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Second Generation Mothers in the Child Welfare System: Factors that Predict Engagement

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Abstract Research with families involved with the child welfare system across generations has largely focused on the intergenerational transmission of maltreatment. However, their feelings about being involved with child welfare as parents are largely unknown. The current study compares risk factors among first and second generation child welfare-involved mothers across a U.S. state. A random sample of mothers ($n = 336$) with children younger than age five in the child welfare system were interviewed. Forty-two percent of mothers reported their own childhood history of child welfare involvement. Findings showed that second generation mothers have less education, more depression and anxiety, and higher rates of intimate partner violence (IPV). Second generation mothers rated four dimensions of engagement in child welfare services lower than first generation mothers. This decreased engagement was predicted by their mental health problems, IPV, and whether they spent time in foster care as a child. Implications for practice are discussed.

Keywords Intergenerational child welfare · Service engagement · Maternal depression · Maternal anxiety · Intimate partner violence

Introduction

Engaging families in child welfare services has been an ongoing challenge for caseworkers in the system. Decreased parental engagement has been linked to drop-out and non-compliance rates, which lead, in turn, to a higher likelihood of child removal into out-of-home care (Dawson and Berry 2002). However, the factors that impact engagement are not well understood, and subgroups of parents within the child welfare system may be at greater risk. One population which may be more difficult to engage is parents who were previously involved in the child welfare system when they were children (heretofore referred to as 'second generation'). Greater knowledge about the risk profiles of these parents, as well as an understanding of how they perceive the child welfare system, can help improve service delivery.

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Engagement in Child Welfare Services

Engaging clients in services has long been considered an essential step in strengths-based social work practice (Platt 2012). Cunningham et al. (2009) define engagement as commitment and active participation consisting of attitudes (e.g., denial, hope, motivation), relationships (e.g., bond, respect, caring) and behaviors (e.g., goal setting, participation, letting guard down). Many studies of engagement come from the mental health field, where it has been found that parental involvement in their children's services resulted in greater program completion and reduced symptomatology (McKay and Bannon 2004). Parental engagement has also been connected to more input in treatment and service planning in children's mental health services (Gopalan et al. 2010). Unfortunately, parents with the greatest needs, such as those living in poverty, have been found to be the most difficult to engage, resulting in poorer outcomes for their children (Ingoldsby 2010).

Parental substance abuse (Guo et al. 2006), parent mental health problems (Darlington et al. 2004), and intimate partner violence (IPV; Kohl et al. 2005) are prevalent

co-occurring issues in child welfare. These issues have all been found to impede family engagement in child welfare services (Littell et al. 2001). A study comparing mothers' participation in court-mandated services after a child was removed into out-of-home care found that low compliance was predicted by reports of both substance abuse and IPV (Butler et al. 1994). Sheppard (2002) found that depression was strongly linked to women's decreased participation in planning and decision making in child welfare services. Moreover, when caseworkers employed a more authoritative than collaborative approach to working with the family, the mothers' depressive symptoms increased, further hindering her capacity to engage in services. Substance abuse can similarly hamper engagement both directly, through the parent's impairment, and indirectly, as parents attempt to manage feelings of shame and stigma by avoiding or minimizing involvement with services (Taylor et al. 2008).

The majority of families involved in the child welfare system are not voluntary clients (Altman and Gohagan 2013; Yatchmenoff 2005). In many communities, the child welfare system is perceived very negatively, and involvement carries a heavy stigma (Buckley et al. 2011; Mirick 2014). The priorities of the child welfare system often feel misaligned with families' own identified needs, which can bring additional tension (Kemp et al. 2009). For example, many parents have reported that the concerns they believed were most imperative for their family were ignored or ineffectively addressed by child welfare services (Altman 2005; Yatchmenoff 2005). If parents have concerns that feel pressing, they are likely to be less motivated to participate in treatment plans that may not prioritize or even address these issues (Kirsh and Tate 2006). Conversely, when services offered feel most relevant to families, this has been shown to predict successful helping relationships (Chapman et al. 2003), and thus increase engagement and retention in services.

Parents involved in the child welfare system are expected to complete a treatment plan within a strict timeframe as part of a specified service plan. Failure to comply with that plan can have severe consequences such as the removal of children into out-of-home care and, ultimately, termination of parental rights. Parents who are found to be uncooperative may be offered fewer services, and cooperative parents are less likely to face court proceedings (Dawson and Berry 2002). Active engagement in services has been connected to greater service plan compliance and better case outcomes in child welfare. DePanfilis and Zuravin (2002) found that merely attending child welfare services reduced rates of maltreatment recurrence during an open case by 32 %. Of course, just being physically present does not indicate engagement. Engagement is a multifaceted construct that can include attendance, compliance, motivation, or collaboration (Mirick 2013). In recognition of this complexity, Yatchmenoff (2005) developed a multi-dimensional measure of engagement of nonvoluntary parents with child welfare services. This measure was used to operationally define engagement in the current study.

Second Generation Families

Much of the research on intergenerational child maltreatment has focused on the transmission of abuse. Estimates of the number of formerly maltreated parents who abuse their own children vary, ranging from 7 % (Dixon et al. 2005a) to 30 % (Pears and Capaldi 2001). While childhood maltreatment may increase the likelihood of maltreating as a parent, the majority of people do not continue the cycle (Thornberry et al. 2012). Given the long term negative consequences of child maltreatment, it is important to develop an understanding of the risks present in those families who do perpetuate abuse across generations.

To better understand the relationship between childhood abuse and later perpetration of maltreatment as a parent, research has focused on potential mediators. There is evidence that mothers who were maltreated as children may experience greater relationship conflict (Colman and Widom 2004), have less social support (Muller et al. 2008), and show more substance abuse problems (Appleyard et al. 2011). Several studies have found maternal mental health problems to play a significant role in mediating the relationship between mother's childhood maltreatment and later maltreatment perpetration (Banyard et al. 2003; Dixon et al. 2005b; Marshall et al. 2011). Given the high rates of these problems in the child welfare system (Kohl et al. 2005; Leschied et al. 2005; Semidei et al. 2001) it is unknown whether these problems are even greater within second generation families.

A small number of studies have specifically examined families who have had cross-generational child welfare involvement. Research on foster care alumni has shown that mothers who spent time in foster care were more likely to be poor and had fewer supportive friendships than their peers (Jackson et al. 2015). These findings were supported by Marshall et al. (2011), who used statewide child welfare data and found that second generation families demonstrated greater risk factors such as less education, greater poverty, and fewer social supports than first generation families. They also found that second generation caregivers had significantly more mental health problems, a risk factor that has been linked with decreased engagement in services (Damashek et al. 2011; Littell et al. 2001).

Marshall et al. (2011) found that second generation families were less likely to achieve reunification after child removal. They hypothesized that this may be due to biases

within the system against second generation parents. Caseworkers and judges may assume that children in families with intergenerational cycles of maltreatment may be at greater risk. The attitudes of a caseworker toward their client, their capability for being supportive and empathic, and their ability to remain open-minded and non-judgmental about a client's situation have all been associated with increased engagement (Northern California Training Academy 2009). Therefore, when child welfare workers have negative preconceptions about second generation families, this may negatively impact engagement.

Given that studies of intergenerational transmission of child maltreatment have found that parents who experienced childhood maltreatment and perpetrate abuse against their own children are more likely to be poor, show mental health problems (Dixon et al. 2005a), and demonstrate substance abuse (Appleyard et al. 2011), and these risk factors have been shown to decrease engagement in child welfare (Kemp et al. 2014), second generation parents are likely to be difficult to engage. The current study focused on both first and second generation mothers involved in the child welfare system. It is important to focus on mothers in the child welfare system because they are often the primary caregivers of their children (Sykes 2011), and they are frequently designated as the perpetrators of child maltreatment (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau 2015). Three primary hypotheses were tested:

(1) First generation mothers will show greater risks (e.g., IPV, mental health symptoms, and substance abuse) compared to second generation mothers receiving child welfare services.

(2) Second generation mothers will show lower levels of dimensions of engagement with child welfare services compared to first generation mothers.

(3) Risk factors (e.g., IPV, mental health symptoms, and substance abuse) will predict lower levels of dimensions of child welfare service engagement among second generation mothers.

Methods

Sample

The sample is part of a larger study examining the implementation of socioemotional and developmental screening of all children 0–5 entering the child welfare system in a highly populated U.S. state. Three hundred and fifty primary caregivers of young children were selected for individual interviews from the statewide data using random sampling techniques. The larger study focused on children who remain in their homes because this represents the largest number of young children (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau 2015). Since this is a county-administered, state supervised child welfare system, first all of the counties were stratified for random sampling. The counties were stratified by population density, rate of poverty, number of children in the county overall, number of children entering the child welfare system across the previous 3 years, and number of child welfare caseworkers. Eighteen counties were randomly selected from the strata for study inclusion, and within each county an equal number of families were randomly selected from the child welfare database. Eight families refused to participate in the study, and three families initially agreed to be interviewed but could not subsequently be located. Eleven more families were then recruited to reach the planned sample of 350. All families had an open case and were receiving in-home services at the time of the interview.

The majority (96 %) of caregivers interviewed were the biological mothers (3 % were grandmothers and 1 % were biological fathers). Interviews were conducted by a team of ten former child welfare workers, and primarily took place in the participants' home. A structured survey using well-validated measures and a few project-developed measures was used. Caregivers were asked questions about their current experiences with child welfare services, their feelings about those services, and their own child welfare experience as a child. Questions were also asked about maternal mental health, health, substance abuse, and IPV history. Interviewers also asked about the child's health, behaviors, and mental health. If the family had more than one child aged five or younger in the child welfare system a target child was chosen at random for the questions. The current study included biological mothers with children currently living in their homes, who had been living there for at least 6 months prior to the date of the interview. All aspects of the study were approved by the university's Institutional Review Board.

Measures

Maternal Demographic Characteristics

All primary caregivers interviewed were asked about their relationship to the target child, and only biological mothers with the target child living in the home at the time of the interview were included in the current study ($n = 336$). Mothers reported their age at child's birth, their race, their household income from all sources over the past 12 months, and their level of education.

Michigan Alcohol Screening Test

Mothers were asked, “Have you consumed any alcohol in the past 12 months?” If they answered yes, all questions from the brief Michigan Alcohol Screening Test (MAST; Selzer 1971) were asked. The MAST is a 10-item scale that measures alcohol use and the extent to which alcohol affects the individual’s functioning (e.g., “Have you ever lost friends or girlfriends/boyfriends because of your drinking?”). Items are yes/no with possible scores range from 0 to 10. Scores of four or higher indicate alcohol problems.

Drug Abuse Screening Test

Mothers were asked, “In the past 12 months have you used any drugs to get high, improve your mood, lose weight, or increase sleep?” If they answered yes, all questions from the brief Drug Abuse Screening Test (DAST-10; Skinner 1982) were asked. The DAST-10 is a 10-item scale that measures drug use and the extent to which drug use affects the individual’s functioning (e.g., “Have you ever engaged in illegal activity in order to obtain drugs?”). Items are yes/no with possible scores range from 0 to 10. Scores of three or higher indicate problem drug use.

Patient Health Questionnaire-9

Maternal depression was measured with the Patient Health Questionnaire-9 (PHQ-9; Kroenke et al. 2001). The PHQ is a self-administered scale that assesses eight DSM IV diagnoses. The PHQ-9 is the depression module, which scores each of the nine items, including “Feeling down, depressed, or hopeless”, on a scale from “0” (not at all) to “3” (nearly every day). The PHQ-9 was normed with 6000 patients in eight primary care clinics and seven obstetrics-gynecology clinics. Construct validity was assessed using the 20-item Short-Form General Health Survey (Stewart et al. 1988), self-reported sick days and clinic visits, and symptom-related difficulty. Criterion validity was assessed against an independent structured mental health professional interview in a sample of 580 patients.

Intimate Partner Violence

The physical violence subscale of the conflict tactics scale (CTS; Straus 1979) was used to assess mothers’ experiences of physical violence by an intimate partner over the past 12 months. The CTS is the most commonly used measure of physical IPV between partners, and this subscale has adequate reliability (α from 0.82 to 0.88) and validity (Straus 1979). The violence measured ranges from less to more severe and include items such as “had something thrown at me”; “was pushed, grabbed, or shoved”; “was beat up”; or “was threatened with a weapon”. All endorsed items on the physical violence subscale were summed to form a total violence score.

Parental Childhood Involvement in Child Welfare Services

All caregivers were asked “Thinking about yourself as a child, did your family ever have a case opened with Children and Youth Services?” If they answered yes, this was followed up with the question “Did you spend any time in foster care?”

Client Engagement in Child Protective Services

Maternal engagement in child welfare was measured using the Client Engagement in Child Protective Services scale (Yatchmenoff 2005). This scale was developed to measure client engagement in non-voluntary child welfare services. There are 19 items developed to measure four dimensions of engagement: receptivity, buy-in, working relationship, and mistrust. “Receptivity” involves recognizing family circumstances or problems that could potentially be alleviated by receiving help (Yatchmenoff 2005). “Buy-in” includes both the expectation that you will benefit from help received, and the commitment to actively participate in service planning and delivery. “Working relationship” is characterized by positive communication and a feeling of reciprocity with the child welfare system. “Mistrust” is the belief that there is a negative intention behind the child welfare system and its workers. In the current analyses, the mistrust subscale has been reverse coded as “trust” so results are easier to interpret.

Questions included “My worker and I agree about what’s best for my child” and respondents were asked to answer with a 5-point Likert scale from strongly disagree to strongly agree. The scale has strong reliability ($\alpha = 0.91$) and construct validity was established with both the interpersonal helping relationship scale (Poulin and Young 1997) and a 7-item personal support scale that was developed specifically for child protective service clients (Shireman et al. 2001).

Data Analyses

Differences between first and second generation mothers were explored with bivariate correlations. The groups were compared by demographic characteristics, risk factors, and scores on engagement dimensions. Significant demographic and risk differences between the two groups were entered into four multiple regression models to examine factors that predict the dimensions of child welfare engagement (buy-in, receptivity, working relationship, and trust) among second generation mothers ($n = 141$)

compared to first generation mothers ($n = 195$). Cohen's d was used to calculate effect sizes (Cohen 1977). Whether or not the mother spent time in foster care as a child was also entered into the models. All analyses were conducted using SPSS 22.

Results

Roughly 42 % of the women interviewed reported child welfare involvement as a child. Almost a quarter (23 %) of them spent time in foster care. The first hypothesis was partially supported. Descriptive statistics showed more similarities than differences in the risk factors of first and second generation mothers, including comparable age at first birth, race, prevalence of substance use problems, rate of TANF receipt, and number of children in the home (Table 1). Second generation mothers were significantly more likely to report IPV in the past year, to show depression, and to report anxiety. They were also less likely to have earned a high school diploma compared to their first generation peers. The effect sizes for these differences were all small, with the largest being past year IPV ($d = 0.37$) and the smallest being high school diploma obtainment ($d = 0.23$).

The second hypothesis was fully supported. Compared with first generation mothers, second generation mothers showed lower scores on all four dimensions of client engagement with child welfare services: buy-in, receptivity, working relationship, and trust (Table 2). These differences were all statistically significant. The effect sizes between second and first generation were small, with receptivity ($d = 0.34$) and trust ($d = 0.35$) showing the largest effects.

All four regression models included the significantly different demographic and risk factors as independent variables: education level, IPV, depression, anxiety, and time spent in foster care (Table 3). There was partial support for the third hypothesis. For the model with buy-in as the dependent variable, depression, IPV, and time in foster care were significant predictors. For the model predicting receptivity, both IPV and time spent in foster care were significant. For the model with working relationship as the dependent variable, both IPV and time spent in foster care were significant. The relationship between time spent in foster care and working relationship was not in the expected direction—mothers who were in foster care as children had a significantly better relationship with their workers. For the model predicting trust, both depression and anxiety were significant. Level of education was not significant in any of the models.

Discussion

Within this random sample of mothers involved in the child welfare system, more than a third had been involved in the child welfare system as children. The second generation mothers reported less education, more IPV, greater depression, and higher anxiety compared to first generation mothers. They also showed lower levels of engagement with the child welfare system across four important dimensions. These dimensions of engagement were impacted by maternal reports of IPV, depression, anxiety, and time spent in foster care when they were children.

Many parents involved in the child welfare system demonstrate mental health problems (Jonson-Reid et al. 2009). The current findings show that depression and anxiety may be even greater among second generation mothers, and may present a barrier to buy-in, receptivity, and trust with the child welfare system. Depression can be debilitating, and depressed mothers have been found to have lower participation in many aspects of parenting (McLennan and Kotelchuck 2000). Mothers who are depressed may feel like they do not have the energy to be involved with services, or may feel hopelessness about services being helpful. Chaffin and Bard (2011) found that adjunctive mental health services did not improve depression among mothers receiving in home child welfare services. A factor in their study that was connected to improvement in depression symptoms was a positive working alliance with their worker, further highlighting the importance of engaging parents in services.

While much has been written about depression among parents receiving child welfare services, little is known about those with anxiety symptomatology. One study of a parenting program found that parents with anxiety were less likely to attend services, but anxiety symptomatology was not related to engagement (Brown et al. 2012). Given that almost one-third of the second generation mothers showed anxiety symptoms, and the connection between anxiety and less buy-in and trust in child welfare, the role of anxiety needs further investigation.

The co-occurrence of IPV with child maltreatment is estimated to be as high as 60 % (Edleson 1999). There has long been acknowledgement of the number of families experiencing IPV on child welfare caseloads. The current findings show that, like with mental health problems, IPV may be more prevalent among second generation families. The relationship between IPV and lower buy-in, less receptivity, and a weaker relationship with their caseworker is not surprising in light of how the system has historically worked with battered mothers.

Table 1 Maternal and family factors showing significant differences between groups

	Second generation mothers ($n = 141$) (%)	First generation mothers ($n = 195$) (%)	Cohen's d
Mother's current age	27.9 (6.1)	28.7 (6.9)	0.12
Age at first birth	19.8 (3.5)	20.5 (4.1)	0.17
Mother's race			
White	74.8	77.4	0.15
Black	14.1	13.5	0.11
Biracial	7.8	5.6	0.13
Other	3.3	3.5	0.14
Mom was in foster care	23.1	N/A	–
HS diploma*	65.6	75.5	0.23
IPV (past year)**	32.7	20.5	0.37
Depression*	29.2	19.5	0.26
Anxiety*	30.9	20.0	0.25
Alcohol problems	16.6	17.3	0.09
Drug problems	9.6	13.4	0.16
Receive TANF	37.3	36.8	0.08
No. of children in home	2.1 (1.4)	2.2 (1.3)	0.04
Child ever in foster care	22.7	17.3	0.16

* $p < 0.05$; ** $p < 0.01$

Table 2 Mothers' engagement with child welfare across four dimensions

	Second generation mothers ($n = 141$) M (SD)	First generation mothers ($n = 195$) M (SD)	Cohen's d
Receptivity**	3.23 (1.08)	3.59 (1.03)	0.34
Buy-in*	2.89 (1.08)	3.15 (1.13)	0.24
Working relationship*	3.53 (1.19)	3.77 (1.11)	0.22
Trust[a],**	3.15 (1.09)	3.41 (1.15)	0.36

[a] Engagement dimension 'mistrust' was reverse coded to reflect 'trust' for simplification of interpretation

* $p < 0.05$; ** $p < 0.01$

Table 3 Regression model showing relationship between maternal factors and dimensions of engagement in second generation mothers

	Engagement dimensions							
	Buy-in		Receptivity		Working relationship		Trust[a]	
	B (SE)	β	B (SE)	β	B (SE)	β	B (SE)	β
Level of education	−0.07 (0.05)	−0.11	−0.06 (0.08)	−0.11	−0.01 (0.02)	−0.04	−0.05 (0.06)	−0.09
IPV	−0.29 (0.12)	−0.32**	−0.62 (0.28)	−0.29**	−0.69 (0.27)	−0.30**	−0.12 (0.21)	−0.04
Depression	−0.15 (0.03)	−0.19*	−0.13 (0.07)	−0.15	−0.18 (0.02)	−0.05	−0.46 (0.24)	−0.27**
Anxiety	−0.01 (0.03)	−0.08	−0.38 (0.15)	−0.21*	−0.06 (0.06)	−0.08	−28 (0.11)	−0.26*
Time in foster care as a child	−0.21 (0.07)	−0.23*	−0.48 (0.23)	−0.28**	14 (0.03)	0.25*	−0.03 (0.08)	−0.09
R^2		0.17		0.49		0.21		0.26

[a] Engagement dimension 'mistrust' was reverse coded to reflect 'trust' for simplification of interpretation, $n = 141$

* $p < 0.05$; ** $p < 0.01$

Mothers experiencing IPV who are involved the child welfare system have reported being treated unsympathetically and disrespectfully by caseworkers, and feeling that workers held them responsible for the actions of their abusive partners (Johnson and Sullivan 2008). Cases with co-occurring IPV and maltreatment have shown higher rates of substantiation and more frequent removals from the home (English et al. 2005; Kohl et al. 2005), but receive fewer services (Beeman et al. 2001). These factors have contributed to greater distrust of the child welfare system from survivors of IPV (DeVoe and Smith 2003; Fusco 2013), which likely contributes to decreased engagement with the system.

Little is known about how children who spent time in foster care may experience working with the child welfare system as parents. In the current study, women who spent time in foster care as a child reported lower buy-in and less receptivity, but a more positive working relationship with their current caseworkers. For mothers who spent time in foster care it may feel particularly distressing to have their own children involved in child welfare. Anecdotally, youth in foster care often pledge that their children will never go into the system. The grief and loss these women may have felt as children removed from their homes may be compounded when, as parents, they face this same separation from their children (Chipungu and Bent-Goodley 2004).

The finding that time in foster care predicted a better working relationship with their current caseworker is certainly unexpected. This may indicate that the mother had a positive relationship with her caseworker as a child, or that she developed a supportive relationship with her foster family. A study of youth who aged out of foster care found that 40 % of the youth reported speaking to former foster parents at least once a week and 20 % reported that their former foster parents provided emotional support and help with decision making after discharge from child welfare services (Courtney et al. 2001). These mothers may have experienced some positive outcomes that they connect more with their caseworker than to the system as a whole.

Implications for Practice

While many families in the child welfare system present multiple risks, parents with their own child welfare history may be even more vulnerable. These families may be very difficult to engage and have even stronger negative stigma around child welfare than other parents. Screening for parental child welfare involvement may be helpful to workers trying to establish therapeutic bonds. In their study finding lower rates of reunification among second generation families in child welfare, Marshall et al. (2011) posited that if social workers and courts know that parents have their own history of childhood involvement with child welfare they may be biased in their reunification recommendations and decisions. Therefore, it is important for caseworkers to examine any preconceived negative ideas they may have about 'second generation' families.

The resistance to engagement in second generation families indicates that they may benefit from motivational interviewing (MI). MI is an evidence based practice that was developed to increase motivation for change (Miller and Rollnick 1991). MI was initially developed for use in substance abuse treatment, but its effectiveness has been shown to be much broader. A rigorous meta-analysis of 119 studies concluded that MI significantly increased client's engagement in treatment and their motivation to change problematic behaviors (Lundahl et al. 2010). MI has shown some effectiveness with families receiving child welfare services (Chaffin et al. 2009; Snyder et al. 2012), and should be tested with second generation parents.

Home visiting programs could have positive benefits for second generation mothers. Examples of home visitation programs that are widely disseminated include Nurse-Family Partnership (Olds 2002), Healthy Families America (Daro and Harding 1999), Parents as Teachers (Zigler et al. 2008), and Early Head Start (Administration for Children and Families, U.S. Department of Health and Human Services 2006). In home visitation, a nurse, social worker, or paraprofessional (depending on the program) provides psychoeducational training, support, and case management for mothers and children. Home visits, which begin as early as prenatally and can continue until the child is 5 years old, focus on diverse areas such as parenting skills, maternal-child attachment, and maternal health and mental health. While findings on the effectiveness of home visiting in reducing child maltreatment are mixed (Howard and Brooks-Gunn 2009), these programs have been found to improve parenting practices (Sweet and Appelbaum 2004), reduce parenting stress (Administration for Children and Families, U.S. Department of Health and Human Services 2006), and increase maternal sensitivity toward their young children (Van Doesum et al. 2008). There is some evidence that depressed mothers may be particularly receptive to home visiting programs, and they have been found to be more engaged in services (Ammerman et al. 2010). Mothers with a childhood history of maltreatment may also be more responsive to home visiting, an association that may be mediated by maternal mental health (Easterbrooks et al. 2013).

Limitations

This study reflects families in the child welfare system in only one U.S. state. Details about the mothers' experience with the child welfare system as a child are largely unknown beyond having a case opened and spending time in foster care. Child welfare involvement can range from

being referred to voluntary services in the community to removal into out-of-home care and termination of parental rights (Child Welfare Information Gateway 2013), and engagement may be impacted by mothers' childhood level of service involvement. While it is unknown whether or not the mothers had substantiated maltreatment cases as children, there is a body of literature showing that there are no differences in the behavioral outcome of children with substantiated compared to unsubstantiated maltreatment (Hussey et al. 2005; Leiter et al. 1994). The participants were mothers of children age five and younger; parents of older children may show less or greater engagement in child welfare.

Conclusions

Child welfare workers are tasked with the difficult job of engaging families who are often not in the system by choice. This is further compounded by the lack of time caseworkers may feel they have to develop relationships with parents due to system mandates. While second generation mothers may be more difficult to engage, the benefits of a stronger alliance with the child welfare system could have positive outcomes for the entire family.

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