Social Work Perspectives of the Children’s Aid Society

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Abstract

This study examined social workers’ conceptualizations of decision-making and the therapeutic relationship in the context of the mandatory reporting of child maltreatment. Participants (n=439) who were members of a provincial social work association responded to an online survey, which contained vignettes of child maltreatment with Likert-scale questions and open-ended questions regarding the therapeutic relationship. Within the qualitative results, two patterns surfaced in participants’ responses: (1) positive experiences regarding the Children’s Aid Society (CAS), such as the opportunity for anonymous consultation and assistance regarding how to inform the family of the report, and (2) negative experiences, such as perceiving that CAS has a punitive versus prevention orientation, and lacks a systemic focus. Implications for social work practice include increased training for child protection workers with an emphasis on ecological systems theory, a trauma-informed lens, and effective engagement strategies.

Keywords: Children’s Aid Society, child protection, mandatory reporting, legislation
Child maltreatment exists worldwide and its prevention is considered urgent in Western nations (Cyr, Michel, & Dumais, 2013). Mandatory reporting legislation reflects society’s interest in curtailing child maltreatment and imposes a limitation on the constitutional rights of parents in order to protect the welfare of children (Bala & Cruickshank, 1986). In Canada, in 2008, there was an estimated 235,842 child maltreatment investigations (Trocme et al., 2010). Professional (educational, medical, law enforcement, and social service personnel) comprised 53% of reporters to child welfare authorities (Trocme et al., 2010). As a profession, social workers have both an ethical and legal obligation as mandated reporters and thus have a higher obligation to report than others have, such as relatives, friends, or neighbours (Canadian Association of Social Workers [CASW], 2005). Mandatory reporting of child abuse and neglect poses considerable challenges for effective and accurate decision-making to the extent that more than half of suspicions of child maltreatment are not reported to the proper authorities (Kenny, 2001). Many professionals do not report due to concerns regarding the functioning of Children’s Aid Societies (CAS), which are the legally mandated child protection agencies in the province of Ontario (Alvarez, Kenny, Donohue, & Carpin, 2004).

This study (Tufford, 2012) examined the strategies by which social workers attempt to repair the therapeutic relationship following their decision to make a report to the CAS. However, discussed below is an unexpected finding that emerged from the qualitative data, in that, participants shared their positive and negative experiences of the CAS. Positive experiences were viewed as conducive to maintaining the therapeutic relationship, while negative experiences were viewed as negatively impacting the clinical relationship.

**Literature Review**

**Decision-making in Mandatory Reporting**

Social sciences research suggests that the concept of decision-making has shifted over the centuries from rational thought to the limitations of rationality (Homans, 1958; Kelly, 1973). Kahneman (2011) asserted that rational thought is limited and includes heuristics or mental strategies, which promote or hinder sound decision-making. For example, vivid memories of a negative experience, media attention to a particular medical or social problem, and overconfidence all impact present and future decisions. Munro (2005) concluded that human error should be the foundation for understanding decision-making. This perspective includes an individual’s skill, knowledge, limitations, analytical judgement, and access to resources.

Decision-making is deeply impacted by emotion and subjective experiences. Within the field of social work, Gambrill (2005) purported a high degree of uncertainty, as there is often insufficient information to have full confidence in one’s decisions. Gambrill and Shlonsky (2000) identified a number of personal and environmental factors that influence decisions, such as the practitioner’s mood fluctuations, influence of perceptions on judgment, inadequate knowledge, limited ability to process information, and difficulty in making predictions under considerable uncertainty.

Mandatory reporting of child abuse and neglect poses considerable challenges for effective and accurate decision-making (Kenny, 2001). Some professionals do not report due to concerns.
regarding child protection workers’ failure to take reports seriously, perceived inadequacy to conduct thorough investigations, and negative response towards reporters (Strozier et al., 2005). Other concerns include a lack of protection for other children residing in the home, an unclear CAS reporting process, and failure to understand the therapeutic interventions previously undertaken by the clinician (Strozier et al., 2005; Tufford, 2016).

In an attempt to understand why professional groups do not report suspected cases of child maltreatment, Tilden et al. (1994) surveyed various helping professionals, including dental hygienists, dentists, nurses, physicians, psychologists, and social workers, as they all were mandated to report suspected child maltreatment. These professionals suggested that reporting maltreatment might lead to child protection investigations, which are outside of their control and may not be in the best interests of the child (Tilden et al., 1994). Thus, Tilden et al. asserted that clinicians face an ethical dilemma between their duty to report and their low confidence in the child protection system’s ability to respond effectively. Indeed, previous negative reporting experiences can foster the development of unsatisfactory attitudes and opinions regarding the functioning of the CAS, which, in turn, may influence a willingness to report (Brown & Strozier, 2004).

Therapeutic Relationship and Mandatory Reporting

The therapeutic relationship is fundamental to many modern and post-modern treatment modalities and its role in beneficial treatment outcomes is established (Castonguay, Constantino, McAleavey, & Goldfried, 2010; Miehls, 2017). In addition, the common factors model puts forth that client, relationship, and clinician factors account for a greater proportion of therapeutic change than do specific techniques or types of therapy (Wampold, 2015; Zilcha-Mano et al., 2016). Mandatory reporting of child maltreatment necessitates breaking client confidentiality. This can diminish the client’s trust and even rupture the therapeutic relationship (Tufford, 2014). Studies conducted on the outcome of the relationship following a report reveal that 25% resulted in a negative outcome (i.e., decreased disclosure, termination, missed appointments, lateness, anger or violence towards the mental health professional; Steinberg, Levine, & Doueck, 1997; Weinstein et al., 2000). The repair of the therapeutic relationship between social workers and clients after a report to the CAS is relevant to social work practice. For example, the repair can promote clients remaining in treatment with the social worker, and may help clients internalize that inappropriate child rearing strategies are not to be tolerated (Tufford, Mishna, & Black, 2010).

CAS and Indigenous People

Building upon the current criticisms of the CAS is the historical relationship between the profession of social work and Indigenous peoples, a relationship, which has been controversial and tenuous at best and colonizing and oppressive at worst. Social workers in Canada were implicated in national attempts at assimilation through the residential school system, which involved the removal of dependent children from reserves and placement in residential schools. It was in these environments that Indigenous children were widely subjected to physical, emotional, and sexual violence (Dion, Stout, & Kipling, 2003; Fontaine, 2010; Truth and Reconciliation Commission of Canada, 2015). Another attempt at assimilation was the “Sixties
Scoop,” which refers to the forced removal by social workers and adoption of Indigenous children away from their families and communities (Sinclair, 2009). The latter attempt at forced assimilation began in 1959 and did not officially end until 1985. Since this time, racial disproportionality in child protection services continues with almost half (48.1%) of all children under 15 in foster care being Indigenous children; however, Indigenous children represent 7.0% of all children in Canada (Statistics Canada, 2011). Deliberate attempts at colonization have left a legacy of trauma and suspicion by Indigenous people towards the profession of social work; often synonymous with the removal of children and the destruction of families as opposed to a profession characterized by concern and compassion (reference).

Current Study

The purpose of this online, cross-sectional survey was to understand how Ontario social workers attempt to repair the therapeutic relationship following a report to CAS. Originally, I intended to delineate the factors that guide Ontario social workers’ decision-making when deciding whether to exercise the obligation to report, and to understand how social workers maintain the therapeutic relationship with children and families following the decision to report. However, in examining the qualitative responses, analyzed by constructivist grounded theory, an unexpected finding emerged wherein participants shared their positive and negative experiences of the CAS. This polarization of experiences suggests that the CAS often serves functions that dovetail with social workers’ therapeutic goals, but in certain situations the philosophical and practice orientation of the CAS is at odds with these goals.

Method

Recruitment

The study received approval from the institutional Research Ethics Board and the provincial social work association. Registered members of the association were emailed an invitation to complete an electronic survey. The provincial association sent five email invitations at 1.5-week intervals to its 2,533 members. Initially, 480 respondents attempted the survey. Of these, 439 had completed or nearly complete surveys, with one or two missing variables.

Data Collection

Survey instrument. The on-line survey, hosted by the associated University, was composed of four sections. Section 1 included three vignettes of child maltreatment cases followed by Likert-scale questions. Section 2 asked participants to respond to two open-ended qualitative questions: What is the initial impact of reporting suspected child maltreatment on the relationship between you and the family? What are the strategies you have found to be effective in maintaining the therapeutic relationship with a family after reporting suspected child maltreatment and why do you think they are effective? Section 3 requested demographic information including age (what was your age on your last birthday), gender (what is your gender), ethnicity (what is your ethnicity), parenthood (do you have children), and education (select your completed degree) (participants were able to select more than one response for the
education category). In section 4, participants could share general comments regarding the survey.

Three vignettes were designed in consultation with the intake department of a local CAS. The vignettes were written according to 2010 child maltreatment legislation in Ontario. Vignette 1 involved a child witnessing Intimate Partner Violence. Vignette 2 portrayed the use of physical force on a child by his caregiver. Vignette 3 concerned emotional maltreatment. To ensure face and content validity of the instrument, ten MSW post-degree social workers and one MA / PhD social worker completed the original survey. Based on their previous experience in the child welfare sector or in children’s mental health settings, these 11 individuals were they deemed experts in the area under study and therefore asked to review the original survey. Through discussion and examination of their feedback forms, revisions were made to the survey, which involved additions to the instructions or the elimination or modification of certain questions or statements, including in sections 2 and 4, there were 9 responses describing positive experiences with CAS and 29 responses describing negative experiences. The focus of the current study is participants’ comments of their positive and negative experiences of the CAS. The findings illuminate broader trends and concerns with implications for social work practice.

Data Analysis

The study used constructivist grounded theory to conceptualize and analyze data with a corresponding method of data analysis that employs an iterative process to generate meaning from the data (Charmaz, 2014). The grounded theory method is inclusive of multiple perspectives. Constructivist grounded theory, particular, accounts for subjectivity and the social construction of experience more than traditional grounded theory that posits a shared truth between researcher and subject that can be generalized (Charmaz, 2014). The constant comparison method was used to refine and organize codes into a coding framework (Padgett, 1998). Once all the participant responses were coded into the framework, some categories were re-examined and regrouped to describe themes.

While reading participant responses, initial impressions of potential categories and themes were tracked. While it was apparent that participants readily responded to the two posed qualitative questions concerning the reactions of family members to a mandatory report and the strategies to maintain the relationship, it became evident that some participants also chose to comment on their experiences with the CAS. As qualitative research can provide unexpected insights into policies or interventions, such as those of the CAS, it was important to examine these responses (Schensul, 2012). Therefore, after completing the analysis of the two posed qualitative questions, participant responses were reread for any reference to the CAS, either positive or negative.

To promote rigour and trustworthiness of the data, participants were reassured that all responses in the qualitative section would remain confidential. Providing ample text space for participant responses allowed for thick description of responses (Geertz, 1973; Ponterotto, 2006). In addition, the combination of open-ended qualitative questions coupled with survey methodology utilizes a process of triangulation, which permits a deeper analysis of the topic (Fielding & Fielding, 1986).
Participants

Of the 38 participants who expressed an opinion regarding the CAS, five (13%) were men and 33 (87%) were women. More than half (n=25; 66%) of the participants were Caucasian and most (n=34; 89%) completed their social work degree in Canada. In terms of occupation, eight participants worked in medical related practice, such as a hospital, 11 worked in child related practice, such as a children’s mental health centre, 6 worked in community related practice, and 13 worked in private practice. The majority had a graduate degree (n=37; MSW or PhD) while five had a BSW.

In comparing the 38 participants to the sampling population of 2,533 members, in terms of gender and degree completion, there is a great deal of similarity. The provincial association’s membership concerning gender is 83% women and 17% men. Regarding degree completion, 50% have a BSW, 81% an MSW, and 2% have a PhD. Thus, participants who offered their opinions regarding the CAS are representative of the sampling population. Note that the provincial association does not collect membership information about ethnicity or field of practice, such as medical or child related practice, thus it was not possible to compare these categories to the sampling population.

Results

Table 1 presents a summary of participants’ positive and negative experiences.

| Positive and Negative CAS Experiences which Impact Participants’ Decision-making |
|---------------------------------|---------------------------------|
| Positive                        | Description                      |
| Offer anonymous consultation    |                                 |
| Assistance around how to inform|                                 |
| the family of the report        |                                 |
| Offer specialized services      |                                 |
| Role is to help families        |                                 |
| Negative                        |                                 |
| Lack of information             |                                 |
| Lack of involvement in cases of|                                 |
| Intimate Partner Violence       |                                 |
| Punitive versus prevention focus|                                 |
| Lack of collaboration and systemic focus |                  |
| Negative experiences with individual CAS workers | |
| Use of stigmatizing language    |                                 |

Positive Experiences

Some participants commented on the fact that their local CAS offers anonymous consultation with child protection social workers to determine if a suspicion requires reporting. One participant (#473) explained, “I have learned to contact CAS and frame questions to them anonymously to obtain their feedback about whether or not cases warrant reporting … This improves my confidence about the process.” Following substantiation of abuse by the CAS, one
participant (#550) received the following assistance, “CAS was also very helpful regarding reporting the abuse and the ways to handle informing the family.” Another participant (#176) commented on the assistance a family can receive from CAS by noting, “The goal of involving CAS is to access their specialized services that will build on a family's adaptive coping repertoire.” Several participants also commented on the role of CAS. One participant (#503) shared “families do encounter difficulties … in parenting and dealing with overwhelming situations, CAS recognizes that - purpose is not to judge parents, but help identify where areas are too big and to implement supports to … keep children safe.”

Negative Experiences

Many participants shared experiences with CAS that were less than satisfactory. One participant (#464) decried the lack of information and selective therapeutic support when noting that “CAS will … NOT share information … they will send to the hospital clients for ‘assessment’ and not state WHY? Also … they will work with certain families ‘hoping’ they might change, despite evidence clearly to the contrary.” Another participant (#498) commented specifically on CAS involvement in cases of intimate partner violence by noting, “CAS will not become involved if parents are separated and there has been domestic violence in the family [and] deals with the mother in a punitive manner.”

One participant (#555) commented on the punitive focus versus prevention focus of CAS: “Because CAS often are solely child protection focused, but do not include in that the child's need for a family … CAS seems to cast their nets too far these days, with no recourse for clients.” Some participants commented on the lack of collaboration and systemic focus, which they perceive as necessary during the investigation process. One participant (#460) shared that “some CAS agencies do not hire BSW / MSW … which seem to affect the effectiveness … Many workers do not seem to think systemically, do not connect families to counselling, doctors, or consult with schools.”

Some participants commented on negative experiences with individual CAS workers. One participant (#470) shared “I personally have had difficulty as a professional trying to maintain relationships with CAS workers ... it has been my experience that often times this is a one way, power relationship.” Another participant (#512) shared the following: “very serious cases often get dismissed and other not so high risk cases get overreacted to. The quality of the response and care the client and family get is very dependent on the social worker you get.” Finally, one participant (#184) noted the use of stigmatizing language, “when I have reported to X CAS, staff has spoken of the concern with very stigmatizing language, which has significantly increased my concern about the service the family will receive.”

Discussion

Positive Experiences

In examining the positive experiences, some participants viewed the perspectives of CAS as a valuable resource in their decision-making around reporting suspected child maltreatment and appreciated the ability to remain anonymous. As one participant noted, the ability to consult
with CAS permits a higher degree of confidence in one’s decision-making. Gambrill (2005) posited that decision-making involves a high degree of uncertainty, as there is often insufficient information to have full confidence in one’s decisions. Gambrill and Shlonsky (2000) identified a number of personal and environmental factors that influence decisions, such as mood fluctuations, influence of perceptions on judgment, inadequate knowledge, limited ability to process information, and difficulty in making predictions under considerable uncertainty. Given the personal and environmental factors coupled with the high degree of uncertainty, anonymously consulting with CAS can provide increased confidence to the decision-making of a mandated reporter. In addition, this finding is consistent with that of other researchers who found clinicians sought and valued the advice of peers when faced with clinical decision-making and challenging clinical issues (Bogo, Paterson, Tufford, & King, 2011a, 2011b; McLaughlin, Rothery, Babins-Wagner, & Schleifer, 2010).

Another positive aspect noted by participants was receiving assistance from CAS regarding how to inform the family of the report. Social workers may dread this conversation, particularly if they anticipate facing a verbally aggressive client when informed of the need for a report (Tufford, 2016). Mandated reporters of many professions may worry about losing an often hard won therapeutic relationship with the family (Alvarez et al., 2004; Chanmugam, 2009; Flaherty, Schwartz, Jones, & Sege, 2013; Horwath, 2007; Jones et al., 2008) and facing premature termination by the client. A client’s decision to cease treatment truncates the social worker’s ability to address conditions contributing to maltreatment and enhance the safety of vulnerable children. In this context, social workers may find themselves triangulated between maintaining the therapeutic relationship to provide ongoing care and acting in an ethically and legally responsible manner (Bean, Softas-Nall, & Mahoney, 2011). Although the participants did not detail the advice given by CAS on how to consult with a family, previous studies have suggested maintaining an attitude of honesty and openness by expressing concern about the child’s care (Asnes & Leventhal, 2010) is a way to preserve the therapeutic relationship. In addition, giving the family options around making the report such as reporting with the family present, reporting in conjunction with the family or allowing the caregiver to self-report (Pietrantonio et al., 2013; Tufford, 2012) can assist in repairing the relationship in the midst of a mandated report.

Another participant shared that his or her CAS offers specialized services. Although the participant did not elaborate further, the specific services may have included counselling or support provided within the home environment (Tufford, 2014). Some social work environments are more restrictive in their scope of service than the CAS, such as those within medical settings where social work services may be offered solely within business hours, community settings that may place limits on the number of counselling hours provided, or other social work occupational contexts, which are fee-based. The ability of the CAS to provide in-home services specific to the needs of the family is a distinct advantage.

Finally, one participant commented that the role of CAS is to help families, and one could argue, it is also to prevent re-victimization (Sege et al., 2011). This view lies in contrast to clients who perceive the role of CAS as remover of children. Caregivers undergoing a child protection investigation often report feeling helpless, intensely fearful of the outcome, and victimized as a parent (Davies, 2011; Dumbrill & Maiter, 2003). To counter these negative feelings and
experiences, many social workers in clinical settings clarify the role of CAS as a protector of children and a supporter of families (Tufford, 2012).

**Negative Experiences**

In examining the negative comments, participants decried the lack of information provided to them by CAS as well as the lack of collaboration in the provision of services. Section 15.3(a) of the provincial Child and Family Services Act (CFSA) it states that the functions of the society are to “investigate allegations or evidence that children who are under the age of sixteen years or are in the society’s care or under its supervision may be in need of protection” (CFSA, 1990, p. 14). In interpreting the CFSA, the Child Protection Standards in Ontario state “the child protection worker … discusses with the reporter the requirement for confidentiality, and assures the reporter that, although he/she may not receive a direct report back from the CAS, the matter is being considered” (Ministry of Children and Youth Services, 2016, p. 9).

Children’s Aid Society workers may interpret the confidentiality provisions of the CFSA legislation as a deterrent to sharing information about the outcome of the investigation with the reporting social worker and other service providers without the caregivers’ consent. However, expectations regarding the roles, responsibilities, and lines of communication among helping professionals may also emphasize a team approach with appropriate disclosure, and sharing of information. If reporting social workers had sought the opinion of the intake worker regarding the decision to report and techniques to inform the family, it is natural that they may want to continue these collaborations. Increased collaboration between CAS and reporting social workers allows the reporter, who may have a lengthy history with the family, to advocate on behalf of the family and point out their strengths and resiliency to CAS, which in turn, may assist in maintaining the therapeutic relationship with the family (Tufford, 2012).

One participant reported that his or her CAS would not become involved in cases of child exposure to intimate partner violence (IPV). This is a concerning perception because from physical and psychological perspectives, studies have found that children who are exposed to IPV may experience internalizing behaviour problems (depression, anxiety, social withdrawal), externalizing behavioural problems (hyperactivity, aggression), and physical symptoms, such as headaches and stomach aches (U.S. Department of Health and Human Services, Administration for Children & Families, 2009). Moreover, IPV has a high recurrence rate if there is no intervention (Smith Stover, Meadows, & Kaufman, 2009).

Some provinces and territories consider exposure to IPV as a separate child maltreatment typology while others consider exposure to IPV as a form of neglect or emotional maltreatment (Black, Trocme, Fallon, & MacLaurin, 2008). Only one jurisdiction, Newfoundland and Labrador, requires a report regarding exposure to IPV, regardless of whether the child is harmed or at risk of being harmed (Mathews & Kenny, 2008). Eight provinces (Alberta, Saskatchewan, New Brunswick, Manitoba, Nova Scotia, Prince Edward Island, Quebec, and British Columbia) and the Northwest Territories have legislation requiring a report if the child has been harmed, is at risk of harm, or is likely to be harmed due to exposure to IPV (Black, 2009; Province of British Columbia, 2017; Publications Quebec, 2017). The Yukon’s legislation refers to children’s likelihood of harm due to history of family violence when determining children’s best interests, but does not explicitly mention exposure to IPV as a reportable circumstance (Black, 2009;
Yukon Government, 2016). Ontario considers exposure to IPV reportable under the auspices of emotional or psychological harm. In Ontario, the Child Welfare Eligibility Spectrum is the screening tool used by Ontario’s Children’s Aid Societies to interpret the CFSA and make consistent and accurate decisions about a child or family’s eligibility for service (Ontario Association of Children’s Aid Societies, 2016). Although exposure to IPV is not included in the CFSA legislation, The Ontario Child Welfare Eligibility Spectrum includes child exposure to IPV within its emotional harm section (Ontario Association of Children’s Aid Societies, 2016) and thus, is eligible for investigation.

The Ontario Incidence Study of Reported Child Abuse and Neglect (OIS) is a province wide study, which examines the incidence of reported child maltreatment, and the characteristics of the children and families investigated in Ontario. This study found that “an estimated 45% (10,034 investigations) involved exposure to emotional violence, 32% (7,215 investigations) involved exposure to physical violence, and 23% (5,124 investigations) involved indirect exposure to physical violence” (Fallon, Black, Nikolova, Tarshis, & Baird, 2014, pp. 72-73). However, the findings also noted, “very few investigations involving any subtype of exposure to IPV result in a placement (~2%)” (Fallon et al., 2014, p. 75). Of further note is that investigations involving substantiated exposure to IPV received the lowest rate of provision of ongoing child welfare services and 64% of cases involving IPV were closed (Fallon et al., 2014). In cases of substantiated exposure to IPV, children were less likely to be removed from their home compared to children experiencing other forms of maltreatment.

One participant noted the CAS lacks a systemic focus by not liaising with therapeutic, medical, or educational services on behalf of the family, but rather targets family members to take responsibility for change, with little support. However, social workers consider the demands placed on the individual and the resources available to meet those demands. When resources are lacking, social workers often refer to community supports to help provide the necessities the family may not currently possess or liaise with educational services such as the school social worker.

**Study Contribution to Social Work Policy, Practice, and Knowledge**

Given that families are embedded in multiple academic, occupational, social, economic, cultural, and other contexts, training for child protection workers should include a focus on ecological systems theory, which views the individual as embedded within his or her social context, and is a foundational aspect of social work practice (Bowers & Bowers, 2017). It is imperative that child protection workers seek consent to liaise and draw upon existing services impacting clients’ lives, such as the participants in this survey (i.e., social workers in community settings or private practice) as this promotes transparency. Research suggests that successfully addressing the chronic nature of IPV entails the adoption of a trauma-informed lens and appropriate engagement strategies (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Ontario Association of Children’s Aid Societies, 2015). Practitioners using a trauma-informed approach would acknowledge and respond to the varying impacts violence has on women, and integrate that knowledge into service provision (BC Society of Transition Houses, 2011; Elliott et al., 2005). Unacknowledged trauma may impede engagement in services; thus, the use of trauma-informed strategies is important to the effectiveness of interventions (Elliott et al., 2005; Ontario
Association of Children’s Aid Societies, 2010). Effective engagement would also facilitate the challenging task of working with abusive men, such as promoting their accountability for IPV and setting limits on their behaviour without judgement or blame (Ontario Association of Children’s Aid Societies, 2010). Training in trauma-informed service provision and engagement strategies would help avoid worker misunderstandings about this type of violence; promote worker safety during investigations, and “break the cycle of violence” (Button & Payne, 2009, p. 365). The World Health Organization (WHO) recently echoed the need for clinician training in IPV (as cited in Feder, MacMillan, & Wathen, 2013).

The mandated requirements for confidentiality under the CFSA legislation must be facilitated within a framework of trust and collaboration. Where possible, child protection workers should inform a professional reporting source with the outcome of the investigation. Increased communication will foster transparency between child protection workers and reporting social workers. In addition, knowing the outcome of the investigation will allow reporting social workers to examine and reflect on the accuracy of their decision-making in the case. Contact between the child protection worker and the reporting social worker will allow social workers to share with child protection workers the strengths they see in the parents or caregivers and, as noted earlier, permit them to play an advocacy role (Tufford, 2014).

Child protection workers and social workers should receive training on the strategies by which social workers attempt to repair the therapeutic relationship following a report to the CAS. This training could foster communication among these two groups of helping professionals and the two groups’ understanding of the nuances of social workers’ practice dilemmas, with practical strategies to address them.

Finally, Children’s Aid Societies that do not provide specialized services to families including in-home counselling support and parent training should seek resources to expand their services into the prevention realm. The benefits of this are manifold. First, the provision of these services within residence eliminates the cost and hassle of transportation to outside counselling services, which for many families is a barrier to accessing treatment. Second, should the family terminate services with the reporting social worker due to feeling betrayed by the report to CAS; the provision of in-home counselling support by the CAS will ensure that the family continues in treatment. Third, and most importantly, in-home counselling support is a preventative measure occurring in the family’s natural environment with many opportunities for learning, which may prevent future maltreatment.

Limitations

There are several limitations regarding this study. First, the overall response rate of 22% is low for an online survey, which limits the generalizability of findings. Second, it was not possible to conduct a constant comparative analysis of the qualitative responses because the same questions were administered each time the survey was sent to participants (Glaser & Strauss, 1967). In addition, participants were not asked in the survey the number of experiences they had with the CAS. Participants with more instances of reporting to and liaising with the CAS would have richer information than those who only contacted the CAS once. Despite these
limitations, the findings offer contrasting experiences of the CAS, which are worthy of further exploration and dialogue.

**Future Research**

Given the dichotomy in these findings, future research must further explore these positive and negative experiences in detail to elicit a deeper understanding of their content, and to allow for the surfacing of additional experiences, either positive or negative, not mentioned here. First, individual interviews or focus groups with the social workers who participated in the online survey will permit further elaboration and clarification of these statements. Second, to triangulate these findings, interviews with child protection workers, whose behaviour forms the basis of these comments, will allow their perspectives to be heard. Finally, future research must include the recipients of the CAS, both adults and children. Hearing the views of this last group is crucial, as ultimately the CAS exists for their benefit.

**Conclusion**

Social workers are occupationally situated close to children or families in need and are imbued with the ethical and legal responsibilities to report a situation of suspected child maltreatment to the CAS. The findings from this online cross-sectional survey reveal a dichotomy of experiences with the CAS amongst reporting social workers. Some social workers view the CAS as a valuable source of assistance for both themselves and their clients, while other social workers cite specific concerns of a systemic, collaborative, and stigmatizing nature. Thus, it is essential to understand the processes that lead to effective, collaborative relationships between the CAS, and community social workers. It is vital that this relationship is strong and trustworthy.
References


