The Florida Senate

Interim Project Report 2004-113 *November 2003*

Committee on Children and Families James E. "Jim" King, Jr., President

RETENTION OF PROTECTIVE INVESTIGATORS PHASE II

SUMMARY

High turnover of the child protective investigators is not the result of one factor of the investigators' work but many. Ameliorating the problem will, therefore, require multiple strategies that address the full range of factors that influence the decision of protective investigators to leave. With the advances made by the 2003 Legislature to improve the retention of child protective investigators, Florida moved into the next and more difficult phase of the problem resolution process. This next phase of the effort requires an intense scrutinizing of both the practice of child protection to identify the policies that are contributing unnecessarily to the workload and the administrative operations that are adding to the pressures of the job instead of supporting the work of the frontline staff.

With the passage of SB 1442 in the 2003 Legislative session, the Protective Investigation Retention Workgroup was formed under the direction of the Department of Children and Families for the purpose of examining a number of the issues that surfaced during the 2003 interim project on retention of protective investigators. These issues focus on the investigative practices of the protective investigator in both familial and institutional settings, the administrative support offered, and the hiring and training requirements.

The product of the Protective Investigation Retention Workgroup was a comprehensive set of recommendations that should clearly provide for greater efficiencies and effectiveness in the practice and operation of the child protection system. This interim project recommends the implementation of most of the Retention Workgroup's recommendations including:

- Continuing the Department of Children and Families' investigation of child abuse in Department of Juvenile Justice facilities but improving the communications between the two agencies and stipulating expectations for each agency's actions and response,
- Developing a framework for an alternative response system to be piloted in multiple sites,
- Adopting enhancements to the minimum background requirements and hiring process for protective investigators and their supervisors,
- Developing organizational improvement plans and frontline recognition programs, and
- Strengthening on-the-job training.

BACKGROUND

Retention of child protection staff has been at the forefront as Florida works to improve its child protection system and more adequately respond to the abuse and neglect of children. When child protection staff leave, lost is the knowledge and the expertise the staff had attained in making recommendations about the families where abuse and neglect have been reported. Even though the vacancies may be filed quickly, it takes time for newly hired staff to gain this knowledge and experience.[1]

The 2003 interim project *Retention of Protective Investigators and Protective Investigative Supervisors* (Interim Project Report 2003-110) examined the problem of protective investigator (PI) turnover and how to improve retention. This examination revealed the many dimensions and factors involved in the problem of turnover.

- **Caseload and Workload:** The factors that appeared to most strongly influence PIs' decision or desire to leave were related to the unmanageable caseload and workload. Caseloads averaging 30 to 40 cases per investigator were more than twice the 12 cases per counselor recommended by the Child Welfare League of America.[2] An extensive set of investigative and administrative activities were required for every report; however, certain reports were found to not warrant a child protective

investigation and other reports not to need a full investigation. Some of the families for whom child abuse reports were received could be more effectively and efficiently served using an alternative response system. The jurisdiction of the protective investigator when investigating child abuse allegations in institutional settings was found to need examination since the primary tools available to the investigator were more relevant with parents.

- **Salary**: Salary issues that contributed to PIs leaving included the adequacy of the salary in comparison to the responsibilities required, the lack of pay differential to reflect performance, new PIs making virtually the same as PIs with more longevity, and the limited overtime available to work the hours required to complete the investigative tasks required.

- **Management:** The protective investigators were under a tremendous amount of pressure, but this pressure was perceived differently by the Department of Children and Families' and sheriffs' child protective investigative staff. While all the PIs felt the responsibility for each child's life, the department investigators felt more solely responsible without a sense of sharing the burden with and getting support from administration.

- **Hiring and Training:** People were being hired who did not fully understand what the PI position entailed, who had no human services experience, and who did not have the characteristics and abilities to perform the work. The training then offered focused more on the classroom training and did not contain sufficient on-the-job training, which has been considered more effective in preparing the protective investigator for the job.

- **Services for Families:** A lack of services for the families appeared to extend the length of time the cases were open and resulted in the families returning through the system, increasing the workload and the frustration level of the staff.

Basically, the 2003 interim project found that most protective investigators love the job of protective investigation and were committed to helping children and families, whether it was bringing a child to safety or providing the family with the tools necessary to stabilize and reverse a dysfunctional situation. However, PIs had been leaving the job, not because of the basic work of child abuse investigation, but because the job had become almost impossible to do.

The 2003 Legislature authorized a number of initiatives that were directed at addressing the issues of PI turnover. First, the Legislature allocated 34 new positions for DCF protective investigative staff effective January 2004 to reduce the caseload, with additional funds for an increase in PI staff at the sheriffs' offices. Second, funding was appropriated to increase the salaries of the frontline child protection workers. This funding was used for a salary enhancement plan implemented in September 2003 that both provided salaries closer to the Child Welfare League of America recommended levels and recognized the experience and abilities of the PIs.

Third, the Legislature adopted SB 1442 (ch. 2003-127, L.O.F.) which was the product of the 2003 interim project and contained a number of recommendations to address the issues identified above. Specifically, ch. 2003-127, L.O.F., provided for the following:

- Modification of the child protective investigation process to provide a two-tiered process that provides differential levels of investigative activities;
- Authorization for the central abuse hotline to determine the response time for institutional child abuse instead of requiring an immediate response for all such reports;
- Removal of the requirement that Temporary Assistance for Needy Families (TANF) non-compliance cases be referred for protective investigation;
- Clarification that the process for proceeding with a child-on-child sexual abuse report is to conduct an assessment instead of an investigation;
- Direction to the Office of Program Policy Analysis and Government Accountability to conduct a study on the impact that the availability of services to families has on the turnover of PIs and the families' re-entry into the child protective system; and
- Direction to the Department of Children and Families to establish the Protective Investigator Retention Workgroup to address a number of issues pertaining to the retention of protective investigators with a report back to the Legislature.

Addressing the major issues contributing to staff turnover among PIs has been seen as a multi-year initiative that will require a comprehensive approach. While some strategies that could ameliorate the turnover problem were identified last year, a number of

aspects of the work of the PI and the organizational structure and administrative support that were found to be factors in PIs leaving were not addressed. These aspects require more detailed examination which was the intended purpose of the Protective Investigator Retention Workgroup (Retention Workgroup). The specific issues the Retention Workgroup was directed to address are as follows:

- "Examine the feasibility of an alternative response system for responding to low-risk abuse and neglect reports, design and describe in detail the alternative response system that would best serve this state, and, if determined viable, develop a plan for implementing the system;
- Examine and develop a plan for an investigative process that provides for different levels of investigative activities based on the level of severity of risk and probability of continued or increased abuse and neglect;
- Examine and make recommendations regarding how institutional child abuse in facilities of the Department of Juvenile Justice should be handled, including the protection against abuse which should be afforded children in those facilities, the entity or entities that should be responsible for conducting the investigations, the penalties or sanctions that should be imposed, a means of providing for the independence of investigations, and how the recommendations will ensure the protection of children;
- Examine the results of the Florida State University protective investigators' task analysis study to determine how to make the child protective investigation process more efficient, including, but not limited to, identifying the tasks that are necessary for an effective protective investigation process, streamlining of forms, and identifying the tasks that should be performed by other positions;
- Examine and develop a plan for building communication and involvement in decision making with front line staff and for promoting nonmonetary recognition;
- Examine and make recommendations regarding the minimum appropriate education and work experience desirable for protective investigators and protective investigator supervisors; and
- Examine and develop a plan for the training needed to adequately prepare protective investigators for the job, including, but not limited to, identifying the training that is applicable statewide and that is specific to each district, identifying instruction that is appropriate for classroom training and that would be more effective through some form of structured field or on-the-job training, strengthening the structured field or on-the-job training, estimating the cost of strengthening the structured field or on-the-job training, and setting forth a 3-year implementation plan for phasing in any identified expansion to the training program."

The turnover rate for PIs appears to be declining but, when compared to the national turnover rate for child protection staff which has been averaging between 15.6 percent and 19.9 percent,[3] Florida's rate is still high and requires continued attention. Specifically, while Florida's turnover rate for the last year (October through September 2003) was 34 percent, for August through October 2003, the turnover rate was substantially lower, providing for a projected annualized rate of 28.5 percent.[4] The initiatives of the 2003 Legislature, when fully implemented, should further reduce this turnover rate. However, those initiatives did not resolve the workload and administrative support issues which were found to be important factors in PIs' decisions to leave or stay. The issues to be studied by the Retention Workgroup will provide the foundation needed to begin to solve these aspects of the retention problem.

METHODOLOGY

This Phase II interim project continues the effort to address the issues contributing to PI turnover by focusing on the specific issues identified for the Retention Workgroup through both monitoring of the workgroup's activities and independent staff research. As part of staff's research, relevant professional literature, as well as agency standards, procedures, and reports were reviewed. Other states were contacted, particularly with regards to their systems for conducting child protective investigations in juvenile justice facilities and utilizing alternative response systems. Data was compiled on child abuse allegations investigated in Department of Juvenile Justice (DJJ) facilities and compared with quality assurance information and DJJ incident reports. Discussions were held with agency staff and national experts.

The Department of Children and Families contracted with the Child Welfare Institute to provide the national perspective, research and analysis, as well as assist in facilitating the Retention Workgroup's activities. These national consultants brought extensive expertise in the child welfare system to the discussions. Members of the Retention Workgroup included not only state agency headquarters representatives, but protective

investigators, community-based care providers, sheriffs' staff, and other key stakeholders. Five two-day workgroup meetings were held during which a tremendous amount of information was provided and discussed and recommendations developed.

FINDINGS

The issues examined by the Retention Workgroup were grouped into the categories as identified below and resulted in recommendations that were extensive and comprehensive. This interim project report highlights the major themes of the recommendations but does not completely capture each recommendation nor the significance of the agreements reached or value of the deliberations among the stakeholders. The actual report of the Retention Workgroup should be reviewed in its entirety in order to gain a true understanding of the complexity of the issues and the progress made by the workgroup members.

Alternative Response System and Different Levels of Investigative Activities:

An alternative response system recognizes the differences in the reports of abuse or neglect and allows for different responses to meet the particular needs of the case. States have implemented alternative response systems utilizing a variety of approaches. Usually there are at least two distinct tracks for responding to child abuse reports. One track continues with the traditional investigative procedures because there are serious safety issues or the possibility of criminal charges. The second track focuses on stabilizing the family to prevent the further escalation of abusive acts by assessing the needs of the families and providing or linking them to appropriate services.[5]

A national study of child protection systems found alternative response approaches in 20 states, 11 of which had implemented this approach on a statewide basis. The identified purpose of the alternative response systems differed among the states but included child safety in 55 percent of the states, family preservation and strengthening in 45 percent, and preventing child abuse and neglect in 20 percent.[6] The five year evaluation of the Missouri Family Assessment Response System found that while the positive effects of the demonstration were modest and the assessment response approach was not appropriate for all cases, there were clearly benefits to both the families and the system including fewer subsequent hotline reports for the demonstration families and fewer new incidents of less severe physical abuse, lack of supervision, proper parenting, and educational neglect.[7]

The discussions of the Retention Workgroup reinforced the importance of an investigative process that allows for different levels and types of investigative activities based on the circumstances of the case. Creating such a process would enable PIs to focus more attention on the serious abuse and neglect allegations and provide certain lower risk families with a less intrusive system that is focused on strengthening the functioning of families and, in turn, child safety and child well-being outcomes. The deliberations surrounding designing this process also revealed some of the current inadequacies of the allegation matrix which is DCF's tool for determining which reports meet the definition of abuse and neglect and, in turn, are accepted for an investigation.

The recommendation proposed by the Retention Workgroup was to pilot an Alternative Response Model in Florida once a full program design has been developed. This proposed model would provide for some child abuse and neglect reports to be eligible for an Assessment Response Track, require other particular reports to be investigated using the current full investigative requirements, allow for reports of abuse to be closed using a streamlined process when there is clear and convincing evidence that no maltreatment occurred, and provide for an expedited closure of certain cases with referrals to community services when there are no safety threats and the family has sufficient protective capabilities. All reports would receive an initial child safety assessment by the protective investigators to establish the credibility of the reported allegations and assess the immediate safety of the children. Certain reports and circumstances would be required to be fully investigated. Reports of abuse and neglect placed on the Assessment Response Track would not be investigated to determine the perpetrator but, instead, the focus would be on assessing the strengths and needs of the family to determine the services that would prevent reoccurrence of the abuse.

Some of the practice reforms that could be achieved with the Retention Workgroup's recommended model are consistent with the system improvements identified by the Office of Program Policy Analysis and Government Accountability (OPPAGA) study on the impact that availability of services has on families' re-entry into the child protection system. Specifically, the OPPAGA study found that the effectiveness of our child protection system could be improved by individualizing the determination of services needed by

each family and by providing these services to the families as expeditiously as possible. Both of these aspects of service delivery would be strengthened with the proposed Decision Response Model.

Institutional Child Abuse in Department of Juvenile Justice Facilities:

Chapter 39, F.S., provides the statutory framework for protecting children from abuse and neglect by their caregivers. While these child protection laws are most closely associated with child abuse by parents or other adults in the children's homes, the chapter also applies to abuse of children perpetrated by other types of caregivers including adults responsible for the children's care in foster homes, private schools, child care centers, mental health and developmental disabilities institutions and facilities, residential settings, and DJJ facilities. Excluded are public school employees and law enforcement officers or employees of detention facilities operated by counties, municipalities, or the Department of Corrections.

Child protective investigations of institutional child abuse are conducted using the same laws and investigative requirements as for familial child abuse and neglect allegations with the exception or addition of the provisions set forth in s. 39.302, F.S. This section, however, only addresses a very narrow scope of the institutional investigative process including unannounced investigations, notification of facility owner or operator, access to information when agencies are conducting joint investigations, a visit to the child's place of residence, communication with the state attorney and law enforcement, the department's authority to restrict access to children when there is evidence of abuse or neglect, the department's responsibility to assist a facility to maintain operation under certain circumstances, notification of the Florida local advocacy council, notification of the state attorney and law enforcement if a criminal investigation is warranted, and the conducting of a specialized investigation under certain circumstances.

For juvenile justice facilities, the Department of Juvenile Justice's Inspector General tracks many of the more serious child abuse allegations reported and investigates allegations of non-compliance with department policies and procedures, including inappropriate or excessive use of force incidents that often result in reports of abuse.

Issues were raised from the field in the 2003 interim project regarding the protective investigators' lack of authority to take action to protect children because the recourse available is limited to actions designed to be applied to parents or other familial caregivers. Further, PIs have identified as a workload issue the high level of abuse reports from DJJ facilities that have no indicators and allegations which are less true abuse reports than they are complaints from disgruntled youth.

The data supports the PIs' perspective that a large proportion of the allegations are found not to be abuse or neglect. For fiscal year 2002-2003, 83.3% of the abuse and neglect allegations from DJJ facilities were found to have no indicators which is much higher than the approximately 50% of all reports of child abuse with no indicators.[8] However, the data shows that a significant portion of the reports are for physical abuse and other types of maltreatment allegations that are usually considered more serious. Specifically, 74% of the allegations were for physical injury-related allegations, inappropriate punishment or use of restraints, and sexual abuse-related allegations. Acts which were alleged to impair the physical, behavioral, or cognitive functioning of the child represented 7.2% of the allegations, and environmental or medical neglect-related allegations were 13% of the allegations.

Most, if not all, states are still wrestling with how to adequately address the problem of child abuse and neglect in institutional settings.[9] Child abuse in non-familial settings can be attributed to not only the behavior of an individual caregiver, but to environmental-related factors, including the policies, practices, supervision, resources, and staffing of the setting. However, as in Florida, many states' investigations of non-familial settings use the same policies and practices as for their familial child abuse systems, a practice which does not recognize the differences and complexities of these settings and, in turn, may not adequately protect these children.[10]

Some states have instituted laws and practices to provide for the important differences in the investigation between familial and non-familial child abuse and neglect. Of the states contacted, Virginia, North Dakota, and New Jersey have full operation manuals specifically for institutional child abuse. North Dakota and New Jersey provide extensive information that would aid in recognizing and addressing the abuse in institutional settings. New Jersey statutes authorize the investigating agency to require corrective action plans from the facilities. North Dakota, New Jersey, Virginia, and Colorado all use the same definitions of abuse and neglect for institutional abuse as are used for familial abuse.

The Protective Investigation Retention Workgroup recommended that the Department of Children and Families continue to conduct the protective investigations of institutional child abuse in DJJ facilities but with modifications to the practice and improvements in the relationship between DCF and DJJ. Specifically, the Retention Workgroup recommended that environmental neglect-related allegations no longer be investigated by DCF but instead be addressed by DJJ. The Department of Children and Families should collaborate with DJJ to provide PIs conducting investigations in DJJ facilities with training specific to institutional investigations. Communication links between DCF and DJJ need to be developed so that DJJ and the actual facility consistently receive information on the allegations and final reports. It is recommended that DJJ develop procedures for expected activities by the facilities when notified of an investigation and of verified findings, including responding to safety concerns and options for corrective actions. The requirements for an institutional investigation should be revised to streamline and more judiciously target investigative activities. Specifically, the required on-site visit to the child's place of residence should be revised to remove the actual site visit since the child's residence is not where the abuse occurred, but retain the PIs' contact with the parents regarding the allegation. The automatic referral of all abuse allegations to the state attorney should be eliminated because such a high percentage of these allegations are found to have no indications of abuse. Instead, notification should be provided to the state attorney if a criminal investigation is believed to be warranted. The institutional child abuse investigation section of law should reflect those actions which are universal to all institutions and distinct procedures for each type of institution should be promulgated in rule. An interagency agreement between DCF and DJJ should be executed to provide a forum to reach agreements on expected activities and to discuss issues surrounding the investigations.

Workforce Issues:

Research has found that factors related to the organization and its structure and operation clearly influence child protection staffs' decisions to leave or stay. Some of the prevalent factors related to the organization include supportive supervisors, administrative support, rewards for longevity, appreciation for the work performed, opportunities for training, and advancement opportunities.[11] The focus groups and surveys conducted last year with the phase I *Retention of Protective Investigators and Protective Investigator Supervisors* interim project identified a number of these factors as particular issues for Florida's PIs. Lack of administrative support and recognition for the work performed was evident and appeared to contribute to the burden the department PIs felt in the performance of their job. The perspective of the PIs was that the department did not provide positive reinforcement, recognize accomplishments, support the work of protective investigators, or shield the front-line staff from the pressures of the media.

Hiring staff with the abilities and expectations required for the job and fully preparing them for the responsibilities are important prerequisites to retaining quality PIs. However, it appeared from the 2003 examination that the demand to get positions filled and taking cases quickly may have outweighed the value of more selective hiring and dedicated time to training.

The Retention Workgroup endeavored to develop strategies that would create a culture of valuing employees from the highest administrative level within the organization to the frontline. The recommendations of the Retention Workgroup included that DCF districts develop organizational improvement plans that would focus on communication and the work environment and include a performance measure for the District Administrators relative to the organizational culture and employee satisfaction. There should be a DCF staff person at the state program office designated to build and maintain a communication tree through all the levels of the agency. PIs should be formally recognized when beginning their job and for completion of the pre-service training. A positive rewards program should be implemented at the unit, local office and district level, the specifics for which should be developed by the frontline staff. Staff retention should be a consideration in the annual performance review of supervisors and managers to both hold management accountable for high turnover and to provide a consistent vehicle for further analysis of turnover and needed improvements. Minimum requirements for PIs and PI Supervisors should include experience, and an enhanced screening and hiring process should be implemented to better assess the applicants for the positions. The training for PIs should include pre-service that is uniform for all PIs. The on-the-job training should be strengthened to include a structured orientation, reinforcement of classroom training, and, most importantly, a mandate for a protected caseload during the full training period.

Task Analysis of Protective Investigator Function:

The task analysis study conducted by Florida State University could not produce sufficient information from which to examine all the specific tasks of the PI and, in turn, those tasks and forms that could be streamlined. However, the Retention Workgroup discussed the investigative process and identified some practices that could be revised to provide for greater efficiencies. Specifically, it was recommended that the Predisposition Study (PDS) requirement for the adjudicatory hearing be eliminated. The information required by the PDS is contained in the other documents prepared by the PI for the court proceeding, and often there is not adequate time to fully review the PDS document at the court hearing. The Retention Workgroup also recommended developing a Child Safety Assessment (CSA) specifically for the institutional investigations because the current CSA was designed for families and requires information not appropriate or necessary for institutions.

CONCLUSION

The scope of the issues examined by the Retention Workgroup required a review of the effectiveness and efficiencies of the current child protection practices and operations. The recommendations developed by the workgroup offer Florida an opportunity for major practice and system reforms that could not only solidly address the issues providing the impetus for staff leaving but could also reshape how the child protection system responds to the abuse and neglect of children.

RECOMMENDATIONS

Amend s. 39.302, F.S., relative to institutional child abuse investigations to remove mandatory reports to the state attorney and on-site contact with the family, reflect only directives pertinent to all institutions, direct reports of environmental neglect in DJJ facilities to DJJ with some exceptions, and authorize DCF to develop rules that provide the specific procedures for conducting institutional child abuse investigations in each type of institution.

Require DJJ to adopt in policy procedures for protecting the youth from abuse and responding to investigations of child abuse and neglect.

Direct DCF and DJJ to enter into an interagency agreement regarding the conducting of and response to investigations of allegations of child abuse and neglect in DJJ facilities.

Provide for training of child protective investigators for conducting investigations in institutional settings, subject to the availability of funding.

Direct DCF to create a Child Safety Assessment that is specific to institutional settings, subject to the availability of funding.

Direct DJJ to annually publish its administrative actions in response to verified findings of child abuse or neglect.

Direct DCF to adopt in rule the minimum education and experience requirements and an enhanced screening and hiring process for PIs and PI Supervisors.

Direct DCF to require that each district develop organizational improvement plans to improve communication, employee work environment, and frontline decision making, to include organizational culture and employee satisfaction measures by which the District Administrators' performance will be evaluated.

Direct DCF to incorporate staff retention into the annual performance reviews of supervisors and management.

Direct DCF to implement a recognition and rewards program for all frontline staff.

Direct DCF to adopt in rule minimum process requirements for child welfare training to include, but not be limited to, the requirement for pre-service and certification, provision of specialty training including investigations of institutional abuse, and district-specific training that incorporates a strong on-the-job training component and requires a protected caseload for the new PIs.

Direct DCF to develop the framework for piloting an alternative response system in multiple sites with a corresponding evaluation of the outcomes to be submitted to the Legislature with recommendations for implementation. This alternative response system is to provide for different levels of investigative activities including a streamlined investigation when the allegation of maltreatment is determined not to have occurred or there are no safety threats, the shifting of cases to a track that focuses on resolving family needs contributing to the abuse instead of determining the

perpetrator, and the continuation of a full investigation for serious maltreatment allegations.

Reduce the predisposition study requirements currently set forth for all children for whom a disposition hearing is held.

Direct DCF to examine the allegation matrix to identify refinements that would reduce the number of abuse reports accepted that do not meet the statutory definition.

Direct DCF and DJJ to report to the Legislature on the actions taken to implement the recommendations of the interim report by December 31, 2004.

[1]Balfour, Danny and Neff, Donna, *Predicting and Managing Turnover in Human Services Agencies: A Case Study of an Organization in Crisis*, Public Personnel Management, Vol. 22, No. 3, Fall 1993, p. 474.

[2] *Recommended Caseload/Workload Standards*, Child Welfare League of America, June 2000, and telephone conversation with Pamela Day, Director of CWLA Child Welfare Services and Standards confirming that the 12 cases applies to any point in time.

[3] Schmitt, Barbara, October 9, 2002, Presentation of *Child Welfare League of America, 2001 Salary Study*, and Cyphers, Gary, *Report from the Child Welfare Workforce Survey: State and County Data Findings*, American Public Human Services Association, Child Welfare League of America, and Alliance for Children and Families, May 2001, p.2.

[4] Separation data provided by the Department of Children and Families.

[5] Schene, Patricia, *Using Differential Response in Reports of Child Abuse and Neglect*, Best Practice Next Practice, Spring 2001, pp. 2 & 3.

[6] *National Study of Child Protective Services Systems and Reform Efforts: Review of State CPS Policy*, U.S. Department of Health and Human Services, April 2003, pp 5-1 & 5-3.

[7] Institute of Applied Research, *A Study of the Missouri Family Assessment and Response System after Five Years and Structured Decision Making: Final Report*, June 2003, pp. 1 & 2.

[8] Percentage of reports of child abuse with no indicators for FY 2001-2002 was 50.67% and 49.64% for FY 2000-2001. FY 2002-2003 was not yet available.

[9] Conversation with Michael Nunno, DSW, Family Life Development Center, New York State College of Human Ecology, Cornell University.

[10] Nunno, Michael and Rindfleisch, Nolan, *The Abuse of Children in Out of Home Care*, Children & Society, Vol. 5, No. 4, Winter 1991, pp 295- 303; and Rindfleisch, Nolan, *Reporting Out-Of Home Abuse and Neglect Incidents: A Political-Contextual View of The Process*, Journal of Child and Youth Care, Vol, 4, No. 6, 1990, pp. 64 & 65.

[11]Bernotavicz, Freda, *Retention of Child Welfare Caseworkers, A Repor*t, National Child Welfare Resource Center for Organizational Improvement; Vinokur-Kaplan, Diane, *Job Satisfaction Among Social Workers in Public and Voluntary Child Welfare Agencies*, Child Welfare League of America, 1991; Rycraft, Joan, *The Party Isn't Over: The Agency Role in the Retention of Public Child Welfare Caseworkers*, National Association of Social Workers, 1994; *When Workers Can't Take it Anymore*, Child Protection Connection, Vol IV, Issue 2; Jayaratne, Srinkia and Chess, Wayne A., *Job Satisfaction, Burnout, and Turnover: A National Study*, National Association of Social Workers, 1984; *Social Worker Retention*, Children's Services Practice Notes, North Carolina Division of Social Services and the University of North Carolina, Vol. 4, No. 3.