroll some clients who negatively associated them with CPS. For a couple of sites, several supervisors explained that their departments lacked funding to pay for certain treatments for their clients, specifically inpatient substance abuse and mental health treatment. A couple of caseworkers and supervisors from two sites also shared about the challenges that came with systemic changes, while one caseworker from a different site explained that it was sometimes difficult to balance oversight from CDHS with decisions made by the local court system when they were in opposition of one another. Some other organizational barriers were related to individual caseworkers who were unwilling to adapt to changes towards more collaborative and family-engagement approaches and supervisors who had conflicting approaches from the director (direct versus indirect) to resolving conflicts within the department.

One prevention worker explained, “Funding is a big issue...The other agencies. Just because we work for DHS does not mean we have money either... No, because my unit has no funding... I’m in a – I can’t tap into core services through Child Welfare, Child Protection – because I am not Child Protection, I’m, I can’t tap or access a lot of those fundings.”

A supervisor shared, “And then, you know, I think of only - the only frustration with those is, you know, we see a lot of benefit to a Prevention worker going out to work with families to mitigate that, but it’s a voluntary service, so families have to buy into wanting to address or see some of the, you know, the risk that’s there as something that they want to change. And so, that could - that can be frustrating with that particular piece because we can’t, you know, make them want to work with Prevention.”

Another supervisor stated, “So as far as, you know, if clients need money to move or certain things like that, we have a hard time coming up with those funds because we just

don't have the funds, or, like I said, inpatient treatment... And we save ours for inpatient but we usually can only send two people a year, which isn't enough... And we don't have enough money in our Child Welfare block allocation to send people to treatment. We're lucky to just pay our staff and our payroll for the out-of-home placements. So I think if we had any barriers it would be that. It's more not being able to help the clients financially."

Another caseworker shared, "You know, it's kind of a funny dance we have to play because we are kind of overseen from CDHS, but then we are also kinda of overseen by the court system. In my opinion, it's two kind of butting entities in that you know, CDHS, we really kind of push for reunification. We try to facilitate you know, a more positive, strength base as if you will approach with the families whereas with court, you know, you're trying to hold them accountable. You know, get court orders and this and that and you know, put terms and conditions for what we need to have the family do you know, per what the judge says."

A supervisor and a couple of caseworkers from one site also shared about their perspectives of barriers with the CPS system. The supervisor explained that his county had been receiving the wrong type of clients in the system, for example medically fragile children, who would be better served by the community. Several caseworkers from this site also shared that families were involved with CPS for too long of a duration and that the CPS system was not a good parent for children.

One supervisor stated, "You know, a lot of - We seem to have this tendency these days with the kids being born with their intestinal stuff on the outside and taking a lot of, you know, time to get through that. And, we don't want them to be taking up space in a Child Welfare agency. They have some issues, but that can be handled in the community, and we don't need to be in their business in that way unless we're supporting the protection of a child."

He also shared, "Families in our system too long. Families are in our system way too long. And, many times it's because, during the process, people do not talk. And, people - Not the right people are involved. If we can have these meetings and get the right people involved at the right - Kids'll go home sooner. Families will not be involved with us as long."

A caseworker explained, "The system as a parent is not a good parent. You know, but we've had those kids who we've had in the system since they were six, and they're gonna - We literally helped raise them, and they're emancipating at 18."

Finally, several supervisors and caseworkers from one site shared about their frustrations in lacking physical space for their work. This was a barrier for supervisors who were unable to adequately support their caseworkers, which led to caseworker turnover and an increased caseload for the remaining caseworkers. Caseworkers found this a challenge because they were unable to utilize their colleagues as resources, store their client's files in a secure location, separate personal from professional life (due to having to work from home), and adequately meet the needs of their community.

A caseworker explained, “Oh, yeah. It’s been a challenge. I mean, we’ve managed — I want to say managed because some of us feel in our unit that we haven’t provided the best casework services that we can under the circumstances. You know, you need a file, you have to go somewhere else to find your file or you need access to a computer that’s not always readily available, and you have to go home and get your computer or see if there’s an opening here. So, just being able to balance that has definitely been a challenge to meet the needs of our community.”

A supervisor regarding the lack of a building for workers shared, “Um, it’s affected right now I have currently — I will have three functional caseworkers and I have one case aide, which I just got and the work we do is still similar. We’ve been able to maintain our numbers, our compliance, which has been great, but it’s very wearing on the workers as well as individuals even just (*unintelligible*). And there’s a piece missing with communication and support I think because you can’t go back in an office and vent and unwind and ask for help and —you know, we have a little room downstairs...”

Education and Training Challenges

With education and training, some caseworkers in several sites explained about different challenges. Some caseworkers in different sites found that the initial training with the Training Academy was lengthy, and when coupled with casework was difficult to balance especially when travel to Denver was necessary. One caseworker explained that the Training Academy needed to offer more education on ongoing casework because it was too focused on intake. Several caseworkers in various sites also shared that similar trainings occurred year after year. In fact, one caseworker expressed that some people had taken the same training again just to fulfil their 40 hour training mandate. A few caseworkers across multiple sites stated that the timing of in-person trainings were not under their county’s control and, as a result, had conflicted with their casework duties when the duration of trainings spanned for multiple days. Finally, a Child Welfare trainer explained that it was sometimes difficult to motivate all caseworkers to attend in-service trainings especially when some caseworkers felt that they had already learned all that they could.

One caseworker regarding the initial training at the Training Academy stated, “And so if you’re only in the office one day that week because we’ve been up Denver for four days, we come back down on Friday and we’re still trying to check our emails and return phone calls for whoever else, even though we’re not, because some people, despite the fact that they had claimed they were not allowed to have cases, some counties had cases because they didn’t have any other options. So those counties were struggling really hard, because they would be at work for one day, and that’s what they’re trying to do, but then turn around and you have to do all this work, meaning shadowing, answering certain questions, writing out these little essays and all that stuff and you have one day to get it all done before you go back up to Denver the following week.”

Another caseworker shared, “And really, our training is so sporadic, because, um, it’s really what Colorado’s offering, and sometimes they offer the same courses over and over again, so you’re just trying to accomplish your 40 hours...”

Another caseworker explained, “It all depends on when it’s available. Sometimes, we get trainings that come here, and we don’t have a choice about spreading it out. (*laughs*) So, yeah, it’s - It depends. Like, I’ve probably done 80 hours this year...A lot of them have become much longer than they need to be.”

A Child Welfare trainer shared, “But, again, it’s getting people to go, like the right people sometimes, can be difficult... but then it’s always you know, ‘I have work.’ And everything kind of gets pushed to the back burner. Not to fault anyone, but, again, you know— ... Yeah but it would be hard, yeah I guess it would be hard. You know, a lot of people think, ‘Like learning all about that, I don’t need to know more.’ Or. So, I don’t know. I don’t know what would motivate people.”

Community Perceptions

Community perceptions and stigma of the CPS system were also raised as a challenge to CPS workers. As previously stated, negative perceptions of CPS by some clients offered challenges to caseworkers when initially building the relationship and garnering cooperation from the family. For some prevention program workers from one site, it was at times difficult to enroll clients into the voluntary program if they had a negative perception of CPS and associated their program with the system. One prevention worker elaborated that most community members lacked an awareness of what services were offered by Health and Human Services and misinterpreted her role as a prevention worker.

One caseworker shared, “Sometimes it just, because Child Welfare has a stigma of taking children, and in small towns, on 1st St, you know that the children on 6th St have been taken, so that stigma kind of sticks out a little bit.”

A prevention worker explained, “I think there could be more. Um - I think as a whole that there’s not very good education around what the Health Department offers the community...And, that’s sometimes the last agency that people think of when they think of families needing any type of assistance... That we’re - Sometimes, I think there’s a misinterpretation of what our role is.”

Challenges With Other Organizations and Resources

In addition, some caseworkers and supervisors in most sites shared about challenges that they had encountered when working with other community organizations and resources. Such challenges were usually related to mandatory reporters, working with medical staff, access to certain resources, access to transportation especially in rural areas, and working with tribal agencies.

In several sites, some caseworkers explained that mandatory reporters had created an added burden for CPS due to large numbers of reports and the need to sort out unwarranted reports. On the other hand, a supervisor from one site shared that hospitals no longer reported on marijuana-exposed infants so that CPS was no longer able to assist those clients who may be in need.

One caseworker shared, “I mean, I know that they have to report everything, but at the same time, just reporting everything (*laughs*) is not - It’s just gonna create more chaos for us with the number of the referrals, and we’re not gonna have really enough time to concentrate on the ones that really need a response, timely response. And, we kind of get overwhelmed with the number of referrals. And, that’s what happened with [school district name removed].”

A supervisor explained, “Marijuana-exposed, most of the time, we don’t - They don’t even report them. Most of the time, we don’t even get those reports from the hospital, and so - If they’re marijuana-exposed at birth, a lot of times, we don’t get them.”

Medical professionals were described as a resource that was sometimes challenging for some caseworkers among various sites to collaborate with. Due to HIPAA and confidentiality concerns related to medical records, some caseworkers found it challenging to gather the appropriate information about their clients. Another HIPAA-related issue in some sites related to hospitals no longer notifying CPS of parents who were considered high-risk (e.g. those with previous terminations of parental rights and were pregnant). Other caseworkers from some sites found it difficult to navigate and understand medical terminology, while some other caseworkers found that they lacked communication with some medical providers. Several caseworkers in various sites also shared that some medical professionals had at times disagreed with the treatment plan, placed them in difficult positions because they did not want to necessarily dispute the professional, disliked being subpoenaed, and were even uncooperative with other agencies.

One caseworker shared, “. . . confidentiality can always be a big one. . . Gathering medical information . . . I would say medical field probably holds the highest level of confidentiality.”

Another caseworker recalled, “I think that’s going to be hard. And, I’ve already had some run-ins with some our medical providers with like, ‘Well, why didn’t you do that? Why did you not take the baby and do what I told you to do?’”

A manager stated, “Well, we used to have a list that the hospital would keep for us, and the hospital would have parents on a red flag list if there were problems. So, say I had a parent that has had 5 children and has been terminated every time, and then we find out they’re pregnant, so we would notify the hospital and say, ‘When this person gives birth, please notify us.’ The problem is that some of those cases completely go under the radar now, because of HIPAA, they won’t let us do that.”

Another caseworker shared, “I think they all don’t collaborate together the way that they should. I think they stay, like, within their own little entity, you know, and everyone has their own, you know, organization that they work with, and a lot of times they don’t do that collaboration with one another or real each other’s role.”

The lack of reliable public transportation was another barrier expressed by some caseworkers in a couple of sites, especially those in smaller and rural counties. This lack of transportation created challenges for clients who were unable to make scheduled appointments and for caseworkers in making visits to their client’s homes. Indeed, working in rural and remote areas

was another barrier for some caseworkers because it was sometimes difficult to access such areas in severe weather.

One director shared, “I think more public transportation would be also helpful, although I don’t think that that’s going to happen anytime soon. There was a grant a few years ago that looked at possibilities in [rural county name removed], and it’s just - It’s not going to happen... There is, there is one bus that, I mean, does a trip every other day from Denver to [redacted], which is in the southern end of the state.”

A supervisor explained, “...and there are lots of people who live in sort of, you know, far-flung houses that are hard to get to that maybe they don’t have transportation...”

Another director stated, “So it’s a little bit of a distance and it’s kinda windy. This is much better right here, but it’s windy. So it’s kinda, there are some transportation issues. They have a rambling bus that goes, but other than that they don’t have much transportation to and from [location name removed].”

Another supervisor shared, “We do, you know, we have 4-wheel drive vehicles. Some day on snowy days I hear workers coming back in saying and I couldn’t get up the driveway. You know, we’ve had vehicles get stuck.”

Among several sites, some caseworkers and supervisors shared about a lack of resources in their community. The type of resource that they lacked varied across sites, and included: residential treatment or transitional group homes for youth, juvenile substance treatment, services for families with multiple children with health issues, mental health providers, local hospitals or other medical providers (especially in rural counties), housing (resulting in long waiting lists), and prevention programs. Some CPS workers from smaller counties explained that resources were especially limited in small towns. Several caseworkers and supervisors from different sites also shared that resources ebbed and flowed in the community and it could become difficult to keep track of them all. Finally, interactions with the Tribal Social Services were a challenge for some supervisors in one site. The challenge arose from a lack of knowledge on the functioning and processes of the Tribal Social Services and not due to animosity.

One supervisor explained, “If a kiddo needs, you know, residential treatment, like I say, we just don’t have anything. And, depending on the age, our closest place for the older kids is [location name removed]... Four hours away.”

A caseworker shared, “We need - juvenile substance treatment is - It just doesn’t exist. Not locally. And, that we really - And, when I say juvenile, I’m even talking about some of our young, first-time moms. You know, under the age of 20 or so. They still function in that world of being a juvenile. And, really, the treatment geared towards them is just not around. It just doesn’t exist. You know, so anywhere from that 12-year-old that’s got a, you know, pot habit and is drinking and blah-blah, all the way up to that 20-year-old who’s got, you know, a 10-month-old baby. If there’s substance use problems, we struggle with that service.”

Another supervisor explained, “I don’t think we, I don’t know that I would say we have enough providers, um, typically because lot’s our clients don’t have transportation, and that’s always... Or they don’t have money to get to the metro area on a regular basis, even if they have access to a car. And so, um, we could certainly use more local providers.”

A director shared, “And, [CPS supervisor name removed] is just as foggy about the tribe as I am, about jurisdictional stuff.”

Another CPS supervisor expressed, “We don’t always have an answer for that... So, there’s no animosity. There’s sometimes confusion.”

Challenges for Other Partners

Among some sites, several community partners shared about challenges they had faced with working with CPS, NFP, and their clients. With regards to CPS, a couple of community partners from one site explained about challenges they had faced. Such challenges were related to ensuring that clients involved in CPS were receiving adequate medical care and maintaining collaborative efforts even when buildings were relocated.

A crisis center director explained, “The other thing that was happening is I was seeing kids that would have an ear infection, or like I said, asthma or whatever. And, I started to say, ‘Alright, so I prescribed this medicine, I sent them home.’ And then, I’d see the kid back a few weeks later because they moved into placement, and nobody ever got the med. Nobody ever followed up. And, I said, ‘So, time out. What’s the-’ So, in Colorado, there is no expectation or requirement where that kid gets their medical care.”

A clinical nurse shared, “You know, and a good example of that is is when the [children advocacy center name removed] built their new place, and the whole investigation for sexual assault and forensic interviewing moved to their place—which is only nine, ten blocks down the road—we did see a decrease in numbers. And, we did see a little bit of fraying at the edges of the collaboration that we had had with that team.”

A public health director from one site shared about her perspectives of NFP nurses and the NFP program. She suggested that many NFP nurses felt pressured in their role of preventing child abuse and neglect among their clients, such that it weighed on their shoulders when they needed to make a report to CPS due to suspected maltreatment. In addition, when needing to report to CPS, this public health director felt that clients had become angry with the nurse and left the program. In these situations, she felt that the nurses had lacked closure. She also felt that many NFP nurses were easily burned out when their caseload involved a number of high-risk clients. Finally she shared about how NFP was structured in a multi-county site as a challenge, such that not all nurses were housed within their designated county’s Department of Public Health.

A public health director shared, “And for the nurse to have all that pressure put on them that they’re going to be the ones to prevent child abuse and neglect, I think it can be pretty heavy at times. And there’s not—they’re not saviors.”

She went on to say, “Um, again, I think it goes back to just an understanding of, um, process, and, you know, again the nurse’s perspective of everything that’s going on with the family, is in a sense very limited...Or that the relationship just ended altogether because the client was angry with the nurse and so that was the end of that. And so, um, I think in those situations, there is not—there’s no closure, um, with the nurse. And I think over time if they have a very challenging case load or high—you know, caseload—that has a lot of high-risks in it, they can easily get burnt out from the challenges and in a sense, you know, I don’t know that it’s necessarily would be considered post-traumatic stress syndrome, but it brings up a lot of emotions and it’s a very challenging time when you have one of your families going through either domestic violence or child abuse and neglect.”

Several community partners from various sites also shared about challenges they had faced when working with various clients. Such challenges were similar to those faced by NFP nurses, and were related to contacting clients, retaining clients, and successfully referring clients to other services or programs. One public health nurse found that some of her clients were difficult to contact due to their lack of transportation, being young, being transient, and frequently changing of phone numbers. A public health director from a different site explained about challenges of enrolling and maintaining clients in a prenatal program due to competition with other programs that served a similar population. An eligibility worker from another site shared that she had faced challenges in referring clients to other programs, because the clients had negative attitudes and/or were in denial of their issues (such as substance abuse). Other areas that were barriers for a public health nurse included a lack of resources available for clients living on reservations and the need to learn and balance cultural practices - as they related to pregnancy and childrearing - with home visit schedules.

A public health nurse explained, “Well, I think it is just hard for lots of, you know, lots of them are teenagers and in school or lots of them, you know, don’t have transportation. And, most of them have cell phones anymore, but limited service. And, it is a hard population for me even when I am, you know, working exclusively in this small community. It’s a hard population for me sometimes to keep, keep up with or be able to contact - so, routinely.”

An eligibility worker shared, “...and my client’s admittedly told me, ‘I’m a recovering addict.’ And then to hear that they’re suspecting use again, it’s very, very disheartening and, you know, I need to talk to her and just have a heart-to-heart with her and tell her, you know, ‘I know, you know this is your history because you told me, and this is what I’ve heard recently and — and we need to get it in line and, you know, what can I do to help you?’, and refer her to programs that I know are going to be of good help to her. And I’m thinking this — this program that you’re — you’re talking about would be perfect for her. The only problem I have is that I don’t think she’s going to be real receptive.”

The same public health nurse stated, “There are a lot of cultural practices surrounding pregnancy and childbirth. Yeah. And, very, and, and, and some of them do hinder our visits in that they have a cultural belief called ‘30 days’ and it’s surrounding the 30 days

right after the birth of the baby. And, it's the, the mother is, is really not to go anywhere or have, have any visitors aside from immediate family for 30 days.”

Other Opportunities for NFP

Among all sites, some nurses and several nurse supervisors shared about other opportunities for the NFP program and in their practice. Areas related to the nursing practice that were suggested as opportunities by some nurses in some sites included: assessment tools, changing nurse attitudes towards utilization of specific resources, increasing nurse knowledge of resources, decreasing workload burden, and maintaining the relationship with the client after making a CPS report. Some nurses in various sites also provided ideas to improve the NFP program and structure, including areas related to the transferring process of clients, electronic medical records, and the NFP curriculum. Among some nurses and nurse supervisors in various sites, opportunities for clients through participating in NFP, collaboration with DHS programs other than CPS, and collaboration with other community organizations were shared.

Opportunities in Nursing Practice

Opportunities for improving nursing practice among NFP nurses were shared by many nurses and nurse supervisors in various sites. Some nurses and nurse supervisors in several sites suggested that there needed to be more guidance on approaching “red flags” and gray areas they had encountered with their clients, as well as learning about supports and appropriate resources. One nurse shared that it would be helpful to continue utilizing colleagues and nurse supervisors as resources, in case conferencing and reflective supervision, to discuss issues that they were encountering with clients. A couple of nurses from various sites shared about an opportunity for developing a simple assessment tool with guidance on timeframes for when to assess for risks and types of risks. One nurse explained that having an assessment tool with step-by-step instructions would be helpful especially for new nurses to feel more confident on their visits.

One nurse expressed, “So, I mean, maybe that also you’d want to know what the warm-up steps are. You know, like kind of like maybe the red flags that happen before it ever gets to that point, so that you can educate- You know, get yourself, get them out of that situation. And, maybe who could support you in that, you know? Or...”

Another nurse shared, “And you know, we’ve all- We have a pretty close knit team that we. I mean, we meet frequently and we also do case conferences, so we take turns and have the opportunity to, not just talk to the supervisor about our clients, which we do on a regular basis, but we can talk to each other... Yes. And getting opinions on things. And just it’s very helpful to share what you’re going through with the clients.”

Another nurse regarding assessment tools stated, “We don’t have any. I know there’s been talk of that, that would be helpful, and you know, using those risk assessment tools, you know, on, you know, a certain timeframe. Like, you know, when we do their admission time, or like maybe after Baby’s born and having those set times, but also knowing that we could use them at any other time if we needed to.”

Another nurse suggested, “To know what—how to do—like, for step-by-step. And feel confident every time we go out there. Because you wouldn’t know what’s going to happen every visit.”

Other miscellaneous opportunities for improving nursing practice were shared by some nurses in a few sites. Several nurses in different sites suggested that nurses themselves needed to change their attitude towards using certain resources in the community and that it was necessary to initiate interactions with and learn about resources that were available in the community. One nurse from another site shared that there needed to be a decrease in caseload and number of visits with clients when adding on new required innovations, collaborations, and paperwork. A couple of nurses from different sites also expressed the need to learn from past mistakes, as they related to risk assessment, approaching gray areas with clients, and transparency with clients on mandatory reporting.

One nurse explained, “And so, knowing, okay, if I have- If I’m meeting a bump in the road. So, that’s what I- There’s agencies out there ...”

Another nurse stated, “They need to reduce – Either - If they still want us to do all this stuff, they need to reduce our caseload. Or, say, reduce the amount of visits we need to see the clients...It’s not- If you want to have more collaboration, then you need- Your job duties need to be decreased.”

Another nurse recalled, “Well, the specific one I was just thinking of was the car seat one, you know? Um, the client, the kid was nine months old, and because he was 20 pounds, she turned him forward. And, I was like, ‘He had to be one and 20 pounds.’...That’s one of those I probably should have and didn’t, and I - I’ll learn from it.”

In addition, some nurses and a couple of nurse supervisors across several sites also shared about opportunities to maintain their relationship with the client after making a mandatory report. Such opportunities related to having honest communication with the client, using humor to lighten the mood, approaching the subject with the desire to help and to be a resource, and having a strong knowledge of the CPS process.

One nurse suggested, “By just being, having communication with the client and just honesty and that, you know, again, trying to explain to them it’s not about them wanting to take away their child because, ultimately, the best situation is that they’re the best parent for their own child...And, that they’re there for a resource and for help. So, trying to make it turn so it’s not so negative.”

A nurse supervisor shared, “Well, the trust relationship, being able to talk to mom and have an open, trusting relationship to talk about things like domestic violence and then initiating the phone call.”

Opportunities in Supervisory Practice

Furthermore, a couple of nurse supervisors from different sites expressed opportunities towards supervisory practice. One nurse supervisor explained that she needed to ensure that nurses were

making her aware of client concerns as they occurred, so that she was able and could continue to provide better care coordination. Another nurse supervisor from a different site stated that supervisors who carried a caseload were able to better relate with their nurses as they more accurately understood the scope of practice. She explained that she would not want to purely supervise but desired to maintain a small caseload. Finally, a nurse supervisor from one site suggested that creating a list of resources that would include different site supervisors, connections to NFP, phone numbers, and available trainings every year would be helpful in her practice.

A nurse supervisor explained, “So I, you know, took a look at that and really it’s unfortunate that the nurse didn’t bring it to my attention, because, you know, we could have been doing case, care coordination. Yeah, so, and I’ve talked with the nurse about the importance of making sure that I know, so before it gets to this point.”

Another nurse supervisor shared, “And, to be perfectly honest, I like it that way. I wouldn’t want to just supervise. I like having the clients. I think that you relate better to your nurse home visitor if you’re doing the job that you’re asking them to do.”

Another nurse supervisor stated, “Maybe having a list of – here’s the NFP supervisors, and here’s the different county supervisors, and here’s who your connection is between the NFP and here. So– if [nurse supervisor name removed] got something in [county name removed], she knows who to call in [county name removed]. Or if I’m in [county name removed], by chance, or [county name removed], I know who to call there.”

Opportunities for the NFP Program and Structure

Across several sites, some nurses shared about opportunities regarding the NFP program and structure. A couple of nurses from one site suggested a better process for transferring clients by having a point person to receive follow up on whether or not the new site had successfully transferred the client. With referrals, one nurse shared about an opportunity to work with Medicaid so that every eligible client would automatically be referred to NFP. In a couple of sites, some nurses explained that there needed to be better coordination for access to clients’ electronic medical records. For example, a nurse shared that she was unaware a client had a miscarriage due to lack of access to medical records, resulting in her reaching out to a woman who was emotionally vulnerable and no longer eligible for the program. Another nurse from a different site explained that she was unable to flag a physician with her concerns on the client because they were not on the same electronic medical record system. With regards to curriculum, a nurse shared that she desired additional NFP facilitator handouts to assist clients on self-care, coping, and grief as it related to miscarriages, stillborns, and/or termination or relinquishment of parental rights.

One nurse suggested, “Um- Let’s see, I think it could work more smoothly somehow. I know we have like a transfer form that we fill out and send over to the appropriate agency. And, I’ve gotten them, and I’ve sent them, but I haven’t really had any contact with any other nurses...I would say maybe email to, you know, one general person, whether it would be like [assistant name removed] or [nurse supervisor name removed]

or something, and that it could be sent, you know, to whichever nurse is picking up that client, just so they can kind of make that contact. After having transferred clients, I'm always curious what's happened."

Another nurse shared, "Or, what's the other thing? Like, if somebody has a miscarriage or something. You can kind of track that without calling up and making a jerk of yourself, you know, hurting their feelings. I had- I mean, I did have somebody—many, many months and months ago—I called up, and she started crying and said that she lost the baby. And, I said, 'I'm so very, very sorry.' And, she's like, 'That's okay. You didn't know.' But, I feel like I could have known. You know? And, I think that, in that case, there wasn't a medical record. It was outside the system. But, you know, it's still like you feel just terrible."

Another nurse stated, "No. And, I was just going to email somebody to say that we need that sort of facilitator that just- You know, all- I mean, all that it would really say would be sort of probably about self-care and how you're coping with this. And, I'm sure, going through like the stages of grief, which we have for like miscarriages and stillborns, but truly, right? And, I've had these two clients in the last three months that have terminated their rights, and it just feels like you should- You know, because I go to always just sort of close and be like, 'You know, this is just difficult, but you know, you seem to be doing however, and just- Okay. Gotta go.'"

Some additional opportunities related to the NFP program were shared by several nurses and a nurse supervisor in some sites. A couple of nurses from different sites suggested that further research, for example on emotional abuse, collaboration, and mandatory reporting, would be helpful to inform their practice especially when such research was distributed and highlighted by the NFP NSO as guidance. Another nurse from one site shared that creating a team who worked on high-risk issues could be helpful to ensure that families received the services that they needed prior to issues reaching the CPS system. A nurse supervisor from another site shared that it was important to continue pushing the momentum on existing projects when newer projects became the priority.

One nurse expressed, "So, if there is more around emotional abuse because I think that... We know how devastating that is now, more and more research about how that affects, you know, children's brains."

Another nurse suggested, "I would like if I was somebody like you, who had lots of time to do research and those kinds of things cause it's a good time. I would ask every single nurse in the entire NFP community what kinds of things they would like to see in a manual like that... But neglect is so, so different, so it would be great to have some kind of more specific guidelines and if it came out of the NSO, then it's like, you know, the word of David Olds, here it is, you must follow."

Another nurse stated, "Or, and then again, maybe- If money were no object having, you know, a team of people who work on the high-risk, but not necessarily abuse and neglect cases, you know. Let's prevent this from becoming abuse and neglect. So, someone we

can call when we have a family on the edge and get services involved before there's a problem.”

NFP as an Opportunity for Clients

Among some sites, some nurses shared about opportunities for their clients as a result of participating in the NFP program. Several nurses shared about the benefits for clients of having a nurse visit the home during and after pregnancy – a time that was described as a window of opportunity. These benefits included learning how to have a healthy pregnancy, about labor and delivery, breastfeeding, healthy development for the child, and caring for the child. A couple of nurses in various sites also hoped that their clients were able to recognize their nurse's investment in their and their child's future. One nurse explained that participation in NFP made an impact on the client such that despite involvement with CPS, her client still learned to value the protection and health of her child; while another nurse from another site shared that she felt her work had impacted not only clients but also their families and communities. Finally, a couple nurses from different sites shared additional perspectives regarding NFP as an opportunity for their clients: a nurse from one site perceived NFP as one of the best preventive programs for child abuse and neglect, while a nurse from a different site shared her successes in interrupting generational cycles of poverty, early pregnancy, and/or child abuse and neglect.

One nurse stated, “But, I think, especially if you've had your client for long enough, they do realize and recognize that you have a vested interest in the health of their child and in their future. And, so hopefully they could see that.”

Another nurse explained, “Pregnancy is a good window, you know, for them to clean up their act, I think. So, I've had a lot of good experience with people that have quit I think maybe before the pregnancy.”

Another nurse shared, “Just that we can have such an impact on so many people, not just the moms we're seeing, but also maybe their families and their communities and- I think it's bigger, and it affects more than I thought it would.”

Another nurse stated, “And, but I think that's a really big thing because sometimes, if they - It's a way our systems can interrupt the generational things that go on...”

Opportunities for Collaboration With Agencies

Improved communication and collaboration with various organizations were also shared as opportunities by some nurses and nurse supervisors in most sites. Programs served within DHS were specifically expressed as needing improved collaboration. Such programs included Eligibility programs like food assistance, TANF, housing, and Medicaid. One supervisor explained that she hoped to utilize an improving relationship with DHS to facilitate quicker client access to mental health services in the community, knowing that DHS had a connection with mental health services in their county. Because many clients had difficulty in accessing DHS services, for example in filling out paperwork, some nurses in different sites also suggested that they needed more interactions with these programs. Several nurses from various sites desired to learn about who worked in these programs and their process for approving services as well as

to have specific contact persons and ongoing communication when serving mutual clients so as to better serve their clients.

One nurse shared, “I think just getting to know the- You know, the employees better. All of them at DHS. You know, not only the Protective Services workers, but also the Medicaid technicians and the food stamps department and the- Just getting to know them better, and you know, letting them know about our program and what our objective is and getting some sort of back office phone numbers where we can get through to ask questions, rather than always having to leave messages. So, I think- And then, just- You know, I think the more you talk to different people, the more you’d learn about the rules and the processes and...”

Another nurse suggested, “But, I see us primarily really working in the services area, you know, with getting these girls on the services that they need, housing, food stamps, TANF. And, making that process go a little smoother because I do see a huge inconsistency with who gets services and who doesn’t. And, some of these girls, you know, have a difficult time filling out paperwork. And so, for me it’s learning how that whole process works. And, also, how we can help our clients better with that process. And, also, maybe help DSS with the whole process of it.”

A nurse supervisor shared, “Yeah. And, I’d like to be able to - You know, accessing mental health is very hard in our community. And, I think it’s very hard in our state. And, DHS has said, ‘Well, we’ve got a little more connection with our mental health facility.’ You know, so if we - I would like to be able to access them, or you know, if it is one of our girls that’s being assessed or looked at, maybe the case isn’t open yet, or it is just open, you know, let’s get - Can we get her in? You know, that - It may not have come to this if we could use them as a resource. It wouldn’t have come to this point had we been able to utilize the mental health facility sooner. And, with DHS and their connections, being able to get somebody in sooner, that would be just be nice to be able to help our clients out. I feel like there’s a lot more mental health issues out there lately.”

Collaboration with other organizations, including medical providers, other home visiting programs, WIC, hospital social workers, other clinic staff, and shelters were also expressed by some nurses among some sites as opportunities. A number of nurses from various sites explained that they desired to have more open communication and interaction with these programs regarding mutual clients. A couple of nurses suggested conducting in-person outreach to learn faces and names as well as attending community-wide meetings that would be attended by various services to improve collaboration. Another nurse from a different site shared that those professionals who were respected in the community, had expertise in their area of work, and had similar philosophies to NFP towards prevention offered greater opportunities for collaboration. In a couple of sites, several nurses also expressed a desire to collaborate with other prevention programs, including those under CPS. These nurses explained that it was important to bring in the necessary resources into the home to prevent problems from occurring and from subsequent penetration into the CPS system.

One nurse stated, “You know, another agency that we really need more collaborative effort with here in [county name removed], I believe, is the WIC Division. But, they

aren't part of DHS, I realize that, so I don't know if that's really pertinent for your research, but it sure does help when we can have some personal contacts."

Another nurse explained, "Well, I think when you have a trusting relationship with another professional who is able to, you know, see the client's best interest and know that you're on the same page about it...it's always helpful when philosophically, you know, you're kind of on the same track as well. You know, and trust...I mean, if you - If I am working, you know, professionally with someone that walks the talk and, you know, they are someone I personally have come to respect in terms of their professionalism, their level of expertise, etcetera, etcetera..."

Another nurse shared, "Because I think the more people that we can get to, to be educated in that, oh, there's so many kids we can save. I mean - We can't be in every single home, you know, you just can't. But, one child even is - If you can just save that one child, who knows? You know?"

Another nurse shared, "It'd be interesting to be able to get people - Like if you, you know, if you did somehow know that there were, or think there was risk, but nothing had obviously happened, you know, to be able to get people help prior - You know, the prevention piece..."

Other Opportunities for CPS

Among all sites, some caseworkers and supervisors shared about opportunities that would benefit their practice. These opportunities related to the CPS organizational structure, processes, and philosophies, communication and collaboration with other organizations, suggestions for mandatory reporters, and needed resources in the community.

CPS Organizational factors

In most sites, some caseworkers and supervisors shared about changes that were occurring within the CPS structure, processes, and philosophies and about changes that they hoped to see in the future. In a couple of sites, several caseworkers and supervisors expressed their excitement for transitioning into DR, because of the new emphasis on incorporating families into treatment planning and connecting families with resources in a more supportive way. Some supervisors and caseworkers in various sites also shared about opportunities related to family engagement and TDM meetings where they could better serve families by integrating care with all service providers and receiving buy-in from the clients themselves. A caseworker shared that enhanced screening, though requiring more time, would allow for more information to be reviewed at the beginning rather than during assessment. A supervisor from a different site explained that receiving the IV-E Waiver funding would continue to be beneficial in creating avenues for caseworkers to communicate with families and providers at PRTs and family engagement meetings.

One caseworker stated, "And we know that taking the referrals are gonna take longer and doing our research before we RED team it is gonna take longer. But it's gonna take, it's

gonna help for whoever doing on assessment so we have all this information up front. So even though it kinda seems like oh my gosh, more work, actually it's really not, it's just switching where the more work is being done and the more work is being done up front rather than during the assessment.”

Another caseworker shared, “So, um, our county I think is moving into Differential Response in the next little bit here, which I think will be a little bit better because I think it works more incorporating families in the process versus just kind of coming in as the investigator.”

On family engagement meetings, a supervisor stated, “Like I said, I’m using it as an opportunity on thinking on how, in the right situation, having the right people at the table also includes all our partners that we’re involved with, even peripherally, so.”

Among some sites, some caseworkers and supervisors emphasized the need for the community to work together to protect children, rather than constantly relying on CPS to remove children from the home. A number of caseworkers and some supervisors across several sites also shared that there needed to be greater emphasis on prevention initiatives and that they were excited for Program Area 3, SafeCare, and CCR to be implemented in their counties. One supervisor explained that too many children were entering the CPS system and costing large amounts of money, so prevention needed to be emphasized within the department. Another supervisor from another site shared that increased funding and/or more staff was needed to alleviate her job duties.

A caseworker explained, “Because, really, I feel like our community’s responsible for our children. And so, to have- I would much rather have these agencies, these programs and other agencies—to help our families, so I don’t have to come in and lay down the hammer, basically.”

Another caseworker shared, “Community Response- it can be a Community Response, Safe Care being prevention programs. So like when we’re getting calls, sending them to those preventive type services. Once again, hopefully not coming into our system if they don’t need to be.”

A CPS supervisor explained, “Because we need a different direction. There’s too many kids coming into care. We need to more with prevention. It’s costing us too much money. (*laughs*) And so, just different things like that. It’s better to have all the community there, you know...”

Philosophical changes were also offered as an opportunity by several caseworkers and senior-level CPS workers in various sites. One director shared that he had led attitudinal changes within his department from an investigatory to more family-oriented approach, while another manager from a different site explained that Child Welfare was experiencing great changes with new initiatives that focused on family strengths and was becoming more trauma informed. Another caseworker from one site suggested a branding-related idea such as changing the department’s name that would facilitate better interactions and collaborations in the community.

A CPS manager expressed, “I wanna say this is a really good time in Child Welfare. All the years that I’ve even worked in Child Welfare I’ve never seen so many initiatives that I’ve seen now that are family focused on building strengths within the family unit. It’s a really good time at keeping families together and trying not to make families dependent upon systems such as Department of Social Services... We want to do that in a way that’s supportive, and not threatening, where you have to have a court and a legal system to court order somebody into substance abuse treatment. I am looking forward to that day.”

Another caseworker shared, “Oh yeah. Yes. And, I, you know... We need change the fact that we’re called the Department of Social Services or Department of Human Services. You know, maybe it should be called something else.”

Opportunities for Collaboration With Other Organizations

In addition to opportunities related to CPS as an organization, some caseworkers and supervisors in a few sites shared about opportunities in collaborating with various agencies. Specifically, better communication and collaboration with medical staff – especially mental health providers - were described as major opportunities for most caseworkers and supervisors in many sites. Since some caseworkers across several sites shared their lack of knowledge in accurately assessing and monitoring a child’s medical condition and of their understanding of medical terminology, they felt that interacting and building relationships with medical providers would facilitate better care coordination for clients.

One caseworker shared, “But it would be easier for me if I could just have that communication with, you know, is he gaining weight? What do we need to do? Um, cause the majority of the babies, for whatever reason, and that’s kind of unique to my caseload, I’ve gotten a lot of the medically fragile babies, so I have home health on almost every case.”

Another caseworker stated, “...especially when you have that mental health piece, because that’s probably one of scariest things. I mean, drugs are scary, but I think mental health for me is the scariest one. And so when you have a family who you’re just kind of like on the fence, you know it’s always so nice to have the extra set of eyes in the home, because it makes you feel a little bit better, cause like I said, they might see something you didn’t see that’s concerning, that you may not even think about. So that’s pretty much all I have.”

Several caseworkers and supervisors from different sites suggested that medical providers should participate in family engagement meetings or TDMs; so that everyone involved with the client would have a better understanding of the services being provided, progress being made, and ensure that duplicative services were not occurring. Having liaisons for providers to contact, designated times for providers to meet with caseworkers, and ongoing outreach were suggested by several caseworkers in different sites as opportunities to collaborate, while another caseworker from one site suggested there to be simple referral processes to get their clients into services. One supervisor from a different site explained that better collaboration needed to occur with their local school district. In another site, several supervisors described the importance of

maintaining collaboration with various organizations and that understanding mutual outcomes and goals would allow for continued collaboration.

A supervisor stated, “And then, sometimes in the past, I know that we’ve had to utilize - We’ve had to utilize medical just to make sure we know what we’re talking about as we’re assessing risk and safety. And so, so I...I could see, moving ahead here, I can see how we can integrate more of those things into our meetings, but that’s basically what the structure of the meetings look like.”

A caseworker suggested, “Um, let me see. I think, uh, I think no matter what, the agent, the organization provides whatever service they provide. I think doing that outreach with one another and realizing that, you know, everyone’s here just for the betterment of the family, and what can I provide, you know? What would help?...I think just reaching out to one another, especially since [location name removed] isn’t a very big community, you know, we can get together, like you and I are, or, you know, people coming to the department or even the department designating however many people to go out to different agencies and talk about what we do.”

Another supervisor shared, “There’s no sense in working against each other. And, there’s no sense in not being able to talk and have everybody on the same page...So, I think that, um - Like I say, over the years, people have just understood that, um - You know, working together is much more beneficial for the end goals than, you know, not... I see it, um, staying the same type of collaboration—.”

Opportunities for Mandatory Reporters

An area of opportunity for mandatory reporters was shared among a couple of caseworkers and supervisors in different counties. One caseworker expressed that it was important for mandatory reporters to understand what warranted a report and that they needed to coordinate (e.g. between the school and the hospital) before making a report to CPS. A trainer and a supervisor from other sites explained that mandatory reporters could attend their mandatory reporter trainings that were offered to the community and/or call at any time to ask questions about gray areas and scenarios.

A caseworker shared, “And so, when I got involved, and I had to find out from the parent that the child was seen, that the school called and the child was taken to this hospital. And, I asked them, ‘Can you request the records, medical records? Can you get the x-rays? And, see, you know, this initially did happen?’ You know, instead of calling, ‘Oh, the child broke their arm.’ And, that happened, what? Two weeks ago, and now they’re at the follow-up appointment, so they need to kind of work together, hospitals and stuff, to get the records before they make a case to child protection.”

A Child Welfare trainer expressed, “But I’m certainly open to doing bigger groups but I think smaller groups are a little more effective because we can share - like scenarios and that always, I think helps... So, yeah, I try and make it a little more, hopefully, interesting to people and hopefully give them what they’re hoping to get out of it. Because there’s only so much about like, ‘Here’s the law. You have to report. You have to report.’”

A supervisor shared, “The other thing that we do for other nurses, doctors, the hospital, schools is that we are an open line for them to call with the hypothetical that we talked about earlier- where it’s not actually a report of child abuse but we can get them feedback on how to support families without us.”

Opportunities for More Resources

Some caseworkers from some sites expressed that they desired to learn about available resources because they felt that the more services to support their clients the better. Several caseworkers and supervisors from various sites also explained that more resources were needed in their community. The type of resource needed differed by county, and included short term interventions, programs for adolescents (e.g., juvenile substance abuse treatment, group homes, transitional housing), programs that were free to participate in, more local providers (for rural and sparsely populated counties), programs that conducted home visits, and reliable transportation. One caseworker also expressed that an intern could help her department update a list of available resources so that caseworkers could continue to be aware of what was available for their clients.

A caseworker shared, “So, we need a transitional living home. (*laughs*)... Yeah. It’s our adolescent population that is... It’s tougher. Yeah, transitional living home or a group home for, you know, emancipation population would be really fabulous.”

A supervisor suggested, “So, I think transportation and more substance abuse providers would be helpful—.”

Another supervisor shared, “We like those because where we work is a rural area and there are lots of people who live in sort of, you know, far-flung houses that are hard to get to that maybe they don’t have transportation and then having somebody going into the home would be, you know, a big — a big help and would help reduce the risk.”

Other Miscellaneous Opportunities

Some other opportunities were also shared by various caseworkers and supervisors in some counties. Several caseworkers in different sites expressed that further research regarding the effects of marijuana use on parenting and child development as well as guidance on approaching marijuana education was needed and that it would be interesting to see the impact of marijuana legalization in Colorado in the coming years. Several supervisors and caseworkers from these sites further explained that education on marijuana for the public would be helpful and should focus on marijuana use’s effects on parenting, effects of exposure to children and in utero, similar to existing education on alcohol and tobacco. Another caseworker from one site shared suggestions in overcoming the burden of casework, including the compartmentalization of cases, self-insight and self-awareness, and participating in self-care when needed. A supervisor from yet another site shared that she felt child abuse and neglect as well as DV needed to be considered in the context of public health issues. In a different site, one supervisor explained that there needed to be a way to track referrals to prevention programs in TRAILS and to identify whether or not those referrals remained out of the CPS system. Finally, a caseworker and supervisor from different sites shared about opportunities related to legislative changes: one

hoped that legislation would change to allow referrals to prevention without confidentiality issues, while the other wished that legislation would change regarding when CPS could intervene (e.g., in pregnancy).

On guidance related to marijuana, a caseworker shared, “Yeah, yeah. And, I’m sure there’ll be more that’ll come out as— ... Yeah, yeah. It will be interesting to see how that all turns out in the next five years, you know, or so.”

Another caseworker shared, “So probably too much compartmentalization, but I think it keeps it clean. I think I have a small amount of self-insight, so I can call myself on things and not let whatever’s going on with me be what’s going on.”

A department director stated, “So, we’ve been talking about the referral process, how to track. So, we’re not sure if TRAILS is going to be tracking those referrals when that’s all up and running at the end of this month. Do we need to do a separate tracking system, so we can kind of see the feedback loop?”

Another caseworker on not being able to intervene with pregnant women explained, “That’s what I understand...I wish we could change that law.”

Opportunities Among Other Partners

Among most sites, some community partners shared about various opportunities related to an integrated health care system that addressed child abuse and neglect, NFP program and structural suggestions, as well as collaborative opportunities with other agencies and with NFP.

For Child Welfare

In one site, a center director suggested the need for an integrated system of health care that addressed issues related to child abuse and neglect. This physician felt that health care could play a role in prevention and suggested that medical case managers would benefit children who were involved in the CPS system. She also expressed that a common medical record system needed to be developed so as to facilitate better communication between medical professionals and CPS. She also shared about opportunities in incorporating the military and Indian communities into a network that were involved in all levels of prevention (including intervention) related to child abuse and neglect.

One center director explained, “So, why do we have to separate prevention and intervention and services? I mean, all of that should be- Because, really, you guys are about prevention, right?”

She also expressed, “Just into TRAILS right now. And, honestly, in a perfect world, to me, it should go into a common medical record, and there should be an automatic data dump to TRAILS for the things that are pertinent to what they need to know. Because they don’t need to know everything, right?”

She went on to share, “So, someone said, ‘Well, we don’t have any control.’ I said, ‘It’s not about control. Indian Country is there because it’s about sharing information. It’s about how –’ So, she’s actually going to put a proposal together for me on how we incorporate the military community.”

In a couple of different sites, several community partners expressed that there should be someone with medical knowledge on Child Welfare teams and that they themselves may need to reengage with CPS to facilitate better collaboration for their own agencies. A nurse clinician from another site explained that CPS’s expansion of DR offered opportunities to collaborate more with outside agencies and partners to address child abuse and neglect issues.

A public health nurse stated, “I, I used to know several case managers or caseworkers there, but I think they are no longer there and, yeah. I am afraid I haven’t, I haven’t kept up in the last, you know - in the most recent turnover... Yeah, well and then I am realizing as we speak that it’s something that I should know and I need to find out, you know.”

A nurse clinician shared, “They are implementing a whole different model of how they respond to cases with the Differential Response. And, you know, I think- I think it could... At the same time, it poses a lot of opportunities because one of the goals of Differential Response is to work more with community agencies and community partners, and so, to - If there’s a case that, previously, they would say, ‘Yes, this is absolutely child abuse,’ now they’re thinking, ‘Well, you know, maybe - Maybe it’s more a matter of a lack of resources. They need some more help with stuff.’”

For the NFP Program

In several sites, several public health directors shared about opportunities related to the NFP program and structure. A public health director expressed that nurses should participate in debriefing (potentially with CPS) after a report was made, a child was removed, or a case became ongoing so as to validate the nurse’s decisions and/or offer closure for the nurse. She also suggested that some nurse supervisors may need additional training and/or support around mental health, to better support their nurses around cases of child abuse, neglect, and fatality, as well as training around building organizational relationships. Mandatory reporting was also shared as another opportunity for NFP nurses by one public health director; she felt that nurses needed to be more transparent at enrollment on the nurse’s role as a mandatory reporter. A public health director from a different site desired there to be expansion of the NFP program within her county so that more clients could be served, while another public health director from a multi-county site explained that there needed to be revisions of MOUs and greater accountability among NFP nurses who were fiscally placed out of one county and served a different county.

A public health director shared, “And so I think providing that behavioral health support is really, really, really important for the nurse supervisor especially, um, to be able to know when a nurse needs more support than what perhaps the supervisor can give her...”

She also suggested, “But I think debriefing after the fact, um—even some of these cases are ongoing depending on what kind of plan is put into place—but I think checking in on

a regular basis might help, um, help the nurse feel more comfortable as well as more, um, more validated and more just realize, you know, that they did all they could and there's so much more involved than just the home visits that—that—that the nurse is doing and what the nurse is observing is just a teeny tiny piece of the puzzle.”

Another public health director explained, “I think it was just, you know, yeah, we're very well aware of Dr. Olds' projects, you know, have been for years, you know, and desired it, desired expansions of it...”

For Organizational Collaboration With Other Agencies

The need and ways to improve collaboration between different organizations were shared among several community partners in various sites. A couple of community partners explained that collaboration was often easier in sparsely populated towns because of the frequency of interaction among providers. Another community partner from the same site explained that it was important for agencies to get away from politics and bureaucracy, to have a leader in the community support such collaborations, and to have transparency when making decisions together. Finally, an eligibility worker shared about opportunities in collaborating with NFP in serving mutual clients. She expressed excitement in this potential collaboration and desired to better understand the referral process and to learn about expectations regarding participation in the program.

One public health director shared, “Oh, well, I think small communities help a lot... Because we all know each other or know someone who knows someone that might help with a certain, you know, resource. So I think that is huge, hugely beneficial in the communities where we are because you see each other at the grocery store or at other meetings.”

A council leader regarding facilitating collaboration explained, “And, decision-making has to be - Has to be transparent and open to all... and ask, ‘Is there an extremely, highly, you know, highly revered leader in your community who cares about the community because I want to talk to them about an issue we're seeing.’ And, I found names that way. And, frequently, it was the same name. And so—I could go on for hours, but I won't, on that. But so, you see the difference? Just somebody who happened to have the disease to [be] an opinion leader who can help you access and shape a community.”

An eligibility worker shared, “I think the first steps would be me getting more knowledge on exactly how to go about referring somebody and to find out a little bit more about the program. And then when I sit down with my client during the individual responsibility contract that's where I'm going to, you know, talk to them about this program... So, I'm kind of excited about it actually.”

Conclusion

Discussion and Implications

Variations in levels of collaboration between CPS and NFP existed within and between the seven NFP sites that participated in this multiple case study. Among many sites, there existed some level of collaboration between individual NFP nurses and CPS caseworkers around education on mandatory reporting, approaching gray areas to mandatory reporting, working jointly with mutual clients, and working together on community-wide initiatives or groups. In several sites, there was also a lack of collaboration between the two organizations mainly due to a lack of knowledge and/or awareness of one another. Interestingly, the perceptions in level of collaboration varied within several sites and between positions in both organizations; often with senior-level workers perceiving a stronger level of collaboration than frontline workers.

There existed a desire to improve or enhance existing collaboration efforts among both CPS and NFP workers in many sites. A few individuals expressed strong concerns regarding organizational collaboration between CPS and NFP. These concerns were mainly a result of past personal experiences and stigma associated with CPS that could potentially transfer onto NFP if organizational collaboration was too close. Many strategies were suggested to improve or enhance organizational collaboration, including: opportunities to interact and engage with one another; developing points of contact in one another's agency; educational opportunities to learn about each other's organizational structure, processes, and scope of work, including those related to how to work together when serving mutual clients; and policy or programmatic changes that needed to take place to facilitate stronger collaborations. Having a consistent contact person was considered necessary and important for both CPS and NFP workers: CPS workers wanted to have a point person to gain clarity on the NFP program and to make referrals, while NFP nurses wanted to have a CPS contact to ask about mandatory reporting, gray areas in their practice, and to follow up with when they made reports to CPS. Finally, strategies towards working with mutual clients were shared by workers from both agencies and included: better communication (such as a stream-lined referral process, follow-up on referrals to NFP or reports made to CPS; facilitated sharing of consent forms), focusing on client strengths and engaging with the family, and increased organizational interactions to discuss cases and/or treatment planning (i.e. through CPS family engagement meetings or staffings).

Challenges to organizational collaboration were also expressed by many caseworkers and nurses across all sites to include: NFP programmatic and eligibility restrictions thereby limiting the chance of having mutual clients; CPS workload and burden; philosophical misalignment between the agencies; individual attitudes towards one another's agencies; and community stigma towards CPS. Many caseworkers explained that a barrier to collaborating with NFP was the strict NFP eligibility restrictions of being a first-time mother, because CPS primarily worked with multiparous mothers; having a small portion of mutual clients limited the opportunity to interact and collaborate frequently. It was also difficult for caseworkers to refer to NFP due to the program's referral timeframe (during pregnancy and within 30 days postpartum); CPS did not become involved with first-time pregnant women and infrequently became involved with infants until past 30 days of birth. On the other hand, many NFP nurses found that CPS workers' workload and busy schedules limited their ability to interact and follow up with nurses. In

addition, there existed a perception that CPS and NFP were misaligned organizationally and philosophically among some NFP nurses and CPS workers; NFP was considered as a preventive program while CPS was perceived as a reactive agency. Finally, caseworkers and nurses recognized that individual attitudes as well as stigma associated with CPS posed challenges that were difficult to overcome, especially when individuals were not open to having any interactions with the other agency. It is important to acknowledge these perceived barriers to collaboration when considering future efforts.

Beyond organizational collaboration, many NFP and CPS workers across most sites shared similar experiences in working with clients of different cultures and of various and complicating risk factors, including mental health, substance use or abuse, developmental or cognitive delays, special medical needs, IPV, and environmental health. Workers from both agencies spoke about the need for developing relationships with their clients but NFP nurses tended to value the nurse-client relationship and client strengths more than CPS caseworkers. In fact, valuing the nurse-client relationship had at times hindered nurses' ability to make a mandatory report, with the worry that clients would drop out of the program if the nurse reported. This finding highlighted the need for additional education and training on maintaining the nurse-client relationship before and after a CPS report was necessary. Risk assessment and gray areas to their scope of practice were similarly shared by CPS and NFP workers. Workers from both agencies took part in risk assessment with their clients within their scope of practice. However, different tools and assessment skills were used; caseworkers tended to differentiate risk from safety, while NFP nurses focused on ongoing assessment and utilized the nursing process and judgment in their practice. Gray areas for workers from both agencies were similar and included marijuana use, severe mental health, failure to thrive, and developmental delays. Having similar gray areas showcases an opportunity for NFP and CPS caseworkers to interact and learn together. Such opportunities may involve mutually relevant topics that are beneficial within their scope of practice, for example: motivational interviewing, building and maintaining relationships, and strengths-based approaches.

Research-practice integration

These findings contributed to several practice-integrated elements within the larger NFP quality improvement project funded by CDHS to prevent child maltreatment. The research helped to inform education for Colorado NFP nurses and nurse supervisors on strength and risk assessments, mandatory reporting, and approaching IPV with their clients. The data also contributed to the development and implementation of regional trainings and Lunch and Learns between local teams of NFP nurses and CPS workers. Finally, the research findings have informed the development of key recommendations to CDHS and to the NFP NSO related to policy and programmatic changes towards facilitating organizational collaboration.

Education

Education specifically designed for NFP nurses was implemented at two multiple day state-wide meetings, one in May 2014 and one in May 2015. In May 2014, the majority of Colorado NFP nurses and nurse supervisors attended education related to assessment of client strengths and risks through the Strengths and Risks (STAR) Framework, mandatory reporting responsibilities, marijuana use and its impact on mandatory reporting, and strategies to maintain the nurse-client relationship after making a report to CPS. In May 2015, most Colorado NFP nurses and nurse

supervisors attended education on approaching IPV with their clients based on a nurse-home visitor intervention designed by Dr. Susan Jack from McMaster University in Canada. These areas (risk assessment, mandatory reporting, marijuana use, and IPV) were identified through the qualitative findings as highly necessary and relevant to NFP nurses because many nurses expressed that they had lacked training in these areas. Lacking training in these areas had a direct impact on nurses' ability to adequately deliver the NFP program and to connect their clients to appropriate resources in the community, such as CPS; thus education and training on these topics were prioritized. Education of these topics was also related to two of the three main objectives of the larger quality improvement project for NFP: increasing collaboration between CPS and NFP and strengthening nurses' ability to work with high-risk clients. Development of cases and scenarios included in the education for nurses were informed through quotes and queries mined from analysis of the qualitative interviews that formed the basis of this multiple case study.

In addition to NFP-specific education, the research findings informed the development and implementation of regional trainings and Lunch and Learns between NFP and CPS. Based on data explaining that many NFP and CPS workers lacked knowledge around one another's agencies, roles, and responsibilities, the regional trainings aimed to:

- educate NFP about Child Welfare roles and responsibilities,
- educate Child Welfare about NFP roles and responsibilities,
- educate local stakeholders about CDHS funded prevention programs,
- strengthen referrals to the NFP,
- provide a venue for NFP and Child Welfare workers to get to know one another, and
- identify ongoing collaboration opportunities and next steps.

Regional trainings took place between April and July 2014 and involved NFP nurses and nurse supervisors, CPS workers, SafeCare service providers, and CCR representatives; other community partners were also invited to participate. Based on participant feedback, regional trainings were transformed to Lunch and Learns tailored to county-specific CPS and NFP participants. Lunch and Learns took place from November 2014 through April 2015 and included only NFP and CPS workers. The focus of the Lunch and Learns were to provide a venue for CPS and NFP workers to meet one another and network, share knowledge and experiences, and identify next steps to strengthen local organizational collaboration.

Recommendations

Community and academic partners identified collaboration recommendations to pursue, drawing on qualitative data and policy-relevant information from key sources within NFP NSO, local NFP teams, local Child Welfare staff, and CDHS. To ensure applicability of recommendations, there was a need to ensure that stakeholder opinion was heard, strategies were adapted to incorporate stakeholder viewpoints, and both NFP nurses and CPS workers were available to reflect on the proposed strategies to improve collaborative relationships between the two agencies.

To achieve this goal, a working group was initially formed in the fall of 2014 while data analysis of the qualitative research was occurring. The working group consisted of academic partners from CSPH, community partners from NFP NSO, and key stakeholders from IIK. The working group met weekly and aimed to discuss analytic memos developed through the research analysis

process as well as to develop recommendations to support improved organizational collaboration. A sub-working group was formed to facilitate weekly discussions and refine recommendations that were initially suggested by the larger working group.

In the winter of 2015, the sub-working group generated a draft list of key recommendations related to policy and programmatic changes both for CDHS and NFP NSO to consider. The draft recommendations were refined through feedback and suggestions from the larger working group. In the spring of 2015, the recommendations were then shared with NFP nurses and nurse supervisors as well as CPS caseworkers and supervisors through focus groups. In sum, five focus groups were conducted with Colorado NFP representatives (including nurses and nurse supervisors across the state) and two focus groups were conducted with CPS workers (from four major urban Colorado counties). After each focus group was conducted, recommendations were refined based on participant feedback and shared with the next group of participants. Finally, the revised recommendations were presented to representatives from CDHS Child Welfare and the Office of Early Childhood in a focus group in May 2015. Feedback was incorporated and informed the development of the Recommendations Report (See Appendix C) that will be presented to CDHS and NFP NSO senior-level stakeholders for consideration.

Strengths and Limitations

By adopting a grounded theory in the methodological approach of this multiple case study, reflections on barriers and success factors were incorporated to improve the data collection and analysis processes. One of the initial barriers was related to not accounting for NFP nurse reluctance in revealing certain information and practices related to collaboration with CPS. Some nurses from a couple of sites were concerned about the potential of having negative consequences for individuals and/or their site based on what they revealed due to lack of anonymity in the original research protocol. Discovering this challenge resulted in a change to the research protocol to de-identify individual participants as well as sites to facilitate the capture of detailed and accurate information from research participants. Although this change resulted in the inability to report findings by specific site, the ability to compare site-level data and report out aggregate findings was still considered important and relevant. Other challenges included lacking the appropriate email address, phone number or full name of a CPS contact to initiate the interview recruitment process; interviewing sites that did not have collaboration contacts in CPS which created difficulties in adhering to the snowball sampling method; and consistent pressure to produce analysis findings to be integrated into practice while balancing the time needed to adhere to research rigor and standards.

Some major successes also arose due to this approach of examining organizational collaboration. The ability to capture on-the-ground efforts for collaboration, learn from challenges that were experienced personally, and glean insight from key partners regarding strategies that were successful helped to create a multiple case study that was grounded in data and stakeholder opinion. In addition, the process of participating in research interviews facilitated change among some NFP sites that had nurses and/or caseworkers initiate organizational interactions to enhance collaboration. Finally, some of the recommendations that were informed through findings from this multiple case study have already been adopted and implemented by the NFP NSO, highlighting the successes of research-practice integration.

Appendix A

Research Interview Consent

Hello – my name is _____ and I am conducting a series of interviews for the “Increasing Collaboration between the Nurse Family Partnership and Child Protective Services to Prevent Child Maltreatment” project. The purpose of this interview is to help us understand the types of collaborations that exist between the Nurse Family Partnership (NFP) program and Child Protective Services (CPS) that you have experienced or are aware of. We are also trying to understand better what factors facilitate or are barriers to effective collaboration between NFP and CPS in their shared goal of preventing child abuse. We are interested in any and all factors that you feel are important to the effective collaboration of NFP and CPS.

I anticipate that this interview should take approximately 1 hour. My questions relate only to your professional experiences as a NFP or CPS worker and I will not ask any information related to you that are not relevant to your work duties and responsibilities. Your decision to speak with me is voluntary. You may refuse to participate or answer any questions, and you may stop this interview at any time. If at a later point you would like to retract certain statements or the entire interview you may do so. Your information will be stored on a password-protected computer and what you share will be grouped together with the information that we collect from the other individuals that we are interviewing. Lastly, this research will have no direct benefit to you; instead it will help to inform efforts to improve collaboration between NFP and CPS with the goal of preventing child abuse.

If you agree to participate, I would like to record our interview so that I am sure to capture all of the important information that you share with me. Anything that you say is on the record but if there is something that you want to tell me off the record please let me know and I will stop recording. In addition, if there is something that you have said on the record that you want to take off the record please let me know at any point and we will remove it from the record.

I have several questions for you: Are you willing to participate in this interview? Do you give me permission to record this interview? Do you give me permission to contact at a later date if I have additional questions about something that you said?

If you have questions about this research at a later date, you may contact the Principal Investigator of this project, Dr. David Olds at [(303)724-2892 or David.Olds@ucdenver.edu], or COMIRB at [(303)724-1055 or comirb@ucdenver.edu].

If you understand and agree with everything I have just explained, then let us begin.

10/14/2013

Appendix B

Research Interview Consent

Hello – my name is _____ and I am conducting a series of interviews for the “Increasing Collaboration between the Nurse Family Partnership and Child Protective Services to Prevent Child Maltreatment” project. The purpose of this interview is to help us understand the types of collaborations that exist between the Nurse Family Partnership (NFP) program and Child Protective Services (CPS) that you have experienced or are aware of. We are also trying to understand better what factors facilitate or are barriers to effective collaboration between NFP and CPS in their shared goal of preventing child abuse. We are interested in any and all factors that you feel are important to the effective collaboration of NFP and CPS.

I anticipate that this call should take approximately 1 hour. My questions relate only to your professional experiences as a NFP or CPS worker and I will not ask any information related to you that are not relevant to your work duties and responsibilities. Your decision to speak with me is voluntary. You may refuse to participate or answer any questions, and you may stop this interview at any time. The information that you provide me is anonymous and our records will be de-identified at both the individual and site level. Our findings will only be reported out in aggregate for the entire state. Your information will be stored on a password-protected computer and what you share will be grouped together with the information that we collect from the other individuals that we are interviewing. Lastly, this research will have no direct benefit to you; instead it will help to inform efforts to improve collaboration between NFP and CPS with the goal of preventing child abuse.

If you agree to participate, I would like to record our call so that I am sure to capture all of the important information that you share with me. Anything that you say is on the record but if there is something that you want to tell me off the record please let me know and I will stop recording.

I have several questions for you: Are you willing to participate in this interview? Do you give me permission to record this call?

If you have questions about this research at a later date, you may contact the Principal Investigator of this project, Dr. David Olds at [(303)724-2892 or David.Olds@ucdenver.edu], or COMIRB at [(303)724-1055 or comirb@ucdenver.edu].

If you understand and agree with everything I have just explained, then let us begin.

Revised, 1/30/2014

Increasing Collaboration between Nurse-Family Partnership and Child Protective Services

Policy and Programmatic Recommendations

6/30/2015

Venice Ng¹, MPH, CHES
Roman Ayele², MPH
Suzuho Shimaskai², MPH, DrPH (c)
Christina Ostrom³, MSW, LCSW
Gregory Tung², PhD MPH
David Olds¹, PhD



Funded by the Colorado Department of Human Services

¹University of Colorado, Prevention Research Center for Family and Child Health

²Colorado School of Public Health

³Invest in Kids

Executive Summary

Background

In February 2013, Colorado’s Governor John Hickenlooper announced an enhanced Child Welfare Plan named “Keeping Kids Safe and Families Healthy 2.0”. The plan built upon Colorado’s existing Child Welfare framework and proposed to enhance existing services and introduce new practices, including prevention initiatives to support families even before they became a part of the Child Welfare system. Specifically, prevention services were deemed necessary to support families at risk for abuse and neglect. As part of the enhanced Child Welfare Plan, the Colorado Department of Human Services (CDHS) provided services and funding that could help families address a broad range of factors that impact their stability and safety. Through CDHS funding from the enhanced Child Welfare Plan, a partnership involving the University of Colorado (CU), Invest in Kids (IIK), and the Nurse-Family Partnership (NFP) National Service Office (NSO) conducted a quality improvement project of the NFP program, with the goal of preventing child maltreatment through improved organizational collaboration, enhanced nurse education, and increased enrollment of clients in the NFP program.

The NFP is an evidence-based, voluntary, nurse home visitation program designed to improve the health and development of first-time low-income mothers and their children. In a series of randomized-controlled trials, the NFP program had consistent effects in improving prenatal health, child health and development, and maternal life-course, as well as decreasing childhood injuries and the incidence of child abuse and neglect. In Colorado, the NFP has the capacity to serve over 3,500 families in 61 of 64 counties, operating through a variety of local implementing agencies. Strengthening the NFP’s ability to reduce child abuse and neglect requires continuous improvements in the implementation of the program model and better collaboration with local CPS. To strengthen collaboration efforts between local teams of NFP nurses and Child Protective Services (CPS) workers, there was a need to understand the types of collaborative efforts currently existing in the state of Colorado and examine factors that facilitate or create challenges towards collaboration.

As part of the quality improvement project, researchers from CU conducted qualitative research to explore factors that facilitate or create challenges towards organizational collaboration. This document presents a set of recommendations (that were informed by qualitative research) to decision-makers of CDHS and NFP on programmatic or policy changes to strengthen organizational collaboration. These recommendations are based on a systematic gathering and analysis of professional experiences and perspectives among CPS and NFP workers, expert validation and opinion, and stakeholder input. These recommendations are evidence-based but also sensitive to the needs, beliefs, and opinions of both CPS and NFP workers in Colorado.

Evidence-based Decision Making

Qualitative Research

A multiple case study approach, using grounded theory, was used to explore how collaboration could be improved between NFP and CPS to prevent child abuse and neglect. This approach allowed for key stakeholders to share their perspectives and experiences. Qualitative data was collected through focus groups with NFP nurses and supervisors as well as key informant

interviews with NFP nurses and nurse supervisors, CPS caseworkers and supervisors (e.g. senior level Child Welfare workers including managers, administrators, and directors), and various community partners. A total of 130 qualitative interviews were conducted with NFP staff (54/130), CPS workers (65/130), and other community partners (11/123) over seven NFP sites serving 15 counties in Colorado.

Recommendations Development

Community and academic partners identified collaboration recommendations for decision-makers, drawing on evidence from qualitative data and input from key stakeholders. To ensure applicability of recommendations, there was a need to ensure that there was stakeholder buy-in, recommendations were adapted to incorporate stakeholder viewpoints, and both NFP nurses and CPS workers were available to reflect on the proposed recommendations to improve collaborative relationships between CPS and NFP. To achieve these goals, a working group was initially formed in the fall of 2014 while data analysis of the qualitative research was occurring. The working group consisted of academic partners from CU, community partners from the NFP NSO, and key stakeholders from IIK. The working group met weekly and aimed to discuss thematic memos developed through the research analysis process and utilize such data to develop recommendations to support improved organizational collaboration. A sub-working group was formed to facilitate weekly discussions and refine recommendations that were initially suggested by the larger working group.

In the winter of 2015, the sub-working group generated a draft list of key recommendations related to policy and programmatic changes both for decision makers within CDHS and NFP NSO to consider. The draft recommendations were refined through feedback and suggestions from the larger working group. In the spring of 2015, the recommendations were then presented to various stakeholders, including NFP nurses and nurse supervisors as well as CPS caseworkers and supervisors. A total of seven focus groups were conducted with stakeholders: five focus groups with Colorado NFP representatives (including nurses and nurse supervisors across the state) and two focus groups with CPS caseworkers and supervisors (representatives from four major urban Colorado counties). The focus groups aimed to gather stakeholder perspectives on recommendations informed through qualitative research. These focus groups ranged from one to two hours, each with four to eight participants, and were led by academic partners from CU. After each focus group was conducted, recommendations were refined based on participants' feedback and shared with the next group of participants. The recommendations were then revised based on input from CPS and NFP workers from the focus groups. These revised recommendations were presented in a joint-meeting to two representatives from the CDHS Division of Child Welfare and four representatives from the Office of Early Childhood in May 2015. Feedback was incorporated and informed the final recommendations presented below.

Recommendations

Recommendations for NFP NSO

1. NFP should *improve follow-up with Child Welfare (CW)* when CW makes a client referral to NFP (*now/short term*)

There is a need to implement an agency policy to have follow-up with referral organizations, including CW. The specific information flow between NFP and CW would depend on the context, but mainly if NFP had initiated contact and/or the client enrolled in the NFP program. The NSO can offer sample ideas and letters based on what sites currently use (e.g. verbal, email or fax communication).

2. Reinforce that each item in the *Informed Consent is verbally reviewed* with the client at enrollment (*now/short term*).

Ensure that mandatory reporter responsibilities are reviewed with the client and that the consent is reviewed in the preferred language of the client (e.g. telephone interpretation).

3. Emphasize the *importance of mandatory reporting and safety of the child* to nurses (*now/short term*).

Address this topic in the next edition of the “Ask David” column (Summer or Fall 2015).

4. NFP should develop written guidance and provide practice-based training on *maintaining the relationship with the client* when needing to report to CW and/or throughout the client’s involvement with CW (*short term*).

When reporting to CW, transparency with the client is encouraged but there is a need to recognize that transparency is not always appropriate (e.g. when nurse safety is a concern). Many nurses already know their client best and need to trust their judgment regarding transparency with their client. Furthermore, this written guidance should be informed through research with known clients who were reported to CW by the nurse (with or without clients’ knowledge) and remained in the program, as well as with nurses who were involved with such clients. Consider partnering with CW to learn and understand what caseworkers do to maintain client relationships. There is also need to emphasize that child safety is the number one priority for NFP nurses and reinforce that nurses are mandatory reporters with legal responsibility.

5. Research is needed to *define what makes a client “high-risk” for poor maternal and child health outcomes* and to inform policies that allow nurses to prioritize and work effectively with such clients (*medium term*).

Additional research is needed on defining high-risk using the Strengths & Risks (STAR) Framework. Consider how CW categorizes high risk (High Risk Assessment versus Family Assessment Response if moderate to low risk family).

Create an incentive structure for nurses to engage with and maintain high-risk clients, for example a decreased caseload if the nurse is visiting more high-risk clients:

- Recognize that legislative changes are barriers in Colorado due to NFP funding requirements.
- Need to understand caseload management and level of support needed for nurses.
- Recognize that cost per client may be impacted if nurses take on more “high-risk” clients.

- Consider nurse home visitor safety and develop guidance to promote safety. (Consider existing federal level guidance on home visitor safety.)

6. Explore opportunities around *expanding the NFP eligibility requirements (long term)*.

Continued research on the effectiveness of the NFP program on multiparous mothers is needed. There is also a need to gather input from nurses in the field. Eligibility considerations:

- Mothers who have had their children up for adoption and have not parented
- Mothers who lost their child within days post-partum and have not parented
- Termination (removal from CW) not just adoption and have not parented
- Kinship or foster parents who have never parented

Create concrete guidelines on eligibility so referring agencies are clear on eligibility requirements. (*Note: The NSO is discussing about revising Model Elements for the current eligibility requirement.*)

7. *Consider workload* before adding paperwork/interventions/innovations on nurses (make it more achievable for nurses) (*long term*).

Conduct a work flow analysis to determine current workflow and amount of burden on nurses. At the administrative level, do not add paperwork without taking something away. There is also a need to integrate innovations into current practice. A national committee of nurse home visitors and nurse supervisors should assist with development, pilot, revision, and implementation of program innovations. Finally, consider the timing of when education occurs (December and May are challenging months due to the holidays and graduations).

Recommendations for NFP NSO Education Team

1. Provide a general *summary of CW mission, scope of work, and processes* to NFP nurses (*now/short term*).

It is helpful for nurses to understand the multiple roles of CW workers and the impact of their caseload on their ability to communicate with nurses. Provide copies of this information at the NFP IPV Education in May 2015 at a booth hosted by the CU Research Team. Include these topics in ongoing mandatory reporting training (*Note: NFP Education Recommendation #3*).

2. Every new nurse home visitor attends *mandatory reporting training*, whether online or in person (*medium term*).

Every new nurse, within 3-6 months of employment, needs to complete at least the CDHS online training before a more suitable option is available. Integrate a home-visitor specific mandatory reporter training into the NSO core education. Education should include:

- Differences between safety and risk (e.g. teach nurses how to assess for and articulate impact on the child and translate risk into safety concerns when reporting)
- Factors that CW considers in their assessment of the report
- What to include in the report (e.g. ongoing relationship with the child, interest in accompanying on the first CW visit, requesting referral number and follow-up on status)
- Ability to call CW within 24 hours to ask about their report status (with referral number)
- (In Colorado) the Enhanced Screening guide and RED (Review Evaluate Direct) team process

3. Develop annual *ongoing education to better address mandatory reporting (long term)*. Ongoing enhanced education should continue to address mandatory reporting and child maltreatment. Ongoing education should include:

- Emphasis that a nurse's primary goal is to protect the health and lives of children.
- Clarity on the legal and ethical responsibilities of reporting second-hand experiences
- Greater guidance on addressing gray areas (e.g. marijuana, intimate partner violence, statutory

rape, and sex trafficking)

- CW mission/philosophy, processes/structure, different models (e.g. Differential Response), family engagement, court processes, legal terminology, etc.

4. Additional *education for supervisors* is needed on effectively supporting nurses throughout a client's involvement with CW (*medium term*).

Education should include being able to provide appropriate support and supervision for nurse home visitors around: mandatory reporting, making the first report, maintaining the relationship with the client, how to work with ongoing CW cases, etc.

Recommendations for local NFP Nurse Supervisors

1. NFP nurse supervisors should coordinate, minimally, an *annual outreach attempt and/or activity with local CW* to develop and/or maintain collaborative relationships (*now/short term*).

The annual activity may include:

- Lunch and Learns or roundtable discussions (e.g. learn about common language, tools, and frameworks used by one another's agency)
- Meeting with leadership teams and/or individual units (e.g. intake, teen units)
- Participation or observation in Child Protection Teams or RED teams or shadowing a caseworker
- Inviting CW to team meetings/staffings or have CW conduct trainings for NFP
- Having a CW representative sit on the Community Advisory Board
- Attending joint trainings on mutually relevant topics (e.g. risk assessment, motivational interviewing, approaching marijuana, strengths-based programs, etc.)

These attempts and/or activities with CW should occur with at least one county if the NFP site serves multiple counties. Consider working with the local Early Childhood Council to organize education activities.

Recommendations for CDHS

1. Create a position for a *state level contact person* for consultation to home-visitation programs, preferably located in the Office of Early Childhood (*short term*).

A full-time (1.0 FTE) contact at the state level would have expertise in mandatory reporting laws, is responsive, and can be readily available for any home-visitor in the state. The state contact would be responsible for:

- Giving guidance and clarity in mandatory reporting responsibilities
- Being a resource regarding child abuse and neglect

- Supporting local relationships with CW (e.g. helping to coordinate meetings, luncheons, trainings, etc. and facilitating information sharing)
- Familiarizing with CW rules and changes that occur at the state level
- Connecting with programs to support prevention or function in a preventive capacity
- Offering a forum or space (e.g. trainings) for home visitors to learn from others' gray-area experiences and share successes

This state contact would ideally be a nurse with social work or child protection background OR a social worker with child protection experience and a medical background or early childhood development experience (aged zero through five).

2. CW needs to *improve follow up with NFP* when NFP makes a report on a client and when CW serves a mutual client with NFP (*short term*).

Encourage memorandum of understandings and planning together as global collaboration points. Improved communication with NFP when serving mutual clients may include:

- Notifying nurses when a report is screened out and referred to prevention
- Sharing of treatment plans*
- Allowing nurses to acknowledge the plan of care*
- Inviting nurses to family meetings*

*Requires a release of information

Ensure standard practice for implementation of the policy that mandatory reporters are notified about the status of a report by letter or by phone call. Finally, intake/assessment workers should engage with the NFP nurse (if reporter) before making their first visit, if appropriate. This needs to be emphasized to CW workers in initial and ongoing training.

3. *Add questions* regarding whether or not the client participates in a home-visitation program (e.g. NFP) *to the existing checklist* or standard of practice for CW assessment (*short term*).

Caseworkers should ask the client at assessment if she is already involved with a home visitation program such as NFP. Rather than asking about general community resources, consider asking specific questions such as, "Does someone visit your home, e.g. a nurse?" or "Does someone help you with (blank)?"

4. Consider *providing NFP as a resource to reporters* when they report on a pregnant woman (with no other child in the home) to CW (*short term*).

5. *Access to prevention programs* (such as Colorado Community Response - CCR) should not be limited to screened-out CW reports (*medium term*).

Create a mechanism for home-visitors to engage their clients in prevention programs (e.g. CCR) without first reporting to CW to then be screened-out. There is a need to bypass the CW system and mitigate potential safety issues before a client penetrates the system.

6. CDHS should continue *implementation of Differential Response (DR)* with quality assurance and quality improvement components (*long term*).

CDHS should develop expectations of oversight and performance monitoring of DR implementation with local counties. Ongoing messaging and communication from CDHS to county departments is needed regarding their status in implementing DR. Continue to focus on a

model that supports transparency, family engagement, relationship building with clients, client strengths, and supports.

7. Create a coordinated plan on *increasing CW staff retention (long term)*.

The staff retention plan should include:

- Increasing direct case-carrying staff (intake and ongoing)
- Standardizing salaries within and across counties based on cost of living
- Providing greater structure for county implementation (e.g. offering reflective supervision or greater supervisory support and self-care for caseworkers; operating in team-based settings; decreasing the burden on caseworkers through engaging with other service providers)

(*Note:* Findings from the Colorado Child Welfare County Workload Study (Aug 2014) supports this recommendation.)