White Paper

Chronic Neglect

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Executive Summary

The D.C. Child and Family Services Agency (CFSA) is increasingly seeing cases with a profile that researchers have identified as **chronic neglect**. Local implementation of Differential Response, so that cases Child Protective Services refers to CFSA In-Home units all have high or intensive risk ratings, and our continuing transformation from an agency geared for foster care to one primarily providing family support may be making certain issues within families more apparent than before. But whatever the reasons for our growing awareness, chronic neglect is a legitimate and troubling phenomenon that we cannot treat as "business as usual."

Neglect has long been the primary report of child maltreatment to public child welfare agencies—so much so that it generally does not raise the alarms that reports of physical or sexual abuse do. On the broad spectrum of neglectful circumstances, however, chronic neglect represents the deep end. The potential for profound and lasting harm to children, especially young ones, from the embedded negative patterns that constitute chronic neglect is real and significant. In the best interests of those we serve, we must learn all that is known about chronic neglect and implement sound ways to recognize and address it.

This paper is intended as a resource in that process. It surveys the literature to define chronic neglect, touches on what brain science has found about impact on children, covers key elements found to be effective in addressing chronic neglect, presents findings of a small study of CFSA in-home cases, and recommends actions to improve our ability to identify and work with families mired in chronic neglect. Following are the highlights.

Chronic neglect is often an insidious pattern within a family.

Chronic neglect is a parent's ongoing, serious pattern of deprivation of a child's basic physical, developmental, and/or emotional needs for healthy growth and development. Chronic neglect is less readily visible and often less sensational but also more pervasive within a family and difficult to resolve than other types of child abuse/neglect.

Chronic neglect families are likely to be poor and have severe psychological and emotional impairments, some substance use and mental health issues, high rates of domestic violence and/or criminal histories, and multiple periods of homeless. Common symptoms are a chaotic, unpredictable, disorganized family life with low social cohesion and few positive interactions or social supports. Living like this results in long-standing social isolation, lack of life skills, limited nurturing capacity, perceived or learned powerlessness, and a history of exposure to violence and crime over a significant period of time.

These families are often caught in an intergenerational cycle where parents who experienced chronic neglect as children repeat that behavior with their own offspring. Chronic neglect may be so ingrained in the family dynamic that parents have great difficulty recognizing how and why their children are at risk.

Children may suffer impaired brain development.

Executive functioning in the brain is associated with attention, memory, learning, problem solving, and emotional and behavioral strengths or weaknesses. Science suggests that child maltreatment is linked to an increased state of anxiety in children. Stress and elevated levels of stress chemicals appear to impair brain development. One study found that several areas of the brains of 28 children and adolescents with

Post Traumatic Stress Disorder (PTSD) from maltreatment were smaller in volume compared to 66 counterparts without a history of maltreatment or PTSD.

Addressing chronic neglect demands skill, teamwork, and time.

Experts agree on several key elements in serving families with chronic neglect effectively.

- **Assessment:** Identifying chronic neglect should start with a comprehensive, individualized assessment that captures the family perspective on their current situation and capacity to change. It must identify the parents' and/or family's underlying issues.

- **Tailored services:** Services must be tailored not only to meet the unique needs of each family member while also addressing the family situation as a whole but also be delivered at a level in line with family capacity and functioning.

- **Teamwork:** The complex, multiple needs of families and children experiencing chronic neglect are too overwhelming for any one helper. This work calls for a strategic, cohesive, and collaborative team approach to delivering services.

- **Communication skills:** Interaction between the social worker and parent is critical because it may be the first positive interaction the parent has experienced and sets the stage for other trusting relationships. Communication skills are critical to deal with parental resistance and capacity issues.

- **Worker support:** Social workers must have ample supports to do this work: small caseloads (8 to 10 families and no more than 25 children), competent communication strategies and leadership practices, and solution-focused supervisors with clinical expertise.

- **Investment of time:** There are no quick fixes for chronic neglect. Families need to be served for a longer period to ensure they fully incorporate changes in behavior into their lifestyle. They need a warm handoff to community resources committed to providing ongoing support, probably for the long haul.

Recommendations

By the end of CY2015, CFSA will:

- Explore best practices in addressing chronic neglect in use in other parts of the U.S. or in international settings.

- Train social workers in applying findings of new screening/assessment tools to develop case plans that address the needs of families with chronic neglect.

- Embed a tool in FACES.net to assist in early identification of families with chronic neglect.

- Solicit proposals for specific services and delivery via a teaming model.

Introduction to Chronic Neglect

Case Scenarios

Scenario 1

Mary T. is 28 years old and has five children, ages 2 to 7. Mary aged out of the foster care system and is determined that her children will not have her foster care experience. Mary receives Temporary Assistance to Needy Families (TANF) but is at risk of being sanctioned due to non-compliance with requirements to participate in vocational training that would lead to employment. Mary states that problems with her two younger children in school have prevented her from attending the classes. The school calls twice a week, threatening expulsion of the two boys. Mary states that she is overwhelmed with the special needs of her children, worried that they will be placed in foster care because of her inability to care for them, and sad about her circumstances.

Mary notes that in the past she has seen a therapist and finds it useful for a while but overall, it did not help her address her concerns about her finances and being able to maintain housing for herself and her children. Mary acknowledges that she counts on her daughters, ages 5 and 7, to dress themselves and prepare their breakfast before school. Sometimes, they also feed the other children before they leave the house because some mornings, Mary cannot get out of bed. Mary states that she was 4 years old when she started to care for her younger brothers and sister. She doesn't understand why she has been investigated by the child welfare agency on four different occasions. She participated in all the required services until the agency closed her case.

Scenario 2

Cary and Arthur B. are ages 22 and 21 respectively. They have been in a relationship for two years and have two children together, Arthur Jr., 2, and Aretha, 1. Cary has two daughters from a previous relationship, Dale, 6, and Tamara, 4. The father of the older children is incarcerated, and Cary's relationship with him has a history of domestic violence.

Cary and Arthur also experienced a period of domestic violence shortly after moving in together but sought counseling and have not experience any bouts in the last 12 months. Cary continues in counseling to address issues related to her bipolar diagnosis and the domestic violence. Tamara and Dale also received counseling in school and medication management through the local mental health provider to address attention deficit disorder. The family lives in public housing but is at risk of losing the housing because Cary failed to put Arthur on the lease, and he failed to report his income from a part-time job. The couple's rent is currently $5,000 in arrears, putting them at risk of eviction.

Cary and Arthur report that as children, social workers visited their families, but they aren't sure why the social workers came to their homes and what they actually did. The social worker visits didn't seem to make any difference in how their respective households operated. Both describe their childhood homes as sometimes O.K., and other times, getting food and clothing was an issue. Both are resistant to additional services because they have no recent concerns about domestic violence, and they don't see why the schools believe they are neglectful because the two older girls help in the home.

Overview of Chronic Neglect

The two scenarios above reflect the complexity of families experiencing chronic neglect. They are characterized by histories of involvement with multiple helping organizations including child welfare, seeing as normal parenting behaviors that others view as inappropriate or unrealistic, and inability to understand the developmental needs of their children or to recognize when their interactions and/or lack of interactions compromise the safety and well-being of their children in the home and community (Pears, Kim, & Fisher, 2008; DeBillis, 2005; Nelson, Saunders,& Landsman, 1993).

Chronic neglect is becoming less of a mystery (De Bellis, 2005 and Glaser, 2000). Since the inception of the formal child welfare system, neglect has been acknowledged as a negative factor in development of a physically, emotionally, and cognitively healthy child. But at the same time, social and medical scientists have debated for decades the extent to which neglect impedes, and exactly how it negatively affects, normal child development. Further mystery exists regarding the extent to which exposure to chronic neglect affects young adults and their ability to interact with and recognize and meet the needs of their own children.

Chronic neglect families . . . are more likely to be poor and have several psychological and emotional impairments, some substance use and mental health issues . . ., and high rates of domestic violence, criminal histories, and multiple periods of homelessness.

Chronic neglect is similar to physical and sexual abuse in that it is recognized as events within the life of the child. But it is unique in that while visible to social workers, it does not evoke the same concerns for safety as do physical and sexual abuse (De Billis, 2005). Chronic neglect may also be a precursor to, or the fallout of, physical and/or sexual abuse occurrences. Its multifaceted nature and complexity often result in services that address one or two issues but leave many others unaddressed, and as a result, these families are more likely to require additional services (Pears, Kim, and Fisher, 2008).

The impact of child neglect is more chronic than other forms of child maltreatment as measured by referral rates, percentage of cases with multiple substantiations, reduced likelihood of reunification, and higher re-entry into out-of-home care following reunification (Wilson and Homer, 2005). Chronic neglect, by definition, is likely to reoccur whether or not child welfare agencies offer or provide treatment or services to neglecting families (2005). Child welfare agencies may respond to the chronicity (recurrence) by undeserving families or serving them but with low expectations for change (2005).

Chronic neglect reveals family and/or child dysfunction in multiple domains (2005). Neglectful behavior of a single-parent mother often opens the door for physical or sexual abuse of the children by males with whom the mother has a relationship (Wilson & Homer, 2005). Chronic neglect families have some common characteristics, the most important of which are that they are more likely to be poor and have severe psychological and emotional impairments; some substance use and mental health issues (such as depression); and high rates of domestic violence, criminal histories, and multiple periods of homelessness (Wilson & Widom,2010; Wilson & Homer ,2003).

Often, parents who expose their children to chronic neglect have impairments due to their own history of abuse and/or chronic neglect. The complex and multiple service needs of families and children experiencing chronic neglect and the fact that services extend to several well-being domain areas can be overwhelming to individual social workers and call for a strategic, strength-based team approach to delivering services (Hildyard & Wolfe, 2007; Wilson & Homer, 2005). Recent studies on the psychobiology of chronic neglect suggest that appropriate services lead to the most positive outcomes with young children under age 6 and parents under age 30 since it is between ages 0 and 30 that the brain continues to expand its white matter due to external and internal stimulation. While services outside this age range can be beneficial, maximum change is evident during this period (Wilson & Horner, 2005; Horwath & Tarr, 2014). All researchers agree that the earlier parents and children get support, the better the outcomes. Supportive services include, but are not limited to, early childhood education, job training, housing support services, GED programs, domestic violence treatment, cultural identity programs, family group conferencing, in-home visitation programs, family-involved mental health treatment, and substance use treatment (Hildyard & Wolfe, 2007).

Services must be planned strategically with families and provided to meet the unique needs of each family member while appropriately addressing the family situation as a whole. Delivery of services also must be carried out in a manner that allows the family to progress to the developmental levels necessary to optimally benefit from the services. Roles and responsibilities of all the service providers must be discussed and adjusted to ensure that goals and objectives the family establishes are achievable and that children are safe in the home while the treatment/services are being provided. Researchers also add that jurisdictions may need to consider extended periods of time for services so that families may develop both the internal and external capacities to benefit from the services and achieve positive behavioral change.

Experts in chronic neglect advocate for a reduced caseload (8 to 10 families) so social workers have time to interact and engage with parents effectively in the complex world of chronic neglect. Interaction between the social worker and parent is critical because it may be the first positive interaction the parent has experienced and sets the stage for establishment of other trusting relationships. These relationships have been noted as the impetus for chemical changes in the brain and are directly linked to the emotional and physical well-being of the parent, which in turn affects the emotional, cognitive, intellectual, and physical development of children in her care (DeBellis, 2005; Wilson& Homer, 2005).

To date, many states and the District of Columbia have relied on social workers and private providers to deliver services to this population. While in-home services units have the history in serving this population, there have been few changes in in-home practice to reflect recent knowledge in brain science and its influence on social work practice with chronic neglect families (DeBellis, 2005). Washington State has been a forerunner in identifying and serving this population. The state has institutionalized a chronicity screening tool to identify families who have previously been involved with child welfare and demonstrate characteristics suggesting that chronic neglect exists in the family environment. Major criteria for identification of families are: three or more Child Protective Services (CPS) referrals in the previous year, four or more CPS referrals in the previous two years, and five or more referrals in the previous three years. Connecticut has taken a statewide approach to providing supportive housing and intensive case management to turn the tide with this population.

Defining Chronic Neglect

Chronic neglect is less visible and often less sensational but also more pervasive and difficult to resolve than other types of child abuse/neglect. Chronic neglect occurs when:

1. One or more needs basic to the child's healthy development are not met **and**
2. The neglect is perpetrated by a parent or caregiver **and**
3. The neglect happens on a recurring and enduring basis.

When these three identifiers result in harm, or serious risk of harm, to a child's safety, health, or well-being, a child can be said to be chronically neglected.

Essentially, Kaplan, Schene, DePanfilis and Gilmore (2009) have defined chronic neglect as a parent or caregiver's ongoing, serious pattern of deprivation of a child's basic physical, developmental, and/or emotional needs for healthy growth and development (CWIG, 2012). Fully 70 percent of all child fatalities involve neglect either alone or in combination with other forms of maltreatment (USDHHS as cited by Corwin, Maher, Rothe, Skrypek, & Kaplan, 2014). Contrary to other forms of abuse, neglect often occurs without intent to harm and displays symptoms such as a lack of nutrition, energy, hygiene, appropriate clothing, medical aids, or medical care (Pekarsky, 2014). Neglect may also occur in conjunction with parental substance use (Carter & Meyers, 2007) and/or domestic violence.

There are many types of chronic neglect, and children may suffer from one or more types at any point:

- **Abandonment**: Abandoned by parent or caregiver.
- **Physical**: Inadequate nutrition, hygiene, clothing, and/or unsafe cluttered, chaotic environment.
- **Medical**: Failure to get, or delays in getting, required health care.
- **Psychological/Emotional**: Deprivation of emotional nurturance, emotional absence of parent/caregiver.
- **Developmental**: Parent/caregiver failure to recognize development capacity or limits; failure to address developmental needs, failure to foster the environment necessary for the child to reach developmental milestones.
- **Supervisory**: Being left alone for extended periods given the child's age and capacities, being left in a closed and locked vehicle, parent or caregiver incapacitation.
- **Guidance**: Exposure to antisocial/criminal behavior by parents or caregiver, exposure to illicit drug use by parent/caregiver; parent/caregiver failure to prevent or discourage risk taking or criminal behavior.
- **Educational**: Parental/caregiver failure to ensure school enrollment or other necessary education, parent/caregiver failure to discourage frequent absenteeism
  (Source: The Australian Office for Children and Youth, and Family Support: http:/www.dhcs.act.gov.au)

Several parental stressors are associated with chronic neglect, including poverty, mental health issues, and substance use (Tanner, Turney, 2003; Wilson& Homer, 2003). Cahn and Nelson (2009), Loman (2006) and Loman and Seigel (2004) suggest a strong contributory relationship between poverty and chronic neglect. Neglect is strongly associated with welfare dependence, homelessness, low levels of education, and single-parent families. Most often, chronic neglect occurs in tandem with recurring bouts of financial insecurity, mental health issues, substance use, domestic violence, and homelessness—and with significant evidence of the parent's lack of concern, insufficient knowledge of parenting, poor

financial planning, mental incapacity, addiction, and/or disabilities and medical conditions (Tanner, Turney, 2003; Wilson & Homer, 2003).

Cahn and Nelson (2009) further suggest that the lives of families exhibiting chronic neglect symptoms are characterized by a chaotic, unpredictable, and disorganized family life; low social cohesion; and few positive interactions or social supports resulting in long-standing social isolation, lack of demonstrable life skills, limited nurturing capacity toward a spouse and children, perceived or learned powerlessness, and a history of exposure to violence and crime over a significant period of time. Unfortunately, due to the nature of factors that contribute to chronic neglect, these families are often victims of intergenerational transference of parenting behaviors. If parents do not engage in developmentally appropriate activities to encourage their children's physical, mental, and academic growth and promote their safety and well-being, their children are less likely to do those things when they become parents.

Child trauma expert Bruce Perry (2003) argues that the impact of child neglect is consistent with behaviors observed in children who have been exposed to trauma. Permanent changes in the brain, including lack of neural connections and pathways, may permanently limit the child's ability to develop normally. Perry (2001; 2003), DeBillis (2005), Hildyard and Wolfe ,2007 and the American Humane Association (2010) note that children who have been exposed to one or more types of chronic neglect demonstrate problems with attachment, cognitive development, emotional self-regulation, social self-confidence, social competence, perseverance in problem solving, and empathy and social conscience. They may also experience language delay and exhibit conduct disorders. Unless effectively addressed, all these problems are then incorporated into their behaviors as parents, perpetuating the cycle. Studies completed by Loman and Seigel 2004)show that costs associated with chronic neglect families are seven times more than those associated with non-chronic neglect families.

Chronic Neglect and Brain Development

Recent studies of neuro-imaging of maltreated children may provide an increased understanding of the early effects of neglect on childhood brain development. The period from birth to adulthood is marked by progressive physical, behavioral, cognitive, and emotional development supported by corresponding brain maturation (De Bellis, 2005) and Perry (2001). Using the findings of neuro-imaging, researchers have found evidence that social interaction, or lack of it, between a mother and child affects development and evolution of the chemical and neurological interactions that promote healthy brain development and subsequent social, emotional, and cognitive development and executive functioning (De Billis, 2005 & National Scientific Council on the Developing Child, 2012).

Executive functioning in the brain is linked to the integrity of the prefrontal cortex, which is associated with attention, memory, learning, problem solving, and emotional and behavioral assets and/or problems. Science suggest that child maltreatment is linked to an increased state of anxiety in children and that due to the lack of parental, environmental, and psychological support, a neglected child is ill prepared to manage the heightened and extended period of anxiety. In some cases, researchers have noted that infants left to cry for long periods have died due to aspiration or have acquired infections due to a suppressed immune system.

The psychobiology of stress is complex. Neglect is likely perceived and processed through a child's senses as intense anxiety (DeBills, 2005 & National Scientific Council on the Developing Child (2012). Multiple neurotransmitter systems and neuroendocrine axes are activated during acute stress (2005). Stress exposure affects the neurotransmitter system and neuroendocrine and immune systems and is interconnected to moderate responses to acute and chronic stressors (Figure 1) (2005).

The sympathetic-nervous system (or catecholamine system), limbic-hypothalamic-pituitary–adrenal (IHP) axis, and Serotonin system are the three major neurobiological stress response systems indicated in mood, anxiety, and impulse control disorders (Vermetta & Bremmer, 2002 as cited by De Bills, 2005). In addition, arousal, stress response, and behavioral and emotional regulation are all dependent on these systems. Likewise, neuro development is dependent on these systems, and the relationships among a child, parent, and environment and the heightened anxiety often associated with child neglect can result in alteration of these biological systems.

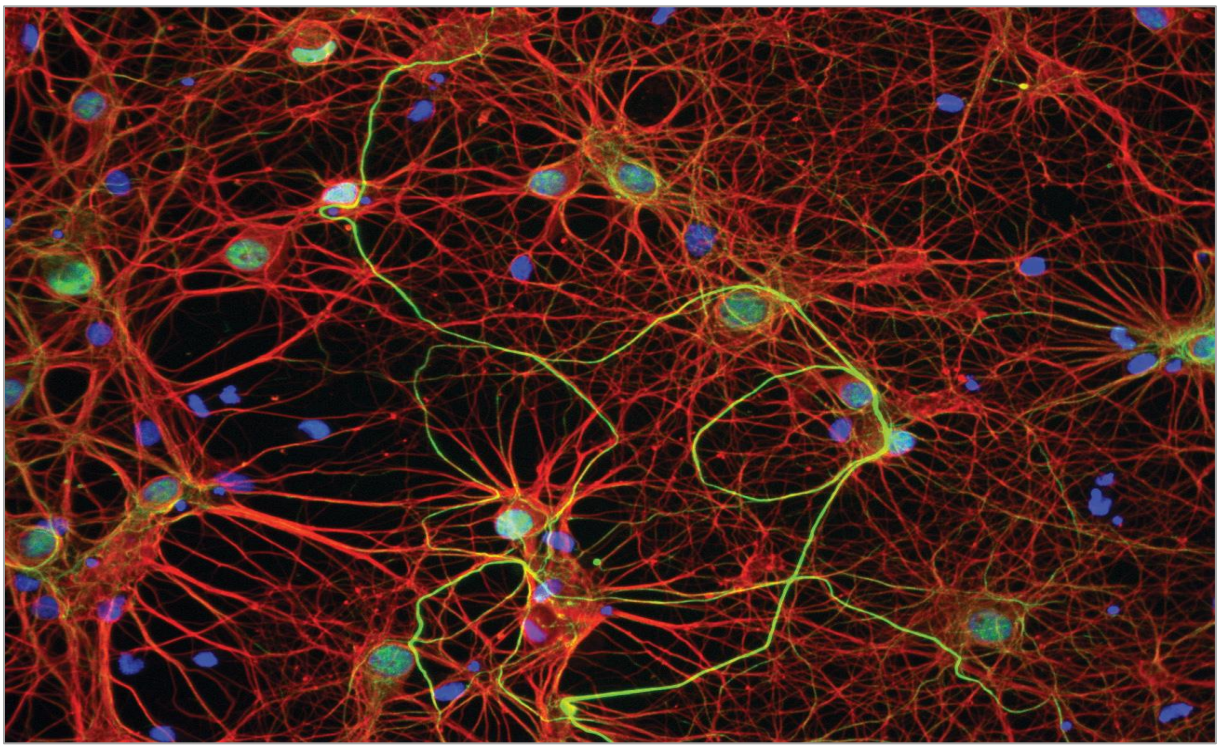

Figure 1: The nervous system, including the brain, is made up of billions of interlinked neurons. This vast interconnected web is responsible for all human thinking.

Quantitative Magnetic Resonance Imaging (MRI) has provided a safe and novel approach to measuring brain maturation in healthy children (De Bellis, 2005; Glaser, 2000). Cross-sectional and longitudinal MRI studies of very highly functioning children and adolescents have greatly increased knowledge of human brain development (De Bellis, 2005; Glaser, 2000). We now know that in the developing brain, stress and elevated levels of stress chemicals may lead to adverse brain development (Figure 1).

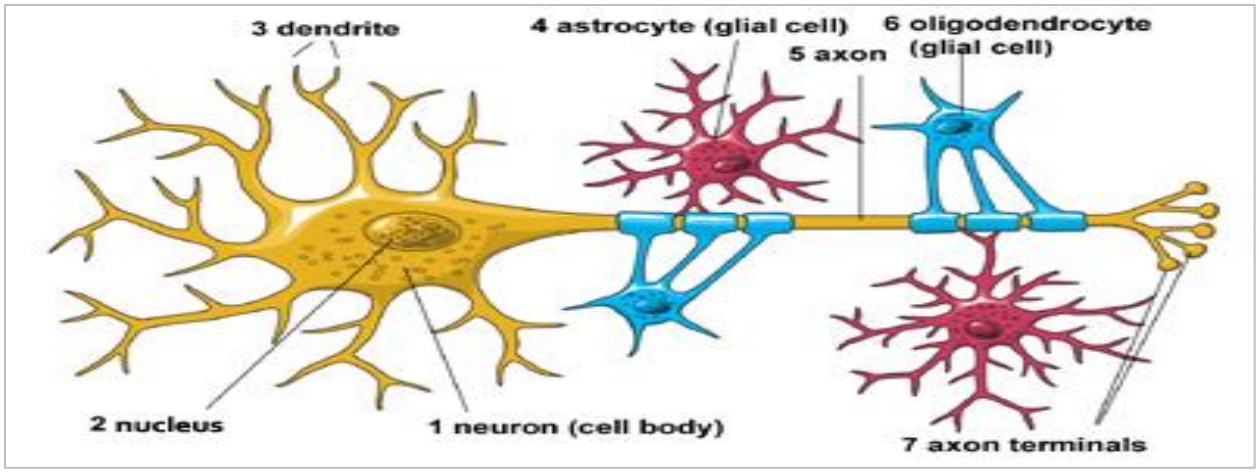

Figure 2: Myelination by Oligodendrocytes

Cortical myelination, the growth of white matter (Glaser, 2000), as demonstrated in figure 2 is one of the primary neurodevelopment changes that occur during childhood. From ages 5 to 18, myelination by oligodendrocytes (Figure 2) influences brain size (2000). The most traumatic increase in myelination is reflected by the corpos callosum, which peaks from age 6 months to 3 years but continues linearly into the third year (Glaser, 2000). The myelination process, or lack of it, appears particularly susceptible to the effects of early exposure to chronic stress (2000).

Four recent studies using MRI imaging to measure brain maturation in maltreated children suggest that Post Traumatic Stress Disorder (PTSD) is associated with adverse brain development (Figure 3). Findings of these studies also suggest disrupted brain development in children with PTSD and indicate that adverse effects may be greater from exposure to trauma in early childhood (2000). There is a correlation between long duration of abuse and lower intracranial volume. Chronic abuse may have a cumulative harmful effect on brain development (2000). Another study of 28 psychometric natures of children and adolescents with maltreatment PTSD showed smaller intracranial, cerebral cortex, prefrontal cortex, prefrontal cortical white matter, and right temporal lobe volume compared to 66 socio-demographically matured healthy counterparts (Glaser, 2000).

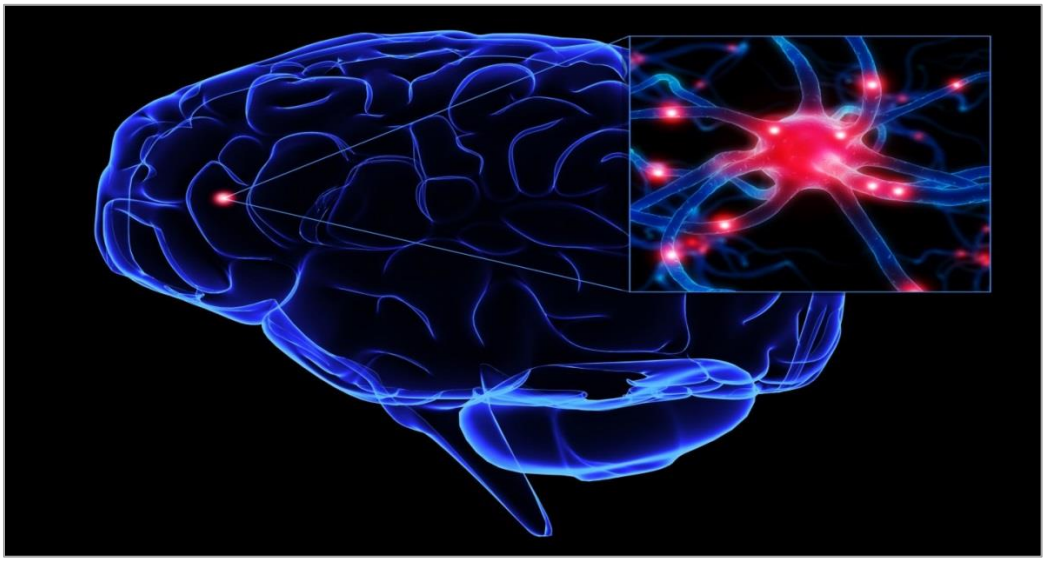

Figure 3: Adverse Brain Development Due to PTSD

While the research argues that positive parent-child interaction, or lack of it, may affect a child's response to anxiety, chemical operations in the body, physiological and neurological reactions, and brain development, there is also increasing evidence that it also affects social, emotional, and cognitive functioning (Hildyard & Wolfe, 2007;Pears, Kim & Fisher, 2007 Glaser, 2000). Essentially, most researchers agree that chronic neglect is much more complex than just a brain development and neuro response system issue (Hildyard, & Wolfe, 2007). Contributing factors in chronic neglect include environmental and ecological stressors such as domestic violence, social isolation, and homelessness (2007).

Many argue that families exposed to long-term poverty have been found to be at higher risk for chronic neglect. Those with only episodic periods of poverty are less likely to be involved in chronic neglectful circumstances, perhaps because these individuals have greater access to physical and mental health services (2007).

Parental factors may interact with ecological variables to protect against or increase the likelihood of neglect. Neglect exists as a broader aspect of parental dysfunction that includes social isolation and family violence. Quality of child care is associated with buffering of LAPA axis to stress. This buffering may lead to fewer and less severe psychobiological and psych sociological impairments (Carter & Meyers, 2007; DeBellis, 2005).

An example of the complexity of chronic neglect can be viewed through the lens of domestic violence. In Washington State, domestic violence complaints preceded 80 percent of 155 cases of chronic neglect. Recently, 42 states and the District of Columbia have recognized that neglected children are more likely to witness interpersonal trauma and experience PTSD from exposure to extreme domestic violence. Domestic violence has been found to be associated with delayed intellectual developmental and functioning (DeBellis, 2005). In addition, poor nutrition and child neglect can co-exist. Both are likely the result of parental ecological factors. Researchers continue to argue to what extent the behaviors seen in abused and/or neglect children are adaptive or maladaptive responses to their internal and external stressors.

Elements of an Effective Approach

Use of a framework that targets interventions at all levels of the individual, family, community, and society is recommended in working with chronic neglect families (DePanfilis, 2002). At a minimum, the framework should include the following elements:

1. Pay attention to basic, emergency, and concrete needs.
2. Support families in identifying and meeting children's basic needs.
3. Practice community outreach.
4. Assess families to tailor their interventions.
5. Form helping alliances with families.
6. Empower families and use strength-based approaches.
7. Address readiness to change.
8. Embrace cultural competence.
9. Use outcome-driven service plans.

Chronic Neglect Casework

The multiple needs of families where chronic neglect is embedded suggest that caseworkers must have access to resources, a flexible working environment, and the authority to make decisions in response to ever-changing family circumstances and needs (Kaplan, Schene, DePanfilis & Gilmore, 2009). Due to the accumulation of harm and the insidious incorporation of chronic neglect in the natural fabric of the family system, the caseworker must be able to engage the family in a manner that is resolute and that employs consistent communication and practice.

Intake and Identification of Chronicity

1. Number and nature of reports in the last 12 months.
2. Number and nature of reports in the last two to three years.
3. Repetition of themes and neglect allegations within these time frames.
4. Parental history of involvement with child welfare as a child for neglect-related issues.

Engagement

Engaging families who have minimal energy and interest requires exceptional skills, patience, and staying power (Kaplan, Schene, DePanfilis & Gilmore, 2009 and Wilson and Homer, 2005; 2003). Caseworkers must have a realistic view of the family's current situation and capacity to change and also their ability to assist in fostering the environment necessary for the change.

Assessment

Identifying chronic neglect starts with a comprehensive, individualized assessment that captures the family perspective on their current situation and capacity to change. It must also tap into the strengths of the family and other internal and external resources using a team approach with family members and community-based resources as supports. The assessment must identify the parents' and/or family's underlying issues (Kaplan, Schene, DePanfilis & Gilmore, 2009). Assessing the detailed circumstances and behaviors within the widest possible context helps to ensure a successful intervention plan (Kaplan, Schene, DePanfilis & Gilmore, 2009; Jones &Gupta, 1998).

Case Planning and Intervention

Wilson and Homer (2005) and Perry (2003) both note that timing of the intervention is critical and that interventions must provide help before the situation and sporadic neglect become chronic and before chronic neglect is combined with physical and/or sexual abuse. The case plan needs to involve a team of interventionists, including those expected to provide services after the child welfare agency is no longer involved.

To be effective, caseworkers must have an infrastructure that supports this work with small caseloads (8 to 10 families and no more than 25 children), competent communication strategies and leadership practices, and solution-focused supervisors with clinical expertise in identifying and responding to the secondary trauma of workers (American Humane Association, 2010). Families should receive services for a longer period—perhaps up to 12 to 18 months—to ensure they fully incorporate changes in behavior into their lifestyle and that a warm handoff takes place to a community resource committed to providing ongoing services and supports. Clinical assessment may require a longer period of intervention. Therefore, results of the clinical assessment should be the basis for setting priorities for services and should drive the length, intensity, and delivery methods.

Competencies and Responsibilities of Caseworkers, Supervisors, and Agencies

To be effective, caseworkers need specialized knowledge and experience with chronic neglect families. Characteristics and skills should include:

- Exceptional engagement skills, patience, and staying power.
- Ability to assess and identify child developmental needs.
- Understanding of the distinction between immediate and cumulative harm.
- Understanding of the concept of low-impact/high-frequency events compared to high-impact/low-frequency events.
- Ability and willingness to enlist not only formal support networks but also informal networks such as extended family, relatives, neighbors, churches, and other nonprofessionals.
- Knowledge of protective factors that families can build and strategies for helping them do so.
- Ability to instill hope, which is key to intervention and change in this population and necessary to counteract the pervasive despair and demoralization this population often displays.
- Awareness of signs and symptoms of secondary trauma and strategies to address it.

Supervisors must be able to coach their workers for both competencies and confidence by building caseworker knowledge, skills, and abilities to implement family-centered, strength-based casework with fidelity including:

- Partnering and relationship building.
- Skillful use of questions.
- Listening.
- Observing.
- Providing constructive feedback.

Supervisors and caseworkers should receive enhance training in:

- Family engagement.
- Communication.
- Comprehensive family assessment.
- Child development.

Child welfare agencies may need to restructure and rethink their organization and policies to better meet the needs of families experiencing chronic neglect (Steib and Blome, 2009). For example, they may want to consider:

- Moving away from the idea of quick fixes and toward plans for long-term interventions to address chronic neglect.
- Fostering leadership that supports and promotes family engagement approaches.
- Reorganizing staff work in teams to ensure continuity with families regardless of worker turnover.
- Relying on sound evaluation and outcome data instead of anecdotal indicators.
- Permitting services to be long term when needed.
- Using cost-benefit research to determine the cost of not providing needed services to children experiencing chronic neglect.

Child welfare research and practice have evolved, and the need for multiple and differential responses for the varying forms of child maltreatment are well recognized. Short-term interventions have little

impact on families experiencing chronic neglect, and using them can be a waste of resources. Public agencies must focus on prevention and early intervention and on developing partnerships with other community and informal support systems to promote effective prevention strategies for chronic neglect (Kaplan *et.al*, 2009). In addition, child welfare agencies must identify ways and means to train the workforce on chronic neglect as well as the co-occurring issues that burden the lives of these families (Child Welfare Information Gateway, 2015).

A Framework for Addressing Chronicity

Agencies can take action in seven areas to gain additional understanding of and strengthen responses to the needs of families experiencing chronic neglect.

1. Develop a better understanding of the phenomenon of repeated involvement (chronicity).
2. Assess whether change is needed in management, staffing, and/or training in the agency and in the court.
3. Assess the current array of services and supports for families with chronic involvement.
4. Listen to parents when developing a plan to address the family's needs.
5. Assess how well the needs of children and youth are being met.
6. Assess the level of involvement with community-based efforts that focus on economic development of neighborhoods, community revitalization, employment training and preparation, and affordable and safe housing.
7. Improve the level of collaboration with other child- and family-serving agencies.

As noted earlier, child neglect is the most prevalent form of child maltreatment and is associated with adverse psychological and educational outcomes. In addition, it has also been suggested that child maltreatment, including chronic neglect, can result in adverse brain and social development. The insidious and cumulative events found in chronic neglect have researchers arguing that extensive and long periods of chronic neglect alter the chemical and neurological engines connected to brain development, which then undermines learning and emotional and social development. While brain development alone cannot be isolated as the sole factor and consideration of environmental and social interactions are also contributing factors, research hypothesize that brain development and functioning are the foundation for the interaction of the individual with his/her environment and with other people.

District of Columbia: What Do We Know So Far?

Within local child welfare, in-home and community services provide a crucial stop gap to families in crisis that helps to prevent unnecessary removal of children and to provide families with the skills they need to keep their households intact. Yet, this service area is still developing to meet the complex needs of the families we serve. After working with the National Center for In-Home Services to identify practice and service gaps, the District won federal approval for a Title IV-E Waiver that is supporting local addition of intensive, short-term, evidence-based family preservation services. However, we have quickly recognized that some families require a different approach and more varied services. To learn more about these families, CFSA In-Home Services collaborated with Agency Performance to review 197 in-home cases.

The sample included three subpopulations receiving in-home services: (1) current in-home cases with a subsequent CPS referral after case opening, (2) current in-home cases that had been re-opened within 90 days of a previous case closure, and (3) current in-home cases where children were subsequently removed and placed in foster care. Data were pulled from a number of sources to complete the study. A survey tool was developed to gather both quantitative and qualitative information for each case. Data were also pulled from FACES.net reports to supplement information from the survey. Data were pulled from CMT 402 reports, which track children removed from in-home cases. Information on household characteristics and recent risk levels was pulled from CMT 404. The Child Information Systems Administration (CISA) also conducted a special data query that provided information on supervisory case consultations and previous CPS history of parents/caretakers in the review sample.

Household Demographics

Nearly two-thirds of the cases had only one caretaker in the home. A little over one-third (36%) had two caretakers in the home. These additional caretakers were the children's parents, step-parents, or other relatives such as grandparents, aunts, uncles, or cousins.

Average age of the caretaker in the home was 32 years. Average of age of children was 6 years. Average number of children on a case was three with a range from one to 11 across all the cases. In 15 of the cases, the children's mother was a former foster care ward.

Average amount of time a case was open was one year. As is appropriate given the current in-home services practice model, the majority of the cases (82%) had a risk-level rating of "high" at the time of case opening. Under the practice of Differential Response, all low- and moderate-risk cases are referred to community-based providers (CFSA Agency Performance, 2014). Approximately 50 percent of the cases had an intensive or high-risk rating during the most recent risk assessment. Only 9 percent had a lower risk level than when initially assessed at the opening of the case (CFSA Agency Performance, 2014).

Table A: Primary Reason for CFSA Involvement (n=181)	
Educational neglect	28%
Lack of care	24%
Physical abuse	19%
Parental substance use	19%
Domestic violence	13%

Table B: Risk Factors at Time of Case Opening (n=181)	
Previous CPS report	81%
More than two children in family	53%
Previous in-home services	47%
History of substance use	42%
Caretaker mental illness	35%
History of domestic violence	32%
Child physical or cognitive disability	19%
Child mental illness	17%
Parent physical or cognitive disability	13%

Based on findings from investigations, in-home families in the sample were struggling with children's school attendance, adequate supervision of children, appropriate discipline methods, and substance use (Table A). The top initial reason for CFSA involvement was educational neglect (28% of cases).

As Table B shows, 81 percent of the cases had a previous CPS report listed as a risk factor. Other common risk factors included having more than two children in the family, previous in-home involvement, and caretaker history with domestic violence, substance use, and/or mental illness. In 78 percent of the cases, families had three or more risk factors.

Reviewers reported that in 72 percent of the cases, caregivers had protective capacities for their children. Although many families had several risk factors, many also exhibited strengths. The most common family strength was availability of an extended family support network (Table C). In 40% of the cases, families had stable housing, and almost a third (31%) were already connected to community support agencies.

Table C: Family Strengths at Time of Case Opening (n=181)	
Extended family support network	57%
Stable housing	40%
Connection to community support agencies	31%
One or more caretakers with stable employment	18%
No history of substance use	15%

Safety Concerns and Follow-up

Reviewers found immediate safety concerns in a few cases and brought them to the attention of the Community Partnerships Administration, which took immediate action. Reviewers also identified another 27 cases as having elevated concerns, and Community Partnerships also addressed those immediately. Twenty of the elevated cases required follow up on issues including but not limited to: medical treatment for children, violence between parents and children, safety assessment not comprehensive (did not assess for issues that brought the case to the attention of the agency), and threats of violence toward the child or a family member that were not adequately addressed.

Needs of Mothers (n=165)

Mothers in this sample had numerous issues in a variety of areas. Consistent with the research on chronic neglect families, they demonstrated a pronounced need for support in mental health and coping skills (55%) and caretaking skills (45%), among others (Table D).

Table D: Mother Needs for Services (n=165)	
Mental health/coping skills	55%
Caretaking skills	45%
Substance use	34%
Resource management	29%
Domestic violence	22%
Social support system	19%

Actual engagement of mothers in services was significantly lower than their identified needs, and mothers frequently declined services. We need additional research into why mothers refused services and whether services we offered specifically addressed identified issues and could have resulted in improved outcomes for the mom and her children.

Some researchers have noted that chronic neglect can impede parents' ability to correctly assess their own capacity to care for their children and to comprehend their children's developmental and nurturing needs. Therefore, mothers may not understand the implications for themselves and their children when they refuse services. However, some researchers have also noted that providers too often do not adapt service offerings to the specific intellectual, cognitive, and emotional developmental level of parents and/or children or otherwise tailor the service delivery model to meet the unique needs of each family (DeBillis, 2005, Wilson &Homer, 2005, CFSA Agency Performance, 2014).

Needs of Fathers (n=97)

Table E: Father Needs for Services (n=97)	
Domestic violence	26%
Caretaking skills	21%
Mental health/coping skills	15%
Substance use	14%
Resource management	13%

Child welfare habitually overlooks the involvement and needs of fathers and underestimates their value to the family system. The case review suggested fathers' needs for services as shown in Table E. Compared to mothers' needs for services (Table D), fathers have a similar array but in a slightly different order of priority. Fathers also need a different service delivery strategy since many do not live in the home with the mother and their children.

Needs of Children

Reviewers reported needs of children in the areas of emotional/behavioral health (51%), education assistance (40%), special education (22%), family relations (18%), and physical health (18%). While children were more often likely to receive the services indicated, we need further research to find out if the services were appropriate to specific needs of the child and to what extent services for children supported parents in making changes that improved family outcomes.

Teaming to Provide Services

As noted earlier, addressing the complexity of chronic neglect and dysfunction in multiple domains requires effective teaming across multiple systems. Too often, in-home social workers seem to feel that they alone must take charge of all aspects of service delivery. However, no one individual is expert in all the domain areas. The need to educate in-home social workers on the necessity of teaming and on the research supporting that approach was evident in the case review.

Only 47 percent of the cases identified the necessary people to participate in team planning with the family. While 88 percent had some extended family involved in the ongoing assessment of their needs, circumstances, and case progress, there was less consistency in ongoing involvement and clarity of roles regarding professional service providers. Some of the professionals noted were: school staff (45%), mental health therapist (29%), health professional (28%), and Healthy Families/Thriving Community Collaborative (18%).

Teaming has been found to be very effective in instances where systemic barriers to services have been identified and creative means of supporting families to participate are needed—for example, arrangements for special child care, transportation, or supportive housing so a parent can fully participate in substance abuse treatment or in-patient mental health services.

Conclusions

Recognition of the effect of brain development on social, educational, physical, and psychological outcomes for children and adults and influence of this knowledge on social work practice are recent developments. Researchers' explorations are providing a deeper understanding of factors that

contribute to chronic neglect and of the corresponding behaviors of both parents and children living in chronic neglect situations. These insights have provided a different lens for the CFSA team in reviewing all cases coming to our attention. More importantly, these new insights have compelled us to take a closer look at families with repeated involvement with child welfare and with extensive histories of mental health and substance use and repeated occurrences of homelessness and unemployment.

In the second quarter of FY15, CFSA removal of children increased. While 48 percent of these were initial removals, a majority were preceded by substantiated neglect. Further exploration of the overall data and specific cases resulted in findings that suggest the following.

- Of the 401 removals in FY14, neglect was by far the most prevalent reason at 48 percent (256). Physical abuse accounted for 17 percent (91), followed by drug abuse at 10 percent (55). The majority were first-time removals. Only a few removals occur from in-home cases.

- Neglect as a reason for removal is increasing. In Q1/Q2 of FY14, neglect was the top removal reason, accounting for 43 percent (125) of all removals. By Q1/Q2 of FY15, neglect as the reason for removal was even more frequent at 50 percent (159 of 315 removal reasons).

Data from the in-home case review and recent analysis of removal patterns in FY14 and the first half of FY15 reinforce the need to serve families experiencing neglect in a way that is different and better. The challenge is to incorporate services that effectively address the most characteristic issues identified by psychobiological and neurological research and in the ecological and social domains (housing stability, mental health, domestic violence, substance use).

Of the 16 in-home cases where removals occurred in FY15 Q1, the need for substance abuse (75%) and mental health (75%) services was prevalent. At the same time, housing was an identified need in 50 percent of the cases. CFSA had offered services, but mothers failed to follow through in actually accessing and engaging in the services (CFSA Agency Performance Removal Report, 2015).

Services must be delivered using family strengthening and empowerment supports and a coordinated team approach to ensure that families have a customized plan that addresses safety and well-being issues of all family members(Howath and Tarr, 2014; Wilson Homer, 2005).

Screening criteria to identify chronic neglect cases in Utah and Washington State include review of previous Child Protective Services substantiations and child welfare interventions. Based on their practices, CFSA should use the following screening criteria for chronic neglect in District families with in-home cases.

- Family has experienced CPS acceptance of four reports **and** one or more CPS family assessments or open In-Home Services cases within three years of the current open case.

- Family has experienced two or more substantiated CPS investigations **and** one or more CPS family assessments or In-Home Services cases within four years of the current open case.

As September 8, 2015, 71 cases (18%) of current In-Home Services cases met one of these proposed criteria. Overall, 24 families met the first criterion, and 47 of the 71 families (66%) met the second criterion. For 48% of these families, abuse or neglect required an open in-home child welfare case on three to six separate occasions.

These 71 families had a total of 243 children. While the average number of children per family was three, 45% of the families had four to eight children. Half the families resided in Ward 8, and 21% lived in Ward 7. Ten percent resided in each of Wards 5 and 6, and the remaining 9% were spread among Wards, 1, 2, and 4. No families lived in Ward 3.

Three In-Home supervisors had the majority of the cases with the remainder scattered among the other supervisors. The In-Home Services Program Administrator is reviewing the assignment of cases to units and movement among units.

Recommendations

Explore best practices in addressing chronic neglect: Consult with the National Center for Housing and Child Welfare to explore best-practice models and services in use with families displaying chronic neglect in other parts of the country or in international settings. Some specific sources are Washington State (Chronic Neglect), Utah Department of Social Services (In-Home Works), and Connecticut Department of Human Services (Chronic Neglect) and American Humane. Target date: June 30, 2015 (Completed)

Strengthen CFSA practice in addressing chronic neglect: Provide training for CFSA and private-agency social workers to build skills in use and analysis of the Child and Adolescent Functional Assessment Scale (CAFAS)®, Preschool and Early Childhood Functional Assessment Scale (PECFAS)®, and Caregiver Strength and Barriers Assessment tools as a basis for developing case plans that more appropriately identify and address the needs of the families with chronic neglect. Target Date: July 1, 2015 (Completed)

- Select two units to specialize in the case management of chronic neglect families. Target Date: December 1, 2015

- Ensure the Red Team framework and teaming process and concurrent planning are incorporated into all aspects of case management in In-Home Services. Target date: January 31, 2016

- Provide training in solution-focused interviewing and case planning. Target date: January 31, 2016.

- Scale up D.C. CrossConnect to address the needs of families involved with three or more service systems and at risk of having their children removed. Target date: December 31, 2015

- Continue to work on engagement of parents resistant to services, including close monitoring of CFSA use of community papering when needed as a persuasion tool. Compile community papering data and review semi-annually as a basis for adjusting protocols as necessary. Target date: First semi-annual report by December 31, 2015

- Test trauma awareness and training for birth parents in Benning Terrace. September 2015(Completed).

Chronic neglect screening:

- Adopt the recommended criteria from Utah and Washington:

    - Family has experienced CPS acceptance of four reports **and** one or more CPS family assessments or open In-Home Services cases within three years of the current open case.

    - Family has experienced two or more substantiated CPS investigations **and** one or more CPS family assessments or In-Home Services cases within four years of the current open case.

- Complete the chronic neglect screening tool, building on work of the Community Papering Team, consultant findings, and best practices and lessons learned from other jurisdictions. Explore embedding the chronic neglect parameters in FACES.NET to provide an early indication at the Hotline that a family has signs of chronic neglect. Target date: March 30, 2015(Completed June 30, 2015).

Case Management:

- Select two or three In-Home units based in Wards 7 and 8 to specialize in providing case management to children and families experiencing chronic neglect. Target Date: November 30, 2015

- Develop a concrete and comprehensive team protocol that includes the roles and responsibilities of social workers, D.C. Department of Behavioral Health family coach, Infant-Maternal Health Nurse, and Healthy Families/Thriving Communities Collaborative worker in developing and executing the case plan and supporting chronic neglect families. Target Date: November 30, 2015

Expand community-based resources for families with chronic neglect:

- Seek proposals from child welfare/behavioral health organizations that can provide (1) community connections to domestic violence, parent education and support, and child development and early childhood education services and (2) service delivery via a coordinated entry and team model. The model must include increased face time with families experiencing chronic neglect, supported by low caseloads of individual practitioners (8-10 families and a maximum of 20 children). Services should be tailored to meet specific family's needs and may extend to up to 18 months. Target date: April 1, 2016.

- Develop an evaluation plan to assess the effectiveness of services and extent to which families are able to maintain stability 12 to 24 months after closure of the case. Target date: September 30, 2015

Introduce peer advocates: Implement and scale up Family Coaching (peer advocates) support for families in partnership with the Department of Behavioral Health. Target date: September 30, 2015 ■

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