Differential Response: Early Implementation and Fidelity

Cross Site Report of the National Quality Improvement Center on Differential Response in Child Protective Services

Brett Brown
Walter R. McDonald & Associates, Inc.

Lisa Merkel-Holguin
American Humane Association

Amy Hahn
American Humane Association

May 2012

CONTENTS

Acknowledgments 4
Chapter 1. Introduction 5
Snapshot: The QIC-DR 5
Terminology 6
Methodology 7
Chapter 2. Descriptions of the QIC-DR Research & Demonstration Sites 9
Colorado 9
Ohio 12
Chapter 3. Differential Response Model and Model Fidelity 13
The Case Flow Model 13
Screening Process 15
FAR Eligibility 16
Random Assignment 19
Pathway Reassignment 21
Safety, Risk, and Needs Assessments 21
Services 22
Case Closure 23
Re-Report 24
Chapter 4. Implementation of DR 25
Competency Drivers 25
Staff Selection 25
Training 26
Coaching and Transfer of Knowledge 27
Supervision 28
Staff Structure 28
Organizational Drivers 30
Administrative Structures 30

Data System Changes 31

Relationship with the Community 32

Chapter 5. Discussion and Conclusions 33

Appendix A: Cross-site Implementation Questions

Appendix B: Differential Response: Detailed Case Flow Models

ACKNOWLEDGMENTS

The authors wish to acknowledge the expertise and efforts of the many individuals who made this report possible. This includes: Representatives of the Colorado Consortium on Differential Response, in particular, Project Director Ida Drury and Colorado's site evaluator, Dr. Marc Winokur; Illinois Differential Response Director, Womazetta Jones and Illinois' evaluator, Dr. Tamara Fuller; and Ohio's QIC-DR R&D site Project Director, Nancy Mahoney and Ohio's site evaluator, Julie Murphy. In addition, we are most appreciative of Federal Project Officers Catherine Nolan and Dori Sneddon of the Children's Bureau for their ongoing guidance and support. Lastly, we thank all of the child welfare staff including administrators, directors, supervisors and frontline workers, and the community stakeholders in the QIC-DR's three Research and Demonstration (R&D) sites for their steadfast commitment, and investment in the implementation of differential response, and their willingness to engage and participate in the rigorous evaluation process of the QIC-DR. Truly, without their dedication, creativity and hard work, this would not have been attainable.

CHAPTER 1. INTRODUCTION

SNAPSHOT: THE QIC-DR

In 2008, the U.S. Children's Bureau awarded a grant to American Humane Association and its partners, Walter R. McDonald & Associates Inc. and the Institute of Applied Research, to operate the National Quality Improvement Center on Differential Response (QIC-DR) in Child Protective Services (CPS). The QIC-DR focuses on advancements related to differential response (DR), a CPS system reform that is being implemented in a growing number of States and countries and is described in more detail in this report. The QIC-DR's purpose is to (1) design and support three research and demonstration (R&D) sites to conduct local evaluations to rigorously study implementation, outcomes, and cost impact of DR and to conduct a cross-site evaluation; (2) learn if differential response is an effective approach in CPS; and (3) build cutting-edge, innovative, and replicable knowledge about differential response, including guidance on best practices.

The QIC-DR spent its first year (2008-2009) conducting a comprehensive needs assessment to identify knowledge gaps in the field of differential response to select research priorities and to construct a rigorous, multi-method evaluation design to support research on differential response. The QIC-DR used a variety of methods to collect information and diverse opinions, including a literature review; multidisciplinary summits; individual interviews of child welfare administrators, supervisors, line workers, attorneys, and judges; a web-based national survey; focus groups with a variety of stakeholders; and listening sessions to hear from families who experienced a non-investigation response. It collected information about the history of differential response and similar CPS system reforms; the strengths and challenges of developing, implementing, and sustaining these reforms; and the effects on children, families, child welfare professionals, and other stakeholders. All of these activities added to a rich knowledge base about differential response and other innovative CPS reforms.

In 2009, the QIC-DR funded three R&D sites to implement and evaluate differential response (DR) in child welfare services. The evaluations are comprehensive and include implementation, outcomes, and cost components. This report presents results for the implementation evaluation focusing on early implementation and model fidelity, between February 2010 and July 2011 and covering the first stages of project implementation. Future reports will address outcomes for families and participating child welfare agencies, and agency costs of DR. The implementation evaluation will continue through at least the summer/fall of 2012, and final reports for the project as a whole will be completed in summer/fall of 2013.

The three participating R&D sites include: the State of Illinois; a five-county consortium in Colorado; and a six-county consortium in Ohio. Local evaluators have produced detailed implementation evaluation reports for each site. They are intended primarily to inform local and State stakeholders, and to provide useful feedback to the programs, though their detailed accounts will also be of interest to broader audiences. This cross-site report summarizes and synthesizes the findings of the local reports, provides some additional analyses, and raises

various issues for the readers' consideration. Its purpose is to present key findings to the growing number of child welfare professionals, policymakers and evaluators across the country who may be considering DR, or who have already adopted DR and are looking to learn from the R&D sites' experiences and evaluations. All local site reports are publicly available on the QIC-DR web site at www.differentialresponseqic.org.[1]

The report begins with a discussion of terminology, evaluation methodology and data collection processes, followed by a brief description of the characteristics of the three sites. Initial findings related to model fidelity and program implementation are presented. The report finishes with a discussion of the major accomplishments and challenges identified across the sites, with implications for the programs and for DR.

TERMINOLOGY

Terms like differential response, alternative response, and family assessment response have been used to refer to a variety of programmatic approaches, and are often used interchangeably in the field.[2] To avoid confusion for the reader we want to be clear about how this report defines differential response, and how it uses other key terms.

Differential Response (DR). DR is a type of CPS system that includes at least two distinct pathways for responding to screened-in reports: the investigation pathway, and a non-investigation pathway that includes no formal finding of maltreatment. Generally, the non-investigation pathway is intended for low- or low- and moderate-risk cases, while the investigation pathway is reserved for more serious cases of child maltreatment.[3] Each R&D site has clear criteria for determining the initial pathway assignment for cases, and in county-administered child welfare systems, there may be variability among counties. Where that line of risk is drawn can vary substantially across jurisdictions implementing DR.

Family Assessment Response (FAR). The FAR, sometimes also called *alternative response*, is the non-investigation pathway described above. With the FAR pathway, child welfare professionals work with families as partners, focusing on building strengths while meeting needs to increase child safety. As described in the QIC-DR's Request for Applications, the core elements of this pathway include:

- Establishment of FAR pathway is formalized in statute, policy, or protocols;
- Initial pathway assignment to FAR can change based on new information that alters risk level or safety concerns;

[1] http://www.differentialresponseqic.org/

[2] For a review of the literature, see "Differential Response in Child Protective Services: A Literature Review, Version 2." November 2011. National Quality Improvement Center on Differential Response in Child Protective Services. http://www.differentialresponseqic.org/resources/qic-dr_lit_review-version-2.pdf

[3] Risk levels are not known at the time of assignment to either pathway and assignment decisions are based on the nature/content of the accepted referral and state/county policy on which types of allegations can be assigned to the FAR pathway.

- Services are voluntary in the FAR pathway: (1) families can choose to receive the investigation response or (2) families can accept or refuse the offered services if there are no safety concerns;
- Families in the FAR pathway are served without a formal determination of child maltreatment; and
- Since no determination of maltreatment is made, no one is named as a perpetrator, and no names are entered into the central registry for those individuals who are served through the FAR pathway.

Investigation Response (IR). The IR pathway requires a formal investigation culminating in a finding that may include substantiated, indicated, or not substantiated. The names of substantiated perpetrators are generally included in a central State registry. While IR cases can also be approached in a strengths-based and partnering manner (or not), substantial time is often absorbed by the requirements of the formal investigation, especially in the early stages of the case. In many States, IR is the only available pathway for screened-in CPS reports.[4]

METHODOLOGY

The larger evaluation features a randomized controlled trial (RCT) design. The RCT data will eventually yield useful information for the implementation, outcomes, and cost components of the evaluation once it becomes available later in the project. This report focuses on results reported in individual site reports, which relied primarily on qualitative data from two major sources: a series of in-person focus groups and interviews carried out during the late spring and early summer of 2011 led by local evaluators with support from the cross-site staff; and a review of project documents.[5]

QIC-DR staff and the local site evaluators, with input from local project directors, developed a core set of instruments to guide the focus groups and interviews covering all aspects of model fidelity and program implementation (See Appendix A). These questions were tailored and extended as needed by local evaluators in order to reflect each site's implementation of DR and to capture site-specific research interests.

The implementation science framework developed by the National Implementation Research Network was used to structure the implementation evaluation (See Figure 1).[6] This framework identifies the core factors (or drivers) needed to successfully implement, develop, and sustain a social service program. These include: competency drivers that shape the performance of front line practitioners; organization drivers that support, develop, and guide practice; and leadership,

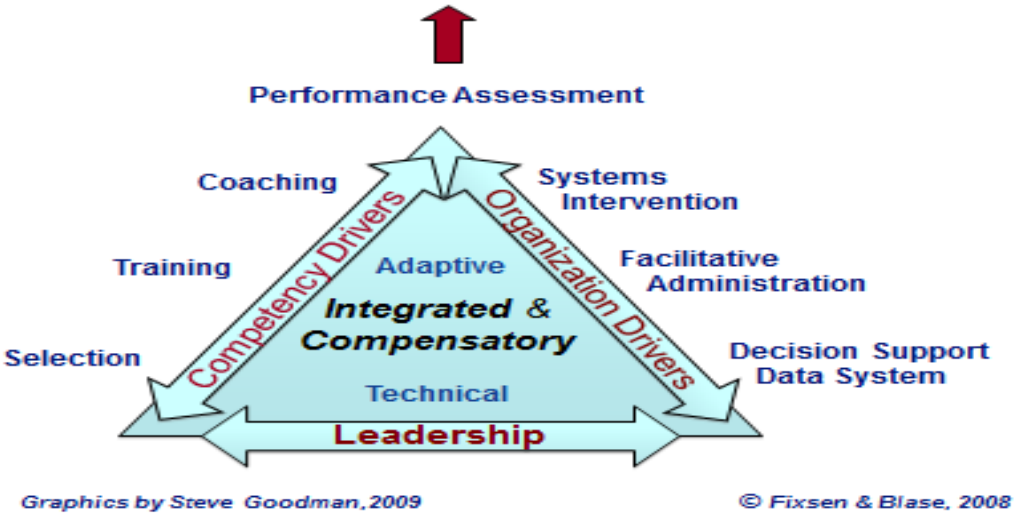
[4] For a national portrait of the implementation of differential response, see the Differential Map at http://www.differentialresponseqic.org/assets/docs/qicdr-map.pdfhttp://www.differentialresponseqic.org/assets/docs/qicdr-map.pdf

[5] Ohio also used monthly implementation reports from its participating counties.

[6] Fixsen, D.L., Naoom, K.A., Friedman, R.M., and Wallace, F. (2005). *Implementation research: A synthesis of the literature.* (FMH#231) Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

which promotes and coordinates both. The framework and the evidence-based research that guided its development was used to develop the implementation instrument, and adapted as needed for each local model.

Figure 1
Implementation Drivers



Site visits were held over approximately a two-to-three week period in Colorado and Illinois and over two months in Ohio, with focus groups and interviews held in each participating county or region.[7] Groups recruited for participation included FAR and IR caseworkers and supervisors, state and local administrators, and community stakeholders.[8] In most cases, FAR and IR staff were interviewed in separate groups. Participants were recruited by the local evaluators with the cooperation of the DR Project Director and DR practice leads in each county/region. Participation was voluntary. The number of participants ranged from 85 in Ohio, to over 100 in Illinois and about 180 in Colorado.

In Illinois and Colorado, focus groups and interviews were recorded and transcribed into NVivo, a qualitative data analysis program. Field notes were also taken and helped guide the coding of the data in NVivo. Detailed field notes were taken in Ohio and also transcribed into NVivo. The data were coded by the researchers for analysis. Both local and cross-site evaluators ran the focus groups. Documents reviewed by local evaluators included: enabling legislation; CPS rules, procedures, and policy documents related to DR; assessment tools used by caseworkers; training curricula; and memoranda of understanding.

[7] Illinois, which implemented State-wide, held focus groups in each of the four major service regions in the State (treating the three regions in Cook County as one). The other sites, Ohio and Colorado, held separate focus groups in each county.

[8] Illinois and Ohio did not contact community stakeholders for focus groups or interviews, though it plans to do so in future site visits.

CHAPTER 2. DESCRIPTIONS OF THE QIC-DR RESEARCH & DEMONSTRATION SITES

The three R&D sites differ in a number of ways that are important if one is to understand the unique features of their DR models and the particular challenges that each faces in implementation and model fidelity (See Table 1).These include CPS system design, system reforms predating and coextensive with DR, and project scope. Prior to the implementation of DR, each site went through an extended process of exploration to find out more about DR, generate buy-in from key stakeholders, develop its own DR model, and develop the legislative and organizational infrastructure needed to support the effort.

Table 1. DR Site Characteristics

Category	Colorado	Illinois	Ohio
Scope of implementation as part of QIC-DR	5 counties	Statewide	6 counties
Previous implementation of DR in the State	No	No	Yes
Child welfare structure	County administered, State supervised	State administered	County administered, State supervised
Percent of screened-in cases determined	About 45 percent	About 15 percent	Not available
FAR service staff	FAR caseworker	Team of public FAR caseworker and private Strengthening and Supporting Families (SSF) worker	FAR caseworker
Maximum days cases can be open	FAR: 60 days for assessment, can be transferred to post assessment services that can extend beyond that time IR: 30 days plus the option for unlimited, supervisor approved 30 day extensions related to completion of paperwork or assessment needs, transferred to ongoing if service delivery if needed	FAR: 90 days with up to three 30-day extensions allowed IR: 60 days with extensions allowed	FAR: No maximum. Officially transfers to post-assessment phase at 45 days but most often same worker continues to work with family IR: 30 days with 15 day extension allowed, then transferred if services are needed

COLORADO

Colorado is a county-administered, state-supervised child protective services system. Counties are responsible for all aspects of CPS service delivery from initial screening through investigation and service delivery, and have some flexibility in how those activities are carried out, with the exception of those areas covered by statute and rule. As a result, practices can vary across counties.

In Colorado, in 2007, the Governor's Child Welfare Action Committee made 35 recommendations to improve child welfare in the State, including one to implement DR. When the QIC-DR grant opportunity was announced, the State solicited letters of interest from each of the 64 counties and they received letters of commitment from the five counties that would form the Colorado Consortium for Differential Response (CCDR). Administrators from these counties

saw DR as a logical next step for what they were already doing in practice. Many already knew something about DR based on reading, conferences, and interacting with officials in states that had already adopted DR, such as Minnesota. Once the CCDR secured the QIC-DR grant, Colorado passed the legislation providing the five counties with a waiver to implement DR. In 2012, legislation was introduced that would expand that waiver to additional counties.

Once funded, the CCDR formed several ongoing workgroups to handle key aspects of the implementation including the following: screening and referral workgroup; FAR practice workgroup; learning development team; data workgroup; cost analysis workgroup; and the DR leadership team. The leadership team, which includes the DR project and evaluation directors, administrators from the five counties, Colorado Division of Child Welfare staff, and a representative of the Colorado Disparities Resource Center, provides overall project leadership, and oversees the work of the other groups.

The five Colorado counties that together make up the Colorado Consortium on Differential Response (CCDR) are: Arapahoe, Freemont, Garfield, Jefferson, and Larimer. The counties range in population from 8,500 to 143,000. The rate of screened-in reports in 2009 ranged from 45 percent in Larimer to 69 percent in Garfield. The percent of screened-in reports referred to ongoing services (following assessment) ranged from 7 to 27 percent.

Closely connected to DR implementation, the Division of Child Welfare, the state agency that oversees child welfare, is working to develop and test a coherent, shared model to guide practice throughout the state called the Colorado Practice Model.[9] Core elements of the model include: data driven decisions; transparent, measurable outcomes; a clear and consistent approach to practice and service delivery; and the development and maintenance of strong, mutually supportive relationships among stakeholders. The Colorado Practice Model is being fielded by 13 counties and one tribal community, and there are plans to involve all counties over time. DR is considered to be a compatible component of this model, and the five CDRC counties have joined in the Colorado Practice Model leadership. The simultaneous implementation of Colorado Practice Model and DR has been a significant challenge for the five counties, who have had to fully integrate DR into an evolving set of Colorado Practice Model practices. However, if the evaluation confirms that DR is effective in Colorado, this integration could facilitate the adoption of DR by other counties within the State.

A second state-level effort for child welfare reform is headed by the Colorado Disparities Resource Center, formed to address disparate and disproportionate outcomes for children of color in the child welfare system and has participation from all of the counties implementing DR. The CDRC counties have participated and actively worked to incorporate these outcomes into their overall service delivery model.

[9] This work has been done in partnership with the Mountains and Plains Child Welfare Implementation Center.

Illinois

Illinois CPS is a centralized, state-run system with six administrative regions: three within heavily populated Cook County, and three covering the remainder of the State. Outside of Cook County, the regions are a mix or urban and rural, with the Southern region predominantly rural. The responsible agency, the Department of Children and Family Services (DCFS) is over 95 percent unionized, and has a long history of working in partnership with private organizations in the delivery of services to families entering the CPS system.

In FY2011 the system fielded over a quarter of a million hotline calls and screened-in 24 percent for further attention, a rate that is less than half the national average.[10] Fewer than half (45%) of children with indicated maltreatment are provided post-investigation services. The state has implemented a number of major CPS reforms prior to and contemporaneous with DR. Major changes in foster care policy have resulted in an over two-thirds reduction in the size of the substitute care population since 1997. Further, beginning in 2006 the State has substantially revised its practice model to be more explicitly family-focused, strengths based, and trauma informed. Activities have included a trauma-informed training curricula for all State child welfare system staff, and the adoption of the Center for the Study of Social Policy's Strengthening Families program. [11] The primary safety assessment tool used is the Child Endangerment Risk Assessment Protocol (CERAP).

The adoption of DR was seen as a logical next step in the pursuit of Illinois' child welfare reform agenda. In Illinois, the then-Director of the Department of Child and Family Services (DCFS), Erwin McEwen, commissioned a literature review summarizing DR, and followed up by creating a state-wide task group to design a DR program for the entire State, as the initial exploration steps. The group included staff from the major offices within DCFS, representation from the Office of the Inspector General, American Federation of State, County and Municipal Employees, Public Guardian's Office, and research staff from the Children and Family Research Center at the University of Illinois. This group organized into sub-committees to address staffing, training and tools, data and SACWIS, and eligibility criteria for FAR. These subcommittees made recommendations to the DCFS Director, many of which were adopted.

Enabling legislation for DR was sought simultaneously by DCFS, resulting in the passage of the Illinois Differential Response Program Act, providing DCFS with the authority to pursue a state-wide, 5-year implementation of DR, and mandating an evaluation. Detailed rules and written procedures were developed to guide the implementation of DR across the State. The Child Welfare Advisory Committee (CWAC) was formed to advise on the implementation of DR. CWAC was in operation early in the project, but has since been disbanded.

Because most of the initial activity in Illinois took place at the state level, a major effort was made to reach out to DCFS staff, private service providers, and community stakeholders in all

[10] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2010). Child Maltreatment 2009. Washington, D.C.: U.S. GPO.
[11] Griffin, G., McEwen, E., Samuels, B., Suggs, H., Redd, J., & McLelland, G. (2011). Infusing protective factors for children in foster care. *Psychiatric Clinics of North America*, 34, 185-203.

regions of the state to explain DR, answer questions, and mobilize support. The ex-DCFS Director and the Project Director held 11 town hall meetings and regional leadership summits to discuss all of the DCFS initiatives going on, including DR. Then regional summits were held that specifically focused on DR and included those doing DR from both the private and public agencies.

OHIO

Like Colorado, Ohio is a county-administered, state-supervised child welfare system. Counties supply a substantial proportion of the funding for child welfare services, and have a correspondingly high level of control over child welfare practice and services. The R&D site in Ohio includes six counties: Champaign, Clark, Madison, Montgomery, Richland, and Summit. The consortium is collectively called SOAR, Six Ohio Counties Implementing Alternative Response. The counties range in population from 34,549 to 542,405. The rate of screened-in reports in 2009 ranged from 41% in Clark to 84% in Richland. Child welfare practices, including DR, vary significantly by county.

Unlike the other sites, Ohio's DR initiative pre-dates the QIC-DR and SOAR. In 2004 the Subcommittee on Responding to Child Abuse, Neglect and Dependency[12] was charged to provide recommendations for improving consistency in screening processes across counties. This subcommittee recommended that Ohio implement a pilot of DR and, in 2008, 10 counties piloted DR and were rigorously evaluated.[13] The SOAR counties constituted Round 2 of a planned state-wide rollout. A third, fourth and fifth set of counties have since launched DR, resulting in 40 out of 88 counties implementing DR as of April 2012. The State plans to continue its phased roll-out to all counties owing in part to the positive results of the pilot evaluation. As a result, SOAR counties have been able to take advantage of an existing state-level infrastructure to support DR, including the experience and expertise of the original 10 counties. The SOAR counties have been able to learn from them through peer to peer technical assistance and shadowing workers in the field. In fact, one of the SOAR counties, Clark, was also part of the original 10 pilot counties, providing the SOAR Consortium with an experienced county and offering the opportunity to evaluate DR in a more mature sub site.

In Ohio, most of the state-level activities required to implement DR had already been accomplished in establishing the initial 10-county pilot project launched in 2008. The Ohio AR Design Workgroup was a joint effort of the Ohio Department of Job and Family Services, the Supreme Court of Ohio, and the 10 original pilot counties tasked with developing a statewide DR practice model. This group later became Ohio's DR Leadership Council, which includes representation from the SOAR counties, a representative from each of the original pilot counties, and two representatives from the third and fourth round of counties to implement DR. It functions as an important body for mentoring, peer-counseling, information sharing, and joint

[12] The subcommittee was established by the Supreme Court of Ohio's Advisory Committee on Children, Families, and the Courts.
[13] Loman, T., Filenow, C., and Siegel, G. (2010). Ohio Alternative Response Evaluation: Final Report. Available at http://www.iarstl.org/papers/OhioAREvaluation.pdf

decision-making. In addition, the SOAR counties have their own Consortium, which meets monthly by telephone (weekly for the first three months of the project), and quarterly in person. The SOAR Consortium focuses on training and learning opportunities, joint problem-solving, and the coordination of efforts for the evaluation. SOAR was formed at the initiative of Clark County, one of the original pilot counties, reaching out to others interested counties to apply for the QIC-DR grant in 2009.

Three additional child welfare initiatives within Ohio are worth noting. First, Casey Family Programs provided supplementary funding and technical assistance to all Ohio counties implementing DR, including the six SOAR counties. Second, Ohio's Title IV-E waiver, known as Protect Ohio, makes a limited amount of federal foster care funds available to invest in up-front services rather than out-of-home services. These funds are being used by two SOAR counties for prevention-oriented, strengths-based services which are wholly compatible with DR. The most recent initiative is through the Midwest Child Welfare Implementation Center. They are collaborating with the Ohio Office of Families and Children to develop and implement a new technical assistance model. The project has several phases including: a formal assessment of organizational culture and climate; development and installation of the technical assistance model; a rule review; implementation of organizational structural and functional changes to facilitate the new model; and ongoing fidelity monitoring. The counties have been a part of the rule review and have made recommendations for changes in both FAR and IR.

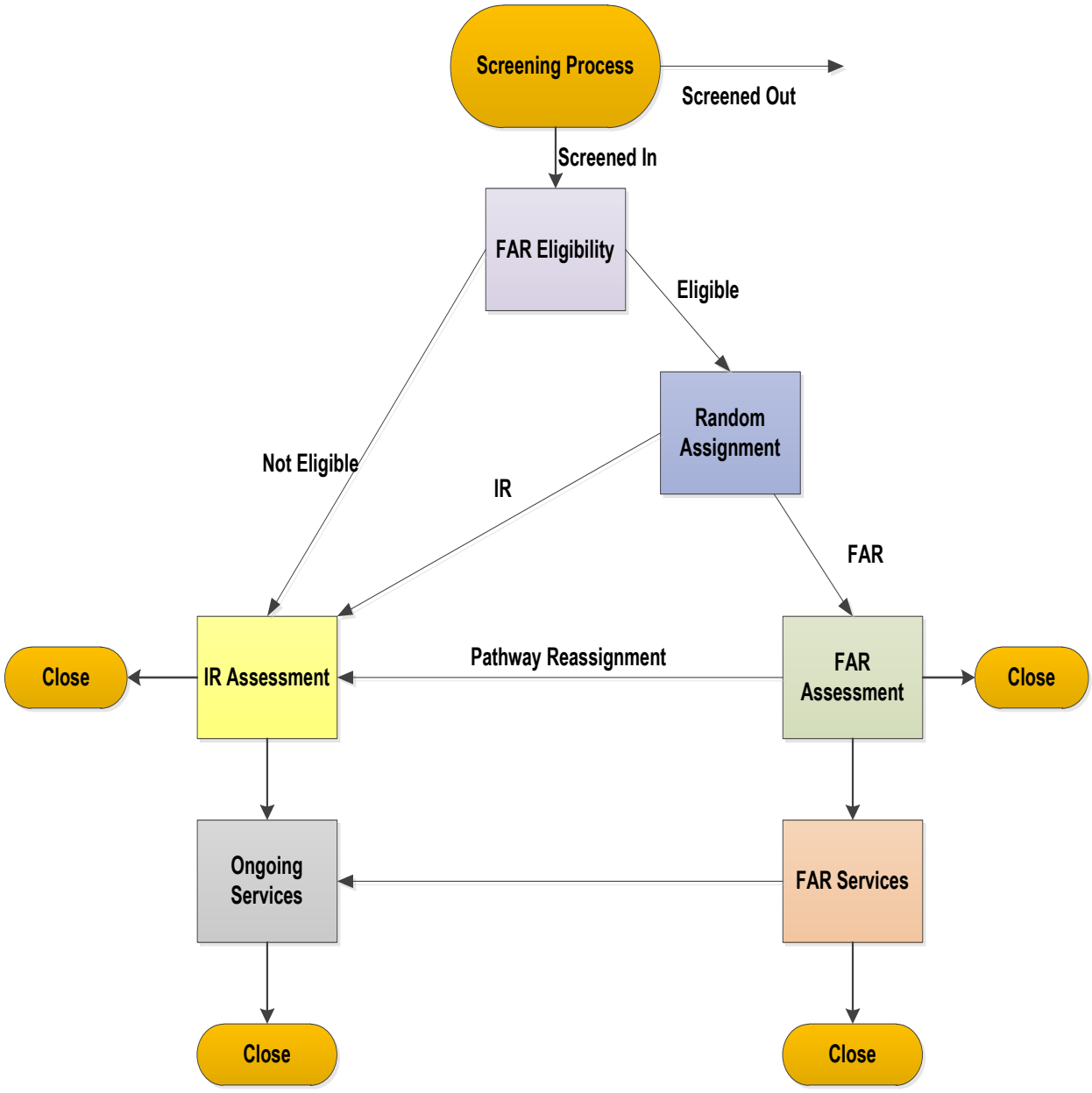
CHAPTER 3. DIFFERENTIAL RESPONSE MODEL AND MODEL FIDELITY

The models of DR developed by the three R&D sites share a common set of core criteria (described above), as well as some basic characteristics of case flow. Beyond that, though, there is substantial variation in all aspects of the DR model including scope, eligibility criteria and pathway assignment process, service approach, and training rigor and approach. These similarities and differences are discussed below.

THE CASE FLOW MODEL

Figure 2 presents a generic case flow model that the QIC-DR sites are using during the RCT implementation phase. The case flow reveals the key stages and decision points in the system, and their relation to each other. Each stage is discussed below, highlighting the similarities and differences among the sites, and summarizing early findings. For each site's more detailed case flow model, see Appendix B.

Figure 2
DR Case Flow Diagram



The stages include, in order: the screening process into the CPS system; determination of FAR eligibility; pathway determination for FAR-eligible cases using random assignment; assessment; pathway reassignment; services; case closings; and, when applicable, re-reports.

SCREENING PROCESS

The initial screen-in process determines whether a report meets the legal threshold for a CPS response. Screeners are guided by tools to gather the information needed for the screening decision. In Illinois there is a centralized hotline for the entire State. In Ohio and Colorado, the screening decision is made by the screener and/or screening supervisor at the county level.

Data collected during initial screen-in is also used to make the FAR eligibility decision in all three sites, though additional information is sometimes requested before eligibility is determined. In Illinois, no formal changes were made in the screen-in process, or in the information collected. In several Ohio counties Screening Decision Makers also collect additional information about agency history with the family to support the FAR eligibility decision. In one Ohio county, the presence of certain family characteristics leads to a review and FAR eligibility determination by a review panel. Colorado developed a screening tool used with reporters of child abuse in neglect, in order to better support the assignment and FAR eligibility decisions. They included questions about family supports and strengths, and additional detail on safety concerns, risk factors, and prior history with community agencies, all used to guide the hotline worker in gathering more consistent and comprehensive information from reporters.[14]

This change in Colorado has had several notable consequences, some anticipated, others not. First, Review, Evaluate and Direct (RED) team members (who determine FAR eligibility in Colorado except when an immediate CPS response is required) were appreciative of the additional information provided by the new screening tool, helping them to make better FAR eligibility decisions, and improving the capacity of caseworkers to serve all families, FAR and IR. Second, county staff report it has led to more transparency in the initial screening decision throughout the agency. Third, screeners and other focus group respondents reported that interview times with those making child abuse and neglect reports have increased with this new tool.

Some of these consequences have led some nonparticipating Colorado counties to consider using the enhanced screening tool even though they are not implementing DR. Finally, the enhanced screening process has produced some concern, principally from mandated reporters, some of whom have complained about the longer interview times; although the screeners appreciated the additional information that a longer call afforded. Some focus group members suggested that additional outreach to mandatory reporters to educate them concerning the importance of the additional information collected and how it is used may be needed.

While Illinois did not make any changes in the screening process to accommodate DR, DR appears to have had an unexpected impact on the screening process itself. Focus group participants reported that they felt some screeners were gratuitously adding allegations to make

[14] Colorado's Screening Tool and Guide was greatly influenced by the Olmsted County MN screening tool.

otherwise eligible cases ineligible for FAR (See Table 2 for a detailed list of eligibility criteria). Specifically, it was reported that some were tacking on allegation 60 (risk of harm due to neglect) in order to make them ineligible for FAR. After this surfaced, allegation 60 was added to the list of allegations eligible for FAR, and the Illinois DR Project team is monitoring these data to identify additional screening decision trends that may be interfering with the intent of the project.

FAR ELIGIBILITY

All screened-in reports are quickly assessed for FAR eligibility, immediately or typically within 24 hours of the report. Each site has clear written criteria to guide the eligibility decision. In Illinois, all criteria are mandatory and uniformly applied at the state level. In Ohio and Colorado, there are both mandatory criteria that apply to all cases, and discretionary criteria that may be considered in making an eligibility decision. In Ohio, individual counties have the capability to use discretionary criteria to exclude families on a case by case basis if they so choose, which several do. The basic criteria for each site are summarized in Table 2.

Table 2. FAR Eligibility Process and Criteria

Category	Colorado	Illinois	Ohio
Who Decides	RED Team	Computer, at screening	Screeners, supervisor or group (varies by county)
How Flexible	Mandatory and discretionary criteria, programmed into the SACWIS system and collected over time	Mandatory criteria only, uniformly applied. Regional Supervisors may change FAR to IR.	Mandatory and discretionary criteria.
Criteria			
Mandatory Exclusion or Inclusion Criteria for FAR	Exclusion Criteria • Allegation of serious harm • Allegation of sexual abuse • Suspicious child fatality or homicide • Institutional referral • Not in FAR County jurisdiction	Inclusion Criteria • Identifying information for the family members and their current address is known at the time of the report; • The alleged perpetrators are birth or adoptive parents, legal guardians or responsible relatives; • The family has no pending or prior indicated reports of abuse and/or neglect or prior indicated reports have been expunged within the timeframe or timeframes established by the Department for the indicated allegation or allegations; • The alleged victims, or other siblings or household members, are not currently in the care and custody of the Department or wards of the court; • Protective custody of the children has not been taken or required in the current or any previous case; and Allegations • The reported allegation or allegations shall only include Mental and Emotional Impairment (neglect only), Inadequate Supervision, Inadequate Food, Inadequate Shelter, Risk of Harm due to Neglect, Inadequate Clothing, Medical Neglect, and	Exclusion Criteria • Report alleging serious harm to a child • Report alleging sexual abuse of a child • Report involving a suspicious child fatality or homicide • Report requiring a specialized assessment (e.g., alleged perpetrator caring for child in out of home setting, or alleged perpetrator with access to child by virtue of employment or affiliation • Report requiring a third party assessment (e.g., involving an employee of an institution or facility licensed or certified by ODJFS, a foster caregiver, or an employee of ODJFS or Public Children's Services Agency PCSA • Report is on a current open investigative case or on-going case • Requested or received court-ordered custody or protective

Category	Colorado	Illinois	Ohio
		Environmental Neglect. The following circumstances involving the allegations of Mental and Emotional Impairment, Inadequate Supervision, and Medical Neglect prohibit the report from being assigned to DR. • Mental and Emotional Impairment reports taken as abuse (Allegation #17) will be assigned an investigation pathway. • Inadequate Supervision reports involving a child or children under the age of eight, or a child older than eight years of age with a physical or mental disability that limits his or her skills in the areas of communication, self-care, self-direction, and safety will be assigned an investigation pathway. • Medical Neglect reports that involve a child with a severe medical condition that could become serious enough to cause long-term harm to the child if untreated will be assigned an investigation pathway. • All other allegations are considered to involve substantial child abuse and neglect, and are ineligible for assignment to DR.	supervision ordered
Discretionary Exclusion or Inclusion Criteria for FAR	• Frequent, similar, recent referrals • Violent activities in the household • Caregiver declined services in the past • Caregiver unwilling/unable to achieve safety • Past safety concerns not resolved • Previous serious child harm offenses • Credible RP alleges high safety concern • High child vulnerability • Substance Abuse not manageable through FAR • Domestic Violence not manageable through FAR • Court ordered investigation • FAR Eligible, approved exemption – staffing • Randomizer down – project director notified • Insufficient info to assess for FAR eligibility • Currently open investigation response • Other (Describe):	None	• Family has had frequent, similar, or recent past reports • Past custody by PCSA • Two or more children under age 5 • Past substantiated or indicated for child abuse or neglect • Previous child harm offenses charged against the alleged perpetrator • Past maltreatment concerns not resolved at previous closing • Worker hazards that require Law Enforcement at contacts with family • Reported intimate partner violence • Current open FAR or on-going FAR case

Sources:

Colorado State University, Social Work Research Center (2012). *Colorado Year 1 Site Visit Final Report Appendices: Colorado Consortium on Differential Response.*

Fuller, T., Kearney, K, & Lyons, S (2011). *Differential Response in Illinois: 2011 Site Visit Report.*

As seen in Table 2, Illinois' eligibility criteria limit FAR to a subset of alleged neglect cases, representing about 15 percent of all screened-in cases since the beginning of the evaluation. Colorado's criteria result in a substantially higher eligibility rate of 45 percent overall, and variations in the percentage of FAR eligible cases among the participating counties in Colorado. Ohio's criteria for FAR eligibility appear broader and more similar to Colorado, though eligibility rates are not available at this time.

Regarding the appropriateness of current FAR eligibility criteria, caseworkers and supervisors were generally comfortable with the existing criteria, though in Colorado and Ohio there were grey areas for cases involving domestic violence, hard core drug use, and families with an extensive history with CPS. In such cases, focus group data indicated that some thought families with these characteristics should not be eligible for FAR, while others thought that many such families could benefit from FAR and should be included more systematically. Workers in both Colorado and Ohio report some evolution over time in how the discretionary criteria are applied. In Illinois, many workers felt that families with one or more prior reports, currently excluded from FAR, should be eligible and could benefit from the program. In addition, a smaller number of focus group respondents felt that it would be appropriate to include some milder forms of abuse in the eligibility criteria. Some focus group participants also discussed the addition of allegation 60 (see above) as a slight concern. They explained that many different kinds of reports fall under allegation 60, including some domestic violence, and that they were not sure they would be comfortable with those cases being served through the FAR pathway.

The process through which an eligibility determination is made also differs substantially across the three sites. In Colorado, except for cases that require an immediate CPS response, FAR eligibility is determined by county level RED teams, a model originally developed in Olmsted County, Minnesota. These teams include staff from all levels and functional areas within the agency. RED teams meet each morning and review the information gathered by the screeners for each referral, except for those cases that require an immediate response. A host of factors are considered including previous history with the agency, history with law enforcement, risk and safety, cultural considerations, and family strengths and supports. If necessary, additional information is requested of the reporting party or collateral sources to assist the team in the final decision. Each case is discussed by the group and an eligibility determination is made by consensus. RED teams in all 5 counties are guided in their determination by a common set of documents including the Agency Response Guide, which outlines statutory assessment criteria and FAR eligibility guidance, and the RED Team Framework. Many of the caseworkers and supervisors who were interviewed consider the RED team approach to be central to the implementation of DR in Colorado.

In Illinois, eligibility is automatically determined once all information has been entered into the State system by one of the screeners. Eligible cases are then submitted to the random assignment tool (or randomizer) built into their SACWIS. Regional FAR supervisors can overturn an eligibility determination within 24 hours after reviewing the details of the case.

In Ohio, two counties rely on individual supervisors to make the eligibility decision, while others use a group decision-making process. Among the latter group, two smaller counties use informal methods, while another, larger county uses a formal review panel similar in many respects to the Colorado RED teams, including screening and FAR supervisors, and representatives from management, quality assurance, and the legal department. All of the counties use a form called the Pathway Assignment Tool (PAT) which includes Ohio's statewide rules for cases that are not FAR eligible, and a set of discretionary criteria that may be considered when making eligibility decisions. How these discretionary criteria are applied varies from county to county, with some counties treating selected discretionary criteria as mandatory exclusions.

RANDOM ASSIGNMENT

Random assignment is not part of the DR process. It is, however, a critical component of the evaluation. Once a case is determined FAR eligible, the RCT design requires that cases be randomly assigned to the FAR or IR pathways. This random assignment assures that any differences in outcomes are a result of the pathways themselves rather than differences in the characteristics of the families that are assigned to the pathways. In practice this means that, once families are determined FAR-eligible, only a certain percentage of them are actually sent to the FAR pathway. The rest receive an investigation response (IR). In the absence of an evaluation, of course, there would be no random assignment.

While necessary for science, this process has created some challenges to managing the workflow of FAR caseworkers, particularly in smaller counties. Random processes can produce seemingly nonrandom results in the short-term. For example, while a series of coin flips will produce heads and tails in approximately equal numbers over the long run, it may also produce runs of five heads in a row on occasion. When this happens in assigning cases, it can result in FAR caseworkers that are alternatively swamped or idle at any given point, particularly when there are only one or two such caseworkers in a unit. Colorado built a blocking factor into their random assignment software which limits the number of cases that could be assigned FAR or IR within a contiguous block of cases, which has been effective in limiting problems with case overload and underload.[15] In Illinois, FAR caseworkers handle the fluctuating caseload as best they can, but are not allowed to take on other types of casework when work is slow. Ohio addresses this problem by temporarily adjusting the randomizer's ratio for assignment to FAR versus IR. For example, if a FAR worker takes a leave of absence, the percentage of cases assigned to FAR from the FAR eligible pool is reduced until the workload problem is resolved. .

Some FAR caseworkers and screeners across the three sites expressed frustration with the random assignment process, since they felt that many families could benefit from FAR were denied access to it. Most understood the necessity of the process for the evaluation, but looked

[15] Friedman, L.M., Furberg, C.D., DeMets, D.L. Fundamentals of Clinical Trials (Third Edition). Springer, pp 64-66.Meinert, C.L. (1995). Clinical Trials: Design, Conduct, and Analysis. Oxford University Press, pp. 95-96.

forward to the time when the randomizer would end and all FAR eligible families could receive FAR services. All three sites have expressed the intention to continue assigning all new eligible cases to the FAR pathway after the RCT sample is complete, at least until the end of the project. One of the challenges they are facing is how to expand system capacity to handle the additional cases once the random assignment process ends.

PATHWAY REASSIGNMENT

All three sites allow FAR cases to be changed over to IR under several circumstances.[16] The primary trigger for a pathway reassignment is a newly discovered threat to child safety. This can be discovered during the safety and risk assessments, through the ongoing interaction between the family and the caseworker(s), or (in Ohio and Colorado) through a new screened-in report that includes an allegation that is not FAR-eligible. In Illinois, any new screened-in report on a FAR family regardless of the allegation results in a pathway change to IR. A pathway change will also happen in all three sites when a FAR worker is unable to complete the initial safety assessment with the family, which is not voluntary in FAR. Finally, a change from FAR to IR can be made at the family's request.

To date there have only been a handful of such requests across all sites. While pathway reassignment has been relatively rare, it has presented minor logistical challenges to several sites. In Illinois, FAR case notes that are developed and input by the private, Strengthening and Supporting Families (SSF) workers cannot be shared or discussed with IR caseworkers; therefore, IR caseworkers must often re-gather significant amounts of information already documented by the SSF worker in another data system, which is a source of frustration for them and for the families as well. Colorado and Ohio have no such restriction, though some Ohio caseworkers report that the change can still be confusing and frustrating for the family, since the tenor of an IR investigation can be very different from FAR. In such cases, one of the Ohio counties does a "warm handoff" involving the family and both the FAR and IR workers take place to minimize stress and confusion for the family.

All three sites will also change FAR cases to IR if the initial eligibility determination was incorrect. This has only happened in a few cases in Colorado, 4% of cases in Ohio, and approximately 5% of FAR cases in Illinois. In Illinois, this occurred mostly because a case had a prior report of which the screener was not aware at the time of the determination. A number of options are being explored to reduce this rate of misclassification as the project moves forward.

SAFETY, RISK, AND NEEDS ASSESSMENTS

Each site uses its own safety assessment tool, which is the same for both FAR and IR cases. While services are voluntary for FAR cases, and sometimes for IR cases as well, safety assessments are mandatory for both FAR and IR, and families in FAR cases who do not cooperate are transferred to IR.[17] Beyond that, however, workers reported important differences in how such assessments were carried out across the two pathways. First, IR caseworkers typically show up unannounced to perform the initial safety assessment, while FAR workers make initial contact by telephone to set up an appointment unless the family is not reachable by

[16] Pathway reassignments from IR to FAR are not allowed in any of the sites.
[17] Complete copies of all assessments can be found at http://www.differentialresponseqic.org/

telephone or the allegation requires a more immediate response. It is important to note that there is variation across the sites in this practice. In Colorado and Ohio, there is no rule requiring the IR worker to show up unannounced so it is not done in some low- and moderate-risk cases. Second, IR cases generally need to be assessed within a shorter time frame than FAR cases (4 days to complete the safety assessment in SACWIS compared to 7 days in the case of Ohio). Third, FAR workers report that in the safety assessment process, they are comfortable with their ability to engage the family and they tend to believe that families are more responsive. Whether this is the result of the engaging approach of FAR workers, a greater emphasis on family strengths, the advance notice families receive, or simply the absence of a formal investigation, or some combination, is unclear. Many reasons were offered.

In Colorado and Ohio, the family assessment instruments are the same for FAR and IR tracks, with only minor differences in wording. In Colorado, for cases stretching beyond the assessment period, the North Carolina Family Assessment Scale (NCFAS) is used, while in Ohio the CAPMIS Family Assessment Form is used. In addition, Colorado and Ohio developed a separate FAR service planning instrument. These new instruments are designed to be more open-ended and flexible, and are intended to be used with the family in the field.

In Illinois, family assessments in FAR cases are not carried out by a DCFS agency caseworker, but by the private SSF worker who partners with them. FAR caseworkers and SSF service workers operate in pairs. The FAR worker is responsible for the initial safety assessment, and the SSF worker focuses on service planning and delivery with the family. SSF workers do the needs and strengths assessment and provide follow-up services to FAR families. The SSF worker uses a different needs assessment form than is used for IR cases, Family Assessment FCS 613-1. It is comprehensive and includes financial status, child education needs, and the physical, mental, and behavioral health of all family members. It feeds into a Voluntary Family Enhancement Plan (Form CFS 613-2), which is developed jointly with the family. The fact that the SSF worker is not a part of DCFS serves to accentuate the point with families that it is intended to be a collaborative and supportive process that is voluntary.

SERVICES

For FAR cases, once the safety assessment is complete and there are no substantial safety concerns, participation becomes voluntary. If there are substantial safety concerns in a FAR case, it may be transferred to IR. Colorado restricts a pathway re-assignment to the first 30 days. Caseworkers across the sites confirmed that in practice the voluntary nature of such cases is respected, though there may be considerable effort made to encourage the family to receive services and, in the case of Illinois, reportedly some pressure from supervisors and DR senior staff to minimize the percentage of service refusals. For IR cases, service receipt can be mandatory, though most often this is not the case.

In all three sites, FAR workers are deeply involved in the provision of services to their families. For example, in Ohio FAR caseworkers will often transport and accompany their families to services rather than simply making referrals. Two of the six Ohio counties require weekly meetings with each family. In Illinois, the SSF worker is required to visit each family two times per week (unless the family requests fewer visits), and takes a much more active role in the

provision of services, acting as coach, advocate, and service broker, as needed. By comparison, Illinois IR workers may provide some service referrals during the assessment phase, or refer the family to intact (aka "ongoing") services once the assessment is complete.

Caseworkers report that services for FAR and IR families differ in important ways. First, they report FAR families tend to receive needed services more quickly for a number of reported reasons. First, with IR cases, it was reported that there can be delays in service access during the transition from Intake to Ongoing Services, with FAR cases not needing to be opened as an ongoing service case. This is intentional and in keeping with the prevention-focus of FAR. In Colorado, community stakeholders who were interviewed also reported this observation. Second, focus group respondents noted that they believed there are delays in accessing services before the formal investigation result is determined, which may reflect their community's practice or policy, or their limited knowledge, since this is a common occurrence in many public child welfare agencies. Third, FAR workers were often perceived to be generally more knowledgeable about available services within the community, to the benefit of the families they serve, likely because of the philosophical orientation of DR resulting in services meeting needs, and workers investment and learning of the various formal programs and recruitment of community resources to serve families. So much so that IR workers in Colorado and Ohio reported that FAR workers have become a valued source of information for the entire agency in bringing attention to new community resources.

Third, all three sites have some dedicated funds for FAR cases that can be tapped to provide quick and concrete support services ranging from bus passes to cleaning supplies, gas cards, utilities assistance, direct cash assistance, and YMCA memberships, though SSF workers report that in practice it has sometimes proved difficult to access those resources in Illinois. IR workers in both Ohio and Illinois expressed some frustration with the unequal access to funds for the families they serve.

In Ohio, both IR and FAR cases can be transferred to the ongoing services unit once their assessment phase is complete and services are needed. If that occurs, it is the tendency in Ohio for the FAR worker to continue working with the family in an ongoing capacity. Since FAR cases may receive services during the assessment period, they are less likely to need services at that point, but the option is there. In Colorado, both FAR and IR cases can receive on-going services if deemed integral to restoration of safety and/or mitigation of risk. In Illinois, by contrast, FAR families are not eligible for transfer to ongoing (intact) services under the assumption that FAR is designed specifically to provide up-front services to families, and intended to be a short-term intervention.

Case Closure

FAR cases close for a number of reasons. If no services are recommended or requested, a FAR case will close once the safety assessment is complete unless there is an over-riding safety concern. Even when services are offered, FAR families may refuse services and the case will be closed, again assuming no over-riding safety concerns. In all three sites, caseworkers and supervisors reported that this right to refuse services has been respected, though in Illinois they have been asked to work with the families to minimize refusals of service.

In Colorado, the assessment period in FAR is 60 days, with completion of assessment tools due at 30 days. If there is need for additional services beyond that point, these are typically delivered by the FAR caseworker and may extend as long as necessary. Sometimes, these on-going FAR cases may be transferred to another unit to assist in workload management, particularly if the family needs a longer term service such as substance abuse treatment. IR cases are closed after 30 days or transferred to ongoing services. In Illinois, a FAR case may be open for a maximum of 90 days, with up to three, 30 day extensions possible with the approval of the State DR Director. After extensions are exhausted the case must be closed, though few have reached that point. IR cases in Illinois are to be closed within 60 days, though extensions can be granted. Ohio does not have a limit for how long a FAR case can be open. Counties in Ohio differ in their guidelines for how long cases remain with the FAR assessment worker post assessment before the case is switched to an ongoing worker in another unit.

A new report can result in a FAR case closing and a new IR case being opened, though practices differ by site. In Illinois, if a new report (not another report of the initial incident) comes in on an open FAR case, that case is closed and an IR case is opened. In Colorado, the case stays open if the new report is deemed FAR eligible. If the re-report is not FAR eligible, the FAR case is generally closed and a new IR case is opened, though the FAR case may stay open in order to continue the provision of services during the new investigation. In Ohio, when there is a new report on an open FAR case and the report is FAR eligible, the case remains open as FAR and a new assessment is done. If it is not FAR eligible, the case stays open but is considered a pathway reassignment to IR, regardless of how long the case has been open. In all three sites, when there is a new report for open IR cases, the case stays open and a new safety assessment is done, though if it comes in shortly after the initial report, they may be rolled into a single safety assessment.

RE-REPORT

The RCT design also affects what happens when a family is re-reported after the initial case is closed, though how this is handled is not consistent across sites. Once the initial case (including any related ongoing services) is closed, what happens to families in the RCT when there is a new report? For those in the RCT who were assigned to the IR track, any subsequent re-report following the closing of the initial case will always be assigned to IR regardless of the content of the report in order to make sure that IR families in the RCT sample never receive FAR services. For those initially assigned to FAR, however, practice on subsequent reports differs across the sites. In Colorado, such cases are assigned to FAR if the new report meets FAR eligibility criteria. Otherwise, they are assigned to IR. In Illinois, closed FAR cases that receive a new screened-in report are assigned to the IR pathway, never to FAR. In Ohio, where counties have the most autonomy among the sites, several handle it as Illinois does, while others handle it like Colorado.

For the purposes of the evaluation, these different practices will need to be accounted for when analyzing and interpreting the RCT data, as they produce different levels of exposure to FAR for those in the FAR pathway with subsequent referrals. In the absence of the evaluation, suitability

for FAR would presumably be determined anew with each subsequent report for prior FAR and IR cases, though number of previous reports may still play a role in FAR eligibility determination.

CHAPTER 4. IMPLEMENTATION OF DR

This chapter reviews the competency drivers (such as staff selection, training) and organizational drivers (such as administrative structures and data system changes) that the sites addressed in implementation.

COMPETENCY DRIVERS

STAFF SELECTION

Skills, experience, education, and attitudes that staff bring to the work initially are important determinants of program success, though to what degree can vary depending on the demands of the program, level of training provided, and so on. It is important to understand how these staff characteristics are identified, what role they play in the recruitment process, as well as other forces shaping recruitment outcomes.

As the QIC-DR sites reorganized their CPS system to offer two pathways—IR and FAR—the selection of FAR staff was seen as a critical decision point. To build a workforce competent in offering FAR, existing staff within the child welfare agency would need to be reassigned or offered new FAR supervisor and worker positions, and in addition, in the case of Illinois, private agency contracts would also need to be secured. While the role of the FAR supervisors and workers varied across the sites, which could translate to varying requisites, skills, abilities and attitudes to perform these new functions, there were a number of themes that were consistent in the area of staff selection. These included:

Allowing for worker self-selection. Sites provided existing staff the opportunity to self-identify to be considered for the (public agency) FAR worker role.[18] Once existing staff indicated their interest, different processes ensued to make staff selections. This included: seniority as the determining factor; and in the majority of instances, prospective staff interviewed so that the agency could best match staff with the skills, knowledge and philosophies that they believed were most important to be successful in that role. Specific to Illinois, the DCFS Union negotiations resulted in seniority being the sole criteria in determining which staff became FAR staff. In addition, this agreement created a rotational basis for DCFS FAR staff, which is a strategic decision by the DCFS leadership to help infiltrate the DR philosophy and program throughout the child welfare agency as they return to their former positions after 12-18 months for FAR specialists (caseworkers), and 24 months for FAR supervisors. Choice to become a SSF worker was not uniform. In a few of Illinois' private agencies delivering FAR services post-safety assessment, existing program contracts were eliminated and replaced with a FAR contract.

[18] In Illinois, the public agency (FAR) worker and private agency (SSF) worker are paired to service the family. This section refers to the selection of the public agency FAR worker. The Illinois site visit report (2011) noted that there was little consistency in the criteria across the private agencies for hiring and selecting SSF workers.

Certain existing positions initially targeted to become FAR workers. Each of the R&D sites informally recruited staff from varying agency functions, including: intake/investigation workers; ongoing workers; child welfare specialists; resource workers; or day care licensing staff (Illinois-only). As stated elsewhere in this report, program, implementers believed that staff who fulfilled certain existing child welfare functions would be best positioned, from a skill and attitudinal standpoint, to competently complete the FAR casework functions.

Prior experience and traits matter. There was consensus that no certain child welfare agency staff position was best suited to become FAR workers. Independent of FAR workers' prior function in the child welfare agency, a consistent theme from the QIC-DR site focus groups was that FAR workers perceive their role as returning to social work fundamentals. Skills in building relationships and trust with the family, and in engaging families in the identification of their needs, were described as essential for the FAR worker function, and were used in some sites in Colorado and Ohio in screening applicants for these positions. In addition to these noted skills, there was agreement across the sites that FAR supervisors and workers' philosophical beliefs about families were tied to their success in fulfilling the new roles. It was noted that it can be challenging for all child welfare staff, especially those who previously served as investigators and who were trained in a more forensic approach to child protection to adapt one's style, tone and demeanor when working with FAR families. Staff from some of the Ohio counties expressed the feeling that the ongoing workers were best able to transition to become FAR workers because they commonly work to resolve issues that families are confronting.

TRAINING

All QIC-DR sites invested a great deal of time and resources to train various child welfare agency staff[19] in the implementation of a DR-organized CPS system. One of the most consistent findings across the sites was the perceived importance of educating the entire child welfare workforce, community stakeholders and other system partners on DR. Within child welfare, this includes screening/hotline, IR, FAR, and ongoing staff, as well as other ancillary units. System and community partners included the range of individuals who represent agencies that commonly work with the child welfare agency, including but not limited to mandated reporters, legal system representatives (court staff, GALs), mental health and substance abuse providers, housing, poverty-related programs, education professionals, and law enforcement.

The length of the initial DR training varied from two days in Colorado and Ohio for FAR workers and supervisors, to a 5 week course in Illinois that consisted of the newly assigned public agency FAR workers and private agency SSF workers. Four of those weeks were classroom based, supplemented by one week of web-based training.

With regard to the initial training, a standard curriculum that described the history of differential response, QIC-DR, and introduced the practice and process changes was deployed in Colorado and Ohio, with opportunities for State-specific modifications. Illinois' DCFS Training Division developed its' 4 week course to cover: DR overview and philosophy; specific FAR procedures;

[19] Community education of various stakeholders is described in sub-section 5 (relationship with the community).

family engagement; CERAP; tools supporting FAR; conflict resolution; community advocacy; and evaluation of DR and data collection. All of the QIC-DR site visit reports share that there were concerns that the training lacked specificity and that there weren't enough hands-on opportunities to role play or practice this new approach to families. This has resulted in mid-course training modifications in the sites, as they have revamped the training curricula to create application opportunities and close connections to FAR policy. In addition, given the complexity of implementation and all of the changes that these public child welfare agencies were instituting to launch DR, the timing of the training challenged the implementation, as it occurred either too soon before the date of DR going live, or too many structures had not been fully finalized (e.g., SACWIS system in Illinois; case flows in some Ohio counties).

While not all of these strategies were consistently deployed across all of the sites, initial training was supplemented through additional formal classroom training, agency and community orientations, webinars, shadowing, organized meetings, conference attendance, and coaching. The various supplemental training classes across the sites focused on evaluation, Signs of Safety[20] screening, SACWIS, domestic violence, case documentation, and group supervision, some of which are core to DR implementation, and others that are additional practice and organizational changes occurring in the sites. A common theme was that these ongoing and additional opportunities were essential to supporting DR implementation, and were essential to advancing the other innovations that were seen as complementing this CPS transformation. These were also noted as important to support relationship building across all staff, community partners and others that play a role in the implementation of DR.

Additional training themes were noted. First, there is a need to develop the knowledge and skills of FAR supervisors through ongoing training. Given the critical role supervisors play in child welfare agencies as teachers, mentors and supporters to advance workers' skills, and given that the majority of supervisors do not have first-hand experience as FAR workers, specialized supervisor training and ongoing learning opportunities are essential to growing that sector of the workforce so that they can better support their staff. Second, ongoing training as staff develop and experience this approach with families was reported as important to transfer learning and solidify new practice skills. Lastly, the need to embed ongoing training opportunities into the training system—either through a State's training academy or other vehicle—was highlighted as essential since high staff turnover plagues many public child welfare systems.

Coaching and Transfer of Knowledge

Formal and informal coaching opportunities occurred for staff in the Ohio and Colorado sites, but were not documented in the Illinois site report. Overwhelmingly, it was positively viewed as another learning opportunity to deepen understanding about practice nuances that could be achieved through observation and one-on-one guidance. Coaching took many forms, including:

Formal, external coaches with experience in DR. In Ohio, supervisors and managers from the 1st round of DR counties provided consultation, shadowing and technical assistance to the SOAR

[20] For more information on Signs of Safety, visit www.signsofsafety.net

counties. For similar purposes, Colorado used external coaches from Ohio, who reportedly provided more guidance to supervisors and administrators, rather than workers.

Formal, internal coaches with experience in DR. Colorado's Project Director had formerly worked in Minnesota and was keenly familiar with FAR. Both she and the State of Colorado's DR lead committed time to coaching its' five DR counties, which was positively received and believed effective during early stages of implementation.

Shadowing workers in other communities implementing FAR. Ohio benefitted from sending staff to Minnesota to shadow caseworkers, and also could rely on the experience of Ohio's Round 1 counties that implemented DR beginning in 2008.

Formation of peer networks. All sites regularly organized some type of meeting for key staff to convene to discuss their experiences, lessons learned, and challenges with implementation. While perhaps not labeled as "peer networks," the result of these gatherings was the building of a collective, diverse community to support and grow with one another during DR implementation.

Supervision

Since the implementation of DR, there have been significant changes in CPS agency functioning. Supervision also took on different forms, with all five Colorado and some of the Ohio counties implementing a model of group supervision for cases. As a new structure, group supervision caused some confusion for workers and supervisors alike, as it challenges the traditional supervision model of one-on-one supervisor-worker meetings. In group supervision, staff across units collaborate and discuss case-specifics, decision points, effective engagement strategies, difficulties, and collectively decide how to proceed, making collaborative decisions. Positively, this has been reported as building a sense of mutual accountability among child welfare agency staff. This structure has also compensated for the lack of supervisor experience with FAR. Conversely, this has also been reported as resulting in a duplication of work and overloading staff with too many meetings.

A consistent theme in the R&D sites was that the role of the supervisor is paramount in building, supporting, teaching, modeling, and sustaining the practice, policy and procedural adaptations that accompany DR implementation. The second common theme, however, was the challenging nature of simultaneously creating a supervisory and worker workforce. Family assessment supervisors and workers alike noted that supervisors' lack of experience in performing FAR functions made it more difficult to skillfully perform the supervisory function. Some family assessment workers—with time and experience—report bypassing their supervisors in knowledge and skills in their work with FAR families.

Staff Structure

There was great variation in the R&D sites, and within the counties in the Colorado and Ohio sites, in how the child welfare agency structures the staff to conduct both IR and FAR. Some consistencies included:

Separate units. Large urban counties typically created separate FAR units. This dedicated workforce serves only FAR families, but in certain instances, except in Illinois, may provide

back-up for other child welfare agency functions. There was consensus across sites that it is difficult for workers to simultaneously carry both IR and FAR cases for various reasons, including: differing timeframes for activities, varying policies and forms, and divergent mindsets in approaching families.

However, even given the preference to separate IR and FAR functions, in some Ohio and Colorado counties, it was determined that this level of flexibility would ease work flow burdens that emerged given the unpredictability of the child abuse and neglect reports., especially in smaller counties. For example, if a higher rate of IR cases were screened in than the IR workers could reasonably handle, FAR workers would fill the agency's needs. In addition, given the highly volatile nature of staff retention rates, even with separate units or having staff perform only one function (IR or FAR), having workers' skilled and knowledgeable to perform both functions was seen as necessary. In such cases, workers are trained as both FAR and IR workers.

Lastly, while the sites are in the early stages of DR implementation, in States and communities with mature DR-organized CPS systems, it is noted that there has been a general transition—over time and after the FAR functions are fully embedded within the agency—for child welfare agency staff to have the capacity to simultaneously perform both IR and FAR functions.[21] This is more likely to occur in jurisdictions with small CPS staff or large agencies, out of necessity to manage caseloads. In addition, over time, there appears to be a fusion of child welfare practice, with increasing similarities between the IR and FAR functions.

Smaller-rural county structures. Given the more limited staff size in smaller or rural counties, across the county-administered sites, a consistent theme was that, out of necessity, intake workers staff both IR and FAR cases. It is not uncommon in rural areas for workers to serve as generalists.

Connection between FAR and IR workers. In agencies where there is clear separation of FAR and IR functions in the workforce, the sites suggested it is necessary to attend to the dynamics that separate units may create. Furthermore, they noted that communicating the value and necessity of both IR and FAR approaches is one of the lessons they learned in diminishing the tendency of the "new approach" being elevated as the "better approach." The sites employed various strategies to promote communication, team building and communication across functions. For example, some placed the separate units in close physical proximity; cross-trained staff; created numerous learning opportunities to understand the agency changes; and continually shared the vision of reorganizing their CPS system to offer multiple pathways. All of these strategies—either collectively or independently—are intended to prevent and/or diminish the "us vs. them" dynamic which tends to crop up in DR-organized CPS systems during early implementation. This phenomenon, while not fully eradicated, did diminish with time in Colorado and Ohio, given the execution of these and other strategies.

Caseload size. As demonstrated by the R&D sites, during and throughout the implementation of DR, one of the important areas child welfare agencies address is caseload size for the various

[21] Carpenter, C. (2009). Process Perspectives: Chronicling Ohio's Alternative Response Pilot Project Experience. Denver, CO: American Humane.

staff positions impacted by reorganizing the CPS system to have multiple pathways. A theme in a few sites was to initially implement a lower caseload size for FAR caseworkers, in an effort to provide them with extra time to gain comfort and competency with the practice changes associated with this pathway. In addition, a few sites viewed a major function of FAR caseworkers to provide services to families, beyond the traditional information and referral function, which would require more time.

As for caseload size, in Illinois, while unintended, the caseload size for FAR was much lower than anticipated and an increased caseload size for the IR workers was reported. The results from the summer 2011 focus groups noted that even though the private agency SSF workers were capped at 12 cases, their caseloads vary across the different agencies, but predominately were reported as manageable. All of the sites monitored and some adapted caseload sizes as implementation ensued. One strategy in Colorado to manage FAR caseloads was to transfer cases that would remain open past 60 days to ongoing services.

Caseload composition. One of the unintended, emerging consequences in all the sites relates to the investigative workers' caseload composition. All site visit reports note that IR workers' caseloads are predominantly comprised of more difficult, higher risk cases. This may have significant impacts on staff recruitment and retention, as it has been described as emotionally taxing and overwhelming. In addition, this type of caseload variation, if not managed well, can lead to resentment within the workforce.

ORGANIZATIONAL DRIVERS

ADMINISTRATIVE STRUCTURES

The implementation of DR requires comprehensive changes in policy, systems, and practice that must be coordinated and properly managed as the program matures. This requires sustained leadership, active input and buy-in from stakeholders inside and outside the system, the alignment of staff selection, training, and service functions, and the use of monitoring and feedback mechanisms to inform program and staff development over time.

All three sites have set up management structures to perform these leadership, advisory and oversight functions for the implementation of DR. These include: Colorado's CCDR Leadership Team; Illinois' Child Welfare Action Committee; and Ohio's DR Leadership Council and the six county Consortium Leadership Team, which were described earlier in this report.

Colorado has a well articulated and active management structure. Its Leadership Team consisting of representatives from the State and the five counties implementing DR meets monthly, overseeing and coordinating the work of the various workgroups (data, practice, screening and referral, learning, and cost), most of whom also meet regularly and have defined tasks. Stakeholders are well represented in these workgroups including county leadership, practitioners, parent partners, state agency staff, and the evaluation team.

In Illinois, overall management and leadership functions are much more concentrated in the hands of the project director. Input is often sought from DCFS and SSF caseworkers and supervisors, but decisions and the responsibility for ongoing program development and any

modifications are strictly those of the project director. There was a diversity of opinion from the workers as to whether their input was being systematically taken into consideration. As identified in the Illinois site visit report, determining the ongoing role of the DR Project Steering Committee could support the Project Director in navigating various implementation challenges.

In Ohio, participating counties have more flexibility and autonomy in the management and design of DR than is the case in the other sites. Its Consortium Leadership Team appears to function more as a means of sharing information and ideas, peer support, and coordinating on issues related to the evaluation. Most of the counties have their own administrative teams overseeing DR.

Data System Changes

The adoption of DR has triggered many modifications to the SACWIS of each site in order to better support the new service approach. These are very complex data systems used to properly document all child maltreatment cases including client characteristics and outcomes, findings, caseworker notes, and the observance of required procedures and timelines, as well as providing for staff and system performance tracking. The systems in each of the three sites had to be tailored to specifically meet the practices, forms, and timelines associated with serving families on the FAR pathway.

Colorado established a Data Workgroup to ensure that their SACWIS system, called Colorado Trails, is able to support FAR and monitor performance as well as gather the data needed for the evaluation. The group meets monthly, and works with the Trails manager (also a member) to specify and develop the required capacities. A monitoring capability has also been built into Colorado's system through a set of ad hoc reports to track such items as FAR eligibility rates, screen-in rates, racial disparities, use of community agencies, pathway assignment (FAR or IR), case opening and closing, and re-reports. These ad hoc reports are regularly reviewed by members of their DR leadership team and data workgroup, and are used to inform program decisions. There have been 7 system revisions or "builds" to date, even though they are supporting the efforts of the five participating counties. Caseworkers, supervisors, and administrators have made a number of specific suggestions for enhancing the capabilities of Trails for FAR cases, which are being considered by the Data Workgroup. This work was time intensive and relatively expensive, but has led to numerous changes that have improved the system not just for FAR, but in general.

Illinois has spent over $340,000 to incorporate DR into the state SACWIS system.[22] This includes building an entire FAR pathway with its own processes, forms, and time frames. It also required allowing access to portions of the system by the private FAR caseworkers, building an interface between their own Child and Youth Information System (CYSIS) and SACWIS. In addition, a monitoring capability was developed so that the project director can track summary statistics on FAR cases, which are used to monitor performance and flag potential problems.

[22] Wolfe, W., Jones, W., Fuller, T. (2010). Implementing differential response in Illinois: SACWIS and evaluation considerations. Presentation given at the 13th National Child Welfare Data Conference, July 20, 2010.

Even though Ohio had already had DR in 10 counties for over two years by the time the six-county SOARS consortium joined them, the capacity of the SACWIS system to support FAR cases was extremely limited first in the early months of the project, consisting only of the capacity to identify FAR cases. No functionality unique to FAR practice had been incorporated at that time. This is partly explained by the fact that Ohio was undergoing a major transition to a new system statewide. By the summer of 2011, about six months after the formal launch of the RCT, those capabilities had been expanded including all FAR-specific assessments, the transfer of cases to ongoing services, and any pathway reassignments from FAR to IR. One county SOAR representative reported that the close working relationship between county program staff and state IT staff to make the needed modifications to SACWIS has been very effective because it has been a partnership from the beginning.

Relationship with the Community

CPS is in part dependent for its success on good relationships with key stakeholders in the community including mandatory reporters, service providers, police, and the courts. Their active cooperation can enhance CPS capacity to serve families effectively, particularly in the case of FAR with its emphasis on preventive services. Their active resistance, on the other hand, has the potential to limit its effectiveness and even prevent its adoption. For that reason, across the sites, the importance and strategic investment in community and stakeholder education about DR has been emphasized.

Illinois made special efforts to reach out initially to such groups at the state level in order to meet their concerns when the DR legislation was being developed and passed. In Colorado and Ohio, a variety of mechanisms are used including town hall meetings, community education seminars, one-on-one meetings with agency heads, consultant presentations, and other events to help the broader community understand DR, how it modifies the CPS system, and how these various stakeholders may interact with, and support, this approach. This outreach is ongoing. In Colorado, particular efforts have also been made to reach out to each participating county's Child Protection Team, composed of stakeholders in the community. These groups, who traditionally have focused primarily on intake and assessment issues, have reportedly shifted their focus more to identifying community resources since the advent of FAR.

In Colorado, most caseworkers felt that the level of positive collaboration with community partners had increased since DR was implemented, particularly with mental health providers, domestic violence providers, victim advocates, and schools. Community partners who were interviewed also had positive feelings about DR overall, and a number within mental health and juvenile probation had started seeing signs that families were more positively engaged more openly communicating under DR. [23]

Not all agency and community feedback has been positive. Specifically, in Colorado and Ohio, a number of county prosecutor's offices, law enforcement officials, and guardians ad litem have expressed concern over the lack of court oversight of FAR cases, continuing concerns for the

[23] In Illinois and Ohio, community partners were not interviewed during this first round of site visits, so less is known about their understanding of and opinions about DR. There are plans to interview these stakeholders in the coming year, however.

safety of the children, and potential problems with preserving the chain of evidence. Some school officials have reportedly been concerned about the practice of interviewing parent and child together, and in Colorado some have complained about the increased time it takes to make a child abuse and neglect report.

The levels of support for and resistance to DR can vary by county. In Ohio, county managers report that the level of resistance to DR is related to the prior history of collaboration (or lack thereof) with these community partners before DR. So, while education and outreach may be important, their effects are certainly shaped by the quality of relationships prior to DR.

CHAPTER 5. DISCUSSION AND CONCLUSIONS

The QIC-DR is guided by a general model consisting of a limited number of clear parameters that allow a lot of flexibility in how DR would be designed and implemented in each of the sites. Further, even within the individual sites, there are varying degrees of flexibility in the design of DR for participating counties, particularly in Ohio and, to a lesser extent, Colorado. A simple, robust model that is tolerant of such local tailoring would be more easily adopted by other jurisdictions.

It is also possible, perhaps likely, that the general DR model is under-articulated. The evaluation may lead to a revised and more detailed model of DR, or to the emergence of several distinct practice models. Further evaluation of DR implementation, coupled with analyses of the RCT outcomes data should shed light on these issues when those data become available. In the meantime, these analyses of model fidelity and program implementation provide important feedback to the sites that may improve the structure and execution of FAR, and will better prepare the cross-site and site staff to understand the implications of the RCT outcomes for the identification of best practices and administrative structures for DR-organized CPS systems.

The experience of these sites confirms that the exploration and preparation phase to implement DR cannot be underestimated, from the perspective of time and level of effort. Legislative changes, community education, data system modifications, gathering agency staff input and buy-in are just a few of the activities that child welfare leaders have attended to during what can be a year-long process. In addition, the sites' experiences suggest that initial implementation efforts, including additional community education, staff training, policy and protocol development, require focused attention to address the myriad of changes that transpire with implementation. It also reveals that DR requires system-wide changes in practice, and will likely result in changes to IR practice as well whether intended or not, potentially affecting IR service approach and awareness of community resources in ways that resemble FAR.

In terms of the core components of DR guiding this project (as noted in the Introduction), available evidence suggests modest differences in fidelity across the sites.

- The FAR pathway is formalized in legislation in all sites. Written protocols have been developed and are in regular use in Illinois and Colorado. In Ohio, whose counties have the

most flexibility, the level of formalized protocols, over and above those baseline protocols established by State rule, varies by county.

- FAR cases have no formal finding of maltreatment in any of the sites, though when new safety concerns emerge FAR cases can be moved to IR.

- Eligibility criteria for DR are clearly identified in all sites. However, the mix of mandatory and discretionary criteria in Colorado and Ohio does allow for different eligibility decisions. It may also invite inconsistency within counties depending on how much latitude is given to decision-makers in the exercise of the optional criteria.

- FAR services have been consistently treated as voluntary. There is no evidence that families are being coerced into accepting services or threatened with a transfer to IR if they do not, though in some cases families were approached several times in an attempt to turn around refusals.

Further, caseworkers and supervisors at all sites report that there is, overall, an emphasis on partner-oriented relationship with families in FAR cases. Families are, with few exceptions, contacted in advance rather than visited unannounced. Family members are seen together rather than interviewed separately. Caseworkers report that FAR families tend to get services more quickly, and based on protocols, are to be seen more frequently.

A number of specific issues have been identified across the three sites, primarily around FAR eligibility determination where a number of grey areas have surfaced regarding who should be eligible for DR. This has led to some evolution in practice and guidelines at the local level as workers become more experienced with the program. Only in Illinois, however, has there been evidence of actual resistance to applying approved eligibility criteria, and a resulting formal change in eligibility criteria.

The review of implementation drivers has revealed a number of potentially important lessons for the sites and for others who may be considering implementing DR. Most supervisors in all three sites indicated that there were certain skills and attitudes that were particularly useful for FAR caseworkers to possess, though they also felt that these would be useful for both FAR and IR casework. These include: the capacity to quickly build a trusting relationship with the families; the ability to engage families in identifying strengths and needs; a more traditional social work focus on assistance rather than determination of whether abuse or neglect occurred; and a strong desire to do FAR work. Yet, these considerations were not consistently applied in the selection of staff for FAR across the three sites. Illinois considered only expressed interest in the position and seniority, the only factors allowed under the union agreement. For the SSF workers, there were specific criteria that were relevant for FAR work, but self-selection seemed to be less of a factor. In Colorado and Ohio, self-selection was also a consistent factor, and most supervisors reported using the above-described criteria in determining who would be selected for FAR. However, these criteria were rarely made official (only one county had a separate FAR job description), and likely varies both across and within counties.

Several important lessons surfaced regarding training. First, it was felt that everyone in the CPS system including FAR and IR caseworkers, screeners, ongoing workers, and administrators, all needed some level of training in DR in order for it to succeed. DR is a system-level change, and a lack of understanding can lead to distrust, confusion, resentment, and even active resistance from other parts of the system. Second, in training FAR workers there needs to be a special emphasis on doing FAR, not just learning about FAR. This means less lecturing and more role-playing, case learning, and hands-on work with the tools that will be used in the field. Sites have begun incorporating additional activities of this sort in their training efforts.

Regarding coaching, FAR supervisors were put in an awkward position in all sites. With the exception of Clark County, Ohio, none of the supervisors had previous experience with FAR. While many received the same training as their caseworkers, once the caseworkers were out in the field, their knowledge and experience with FAR quickly outpaced their supervisor's. This was partially compensated for in some cases by moving to RED teams (Colorado) and a group supervision model, and as programs mature and more FAR workers work their way into the supervisory ranks, this may become less of an issue. Clearly, some special up-front training and ongoing support for FAR supervisors that addressed FAR supervision tasks specifically would have benefited all sites.

The proper administrative structures and data systems are clearly important to the success of DR, providing access to resources, a structure for group decision-making, as well as providing important feedback loops to inform program development over time. The experience of the three sites indicates that appropriate structures will differ according to the level of autonomy that counties have relative to the state. Those with substantial county autonomy must have structures that allow for significant local input, and support local flexibility. Colorado seems to have been particularly successful in this regard. Illinois, on the other hand, is a State-run system with highly centralized administrative structures to support DR. Clearly the degree of central control has been a source of some friction even at the State level, though in many respects (especially in the development of data support systems) it has been highly successful. Regardless of administrative structure, however, the experiences of all three sites highlight the level of effort and funding required to change SACWIS systems to support DR, and the benefits of such investments.

The perception of workload inequities between FAR and IR workers has been an issue in all three sites at least to some extent. Potential sources include: IR caseloads that have more high-risk cases, as lower-risk cases are diverted to FAR; perceived increases in IR workloads resulting from the lower caseloads of FAR workers who are required to spend more time with each client; and as an example in Colorado, the notion from workers that FAR cases initially took more time, as there were considerable changes in workflow and documentation. Sites have used a number of strategies to address these problems including efforts to rebalance workload, and efforts to better inform IR workers about the nature and service intensity of FAR cases.

This report offers a midcourse view of the implementation of DR in the three sites over the first 18 months. Over the next 18 months, the RCT data and subsequent site visits will provide a more complete picture of the programs including their evolution, sustainability, cost, and their capacity to improve outcomes for the children and families they serve.

APPENDIX A: CROSS-SITE IMPLEMENTATION QUESTIONS

Table A-1
Fidelity to the DR Model
Cross-Site Questions and Data Sources

Stage	Question	Source	Lead/Probe
Initial Screen-in			
	Has the percentage of reports that are screened in changed under DR? In what direction?	SACWIS, Document review	
	Has the number of reports to CPS changed under DR? In what direction?	SACWIS, document review	
FAR Eligibility Determination			
	What are the criteria for FAR eligibility/ineligibility?	Document review	
	Please describe the process for determining FAR eligibility?	Document review, screeners, PD	Lead
	Beyond formal eligibility criteria, what are the guidelines and procedures for determining whether a case is eligible for FAR?	Document review, PD, screeners, supervisors.	Lead
	Have there been any challenges or problems in achieving consistency in how the eligibility criteria are applied?	PDs, supervisors, screeners	Lead
	How often is an assignment based on formal criteria changed? By whom?	PDs, supervisors, screeners	Lead
	Are there any aspects of the eligibility process that you would like to change?	Supervisors, screeners	Lead
	What percent of all screened-in reports are determined to be eligible for FAR?	SACWIS	
	Do you expect the percentage of screened-in reports determined eligible for AR is likely to rise over time as workers become more comfortable with FAR?	PD, supervisors	Lead
	Do you think there are cases being assigned to FAR that should not be? Examples?	Supervisors, caseworkers, screeners	Lead
	Do you think there are types of cases which are not currently eligible for FAR that should be? Examples?	Supervisors, caseworkers, screeners	Lead

Table A-1
Fidelity to the DR Model
Cross-Site Questions and Data Sources (continued)

Stage	Question	Source	Lead/Probe
Random Assignment			
	Have there been any problems resulting from the random assignment process?	PD, local administrators	Lead
	How were these resolved?	PD, local administrators	Probe
	Has the random assignment process produced an excessive workload for FAR or IR caseworkers?	PD, local administrators	Lead
	Has this been addressed? How?	PD, local administrators	Probe
Assessment			
	How soon after the initial report is a safety assessment generally done in FAR, IR cases?	Document review	
	How often are safety assessments performed while a case is open (FAR, IR)?	Document review	
	How, if at all, do safety assessments differ for FAR and IR cases?	PD, document review	Lead
	Do you feel that the safety assessments for FAR/IR cases are adequate?	Administrators, supervisors, caseworkers	Lead
Re-assignment			
	What percentage of FAR cases are re-assigned to the IR track after the initial track assignment? For what reasons? (e.g. family requests reassignment; caseworker reassigns based on safety concerns)	SACWIS, PD	
	Are these reassigned cases tracked over time? How?	PD	
	Have you ever had a FAR case reassigned to the IR track?	Supervisors, caseworkers	
	For what reasons?	Supervisors, caseworkers	
	Are AR families that refuse services ever re-assigned to IR for that reason alone?	PD	
	How many times have families requested to change from FAR to IR?	PD	

Table A-1
Fidelity to the DR Model
Cross-Site Questions and Data Sources (continued)

Stage	Question	Source	Lead/Probe
Service Delivery			
	Please describe the major differences in the procedures for responding to FAR and IR cases in your county.	Administrators, supervisors, caseworkers	
	Please describe what FAR workers do when they meet with a family (initial and follow-up meetings). Is it substantially different from what was done in the past?	Supervisors, caseworkers	
	Are there differences in the availability of services between FAR and IR cases?	Supervisors, caseworkers	Lead
	Differences in how quickly they receive services?	Supervisors, caseworkers	probe
	Differences in the amount of services received?	Supervisors, caseworkers	probe
	Differences in the types of services received? (Examples)	Supervisors, caseworkers	probe
Case Close			
	Do FAR cases tend to be open for longer than IR cases? About how much longer? Why?	Supervisors, caseworkers, document review	lead
	What are the guidelines for how long FAR and IR cases should be open? What is the procedure for extending that time?	PD, administrators	lead
Re-Report			
	What are the guidelines for track assignment for FAR cases that are re-reported? (e.g., always IR; FAR if eligible)	PD, administrators, document review	lead
	What are the track assignment guidelines for IR cases that are re-reported?	PD. administrators, document review	lead
	What, if any, quality assurance mechanisms are in place to assure proper tracking for re-reported cases.	PD. administrators, document review	lead
	How consistently would you say these guidelines are followed?	PD, administrators	lead

Table A-2
DR Implementation Question for Site Visits

Topic	Site Visit Questions	Who is to be asked?	Type of Question
IMPLEMENTATION			
Exploration and Adoption			
	What led you all to consider DR?	Administrators, PD, state level actors	Lead
	Who were the primary leaders in the process?	Administrators, PD, state level actors	Lead
	What key stakeholders were involved at this stage?	Administrators, PD, state level actors	Lead
	What if any other child welfare reform efforts were being initiated at the time? How did this influence the consideration of DR?	Administrators, PD, state level actors	Lead
	Would differential response have been adopted without the QIC-DR?	Administrators, PD, state level actors	Lead
Program Installation			
policy	Is DR clearly defined in state statute?	Document review	Lead
policy	Is DR practice clearly defined in state and county policy documents/manuals?	Document review	Lead
DR model	Please describe the process used to develop the DR model and practice guidance for your site.	PD, state level actors	Lead
DR model	Since initial implementation, have there been any formal changes to the DR model? How did those come about?	PD, state level actors	Probe
training design	Was a formal training curriculum developed for DR? Please describe.	PD, state level actors	Lead
training design	Who was involved in developing and reviewing the DR training?	Document review, PD, state level actors	Probe
data development	From your perspective, what changes to CPS administrative data systems were needed to support DR?	Administrators, state level actors	Lead
data development	How were those changes identified?	Administrators, PD, state level actors	Probe
data development	Who implemented those changes?	Administrators, PD, state level actors	Probe

Table A-2
DR Implementation Question for Site Visits (continued)

Topic	Site Visit Questions	Who is to be asked?	Type of Question
data development	What were the major challenges in making those changes?	Administrators, PD, state level actors	Lead
data development	What remains to be done to make the data system fully supportive of DR?	Administrators, supervisors, caseworkers, PD, state level actors	Probe
community buy-in	What outreach was done to key community stakeholders?	Administrators, PD, state level actors	Lead
community buy-in	What was the purpose of that outreach? (education, buy-in, active involvement)	Administrators, PD, state level actors	Probe
community buy-in	What groups were specifically targeted? (e.g. mandated reporters, law enforcement, service venders, lawyers, the courts)	Administrators, PD, state level actors	Probe
community buy-in	What has worked well in the community outreach process?	Administrators, PD, state level actors	Lead
	Were any groups not brought into the process initially that should have been?	Administrators, PD, state level actors	Lead
	What has NOT worked well in the community outreach efforts?	Administrators, PD, state level actors	Lead
community buy-in	Have suggestions from community stakeholders been incorporated into the DR model? Please provide examples.	Administrators, PD, state level actors	Lead
Implementation - Competency Drivers			
staff selection	What are the criteria for selecting caseworkers for alternative response? (e.g. skills, prior training, time in service, desire)	Administrators, supervisors	Lead
	If AR workers were drawn from existing pools of child welfare staff, what are the characteristics of those groups? (e.g. education level, training, age)	Administrators, supervisors	Probe
staff selection	How, if at all, are the criteria different from criteria for selecting workers into investigation response?	Administrators, supervisors	Probe
staff selection	How are those criteria related to the practice of alternative response?	Administrators, supervisors	Probe

Table A-2
DR Implementation Question for Site Visits (continued)

Topic	Site Visit Questions	Who is to be asked?	Type of Question
staff selection	How are those criteria distinct from those used to select caseworkers for investigation response?	Administrators, supervisors	Lead
staff selection	What was the process for selecting caseworkers for alternative response?	Administrators, supervisors	Lead
training	Who were the trainers?	PD	Lead
training	What was the trainers' level of prior experience with DR?	PD	Probe
training	Who was trained? (e.g. FAR caseworkers, IR caseworkers, Supervisors, Screeners)	Administrators, PD	Lead
training	How did the training differ for each of these groups? (length, content)	Document review	Lead
training	After the initial implementation of DR, how are new DR workers trained?	Administrators, PD	Lead
training	What if any changes have been made to the training curriculum since the beginning, and why?	Administrators, PD	Lead
training	During the training, what activities address the following: learning; skill development; buy-in?	Document review	
training	Must trainees demonstrate proficiency in the knowledge and/or practice of DR at the conclusion of training? How?	Document review	
training	Were you given an exam at the end of the training process to assess your knowledge of DR?	Document review	
training	How successful was the training in preparing you for your DR role?	Supervisors, caseworkers	Lead
training	How would you improve the DR training?	Supervisors, caseworkers	Lead
performance assessment	How is caseworker performance monitored for DR, IR?	Supervisors, caseworkers	Lead
performance	Have there been any concerns by caseworkers that IR caseloads are more taxing than FAR caseloads, or vice versa? Explain.	Supervisors	Lead

Table A-2
DR Implementation Question for Site Visits (continued)

Topic	Site Visit Questions	Who is to be asked?	Type of Question
coaching	Please describe the process used to coach FAR and IR caseworkers to improve practice. (what, how often, etc.)	Administrators, supervisors, caseworkers	Lead
coaching	Do you receive any ongoing training or coaching? (from trainers, supervisors)	Caseworkers	Lead
coaching	Do you feel that the coaching you receive is effective?	Caseworkers	Lead
supervision	How has worker supervision changed since DR was introduced?	Supervisors	Lead
supervision	Has the supervision of IR caseworkers been influences in any way as a result of DR? If yes, how?	Supervisors	Lead
Implementation - Organizational Drivers			
Decision Support Data System			
monitoring	What outcomes are monitored to assess DR performance?	Administrators, supervisors	Lead
monitoring	What DR and IR practice measures are monitored?	Administrators, supervisors	Lead
monitoring	How are these measures monitored? By whom?	Administrators, supervisors	Probe
monitoring	How frequently are these outcomes reported, and to whom?	Administrators, supervisors	Probe
Facilitative Administration			
	What administrative teams are responsible for the ongoing development of DR?	Administrators, PD	Lead
	What was the role of each team in the implementation of DR?	Administrators, PD	Probe
	What adjustments have these teams made to DR implementation since initial implementation? (staffing training, coaching, monitoring)	Administrators, supervisors, PD	Probe
	What changes or additions have been made to DR policies and procedures since initial implementation?	Administrators, supervisors, PD, state level actors	Lead

Table A-2
DR Implementation Question for Site Visits (continued)

Topic	Site Visit Questions	Who is to be asked?	Type of Question
	In what ways are administrative and other data sources used to inform changes to DR policy and practice?	Administrators, supervisors, PD, state level actors	Probe
Systems Intervention			
	Please tell us about instances in which implementation of DR has required additional changes in policy or practice that were not initially anticipated. How were these needs identified and addressed?	Administrators, supervisors, state level actors	
	Who are the DR champions in your county? What do they do that makes them effective?	Administrators, supervisors, state level actors	
	Has the implementation of DR affected practice in the IR track? How?	Administrators, supervisors, state level actors	
Community Environment			
Service Resources			
Awareness of DR	Are you familiar with the Differential Response (DR) demonstration that is being piloted within your county/state?	Community stakeholder	
Awareness of DR	Are most of the people in your organization familiar with DR?	Community stakeholder	
Awareness of DR	How did you learn about the DR demonstration project in CO?	Community stakeholder	
Awareness of DR	Have you ever attended a meeting or training related to DR?	Community stakeholder	
Opinion of DR	What is your overall opinion of the DR approach?	Community stakeholder	
Opinion of DR	Overall, what affect do you think DR has had on child safety?	Community stakeholder	
Agency role in DR	What role does your agency play, if any, in DR?	Community stakeholder	
CPS as a source of services for families	To what extent do you view DR as a source of services and assistance for families in your community?	Community stakeholder	
CPS impact on child welfare system	How has the DR project impact your role and your agencies work in child welfare?	Community stakeholder	

Table A-2
DR Implementation Question for Site Visits (continued)

Topic	Site Visit Questions	Who is to be asked?	Type of Question
CPS impact on child welfare system	How do you think DR will affect the safety of children and families in the child welfare system?	Community stakeholder	
Community resources	Do you feel there are adequate resources in the community to meet the needs of families that you see? What is missing?	Caseworkers, supervisors	
Community involvement	How are other community agencies and businesses being used in DR?	Caseworkers, supervisors	
Community role in DR	Since DR started, would you say that the relationship between CPS and other community service groups has improved, declined, or been unaffected? How has that varied by group?	Caseworkers, supervisors	
Community role in DR	What role do these groups play in DR?	Caseworkers, supervisors	

APPENDIX B: DIFFERENTIAL RESPONSE: DETAILED CASE FLOW MODELS

Figure B-1
Colorado DR Case Flow Model

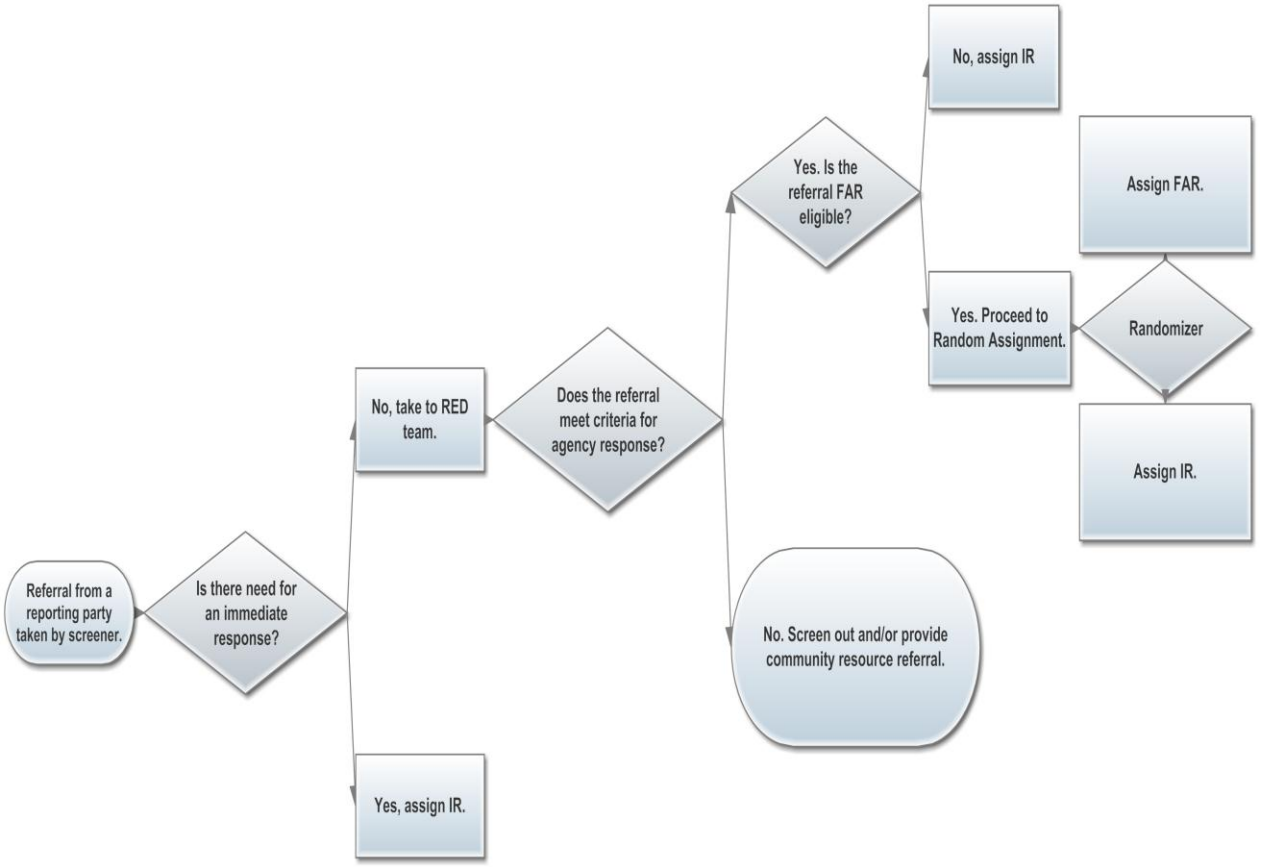
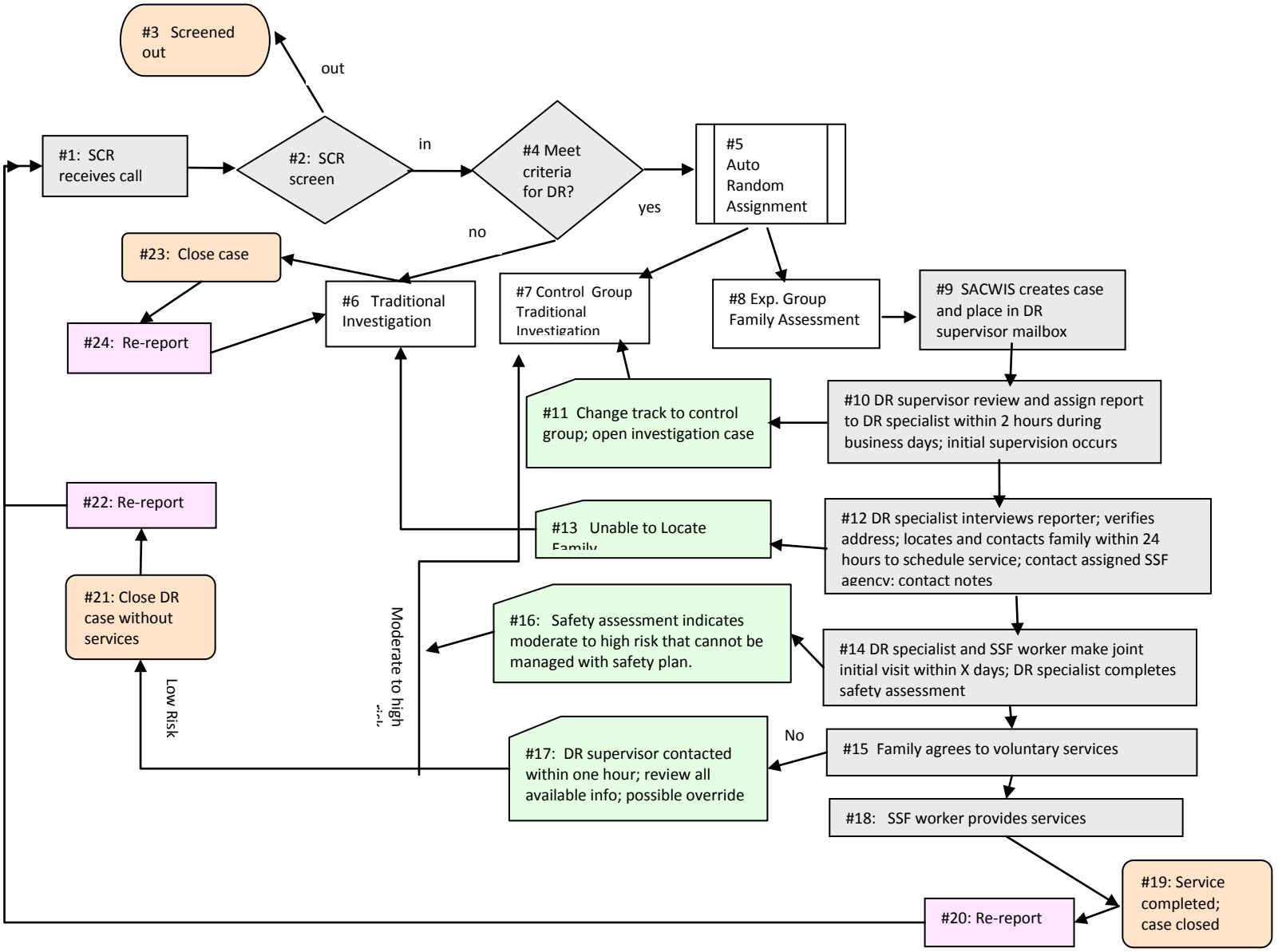


Figure B-2
Illinois DR Case Flow Model



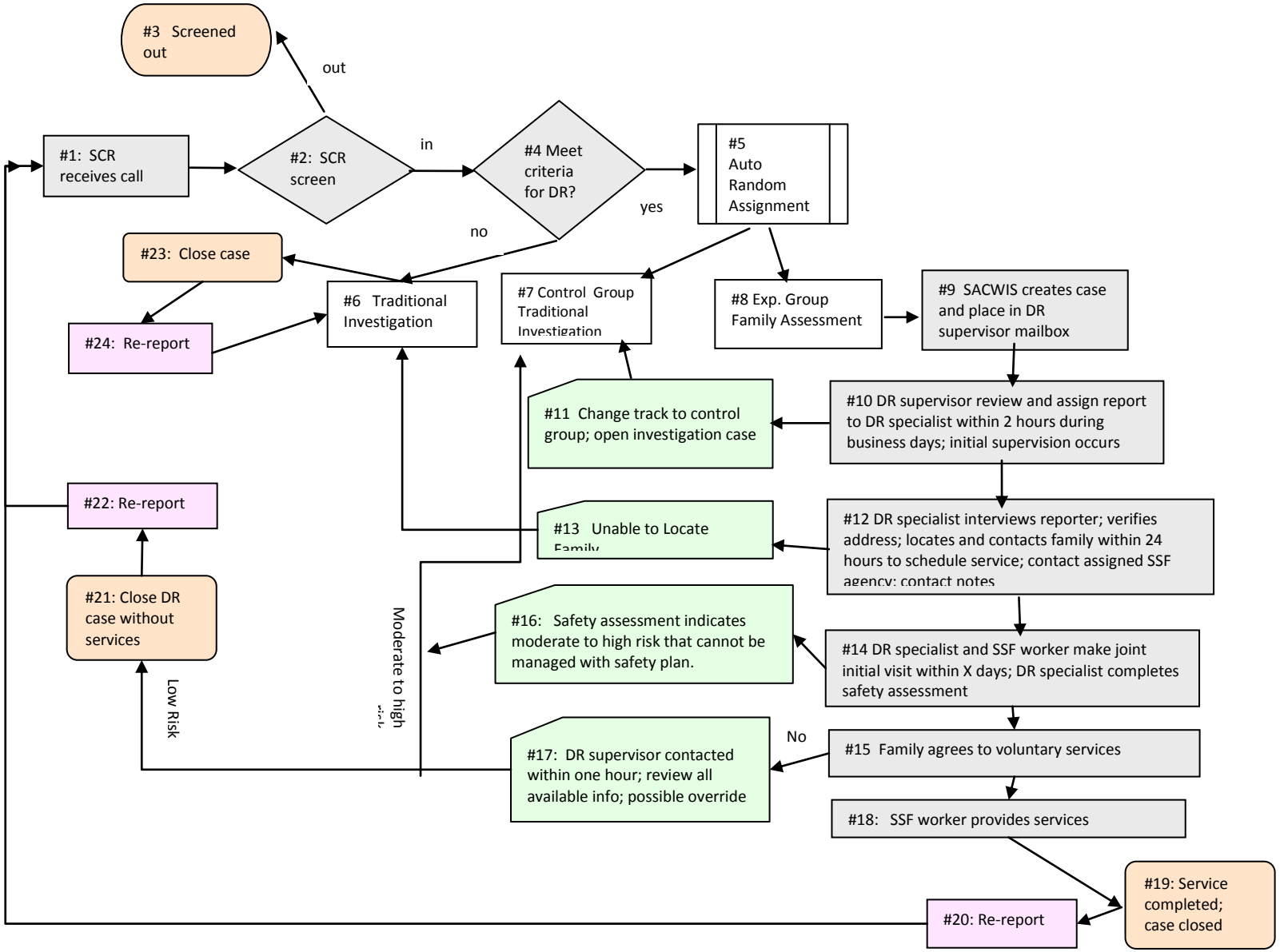
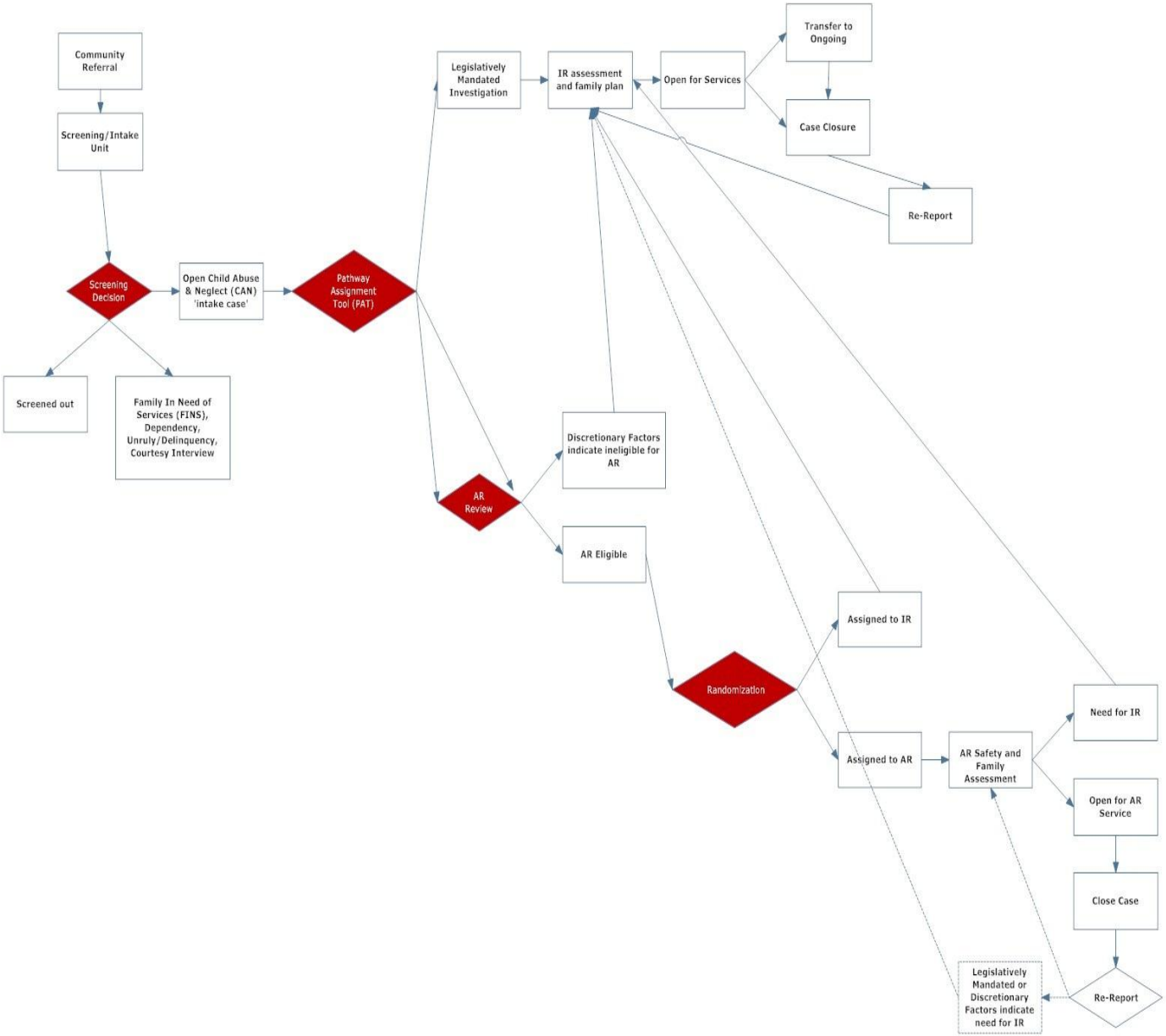
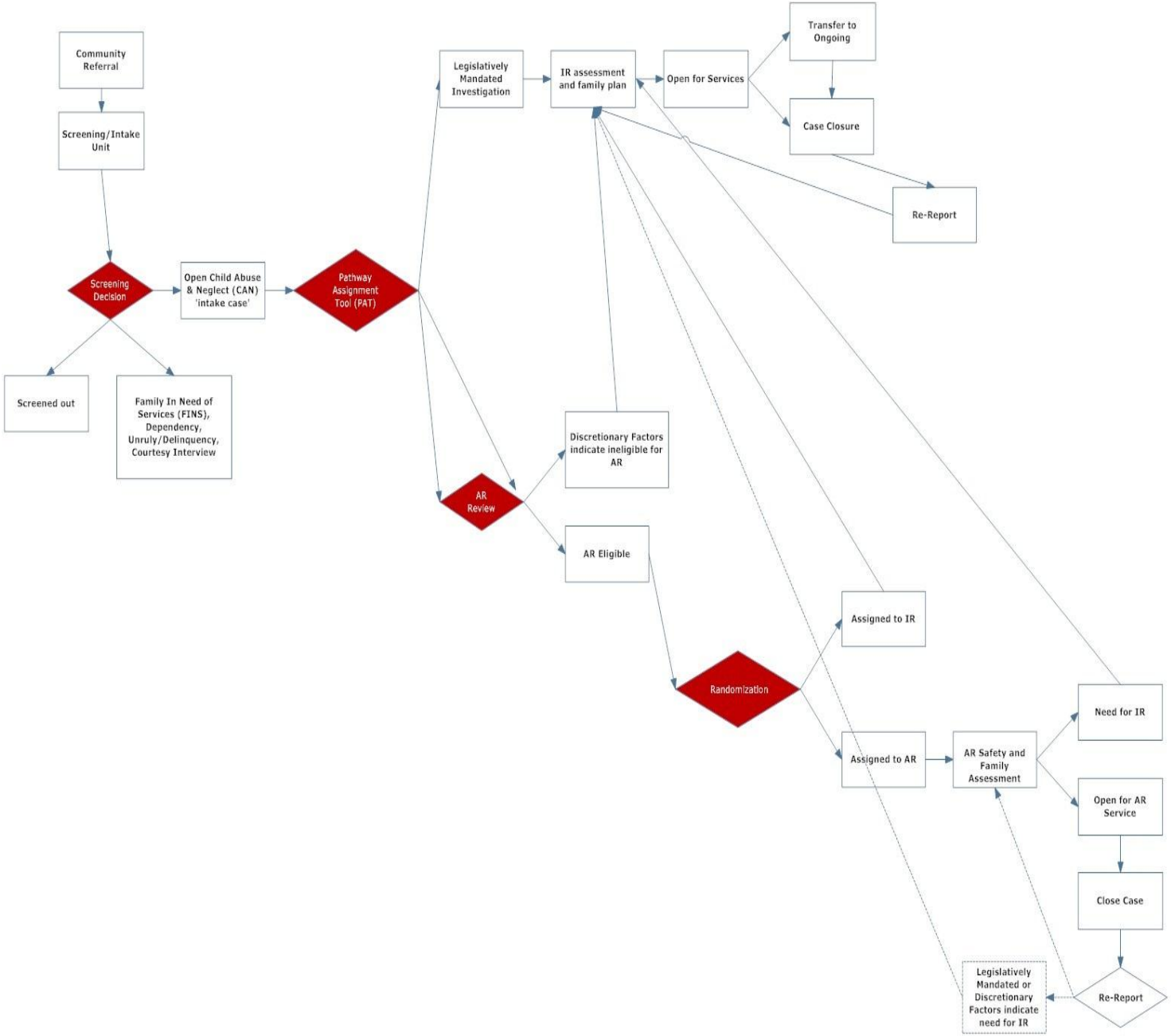

#3 Screened out
out
#1: SCR receives call
#2: SCR screen
in
#4 Meet criteria for DR?
yes
#5 Auto Random Assignment
no
#23: Close case
#24: Re-report
#6 Traditional Investigation
#7 Control Group Traditional Investigation
#8 Exp. Group Family Assessment
#9 SACWIS creates case and place in DR supervisor mailbox
#11 Change track to control group; open investigation case
#10 DR supervisor review and assign report to DR specialist within 2 hours during business days; initial supervision occurs
#22: Re-report
#13 Unable to Locate Family
#12 DR specialist interviews reporter; verifies address; locates and contacts family within 24 hours to schedule service; contact assigned SSF agency; contact notes
#21: Close DR case without services
Low Risk
Moderate to high
#16: Safety assessment indicates moderate to high risk that cannot be managed with safety plan.
#14 DR specialist and SSF worker make joint initial visit within X days; DR specialist completes safety assessment
No
#17: DR supervisor contacted within one hour; review all available info; possible override
#15 Family agrees to voluntary services
#18: SSF worker provides services
#19: Service completed; case closed
#20: Re-report

Figure B-3
Ohio DR Case Flow Model




Community Referral
Screening/Intake Unit
Screening Decision
Screened out
Family In Need of Services (FINS), Dependency, Unruly/Delinquency, Courtesy Interview
Open Child Abuse & Neglect (CAN) 'intake case'
Pathway Assignment Tool (PAT)
Legislatively Mandated Investigation
IR assessment and family plan
Open for Services
Transfer to Ongoing
Case Closure
Re-Report
AR Review
Discretionary Factors indicate ineligible for AR
AR Eligible
Randomization
Assigned to IR
Assigned to AR
AR Safety and Family Assessment
Need for IR
Open for AR Service
Close Case
Re-Report
Legislatively Mandated or Discretionary Factors indicate need for IR