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Early case closure of the Intensive In-Home Program in Arkansas

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Walden University

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Abstract

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Abstract

Families First Prevention Services Act (FFPSA) passed in February of 2018 at the federal level to preserve families and reduce the number of children entering foster care. The State of Arkansas implemented Intensive In-Home Services (IIHS) in 2019 to support the Families First Prevention Services Act. It was observed that more than half of the closed IIHS cases had closed before a family had the opportunity to successfully complete their treatment goals. This study explored reasons Intensive In-Home Service cases are closing early. A basic qualitative design using semistructured interviews was applied through the purposeful sampling of 7 social workers using IIHS. The study was grounded in ecological systems theory. The findings highlighted the need to cultivate proper referrals to the program and provide additional engagement training to social workers implementing this program. The need to increase knowledge about substance use and treatment was identified by social workers providing Intensive In-Home Services. This study will positively inform social change as other states are implementing programs through FFPSA to preserve families and reduce the number of children in foster care.

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Dedication

This work is dedicated to my children, Ava Jane and Annabelle. Everything I do is for you. I also dedicate this work to my husband, John Michael, I love you. John Michael, you have supported this work during the course of our entire marriage and have encouraged me every step of the way. Additionally, this work is dedicated to the ladies of Saint Francis Ministries Arkansas.

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I would like to acknowledge Dr. Rullo. Dr. Rullo has been a constant source of support and guidance during this process. Dr. Rullo has allowed me to expand what I thought was possible when I began this journey and I am forever grateful. I also want to thank Dr. Bliss and Dr. Wilson for all of their feedback during this project.

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Section 1: Foundation of the Study and the Literature Review

Introduction

The United States Department of Health and Human Services (2019) reported that on September 20, 2018, there were 437,283 children in the foster care system in the United States, with 46% placed in foster homes (DHHS, 2019). The remainder of children placed outside the home were living with relatives other than their family of origin, placed in congregate care, or other out of home placements (Depart of Health and Human Services, 2019). In recognizing the high number of children in the foster care system, the federal government identified the need to preserve families and reduce the foster home placement of children by passing the House of Representatives Bill 253 (2018), also known as Families First Prevention Services Act (FFPSA; House of Representatives Bill 253, 2018). The FFPSA provides funding to states to use prevention programs in an effort to reduce the number of children in foster care and place an emphasis on preserving the family unit (H.R. 253, 2018; Wiltz, 2018). While the FFPSA is a federal policy, states have the freedom to select programs based upon evidence-based practices (Brown, 2018). States that prioritize family preservation by providing intensive in-home methods, substance use treatment, and mental health counseling can access federal funding to support these efforts (Brown, 2018; House of Representatives Bill 253, 2018).

Arkansas trends of children in foster care are similar to the national percentage, as approximately 33% of children were in foster home placements during 2018 (Arkansas Division of Children and Family Services [DCFS], 2019). When there are not enough

foster home placements, Arkansas children in foster care also utilize other out-of-home placement options (DCFS, 2019). Between 2013 and 2018 there was an eight percent increase of children in foster care in Arkansas (DCFS, 2019). By the second quarter of 2018, the number of children in foster care was 4,902 (Arkansas DCFS, 2018), with only 4,097 available foster beds at that point, leaving 805 children without a foster home placement (Arkansas DCFS, 2018).

Arkansas Department of Children and Family Services (DCFS) selected to submit a proposal for the Families First Prevention Services Act (FFPSA), in striving to lower the number of children in Arkansas needing a foster care placement (Arkansas Title IV-E Prevention Program, 2019). Arkansas DCFS created a five-year plan for implementing FFPSA policy (Arkansas Title IV-E Prevention Program, 2019). Arkansas received approval for FFPSA funding, making Arkansas one of the first states to receive this approval (Kelly, 2020). Arkansas DCFS has elected to use SafeCare, Nurturing Parenting Program, and Intensive In-Home Services (IIHS) as specific methods to preserve families as a result of Families First Prevention Services Act (Arkansas Title IV-E Prevention Program, 2019). One of these methods, Intensive In-Home Services, began in Arkansas in February of 2019 (Arkansas Title IV-E Prevention Program, 2019).

Referrals are made by DCFS to the three agencies providing IIHS (Arkansas Title IV-E Prevention Program, 2019). Social workers intervene with families in their own homes to prevent foster care placement of their children (Arkansas Title IV-E Prevention Program, 2019). IIHS utilizes intensive behavioral health treatment to improve long-term family stabilization (Arkansas Title IV-E Prevention Program, 2019). One intervention

model within Intensive In-Home Services currently being used in Arkansas is Family Centered Treatment (FCT; Arkansas Title IV-E Prevention Program, 2019).

The FCT program is designed to help families meet their treatment goals by teaching families new behaviors (Family Centered Treatment, 2019). FCT clinicians use four phases of treatment when working with families to first join with the family, teach the family new behaviors, allow the family to demonstrate the new skills on their own, and then apply those new skills to their family's future (Family Centered Treatment, 2019). Diversion referrals are meant to maintain children in the home, and the interventions last between four to six months. Reunification referrals are designed for children to return home, and interventions last up to nine months. The FCT program maintains that the family must successfully meet their treatment goals prior to discharge, which ensures adherence to the model (Sullivan & Wood, 2018). Recipients benefit more when adhering to the fidelity of evidence-based practices (Schwarz et al., 2019). Arkansans benefit from IIHS social workers remaining compliant with the treatment model guidelines set forth (Schwarz et al., 2019).

The first section of this paper includes the foundation of this study in an effort to provide a detailed understanding of the social work practice problem at hand, as well as provide a discussion to the theoretical framework guiding the backbone of this study. A thorough review of the literature is provided to allow for a detailed understanding and history related to all pertinent themes addressed in this study. I also address the research design, methodology, and data analysis, and outline of the specific ethical procedures that I followed in the second section. Section 3 includes a data analysis specific to the

findings in this study. Finally, Section 4 includes the application of these findings to professional social work practice as well as implications for social change.

Problem Statement

Arkansas DCFS contracted with three separate organizations to provide Intensive In-Home Services (IIHS), which started February 2019 (Arkansas Title IV-E Prevention Program, 2019). These services are provided to families who have a child or children between the ages of birth through 17 years who are in jeopardy of entering the foster care system (Arkansas Title IV-E Prevention Program, 2019). IIHS is a 4–9 month program from start to finish depending upon whether it is a diversion or reunification referral (Arkansas Title IV-E Prevention Program, 2019). Families who have the opportunity to complete evidence-based interventions have demonstrated family preservation success rates as high as 90 % (Sullivan & Wood, 2018).

IIHS are only available to families as long as families have an active open case with DCFS (Arkansas Department of Human Services, 2018). In the 18 months since the start of this program in Arkansas, admission dates and discharge dates in all IIHS cases (Keller, 2020) have been documented. As of July 31, 2020, there have been a total of 135 cases discharged from this IIHS program (Keller, 2020). Of the 135 discharges, sixty-five cases completed their treatment goals and were successfully discharged (Keller, 2020). Seventy cases have closed early or before a family has completed their treatment goals (Keller, 2020). This number of case closures equates to 52% of IIHS cases closed early. Early case closure places the family at a higher risk of recidivism in the future (Cao et al., 2019; Trotter et al., 2019). Schweitzer et al. (2015) noted that when programs, like family

preservation, do not adhere to evidence-based practices, the family is placed at a higher risk of having a child enter foster care. As this program just started in 2019, there is no known research indicating the reasons IIHS cases are closing early in Arkansas. Social workers in Arkansas are expected to implement IIHS; however, there are barriers that impede the accomplishment of services (Nhedzi & Makofane, 2015).

Purpose Statement

The purpose of this study was to explore the reasons IIHS cases are closing early in Arkansas. This doctoral study serves to advance social work practice by informing key stakeholders in Arkansas of the reasons for early discharges, which prevent families from successful completion of IIHS services. Stakeholders include but are not limited to the Department of Children and Family Services, social workers, political leaders, and families.

Research Question

The primary research question (RQ) for this study was: What are the reported reasons Intensive In-Home Service cases are closing early in Arkansas?

Key Terms

Congregate Care: is a group home or residential-style placement.

DCFS: stands for the Department of Children and Family Services and falls under the Arkansas Department of Health and Human Services. DCFS is charged with the overall safety and wellbeing of children in Arkansas.

Evidence-Based Treatments: are interventions or strategies proven to be effective with particular groups and delivered by individuals trained in the specific method to ensure best-care (Ekeland et al., 2019; Mullen, 2016; Roscoe & Marlow, 2013).

Family Intervention Specialists: are the social workers implementing Intensive In-Home Services with families.

Family Preservation: is an effort to support families considered to be high-risk of losing a child or children to foster care by wrapping intensive in-home services around the family to support and strengthen the family unit while maintaining the safe placement of children (Bezeczky et al., 2020; Kelly & Blythe, 2000).

Foster Care: is a term used to describe a temporary placement for children who have been removed from their primary home.

Kinship Care: is a type of foster care placement that is provided by a relative of the child or family.

Nurturing Parent Program: is an evidence-based, trauma-informed in-home parenting program (Arkansas Title IV-E Prevention Program, 2019).

SafeCare: is a home visiting program that has demonstrated effectiveness at reducing child abuse and neglect while improving parenting skills (Arkansas Title IV-E Prevention Program, 2019).

Treatment Goals: are a set of goals made in a collaborative effort between staff and family that serves to guide the focus of treatment.

Nature of the Study

I used a basic qualitative research design for this study. When exploring the reasons Intensive In-Home Service (IIHS) cases are closing early in Arkansas, I interviewed the social workers who are actually implementing IIHS. Social workers in Arkansas implementing IIHS constituted the study sample. Ravitch and Carl (2016) reported the key informant strategy allows for researchers to deliberately select participants who match the criteria in a study. I deliberately selected the sample of participants in this study through the purposeful sampling technique, the key informant strategy.

Using my professional network to gauge interest in this research project, I sent a letter of request for participation to the social workers who referred a case to IIHS or who are implementing IIHS with families in Arkansas. After a social worker expressed interest, I sent an informational letter to the interested party along with informed consent. Ravitch and Carl (2016) described semistructured interviews as a type of interview that does not lead the participant but guides the interview to remain on the research topic. I used semistructured individual interviews to explore the reasons for early case closure. Interview transcriptions are used to remain loyal to the participant's words and meaning (Ravitch & Carl, 2016). I transcribed the individual interviews to produce codes to develop an answer to the research question in this study.

Significance of the Study

It is helpful to find the reasons for early discharges, which potentially interfere with the successful completion of family preservation efforts through IIHS. To best serve

the families who are at a high risk of having a child enter the foster care system, social workers in Arkansas are currently implementing SafeCare, Nurturing Parenting Program, and Intensive In-Home Services as result of Families First Prevention Services Act (Arkansas Title IV-E Prevention Program, 2019). IIHS contribute to family stability, family preservation, reduction of subsequent encounters with the child welfare system, and the reduction of out of home placements (Arkansas Title IV-E Prevention Program, 2019). These early discharges interfere with the families' ability to complete treatment goals, which are designed to help preserve the family and prevent foster home placement (Indiana University Evaluation Team and The Department of Child Services, 2019).

Theoretical Framework

The field of social work has long used ecological systems theory (Bronfenbrenner, 1977) to holistically frame individuals' interactions with multiple systems (Siporin, 1980). Bronfenbrenner (1977) concluded that to truly understand the complicated human experience, one must think outside of traditional research methods involving a single setting and allow for all possible circumstances. Direct and indirect influences must be taken into consideration when exploring experiences (Bronfenbrenner, 1979). The ability to utilize this holistic framework promotes the researcher's ability to consider multiple factors contributing to an individual's perception of their world (Siporin, 1980).

As ecological systems theory is used to describe the exploration of a reciprocal relationship versus a one-directional transaction (Bronfenbrenner, 1977), I explored the reasons IIHS cases are closing early according to social workers implementing IIHS. The

reciprocal relationship of multiple systems (Bronfenbrenner, 1979) allowed for all of the social worker's reasons for early case closure to be included in this study, as well as the way in which the various systems may drive those reasons. The social worker's reasons for early case closure and understanding of this research problem are pertinent in developing valid answers to the research question, as Bronfenbrenner (1979) reported a participant's understanding of the situation helps to validate the study.

Bronfenbrenner (1979) stated that the microsystem is an individual's experiences connected to external stimuli. There were several microsystems in this study, including child welfare workers, the individual members of the family, and the IIHS staff. In addition to the consideration of the microsystem, microsystem elements add to a deeper understanding of the social work problem (Bronfenbrenner, 1979). Brofenbrenner (1979) stated that understanding the role of the microsystem helps the researcher to establish accuracy in the complicated interaction of the microsystem and its function. Social workers have many roles (Fluke et al., 2016), and delineating clear definitions for those roles added to the quality of this study.

The interconnectedness of the microsystems (Davidson et al., 2019) develops influential opportunities on one another at the mesosystem level (Bronfenbrenner, 1979). Mesosystems are represented by two or more microsystems that interact (Bronfenbrenner, 1979), while macrosystems are overarching and can be policies that influence service delivery or practice (Davidson et al., 2019). Ecological systems theory considers these multiple systems along with the interdependent nature in which the various systems relate to and influence one another (Piel et al., 2017). If a researcher fails

to consider the influence that other systems have on the microsystem, the researcher risks inaccurate findings (Bronfenbrenner, 1979). Additionally, the researcher must account for the participant's perception of these various systems in their environment (Bronfenbrenner, 1979). In this study, I considered the social worker's perceptions and accounts of the multiple systems in developing an understanding of the influential relationship on one another and then in the presentation of trustworthy data.

Values and Ethics

The National Association of Social Workers (NASW; 2020) provides a Code of Ethics that I used as an additional guide for this study. There are several ethical principles and standards that were applicable to this study. The NASW (2020) ethical standard 1.16 states that social workers should only terminate services when the services are no longer needed. However, in Arkansas social workers are terminating IIHS before the family has met their treatment goals. Further, the NASW (2020) ethical standard 1.16 maintains that social workers should ensure all reasonable efforts have been made in sustaining the continuation of services in an effort to prevent any negative impact to the client. When families are discharged before meeting their treatment goals, there is an increased risk of a negative impact to the family (Cao et al., 2019; Trotter et al., 2019). Social workers are also required to make proper notifications of case closures to prevent any gap in services (NASW, 2020), but when cases are closed early, it is difficult to ensure families have the appropriate supports in place to prevent gaps in services or regression. Due to the reasons listed, ethical standard 1.16 guided the clinical social work practice problem in this study.

Other aspects of this study support the NASW (2020) Code of Ethics. Regarding the NASW (2020) value of social justice, the NASW states that social workers have a responsibility to advocate for those considered to be vulnerable (NASW, 2020). IIHS are designed to help families who are at risk of having a child enter the foster care system (Arkansas Title IV-E Prevention Program, 2019), which places these families in a vulnerable position. The NASW (2020) also values the importance of human relationships, outlining the importance of strengthening families, which is what IIHS is designed to do (Arkansas Title IV-E Prevention Program, 2019). IIHS wrap multiple supports around the family in order to strengthen the family and uphold the NASW (2020) value on human relationships. Social workers are also using FCT through IIHS (Arkansas Title IV-E Prevention Program, 2019), which honors the ethical principle of competence (NASW, 2020). Staff implementing FCT are required to go through a certification process that can last up to 12 months to ensure competent services are being delivered to families (Family Centered Treatment, 2019), which indicates a dedication to the NASW (2020) ethical principle of competence.

Review of the Professional and Academic Literature

The Walden online library was the primary source of literature gathered for this study. I also used Google Scholar to collect scholarly material for this study. All databases that I used for this study were located through Walden's library and included *ProQuest Central, ScienceDirect, EBSCO Discovery Service, Psychiatry Online, SAGE, and Taylor & Francis Online.* I used current publications regarding Families First Prevention Services Act to inform the study. Specific terms that I used in the search

engine included *Child welfare agencies and staff, Families First Prevention Services Act, history of foster care in the United States*, *foster bed shortage*, *Children's Aid Society, child maltreatment, US Children's Bureau, Social Security Act, Bronfenbrenner's ecological systems theory*, and *family preservation*. I started the search including articles from 2014 to present but expanded search dates to include original work. I also extended the dates to include relevant information that was not available within the last 5 years. I primarily used peer-reviewed scholarly journals but also included material from government or nonprofit websites.

The professional and academic literature for this study features several critical focal points related to the social work practice problem. IIHS began in Arkansas as a result of FFPSA (Arkansas Title IV-E Prevention Program, 2019). As FFPSA is new, there is a deficit in the professional and academic literature specific to this act. Due to this literature deficit, I explored pertinent themes related to child welfare workers, foster care, family preservation services, and the reasons leading to the passing of FFPSA.

Child Protective Services

Child welfare agencies, often referred to as Child Protective Services (CPS), are responsible for maintaining the safety and wellbeing of children (Brown et al., 2019; Edwards & Wildeman, 2018; U.S. Department of Health and Human Services, 2013). In the United States, each state has a child welfare system responsible for carrying out this obligation (McCroskey, 2001). After a family has been referred to CPS due to a report of child abuse or neglect (Simon & Brooks, 2017), child welfare social workers are responsible for making necessary referrals to needed and appropriate resources ensuring

the welfare of the youth (Bunger et al., 2012; Edwards & Wildeman, 2018; Mendoza, 2014). CPS typically offers services and resources related to prevention, foster care, and adoption (McCroskey, 2001). Child welfare agencies also work to empower families to develop internalized resources to maintain their family unit to further secure the wellbeing of children (Lovato-Hermann et al., 2017; Stoltzfus, 2019).

Child Welfare Workers

Child welfare workers are charged with carrying out the details of the necessary steps outlined above, which are required to keep children and families safe (Fluke et al., 2016). In determining steps or resources to keep children and families safe, most child welfare workers have primary discretion in what trajectory the family case takes (Font & Maguire, 2015; Fluke et al., 2016; Griffiths et al., 2019). The case trajectory may include what will be investigated after a report is made, what services are offered to the children and family, as well as if the child is placed outside of the home (Fluke et al., 2016).

In addition to the vast range of potential decisions to make within a case, child welfare social workers have different roles (Fluke et al., 2016). Different roles come with varying levels of responsibility and decision-making power (Fluke et al., 2016). Some child welfare social workers carry a caseload of families (Fluke et al., 2016), while others provide supervision as well as carry a caseload of families (Fluke et al., 2016). Child welfare social workers can also be charged with carrying out the investigation regarding a report of child abuse or neglect (Fluke et al., 2016). Due to different child welfare social worker's roles, there is an increase in the subjectivity in which a social worker makes decisions about a family's case (Fluke et al., 2016). Subjectivity within the child welfare

social worker brings differing vantage points, and subsequently varied routes a case may take while involved in the child welfare system (Fluke et al., 2016). One route a child welfare social worker can take is to place children in foster care when the child's safety is a concern (Fluke et al., 2016).

History of Foster Care

During the 19th century, children were separated from their families for a variety of reasons (Batista & Johnson, 2017; Hacsi, 1995). Poor and orphaned children were frequently separated from their families and were considered displaced, as they were often found abandoned and sleeping in the streets (Batista & Johnson, 2017; Hacsi, 1995). When found on the streets, children as young as five years old were often locked in prison with adults (Batista & Johnson, 2017). Other children were placed in family homes in which education was not guaranteed, servitude was often expected, and treatment was unequal (Hacsi, 1995). Due to the noted poor and unequal treatment of children who became separated from their families of origin, early forms of foster care began during the 19th century (Batista & Johnson, 2017; Hacsi, 1995; & Joyce, 2019; Rymph, 2012).

Charles Loring Brace started the Children's Aid Society (CAS) in response to the manner displaced children were being treated during this period of time (Batista & Johnson, 2017; Chiodo & Meliza, 2014; Hacsi, 1995; Sabini, 2017). The CAS was founded in the mid-19th century on the belief that children should not be institutionalized but sent to live in rural areas with fewer crowds and the potential for opportunity, education, and employment (Batista & Johnson, 2017; Hacsi, 1995). The CAS worked to

create housing opportunities through relocation programs for displaced children (Batista & Johnson, 2017; Hacsi, 1995).

The relocation programs often sent children to live in the western United States with families who were able to house children (Batista & Johnson, 2017; Chiodo & Meliza, 2014; Cook, 1995; Hacsi, 1995; Joyce, 2019). At least 200,000 displaced children were sent away to rural areas during this time (Chiodo & Meliza, 2014). The quality of treatment the children received continued to be inconsistent as some children were treated like slaves or servants in their new homes (Joyce, 2019; Sabini, 2017), and many children were also required to move to several different homes (Hacsi, 1995). By the last quarter of the 19th century, as these inconsistencies continued, it became clear to child advocates and policymakers that change was needed to try and protect children (Batista & Johnson, 2017; Chiodo & Meliza, 2014; Cook, 1995).

Through the creation of the Social Security Act, child welfare advocates observed the possibility of potential relief surrounding child welfare (Rymph, 2012) as various child welfare organizations sought a shift to child welfare policies during the early part of the 20th century (Hacsi, 1995). The CAS and other child welfare organizations began a movement that placed value on a child's life and began to highlight some of the abuse that children experienced (Batista & Johnson, 2017; Chiodo & Meliza, 2014; Cook, 1995). One of the first shifts in child welfare history during the 20th century began as policy encouraged the preservation of children with their mother (Joyce, 2019). It was also during this time that states began to take responsibility for the placement of children

who could not remain in the custody of their biological mother or family (Hacsi, 1995; Sabini, 2017).

Aid to Dependent Children (ADC), Title IV, started as a result of the Social Security Act (Rymph, 2012). This provision first gave states the opportunity to create child welfare programs in return for federally matching reimbursement dollars (Rymph, 2012). By 1939, after the passing of the Social Security Act, all states had child welfare agencies and workers (Rymph, 2012). While all states had child welfare agencies, not all children and families in need received equal services (Rymph, 2012).

Despite the widespread implementation of CPS since the 1930s (Rymph, 2012), it was not until mandated child abuse reporting requirements started during the 1960s that the number of children in foster care started to grow (Rymph, 2012). After the mandated requirements began, the number of children in the foster care system in the United States increased to 208,000 children in 1965, compared to half of that in the 1930s (Rymph, 2012). The mandated reporting guidelines called attention to children being abused and neglected, which had not been a point of contention prior to the 1960s (Joyce, 2019). By the 1970s, there were around 500,000 children in the foster care system, which models the current trends today (Sabini, 2017).

Parental Factors Leading to Foster Care

There are times in which parents are simply unable or unwilling to provide a safe and healthy environment for their children (Simkiss et al., 2013), and there are a plethora of potential parental factors leading to foster care placement (Simon & Brooks, 2017). Child welfare social workers must consider these multiple parental factors when deciding

on the best course of action to take in effort to maintain a child's safety (Fluke et al., 2016).

Mental Health

Mental illness can impede a parent's ability to provide a safe environment for their children (Brown et al., 1998; Bunger et al., 2012; Lamela & Figueiredo, 2015; Patwardhan et al., 2017; Simon & Brooks, 2017). Mental health concerns are known risk factors that may contribute to child abuse and neglect, especially when combined with other risk factors (Silovsky et al., 2011; Simon & Brooks, 2017). Bunger et al. (2012) believed that mental illness interferes with a caregiver's ability to manage daily requirements of caring for a child, which is often attributed to inadequate support systems and unmet needs for parents with mental illness (Park et al., 2006; Simon & Brooks, 2017).

Substance Use

Substance use can play a significant role in increasing the likelihood of child abuse, neglect, and out of home placement (Doughty & Lutzker, 2011; Estefan et al., 2012; Ghertner et al., 2018; He, 2017; Patwardhan et al., 2017; Silovsky et al., 2011; Simon & Brooks, 2017). Ghertner et al. (2018) reported that substance use often amplifies the level of child maltreatment. Substance use not only interferes with the proper care of children but also increases financial hardships, environmental concerns, and an increased risk of domestic violence (Patwardhan et al., 2017; Simon & Brooks, 2017). There is currently a strong correlation between the rise of substance use and the number of children entering the foster care system (Leake et al., 2019).

Domestic Violence

Domestic violence is an essential indicator of child maltreatment when children are in the home, as domestic violence increases the chances of abuse from caregivers to a minor (Estefan et al., 2012; Patwardhan et al., 2017; Simon & Brooks, 2017). Eldred et al. (2016) reported a number of caregivers charged with child maltreatment are also charged with other offenses. Incarcerated parents or caregivers account for 15 to 20 % of children involved with the child welfare system (Rutgers University, 2014).

Childhood Trauma

A correlation has been noted between childhood trauma and abuse with becoming an adult offender (Cao et al., 2019; Doughty & Lutzker, 2011; Lamela & Figueiredo, 2015). Cao et al. (2019) noted that childhood trauma directly correlates with harsher adult parenting styles. When appropriate services are not linked to parents who have a history of childhood trauma and these caregivers have additional risk factors, there is a higher likelihood of abuse and neglect (Cao et al., 2019).

Socioeconomic Status

Socioeconomic status presents as a recurring theme across the literature in the association between lower socioeconomic status and the risk for child maltreatment (Patwardhan et al., 2017). Families committing physical abuse, and are involved in the child welfare system, are more likely to fall into a lower socioeconomic status (Patwardhan et al., 2017). Environmental concerns linked to neglect, like unstable housing, are connected to this risk factor (Bai et al., 2019).

Child Experiences Leading to Foster Care

Children are typically noted to be at highest risk of being placed in foster care after an investigation is completed due to substantiated abuse findings (Joyce, 2019; Konijn et al., 2019; Patwardhan et al., 2017; Semanchin-Jones et al., 2018; Simon & Brooks, 2017). Patwardhan et al. (2017) reported that in 2014, there were around 6.4 million children who were reported as being a possible victim of child abuse and neglect. Physical abuse is one of the possible reasons for a child to be removed to a foster home placement (Joyce, 2019; Konijn et al., 2019) and is considered to be when there are markings or injuries on the body (Muenzenmaier et al., 2015).

Child neglect is another form of abuse and is one of the most frequently cited forms of child maltreatment (Green et al., 2016). Neglect occurs when a parent or caregiver neglects the needs of a child like providing inadequate shelter, meager food supplies, insufficient supervision, as well as neglecting to seek proper medical attention (Children's Bureau, 2020; DCFS 2020; Weegar et al., 2018). Beyazit and Ayhan (2019) reported neglect of children by their caregivers can also extend to the parent or caregiver not meeting the educational needs of a child or failing to protect a child. In addition to physical abuse and neglect, childhood sexual abuse is another form of abuse (Alaggia & Wang, 2020). Sexual abuse involves any kind of coerced or forced sexually explicit behavior (Children's Bureau, 2020; Muenzenmaier et al., 2015). Alaggia and Wang (2020) report that nearly 25 % of children experience childhood sexual abuse during their childhood.

Types of Foster Placements

Once the child welfare social worker decides to remove a child for one or more substantiated abuse findings, the child is typically placed into one of several placement options (Semanchin-Jones et al., 2018). One of the placement options is a foster home. Foster homes are intended to be a temporary solution to provide children a safe place to live until it is safe to be reunited with the parent or until an alternative permanent placement is arranged (Hacsi, 1995; Konijn et al., 2019; Stoltzfus, 2015; Stoltzfus, 2019).

Another type of placement is with a relative of the child, also known as a kinship placement (Konijn et al., 2019; Landsman & Boel-Studt, 2011). Kinship care helps to provide placement for children due to the lack of available foster beds and is well-supported in allowing children to maintain family connections (Landsman & Boel-Studt, 2011). Congregate care like a group home or a residential placement is considered to be the most restrictive type of out of home placement (Semanchin-Jones et al., 2018).

Foster Bed Shortage and Contributing Factors

There are not enough foster beds in the United States to house the number of children in foster care (Kelly et al., 2017). Half of the states in this country saw the number of available foster homes decrease during the 5-year span between 2012 and 2017 (Kelly et al., 2017). Foster homes currently provide shelter to nearly 45 % of all children in the foster care system (Strickler et al., 2018); it is pertinent to thoroughly examine the factors contributing to the current shortage of foster home beds.

Concerns with Foster Care Training

Training is a necessary component of becoming a foster parent as training equips foster parents with skills and knowledge related to serving an at-risk population (Herbert & Kulkin, 2018; Kaasboll et al., 2019; Solomon et al., 2016; Strickler et al., 2018). Lack of appropriate foster parent training contributes to the shortage of foster beds and is often cited as the primary reason foster parents decide to quit fostering (Greeno et al., 2016; Kassboll et al., 2019). The turnover of foster homes creates increased pressure on state agencies to spend time and money on foster parent recruitment and training (Leake et al., 2019; Randle et al., 2017; Shklarski, 2019).

Shklarski (2019) documented that about half of potential foster parents make it through the foster parent training classes. While Title IV-E of the Social Security Act specifies some of the training requirements for foster parents, a lot of the training specifics are left up to the individual states providing the training and may not include research-based or trauma-informed training (Benesh & Cui, 2017; Herbert & Kulkin, 2018; Horwitz et al., 2010; Leake et al., 2019; Soloman et al., 2016). Herbert and Kulkin (2018) reported that foster parent training typically lasts between 20–30 hours and includes several pertinent topics related to children in foster care. Training also includes learning about vital local resources for children in foster care within the community (Solomon et al., 2016), which may include mental health resources (Leake et al., 2019).

After completing training, some foster parents report feeling unprepared to handle some of the extreme emotional and behavioral issues that are often presented by children in foster care (Greeno et al., 2016; Herbert & Kulkin, 2018; Leake et al., 2019). Strickler et al. (2018) also noted a lack of follow-up training for foster parents after the initial

training is completed. Post training follow-up has been associated with foster parent retention and an increased ability on behalf of the foster parent to practice trauma-informed care (AdoptUSKids, 2015).

Concerns Regarding Foster Parent Preparedness for Behavioral Health Issues in Foster Children

Many children presenting in foster care have extreme behavioral and emotional issues due to the abuse and neglect experienced before entering the foster care system (Washington et al., 2018), and these behavioral and emotional issues may leave foster parents feeling depleted (Hannah & Woolgar, 2018; Leake et al., 2019; Octoman & McLean, 2014;; Solomon et al., 2016). Behavioral health issues present in foster children at greater rates than the general population (Barnett et al., 2019; Scozzaro & Janikowski, 2015). Leake et al. (2019) noted that as many as 50 % of the children in foster care have a diagnosed mental health disorder. Lack of respite care (Shklarski, 2019), as well as foster parents not understanding how to address these behavioral and emotional issues, contribute to further burnout among foster parents and their desire to quit fostering (Cooley et al., 2015; Leake et al., 2019; Octoman & McLean, 2014; Salas et al., 2015). Washington et al. (2018) reported that behavioral health issues among children in foster care are the primary reason foster placements do not work out for the child.

Inadequate Support for Foster Parents

Foster parents have reported interactions with child welfare departments and child welfare social workers as two of the most notable challenges associated with being a foster parent and choosing to continue to foster (Hannah & Woolgar, 2018; Randle et al.,

2017; Randle et al., 2018; Shklarski, 2019). Expressly, foster parents have reported a lack of support from child welfare social workers as a contributing factor associated with foster parent burnout or the decision to quit fostering (AdoptUSKids, 2015; Piel et al., 2017; Shklarski, 2019). There are numerous reports of communication issues between foster parents and child welfare social workers (Randle et al., 2017), such as child welfare social workers neglecting to include foster parents in changes of meeting and appointment times or communication regarding information about the foster child before placement in the home (Tullberg et al., 2019). The communication barriers can leave foster parents feeling frustrated and not included as part of the foster child's team (Tullberg et al., 2019).

Financial Concerns for Foster Parents

Financial support has been proven to be a primary source of strain for families fostering youth and who are in need of financial support (Cooley et al., 2015). Foster families are often forced to provide their own funds to support the foster children in their care, with foster payments in some states as low as $8 per day (Miller et al., 2019). The low foster payments, combined with lack of assistance for food or work, place some foster parents in a place in which they must choose to discontinue fostering youth (Cooley et al., 2015).

Foster Parent Reactions

As a result of some of the issues listed above, many foster parents lose their desire to foster youth (Leake et al., 2019; Miller et al., 2019; Randle et al., 2017; Strickler et al., 2018). The culmination of issues related to fostering youth can lead foster parents to have

negative reactions to the foster care process (Hannah & Woolgar, 2018; Randle et al., 2017; Shklarski, 2019). Compassion fatigue is one of the negative reactions that can present as a result of fostering youth and is described as what individuals may experience as a result of working with other individuals who have been traumatized (Hannah & Woolgar, 2018). Abuse and neglect can lead to trauma in foster children, and foster parents may then develop compassion fatigue as a result of working with the youth (Hannah & Woolgar, 2018).

Secondary trauma is more severe than compassion fatigue and may result in an individual having symptoms similar to PTSD when working with another individual who has been traumatized (Hannah & Woolgar, 2018; Perron & Hiltz, 2006; Sprang et al., 2011). Leake et al. (2019) reported there is a lack of attention paid to the secondary trauma that foster parents experience, which further exacerbates the turnover rate in the provision of foster care. As a result of compassion fatigue and secondary trauma, foster parents may then experience burnout (Hannah & Woolgar, 2018; Perron & Hiltz, 2006). Burnout includes a level of physical and mental exhaustion that can overwhelm a caregiver (Hannah & Woolgar, 2018; Perron & Hiltz, 2006). All of this combined may then contribute to a foster parent's desire to quit fostering (Leake et al., 2019).

Family Preservation

For well over a century, it has been universally understood that children are healthiest and best served in a home or family-style environment (Chiodo & Meliza, 2014; Rymph, 2012). Preserving the family unit or reunifying children with their family is another option for child welfare social workers (Konijn et al., 2019), as it is an

alternative to foster home placement and one that can ultimately reduce the number of children needing a foster home placement (Fluke et al., 2016; Wiltz, 2018). Family preservation has been called many different names, but the primary purpose of family preservation efforts are to support families considered to be high-risk of losing a child or children to out of home placement by wrapping highly supportive in-home services around the family to support and strengthen the family unit while maintaining the safe placement of children in the home (Bezeczky et al., 2020; Kelly & Blythe, 2000; McCroskey, 2001; Patwardhan et al., 2017). Family preservation services may be offered to a family to strengthen parenting skills and family connectedness (McCroskey, 2001), while other family preservation services may also be offered after a significant event related to child abuse or neglect to prevent removal or help with family reunification (McCroskey, 2001).

History of Family Preservation

The 1980s saw an uptick in poverty, reports of child abuse and neglect, drug use, and extended out of home placements (Kelly & Blythe, 2000). The increase of these issues led to the creation of family preservation services during the 1980s (Kelly & Blythe, 2000). Family preservation services encompassed a wide range of treatment modalities, varied structure, and different frameworks (Schweitzer et al., 2015; Steens et al., 2018). During this period of time, family preservation services were delivered with no secure sources for funding (McCroskey, 2001). Despite not having secured funding or standard treatment modalities, family preservation efforts demonstrated positive results

(Steens et al., 2018), and subsequently started a surge of excitement through the child welfare community (Kelly & Blythe, 2000).

Functions of Family Preservation

Family preservation services aim to work with every family member (McCroskey, 2001) as early as possible as early intervention is an essential function of family preservation (Churchill & Sen, 2016). Early intervention is important because families in need of services often have layers of simultaneous and urgent demands (Littell & Scherman, 2002). The vast majority of families referred for family preservation services suffer from multiple stressors, including numerous reports of child abuse and neglect as well as economic hardships (Littell & Scherman, 2002).

Another critical function of family preservation is the staff's ability to maintain very low caseloads in an effort to provide the highest intensity of services to the family (Bezeczky et al., 2020). A family preservation practitioner is available to the family at all times in case of emergency (Bezeczky et al., 2020; Patwardhan et al., 2017). Family preservation services generally occur in the family residence and are time limited (Patwardhan et al., 2017).

Intensive In-Home Services

IIHS are a form of family preservation services (Polkki et al., 2016), and a focal point for this study. Families in need of IIHS are often at risk of children being removed from the home (Bezeczky et al., 2020). IIHS staff spend multiple hours in the home with the family in order to learn first-hand knowledge regarding the systemic family issues within the home (Berry et al., 2000). In order for staff to spend multiple hours in the

family home, IIHS maintains that staff will have low caseloads (Berry et al., 2000). Low caseloads allow for the staff to have the freedom to utilize individualized and in-depth approaches to best serve the family (Berry et al., 2000) and are structured through the use of evidence-based practices (Arkansas Title IV-E Prevention Program, 2019).

Evidence-Based Practices

Social service organizations began to use evidence-based practices as a result of the Government Performance and Results Act of 1993 (Kautz et al., 1997; Okpych & Yu, 2014; Pokharel et al., 2016). This act ensures agencies at the federal, state, and local levels execute performance metrics for their respective programs to further legitimize specific programs being utilized within various social service organizations (Kautz et al., 1997; Okpych & Yu, 2014; Pokharel et al., 2016). This act assists in requiring service providers to demonstrate the need for continued services by eliciting a level of achievable and successful outcomes (Kautz et al., 1997), which aligns with the call for evidence-based practices to demonstrate proven and measurable success (Okpych & Yu, 2014).

Implementation of Evidence-Based Practices

The success of evidence-based practices in the child welfare field is dependent upon several factors (Bryson et al., 2014; Green et al., 2016; Hodge & Turner, 2016). Collaboration and engagement between public sectors and private providers (Aarons et al., 2011; Green et al., 2016; Hodge & Turner, 2016), as well as the perceived effect of the program by community stakeholders and referral sources, is critical in the successful implementation and use of evidence-based practices (Aarons et al., 2011; Hodge & Turner, 2016). When a child welfare organization decides to adopt a particular evidence-

based practice, the evidence-based practice must fit well within the organizational structure for the method to be successfully implemented and sustained over time (Bryson et al., 2014; Green et al., 2016; Hodge & Turner, 2016; Weegar et al., 2018).

Organizations choosing to implement an evidence-based practice are then charged with training staff to provide the selected practice (Bryson et al., 2014). Evidence-based practices mandate stringent supervision and training guidelines to ensure fidelity to the model's guidelines (Hodge & Turner, 2016). If staff are not appropriately trained to implement the practice, this may lead to unsuccessful implementation and inadequate program delivery (Hodge & Turner, 2016). Effective leadership is another critical factor in the success of evidence-based practices (Hodge & Turner, 2016). Administration committed to the implementation of evidence-based practices ensures the foundation for evidence-based practice related growth is in place and well-supported (Aarons et al., 2011; Hodge & Turner, 2016).

Evidence Based-Practice and Families First Prevention Services Act

The requirement of evidence-based practice is a critical provision within FFPSA (Arkansas Title IV-E Prevention Program, 2019), and multiple levels of government continue to push for evidence-based practice to be used within the social work field (Abrefa-Gyan, 2016). The federal government maintains they will reimburse states, with accepted prevention services plans, for up to 50 % of their prevention services or programs as long as they are rooted in an approved evidence-based treatment (Stoltzfus, 2018). The California Evidence-Based Clearinghouse for Child Welfare has approved options for child welfare providers (Horwitz et al., 2010), and FCT is an evidence-based

practice approved for use within states seeking FFPSA reimbursement dollars (Arkansas Title IV-E Prevention Program, 2019).

Previous Legislation

Since the Social Security Act in 1935, there have been numerous policy attempts aimed at helping children and families (Stoltzfus, 2019). CAPTA, the Child Abuse Prevention and Treatment Act, was initially passed in 1974 and most recently renewed in 2010 (Stoltzfus, 2015). Through CAPTA initiatives, states were required to focus on the response given from the time a family has been reported for child abuse and neglect concerns through the investigation, which determines what services to provide a family (Fluke et al., 2016; Hilmer, 2020; Stoltzfus, 2019). CAPTA provides funding to states in the form of grants in an effort to improve the state's child abuse prevention plan, which includes preventative services, with the emphasis being placed on child welfare response given once child abuse and neglect have already occurred in the home (Stoltzfus, 2015; U.S. Department of Health and Human Services, 2013).

Title IV-E of the Social Security Act, created in 1980, is a modern federal attempt in assisting each state's support system of children in foster care by allotting funds specifically for states that have an approved plan of compliance with Title IV-E (Hartinger-Saunders & Lyons, 2013; Stoltzfus, 2015). The compliance plans from states include strategic plans for adoption assistance, increased adoptions, legal guardianship, as well as increased aid for children who become adults while in the foster care system (Stoltzfus, 2015; Stoltzfus, 2019). The incentives offered to states through Title IV-E have plans for adoption, legal guardianship, and children aging out of care all happen

after a child has been removed from the home (Stoltzfus, 2019). Stoltzfus (2015) reportedthat through Title IV-E, funding is available to states to assist in reunification efforts with the legal guardian or parent. If reunification is not an option, funding for alternative permanency planning is funded through Title IV-E. Starting in 2020, Title IV-E funds can be used to provide prevention services as a direct result of the Families First Prevention Services Act (Stoltzfus, 2019).

In 1980, The Adoption Assistance and Child Welfare Act (AACWA) was also passed in response to a growing concern regarding the number of children in the foster care system (Aarons et al., 2011; Hilmer, 2020). The AACWA was the federal government's first attempt to rectify extended lengths of time that children were remaining in foster care (Hilmer, 2020). The AACWA also required states to provide services to assist in family preservation and reunification efforts to aid in the effort to reduce the amount of time children were spending in foster care (Hilmer, 2020). The AACWA was the first piece of legislation that stipulates how often the court will review a child welfare case in which the child has been placed in foster care in an effort to reduce the amount of time a child is in the system (Hilmer, 2020).

The Omnibus Budget Reconciliation Act of 1993, part of Title IV-B, included stipulations that placed an emphasis on family preservation efforts before removing children from the home (Stoltzfus & Spar, 2002). Through Title IV-B, federal funds can be used in a discretionary manner to assist families and child welfare agencies in protecting children and preserving families (Stoltzfus, 2019). Promoting Safe and Stable Families (PSSF), also a result of Title IV-B, utilizes funds to assist children in foster care

or at home (Stoltzfus, 2019). PSSF also provides funding meant to increase the number of visits a child welfare worker makes to a child in foster care during each month, as well as provide assistance to children affected by substance abuse (Stoltzfus, 2019).

The Adoption and Safe Families Act of 1997 was passed due to the number of children in foster care continuing to rise (Hilmer, 2020). Like the AACWA, the Adoption and Safe Families Act of 1997 sought to decrease the amount of time a child is in foster care so the child can either be returned home or be eligible for adoption (Hilmer, 2020). This act also moved the timeliness of court procedures up to 12 months to further ensure children were not being left in foster care for extended periods of time (GPO, 1998). Within 15 months from the date of removal, a child must be returned home or be eligible for adoption under the Adoption and Safe Families Act (Bowman, 2019).

The Adoption and Safe Families Act of 1997 also emphasized family preservation efforts by noting the importance for states to make reasonable efforts to reunify children with their biological parents, except in cases where there has been extreme harm to a child (GPO, 1998).The Fostering Connections to Success and Increasing Adoptions Act of 2008 was passed with the intention of creating a focus on relative placements for children in foster care and coined the term kinship care (Landsman & Boel-Studt, 2011). This act focused on children being able to maintain some sort of familial connection as opposed to being placed with strangers (Landsman & Boel-Studt, 2011).

Families First Prevention Services Act

The legislation discussed in the previous section contributes to the 9.8 billion dollars allotted to be spent on child welfare in 2019 alone (Stoltzfus, 2019). That is 9.8 billion dollars primarily being spent after a child has already been removed from the primary parent or guardian.

The House of Representatives Bill 253 (2018), or FFPSA, is impacting the way in which the current foster care system works as there is now funding available to offer states incentive to provide prevention services (Brown, 2018). The first section of House of Representatives Bill 253 (2018) is devoted strictly to the prevention of foster care through prevention programs and related services (House of Representatives Bill 253, 2018). For a family to qualify for prevention services through FFPSA, there must be an ineluctable situation that places the children in the home at risk for entering the foster care system (House of Representatives Bill 253, 2018). Children in these situations are referred to as candidates for foster care (House of Representatives Bill 253, 2018). In addition to serving the families of the candidates for foster care, prevention services through FFPSA can also be used to work with pregnant teenagers, adoptive placements, and other kinship placement for a maximum of twelve months to prevent foster home placement (House of Representatives Bill 253, 2018). Finally, child welfare social workers are responsible for ensuring a family has a required prevention plan in place in order to receive FFPSA funding (H.R. 253, 2018).

Child Welfare Workers and the Implementation of FFPSA

Child welfare social workers are responsible for making decisions regarding children and families (Fluke et al., 2016). Research outlines how the child welfare social worker's interpretive outlook of the world around them can influence their decision-making in regard to the children and families they serve (Fluke et al., 2016). Child welfare social workers have stressful and demanding jobs (Griffiths et al., 2019), and child welfare agencies have historically struggled with staff turnover and low staff retention rates (Bowman, 2019; Griffiths et al., 2019).

The turnover rate of child welfare social workers is a concern due to the financial cost of training new workers, but more importantly, the potential emotional damage that losing a child welfare social worker may have on children and families they serve (Griffiths et al., 2019). The loss of a child welfare worker potentially increases safety risks for children, as another worker has to take over the case, which leaves the possibility for gaps in service (Griffiths et al., 2019). When child welfare workers leave, the burden of their workload falls on other child welfare staff to complete (Griffiths et al., 2019) and damages a child's ability to obtain permanency (Edwards & Wildeman, 2018).

Summary

The literature outlined in this review brings us to the cusp of previous and current problems within the child welfare system, along with the latest effort to rectify the historical shortcomings through FFPSA. While Intensive In-Home Services (IIHS)

are new in Arkansas, there was a need to explore the reasons IIHS cases are closing early in Arkansas. The literature outlined in this study described numerous issues related to the shortage of foster home placements and previous attempts to address the issues within the child welfare system.

A specific area of concern for social work practice includes the need for families to successfully complete IIHS to reduce the need for foster care placements. The following section highlights the research design for this study. The data collection process is also examined in detail. The reasons IIHS cases are closing early in Arkansas is explored through basic qualitative research.

Section 2: Research Design and Data Collection

The social work practice problem for this study was Intensive In-Home Service (IIHS) cases closing early in Arkansas or before a family has had the opportunity to successfully meet their treatment goals. Providers of IIHS can only work with the family if the family has an open DCFS case (Arkansas Department of Human Services, 2018). This section contains an explanation of the research design, methodology, data analysis, and ethical procedures for this study. During the research design section, I include the research question and social work practice problem, as well as provide an explanation regarding how basic qualitative research fits with this study. I explore the method of collecting data, instrumentation, and participants for this study during the methodology section. I will address and discuss the process for analyzing the data and the ethical procedures that I followed.

Research Design

Arkansas DCFS contracted with three separate organizations to provide Intensive In-Home Services (IIHS), which started February 2019 (Arkansas Title IV-E Prevention Program, 2019). These services are provided to families who have a child or children between the ages of birth through 17 who are in jeopardy of entering the foster care system (Arkansas Title IV-E Prevention Program, 2019). IIHS is a 4 to 6 month program from start to finish depending upon whether it is a diversion or reunification referral (Arkansas Title IV-E Prevention Program, 2019). Families who have the opportunity to complete evidence-based interventions have demonstrated family preservation success rates as high as 90 % (Sullivan & Wood, 2018).

IIHS are only available to families as long as families have an active open case with the DCFS (Arkansas Department of Human Services, 2018). In the 18 months since the start of this program in Arkansas, admission dates and discharge dates in all IIHS cases (Keller, 2020) have been documented. As of July 31, 2020, there have been a total of 135 cases to discharge from this IIHS program (Keller, 2020). Of the 135 discharges, 65 cases have discharged from this program successfully (Keller, 2020), meaning the family discharged after completing their treatment goals (Sullivan & Wood, 2018). There have been 70 cases close early or before a family has completed their treatment goals, which means that 52 % of IIHS cases have closed early. Early case closure places the family at higher risk of recidivism in the future (Cao et al., 2019; Trotter et al., 2019).

The primary RQ for this study was: What are the reported reasons Intensive In-Home Service cases are closing early in Arkansas?

I used qualitative research to guide this study. Ravitch and Carl (2016) explained that qualitative research allows researchers the ability to seek individuals with the most knowledge in a targeted subject. I sought to understand the reasons for early case closure, and qualitative research allowed for the social workers involved with IIHS to guide this venture. Kirk and Miller (1986) stated qualitative research is rooted in the researcher's ability to meet people within their norm or unique circumstance, which applies to my ability to meet with social workers in Arkansas who are in the unique position of referring to and implementing IIHS.

Ravitch and Carl (2016) reported through qualitative research, researchers can build upon shared experiences and information gathered, which is an inductive approach.

When exploring the reasons IIHS cases are closing early in Arkansas prior to the family successfully meeting their treatment goals, I used basic qualitative research and an inductive approach in building the answer to the research question through data that emerged from the social workers. Ravitch and Carl (2016) reported qualitative research can be fluid in nature and using an iterative approach allows for the researcher to go back and forth with the data to accommodate this fluidity of qualitative research. As I engaged in an iterative approach, I was able to make necessary changes throughout the data analysis in an effort to accommodate the fluid nature of this research. This type of research design is used to bring awareness to something, build knowledge, or to accentuate a phenomenon (Given, 2008; Shaw & Holland, 2014), and this study brought awareness to the reasons IIHS cases are closing early in Arkansas.

Operational definitions for the key aspects of this doctoral study include definitions for basic qualitative research, dialogic engagement, in-vivo coding, , key informant sampling, member checks, semistructured interviews, and trustworthiness.

Basic qualitative research is considered to be a form of qualitative research that seeks to develop knowledge within an area of interest for the researcher (Given, 2008).

Dialogic engagement is another step taken by researchers to ensure the trustworthiness of the research (Ravitch & Carl, 2016). In this research, I used dialogic engagement that involves collaborating with an advisor to engage an outside source to consider any potential biases or assumptions (Ravitch & Carl, 2016).

In-vivo coding is a form of qualitative coding that focuses on the participant's voice and is applicable for all types of qualitative research (Saldana, 2016).

Key informant sampling is a form of purposeful sampling used to select participants who have knowledge regarding the research topic (Ravitch & Carl, 2016).

Member checks involve the researcher checking back with the participant to ensure the researcher is portraying the participant's thoughts in the manner meant by the participant (Ravitch & Carl, 2016; Saldana, 2016). Member checks also serve to increase the trustworthiness of the study (Ravitch & Carl, 2016).

Semistructured interviews are conducted by the researcher with a specific topic in mind (Rubin & Rubin, 2012). The researcher also prepares some questions in advance to guide the interview process and plans to ask follow-up questions (Ravitch & Carl, 2016; Rubin & Rubin, 2012).

Trustworthiness in qualitative research is the ability to disseminate rigorous and credible information while remaining loyal to what the participant conveyed (Ravitch & Carl, 2016).

Methodology

Two parties are able to discuss a common topic through the interview process (Kvale, 2007). When exploring the reasons IIHS cases are closing early in Arkansas, I engaged social workers who are referring to and implementing IIHS in semistructured interviews as the methodology in this study. Rabionet (2011) advised semistructured interviews do not directly lead participants in a particular direction within the interview conversation, but does allow for the discussion to focus on pertinent themes within the study. This type of interview also gives life to the roots of the social work practice problem being explored (Kvale, 2007), as the social worker participants in this study will

have first-hand insight into the social work practice problem. The semistructured interview questions for this study are located in Appendix A.

Participants

With the purpose of this study in mind, social workers in Arkansas who are in the unique position of referring to and implementing IIHS constituted the study sample. These social workers in Arkansas were the participants in this study as they have first-hand insight into the social work practice problem. Ravitch and Carl (2016) reported the purposeful sampling technique, the key informant strategy, allows for participants to be deliberately selected based on their expert knowledge into the social work practice problem. Participants were identified for this study through the key informant strategy based on their expert knowledge regarding the social work practice problem, IIHS cases closing early.

Using my professional network to gauge interest in this research project, I sent an informational letter. The informational letter was sent to social workers referring to and implementing IIHS, and who have had a case close early. Since the program is so new, the sample size of social workers available or able to participate in the study was limited. The target sample size for this study was eight social workers in Arkansas, which is based on the number of social workers who have had a case closed early. After a potential participant reviewed the informational letter and informed consent and agreed to participate, the participant responded to me through email and stated “I consent.”

Instrumentation

A set of interview questions (Appendix A) were developed to use during the semistructured interviews, based on IIHS and the early case closures. Another instrument used to conduct a qualitative interview is the researcher (Ravitch & Carl, 2016). Ravitch and Carl (2016) reported the researcher is a unique instrument during the interview process as the researcher is the primary tool used during the interview process. As an instrument for this study, my role as it relates to this research becomes a critical point in the way the research will take place, as well as be presented. A recording device to assist with the accurate transcription of the interviews was used, as Rabionet (2011) reported audio recorders are the most popular means of recording interviews.

Data Analysis

Ravitch and Carl (2016) recommended using an iterative approach through the course of data analysis as a reflexive process to help make meaning of the data. Through an iterative approach to data analysis, I sought to present trustworthy data through the use of various tactics that furthered the level of rigor and validity. In this section, I will discuss the process for analyzing the interviews to answer the research question, the steps I took to analyze the data, as well as all methods used to ensure a high level of rigor within this study.

Saldana (2016) reported In Vivo coding is used to remain true to the words of the research participants and draw valid meaning from the data analysis process. In Vivo coding was used during the data analysis portion of this study to remain true to the social work participants. Saldana (2016) stated that interviews should be transcribed verbatim in

order to produce codes from the actual participant words to assign meaning to the data. In vivo coding requires researchers to be conscientious of phrases, particularly those phrases that seem to repeat within the transcription, as this indicates a loyalty to the participant's words (Saldana, 2016). Saladana (2016) also reported that common codes then fall into categories that assist the researcher in forming answers to the research question. Following the interviews, I transcribed each interview verbatim before assigning codes and meaning to the data. Once I assigned codes to the interview transcriptions, I was able to identify patterns within the codes. These patterns allowed me to identify categories or themes that ultimately led to answering the research question in this study.

The use of analytic memo writing is used to record thoughts and reflections regarding the codes that are presented during the course of transcription (Saldana, 2016). Analytic memo writing is used by researchers to document ongoing thoughts regarding the research as it unfolds, which allows for increased validity of the research by providing additional insight into the researcher's coding choices (Ravitch & Carl, 2016; Saldana, 2016). I engaged in analytic memo writing following every interview and data transcription, which allowed me to record my ongoing thoughts about the data as it unfolded. Recording analytic memos also served to increase the confirmability of the study findings by documenting my own subjective relationship by processing any potential bias.

Member checking involves validation of findings with the interview participants (Ravitch & carl, 2016). Therefore, member checks with the participants in this study were

conducted to increase the validity and credibility of this study. Finally, dialogic engagement was used. Dialogic engagement is a collaborative effort in discussing the research findings with a person not directly engaging in the research (Ravitch & Carl, 2016), which was the doctoral chair for my research committee.

Ethical Procedures

Considering possible ethical issues or concerns before conducting research allows researchers to work through the processes of the study to ensure ethical practices are used during the course of the study to protect all aspects of the research and the participants (Kvale, 2007). In this section I will discuss the use of informed consent. The ethical protection of participants will be outlined and the confidential nature of the participant related to this study. All provisions to ensure data safety will be addressed within this section as well. I obtained IRB approval number 02-03-21-0757011 on February 3, 2021.

A natural apprehension regarding participation in this research endeavor was expected, as the participants were interviewed about their ideas regarding a new program in which the participant is helping to implement. Kvale (2007) reported that obtaining a participant's informed consent is the first step in maintaining an ethical research endeavor. Ravitch and Carl (2016) reported the informed consent serves to ensure the potential participants are fully informed regarding the nature of the study, the transcription process, how the data will be maintained and shared with others when the project is completed, and allows for participants to ask questions about the proposed study. Proper informed consent also includes any potential risks associated with the research (Ravitch & Carl, 2016). Using this information as a guide, and in conjunction

with the IRB approval process, an informational letter and informed consent were sent to the potential participants.

Ravitch and Carl (2016) reported the informed consent and informational letter should include an overview of the study goals, as well as a clear statement about the study's voluntary nature. Sending a letter with information regarding this study and the informed consent allowed the potential participant to take their time in reading and considering their desire to participate. I allowed time for the potential participant to reflect on participating in the study and then I sent a follow-up email to the potential participant to answer any questions.

The participant's identity will remain confidential. Kvale (2007) reported that confidentiality will be sustained when any identifying private data is not revealed. As stated in the informational letter and informed consent, the participants' identity was not documented in the transcription of the interview. Another step taken to ensure the participants' ethical protection was for the participant to decide the time of the interview call to increase the level of comfort during the interview process. As mentioned in the previous section, dialogic engagement was used to further the credibility of this study. I was the only researcher conducting this study, therefore using the dialogic engagement technique with my committee chair served to further ensure participants were ethically protected.

All information collected during the interview for this study will be kept strictly confidential, except as may be required by law. Identifying participant information was not used in the study. The data collected during the interviews have been stored on a

private password-protected computer. The actual names of interviewees were not documented on the computer during the transcription process. The interview recordings will remain on my password-protected phone for five-years post research, and the recordings will be destroyed after five years.

Summary

During this section, I thoroughly outlined the research design and data collection process. Semistructured interviews with social workers in Arkansas were discussed within the methodology section. The detailed process for analyzing the data was addressed, and the ethical procedures that were followed in this study were discussed. In Section 3, I will present the data analysis techniques used in this study, as well as the findings in an effort to answer the research question.

Section 3: Presentation of Findings

The purpose of this study was to explore the reasons Intensive In-Home Service (IIHS) cases are closing early in Arkansas. The following RQ guided this study: What are the reported reasons Intensive In-Home Service cases are closing early in Arkansas?

Of the 135 discharges from one organization implementing IIHS, 65 discharged from this program successfully (Keller, 2020), completing their treatment goals (Sullivan & Wood, 2018). During the same period of time, 52 % of IIHS cases closed early before a family had completed their treatment goals. Early case closure places the family at higher risk of recidivism in the future (Cao et al., 2019; Trotter et al., 2019). During this study, I sought to explore the reasons for early case closure through semistructured interviews with social workers in Arkansas implementing IIHS cases.

An invitation and informational letter were sent to the potential participant's email addresses. Potential participants interested in completing this study responded to the email by stating, "I consent." After receiving informed consent from the participant, interviews were scheduled at a date and time convenient for the participant. Semistructured interviews were then held with seven social workers who are implementing IIHS with families in Arkansas. The interviews were held over the phone due to ongoing COVID-19 risks.

Kvale (2007) reported that to uphold maximum ethical standards for research endeavors, which serves to increase the overall trustworthiness and reliability of research findings, several quality assurance practices need to be followed. In-vivo coding was

used to remain loyal to the participants' actual words and phrases (Saldana, 2016). I also engaged in analytic memo writing to record ongoing thoughts throughout the course of the data analysis process (Saldana, 2016), which also allowed for insight into the final coding choices for this research (Ravitch & Carl, 2016; Saldana, 2016). Analytic memos began before the first interviews to record any subjective thoughts I had before entering the interview (Ravitch & Carl, 2016). Dialogic engagement adds an objective perspective to increase this research's overall trustworthiness (Ravitch & Carl, 2016). I engaged in dialogic engagement with the committee chair on March 18, 2021.

In section 3 I include the detailed process regarding the recruitment of the social work participants in this study. Kvale (2007) reported the need to eliminate risk of participant identification, therefore I present why I omitted professional demographics in an effort to preserve the participant's confidentiality. I then outline the data analysis techniques, validation procedures, limitations to this research, and finally, the research findings.

Data Analysis Techniques

Ravitch and Carl (2016) stated the key informant strategy is a type of purposeful sampling that targets participants with knowledge in the research topic. Recruitment for data collection began through purposeful sampling, the key informant strategy. Social workers were considered credible (Rubin & Rubin, 2012) when they directly experienced implementing IIHS in Arkansas. Social workers from one organization were then deemed to qualify as potential participants for this study based on their experience. The

informational letter and informed consent were sent via email to the potential participants. A total of 16 emails were sent to potential participants from an organization implementing IIHS on February 10, 2021.

A total of eight social workers, a response rate of 50 %, from the organization responded by expressing interest in this study and agreed to an interview. One potential participant declined to talk as this potential participant was not a social worker but a mental health worker. This brought the total number of participants to seven. The interviews were conducted between February 19, 2021, and March 16, 2021. I used a semistructured interview approach which allowed for consistent direction within each interview (Ravitch & Carl, 2016). The same set of five open ended questions (Appendix A) were asked during each interview. The IRB approved this set of interview questions before I engaged in this research. Ravitch and Carl (2016) documented the importance in allowing a research participant to elaborate during follow-up questions for clarity. I did allow for elaboration and follow-up questions as each interview was unique to the particular participant.

The individual semistructured interviews conducted in this study lasted between 11 and 30 minutes. Each participant's elaboration on follow-up questions varied regarding the length of the answer. Each interview was recorded on the "Tape-A-Call" recording device on my phone, as approved by the IRB. The interviews were transcribed verbatim after each interview concluded. Ravitch and Carl (2016) noted the value in documenting personal thoughts and feelings regarding the interview in an analytic memo. I engaged in this opportunity to document my thoughts and feelings after each interview.

Potential identifying demographics were not used to describe participants in this study. There are only three organizations implementing IIHS across a number of counties in Arkansas. Rubin and Rubin (2012) concluded that when studies involve a small number of professionals in the same field, it is increasingly difficult to maintain confidentiality. I believe that any identifying demographic information could potentially lead someone to identify one of the individual participants. Rubin and Rubin (2012) reported that codes can be assigned to participants to reduce the chance of participant identification. I assigned a number and letter to each participant and used these codes to protect the participants' identities. I also excluded any demographic information tying the participant to this research.

Data Analysis Procedures

Ravitch and Carl (2016) reported In Vivo coding is used to remain true to the participants' actual words by using the participant's words and statements when assigning codes versus using the researcher's own words as codes. In vivo coding allows for valid meaning to be drawn from the data analysis process (Saldana, 2016). Following each interview, the interviews were transcribed verbatim, and the transcriptions were used to produce codes that assigned meaning to the data (Saldana, 2016). In vivo coding required me to be conscientious of phrases, particularly those phrases that seemed to repeat within the transcription (Saldana, 2016).

Initial coding was completed by highlighting the key phrases that continued to repeat and project from the text (Ravitch & Carl, 2016). The use of common words or phrases indicates loyalty to what the participant actually said versus the researcher's

meaning (Saldana, 2016). After highlighting key phrases that peaked from the transcription, I engaged in a focused second round of coding to hone in on those phrases directly tied to the research question asked in this study (Ravitch & Carl, 2016). The second round of coding drilled down to precise phrases and used a different color of highlight (Ravitch & Carl, 2016).

Validation Procedures

The use of analytic memo writing is used to record thoughts and reflections regarding the codes that present during the course of transcription (Saldana, 2016). Analytic memo writing also serves to increase a study's validity by providing additional insight into the researcher's coding choices throughout the data analysis process (Ravitch & Carl, 2016; Saldana, 2016). Analytic memo writing allowed for me to document ongoing thoughts regarding the research as it unfolded. Recording analytic memos also serves to increase the study findings' confirmability by documenting the researcher's own subjective relationship to the research topic by allowing a platform to process potential bias (Ravitch & Carl, 2016).

Member checking involves validation of findings with the interview participants (Ravitch & Carl, 2016). Member checks with the participants in this study were conducted to increase this study's validity and credibility. Member checks were conducted by using the same email addresses used when the invitation and informed consent were sent. The emails included my understanding and interpretation of what the participant intended to communicate during the interview and specific phrases used by the participant. Participants were asked to respond with "okay" if they did not have

anything to change or elaborate on or encouraged to clarify what they meant during the interview if needed.

Finally, dialogic engagement was used to increase the trustworthiness of the findings in this study (Ravitch & Carl, 2016). Dialogic engagement transpired with the doctoral chair of my research committee. The process of dialogic engagement allowed for increased awareness in regard to potential areas of bias in the findings section of this study.

Limitations

There were minimal limitations encountered during the course of this research. I initially intended to email social workers from two organizations; however, only one organization agreed to participate in this study. All email addresses used to contact potential participants were collected from an organization using the same evidence-based practice (EBP). Social workers in Arkansas use different evidence-based practices when implementing IIHS (Arkansas Title IV-E Prevention Program, 2019). Varying perspectives from social workers using another evidence-based practice in this study may have contributed additional insight to the reasons for early case closure of the IIHS cases in Arkansas.

Findings

I sought to explore the reasons IIHS cases are closing early in Arkansas. A total of seven social workers implementing IIHS in Arkansas participated in this study through individual semistructured interviews. Rubin and Rubin (2012) reported a small number of participants can impact the participant's level of confidentiality and places the participant

at risk. Given the small number of social work participants, no demographic details will be reported in this study to uphold the confidentiality and protection of the research participants. The participants were assigned numerical and alphabetical codes, 1A through 1G, to protect their identities.

In-Vivo Codes to Interview Questions

The questions listed below are followed by the codes extracted from the data. The following codes are a representation of the participant's actual words used to answer each interview question which will demonstrate the path to answering the research question for this study.

Question 1: Tell me about your role in Intensive In-Home Services

All seven participants answered this question in a variety of manner. Participant 1A simply replied, "I mean I see families three times a week." Participant 1B reported, What we do is we are subcontracted through DHS and based upon it is like reconnecting the family either the child has been removed from the home or the child is still in the home but it is in the custody of DHS and so we go in the home and we sort of educate you know on the skills and tools they need for the family to come back together.

Participant 1C elaborated, "We are meeting the parameters on the contract in our day to day tasks and that we are following the you know the (organization name) standard model."

Participant 1D explained,

Just being engaged with the family more basically coming in going into the home just providing services for them to try to keep the kids in the home to prevent the kids from

being removed. Bringing tools to the family such as parent skills, financial you know meet budgeting and stuff like that just like a basic home needs because our parents don't know how to you know so those are some of the techniques that we teach as a specialist.

Participant 1E also elaborated,

Work with the clients that are referred to us and serve on different teams that go over the treatment plans or the family plans that have been written by the clinicians to help brainstorm any new ideas or things that we can do to make treatment most effective for the clients.

Participant 1F reported, "I oversee their treatment supervision, case movement discharges, admissions pretty much everything from start to finish with all of the cases my team admits."

Participant 1G stated,

My title is family intervention specialist and basically go into people's homes to meet them where they need me and help them find appropriate ways to communicate their issues so we go into the home we go to court with them. We go to a doctor's appointment therapist offices, we go to the schools and I mean all of this was in person pre-covid now a lot of it you know is over the phone and telehealth but you know whatever they need wherever they need us we are there for them.

Question 2: What is your experience with case closure?

Some participants needed me to further clarify the meaning of this question. For example, Participant 1E asked, "Are you referring to closure or are you referring to when a client completes the program?" Participant 1G asked, "Do you mean, like, if they're

positive or negative?" Participant 1B asked, "What kind?" In order to provide clarity, I asked the participants to think in general terms surrounding case closure.

Participant 1A stated,

I mean, I mean it's been fairly easy. I think you know, we talk weekly with the case workers. So you know we're not closing out before they're ready for us to and so I think that helps a little bit because it's going pretty smoothy, closing out cases.

Participant 1B stated, "the family fails to comply with the case plan those cases once it is given ok they are not going to comply with the case plan close the case."

Participant 1C explained,

Usually I try to assess why the case is closing, is this a scheduled discharge, unscheduled discharge, successful, unsuccessful, if it is unsuccessful or unscheduled trying to assess why what could we have done differently to meet the needs of the family or the department you know try to help increase engagement alignment around the family or increase engagement alignment with the department. You know we have a lot of substance use so a lot of our parents you know they are just not at a place where they are ready to stop we have a lot of domestic violence so its either the abuser is the financial person in the home so I can't get rid of him because he is you know how we pay our bills." As outlined, the second question also produced a variety of answers.

Participant 1D responded by stating,

Things have changed within the state because we are under contract with the state that we only have so many reunification cases and so right now with the reunification we had a family that kid went to care and we have to close the case. Okay so we have so many

reunifications at this time, so we have you know closing the case. And that's something that's kind of like a hurtful it hit us right there because that's the family that we really can work on.

Participant 1E informed me that "initially when our program was new there were times when DCFS would for example would be ready to close the case or in a hurry to close the case." When asked to elaborate on the difference now regarding DCFS closing the case, participant 1E reported, "Well good rapport with them and then also for some of the workers and supervisors seeing the results of the families that have actually been able to complete the program."

Participant 1F explained,

When it close well we have when we admit cases it is normally somewhere between 4 to 9 months depending on the type of case that we have so we start discharge planning when we first admit the case so we already tell the family as far as if they're in the six month mark or a nine month mark that we're looking for if the family is doing really well and they are a six month type case then they can discharge earlier so like four months if the family is really struggling then we can ask for an extension of time and normally our extensions are about 90 days.

Participant 1G reported,

I mean some families are very happy. Some families that are kind of sad and usually if the family is sad and it's the specialist specifically, you know there has been that rapport and right I am going to miss having staff.

Question 3: What is your experience with cases who have successfully completed their treatment goals?

In contrast to the first two questions, the participant's answers to the third question really aligned with one another and a clear picture developed in regard to families successfully completing their treatment goals.

Participant 1A stated, "I mean they're doing really well they haven't had any issues and safety concerns like they're just they're doing overall better." Participant 1B stated, "they have gone that length of time you know you have seen them fall, get up you know the whole nine but yet they didn't quit."

Participant 1C elaborated,

I think at some point whether it is at the very beginning of services or throughout our pushing them to get engaged and aligned it is just they really see the benefit in it they are ready to heal they are ready to move on. This is for me to get better this is so we can't have the department in our lives anymore it is for us to move on from whatever the situation was that led us here.

Participant 1D summarized, "Everything is going well and they meet their discharge date and that's a successful discharge."

Participant 1E reported, "Every family may not be the success as we would label success but is enough for them you know it has changed their family that they can stay together and that's you know what we want to have."

Participant 1F summarized, "it is hard to give a general because like I said each case is very different."

Participant 1G reported that a family may say, “they’re telling me you know what I am excited thank you but I am ready never to see your face again exactly.”

Question 4: What is your experience with cases who have not successfully completed their treatment goals?

Participant 1A reported, “There’s been instances where you know we’ve had to close early. Not due to the family, just due to the circumstances of you know the contract with the state of Arkansas.” When asked to elaborate, Participant 1A stated, “When we first started here two years ago, you know we could have as many stabilization as reunification but that’s changed.”

Participant 1B stated,

That’s a lot of anxiety so I think for a good FIS when you know you fixing to go tell your family you know we are going to discharge you and you know that they haven’t got their child back yet.

Participant 1C concisely pointed out, “They’re back.”

Participant 1D stated, “The kids go into care the parents are not completing their drug and alcohol assessment not completing their outpatient rehab and by the kids being in foster care the case is closed.”

Participant 1E also reported,

One might be extreme substance abuse and not being able to become sober. You know we’ve had that have had some substance these issues but not so severe that they couldn’t participate but then there are some that are so severe that you know they can’t comprehend the material until they get to a point where they’re sober.

Participant 1F reported,

It is because of a lack of engagement so if we have a parent who is really struggling to meet with us. We have had parents who have been you know gone to rehab while we are working with them and so since the kids have been removed from their custody so they can do rehab.

Participant 1G explained,

Usually in my experience it has been that they just refuse to give up drugs if that's why they were involved and they refuse to give up and so they you know kind of quit DHS as well its not just that they're not successful with us but it you know they're just given up their kids or they are just saying you know what forget it. Sometimes it is an unplanned or unsuccessful uh because people move and we're not that far into services and so they haven't completed goals but it is because they have moved out of our service area.

Question 5: Describe reasons for the cases that have closed before a family has met their treatment goals.

Participant 1A reported, "well I mean we've had families that just you know either were moving out of the service area, so they were moving somewhere else in the state." Additionally, participant 1A reported, "the kids have to be ready to come back in the home for reunification cases in order for us to take them. So we can only have a certain amount of cases that the kid is not already back in the home."

Participant 1B stated, "I think the biggest one is noncompliance. They feel like they don't need it. The family that continues to fail a drug test." When asked to elaborate on noncompliance, Participant 1B reported,

The noncompliance is those that would not comply with the case plan because you know whenever they come to us we get a package say ok this is the case plan for this particular individual and the case plan and what was in the house. That was the case plan for something that happened with the family. They say I don't want to don't want to do that right there and you know as an FIS you know you want to encourage them ok you know that is part of your case plan. You review with this with your DHS representative, it is our job to carry it out and they have made up in their mind for whatever reason I cannot I will not do it, whether that is making the sessions, whether that's quit failing drug tests, whether that is visiting the child every so often that they just refuse to do those things.

Participant 1C reported,

Yeah, so definitely the department just being understaffed and overwhelmed. Like we have had counties where they have only had one worker like I had a county where the supervisor was the only foster care worker for the entire county.

Participant 1D reported, "the child goes into a facility and go to a facility due to their behavior so we have to close the case because they have no date that the child will be discharged so some kids we had to close."

Similarly, Participant 1E reported, "they don't follow through and so they're not available for appointments like they should be there not there when they say they're going to be and that can only happen for so long until we have to move on."

Participant 1F stated, "we have had situations where the children have been removed to foster care."

Another out of home issue was mentioned as Participant 1G reported, “There has been a few where the client ends up in jail or a caregiver ends up in jail.”

Research Question Answered

Through In Vivo coding, I was able to use the participant’s words to answer the research question: What are the reported reasons Intensive In-Home Service cases are closing early in Arkansas?

Rubin and Rubin (2012) reported themes assist researchers in explaining and formatting the answer to the research question through reflection during the course of data analysis. While the seven participant’s words emerged unique and individualistic, there were two primary themes throughout the data analysis. These two themes will serve to answer the research question in this study.

Substance use is the first theme derived from the participant’s words. Substance use, or the term “drugs,” is mentioned six times in the transcription representation above and was prevalent during the analysis of the interviews conducted regarding the reported reasons IIHS cases are closing early in Arkansas. Multiple research participants discussed substance use interfering with the parent or caregiver’s ability to engage in treatment and successfully complete their family treatment goals.

As stated in the coding section above, some parents or caregivers continue to fail drug tests once IIHS is providing services in the family home. Failed drug tests are counterproductive for families enrolled in IIHS. Continued substance use by the parent or caregiver may violate the case plan a family has with DCFS and the IIHS family plan. Parents or caregivers who demonstrate an inability to comply with the stated goals on the

case plan through continued substance use place their children at risk of entering the foster care system as they are unable to meet the requirements to maintain their children safely in the home through successful IIHS completion.

Concerning substance use, participants also addressed parents or caregivers going to rehabilitation centers or jail, which caused cases to close early. IIHS cases remain open when there is a viable family unit to preserve, but when parents or caregivers go to rehabilitation or jail, the family unit dissipates. Without identified parents or caregivers in the home, IIHS cannot continue. As demonstrated throughout the participant codes, substance use leads to early case closure of IIHS cases.

The second theme to emanate from the participant codes is noncompliance. Research participants described a lack of engagement with IIHS social workers, exhibited by some families reportedly refusing to work with the social workers through the IIHS program. The noncompliance theme was reported to occur after the family had initially agreed to work with the social worker through IIHS.

The coding recounted above includes occurrences of families with an open IIHS case refusing to keep scheduled appointments. Participants reported some families refused to open their door for the IIHS session and reported general noncompliance with keeping scheduled appointments. Research participants also detailed issues with the parent or caregiver's lack of willingness to comply with the DCFS case plan requirements to keep their family together. A family's IIHS case can only remain open for so long before it will be closed unsuccessfully due to noncompliance. While there were specific examples of noncompliance reported, general noncompliance issues around

family engagement were prevalent through the participant's descriptions. Substance Use and Noncompliance are two reasons for the early closure of IIHS cases in Arkansas.

Unexpected Findings

The current study addressed the reported reasons IIHS cases are closing early in Arkansas. I encountered statements and information during the course of the individual interviews and data analysis that were unexpected and somewhat surprising. As reported under Question 1, an unexpected aspect of this study was the various ways in which the participants described their roles within IIHS. Each participant reported varied responsibilities regarding their IIHS role. Only two out of the seven participants used language relating to family preservation or reunification to describe their role, which are the ultimate goals for IIHS cases.

Residential treatment utilization was presented as prevalent during the course of IIHS treatment, as one participant described during the interview. It was unexpected that residential treatment is being used for one child in the home during the course of active IIHS cases. IIHS serves the entire family system to create meaningful and permanent changes within the family unit. There are times when acute treatment is needed, but I did not expect to hear high-frequency rates of reported residential treatment.

At the time of this research, IIHS has been serving families in Arkansas for two years. A widespread pandemic consumed one entire year of this time. The COVID-19 pandemic changed the way in which many services are rendered in the social work profession. It was unexpected that none of the participants linked the COVID-19 pandemic to early case closures.

Summary

In this section, I focused on the processes employed before, during, and after data analysis. Through employing qualitative interviews, rich data were collected from seven participants. In-vivo coding was then used to remain faithful to the participants' language in this research, followed by in-depth validation procedures to ensure the data's credibility and reliability. This research study's findings did serve to answer the identified research question regarding reported reasons IIHS cases are closing early in Arkansas. **Substance use** and **Noncompliance** with IIHS are the two primary reported reasons IIHS cases are closing early in Arkansas. Keller (2020) reported that over half of the closed cases within one organization closed early, this information will be crucial for organizations and stakeholders to use in order to potentially reduce the number of early case closures.

With the identification of substance use and noncompliance, I will dive into how these findings directly impact professional social work practice in Section 4. The NASW Code of Ethics will be explored as well as professional social work recommendations for practice as they relate to the findings. During section 4, I will also explore how this research can be used across clinical social work fields and any limitations that might exist. Looking to the future, social change implications will be addressed and applied to this study.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose for conducting this study was to explore the reasons Intensive In-Home Service (IIHS) cases are closing early in Arkansas. Keller (2020) reported one organization's data indicated that over half of IIHS cases were closed early or before a family had successfully met their treatment goals. Reasons for early case closures were needed to inform practice and reduce the number of families being placed at risk of recidivism in the future (Cao et al., 2019; Trotter et al., 2019).

I used semistructured individual interviews as the methodology to explore the reasons for early case closure. Semistructured interviews allow for researchers to have a conversation with the participant using set interview questions and allows for follow-up questions and discussions related to the research question (Rabionet, 2011; Ravitch & Carl, 2016). Data collection took place between February 19, 2021, and March 16, 2021.

This research study's findings did serve to answer the identified research question regarding reported reasons IIHS cases are closing early in Arkansas. Substance use and noncompliance with IIHS are the two primary reported reasons IIHS cases are closing early in Arkansas. IIHS practitioners and stakeholders can use the lessons learned to not only understand reasons for early case closures, but plan for IIHS practitioner training and education related to substance use and noncompliance. It is the hope that further education will ultimately reduce the number of early case closures and reduce the chance of recidivism in the future (Cao et al., 2019; Trotter et al., 2019). In this section, I will expand upon needed training and education.

During Section 4, I will allow for solutions to this social work practice problem to be explored through the lenses of utilization and application. Any professional ethical concerns regarding the reasons for early case closure will be explored as they pertain to social work practice. The findings in this study will be used to make recommendations for social work practice, and implications for further social change will be discussed using the findings from this study.

Application for Professional Ethics in Social Work Practice

The act of practicing social work aims to enrich the lives of those served (NASW, 2020). The NASW Code of Ethics (2020) functions as a guide for social workers during this work with others but does not explicitly dictate how to respond to every situation. Social workers interpret professional social work ethics differently (NASW, 2020). Specific principles and values from the NASW Code of Ethics (2020) related to this social work practice problem will be assessed in this section.

I have selected ethical considerations to examine related to reasons for early case closure of IIHS cases in Arkansas. As stated in ethical standard 1.01, Commitment to Clients (NASW, 2020), it is integral in best practice for social workers to advance the wellbeing of the client. This ethical standard denotes the social worker is bound to uplift the clients' interests first and foremost (NASW, 2020). When contemplating how this ethical standard relates to early case closures in Arkansas, social workers need to bear in mind the families' understanding of their own situation. The reason for the family referral to IIHS, according to the family, highlights the needs within the family unit and helps the social worker to have a deeper understanding of the family's interests and unique needs.

Early case closure is specific and unique to a family unit when it occurs. When honoring families' individual needs, even if that need is an early case closure, social workers adhere to this ethical standard by demonstrating a commitment to meet and uphold the families' interests.

Ethical standard 2.06 of the NASW Code of Ethics (2020) maintains a social worker's responsibility to conduct referrals to needed services when applicable. When an early case closure happens, it is the social worker's responsibility to ensure appropriate services are in place for the family, no matter the reason for termination (NASW, 2020). If an early closure occurs due to substance use, as found in this research, the social worker is behaving in an ethical manner when closing the case and ensuring appropriate referrals are made to meet that specific need.

Early case closures of IIHS cases in Arkansas are also justly related to the NASW (2020) ethical standard 1.16, termination of services. Any time a case is closed, the IIHS case is terminated for that family. Along with this ethical standard, the NASW (2020) states that social workers should close cases even when the service no longer interests the client. This statement aligns with the reason found in this research: noncompliance. Therefore, no matter the reason for early case closure, ethical practice includes uplifting the families' needs and interests.

This study's findings will directly impact social work practice as they relate to the NASW Code of Ethics. Social workers implementing IIHS cases now have direct insight into the reasons for early case closure and how early closures relate to ethical practices. Meeting families' unique needs, even when those needs do not allow social workers to

continue treating the family through IIHS, is a sound ethical practice. Specific recommendations for social work practice will be made in the following section.

Recommendations for Social Work Practice

The findings extrapolated from the data, substance use and noncompliance, are reasons for early Intensive In-Home Services (IIHS) case closures in Arkansas. The results also present opportunities for social work practice recommendations. As early case closure places the family at higher risk of recidivism in the future (Cao et al., 2019; Trotter et al., 2019), it is imperative that social work practitioners implementing IIHS understand the reasons that lead to early case closure.

The first social work practice recommendation is for the referral source and the IIHS provider organization to improve the quality of referrals to the IIHS program. Quality of referrals means that the referral of a family to IIHS is appropriate and needed. The referral source, DCFS (Arkansas Title IV-E Prevention Program, 2019), knows why a family is involved with the child welfare organization.

A meeting with the family, DCFS, and the IIHS organization prior to the referral being sent will improve referrals' quality. This meeting will serve to help the family understand what IIHS provides and how this service will help their family. If the family is unable to attend this meeting, DCFS and the IIHS provider can discuss the referral's appropriateness with no names being used to prevent any confidentiality issues from occurring. This meeting will also increase the levels of partnership and communication between the IIHS provider and DCFS.

Substance use can play a significant role in increasing the likelihood of child abuse, neglect, and out of home placement (Doughty & Lutzker, 2011; Estefan et al., 2012; Ghertner et al., 2018; He, 2017; Patwardhan et al., 2017; Silovsky et al., 2011; Simon & Brooks, 2017), therefore DCFS may have knowledge of substance use within the family unit that led to abuse and the subsequent referral to IIHS services. Based on the findings produced during this study, referring the parents or guardians to treat substance use before referring the family to IIHS will reduce the number of early case closures.

The second recommendation based on the finding of substance use is for organizations implementing IIHS to provide additional training and education to IIHS social workers around substance use resources in all areas served by the IIHS organization. This recommendation is made on the premise that the family is already involved in IIHS. There are outpatient treatment options for substance use that may be utilized concurrently with IIHS if needed. There are also inpatient substance use treatment options to use, if required, based on the family's need. Ensuring that all IIHS providers understand every resource in each community served will secure holistic care for each family that needs substance use treatment.

The subsequent recommendations for social work practice are related to early case closures based on the reported reasons of noncompliance. Parent and caregiver compliance with treatment is not a new problem and one that has plagued practitioners of family-based interventions (Smokowski et al., 2018). Strong engagement is paramount in reducing levels of noncompliance among parents and caregivers (Smokowski et al.,

2018). It is recommended that multiple providers collaborate with the family to maximize engagement levels and reduce noncompliance (Smokowski et al., 2018). For IIHS cases, this means the IIHS organization and DCFS need to ensure a solid partnership with one another when meeting a family's needs. I am recommending increasing the amount of communication between DCFS and IIHS providers during the first month of treatment. As suggested above, having a meeting prior to the family being referred to IIHS will help ensure this solid partnership.

Another consideration for social work practice, specific to IIHS cases, is to ensure organizations are providing clear expectations and definitions around the IIHS social worker's role. As described in Section 3, each participant described their role within IIHS differently. I believe the manner in which one views their role impacts engagement and noncompliance issues reported during the individual interviews.

Every participant in this study implements the same evidence-based practice, which indicates that roles should align among the participants. Unclear expectations for one’s job description cause concern with respect to the manner in which treatment is being delivered to the family. One recommendation to clear the reported discrepancies is to ensure every IIHS social worker has the opportunity to discuss their role in supervision periodically in an effort to solidify a clear understanding. This social work practice recommendation will help ensure families receive consistent service delivery among every IIHS practitioner.

Due to noncompliance issues reported during the data collection phase, another recommendation is to provide social work practitioners additional education and training

on best engagement practices with a family. Increased training in evidence-based practices, like motivational interviewing (MI), will increase the levels of engagement from families participating in in-home services (Biggs et al., 2018). MI is designed to increase guardian engagement within in-home services within the first few sessions (Biggs et al., 2018). MI is just one example of many engagement practices used to increase levels of engagement with families.

As an advanced social work practitioner, this research's findings will impact my own practice. I currently serve as the Arkansas Director of an IIHS organization and am directly involved in this program's daily practice and delivery to families. The findings to this social work practice problem will allow me to consider program delivery and changes that need to be made within my own organization. For example, I plan to review job descriptions with all IIHS social workers to ensure consistent understanding and implementation. This particular organization currently meets with a referring county once a month; however, I will begin discussions with county leaders within DCFS to increase the amount of communication before a referral is sent.

I will disseminate the recommendations made in response to the findings of this research. I will also plan to coordinate training and continuing education opportunities for social workers and other organizations interested in learning about IIHS and reasons for early case closures in Arkansas. I have also been asked to present for the Family Centered Treatment Foundation, one of the evidence-based practices being used in Arkansas.

This study's findings can transfer across clinical social work fields and are not specific to IIHS cases. As discussed in the literature review, substance use is not isolated

to IIHS cases. Smokowski et al. (2018) discussed the notion that noncompliance is a long-standing issue within the field. Universally, social workers will value understanding reasons for early case closure as this issue is not isolated (Smokowski et al., 2018) to IIHS and therefore applicable to social workers from the broader social work field.

Some limitations reduce the level of generalizability in this study. One limitation is the fact that all participants came from one organization using the same evidence-based practice (EBP) to implement IIHS. The EBP used by the participants in this study will not align with all practices other social workers are using in the field. Moreover, not all social workers use an EBP in their work, which further reduces this research's generalizability.

This research study is based on a program, IIHS, which is specific to the prevention plan that Arkansas submitted for Family First Prevention Services Act. Due to the specific contract requirements that IIHS providers follow, further limitations present to reduce generalizability. One example is that IIHS social workers only work with families with a child between the ages of birth and 17. Many social workers work outside of this parameter. Another example is that only rural counties are currently being served; therefore, these findings may not generalize to the state's more populated areas. Due to the specificity surrounding IIHS, the results of this study may reduce levels of generalizability.

Recommendations for further research are grounded in the strengths and limitations specific to this study. Recommendations include the analysis of engagement practices, including but not limited to MI techniques specific to IIHS cases. This research

would serve social workers implementing IIHS to reduce levels of noncompliance by using the most effective engagement practices with the targeted population.

Additional research is also needed to determine local substance use resources' effectiveness within the current IIHS communities. Research regarding local substance use resources' effectiveness will allow both DCFS and IIHS social workers to implement best practices when making appropriate referrals. Effective substance use treatment through local resources will enable families to reconnect sooner and reduce the time parents and caregivers spend away from home due to substance use.

The results of the research endeavor will be shared with the other IIHS organizations in Arkansas. I plan to share the results with each participant who contributed to the knowledge gained during this study. Preparations are being made to provide training to organizations and practitioners implementing IIHS and stakeholders associated with Intensive In-Home Services. The Family Centered Treatment Foundation, one of the evidence-based practices used in Arkansas, will receive a copy of the approved publication.

Implications for Social Change

As Arkansas was one of the first states to implement programs resulting from Families First Prevention Services Act (Kelly, 2020), the knowledge gained from this study can help other states move FFPSA programs forward. Other states are in the early stages of implementing FFPSA or even the planning stage (FamilyFirstAct, 2020). The findings from this research can be used to help these other states and programs plan for

preventing early case closures described in this study. By learning about these barriers early in the implementation process, there is time to prepare for the obstacles before starting services. It is my hope that other organizations and other states use lessons learned from this research to serve families in their area better.

Summary

Three years ago, the federal government passed legislation prioritizing family preservation (House of Representatives Bill 253, 2018). Arkansas responded quickly to this call for change. In response to this legislation, the state's prevention plan was approved for implementation in 2019, which included the IIHS program. One organization documented that during the first 18 months of the program, more than half of their IIHS cases closed early or before a family had successfully met their treatment goals. The purpose of this research was to explore the reasons IIHS cases are closing early in Arkansas.

I engaged in the exploration of the reasons for early case closure through individual semistructured interviews with social workers implementing IIHS with families in Arkansas. Through in-vivo data analysis and validation procedures, common themes were discovered that produced reasons for early closures of IIHS cases. Knowing the reasons, substance use and noncompliance, is just the beginning of advancing social work practice.

IIHS organizations now have an opportunity to focus on systemic changes to correct the current path of unproductive and potentially harmful early case closures for families in Arkansas. The reasons for early case closure also serve to advance social work

practice for other states working to implement programs through Families First Prevention Services Act. Most importantly, social workers are able to use the reasons to help improve the quality of care families receive through IIHS in conjunction with their DCFS partners.

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Appendix A: Individual Semistructured Qualitative Interview Questions

RQ1: What are the reported reasons Intensive In-Home Service cases are closing early in Arkansas?

1. Tell me about your role in Intensive In-Home Services.
2. What is your experience with case closure?
3. What is your experience with cases who have successfully completed their treatment goals?
4. What is your experience with case closures who have not successfully completed their treatment goals?
5. Describe reasons for the cases that have closed before a family has met their treatment goals.