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Guest Editor

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In the fall of 2008, the Children’s Bureau awarded a five-year cooperative agreement to create the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR). The QIC-DR was created in response to the need to explore the evidence behind differential response and to support additional research in the field. Through the QIC-DR, a project team of national experts led by American Humane Association is tasked with generating and disseminating new knowledge and robust evidence about differential response systems and strategies. As a part of this work, in 2009 the QIC-DR awarded three research and demonstration projects in Colorado, Illinois, and Ohio to pilot and evaluate their differential response efforts. The research and demonstration sites are currently working to answer the following questions as developed by the QIC-DR:

1. Are children whose families participate in the non-investigation pathway as safe as or safer than children whose families participate in the investigation pathway?

2. How is the non-investigation pathway different from the investigation pathway in terms of family engagement, caseworker practice and services provided?

3. What are the cost and funding implications to the child protection agency of the implementation and maintenance of a differential response approach?

This is an opportune time to explore and apply the findings from these critical questions and improving practice. Currently, 21 States and tribes have reorganized their CPS systems to implement differential response, with an additional 7 States contemplating such an innovation. The interest in employing differential response to enhance child protective systems has been steadily growing. The recent Child Abuse Prevention and Treatment Act Reauthorization of 2010 (PL. 111-32) (CAPTA), passed in December 2010, contained a thematic emphasis on differential response, States’ use of this approach, and reporting on these efforts. While States can define differential response in a manner that is consistent with individual State law, States are now required to describe their actions and submit additional data in the annual State data reports, including the number of families that receive differential response as a preventive service. As the child welfare field moves forward in the application of these provisions, the findings from the QIC-DR research and demonstration site evaluations will be very relevant as they will offer a more robust knowledge base from which States can learn and shape local efforts.

The QIC-DR’s research focuses on themes consistent with the Children’s Bureau’s mission of safety, permanency, and well-being. It is the intent of the QIC-DR that the knowledge developed through these efforts will move the field forward in improving the well-being and outcomes of children and families.

Inside this issue

This issue of Protecting Children features the initial work of the three research and demonstration sites funded through the QIC-DR.
The efforts presented here share the successes and lessons learned as the research and demonstration sites work through both the programmatic and evaluation aspects of the implementation of differential response in their communities. Also included in this edition are several articles on the implementation of differential response outside of the work of QIC-DR. Contributors to this volume provide a broad variety of perspectives that reflect various stakeholders’ views on the implementation of differential response systems, key considerations, and areas for advancement in the field and further research.

The Illinois research and demonstrate site of QIC-DR opens this issue with Putting It All Together: Lessons Learned from the Planning and Development Phases of Implementing Differential Response in Illinois by Kathleen Kearney, Tamara Fuller, Womazetta Jones, and Erwin McEwen. Their article details the lessons learned during the first two years of the project planning and development through the lens of emerging implementation science and research. The article focuses on the collaborative planning process used to design the Illinois program model, their plan to assess community readiness and engage critical stakeholders. Core implementation drivers used by the Illinois Department of Children and Family Services to support differential response in a state administered but largely privatized child welfare system are identified and assessed.

The Ohio SOAR project presents the article, From “Pie in the Sky” to the Reality of Implementation: Lessons Learned by the SOAR Consortium on the Journey to Differential Response by Kevin Brown, Stacy Cox, and Nancy Mahoney. This article features counties that participated in an initial pilot of alternative response in Ohio and paved the way for the additional multi-county pilot that was awarded a project also by the QIC-DR in 2009. This practice-focused article thoughtfully provides answers to the question: “If my organization was thinking of implementing alternative response, what would I want to know?” Sharing lessons learned from the Ohio research and demonstration project, the authors outline the changes in practice, examples of successes, and challenges that counties have faced during implementation. Information is presented from the perspective of the worker and supervisor in the field, adding a unique voice to this body of work.

In Decision Point: Screening Practice as the Foundation for Differential Response by Marc Winokur, Ida Drury, Keri Batchelder, and Marc Mackert, the Colorado research and demonstration site describes the design and implementation of a screening and assignment process in five Colorado counties that are piloting differential response. The process was initiated to promote readiness for differential response for their pilot, and includes analysis of data from a six month period following implementation, as well as interviews with supervisors, caseworkers, and screeners who engaged in the process. This work is seen as foundational in institutionalizing effective systems change in practice in Colorado.

Another perspective can be found in New Brunswick's Vision for the Future of Child Welfare and Child Protection, by Joan Mix, which outlines the practice change efforts in the child welfare system in New Brunswick, Canada. The perspective shared by the author provides a broad view of the role of differential response as part of system reform and practice change efforts including Family Group Conference, Immediate Response Conference, and Family Enhancement Services.

The next article connects the work of the QIC-DR research and demonstration sites through an examination of the development of the QIC-DR cross-site evaluation. In Building a Multi-Site Evaluation of Differential Response, Brett Brown
describes the development of the methodology and instrumentation for the cross-site evaluation of the QIC-DR project sites that includes an outcome, process, and cost evaluation. The author highlights the importance of partnerships between cross-site evaluation teams, local evaluators, and project directors, as well as the importance of partnerships between the project staff and local key stakeholders.

Once designed, an evaluation must be implemented at the local level. This process can be both a very exciting opportunity, as well as a challenge on both a technical and practice level. In *Evaluation of Differential Response in Ohio: Challenges in Implementing a Randomized Control Trial*, Linda Newton-Curtis and Madeleine Kimmich present a down-to-earth discussion of the challenges that local agencies face when asked to participate in a randomized control trial and how these concerns might be addressed. The article focuses on several specific issues Ohio has been experiencing as they implement their evaluation.

Another approach to evaluating a systems change effort, such as implementing differential response, is through the qualitative method of chronicling. In *Making the Case for Chronicling Systems Change*, Carla Carpenter provides a first-hand account of the benefits of chronicling child welfare reforms such as the Ohio alternative response pilot project. The article includes a discussion of how the chronicling process benefitted the project as well as some of the important lessons learned through this process.

*Worth the Investment? Analysis of Costs in a Differential Response Program* by Gary Siegel closes this volume. This article provides a robust examination and overview of the cost study element of a three-part evaluation of the Minnesota differential response pilot conducted by the Institute of Applied Research (IAR) from 2001 through 2004 with a subsequent extended follow-up that covered 2004-2006. The impact and cost studies used an experimental design in which 14 of the 20 counties in Minnesota participated. The cost study included both a cost-tracking analysis and a cost-effectiveness analysis. The work that IAR presents here begins to examine the possible cost benefits of differential response and the positive cost differences attributable to the family assessment approach based upon their 2004 evaluation and the extended follow-up in 2006.

**Acknowledgments**

American Humane Association has gathered an excellent collection of contributors to this issue of *Protecting Children*. We are pleased to have the QIC-DR research and demonstration sites share their successes and lessons learned as many work through both the programmatic and evaluation aspects of the implementation of differential response in their communities. We look forward to their continued contributions to the child welfare field as they continue to innovate and advance their implementation. We would also like to express our thanks and appreciation for the other authors from the field who have shared their work in this issue and continue their efforts to move the field of differential response and child protective services reform forward.

Finally, we would like to give special thanks to the staff of American Humane Association for their diligent efforts and dedication to the work of the QIC-DR and the compilation and coordination efforts to create this issue of *Protecting Children*. 
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Putting It All Together: Lessons Learned from the Planning and Development Phases of Implementing Differential Response in Illinois

Kathleen A. Kearney, Tamara L. Fuller, Womazetta Jones, and Erwin McEwen

Introduction

As of December 2010, approximately 17 states are either using a statewide differential response (DR) system or have implemented DR in localities, and at least seven additional states, tribes, or jurisdictions are known to be considering or planning implementation of DR (Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR], 2010). States and jurisdictions that are considering DR implementation need information that can guide their early decision-making and planning processes. There is growing consensus that implementation is a process, not an event, and that it occurs in stages. Aarons et al. (2011) identified four distinct phases: exploration, adoption/preparation, implementation, and sustainment. The following paper documents the early stages of the implementation process in Illinois, a large, state-administered child welfare system. Each of the early implementation activities is discussed in sequence, including the exploration of existing DR models in other states, development of legislation and rule to support DR, and development of the DR practice model. In addition, the paper describes the core implementation “drivers” that were used to support early implementation of DR, viewed through the conceptual lens offered by the burgeoning field of implementation science (e.g., Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Although Illinois is still in the initial stages of implementation, important lessons have already been learned that may assist those jurisdictions contemplating DR implementation.

Exploratory and Planning Phase for Differential Response

In 2008, the Illinois Department of Children and Family Services (DCFS) asked the Children and Family Research Center (CFRC) of the University of Illinois at Urbana-Champaign to review existing literature on DR and advise regarding the feasibility of implementing DR in Illinois. Following the submission of the CFRC findings, DCFS Director Erwin McEwen convened a task group of interested stakeholders in July 2009 to attend a peer-to-peer technical assistance conference sponsored by Casey Family Programs, featuring representatives from Minnesota responsible for the implementation and management of DR in that state. Following the peer-to-peer meeting, this stakeholder group met frequently to envision and design the Illinois DR model.

DCFS relied upon literature related to home-visiting programs and the use of recovery coaches in child welfare in developing the Illinois model. DePanfilis and Dubowitz (2005) examined a multi-
faceted, community-based service program which worked with families in their homes and in the context of their neighborhoods to help them meet the basic needs of their children and to reduce the risk of child neglect. The practice principles of this model include individualized family assessment, tailored interventions delivered in the home, and a strengths-based perspective and focus. This study found positive changes in protective factors, diminished risk factors, and improved child safety and behavior. A second model, employing the use of a recovery coach to provide an integrated approach to case management, including comprehensive assessments, advocacy, service planning, outreach, and case management, has been found to be effective in increasing the rate of service access and the likelihood of reunification (Ryan, Marsh, Testa, & Louderman, 2006). Both the home-visiting and recovery coach approaches were incorporated into the Illinois DR practice model.

Once the initial DR practice model was developed, further oversight for DR in Illinois was provided by the Differential Response Project Steering Committee established under the Illinois Child Welfare Advisory Committee (CWAC). The Illinois child welfare system is largely privatized, with over 80% of services delivered to children and families by private agencies under purchase of service (POS) contracts with the department. CWAC was created in 1995 to provide a forum for collaboration between the public and private child welfare agencies in Illinois. The express purpose of CWAC is to advise the department regarding “programmatic and budgetary matters related to the provision of purchase of child welfare services” (Illinois Administrative Code § 428.50). All CWAC subcommittees and work groups have representatives from both the public and private sectors. During the first year of operation, the work of the DR Steering Committee centered on further exploration of the organizational and services infrastructure required to successfully adopt DR (e.g., Simpson, 2009).

Departmental leadership determined that it was a necessary first step to expose existing DCFS child protective services (CPS) and child welfare staff, as well as local community stakeholders, to DR in order to imbed DR as part of the department’s bigger vision of child welfare reform, to increase interest and mobilize support, and to allay fears and clear up misconceptions. A series of 11 town hall meetings were held throughout the state between August and October 2010 in which the DCFS director and DR project director presented the proposed DR model, answered questions, and received comments.

Legislative and Rule Changes to Support Differential Response

The Illinois Differential Response Program Act (Public Act 096-0760) was enacted in August 2009. Amending the Illinois Children and Family Services Act and the Abused and Neglected Child Reporting Act, it provided the authority for the department to implement in rule a 5-year demonstration of DR. This legislation includes the core elements of a DR approach as identified by the QIC-DR, including a discrete pathway for eligible cases and the provision of voluntary services with no formal determination of maltreatment on the state’s central register for those cases assigned to the DR pathway. The legislation also required that an independent evaluation be conducted in order to determine if the DR program was meeting its stated goals.

The Illinois Administrative Code was amended to add a new section in August 2010 to allow for the family assessment response (Illinois Administrative Code § 300.45). According to the amendment, in addition to setting forth eligibility criteria, an initial assessment is required to
confirm that the case is appropriate for family assessment services. Family assessment services are provided without a formal substantiation of alleged maltreatment and a record of the case is not entered in the State Central Register (SCR). Cases opened for these services are short term and may not exceed 120 days. Participation is voluntary, and cases involving families that refuse these services are closed if no safety and/or risk issues are identified as a result of this assessment. If it is determined that a child’s safety is compromised by this refusal, the case may be reassigned to the investigative pathway. The rule makes clear that if, at any time during the service delivery period, a family’s caseworker has reasonable cause to believe that a child in the family has been or is being abused or neglected and is at risk of harm, the caseworker will contact the hotline without delay to make a report of abuse or neglect.

3. Protective custody is not needed or taken; AND

4. Allegations include, singly or in combination:
   - Inadequate food
   - Inadequate shelter
   - Inadequate clothing
   - Environmental neglect
   - Mental injury
   - Medical neglect
   - Inadequate supervision, unless the child or children are under the age of 8 or demonstrates an emotional/mental functioning equivalent to that of a child under the age of 8, and there is no adult present or able to be located or if the adult is present but impaired and unable to supervise.

The Illinois DR Model: Pathways to Strengthening and Supporting Families

The DR model in Illinois was named Pathways to Strengthening and Supporting Families (PSSF) in recognition of the greater vision of child welfare in Illinois to protect children by strengthening their families. Under the PSSF approach, accepted reports of abuse or neglect are eligible for PSSF if they meet all of the following criteria:

1. Either no prior family reports to the SCR; OR no prior indicated allegations of abuse and/or neglect; OR prior indicated reports have been expunged within time frames ranging from 5 to 50 years; AND

2. Alleged perpetrators are parents (birth or adoptive), legal guardians, or responsible relatives; alleged victims are not currently in DCFS care or custody or wards of the court; AND

3. Protective custody is not needed or taken; AND

4. Allegations include, singly or in combination:
   - Inadequate food
   - Inadequate shelter
   - Inadequate clothing
   - Environmental neglect
   - Mental injury
   - Medical neglect
   - Inadequate supervision, unless the child or children are under the age of 8 or demonstrates an emotional/mental functioning equivalent to that of a child under the age of 8, and there is no adult present or able to be located or if the adult is present but impaired and unable to supervise.

Reports that do not meet each of these criteria receive a CPS investigation according to current DCFS rules and procedures.

DR cases are assigned to a two-person team comprised of a public sector DR specialist employed by DCFS who assesses initial safety and an SSF (DR) caseworker employed by a private agency under contract with DCFS to provide direct services to families who are eligible and agree to participate in the DR program. The initial visit to the home is conducted jointly by both workers using a paired team approach, and a thorough family assessment process is conducted, which includes the following:

- The DCFS DR specialist assesses the safety of all children in the home through the use of the Illinois Child Endangerment Risk Assessment Protocol (CERAP).
- If the child/children is/are determined
to be unsafe, the DCFS DR specialist consults with his or her supervisor, who has the authority to reassign a family to the investigation pathway.

- If there are no immediate safety concerns, the DCFS DR specialist closes the case and hands over all future services, including ongoing safety assessment, to the private agency SSF caseworker, thereby ending DCFS involvement with the family.

The SSF worker completes a family needs and strengths assessment.

In the Illinois model, the SSF worker functions as “the agent of change” on behalf of the family by providing the family members with a wide array of family-focused services targeted to their specific concerns. The Illinois DR practice model requires the PSSF worker to offer the following services pursuant to Illinois Administrative Rule § 300.45:

1. A comprehensive and collaborative evaluation of the family’s strengths and needs, including the family’s financial status, basic educational screening for the children, and physical health, mental health, and behavioral health screening for all family members. Information obtained will be used to construct a genogram and an ecomap for use with the family;

2. Services to meet any immediate needs of the family, including food, shelter, and clothing;

3. A minimum of twice-weekly face-to-face contacts with the family which will include the children in the household;

4. Service planning;

5. Services to mitigate or control the causes of neglect;

6. Ongoing CERP safety assessments by the private agency SSF worker, to be completed throughout the life of the case in accordance with the requirements for intact families established by CERP;

7. Assessment of the family’s reasonable progress in resolving the issues that brought the family to the attention of the department;

8. Advocacy services; and

9. Discharge planning.

While the model is not one of linkage and referral, it does require that the PSSF worker educate the family about available services in its community as part of aftercare planning. It is expected that the PSSF worker will assist the family in accessing local services needed by the family before the case is closed. The contract between the department and the private agencies performing DR services contains specific language mandating that all interaction with and advocacy for the family be strengths-based and family-focused, thereby infusing the protective factors set forth in the Strengthening Families model which has been adopted by Illinois as a best practice (Illinois Department of Children and Family Services [DCFS], 2011b).

Cases assigned to the DR track may remain open for up to 90 days. After 90 days, an extension of services for an additional 90 days (a maximum of three extensions of 30 days each) may be approved based upon the family’s needs and the availability of funds. Cash assistance is available of up to $400 per family through the Differential Response Cash Assistance Program set up to
support concrete needs of families. Additional funds can be approved if necessary by the DCFS DR project director. The private agency SSF supervisors will review and approve family assessments, service plans, ongoing CERAP safety assessments, cash assistance requests, appropriateness of service referrals, case file documentation, requests for service extensions beyond 90 days, and requests to close DR cases (Illinois Administrative Code § 300.45, 2010). If a new CPS call pertaining to the family is made to and accepted by the SCR during the time the DR case is open for services, the case is immediately transferred to the investigative track.

Core Implementation Components: Lessons Learned Year 1

Implementation science is an emerging field of research which examines the adaptation of evidence-based interventions within real-world settings. During the past decade, the growing body of literature reflects the difficulty of translating research findings to effective practice, especially in the delivery of human services, which are delivered through the actions of individuals and organizations within the context of a complex multi-systemic framework in which they operate (Aarons, Hurlbert, & Horwitz, 2011; Mitchell, 2011). According to Fixsen et al. (2005), the practitioner is the intervention in human service programs; therefore, the science and the quality have to be built into the practitioner situated within a variety of provider organizations operating under policies mandated by both the federal and state governments.

Fixsen et al. (2005) identified core implementation components (also called implementation drivers) essential to successful human service change efforts. These core components are staff selection, pre-service and in-service training, ongoing coaching and consultation (supervision), staff performance evaluation, decision support data systems, facilitative administrative support, and systems interventions. These interactive processes are both integrated to maximize their influence on staff behavior and compensatory in that a weakness in one component can be overcome by strengths in other components (Fixsen, Blase, Naoom, & Wallace, 2009). An examination of the core implementation components of the Pathways to Strengthening and Supporting Families project during its first full year of operation follows.

Staff Selection

Child protective services in Illinois are conducted by department workers who are unionized. The initial DR stakeholders group believed strongly that the determination of child safety in cases where child abuse and neglect are alleged is a critical function of government and should rest in the hands of a public sector employee. Illinois also has a long-standing tradition of privatizing child welfare services through contracting with local community-based organizations. The Illinois DR model incorporates a team approach wherein the public sector worker (DR specialist) determines initial child safety and the private sector worker (SSF caseworker) provides services and supports to the family. The SSF worker is also responsible for ongoing safety assessment throughout the life of the case. In the event child safety is deemed compromised by the SSF worker, the case will be referred back to the department for a traditional CPS investigation.

The initial stakeholder group included representatives of the public employee union. Once the DR specialist positions were created, a memorandum of understanding was negotiated between the DR project director and the union (DCFS, 2010). Pursuant to these negotiations, the DR specialist positions were considered voluntary temporary assignments for a specified period of time, after which the public worker would return
to his or her prior assignment within the department. Only child welfare specialists, CPS workers, and day care licensing representatives were eligible to apply for temporary assignment as a DR specialist to ensure the necessary credentials to serve in this capacity. All DCFS employees assigned to DR must be certified to use the CERAP and must be child welfare licensed. In keeping with the master contract between the department and the employee union, length of service of the employee was the prevailing factor in determining who was hired into these positions.

Private agencies were selected at the regional level. These agencies were selected based on the following variables: the existing service catchment area and familiarity with local social services; previously demonstrated engagement skills with families needing child welfare services; and financial stability to ensure continuity of service provision. A standardized rate was used for all prospective DR agencies; therefore, competitive procurement was not required. Data from FY 2009 was used to project staffing needs. Agencies were funded at a 12:1 caseload ratio with guaranteed full funding for FY 2011 contracts. The contract requires that agency staff assigned as SSF workers have a bachelor’s degree acceptable by Council on Accreditation (COA) standards. SSF workers must also be certified to use the CERAP since they are responsible for ongoing safety assessment once the DCFS DR specialist is no longer involved in the case. All staff assigned must also have documented experience working with youth and families and are to be knowledgeable of the child welfare system. Supervisors must have a master’s degree or higher, as well as extensive experience working with families at risk (DCFS, 2011b).

Training

The department has a centralized training division which it utilized to train both public and private agency DR staff. The curriculum was developed by the training division under the direction of the DR project director. In order to cover all of the subjects deemed necessary by the project director, and to allow the trainees the opportunity to practice new skills acquired during training, a mandated face-to-face training of 4 weeks was developed for all private and public DR front-line and supervisory staff. Training sessions were delivered regionally. The DCFS DR specialists and the private agency SSF workers were trained together to allow them to form strong working relationships and to build trust for one another over the extensive training period.

Areas covered by the training included:

- DR overview and philosophy;
- Illinois-specific DR procedures;
- Family engagement;
- Child Endangerment Risk Assessment Protocol (CERAP);
- Tools supporting DR (e.g., family assessment protocol, voluntary family assessment plan, domestic violence screen, home safety checklists, ecomaps, genograms, and statewide provider database);
- Conflict resolution;
- Community advocacy; and
- Evaluation of DR and data collection.

The Illinois DR project is part of a larger randomized control trial with the control group consisting of cases assigned to the traditional investigative pathway; therefore, all DCFS child protective caseworkers and supervisors are likely to be assigned a case in the control group during the period of evaluation. Mandated training for all case-carrying investigators and supervisors was developed and delivered through a 2-hour instructor-led webinar. This training has also been incorporated into the DCFS pre-service training for all new CPS investigators hired after November 1, 2011.
Supervision and Coaching

It is well established that training alone is insufficient to effectively implement a new approach (Fixsen et al., 2009). It is necessary to transfer what is learned from the training curriculum into skills which can be used in performing the daily work. Recent studies have found that supervisor support and training reinforcement enhance the transfer of skills following child welfare training (Antle, Barbee, & van Zyl, 2008; Antle, Barbee, Sullivan, & Christensen, 2009). Because innovations such as DR require behavior change at the practitioner, supervisor, and administrative support levels, it is necessary to provide for transfer of knowledge through both formal supervision and coaching at all levels. Formal supervision is more compliance-driven and determines practitioner fidelity to the practice model; coaching is more skills-based and helps to develop clinical judgment grounded in best practices. Both are necessary for successful implementation (Fixsen et al., 2005).

A list of specific supervisors’ objectives and expectations was prepared by the DR project director for the DR specialist supervisors within the public agency. These supervisors are expected to speak immediately to the assigned DR specialist at the time of case assignment to review and discuss case information. Supervision may be held telephonically for those cases in which the supervisor may not be working in the same location as the DR specialist. A supervisory conference is to be held within 24 hours after the DR specialist’s initial in-person contact with the family for the purpose of reviewing contact notes and the initial CERAP prepared by the DR specialist, as well as to ensure procedural compliance. DCFS DR supervisors are required to meet with their staff members individually twice per month for face-to-face supervision and to hold monthly team meetings in person with all unit members.

Private agency contracts require significant supervisory review and oversight of the SSF caseworkers’ tasks and duties. The private agency SSF supervisor must review and approve family assessment and service plans, and review family service plan progress weekly. Supervisors must also approve all safety plans, ensure weekly review of all unsafe CERAPs, and ensure the weekly monitoring of children who are the subjects of safety plans. Supervisors must also approve all terminations of safety plans, all case-closing CERAPs, and, ultimately, case closure. In addition, supervisors may participate in person in family meetings, and review and approve cash assistance requests and worker requests for extension of DR services. Specific contract language requires supervisors to make diligent efforts to contact and engage birth fathers and paternal family members.

Public agency DR supervisors and private agency SSF supervisors were trained at the same time and with the front-line workers. The DR training curriculum did not specifically address supervision and coaching. A separate stand-alone training to teach coaching skills will be developed in the future by the department. The DR project director conducts weekly teleconferences with DCFS DR supervisors and monthly teleconferences with the private agency SSF supervisors to provide both supervision and coaching on the program model. The project director personally reviews cases assigned to the DR track and provides guidance on recommended approaches.

Staff Performance Evaluation

According to Fixsen et al. (2005), staff performance evaluations should be designed to assess the use and outcomes of the skills that are reflected in the selection criteria, taught in training, and reinforced and expanded upon through supervision and coaching. Staff evaluations should first and foremost be used as a means to help the practitioner continue to
improve in effectively providing services to children and families eligible for DR services. Assessments of performance at the practitioner level should be aligned with programmatic fidelity measures.

This core component was not as fully developed as others during the first year of program development and implementation. DCFS DR specialists’ performance evaluations are governed by the master contract with the union. Any changes to reflect DR-specific performance indicators must be negotiated with the union. Job descriptions were prepared for the department’s DR specialists and DR supervisors, but they do not contain any specific qualifications beyond educational requirements and minimum number of years of child welfare work experience. The memorandum of understanding between the department and the union indicates that since the employee’s assignment to DR is strictly voluntary on the employee’s part, and the DR program is new, the department will not utilize progressive and corrective discipline to address work performance or case related/case outcome issues and problems (DCFS, 2010). Counseling and corrective action plans will be used to address performance deficiencies. The memorandum of understanding also states that the master union contract controls employee evaluations. The memorandum encourages “periodic informal evaluation conferences” between the DR specialists and their supervisors, as well as between the DR supervisors and the DR project director, but restricts written employee evaluation to DR work performance only and must acknowledge that the assignment is voluntary and the performance evaluated is not reflective of the employee’s permanent job assignment.

The FY 2011 contract with the private agencies indicates that annual employee performance evaluations shall be maintained in the personal records of the private agency providing DR services. The criteria upon which those performance evaluations should be based are not specified. Significant work remains to be done with both the public and private agencies to more fully develop and align staff selection and staff performance evaluation with the core competencies required of a DR caseworker and supervisor.

Decision Support Data Systems

Quality assurance and programmatic monitoring.

Programmatic evaluation assesses the effectiveness of the intervention at the organizational level by analyzing the relationship of model fidelity to expected outcomes. Reliable programmatic data is critical to quality assurance and continuous quality improvement efforts in order to ensure successful implementation of the practice change over time. A frequent and user-friendly feedback loop which provides process and outcome data for decision making at both the policy and practice levels is helpful in ensuring organizational fidelity and assessing future program development needs (Fixsen et al., 2009).

DCFS has extensive programmatic monitoring capability both internally (for programs housed within DCFS) and externally (for contracted services provided by other entities). The department’s Division of Quality Assurance is responsible for determining fidelity to programs and services delivered directly by DCFS. This division also develops and oversees the progress of the program improvement plan (PIP) that is required as a result of Child and Family Services Review (CFSR) findings. The Division of Monitoring, which is a separate and distinct division within DCFS, is responsible for programmatic oversight of private agencies under contract with the department.

The department’s contracts with the private
agencies provides that “the mechanism of change in the DR pathway is worker collaboration with the family which leads to better and quicker identification of family needs as well as increased family engagement,” which in turn lead to better service provision (DCFS, 2011b). Specific program treatment goals are set forth in the contract and are required to be reported to the DR project director on a monthly basis. The contractual treatment goals for FY 2011 include:

1. 90% of children served will remain safely in their homes during the intervention period;
2. 90% of clients will not have a subsequent report 6 months after receiving DR services;
3. 90% of children will not have substantiated maltreatment allegations 6 months after receiving DR services;
4. 90% of children will not be removed from their homes 6 months after receiving DR services; and
5. 90% of clients that receive DR services are satisfied with services provided by the SSF provider.

The department agreed contractually to provide quality assurance reviews in FY 2011 which would include special record reviews in response to indications of potential performance problems; ongoing review of administrative processes and outcome data; and program plan reviews to ensure that agencies are adequately staffed, trained, and have the required academic credentials (DCFS, 2011b). The protocols and monitoring tools for these reviews are in the process of being developed.

At this stage of program implementation, specific quality assurance measures and monitoring protocols have yet to be developed for the department’s own internal quality assurance of the DR program. As part of the Illinois program improvement plan (PIP), a quarterly report will be prepared by the Quality Assurance Division to address DR staffing needs, case tracking and cost data, and strengths and barriers to program implementation (DCFS, 2011a). Plans to address identified barriers and challenges and a follow up on identified issues are to be addressed in this quarterly report.

Data systems supporting DR.

One of the first decisions made by the initial task group assigned to project design was to determine that the state’s existing Statewide Automated Child Welfare Information System (SACWIS) would be used for data collection and management. Private providers responsible for delivering child welfare services under contract with the department utilize another statewide DCFS database, the Child and Youth Centered Information System (CYCIS). To streamline data collection and reporting for the DR project, an interface between the two systems was developed, allowing the private agencies to enter case specific information into SACWIS. Access to cases assigned to the DR track is limited to DR staff; that is, information about DR cases is not available to investigators even if the case is reprocessed to the investigative pathway. The department’s rationale for this is that DR cases are not “investigations,” and as such are not substantiated. The DR project director indicates that cases which have not been investigated and substantiated should not be accessible or viewable by anyone. Additionally, once the safety of the children has been determined by the DR specialist, the family’s involvement is voluntary. The DR record will ultimately be expunged because there was no substantiation.
In addition to the interface with CYCIS, significant modifications were made to the existing SACWIS to support the DR program. Reports to the hotline are automatically screened for DR eligibility and, if eligible, are assigned to either the traditional track or DR track by a randomizer built into SACWIS. Operational protocols related to intake and investigation assignment had to be developed to allow for the DR pathway. Access to the SACWIS system is limited to personnel serving in clearly defined roles/assignments; therefore, the roles of those individuals performing DR-related services and tasks had to be clearly delineated to allow them access. SACWIS automatically requires certain entries in accordance with statute, rule, and procedure. DR-process and DR-specific time frames were built into the system for DR users. Issues related to case closure and retention of records had to be resolved, since those cases assigned to the DR pathway are not formally substantiated and maintained on the SCR.

**Facilitative Administration**

Facilitative administration provides leadership and makes use of a range of data inputs to inform decision making, support the overall processes, and keep staff focused on the desired intervention outcomes (Fixsen et al., 2005; 2009). The primary purpose is to provide clear guidance through policy, procedures, and structures which are aligned with one another and support the needs of practitioners as they interact with children and families. Legislation creating the DR pathway was enacted over one year prior to project implementation, which allowed sufficient time for the department to promulgate Section 300.45, setting forth the criteria for DR in the Illinois Administrative Code prior to program enactment on November 1, 2010. Careful attention must also be paid to organizational culture and climate in order to ensure alignment of the goals of the project with the needs of practitioners (Fixsen et al., 2009). To this end, the department and the CFRC held regional DR summits in early 2011 that brought together private and public agency DR staff, supervisors, and administrators for a day-long meeting in each region. Presentations on the status of the project and roundtable discussions were held to share information about the first 6 months of the project’s operation.

**Systems Intervention**

Child welfare practice does not occur in a vacuum, but is part of a larger systems framework which can either inhibit or support its success. Systems interventions are strategies to work with external systems and stakeholders in order to ensure the availability of the financial, organizational, and human resources required to support the work of practitioners (Fixsen et al., 2005; 2009). The department made the strategic decision to fund the rollout of DR within existing resources by realigning departmental priorities to support this initiative, which, in turn, generated support from the governor’s office and the state legislature. A project steering committee was established with external stakeholder representation to allow for dialogue and identification of systemic barriers and facilitators of the new DR approach. Members of the project steering committee also act as ambassadors of the DR program to their respective constituencies.

**Conclusion**

Significant progress has been made during the first year of the Illinois DR project to bring it from concept to realization as viewed through an implementation lens. A 2-year period of time was used to determine the feasibility and appropriateness of fit of the DR model for Illinois by researching existing models and seeking the advice of experts. First and foremost, the importance of this period of exploration cannot be understated in setting the foundation for this change effort. State and local child protective
systems should take advantage of a comprehensive planning period if they are considering DR. Secondly, through the leadership and personal involvement of the DCFS director and DR project director, the project was highly visible and a sense of urgency was established for the change effort. Their personal engagement was instrumental in moving the project forward, particularly in generating the political support of the governor’s office and Illinois legislature. The usually arduous rule-making process was streamlined due to the time spent effectively preparing a rule which provided clear guidance to the field. Other jurisdictions seeking to implement DR should consider the careful crafting of a proposed rule as part of their planning period.

Each child welfare system has its own unique challenges and complexities. A careful examination of the core implementation components is necessary to bring about the changes to the overall practice environment. Changes in practitioner skill levels, organizational capacity, organizational culture, and organizational climate require that sufficient attention be paid to these core drivers. The Illinois DR project is in the initial stages of implementation. Much work remains to be done in determining the core staff competencies needed to successfully engage families and in inculcating those competencies into both staff selection and staff performance evaluation. In Illinois, this must be accomplished through negotiation with the union for public sector employees and through contract with the private agencies providing DR services. The effectiveness of the training provided will be examined as part of the project’s evaluation and changes will be made as necessary. The department recognizes the need to improve supervision and coaching models throughout the system and is undertaking efforts to revise existing supervision models in order to more effectively transfer knowledge and improve practice skills. Programmatic monitoring to ensure fidelity is essential in determining the success of the project model and to provide a means by which the program can be held accountable. Even in systems with strong quality assurance programs, it takes time to develop and align the monitoring tools and mechanisms necessary for effective oversight. Substantial fiscal and human resources were devoted to the modifications made to the state’s SACWIS system to support data collection and management. Jurisdictions should carefully consider the resources required and the resources available for this purpose prior to implementing DR.

The successful implementation of DR is one of the primary strategies of the Illinois PIP resulting from the second round of CFSR. The department believes that DR will have implications for improving child welfare practice in many areas, through more effective engagement of families and communities, enhanced safety planning, and a heightened focus on service provision and family support (DCFS, 2011a). As a cornerstone of the Illinois child welfare system’s innovation efforts, DR is poised to lead the way for the entire system to embrace a family-centered, trauma-informed, and strengths-based practice model.

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References


From “Pie in the Sky” to the Reality of Implementation: Lessons Learned by the SOAR Consortium on the Journey to Differential Response

Kevin E. Brown, Stacy L. Cox, and Nancy E. Mahoney

Introduction

The purpose of this article is to describe worker and supervisor perceptions of certain aspects of the implementation of differential response (DR) in six Ohio counties, one of which, Clark County, had experience with DR as part of Ohio’s initial groundbreaking work of piloting DR in 10 Ohio counties. As one Ohio county project leader put it, “[W]e wanted to talk about how it was to go from ‘pie in the sky’ to putting pen to paper.” The five new counties entered into this experience as novices looking to be guided by a county which had experienced the trials and tribulations of implementing a major reform in Ohio’s approach to allegations of child abuse and neglect. This article is written to share the perspectives of workers and supervisors, from large, medium, and small counties, both rural and urban, in hopes of benefiting those who may be thinking of implementing DR in the future.

For this article, DR is defined as a system of response to reports of abuse and neglect that contains at least two distinct response pathways. In Ohio’s DR system, the two distinct pathways are called alternative response (AR) and traditional response (TR). The term DR will be used to refer to the two-track system. AR will refer to use of the AR pathway, and to the staff who practice AR.

Methodology

In February 2011, three focus groups were conducted over the phone, comprising each of the six Ohio counties; this occurred 5 months into implementation of the AR pathway. A total of 6 AR supervisors, 2 intake phone room and screening supervisors, and 13 AR caseworkers participated in the groups. Due to geographic distance among the six counties involved, in-person focus groups were not feasible. The focus group phone calls were structured so that the six counties were grouped together by county size: small/rural, medium/urban, and large/urban. The small counties within the SOAR (Six Ohio Counties Alternative Response) project had an estimated 2009 population of under 45,000 people, while the medium-sized counties’ population was under 140,000, and the large counties were over 530,000 (American Fact Finder Census Data, n.d.). Structuring the focus groups by county size was used to test whether differently sized counties revealed diverse pieces of information about their DR experiences.

During each focus group, note takers were used to capture participant responses and the focus groups were also audio recorded. Each of the three focus groups was asked the same six questions:

1. As an AR worker or supervisor, what is the difference between what you are doing now as an AR worker or supervisor and what you were doing before?
2. What are examples of challenges or frustrations and successes you have encountered in changing over to the practice of AR?
3. What has been or is still hard about “switching gears” from what you were doing before to what you are doing now?

4. Now that you and your organization have experienced going from thinking of DR as a “pie in the sky” idea to the reality of implementation, what do you wish someone had told you or that you had known back when it was still just an idea? What would have made implementation easier?

5. What would you tell agency staff members who are considering implementing a DR system that they should be doing to prepare? Is there anything they should NOT be doing?

6. What do you need most right now?

Respondents were asked to identify themselves by name, role, and county each time they commented, and this information was recorded along with responses. All participants in the focus group calls made at least a few comments.

Data from notes and the audio-recording transcriptions were analyzed. Each research team member individually categorized 89 distinct participant comments using qualitative open-coding techniques (Creswell, 2007). Finally, as a team, the researchers reviewed and discussed each others’ coding, resulting in the emergence of four major categories or themes that were used in the final qualitative analysis: workload management; the approach and focus of AR casework; training, education, and understanding; and service and resource availability.

Findings

Alternative Response & Workload Management

The most common theme emerging from the focus group interviews was workload management. Of 89 responses that were captured from the three focus group interviews, 40 comments were categorized as workload management issues. Caseworkers frequently spoke about struggling with the management of time in general, as well as the new and unfamiliar mandated time frames specific to the new AR model—especially the increased frequency of contact and extended duration of contacts with each AR family. The new “open and friendly” approach of AR, as several participants called it, was mentioned in a positive light, as evidenced in comments such as: “Families are willing to open up and they’re giving more information about the family when we’re using this courteous approach” (AR caseworker from a large county). However, others felt that the friendliness of the approach focused so heavily on relationship building in the beginning that, in turn, later workload problems developed because of how the initial time was utilized: “It’s too friendly early on and [that leads to problems] with time frames [and completing work. [I had to learn about] being assertive with time frames in a [respectful] way” (AR caseworker in a small county).

“The alternative response is a wonderful model, but it takes so much time.”

—AR caseworker from a small county

The most common sub-theme linked to workload management was that of caseload size. “Caseload size is the biggest issue,” stated one AR caseworker in a medium-sized county. This sub-
theme emerged in all counties; however, when the county-size analysis was conducted, the smaller and medium-sized counties talked about struggles with achieving a fair rotation in the assignment of cases, while the larger counties talked about the importance of managing caseload size. The difference is likely attributable to larger counties having more staff dedicated to the AR pathway, while the medium and small counties have limited staff assigned to AR.

Workers who held AR cases in addition to TR intake or ongoing cases expressed additional challenges in managing their work time and service delivery to clients. “I’m still an ongoing worker and I’m still holding an ongoing caseload. It’s challenging having different time frames,” stated one AR caseworker from a small county. Learning new AR work rules and mandated time frames commonly came up during the three focus groups. Time or time frame struggles were mentioned 18 times during the focus groups; 13 of these comments came from caseworkers and 5 came from supervisors. For both caseworkers and supervisors, the time struggle centered on the learning attached to the new AR process, as well as managing the amount of time spent with clients on the caseload. Further complicating the struggles, different time frame requirements exist for TR intake, AR intake, and ongoing casework.

One supervisor in a large county also made the point that closing cases has been problematic because of the strong worker-client relationship that forms in AR: “Terminating the case may be difficult because the family and worker are so involved.” Additionally linked to the time issue was the intensity experienced by workers during the time they spent in family visits. One supervisor from a large county said, regarding her AR caseworkers, that the family contacts are “time consuming and [my staff is sometimes] exhausted from long visits and emotional attachments.” Loman and Siegel (2005) also addressed the time and intensity issues arising in AR cases. By broadening the scope of initial assessments beyond the narrow focus of investigations on maltreatment allegations, encouraging involvement of family members in decision making, and changing the criteria for continued work with families, the AR approach increased the amount of time and effort that some AR workers expended per family. (p. 88)

However, the majority of workers interviewed by Loman and Siegel mentioned slight increases in this area. The National Quality Improvement Center on Differential Response in Child Protective Services (2009) addressed the issue of AR cases taking more staff time than TR cases by citing the recommendation of the Center for Child and Family Policy (2004) that caseload size not surpass eight for each AR worker, thus allowing the worker the ability to dedicate the time needed for true fidelity to the AR model of practice.

Both caseworkers and supervisors spoke about views of the AR pathway within their agencies: “Traditional workers feel [that AR workers are] not getting enough cases,” said one caseworker from a large county. Managing the system change within the agencies was an issue for both caseworkers and supervisors: “There are challenges [and] frustrations—but these are more internal than external. Getting everyone to understand what the AR process is [can be difficult]. Workers spend more time on [AR cases] than traditional intake workers,” said an AR supervisor from a medium-sized county.

This qualitative study suggests that separate training is needed for supervisors to help them manage the new form of service delivery. Carpenter’s process chronicling (2010) suggests that this is true. A review of the literature for this article, however, revealed no supervisor-specific training literature regarding management or supervision of AR-track cases.
The New Approach & Focus of Alternative Response Casework

“Clients seem more receptive with the AR worker and get services started much sooner than traditional.”
—Supervisor in a medium-sized county

“I’m more open to group decision making—thinking outside of the box to resolve issues. AR opened my mind to child welfare.”
—AR supervisor in a small county

“The challenge of getting in the door is the same as with traditional [intake]. Once we get in the door, the AR program sells itself.”
—AR caseworker in a large county

Of the 89 focus group comments analyzed and coded, 23 were grouped in the new approach and focus category. This second most common theme focused on the AR approach as being more open and transparent with an emphasis on identifying needs and helping and empowering families, as compared to the traditional investigation with its focus on a reported incident, investigation of the incident, and subsequent disposition, including labeling of perpetrators. While time management was found to be a common workload struggle for both AR supervisors and caseworkers, the time invested in direct client contact was also identified as a major strength within the AR approach. “I spend less time focusing on one concern, but focus on family strengths,” said an AR worker from a large county. Although time is a struggle, as identified in the workload management analysis, it is also identified as the foundation for this service delivery model with its emphasis on relationship building and a deeper exploration and understanding of client needs.

Only 5 months into the SOAR project, the AR model was credited by focus group participants with making contributions to professional growth and development. A supervisor in a small county stated, “As far as supervision, I feel that has changed with AR—where I have been trying to forge a holistic view of the family and not [to just focus] on a specific incident.” A supervisor in a large county said, “I’ve seen growth in my AR workers,” as she described her AR unit’s efforts to develop case decision-making skills and ways to better empower the people they serve to make good decisions, too. One large-county supervisor described the challenge involved in shifting from the prescriptive mindset of traditional intake practices to the AR family-empowerment approach: “We’re good about telling families you need to do this, this, and this, then you can have your kids back or keep your kids. Supervising these [AR] cases is challenging since the family is making the family plan, not the worker.”

Metz and Bartley (2011) suggested that identification of the skill set needed for AR casework versus TR casework remains a gap in current knowledge. While this qualitative study suggests a few identified areas for AR skill development and training, further research is needed in this area. Helping both workers and supervisors build skills that facilitate family empowerment with greater ease may be an area for future research, and is certainly an area for further training. The next section speaks specifically to training, the third most common response category among focus group participants.

Training, Education, & Understanding: Developing the Needed Skills for Alternative Response

A total of 19 out of the 89 focus group comments were grouped into the training, education, and understanding category. These comments also touched upon concepts of “better
AR understanding” throughout the agency and even extended to community understanding as an important piece of the AR implementation process.

“For the SOAR supervisors and caseworkers, understanding the AR definition and process was critical. The focus group participants felt that more training was needed prior to implementation in order to take the AR process from a “pie in the sky” concept to real practice. Specifically, 8 of the 19 focus group comments categorized into the training, education, and understanding category were related to an identified need for more training and a deeper understanding of how to carry out AR practice with greater competence and ease. Both supervisors from the small-county agencies said that a deeper understanding prior to AR implementation was needed. One of these supervisors stated, “I would have liked more and better training. Implementation training should have had more hands-on examples.”

To capture the concrete AR examples and to provide real-life exposure to the AR process prior to implementation, a caseworker from a medium-sized county stated, “Shadowing helps—especially when learning how ‘not to disposition.’” A large-county supervisor agreed that more shadowing experiences with others using the AR model would have been helpful.

Specific AR skill development needs identified by caseworkers were related to interviewing techniques used within the AR model and helping former traditional intake workers transition to the longer-term AR service delivery model. One AR caseworker from a large county felt that caseworkers who had a background in traditional ongoing services, and were now AR caseworkers, had an easier shift into the AR practice because of their experiences of working with families on a longer-term basis: “There’s a benefit in coming from ongoing. It’s easier to make the AR decisions [such as when to close the case].” These comments suggested that the short-term focus of traditional intake experience was an obstacle to overcome through training.

There was no supervisor-specific training offered leading up to the SOAR project implementation. Specific AR skill development for supervisors identified through the focus groups included creating a deeper understanding and proficiency related to a strengths-based approach with the family, as well as developing skills to help staff overcome obstacles when transitioning to the AR model, such as use of group supervision.

Despite the 2-day formal AR training provided, the shadowing experiences, and the community AR presentations that occurred in each of the six SOAR counties, all counties expressed a need for more training that involved not only AR staff, but also included traditional intake staff, staff outside of intake, and even the community, so that there could be all-around buy-in to the two-track DR model and specific understanding of the AR pathway. A supervisor from a medium-sized county directly said, “All staff at the agency should have been involved [with training].” Additionally, one supervisor expressed concern over the legal community’s understanding and perception of the AR pathway when she recounted being told by a prosecutor that there were deeply concerning liability issues embedded in the AR practice. Metz and Bartley (2011) identified buy-in at all levels as a crucial implementation factor affecting both staff and system performance.
Only 4 out of the 89 responses captured from the three focus group interviews were directly related to service and resource availability. Analysis of these data showed some difference among the counties based on size. Small and medium-sized counties mentioned a lack of resources, while large counties did not struggle with access to needed services.

Related to the resource availability issue, the only remaining difference between the two large SOAR counties and their four smaller-county counterparts was that of internal resources use. In this case, the larger SOAR counties had more staff assigned to solely handle AR-track cases, while the medium and smaller counties had either a limited number of staff assigned to the AR-track cases, or had caseworkers assigned to both AR and TR or ongoing cases.

Considerations

The information obtained in the focus group interviews has provided the SOAR Consortium with increased understanding of and insight into specific successes and challenges in implementing DR. There is a broader understanding of how implementation of a new practice model is more than just the act of “doing,” but rather a process that impacts various areas of the organization. The National Implementation Research Network (2008) addresses adoption of a new practice model as a progression by stating that “implementation is a process, not an event” (p. 15). Using the lens of implementation science research, the previously identified themes of workload management; approach and focus; training; and services and resource availability will be examined to provide insight into how organizations can use both lessons learned in implementation research and lessons learned by the SOAR Consortium to guide an organizational change to the practice of DR.

Consideration of Alternative Response Workload Management: Caseloads & Staff Time

Data collected from the focus group interviews suggest that working with families in a manner that relies heavily on engagement and family participation requires a great deal of time spent with the family. This raised several questions for the researchers: How does the time needed for AR cases impact considerations on caseload assignments? How should an agency quantify a reasonable caseload size for AR workers? The answers to these questions are not known and may be different depending on the resources that specific jurisdictions are able to devote to AR cases. Small and medium-sized SOAR counties reported a lack of external resources, which placed a greater burden on the internal resource of caseworker time. What is known is that those responsible for assigning cases must give special consideration to this matter. An organization considering implementation of AR practice should ensure that there are adequate provisions in place to support implementation. The National Implementation Research Network (2008) notes
the importance of configuring the organization to align with the new program being implemented in its discussion of “program installation.” Specific examples include paying special attention to staffing resources, policies and procedures, and fiscal resources to support the new work. The fact that nearly half (40 of 89) of the comments made by focus group participants focused on struggles with workload management suggests that decisions about workload distribution are a major consideration when planning to implement the AR service delivery pathway.

Consideration of the AR Approach: Knowing How to Listen To & Engage Clients

Looking through an implementation lens, successful implementation of AR requires a supportive, facilitative administration which is willing to re-align the organizational initiatives, as necessary, to ensure success (Metz & Bartley, 2011). Implementation is an interactive process which should result in integration of change that will influence staff behavior and the organizational culture (The National Implementation Research Network [NIRN], 2008). The focus group interviews of the SOAR Consortium showed evidence of change in staff behavior, and anecdotal evidence of changes in organizational cultures.

Actively seeking to engage and partner with families in assessing problems and identifying solutions is fundamental to AR practice, and is a new experience for some focus group participants. “Spending time to listen to the family gives a worker a better understanding of how to help,” said one caseworker from a large county. A large-county AR supervisor described the behavior change necessary for AR practice, stating, “We so quickly want to go in and make the plan instead of allowing the family to determine what’s going to happen.”

There appear to be some rewards inherent in the practice for AR workers. Loman and Siegel (2005) showed that caseworkers had positive feelings about the work they were conducting using AR. Positive feelings from AR caseworkers about the work being done appeared to be tied to addressing the family unit as a whole, as well as the ability to provide timely linkages with services needed to address the families’ needs (Loman & Siegel, 2005).

Synthesis of the comments in the approach/focus category seemed to lead back to the need to integrate behavior changes experienced in using the AR approach into the everyday experience of organizations, supervisors, and workers. This led to the almost inevitable topic of training and education as the means to promote that integration. Thus, it seems logical that training issues were mentioned almost as frequently as approach/focus comments among focus group participants.

Consideration of Needed Training

Both caseworkers and supervisors in the focus groups called for intensified trainings in the techniques associated with AR, including direct service techniques for the caseworkers and techniques for management of AR cases for supervisors. One small-county supervisor suggested more “hands-on training” with role-playing and decision-making exercises. Both workers and supervisors in the focus groups identified unique work skills that required position-specific skill development.

Loman, Filonow, and Siegel (2010) also mentioned that many of the workers involved in direct practice of implementing AR felt that they had the basic knowledge set needed to do the work; however, many felt that knowledge needed to be expanded on in specialized areas related to this practice model. The comments of the focus group participants suggest that caseworkers and
supervisors wanted to learn more about applying AR skills in specialized cases, such as cases involving intimate partner violence. At least three of the six SOAR counties expressed interest in further training about handling domestic violence cases within the AR model.

The comments from workers and supervisors about training should not be surprising, given what has been learned from implementation research about training. Training is seen as a way to provide knowledge of background information, theory, philosophy, and values, as well as to introduce key practices. However, most skills introduced in training are really learned on the job with the help of a consultant or coach (NIRN, 2008). This synchronizes well with focus group opinion that fine-tuning the skills learned in the overview training requires follow up. The focus groups were not specific about what relevant follow up would look like, but answers and guidance can be found in implementation science research.

Specific skill development areas identified for AR caseworkers related to learning the interviewing techniques used within the AR model and helping traditional intake workers move toward comfort with the longer-term AR service delivery model, which differs from the short-term focus of traditional investigation. The SOAR study suggests that immersion into AR process and practice is an essential linchpin to truly understanding how the work should be operationalized. Shadowing was viewed as an important addition to classroom training.

There is a gap in training specific to AR supervisors, since AR caseworkers are currently the targeted recipients of available training. One AR supervisor described “feeling left on her own to figure out how” to adequately supervise this new practice model. As noted earlier in this article, Carpenter’s (2010) work identified a lack of supervisory education about how implementation would affect supervisors involved, and this was conveyed in the comments of supervisors participating in the focus groups. This identified need for additional support and training for supervisors who are responsible for guiding their workers through the adjustment to and execution of this new practice model is something that new AR sites should consider when they are planning to embrace AR practice in their respective organizations.

Specific AR skill development areas for supervisors identified in this qualitative study included creating a deeper understanding of and proficiency with a strengths-based, solution-focused approach with families, as well as developing skills to help staff overcome obstacles when transitioning to the AR model. While the overall skill set needed for effective AR supervision remains undefined, the findings of this qualitative study agree with Metz and Bartley (2011), who discussed supportive and facilitative administration, training, and coaching as crucial drivers in the implementation of a change such as transition to the AR model of work.

Consideration of Services & Resource Availability

At 5 months into the SOAR project, focus group participants perceived that AR families received services faster than traditional families. While it is too early to tell if the perception is accurate, it is supported by the prior research conducted by Loman et al. (2010), which showed that families assigned to the AR pathway were more likely to receive services faster than their counterpart families assigned to the TR pathway.

A key aspect of any AR system is the focus on service availability and delivery, which often vary depending on the community (National Quality Improvement Center on Differential Response in Child Protective Services, 2009). The SOAR focus
group interviews did indicate that there are notable differences in this area based on community size. The service availability difference based on geographic and agency resources may be a crucial consideration for agencies planning to use the AR model. At the same time, the identification of gaps in services prior to AR implementation may be the opportunity to open the door to increased community collaboration, which will enhance service availability and access. Schene (2005) suggested that safety can be enhanced when child welfare agencies team with community service providers to identify needed social services within their jurisdictions and to create a plan for responding to gaps in needed services.

Another implementation consideration discussed by the National Implementation Research Network (2008) is the importance of conducting a community readiness assessment to determine things such as the community’s commitment to the selected intervention, as well as available assets to assist in the intervention. Schene (2005) suggested that service provision can be enhanced when child welfare agencies partner with community service providers—especially when community service providers and child welfare agencies share knowledge of individual families’ safety concerns and protective issues to ensure that needed services continue after child welfare involvement ceases.

Conclusion

Overall, the SOAR Consortium’s perceptions reported during the three focus groups mirror the same positive advancements and growing pains identified in those jurisdictions implementing AR before them. Supported by prior research, the SOAR qualitative research suggests that new sites should carefully consider issues around:

- Workload management—with special attention to time management, caseload size, and learning curves associated with the new AR model (supported by Loman & Siegel, 2005);

- Skill sets needed to handle the AR approach and focus. Loman and Siegel (2005) discussed how Minnesota’s implementation sites were often able to successfully engage with their families and provide consistent service delivery sooner through the use of the AR model. Loman et al. (2010) reported the same positive results associated with family engagement and service delivery in the pre-SOAR, Ohio 10-county pilot project;

- Training—especially caseworker-specific and supervisor-specific training. Carpenter (2010) shared that there was a desire for supervisor-specific training in the Ohio pilot project, while Loman et al. (2010) spoke about caseworkers’ wishes for advanced competency training specifically related to AR practices; and

- Availability of services (supported by Schene, 2005).

In order to have a systematic plan for effective implementation of the AR practice model, these considerations may be crucial and should be well thought out, using knowledge gained from implementation science research to assist in building a methodical and sustainable change in practice.

Acknowledgments

The authors would like to thank the workers and supervisors in the SOAR (Six Ohio counties implementing Alternative Response) Consortium,
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References


Decision Point: Screening Practice as the Foundation for Differential Response

Marc Winokur, Ida Drury, Keri Batchelder and Marc Mackert

Decision making is a critical driver of child welfare practice. Typically, the first decision point is whether or not a public child welfare agency should respond to a report of suspected child abuse or neglect. The screening decision is extremely consequential, as it influences all subsequent actions in the child protective services (CPS) system. The decision to act upon a child protection referral poses many challenges, such as the relatively short time frame for decision making and the limited information often provided from reporters (National Council on Crime and Delinquency Children’s Research Center [NCCDCRC], 2009). Furthermore, this decision point is typically the responsibility of one supervisor, which is exacerbated by a lack of training, experience, and workload. The practice of “screening” calls from reporters alleging child maltreatment varies from state to state and county to county. For example, screened-in rates vary from 24% to 97% across the United States (U.S. Department of Health and Human Services, 2010). Few states have clear procedures outlining the types of referrals that should be screened out, while fewer utilize assessment tools to guide screening decisions (Downing, Wells, & Fluke, 1990).

In Colorado, which is a state-supervised and county-administered child welfare system, the screening procedure is determined on a county-by-county basis, as the state does not have a central screening hotline. As a result, CPS screening practices in Colorado have been criticized for the perceived variation in screening outcomes between counties. To address this concern, a screening and referral work group comprised of hotline workers, supervisors, and state child welfare division staff was established to examine the entire screening process. The work group determined that, at the time a call is made by a reporter to the county hotline, there was not a uniform guide for breadth and quality of the information taken by the hotline worker. Additionally, a current training on hotline strategies and requirements does not exist in Colorado. The group developed a comprehensive Referral Guide to assist hotline workers in gathering necessary information on the allegation, family needs and strengths, and child safety (see appendix). In addition to prompting for details related to common types of child maltreatment, the guide includes suggestions for phrasing questions in a solution-focused manner, such as, “How do family members usually solve this problem?”

According to Sawyer and Lohrbach (2005), differential response (DR) occurs when CPS agencies employ alternative options for intervening with families when child maltreatment concerns are reported. Traditionally, the decision to intervene in child maltreatment cases necessitates that CPS investigate the allegation reported in the referral, which results in a determination of whether or not abuse or neglect occurred. More recently, an alternative response has been developed in many states, in which CPS is charged with assessing the need for services, while the requirement to make a finding of child abuse or neglect is not present.

Colorado was accepted as a demonstration site for the National Quality Improvement Center on
Differential Response in Child Protective Services (QIC-DR) in 2009. During the pre-implementation phase, the five Colorado counties participating in the Colorado Consortium on Differential Response (CCDR) were focused on enhancing the screening practices in each agency by incorporating the changes suggested by the screening and referral work group. The work group also developed and delivered a 3-hour training entitled Screening: What’s In Your Bucket? for hotline workers and on-call practitioners on the use of the Referral Guide and solution-focused practice techniques (e.g., including a scaling question at the end of each call). The name and structure of the training came from a hotline worker who said he feels like he has buckets of questions that he uses when interviewing and engaging reporters. He knows he can’t ask every possible question, but uses practice skills in choosing the right question at the right time. The training included a videotape of a simulated hotline call and several role plays to develop comfort with the guide. To facilitate and prompt use of the Referral Guide, hotline workers developed a system using a flip chart at each screening station to guide the worker in eliciting safety concerns, presenting danger/harm, and family strengths.

The development of the Referral Guide also encouraged the use of RED (review, evaluate, and direct) teams in the five demonstration counties. RED teams are designed to improve consistency among county agencies through more collaborative decision making with regard to response time and track assignment (Sawyer & Lohrbach, 2005). The screening and referral work group determined that these RED teams would be used to replace the common practice of solitary decision making by supervisors in the intake units. The work group reasoned that a more intentional and refined group decision-making process, similar to the RED team approach, would better serve the types of new information being gathered by the new Referral Guide. RED teams first follow a process of visually outlining each call to compare the danger/harm, complicating and risk factors, family strengths, and history. RED teams then engage in a specific decision-making process, which is outlined in the Agency Response Guide (see appendix).

In a differential response system of child welfare, the decision about whether or not to intervene is followed by assignment to a distinct response type. This decision point is often referred to as “track assignment” or “pathway assignment.” In Colorado, families can be assigned to a family assessment response (FAR), which is the non-investigation pathway, or investigation response (IR), which is the investigative pathway. According to the QIC-DR, this decision should arise from an initial assessment of the immediate safety of children in the family, which is based on family information gathered at intake and jurisdictional requirements (www.differentialresponseqic.org). Further complicating this decision point are various choices about time frames for response.

The Agency Response Guide not only assists with the decision about whether or not to respond to a call alleging child maltreatment, but also outlines statutory response times and track assignment guidance for the implementation of a DR model. Again, the work group reasoned that another concrete and clearly formatted tool would work in tandem with the additional information found in each referral (because of the new Referral Guide) and the new RED team process. Figure 1 provides an illustration of the screening process and corresponding instruments used.

Given the complexity of screening in public child welfare, it is important that screening and assignment decisions be made in compliance with policy, and that policies are applied consistently across workers, counties, and within the state (NCCDCRC, 2009). Without such consistency, this decision is solely based on worker discretion,
which makes the goal of achieving equity in the child welfare system a challenging one. However, the consistency and validity of decision making is likely to increase with the implementation of referral and screening tools that outline agency policy (NCCDRC, 2009). Few empirical studies have been conducted on the usefulness of such guides, even as these types of approaches to child welfare decision making are being increasingly utilized in CPS agencies.

**Literature Review**

The process of referral and screening in CPS practice is complex and multifaceted (Wells, Lyons, Doueck, Brown, & Thomas, 2004). According to Wells, Fluke, and Brown (1995), the screening decision point is a “complex set of interactions between federal and state laws, organizational policies and procedures, organizational customs or norms, interpretations of those laws, policies, procedures, and customs by child protection workers” (p. 982). Although the screening of CPS referrals was originally proposed as a means for controlling the quantity of reports subject to investigation, current screening practice allows “CPS staff to do more thorough investigations and provide better service to children at risk, reducing the emotional burdens to families of unsubstantiated investigations, and reducing the financial burdens to the state for unnecessary investigations” (Downing et al., 1990, p. 358).

In 1997, the Urban Institute conducted a survey of state child welfare agencies to obtain data on official screening policies and practices. According to Tumlin and Geen (2000), there were high levels of variability in screening processes between states and across counties within states. Of the 40 states that participated in the survey, the majority had single-review screening processes, while one-third utilized multiple-review screening processes. For a majority of the states with single-review screening, a supervisor was the decision maker rather than a hotline worker, investigator, or social worker. For the states with multiple-review screening, the most...
frequent arrangement was an intake worker making an initial screening decision, which was then reviewed by a supervisor. This survey also found that training and experience for hotline workers varied by state, as some states had strict educational and tenure requirements, while others did not have any requirements.

As for track assignment decisions, Sawyer and Lohrbach (2005) argue that “crucial decisions to accept and direct the outcome of reports of concern from the community could no longer be the sole responsibility of individuals making independent decisions” (p. 44). As an early adopter in the implementation of DR, Olmsted County in Minnesota adopted a group decision-making approach to determine whether the agency response should be family assessment or traditional investigation. The implementation of RED teams was seen by practitioners as a more reliable and consistent method by which to determine the most appropriate response to diverse referral circumstances. Sawyer and Lohrbach suggest that RED teams comprise a cross-section of the CPS agency to include intake, assessment, investigation, and ongoing services. Broad representation of workers with different roles and responsibilities allows for the development of norms guided by supervisors and reinforced through the continued work of the team. In addition, the established culture is one in which the agency is internally transparent at all decision points in the process of protecting a child. Again, this process highlights the complexity of the decision, and thus the need for a complete set of information from the reporting party and available administrative data.

Recently, social services administrators in Maryland worked in partnership with Casey Family Programs and the Children’s Research Center to evaluate the consistency of screening decisions based on a screening assessment (NCCDCRC, 2009). The assessment was a succinct list of observations and definitions for each maltreatment type that workers could refer to when deciding whether a referral should be screened in for investigation. Results from the qualitative review suggest that implementation of the assessment enhanced workers’ documentation within the referral narrative, which may have enhanced their screening decisions. In the post-implementation reviews, a significantly greater number of referrals had narratives that thoroughly justified all types of maltreatment specified in the referral, and also had narrative justifying the response time.

These results are especially important in light of Wells et al. (1995) finding an association between missing information and the likelihood of an investigation for numerous referral characteristics. Specifically, when information on one or more characteristics was missing, there was a decreased likelihood of being investigated. These studies support the notion that the completeness of the referral is a vital factor in whether a report is investigated (NCCDCRC, 2009; Wells et al., 1995). The responsibility of screening referrals in child protection is perhaps the most difficult, yet critical, decision point in the process of a family’s involvement in the child welfare system. This article provides a rare opportunity to examine a primary part of the screening process: the documentation of the initial exchange between the hotline worker and the reporting party.

**Research Questions**

The purpose of the study was to evaluate the implementation of the new Referral Guide in the context of the differential response demonstration pilot currently under way in Colorado. Anecdotal feedback from agencies suggested that the Referral Guide had improved screening practices by hotline workers, and that RED team implementation was benefiting from the enhanced information provided in referrals, which was then assisting with
the challenges of track assignment. The specific research questions were as follows:

1. Is the new Referral Guide assisting hotline workers in eliciting sufficient information from reporters in regard to child protection concerns and possible protective factors of the family named in the referral?

2. Is there a difference between reviewer perceptions of mandated and non-mandated reporters on completeness for the information collected using the Referral Guide?

3. Is there a difference between reviewer perceptions of types of reporters on completeness for the information collected using the Referral Guide?

Methodology

This study uses a non-experimental descriptive and comparative research design, in which child welfare professionals served as reviewers of completed referrals in order to determine if sufficient information was collected by hotline workers and provided by reporters using a new Referral Guide.

Sampling

In order to provide a representative selection of referrals for review, a random sample was selected from all referrals accepted as being eligible for FAR by the five demonstration counties between October 1, 2010, and February 15, 2011. Overall, the five counties had a total of 3,614 referrals deemed eligible for FAR during this time. The rationale for the inclusion of only those referrals deemed as meeting criteria for response and then also deemed FAR eligible was to ensure that the entirety of both the Referral Guide and the Agency Response Guide were employed. To allow the results of the study to be generalized across all referrals deemed FAR eligible, a sample size was selected to provide a 90% confidence level. In addition, a 15% oversample of eight referrals was identified to allow for replacements in case any of the original referrals needed to be dropped. The final sample size was 55 referrals, of which 32 were randomly assigned to the FAR pathway and 23 were randomly assigned to the IR pathway. This sample provided a manageable set of referrals for review process given personnel and time restrictions.

Data Collection

The CCDR project director recruited participants from the screening and referral implementation work group to participate in this study. Work group members were asked to participate in a 3-hour session. They also were asked to recruit at least one other interested practitioner from their agencies. A total of 11 reviewers from four of the five demonstration counties and the Colorado Division of Child Welfare participated in the referral review. Reviewers were assigned referrals from the sample and were asked to evaluate the completeness of the information using a tool that focused on the five domains included in the Referral Guide. These domains are as follows:

1. Reason for Referral/General Questions/Referral Type Specific Questions
2. Family Community/Tangible Support
3. Child Information/Child Functioning/Special Needs/Vulnerability
4. Family Coping/Strengths
5. Intervention/Solutions/Wrap-Up

Each domain corresponds to a specific group of questions in the Referral Guide. The domains were determined by consolidating various types of questions and needs for referrals. Reviewers were
asked to examine the referral and attempt to determine whether hotline workers had attempted to obtain information in each of the areas. Reviewers were asked to select “Yes” or “No” on the evaluation sheet for each referral. Reviewers were not allowed to evaluate their personal work, but could review referrals from their own agencies. There were multiple reviewers for 26 of the referrals and single reviewers for 29 of the referrals.

Following the review, the project director asked the group to identify strengths and concerns about the referrals they reviewed and what steps they would take following this experience. The project director transcribed the responses and received clarification of meaning and detail as needed.

Data Analysis

Prior to data analysis, the completed referral reviews were submitted to researchers from the Social Work Research Center in the School of Social Work at Colorado State University without identifying information. The quantitative data were entered into the Statistical Package for Social Sciences (SPSS) and were analyzed using descriptive and inferential statistical techniques, as chi-square tests were used to determine if there was a statistically significant relationship (p < .05) between the attribute independent variables and the screening review ratings. Responses to the review debrief were entered into Microsoft Word for formatting and further refining. A constant comparative analysis approach was employed to code the responses collected during the debriefing to uncover the main themes from the qualitative data.

Results

The quantitative results from the study are presented first and are organized by research question. The qualitative results are presented next and help to further answer the research questions.

Quantitative Results

As displayed in Table 1, the results for the first research question are separated into two columns to reflect referrals reviewed by a single reviewer and referrals reviewed by multiple reviewers. For each domain on the Referral Guide, reviewers were asked to indicate whether the information was complete or incomplete. If multiple reviewers did not agree on whether the information was complete or incomplete, the response was marked as a disagreement. Finally, if reviewers did not provide a rating for a given domain, it was marked as missing.

The Referral Guide domain perceived by single reviewers to have the most complete information was reason for referral/general questions/referral type at 93.1%, while the interventions/solutions/wrap-up domain was perceived to have the least complete information at 27.6%. For multiple reviewers, the referral/general questions/referral type domain was perceived to have the most complete information at 83.6%, while the child information/child functioning/special needs/vulnerability domain was perceived to have the least complete information at 19.2%. The domain with the most disagreement between multiple reviewers was child information/child functioning/special needs/vulnerability at 38.5%, while the referral/general questions/referral type domain had the least disagreement at 7.7%. Overall, the domain perceived to have the most complete information was reason for referral/general questions/referral type at 83.6%, followed by family/community/tangible support at 45.5%, child information/child functioning/special needs/vulnerability and family coping/strengths at 32.7% each, and intervention/solutions/wrap-up at 27.3%.

To answer the second research question, referrals were divided into two groups: those given
Table 1. Reviewer Perceptions of Completeness of Information on Referral Guide Domains (N = 55)

<table>
<thead>
<tr>
<th>Domain</th>
<th>1 Reviewer</th>
<th>2-3 Reviewers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Referral/General Questions/Referral Type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete</td>
<td>27</td>
<td>93.1</td>
<td>19</td>
</tr>
<tr>
<td>Incomplete</td>
<td>1</td>
<td>3.4</td>
<td>1</td>
</tr>
<tr>
<td>Disagreement</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3.4</td>
<td>4</td>
</tr>
<tr>
<td>Family Community/Tangible Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete</td>
<td>11</td>
<td>37.9</td>
<td>14</td>
</tr>
<tr>
<td>Incomplete</td>
<td>17</td>
<td>58.6</td>
<td>5</td>
</tr>
<tr>
<td>Disagreement</td>
<td>0</td>
<td>0.0</td>
<td>6</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3.4</td>
<td>1</td>
</tr>
<tr>
<td>Child Information/Functioning/Special Needs/Vulnerability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete</td>
<td>13</td>
<td>44.8</td>
<td>5</td>
</tr>
<tr>
<td>Incomplete</td>
<td>15</td>
<td>51.7</td>
<td>11</td>
</tr>
<tr>
<td>Disagreement</td>
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<td>0.0</td>
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<tr>
<td>Missing</td>
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<td>0</td>
</tr>
<tr>
<td>Family Coping/Strengths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete</td>
<td>11</td>
<td>37.9</td>
<td>7</td>
</tr>
<tr>
<td>Incomplete</td>
<td>17</td>
<td>58.6</td>
<td>9</td>
</tr>
<tr>
<td>Disagreement</td>
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<td>0.0</td>
<td>8</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3.4</td>
<td>2</td>
</tr>
<tr>
<td>Intervention/Solutions/Wrap-Up</td>
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<td></td>
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<tr>
<td>Complete</td>
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<tr>
<td>Missing</td>
<td>2</td>
<td>6.9</td>
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by mandated reporters consisting of school staff, therapists, medical professionals, department of human services (DHS) employees, law enforcement personnel, and probation workers, and those given by non-mandated reporters consisting of family members, friends, and community members. The reporting party was mandated for 36 of the referrals and non-mandated for 16 of the referrals; the reporting party type was unknown for 3 of the referrals. The two groups were compared using chi-square tests on perceptions of completeness of referral information collected by the hotline workers using the Referral Guide. As displayed in Table 2, the only statistically significant difference between the groups was on perceptions of completeness of the
intervention/solutions/wrap-up domain ($p = .023$). Specifically, information provided by non-mandated reporters (53.3%) was perceived to be more complete than information provided by mandated reporters (15.6%).

To answer the third research question, the reporting parties were divided into four groups: school personnel, law enforcement, friends/family, and other (including medical personnel and therapists). The four groups were then compared using chi-square tests on perceptions of completeness of referral information collected by the hotline workers. The only statistically significant difference between the groups was on the intervention/solutions/wrap-up domain of the Referral Guide ($p = .042$). Specifically, post hoc chi-square tests show that information provided by friends and family (58.3%) was perceived to be more complete than information provided by law enforcement (0.0%).

**Qualitative Results**

The qualitative results are based on strengths, concerns, and next steps identified by the reviewers during the debriefing session. Overall, the reviewers believed that the referrals completed using the Referral Guide were sufficiently detailed and relatively consistent. For example, it appears that the narrative section of the referrals is covering similar information across the five counties. According to one reviewer, “a lot of the referrals were very thorough so you get a good picture of what the specific concerns are and why the agency is being called.” Other areas with more complete and specific information included injuries related to allegations of physical abuse, domestic violence in the home, and substance abuse and its impact on children. Other strengths identified in the referrals were including the protective parent, recording the age of the child, and using names rather than simply the role of the reporting party. As for the format of the referrals, participants appreciated having scaling questions with follow ups, more precise descriptions of the allegations, and better information about whether children were still in the home. Reviewers also appreciated that hotline workers were asking the reporting party how they came to know the reported information. Finally, the reviewers expressed a sense of confidence in screening decisions made using information gained through use of the Referral Guide.

The biggest concern noted by the reviewers was the lack of information sometimes received or

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mandated</th>
<th>Non-Mandated</th>
<th>Total</th>
<th>$\chi^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral/GeneralQuestions/Referral Type</td>
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<td>14</td>
<td>93.3</td>
<td>3.11</td>
</tr>
<tr>
<td>Family Community/Tangible Support</td>
<td>13</td>
<td>37.1</td>
<td>10</td>
<td>62.5</td>
<td>2.93</td>
</tr>
<tr>
<td>Child Information/Functioning/Special Needs/Vulnerability</td>
<td>11</td>
<td>31.4</td>
<td>7</td>
<td>43.8</td>
<td>0.88</td>
</tr>
<tr>
<td>Family Coping/Strengths</td>
<td>8</td>
<td>23.5</td>
<td>9</td>
<td>56.3</td>
<td>5.26</td>
</tr>
<tr>
<td>Intervention/Solutions/Wrap-Up</td>
<td>5</td>
<td>15.6</td>
<td>8</td>
<td>53.3</td>
<td>7.52</td>
</tr>
</tbody>
</table>
requested by hotline workers, even while employing the Referral Guide. For example, reviewers noted that hotline workers typically receive limited information from law enforcement reporters, which points to related difficulties with mandated reporters in regard to community interaction and providing strengths as part of the referral. Reviewers also were concerned that insufficient information was being collected about siblings in the home, as the focus is mostly on the alleged victim. Furthermore, reviewers perceived that safety questions related to the whereabouts of the alleged victim were not asked consistently.

A common concern was related to the time constraints faced by hotline workers, as there seems to be a decrease in time available to spend with reporters. Reviewers perceive that there are a lot of demands on hotline workers, which translates into reporters sometimes becoming frustrated when they do not receive prompt responses. For example, there are increasing numbers of calls coming in for community supports which add to the workload of hotline workers. A related concern is that there does not seem to be a lot of inquiry by the hotline worker if the referral appears likely to be accepted based on initial information. Reviewers with a caseworker background noted that they would still need to know all of this information, especially if they have to make a track assignment and/or respond to the family.

Similarly, a few reviewers were concerned with how the information being collected by hotline workers using the Referral Guide was presented to caseworkers. One reviewer stated that “we need to still work on being more succinct to capture and summarize the important information without it sounding like an ongoing ROC [case] note.”

Another commented that the “narrative piece will sound like a ‘logic problem’ and I have to really concentrate on where the [hotline worker is] going with the story.”

**Discussion**

The following discussion highlights the conclusions that emerged from the referral review findings and examines the methodological limitations of the study. Implications for child welfare screening and assignment practice in a differential response model are presented.

---

**Table 3. Reviewer Perceptions of Completeness of Information on Referral Guide Domains by Type of Reporting Party (N = 55)**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>School</th>
<th>Police</th>
<th>Friends/Family</th>
<th>Other</th>
<th>( \chi^2 )</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral/General Questions/Referral Type</td>
<td>11</td>
<td>91.7</td>
<td>8</td>
<td>88.9</td>
<td>13</td>
<td>100.0</td>
</tr>
<tr>
<td>Family Community/Tangible Support</td>
<td>4</td>
<td>30.8</td>
<td>4</td>
<td>44.4</td>
<td>9</td>
<td>69.2</td>
</tr>
<tr>
<td>Child Information/Functioning/Special Needs/Vulnerability</td>
<td>5</td>
<td>41.7</td>
<td>3</td>
<td>30.0</td>
<td>6</td>
<td>46.2</td>
</tr>
<tr>
<td>Family Coping/Strengths</td>
<td>2</td>
<td>16.7</td>
<td>2</td>
<td>20.0</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Intervention/Solutions/Wrap-Up</td>
<td>1</td>
<td>9.1</td>
<td>0</td>
<td>0.0</td>
<td>7</td>
<td>58.3</td>
</tr>
</tbody>
</table>
**Conclusions**

The decision point at which a child welfare agency responds or does not respond to a report of child maltreatment rests on the information gathered at the initial contact with the reporting party. The agency is charged with determining this response under the tightest of time restrictions and resource limitations. This study identifies some of the challenges that hotline workers face in gathering information from a reporting party about alleged child maltreatment. The biggest concern noted by the reviewers was the lack of information sometimes received or requested by hotline workers, even while employing the Referral Guide. Overall, less than 50% of reviewers rated the family community/tangible support, child information/child functioning/special needs/vulnerability, family coping/strengths, and intervention/solutions/wrap-up domains as having complete information. Furthermore, information provided by mandated reporters was perceived to be less complete than information provided by non-mandated reporters about interventions, solutions, and wrap-up. In addition, reviewers found that time, training, and reporter knowledge and expectations were constraints on the consistent collection of information and efficient managing of incoming referrals. Thus, reviewers concluded that there was room for the improvement of screening practice in CPS agencies.

One possible solution is the adoption of a Referral Guide to assist hotline workers in eliciting comprehensive information on concerns and strengths from reporting parties, both mandated and otherwise. The Referral Guide is part of a larger trend toward promoting shared responsibility in decision making, as evidenced by the implementation of RED teams and group supervision as cornerstones of the differential response model being piloted in Colorado. However, the Referral Guide needs refinement, more consistent adaptation, and continued testing as evidenced by the high percentage of disagreement by multiple reviewers on some of the domains.

**Limitations**

This study had several methodological limitations in regard to sample size, missing data, and psychometric testing. First, the sample size of referrals to review was small because of personnel and time restrictions. The 11 reviewers were only available for one morning session. However, it was a random sample, which helps its ability to provide generalizations for use by other accepted and FAR eligible referrals in the five demonstration counties. There were some missing data for the reviewers’ perceptions of completeness of information on certain Referral Guide domains and for the reporting party and mandated reporter variables. This further reduced the sample size for some subgroup analyses and may have impacted the power needed to detect statistically significant differences for some of the research questions.

The Referral Guide was not tested for inter-rater reliability, as only half of the referrals were reviewed by more than one person. As a result, there could be some measurement error in regard to perceptions of completeness for the identified domains. Another limitation is that the study was not able to answer the question of whether or not the Referral Guide helps to adequately employ the Agency Response Guide or RED team process, because administrative data on the outcomes of these referrals (e.g., substantiation, caseworker assessments of risk and safety, and new involvement) were not collected. However, this is an area for future research. Finally, the Referral Guide is designed to assist in comprehensively interviewing the reporter to gain enough data for an informed decision, but if the reporting party doesn’t know details or is reluctant to share, this can limit the comprehensiveness of any referral,
regardless of whether or not a guide is used. The following implications should be interpreted and applied within the context of the limitations of the study.

**Implications**

The primary implication of this study is that, at the point of initial CPS contact with a referral source, there is a need for continued development of structured interviewing techniques to elicit complete and comprehensive information. Specifically, the Referral Guide needs more refinement and consistent adaptation to make sure that sufficient information is being collected from reporters to ensure accuracy and consistency at the screening decision point. There was a good deal of disagreement between reviewers on the completeness of information for these domains, which may indicate that the guide is not providing precise enough guidance for hotline workers and additional training is needed for the implementation of the guide.

The main recommendation from the reviewers was that additional and ongoing classroom training, coaching, and supervision should be provided to hotline workers. For hotline workers, there is a need to emphasize scaling questions and questions related to domestic violence and substance abuse. Several reviewers suggested hands-on activities in addition to vignettes to help hotline workers understand the reasons they are being asked to use the Referral Guide. Hotline workers from the five counties should meet together more regularly to promote greater cooperation and allow them to explore other opportunities to enhance their skill sets and career possibilities. A related recommendation is to conduct cross-county peer reviews to refine the Referral Guide and build relationships. This could apply to referral entry in SACWIS, as cross-county strategies could be developed to achieve better consistency. One barrier to involving hotline workers in training and RED team meetings is coverage of staff. One solution is to plan future trainings for hotline workers when school is not in session, as referrals tend to drop during that time.

For mandated reporters, there is a need for more experience in answering solution-focused questions, as demonstrated by the findings that they were perceived to provide less complete information for the intervention/solutions/wrap-up domain. This lack of experience may create a barrier to asking for community support when referrals are given, and may indicate that hotline workers should reach out beyond law enforcement to get this information. Mandated reporter trainings and community outreach related to DR implementation have been amended to include this significant change in relation to mandated reporters. Specifically, counties have better articulated these new reporting expectations while addressing concerns about how these new expectations impact their roles and relationships with the CPS agency.

A somewhat unanticipated implication is the synergy created by the parallel timelines for the implementation of the Referral Guide and RED teams in the five demonstration counties. Specifically, part of the RED team process is to map the presenting danger/harm, complicating and risk factors, and family strengths. As teams of child welfare practitioners come together to read and map referrals, they provide an informal feedback loop to hotline workers about good practice and areas for improvement in the use of the Referral Guide.

Prior research indicates that strong administrative support, effective training and supervision, and skilled staff are essential for the successful implementation of this type of practice change (Mihalic, Irwin, Fagan, Ballard, & Elliott, 2004; Toth, Manly, & Nilsen, 2008). However, research is limited with regard to screening and
referral practice in the CPS system. Future studies should explore the psychometric properties of the Referral Guide along with its application in practice decisions. In addition, the outcomes of the screening process should be studied, especially as it relates to providing information for the pathway assignment decision point (i.e., whether a screened-in referral should be assigned to FAR or IR). It is important that research and evaluation keep pace to ensure that the desired purposes of referral guides, screening decisions, and the RED team approach are realized with minimal adverse consequences.

A shift of this magnitude in the child welfare system is often accompanied by a need for change on many levels, including practitioner, agency, and community. This type of change can be assisted by evaluation at each stage of implementation. In this case, the referral review will be the first of many opportunities to further refine the process of screening and enhance the crucial decisions that rely on it.

Marc Winokur, Ph. D., is the Director of the Social Work Research Center in the School of Social Work at Colorado State University. His research interests include kinship care, evidence-based practice, and systematic reviews. He has eight years of experience with program evaluation and applied research in diverse child welfare settings. Dr. Winokur is currently the lead evaluator for the Colorado Consortium on Differential Response, which is a research and demonstration site for the national Quality Improvement Center on Differential Response in Child Protective Services.

Ida Drury, M.S.W., has worked for seven years in public child welfare in numerous capacities, including casework, leadership, and training roles. Currently, she is the CAPTA Administrator at the Colorado Division of Child Welfare and the Project Director for the Colorado Consortium on Differential Response, a site for the national Quality Improvement Center on Differential Response. Prior to child welfare, she worked in the areas of domestic violence and mental health. Her passion is for family empowerment, community collaboration, and child welfare system improvement.

Keri Batchelder, M.S.W., is the Assistant Director of the Social Work Research Center in the School of Social Work at Colorado State University. She earned her Master of Social Work Degree from Colorado State University. Additional educational credits include a Bachelor of Arts degree in Psychology from the University of New Hampshire. Ms. Batchelder has worked in the field of social work for 10 years. She has experience in child welfare, adult/ juvenile corrections and school social work.

Marc Mackert holds a Ph.D. in counseling psychology with an emphasis on organizational development. He has consulted with organizations in both the private and public sector and has worked for the Colorado Department of Human Services’ Administrative Review Division for the past 10 years. He is a member of the American Evaluation Association and the Organization for Program Evaluation in Colorado. His main focus is on applying program evaluation and continuous quality improvement methodologies to the field of child welfare to lead to improved outcomes for children and families.
Agency Response Guide

1. What is the alleged maltreatment in this referral?

2. Does the alleged maltreatment meet criteria for agency response?

The following definitions were taken from Colorado Children's Code Title 19, 19-1-103:

___ Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition or death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product of an accidental occurrence.

___ Any case in which a child is subjected to unlawful sexual behavior.

___ Any case in which a child is a child in need of services because the child's parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take.

___ Any case in which a child is subjected to emotional abuse. As used in this subparagraph (IV), “emotional abuse” means an identifiable and substantial impairment of the child’s intellectual or psychological functioning or development or a substantial risk of impairment of the child’s intellectual or psychological functioning or development.

___ Any case in which, in the presence of a child, or on the premises where a child is found, or where a child resides, a controlled substance, as defined in section 18-18-102 (5), C.R.S., is manufactured or attempted to be manufactured.

___ Any case in which a child tests positive at birth for either a schedule I controlled substance, as defined in section 18-18-203, C.R.S., or a schedule II controlled substance, as defined in section 18-18-204, C.R.S., unless the child tests positive for a schedule II controlled substance as a result of the mother’s lawful intake of such substance as prescribed.

___ No, does not meet criteria (screen out/I&R only).

3. Determine Response Time: (7.2.02.4 J)

1. **Immediate** and/or same day response is required when the report indicates that:
   a. Without immediate response, the child is in danger of moderate to severe harm, or
   b. The child’s vulnerability or factors such as drug and alcohol abuse, violence, isolation, or risk of flight from one county to another county or state, increase the need for immediate response.
      (If the report is received after hours, the time frame is immediate and/or up to eight hours)
2. **End of the third calendar day** following receipt of the report when the report indicates that:
   a. Without a response within three days, the child is in danger of moderate to severe harm, or
   b. Factors such as drug and alcohol abuse, violence, isolation, or risk of flight from one county to another county or state, increase the need for intervention in the near future.

3. **Within five working days** from the date the report is received when the report indicates maltreatment or risk of maltreatment to a child and indicates an absence of safety concerns.

4. Based on the allegation(s) identified in the report, select one of the following: (Reference Differential Response Alleged Maltreatment Guide)

   □ **INVESTIGATION RESPONSE (SELECT REASON)**

<table>
<thead>
<tr>
<th>Mandatory Reason:</th>
<th>Discretionary Reasons:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Allegation of serious harm</td>
<td>□ Currently open investigation response</td>
</tr>
<tr>
<td>□ Allegation of sexual abuse</td>
<td>□ Frequent, similar, recent referrals</td>
</tr>
<tr>
<td>□ Suspicious child fatality or homicide</td>
<td>□ Violent activities in the household</td>
</tr>
<tr>
<td>□ Institutional referral</td>
<td>□ Caregiver declined services in the past</td>
</tr>
<tr>
<td></td>
<td>□ Caregiver unwilling/unable to achieve safety</td>
</tr>
<tr>
<td></td>
<td>□ Past safety concerns not resolved</td>
</tr>
<tr>
<td></td>
<td>□ Previous serious child harm offenses</td>
</tr>
<tr>
<td></td>
<td>□ Credible RP alleges high safety concern</td>
</tr>
<tr>
<td></td>
<td>□ High child vulnerability</td>
</tr>
<tr>
<td></td>
<td>□ Substance Abuse not manageable through FAR</td>
</tr>
<tr>
<td></td>
<td>□ Domestic Violence not manageable through FAR</td>
</tr>
<tr>
<td></td>
<td>□ Court ordered investigation</td>
</tr>
<tr>
<td></td>
<td>□ FAR Eligible, approved exemption – staffing</td>
</tr>
<tr>
<td></td>
<td>□ Not in FAR County jurisdiction</td>
</tr>
<tr>
<td></td>
<td>□ Randomizer down – project director notified</td>
</tr>
<tr>
<td></td>
<td>□ Insufficient info to assess for FAR eligibility</td>
</tr>
<tr>
<td></td>
<td>□ Other (Describe):</td>
</tr>
</tbody>
</table>

□ **THIS REFERRAL IS FAR ELIGIBLE.**

5. Proceed to Randomization Tool if FAR eligible.
**DIFFERENTIAL RESPONSE ALLEGED MALTREATMENT GUIDE**

Track assignment determined by presence of imminent danger, level of risk, number of previous reports, source of the report and / or presenting case characteristics such as type of alleged maltreatment and age of the alleged victim.

### NEGLECT

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Family Assessment Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Failure to provide medical care in life endangering situations</td>
<td>• Vulnerable child without supervision</td>
</tr>
<tr>
<td>• Child inadequately supervised, imminent danger</td>
<td>• Medical diagnosis of failure to thrive</td>
</tr>
<tr>
<td>• Child abandonment</td>
<td>• Housing conditions pose health, safety or harm to children</td>
</tr>
<tr>
<td>• Child exposed to Meth Manufacturing</td>
<td>• Domestic issues between adults in residence endanger safety and welfare of child</td>
</tr>
<tr>
<td>• Child access to drugs</td>
<td>• Educational neglect</td>
</tr>
<tr>
<td>• Alleged PRAN assaults non-offending victim while holding child</td>
<td>• Child born exposed to chemicals / drugs</td>
</tr>
<tr>
<td>• Weapons are being used in vicinity of child</td>
<td>• Caregiver involved in possession, use, sale of a controlled substance in the presence of child</td>
</tr>
<tr>
<td>• Child intervenes in an incident of DV and is injured</td>
<td>• Child has a physical, mental or emotional condition requiring care that is not being received</td>
</tr>
<tr>
<td>• Alleged DV PRAN has made suicidal or homicidal statements</td>
<td>• Failure to protect from conditions/actions which endanger child</td>
</tr>
<tr>
<td>• Life threatening injury</td>
<td>• Child present or involved with parent committing a criminal act</td>
</tr>
<tr>
<td>• Report of non-accidental injury which requires medical attention</td>
<td>• Items thrown in vicinity of child</td>
</tr>
<tr>
<td>• Severe injury (i.e. broken bone, injury to head, torso, genitals)</td>
<td>• Child intervenes in an incident of DV and is not injured</td>
</tr>
<tr>
<td>• Third degree burns – non-accidental</td>
<td></td>
</tr>
<tr>
<td>• Physical punishment to child less than 3 y/o involving shaking, throwing or hitting head or trunk</td>
<td></td>
</tr>
<tr>
<td>• Excessive Physical Injuries</td>
<td></td>
</tr>
<tr>
<td>• Unreasonable confinement or restraint including tying, locking, caging, chaining</td>
<td></td>
</tr>
<tr>
<td>• Child has injuries</td>
<td></td>
</tr>
<tr>
<td>• Child fatality with other children living in home</td>
<td></td>
</tr>
</tbody>
</table>

### PHYSICAL

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Family Assessment Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Life threatening injury</td>
<td>• Threatened physical abuse</td>
</tr>
<tr>
<td>• Report of non-accidental injury which requires medical attention</td>
<td>• Present visible injury</td>
</tr>
<tr>
<td>• Severe injury (i.e. broken bone, injury to head, torso, genitals)</td>
<td>• First or Second degree burns – non-accidental</td>
</tr>
<tr>
<td>• Third degree burns – non-accidental</td>
<td>• Report of non-accidental injury; not currently present</td>
</tr>
<tr>
<td>• Physical punishment to child less than 3 y/o involving shaking, throwing or hitting head or trunk</td>
<td>• Unexplained injury</td>
</tr>
<tr>
<td>• Excessive Physical Injuries</td>
<td>• Excessive/extreme/severe punishment without injury</td>
</tr>
<tr>
<td>• Unreasonable confinement or restraint including tying, locking, caging, chaining</td>
<td></td>
</tr>
<tr>
<td>• Child has injuries</td>
<td></td>
</tr>
<tr>
<td>• Child fatality with other children living in home</td>
<td></td>
</tr>
</tbody>
</table>

### SEXUAL

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Family Assessment Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All allegations of intra-familial sexual abuse</td>
<td></td>
</tr>
</tbody>
</table>

### EMOTIONAL MALTREATMENT

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Family Assessment Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child is restrained or restricted from leaving during the DV incident</td>
<td>• Verbal acts or omissions which have an observable adverse effect on the child (i.e. name-calling and language; constant yelling)</td>
</tr>
<tr>
<td>• Unreasonable confinement or restraint including tying, locking, caging, chaining, or unreasonable force or cruelty.</td>
<td>• Caregiver shows little or no attachment to child</td>
</tr>
<tr>
<td></td>
<td>• Child intervenes in an incident of DV and is not injured</td>
</tr>
<tr>
<td></td>
<td>• Child shows behavioral changes that appear to be related to DV and is fearful of physical injury or death to self or others.</td>
</tr>
</tbody>
</table>
Screening Guide

**General Information**
What: Nature of the abuse or neglectful environment.
Where is the child now?
Where is the alleged perpetrator now?
When were the children last seen and by whom?
How long has this been occurring? Have things stayed about the same, become worse or improved? How did the reporter come to know this information?
What school does the child attend and how long are they there?
Is the child reporting how often this occurs?
Is domestic violence a concern?
Are there any weapons in the home or drug use by family members? Are there any other environmental hazards in the home (vicious animals, meth labs, criminal activity, etc.)?
Who else lives in the home? Are there other children in the home?

**Safety/Maltreatment**

**Neglect**
What specifically did the reporter see?
Description of the environment and who saw it?
When did they see it?
Age of children and what have they been exposed to?
Regarding the appearance of the child, what did the reporter see (clothing not appropriate for season, in poor condition, etc.)?

**Emotional Abuse**
What is being said to the child or what did they witness?
When, where and how often does this occur?
How is the child being affected?

**Domestic Violence**
Where were the children during the incident? Were the police called?
Who called 9-1-1 and at what time? Were any charges filed or was either parent incarcerated? Was the child(ren) physically injured?
Did child(ren) make any statements about how they “feel” regarding what occurred?

**Lack of Supervision**
How often and what time of day does it occur?
How long is the child(ren) left alone? Are they alone now?
Do they know where the parent goes at these times?

**Physical Abuse**
Did the reporter see an injury? What does it look like?
Where on the child’s body is the injury?
Is medical intervention necessary?
When/where did it occur and by whom?
Have any siblings ever suffered similar abuse?
Has this happened before?

**Drug Allegation**
How do you know the parent is using drugs?
What substance is the parent using?
What is the impact on the child?
Is the substance accessible to the child?
Does the parent have a medical marijuana prescription?

**Drug-Exposed Child**
Is the mother still at the hospital? Who else is at the hospital?
Has mecsat been ordered? Types and level of drugs present?
Does mom have a place to go? Do they have a car seat and other supplies?
How long will the child remain in the hospital?

**Sexual Abuse**
What, when, who, where and how often?
Did anyone else witness the incident? If the perpetrator is over age 10, has law enforcement been notified?
Have the parents been notified?
Are there any physical indicators?
Has the child made a direct outcry? What was said?
Is the child reporting they have been inappropriately touched before?
What is the relationship of the perpetrator?
Youth in Conflict
What specific behaviors have you seen that worry you about this youth?
How often are these behaviors occurring?
When was the last time you observed it?
(If reporter is not the parent) Have you contacted the parents about this? Response?
Describe what you know about the youth's friends?
Gang involvement? Drugs/alcohol?
Is the youth attending school?
Has the youth runaway? How many times? How long are they gone when they run?
Are there other agencies involved such as the courts or therapists?
How are the youth's behaviors affecting the family?
Does the youth have any informal supports such as mentors and/or close friends or family?

Strengths/Supports
Tangible Supports
How long has the family lived in the community?
How long at the current address?
Does the family have a telephone, transportation, car seats etc?
Are the adults in the home employed?
Is the family receiving any public assistance (cash assistance, food stamps, Medicaid)?

Child Information
How would you describe the child (happy, sad, worried, tired, fun loving)?
Does the child have any developmental delays or physical handicaps?
How does the child do in school and do they express any fear/apprehension of going home?
Does the child have friends?
What does the parent say about the child – how would they describe the child?

Family/Community Supports
Does the family call on others to help solve problems?
Who do they call upon?
Are you familiar with any of the extended family?
Who are they and how is their relationship with the family? What do they say?
Are there aspects of your relationship with the family that, in conjunction with our intervention, might help to influence them for the better?

Family Coping/Strengths
Are the parents concerned about these problems?
How did they react to you expressing concern?
How do family members usually solve this problem?
What have you seen them doing?
What would you say is good about mom’s/dad’s parenting? What would the child say about the same?
Based on what you know, who is in charge of the family?
Has the family had any previous involvement with the law/courts? Have any children been previously removed from the home?
Are there times when the mother/father is attentive rather than neglectful? Can you tell me more about those times? What did the parent and child do instead?
What do you think contributed to the parent’s responding differently?
According to what you know, how did the non-offending parent react to what occurred?
If this has happened before – how has the family addressed the situation?

Solutions
Have you taken any other action in addressing this problem, other than making this call?
Have you talked about these concerns with anyone else who knows the family?
Did you tell the parents you would be calling? How did they react?
What do you think is the cause of the problem?
What convinced you to make this call?
What would it take to make the child safer?
How will you know when this problem has been solved?
What else happened? Is there anything else you can think of that you would like to add to this report?

Scaling
If this situation remained unchanged how would you rate the level of safety in the home on a scale from 0 to 10, 10 being very safe with no concerns and 0 being very dangerous?
Tell me about how you reached this number.
What do you believe needs to happen to move it one point higher on the scale?
References


The intent of the following article is to provide the reader with an example of how a child welfare system can completely transform itself from a legalistic and excessively adversarial system to a collaborative, preventative, and strengths-based approach. New Brunswick has transformed its child welfare system by implementing a series of practice changes, including family group conference, immediate response conference, child protection mediation, family enhancement services, multiple response, and kinship care.

Introduction

The primary responsibility for the well-being of children in Canada rests with parents. However, it is understood that in order to protect the safety and well-being of children, there are times when others must intervene. The Canadian provinces and territories have the authority to operate child welfare systems and to establish legislation to govern those systems.

In New Brunswick, child maltreatment includes sexual abuse, physical abuse, physical neglect, and emotional maltreatment. Children and youth up to the age of 16, or disabled children and youth up to the age of 19, are in need of intervention if there are reasonable and probable grounds to believe that their security or development is endangered.

The Minister of Social Development, under the authority of the Family Services Act, has responsibility for the delivery and quality of child welfare services (including child protection, children in care, children’s residential services, and adoption; under this umbrella, the Department of Social Development also provides services to youth at risk and community-based services for children with special needs). In addition, the Federal Department of Aboriginal Affairs and Northern Development Canada provides funding for 11 First Nations child and family service agencies, delegated by the province to provide child welfare services to children and families on reserves in New Brunswick. These agencies provide services to 15 First Nations communities. Aboriginal families living off reserve receive services from the regional office of the Department of Social Development. There are protocols for the identification of band affiliation1 and provisions for co-management of cases with First Nations child and family service agencies. If desired by Aboriginal families or if appropriate, cases may be transferred entirely to a First Nations child and family service agency.

Background

In the 1990s, the neglect of children resulted in the deaths of a number of children in New Brunswick, including the highly publicized cases of John Ryan Turner, a 3-year-old who died of starvation in 1994; Jacqueline Dawn Brewer, a 28-month-old who died in her crib of dehydration and neglect in 1996; and

1 In Canada, “band” refers to a body of Aboriginal peoples. Each band has its own governing council generally composed of one chief and several councillors. The chief and councillors are chosen through an election process by community members or sometimes through custom. Members of a band usually share common traditions, practices, and values that are embedded in their heritage. There are three groups of Aboriginal peoples recognized under the Canadian constitution: First Nations, Métis, and Inuit. There are two distinct groups of First Nations people in New Brunswick: Mi’kmaq and Maliseet. According to Indian and Northern Affairs Canada statistical data (http://www.ainc-inac.gc.ca/edu,ep/msc-eng.asp), as of December 2009 there were approximately 13,366 First Nations peoples living in New Brunswick, of which 8,632 were living on reserve and 4,734 were living off reserve.
Courtney Grimmer, an 8-week-old who died of internal injuries after being shaken in 1997. According to the assessment tools used at the time, these three situations were deemed to be low-risk child protection cases and no intensive child protection interventions were required. However, based upon the police investigations, the parents in all three cases were charged in court and found responsible for the deaths.

Cries such as these result in panic in communities, and New Brunswick faced a growing dissatisfaction with traditional child protection systems and practice. Child protection caseloads were increasing and the system struggled to manage the demands for service and to meet the complex needs of children and their families. Families were facing a multitude of problems, such as domestic violence, cross-addiction to alcohol and “hard” drugs, addiction to prescription drugs, and more complicated mental health issues. In addition, the primary problems that families were presenting were compounded by severe secondary problems. In an attempt to alleviate the pressures, New Brunswick, like many jurisdictions, implemented a standardized and legalistic approach focused on case management, risk management, and staff training.

A comprehensive review of the child welfare services (child protection, children in care, children’s residential services, and adoption) in New Brunswick was undertaken in 1998. The results of this review were published in the report Children Come First: Child Welfare Comprehensive Review and Redesign, released in January 2000 (Department of Health and Community Services). Over the next several years, the department hired an additional 89 front-line social workers for child welfare, of which 63 were allocated to child protection services; implemented a competency-based child welfare training system; redesigned the Adoption Program for older, special needs children and launched the Special Adoption Program, resulting in a 400% increase in adoption placements; and eliminated numerous unnecessary procedures. All of these initiatives were attempts to relieve stress in an overburdened child welfare system. Although each initiative was well founded and resulted in positive results, the pressure continued to intensify in child protection services and throughout the remaining child welfare programs. The New Brunswick child protection system that emerged, based on a strict risk assessment approach, was extremely dependent on the judicial system, considered too formal and excessively adversarial, and impeded movement towards permanency for children. This was having a negative impact on the workload of social workers, on legal processes, on perceptions of due process, and on the department’s ability to provide critical social work therapeutic interventions.

In March 2004, a survey of child protection supervisors reported consistent responses that family court-related administrative duties interfered with social workers’ abilities to provide child protection services according to prescribed standards and guidelines as well as clinical therapeutic interventions. Furthermore, child protection social workers, as part of their mandate, were required to provide legal administrative services for court purposes by preparing notices of motion, notices of application, social worker affidavits, witness affidavits, documents for disclosure, witnesses to testify for court, and court orders on behalf of the Family Crown Counsel responsible for representing the Minister in court. Based on the 2004 data, it was determined that the average family court application required 64 hours of child protection social worker time and, for that year, social workers spent 85,000 hours completing legal administrative functions.

Compounding the problem for child welfare services, children were in limbo in the judicial system, alternating between foster care and their birth parents as decisions regarding permanency were being delayed in favor of the rights of the parents.
Data collected in June 2006 indicated that 89% of the children in permanent care of the Minister were 6 years of age and older, and the average age of a child coming into permanent care was 9 years of age. By then, the children exhibited a number of complex problems that were having negative effects on an aging foster parent population, the children’s mental health system, and education services. In addition, the department was experiencing a serious social worker retention problem in child protection services.

The child protection system was also under pressure as it was not able to service low- and medium-risk families due to caseload size, the demands of the high-risk cases, the requirement to meet provincial program standards, and the time that had to be devoted to legal administrative functions for court purposes. As a result of services not being provided, the medium-risk cases eventually became high risk. It was obvious that the challenges being faced were of a systemic nature and could not be resolved merely by hiring more social workers. Child abuse and neglect have far-reaching consequences across society (education, hospitals, mental health, public health, courts, jails, income assistance, subsidized housing, and the workforce). The annual cost to society is more than 15 billion dollars in Canada and more than 65 million dollars in New Brunswick, according to a 2003 study (Bowlus, McKenna, Day, & Wright, 2003, pp. 67, 91).

**Overall Vision for the Future**

During 2002-2003, the newly formed central office branch of Child Welfare and Youth Services undertook a strategic planning to determine the future direction of the organization and developed a 5-year strategic plan. In early 2004, the Deputy Minister agreed to these strategic directions that formed the basis of future work.

In April 2004, the death of a fourth child as a result of neglect was highly publicized. Once again, the assessment tool indicated that this was a low-risk situation. The child, Juli-Anna St. Peter, was 2 years of age at the time of her death. Her mother and her mother’s boyfriend were jointly charged with failure to seek medical assistance for the child, causing her death. The mother was found guilty but the boyfriend was acquitted as it was deemed that he did not have a duty of care for the child.

In 2005, the Deputy Minister and the director of Child Welfare and Youth Services made a presentation to the Policy and Priorities Committee of the government, seeking their support for a major transformation of child protection services as put forth in the Child Welfare and Youth Services Strategic Plan. As a result, the New Brunswick government made a commitment to transform the child protection service delivery system by introducing several practice changes, including family group conference, immediate response conference, child protection mediation, family enhancement services, multiple response, and kinship care.

The New Directions in Child Protection Initiative, launched in December 2006, was given the mandate to design a collaborative, preventative, and strengths-based approach with children, families, and community partners that would reduce reliance on the family court system and provide better outcomes for children and their families. It was acknowledged that not only would changes be required to child protection services, but that changes throughout the child welfare system would be necessary in order to provide support and sustainability.

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2 Bowlus, McKenna, Day, and Wright used the economic costs of violence model developed by Tanis Day, which focuses on six major areas: judicial, education, health, social services, employment, and personal costs. These costs factored in those assumed by government and those to an individual. For example: judicial costs included policing, court trials, legal aid, penal costs (incarceration, parole, and statutory release), and the Criminal Injuries Compensation Board; education costs focused on the demand for special education services due to learning and behavioral problems in child abuse victims; and health costs took into consideration the immediate effects of abuse, persistent medical costs, and long-term medical costs experienced by adult survivors of child abuse.
The vision for the future focused on the research and best practices that demonstrate that children and their families are frequently best suited to make decisions regarding their own lives. It was recognized that parents needed to be more motivated to change the behaviors that put their children at continued risk of abuse or neglect. The belief was that by engaging more parents in the process of making sustainable changes, more children would be protected over time. As New Brunswick is a small province with limited resources and services, it was vital that the new model be financially viable, prevention-focused to meet the needs of low- and medium-risk families, and allow social workers to use their skills by providing child-centered, family-focused clinical therapeutic interventions.

However, it was recognized that change can result in further pressure, resistance, and a lack of acceptance. Knowing that the social workers were feeling completely overwhelmed, it was acknowledged that attempting any reform was futile until some type of relief was provided. An immediate solution was required to resolve the escalating problems related to the legal administrative duties for court. Twenty legal administrative assistants were hired to assume the legal administrative functions then being carried out by child protection social workers. The trained legal assistants possessed specialized skill sets, which allowed them to complete the legal administrative tasks in a shorter time frame without the competing priorities faced by social workers.

**Changing Practice: “New Directions in Child Protection Initiative”**

It was recognized in the early stages of the New Directions Initiative that strong family group conference and child protection mediation processes were required as a foundation to support the implementation of multiple response. The intended reforms are depicted in Appendix A.

Due to the magnitude of this transformation, the initiative was divided into two phases. Phase 1 focused on designing a child protection mediation model/collaborative process while Phase 2 was responsible for developing the New Brunswick Multiple Response System.

In early 2007, a Phase 1 team responsible for designing a child protection mediation model/collaborative process was established. The design team was composed of two provincial child protection consultants, a director from First Nations child and family services agencies, a consultant from the Department of Justice, and five child protection supervisors, including representation from the union and the New Brunswick Association of Social Workers. The team conducted an exhaustive literature review and consulted with various jurisdictions across Canada, North America, Europe, Australia, and New Zealand. Decisions were made by consensus, after much deliberation. Consultations were also held with the Department of Justice and the Office of the Attorney General.

A Phase 2 team, formed in 2009, was given the mandate to design the New Brunswick Multiple Response System. The team consisted of two provincial child protection consultants, a project consultant, a representative from First Nations child and family services agencies, two child protection supervisors, and three social workers, including representation from the union and the New Brunswick Association of Social Workers, a policy analyst, a consultant representing Housing and Income Support, the project manager of the Early Childhood Redesign Initiative, and representatives from the Departments of Education and Health (Mental Health and Addictions). As family group conference and multiple response require a strong alternate child placement mechanism, and since child welfare services in New Brunswick was also feeling the negative effects of having an aging and decreased foster parent population, kinship care was seen as an integral alternative, forming part of Phase 2.
Phase 1

Collaborative processes reduce the focus of assigning blame and empower families to be an integral part of the solution. Based on the success of other jurisdictions, New Brunswick proposed that implementing a collaborative model could reduce by 70% the number of child protection cases going to court.

The cornerstones of the re-conceptualized child protection service model in New Brunswick are the family group conference and child protection mediation. Two other key components are immediate response conference and family enhancement services. The new child protection service model was designed to be supported by the provision of clinical therapeutic interventions by departmental social workers, the introduction of a clinical supervision model throughout child welfare services, an increased focus on permanency for children, and extensive training.

New Brunswick’s family group conference process, based on New Zealand’s model, is one that brings together the nuclear and extended family as well as friends and service providers to develop a plan that meets the needs of safety and permanency for the child and family. Family group conference places the extended family at the center of problem resolution and supports their efforts with professional services. The conference is a well-organized pre-planned meeting facilitated by a family group conference coordinator who is independent of case management. An essential feature, not found in other child protection models, is the un-facilitated private family time, during which no service providers are in the room, so that the family can devise a plan that meets the child’s need for safety. Plans can only emerge from a family group conference where there is consensus, and this includes the agreement of the professional acting on behalf of the Minister.

It is mandatory for a social worker to consider collaborative approaches with all families and, further, it is mandatory for a social worker to make a referral to a family group conference when a child is in the Minister’s care or there is a strong possibility that a child will be coming into care, as well as when a child under 8 years of age is a member of a family that has been open for ongoing child protection services as a result of chronic neglect concerns for a period of 6 months or longer.

Family group conference is available to all residents of New Brunswick, including First Nations families living on reserve. This service is provided through 21 coordinators whose only responsibility is preparing for and convening family group conferences. The coordinators are provincial resources that report to the centrally located supervisors, but they are physically located in regional offices throughout the province. It is imperative that the family group conference coordinators are perceived as impartial, objective, and independent of the regular child welfare system and responsibilities. The coordinators are not involved with families in any manner that requires a position of decision making or authority.

Having adequate preparation time is crucial to the family group conference process, but there are times when immediate risk factors require more immediate intervention and exercise of powers. To meet this need, New Brunswick has introduced a process known as an immediate response conference. The objective is to engage the family and community supports in safeguarding children who come under a protective care status or are at immediate risk of placement. It may also provide a response that prevents a child being placed outside the family and/or extended family. Although an immediate response conference is facilitated by a family group conference coordinator, allowing the social worker to remain focused on the safety plan for the child, it differs in that it is professionally driven. In New Brunswick, an immediate response conference must be held within 3 working days of the initial
intervention. An immediate response conference is available at child protection investigations, family enhancement services, ongoing child protection, and for First Nations child and family services.

**Child protection mediation** in New Brunswick is a voluntary process, but the law requires that social workers consider this alternate dispute resolution approach as a mechanism to reach a mutually acceptable agreement between the Minister and the parents when there is a difference of opinion about what is best to ensure a child’s safety. It cannot be mandated by the court.

As with family group conference, the credibility of child protection mediation rests on perceptions of impartiality and objectivity. The New Brunswick child protection mediators are required to have professional degrees (social work, law, psychology) and be accredited members of the appropriate associations; have completed basic as well as advanced mediation training; have received training in child protection mediation; and have knowledge of child protection issues, legislation, dynamics of abuse, and power imbalances. They are not employees of the Department of Social Development but are third-party professionals. A roster of nine child protection mediators is maintained and administered by the Department of Justice. These mediators are considered to be a provincial resource to provide service to clients of the Department of Social Development and to First Nations child and family services agencies. The Department of Justice provides a single entry point for child protection mediation services, ensuring provincial consistency.

An interim form of **family enhancement services** was also introduced under Phase 1, as it was recognized that, in order to reinforce the change to collaborative approaches in the delivery of child protection services, the provision of prevention services was required from the onset. These services are brief, solution-focused intensive interventions provided by professional social workers intended to restore family functioning within 6-9 months and to maintain the child’s security or development. Initially, the following criteria had to be met in order to receive these services: (a) the major presenting problem involves a child 12 years of age or older who is beyond control of a parent or caregiver; or (b) any other identified child protection issue, which, in the clinical judgement of the social worker, is likely to be amenable to resolution within 6-9 months. A family can be referred to family enhancement services at the conclusion of a child protection investigation, when it is ascertained that there are characteristics of protection indicating that a child’s security or development might be in danger if no intervention is offered. A family receiving family enhancement services may be referred to family group conference when there is a substantial planning issue. The family enhancement services social worker is mandated to ensure the child’s ongoing protection until the case is closed or is transferred to ongoing child protection services.

These services are to be revised in accordance with the final design of Phase 2, which is to include a strengths-based assessment of family needs rather than sole reliance on risk assessment. The category of children/youth out of control was chosen based on the number of referrals being received.

Phase 1 was implemented in two stages: Family group conference and child protection mediation were implemented in late fall 2008, and immediate response conference and family enhancement services were implemented in January 2009. Prior to implementation, extensive training was provided to the family group conference coordinators, child protection mediators, and front-line social workers.

**Phase 2**

**Multiple response**, elsewhere known as alternate response or differential response, refers to a process that offers response options to child protection referrals of child maltreatment, abuse, or neglect. A
key element of the system is that it offers preventative and supportive services to some families without having to substantiate an allegation or to conduct an investigation. It is much less intrusive or adversarial. This system empowers and engages families in identifying solutions and building strengths and recognizes that the safety of a child is a shared community responsibility. The intent is to enhance services to support low- to medium-risk families so that children can remain safely in their homes, reduce the number of days children must come into temporary care, and provide intensive services to high-risk families. The province will use tools to assess the strengths and needs of a family and a child risk assessment.

The New Brunswick Multiple Response System builds upon the strategies implemented in Phase 1 of the New Directions in Child Protection Initiative. Under the New Brunswick design, social workers use their professional training to deliver clinical therapeutic interventions and work in partnership with other professionals so that clients can readily access services from the Departments of Mental Health, Education, Public Safety, and Justice. It is a collaborative approach that is child-focused, family-centered, and strengths-based, and is supported by partnerships built between families, community-based agencies, and government departments.

The vision in New Brunswick is to launch the Multiple Response System with two pathways or tracks: (a) the traditional child protection pathway for investigations, and (b) the family enhancement pathway for the assessment of service needs. By commencing with only two pathways, the culture shift for staff will be facilitated by keeping changes simple. The future vision includes a pathway for 16- to 18-year-old youth at risk through voluntary youth agreements and a pathway for intimate partner violence.

In addition to replacing the New York model of risk assessment, a consensus-based model was adopted in 1996 with the structured decision-making tools, an actuarial model, made available North Carolina. The North Carolina tools are strengths-based and safety-focused. Further, the intention is to equip social workers with additional skills and assessment tools in parental capacity assessment, child development and child sexual development, attachment, mental health and personality disorders, addictions, family violence, and family therapy. This will help the department meet the challenges of a small province having limited community services and a large rural area.

A strong alternate child placement mechanism is required to augment multiple response and family group conference approaches. Based on research, it was determined that a kinship care strategy was a viable alternative, as New Brunswick was also feeling the negative effects of having an aging and decreased foster parent population.

There are instances when a child must be removed from the parental home to ensure the safety of the child. In some cases, placement with family (kin) or members of the child’s community is the best option to ensure that the child is in a safe and nurturing home. This approach builds on existing family and community relationships and facilitates easier and greater contact with birth parents. For those children who are already in the care of the Minister, kinship care facilitates earlier placements in permanent or long-term homes. Such options reduce the stress for children coming into care, maintain family and community ties, and increase the likelihood of the child’s reunification with his/her primary family. The effective use of kinship care can be constrained because of concerns about liability when provincial staff are involved in making or agreeing to placements. It is important to note that the New Brunswick strategy resolves this dilemma by distinguishing in law between those cases in which the department is supporting families who retain legal responsibility for a child and those in which the department holds the legal responsibility for the child.
The New Brunswick Kinship Strategy proposed two options for care with family or community members: **kinship service** (child not in Minister’s care) and **kinship care** (child in Minister’s care). In both instances, prospective family or community caregivers are thoroughly assessed through the completion of criminal record and departmental prior contact checks, personal interviews, and an assessment of the home and family. Kinship care families are further assessed and prepared for their responsibility of caring for a child who is in the care of the Minister of Social Development through the use of home assessment and participation in the program PRIDE (Parent Resources for Information, Development and Education). In either case, financial compensation is available to help offset the additional costs (Child Welfare League of America, 1998).

Kinship service authorizes the Department of Social Development to provide services that ensure child safety in instances when the child is not in the care of the Minister and remains within his/her family or community. The departmental social workers will be required to evaluate the capacity of the family or community member to care for the child in a safe home environment. Wherever possible, the assessment will occur before the child is placed in the kinship home. Where it is determined that the child cannot return to the parental home and the kinship family is willing to continue to care for the child, the case will be closed for child protection services with financial support to the kinship family being maintained.

Kinship care is provided for children who are in the care of the Minister and are placed with members of their extended families or communities. Bringing a child into the care of the Minister is a more intrusive measure and provides a different level of service for the child. The decision to pursue a kinship care placement rather than kinship service is generally driven by the protection needs of the child and the willingness or ability of the birth parents to work on resolution of the child protection issues. Regardless, kinship care provides a familiar home for the child and, for some children, is a good alternative to foster care. In these cases, the Minister becomes the child’s legal guardian and assumes the rights and responsibilities associated with being a child’s guardian. Therefore, the standard for assessing and preparing prospective kinship care families is the same as that for evaluating all foster parent applicants. This model of care is to be supported in legislation.

Initially, Phase 2 was to be launched by September 2010 but was delayed. The department gradually implemented Phase 2 throughout 2011.

**Success Factors**

The success of any major transformation requires commitment, dedication, and leadership at all levels, from the grass roots of the organization to the final decision makers. The success of Phase 1 is largely due to the director of Child Welfare and Youth Services at the time, the two provincial child protection program consultants and the various project teams, the other child welfare program consultants, the project managers, and staff of the First Nations child and family service agencies. This highly dedicated team was able to bring its vision to reality. Further, the consultations by phone or in person with Mike Doolan, as well as the training he provided, were invaluable. Mr. Doolan is the former chief social worker, New Zealand Children, Young Persons and Their Families Agency, who helped develop Family Group Conference in New Zealand and has assisted such initiatives in the United Kingdom, Ireland, Denmark, Sweden, Canada, the United States, and Israel. Mr. Doolan, an American Humane Association fellow, is also an author and former senior adjunct fellow, School of Social Work and Human Services, University of Canterbury. Furthermore, Phase 1 would not have been a success without the support of the
It is proposed that the implementation of Phase 2 be supported by providing adequate resources and through further training in the following areas: the new decision-making tools; parental capacity assessments; child development; child sexual development; attachment; family violence; addictions; mental health issues and personality disorders; family therapy; and kinship care.

**Phase 1 Success to Date**

According to data released in spring 2010 (Department of Social Development), New Brunswick has seen 18% fewer children in the care of the Minister of Social Development since the launch of Phase 1 of the New Directions in Child Protection Initiative. Although it is a more time-consuming process initially, there are greater long-term benefits, fewer cases going to court, and greater social worker satisfaction. The positive feedback from the regional staff and from New Brunswick families has been overwhelming. Phase 2 will complete the vision for the future. The team is hoping to build upon the successes of Phase 1 with the implementation of Phase 2.

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Appendix A. New Brunswick’s Vision for the Future

Centralized Regional Intake System
Receives Report of Concern & Determines Whether it Meets the Legislated Mandate

YES

Report Meets Mandate
Determination of Priority of Response & Pathway

NO

Report Does Not Meet Mandate
Close or Refer to Community-Based Services and Close

Immediate Response Conference

Family Enhancement for Assessment
- Family Group Conference
- Mediation
- Clinical Therapeutic Interventions
- Involvement of Other Professionals
- Community-Based Services
- Close

Child Protection for Investigation
- Family Group Conference
- Mediation
- Family Court
- Clinical Therapeutic Interventions
- Involvement of Other Professionals
- Community-Based Services
- Close

Family Enhancement Services
- Family Group Conference
- Mediation
- Clinical Therapeutic Interventions
- Involvement of Other Professionals
- Community-Based Services
- Close

Child Protection for Services
- Family Group Conference
- Mediation
- Family Court
- Clinical Therapeutic Interventions
- Involvement of Other Professionals
- Community-Based Services
- Close

2 Future Pathways
Youth at Risk & Intimate Partner Violence

References


Building a Multi-Site Evaluation of Differential Response

Brett Brown

Introduction

A primary goal of the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR) is to substantially strengthen the knowledge base about differential response (DR) in several core areas, including the impact on child safety, identifying effective practices, and assessing cost. To that end, the QIC-DR has launched a coordinated, multi-site evaluation using a rigorous randomized control trial (RCT) design.

In the fall of 2009, the QIC-DR awarded grants to three sites to implement and evaluate DR, including: a consortium of five counties in Colorado; another consortium of six counties in Ohio; and a statewide effort in Illinois. Each site has its own highly experienced evaluation team responsible for carrying out the local evaluation, each of which has contributed to a paper in this volume. The QIC-DR cross-site evaluation team, led by Walter R. McDonald & Associates, Inc. (WRMA), is responsible for maximizing the knowledge gained from the multi-site design by coordinating the methodology and instrumentation across the sites, supporting the local evaluators in their work, and synthesizing findings across the three sites.

This paper is an early report on how we have managed the work of this ambitious evaluation effort. I have focused on the practical lessons learned that may be useful to evaluators and program directors who may undertake similar efforts in the future. Substantively, the major focus is on research and instrumentation design issues, and the Institutional Review Board (IRB) review process. Thematically, the focus is on how one coordinates the perspectives and interests of local evaluators, project directors, and cross-site evaluators to produce a strong evaluation effort. These are important practical issues that rarely receive attention in the implementation research literature.

Background

Differential response (DR), an increasingly popular approach to child welfare service delivery, has been adopted at some level in about half the states, sometimes statewide, but more often as pilot efforts. It is, in the parlance of program evaluation research, a “promising practice,” with a number of evaluations indicating positive results for children and families. The Children’s Bureau funded the QIC-DR with the goal of strengthening the evidence base on DR to better inform practice. The QIC-DR was to accomplish this by funding three to five sites around the country to field rigorous evaluations, with a clear preference for randomized controlled trial (RCT) approaches. Further, the QIC-DR was to encourage comparability across the sites regarding research questions, methodologies, and instrumentation so that important lessons could be drawn from across the evaluations.

In the request for proposal (RFP) to potential sites, the QIC-DR set the following parameters:

- The proposed program must adhere to the seven key characteristics of DR as adopted by the QIC-DR (National Quality Improvement Center on Differential Response).
Improvement Center on Differential Response in Child Protective Services [QIC-DR], 2009b):

- Two or more discrete response pathways for screened-in reports of maltreatment;
- The pathways are formalized in statute, policy, or protocols;
- One of the pathways must be a non-investigation pathway in which no formal finding of maltreatment is made;
- Initial pathway assignment depends on a stated array of factors (e.g., presence of danger to the child, level of risk, number of previous reports);
- Cases assigned to the non-investigation pathway can be reassigned to investigation if new safety concerns emerge;
- Services are voluntary in the non-investigation pathway unless there are continuing safety concerns;
- In the non-investigation pathway, no perpetrators are identified, and no names are entered into a central perpetrator registry.

- There must be three components to the proposed evaluation: outcomes, process/implementation of DR practices, and cost.
- The design must be rigorous, preferably an RCT, with sample sizes of sufficient power to detect expected differences.

Contracts were awarded to three sites in Illinois, Colorado, and Ohio. All three have adhered to the requirements listed above, including the RCT design. Within those requirements, however, there is a lot of room for diversity. For example, Illinois is implementing statewide, while the other sites are limiting to five to six counties. Illinois is a state-administered system, while Ohio and Colorado are county-based. There is also diversity in the program models representing DR in areas that include eligibility criteria, access to services, and staffing (union/non-union, public/private). These differences can be viewed as strengths, in that difference may allow the cross-site evaluation to assess the robustness of key factors across diverse contexts and implementation strategies. This also creates a challenge to the evaluation teams to achieve maximum cross-site comparability in the evaluation designs while incorporating the features that are specific to each site.

**Research Design and Instrument Development**

Over the past 18 months, the QIC-DR and its local site partners have designed the outcomes and process/fidelity components of the evaluation for each of the sites. A third component, the cost evaluation, is, in many ways, the most challenging and is still in process. This section describes how the various groups involved were able to work together to produce a strong design that took account of the particular goals and considerable gifts of each group.

While the bulk of this work has been carried out by the cross-site and local evaluation teams, the program directors, who are responsible for implementing DR at each site, were also important participants in every step of the process. Thus, this process has been, in many ways, a dance of three partners: the cross-site evaluators, the local evaluators, and the project directors. This inclusive approach has been very time intensive, involving three in-person meetings of all partners for several days during the first year, group teleconferences several times per month, and a great deal of preparatory and follow-up work for all concerned. It has, however, paid off in innumerable ways, including the quality of the instruments and...
The Research Framework

Our first goal was to build a common research framework that identified the research questions that would be addressed by all sites, as well as the data source(s) that would be used to address each question. In identifying the questions (more than 40 in all) and potential data sources, we were able to draw on several resources, including: a comprehensive literature review of DR recently completed by QIC-DR staff (QIC-DR, 2009a); reports from the two existing RCT-based evaluations of DR (Loman & Siegel, 2004; Loman, Filonow, & Siegel, 2010);¹ and the individual site proposals. Data sources for this ambitious design included: CPS administrative data; supplemental case reports; surveys of families; surveys of workers; site visit interviews and focus groups; and written documentation.

QIC-DR evaluation staff drafted a table of research questions by potential data resources that included suggestions for which questions would be best addressed with each data source. This was circulated to each of the local evaluation teams. During the initial 2-day project meeting, the questions were discussed extensively among the local and cross-site evaluation teams to achieve a common understanding among the participants and a sense of the relative priority of each of the questions. Over the next month, through a succession of group teleconferences and round-robin emails, the questions were edited, added to, prioritized, and, importantly, culled to a manageable number (though individual sites were free to pursue dropped questions for their own sites if they chose to). Data sources to address each question were also identified. Once the evaluators had reached broad agreement, the table was shared with the project directors (PDs) for their review and input. The PDs, as one of the primary consumer groups of the evaluation results, suggested a number of additional questions that would be helpful to them in refining their programs over time.

The end product was a strong common framework that would guide the rest of the design process. In addition, by involving all parties up front in the design process, we were able to achieve a level of buy-in from the three partner groups that would come to be as important as the common framework itself. The process was not perfect, however. As we moved to the task of developing the actual research instruments, the PDs pointed out that the process would benefit if they were brought into the conversation from the very beginning this time, rather than commenting on a near-finished product, a suggestion that the group adopted for its subsequent work.

Outcomes Evaluation

Developing the outcomes component of the evaluation required a lot of work setting the details of the RCT design (unit of analysis, randomization techniques) and addressing issues related to informed consent (see below in IRB discussion for details). The majority of our efforts, however, were focused on the development of the original data collection instruments: the family exit survey, case report, and the caseworker surveys. The family exit survey is to be filled out by an RCT family member after the initial case has been closed and includes questions related to engagement, satisfaction, service needs and receipt, and outcomes. The case reports, filled out by the caseworkers, supplement administrative data for each case. They provide a level of comparability across the sites that would not have been possible through existing administrative data sources alone. Finally, the

¹These evaluations were carried out by the Institute for Applied Research, whose key staff are also consultants for the QIC-DR on the current project.
caseworker surveys explore a variety of caseworker issues, including job satisfaction, skills, training, knowledge about DR, and the adequacy of available services in the community.

The major goal of the QIC-DR evaluation staff for these data collection instruments was to achieve a high level of comparability across sites to support the cross-site evaluation. The primary goal of local evaluators was for instruments that would be easily understood by local respondents (reflecting local terminology and practices) and that would cover issues of particular interest to an individual site, in addition to the core issues of concern to all sites. An additional goal of local evaluators that emerged during the development process was the desire for some level of input from local respondent groups regarding content. They felt this would help achieve higher levels of cooperation, thus making data collection more successful, and could also make evaluation results more useful to these groups. Finally, project directors were also concerned about buy-in, but were particularly keen to minimize the burden that any data collection instrument would place on the caseworkers. All three groups were focused on the overall quality of the instruments.

The instrument-building process began with the QIC-DR staff adapting similar instruments that had been developed for the two previous RCT evaluations of DR performed by the Institute for Applied Research (IAR) (Loman & Siegel, 2004; Loman et al., 2010). These instruments had been thoughtfully developed and field-tested. The questions from these instruments were sorted according to the current project’s list of research questions contained in the research framework (see above) to reveal where the holes were that would require filling with measures from other sources. In addition, IAR staff were able to provide the working group with information on which of their questions had performed as intended, and which would need to be dropped or reworked. This was done for all three of the instruments.

The three groups (QIC-DR staff, local evaluators, and local PDs) held joint teleconferences two to three times per month for several months, reviewing the proposed questions, proposing and adopting wording changes that would help the questions to work across the three sites, and filling gaps with new questions or by adapting measures from other evaluation efforts. This was followed by a 2-day in-person project meeting to finalize agreement on as much of the instrumentation as possible, including reducing the number of questions in each to minimize respondent burden.

All members of the working group, particularly the evaluators, had devoted a lot of time to developing these instruments at this point. While much had been achieved, the local evaluators felt strongly that these instruments needed input from respondent groups, and that additional work beyond that was required to finalize them. They also felt strongly that the process of developing the instruments had already taken up a great deal of staff time, and a new and more efficient strategy was needed in order to gain and incorporate input from local respondent groups and to finalize the instruments.

The evaluators proposed that each local evaluation team take over responsibility for one of the three instruments, getting input from the appropriate local respondent groups at their sites, and producing a draft for approval by the larger group. This was done, and, with minor tweaks, these were accepted as the core instruments. Each local site was free to add its own questions for its own site as long as it did not substantially increase respondent burden. In addition, local sites were allowed minor changes in the questions to reflect local terminology.

Once this had been accomplished, however,
members of two of the local evaluation teams lobbied the larger group to have the family exit survey psychometrically tested, arguing that there had been enough changes and additions to the questions in the original IAR questionnaire that testing was needed. Many of the researchers felt comfortable with the quality of the existing draft and were not ready to foot the bill for this relatively expensive testing. In the end, the two sites that wanted the testing were willing to pay most of the costs to have it done, and the testing went forward. Testers recommended a number of changes based on their lab results, and after considerable group discussion many, though not all, were adopted for the final instrument.

**Process/Fidelity Evaluation**

Once the RCT design and its instrumentation were finalized, the group moved on to designing the process evaluation, including a fidelity assessment of each site’s DR program model.² A process evaluation assesses how well a program has been implemented. It is a critical complement to the outcomes evaluation, since even the best program model can fail when improperly implemented. While some aspects of the process evaluation had been addressed in the RCT instruments discussed above, most of the data would come from site visit interviews and focus groups, as well as local documentation.

Several of the evaluators were familiar with the implementation science framework developed by Dean Fixsen and colleagues at the National Implementation Research Network, and were working with it in other projects. The framework focuses on key drivers of the implementation process (competency, organization, and leadership) and the stages of implementation (exploration, installation, initial implementation, and sustainability) (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Metz, Blase, Fixsen, & Van Dyke, 2010). The group felt this to be the most complete and well-articulated implementation framework available, as well as an increasingly popular and influential one in the implementation field. It was quickly adopted by the working group, providing a strong framework for developing the site visit instruments and targeting relevant actors to interview.

Initial drafts of the instruments for guiding the semi-structured interviews and focus groups were drafted by the QIC-DR evaluation team, drawing on Fixsen’s work and on the IAR site visit instruments from their previous DR evaluation efforts. Over a period of several weeks, the group discussed and serially edited the early drafts, quickly producing a refined and more detailed set of instruments. The resulting number of questions, however, in part a result of the well-articulated and detailed guiding framework, were a major concern to the local evaluators and project directors, who felt that resulting interviews and focus groups would be far too long and burdensome for participants.

The evaluation teams were able to reduce the instruments to manageable length using a number of strategies that included identifying only the most critical stakeholders that should be asked each question and identifying questions that could be adequately answered using existing project documents. Suggestions from the individual evaluators were compiled, and a final set of instruments were developed— instruments that would not overburden any of the groups of participants. These were approved by the cross-site and local partners, and adapted as appropriate by the local evaluation teams.

The process of producing the core instrumentation and design for the process
evaluation went more quickly and smoothly than the group’s efforts with the RCT-based instruments. In large part, I believe this was made possible by the successes of the prior effort, including the familiarity and trust that had developed among the groups. This allowed the group as a whole to work more efficiently.

**IRB Review and Approval**

Building a solid research design and instrumentation is only half the battle. The crucial next step on the road to implementing the evaluation is the IRB approval process, which can be particularly challenging with so many organizations involved.

The primary purpose of Institutional Review Boards (IRBs) is to protect the safety, well-being, and rights of human research subjects. IRBs certify that participation is voluntary, that subjects are adequately informed about any risk involved in their participation, and that the risks are justified by the potential benefits of the knowledge generated by the research. IRB oversight and approval is required for all applicable research projects funded by the U.S. Department of Health and Human Services.¹ IRBs may withhold approval, or may require changes in the study design and consent procedures before the research may begin. Any subsequent changes in the design also require IRB approval.

In complex, multi-site research projects such as this one, the IRB of each participating organization will usually need to be involved and their respective applications coordinated. Our evaluation required review by five separate IRBs, including two for Colorado (university and government), in addition to the IRB for American Humane Association, which reviewed both the cross-site application and Ohio’s site-specific application. All of the IRBs had to review and approve the common core design, instrumentation, and consent procedures, though some local variation was allowed.² While all IRBs operate under a common set of federal guidelines, they enjoy substantial autonomy, and their standards regarding consent, confidentiality, acceptable levels of risk, and other core IRB concerns can vary substantially across IRBs, and even within IRBs as leadership changes over time.

The successful navigation of these reviews required a solid core design, advanced (if sometimes informal) coordination with the IRBs prior to submission, and strategic planning with respect to the order of submission. IRBs require that a fully articulated design and instrumentation be submitted for review at the time of the review application, including plans for securing (or not securing) the consent of human subjects. Once those were developed and agreed to by the cross-site and local evaluation teams, each team had a meeting with one or more representatives of their respective IRBs to get informal reactions to key aspects of the design, particularly the consent procedures. This was done prior to submitting any of the IRB applications in order to identify any changes that might be required to the core design, as well as any modifications that might be required for the individual sites.

This strategy surfaced a number of potential differences across the IRBs. Where the core design did not require written consent from caseworkers, one local IRB would likely require written consent for the caseworker survey because caseworkers were by law a protected group in that state.

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² For example, local IRBs could require a more rigorous consent procedure than the cross-site IRB as long as this does not undermine the research design.
Further, some IRBs were going to require written consent from all focus group and interview participants, while others would be satisfied with oral consent. Local IRBs were also likely to require different levels of detail in the consent forms for families and caseworkers. As none of these issues was likely to substantially affect comparability across sites, such differences could be accommodated by building in flexibility for the sites on these issues in the main, cross-site IRB application, while allowing local sites to tailor the applications to satisfy the particular requirements of their local IRBs.

One of the local IRBs, however, had a blanket policy of requiring active consent from all participants in RCT evaluations. All of the evaluators felt that such consent was not a practical possibility (though participants were to be fully informed about the study), and that a waiver of the consent requirement would be needed. Further, all were agreed that any survey data collected from the families would require informed consent. For the IRB that was clearly not going to grant a consent waiver (one of two for that particular site), the local site requested and received an exemption for the entire study.

Once the group had an idea of what to expect from each of the IRBs, the cross-site evaluation staff drafted the cross-site IRB application based on the common core design, which was reviewed and approved by the three local evaluation teams prior to submission. The cross-site IRB application was to be submitted and approved first so that any changes to the core protocols could be worked into the local IRB applications before they were submitted. In addition, the evaluation staff felt that the local IRBs would be less likely to raise objections if they knew that the cross-site IRB had already reviewed and approved the design. Local teams were able to draft their own applications while the cross-site IRB was reviewing the core application, and to incorporate several minor but important changes required by the cross-site IRB. This allowed the local IRB applications to be submitted very quickly once the core application had been approved.

No amount of planning can foresee all potential issues that may surface during actual IRB reviews. One of the local IRBs requested that active consent from each RCT family be gained to allow researchers access to administrative data on their cases. If that requirement had stood, it would have been a major challenge for that site since, as a practical matter, such permission would have been very difficult to secure. The local evaluators for that site were able to argue persuasively that such a requirement was not necessary to protect the rights and dignity of the participants, and was problematic from a practical standpoint. The request was eventually withdrawn.

In the end, careful advanced planning and coordination allowed the QIC-DR and the local evaluators to successfully orchestrate the timely approval of six IRB applications in a way that preserved the core design while allowing for local site variation where needed. Once the team had the designs set and started writing the IRB applications, the entire process took about three and a half months.

**Conclusion**

We are now at the mid-point of this evaluation. There are many challenges ahead for the group, including: completing cost analysis plans; developing a coordinated data analysis plan for the cross-site and local evaluation teams; and finalizing a dissemination plan that will have maximum impact while minimizing duplication and (avoidable) contradiction.

The lessons we have learned to date will be useful to the project as we move forward and, one hopes, useful to those in research and practice.
who may wish to consider undertaking similar evaluation efforts. These lessons include:

- **Inclusive design processes pay off.** Each of the three partners in this process (cross-site evaluation team, the local evaluation teams, and the project directors) has individual perspectives and goals for the project that grow out of their roles. All have been necessary to the success of the project. By keeping each group represented and in balance, the overall research design benefited greatly. In addition, this has produced a sense of ownership and buy-in from the groups responsible for actually carrying out the data collection and analyses, which will also benefit the project.

- **Inclusive design processes are a time hog.** While the fruits of our inclusive approach have been substantial, they have taken substantially more time, more staff hours, than anyone had imagined. The time required to coordinate our design decisions across so many groups could have easily overwhelmed the project. At critical points, practical compromises had to be made to keep the project moving forward in a sustainable way, such as what happened when the local evaluators split up the remaining work on the surveys, or when we came to a compromise for psychometric testing of the family survey.

- **Early success is key.** The very substantial time investment made by all groups early in the process produced a strong foundation for success and mutual trust that has allowed us to be substantially more time efficient in subsequent efforts. Early investment pays off in later efficiency when it produces success.

- **Plan ahead to stay ahead.** With so many moving parts that need to be coordinated in a multi-site evaluation of this sort, nothing can be left to the last minute or even to the last hour, day, week, or month. Our IRB experience is a fine example of how necessary such planning is simply in order to keep the project as a whole on a reasonable timeline.

- **Trust the IRB process.** Institutional Review Boards exist to protect the rights and dignity of research participants while advancing knowledge. There are times when they must weigh one against the other, and delicate compromises are made on one side for the sake of the other, in both directions. It is an unavoidable tension within the program evaluation field. Yet it is impressive that, with sufficient time and preparation, multiple IRBs can coalesce behind a common approach that advances both goals.

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References


Introduction

In 2010, the Quality Improvement Center on Differential Response (QIC-DR), funded by the Children’s Bureau, U.S. Department of Health and Human Services, began a three-site study of the impact of differential response (DR) on outcomes for children in the child welfare system. Using a randomized controlled trial methodology, this study seeks to replicate and extend previous research, and to contribute materially to the question of whether DR is an evidence-based practice (i.e., an effective intervention with certain child welfare populations). Ohio is one of three sites participating in the study, through a coalition of six counties.1

DR is being increasingly used across the nation as a method to intervene with families entering the child welfare system. It is designed to quickly engage families in services and offers an alternative to the traditional abuse/neglect investigation. DR represents a philosophical shift in the approach used by some child welfare agencies toward families with lower risk reports of abuse or neglect; punitive procedures and terminology associated with a typical investigation are reduced or negated, thus eliminating many of the initial barriers that caseworkers confront when first seeking to engage families. DR caseworkers interact closely with families in assessing family needs; appropriate services and supports may then be provided, without any formal allegation or determination of maltreatment being made.

Workers are encouraged to partner with families, encouraging families to take the lead in describing their needs. The worker acts as a conduit through which families can connect with community agencies and resources that the families believe are necessary to support their well-being. For the current study, as each family enters the child welfare system, each of the six local agencies applies the common eligibility criteria to determine whether the case is eligible for DR; if so, the case is entered into a randomizer which then assigns it to the investigation track (IR) or to the alternative assessment track (DR).

Before proceeding to discuss the early experiences in Ohio, it is important to clarify the context in which this system reform occurs. Two factors bear careful consideration: First, the decision to employ a randomized control trial for the evaluation places increased procedural and data collection demands on the Ohio sites; and, second, Ohio enters this study already having substantial awareness of and commitment to the DR approach, so it does not offer a “clean slate” as is the case in the other QIC-DR study sites.

Randomized Control Trials

In studying the effectiveness of DR as a system reform, the QIC-DR chose to mandate that its pilot sites utilize a randomized control trial (RCT) evaluation design. Because of its potential to clearly determine cause and effect, this

1 Ten Ohio counties were also involved in an earlier study of DR (2007-2009). One of those original 10 counties is also a part of the current QIC-DR study.
methodology is strongly favored by many policymakers and researchers in the social services arena (Chelimsky, 1997; Wolff, 2000). The RCT design requires three conditions: precisely-defined intervention/protocols (both experimental and control), equivalent groups (tied to a meaningful target population), and equivalent trial environments. Evaluators need to be especially attentive to these conditions, assessing at the outset the degree to which they are met, and adjusting the scope of data collection as necessary to minimize threats to validity of the research findings. Indeed, when studying the effectiveness of a complex social reform such as DR—characterized by variations in staffing arrangements and participant motivation, loosely-defined interventions, and interaction with broader social environments—evaluators are challenged to understand and control a wide array of factors within the service delivery agencies as well as the larger child-serving community (Wolff; Audrey, Holliday, Parry-Langdon, & Campbell, 2006). Randomly assigning families to the IR and DR tracks is but the first step.

**Ohio’s Involvement with DR**

Beginning in 2007, Ohio was originally the site of a DR pilot project sponsored by the Ohio State Supreme Court and the Ohio Department of Job and Family Services (ODJFS). The study encompassed 10 of Ohio’s 88 counties, including one of the most populous (see Table 1: Phase 1). Ohio has a county-administered child welfare system, operated through local Public Children Services Agencies (PCSA); this local decision-making role, coupled with significant funding generated at the local level, introduces substantial variation into local practice, in general and specifically in implementation of a systemic reform such as DR. The 2007-2009 study, also an RCT design, found favorable effects of DR when compared with IR, leading the state to commit to steadily expanding DR in subsequent years (Loman, Filonow, & Siegel, 2010). Indeed, ODJFS brought 10 more PCSAs into the DR arena in 2010 and 2011 (see Table 1: Phase 3), with the expectation that further rollout waves will occur. This means that all of Ohio’s PCSAs are aware of the DR approach and are somewhat familiar with the DR philosophy. The fact that, in 2009, six additional PCSAs (including one that participated in the original 10-county pilot project) came together to seek funding through the QIC-DR (Table 1: Phase 2) is but further testament to the widespread belief in Ohio that the future of child welfare lies in embracing DR. Clearly, the varying levels of understanding of and commitment to DR predating the current study will need to be examined in the evaluation.

The current SOAR project (Six Ohio Counties Alternative Response) includes a mix of jurisdictions—large metro areas as well as tiny rural counties—and PCSAs with varying exposure to and experience in DR.

This paper focuses on phase 2 of DR implementation in the six Ohio counties (highlighted in Table 1). The first section briefly describes the initial work in the SOAR counties to build the foundation for implementing and evaluating DR. The next section highlights four areas in which the counties and the evaluation team encountered particular challenges, and offers some remedies to the problems. The final section reflects on these experiences to identify key lessons learned, pinpointing actions which can be taken in future DR implementation efforts to help the process proceed more smoothly and effectively.

**Laying the Foundation**

The SOAR counties approached the implementation of DR and its evaluation with excited energy and enthusiasm combined with a little trepidation. Implementing a new practice
In preparation for implementing DR and the accompanying evaluation activities, the SOAR sites engaged in four key activities: making changes in staffing arrangements, developing and documenting a standard case flow for the DR and IR tracks, training all staff, and establishing methods of ongoing support for the implementation process. To carry out these activities, several task-specific work teams were organized and operated over several months during the initial planning period of the study. The SOAR team and the evaluators participated in semi-monthly teleconferences or face-to-face meetings to establish a mutual support system and a common understanding of the goals of the study and the effort that would be required.

Table 1: Schedule of DR Rollout Across Ohio

<table>
<thead>
<tr>
<th>Phase</th>
<th>Number of Counties</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: Original Study</td>
<td>10 counties</td>
<td>2007-2009</td>
</tr>
<tr>
<td>Phase 2: QIC-RCT</td>
<td>6 counties</td>
<td>2010-2013</td>
</tr>
<tr>
<td>Phase 3: Third Rollout</td>
<td>10 counties</td>
<td>2010/2011</td>
</tr>
<tr>
<td>Phase 4: Fourth Rollout</td>
<td>Up to 10 counties</td>
<td>Expected 2011/2012</td>
</tr>
</tbody>
</table>

Changes in Staffing Arrangements

One of the recommended changes for agencies adopting DR is to have caseworkers dedicated to DR and others dedicated to IR. The reasoning behind this recommendation is that, since DR and IR have different philosophies, it would be difficult for individual workers to bounce between DR and IR cases and still continue to preserve the respective philosophies. The larger SOAR counties have designated at least one whole unit, made up of several workers, to exclusively serve DR families. Each unit has its own DR-specific supervisor to provide advice and support to the workers. In the very small PCSAs, just one or two workers are designated as DR caseworkers. Their supervisors oversee both DR and IR caseworkers.

It is also important to note two other changes which occurred for workers involved in implementing DR. In each PCSA, workers interested in becoming DR caseworkers volunteered for the position, and then the manager responsible for DR made the selection from the pool of volunteers; this process often involved an in-depth interview with the candidates. The other crucial change regarded existing caseloads. Investigation workers

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2 The SOAR team consists of the manager and coordinator for DR in each of the six PCSAs plus the SOAR project manager.
maintained their cases as usual; in contrast, just prior to implementation, the caseloads of the workers assigned to DR were cleared. Both of these differences potentially influence the way the IR and DR workers handle their job responsibilities and the way in which they view the DR model and approach.

**Understanding Agency Case Flow**

In order to ensure that DR practice was implemented similarly across the SOAR sites, the SOAR team, with the support of the evaluator, initially focused on creating a flow chart that documented in detail the course a family typically takes through the child welfare system. Included in this diagram were the different processes and procedures used in screening a report of abuse/neglect, as well as information about where in the case flow major decisions occurred, who was responsible for making each decision, and the criteria upon which each decision was based. Complicating this picture, of course, is the fact of county-level administration, meaning that even the small group of six SOAR counties had distinct differences, not only in sequencing of decisions and assignment of tasks, but also in the method of data entry into SACWIS (Statewide Automated Child Welfare Information System). SOAR representatives worked closely with the evaluation team over several months in order to explain precisely where those differences lay so that the research team could appropriately refine the evaluation process. Ultimately, the SOAR team was able to come to agreement on a generic case flow diagram. The evaluation team was then able to embed into the standard case flow the needed evaluation processes, especially the randomization step and subsequent data collection activities. Figure 1 provides a simplified view of this mapping.

*Pathway Assignment Tool: A particularly critical step in the case flow process is determining a case’s eligibility for DR. Initially, the SOAR sites varied in their judgments about the nature and the severity of abuse and family circumstances that were acceptable for DR services; these differences reflected both varying community norms as well as the perceived role of the PCSA in the larger county human services arena. While state rules clearly defined situations that required investigation, PCSAs had full discretion over a wide array of maltreatment reports. Consequently, while counties all agreed that they were unwilling to accept for DR services families they felt posed too great a risk, they varied somewhat in what they considered to be “too great a risk.” To ensure the equivalence of the IR and DR populations, the evaluation team sought to bring more agreement to the discretionary decisions about DR eligibility, and, where full agreement was not possible, to assure full documentation of the reasons for differing decisions. With additional data, the evaluation team would be able to examine the effects of the differing practices on the validity of the RCT. A work group formed to revise the pathway assignment tool, which had been originally developed for the 2007-2009 10-county pilot (while not required, this tool is still being used by some of the Phase 1 Ohio counties practicing DR). The work group’s main objective was to build into the tool a new family characteristics section. In this way, characteristics that were acceptable to some counties while unacceptable to others could be closely tracked as counties accepted or rejected families for randomization. This tool enables evaluators to assess the impact of additional characteristics on family outcomes.*

*Training All Staff*

Training is an essential step in preparing for implementation of any new intervention. In the SOAR sites, a wide array of staff needed to be trained, both in the philosophy of DR and in the practice changes that define the alternative
approach. All of the basic training in DR was provided by the QIC-DR, through staff and consultants of the American Humane Association. In addition, several key staff in each SOAR site visited other Ohio counties that had already implemented DR in order to observe the screening and casework activities; these visits were extremely valuable in alleviating anxiety and providing concrete answers to questions and concerns.

Equally important was evaluation training. Relevant information was shared with the SOAR team during semi-monthly teleconferences as well as through individual county conversations between the evaluators and key DR staff. The research team consistently sought local input to proposed evaluation tools and processes in order to ensure that burden would be minimized and accuracy enhanced. One month prior to implementation, all counties participated in a one-day in-depth evaluation training conducted by the evaluation team. The training included two sections: one for staff having screening responsibilities and another longer portion for supervisors and workers carrying caseloads of IR or DR cases. Both sessions explained the randomization process in detail, focusing on its critical importance to the evaluation as well as what it would mean in practical terms to agency workers. To make the training as accessible as possible to workers and supervisors, evaluators held multiple training sessions over a 2-week period, spread across locations in all the counties. Subsequently, training refreshers were offered through web-conferencing,affording smaller groups of staff the opportunity to ask questions that had arisen in their initial use of the evaluation tools.

Providing Ongoing Support

The final preparation activity was to institute

Figure 1
fashion creative solutions.

This section highlights four areas that proved particularly challenging to the SOAR counties, both during the pilot period and in the first few months of the demonstration: random assignment, technology, workload, and exposure to the intervention. The discussion provides insights to inform future decisions by both agencies and evaluators who are considering a human services RCT. Implementation of DR itself presents challenges (as described in other articles in this journal); overlaying a new practice with the demands of an RCT can be formidable. The following sections describe each issue and its challenges, and offer some solutions or at least ways to reduce the impact of the challenges on practice and evaluation.

Random Assignment

The use of random assignment of cases to an innovative intervention or to the traditional casework approach immediately raises concerns among most child welfare workers. In the first instance, they may be reticent to see the families they support being denied the best intervention that is available, regardless of whether scientific evidence has proven its effectiveness for similar families (Little, Kogan, Bullock, & van der Laan, 2004). In addition, caseworkers value their roles as gatekeeper and advocate, using their discretion to decide which interventions are most appropriate for a family. To relinquish that role in the interests of evaluation, they must come to believe that the knowledge gained from the study will bring even

Reflections on Early Challenges Faced in Implementing the RCT

Funding for the SOAR project began in February 2010, and will continue until June 2013. The random assignment of cases formally began in December 2010; a 3-month pilot period preceded the start to enable county staff to become familiar with the new intervention model and to iron out any wrinkles in the random assignment and data collection processes. During this pilot period of implementation, the six counties encountered varying obstacles related to both the new practice and the evaluation, and worked together to

Random assignment is truly random and will not immediately generate a constant flow of cases into each track.
greater benefit to families now and in the future. Without this perception, caseworkers will face a continuing ethical dilemma that may ultimately lead to compromises in the random assignment process.

Separate from the ethical issue is a complex practical issue: Random assignment is truly random and will not immediately generate a constant flow of cases into each track. The six SOAR counties and the evaluation team developed county-specific ratios for the number of cases eligible for DR that would be randomized to the DR track versus the IR track. The ratios varied greatly between counties and ranged from 49% of all study-eligible cases tracked to DR in one county to just 18% of cases in another. The ratios were initiated to reflect a balance between evaluation requirements and caseworker resources in counties of various sizes. Nonetheless, such ratios do not ensure that cases will be evenly spaced. The ratios apply over a long period of time and do not guarantee that new DR workers will immediately have a full caseload. The ebb and flow of cases is not unknown to child welfare; all agencies face periods of time in which reports of abuse and neglect are heavier than at other times, and intake workers are accustomed to adjusting and sharing the strain. However, DR is a new option in the intake phase exercised only by certain workers. Where IR intake workers equally share the times of high caseloads and low caseloads, random assignment may serve to screen DR workers from becoming as overwhelmed as traditional IR sometimes become; similarly, when random assignment does not immediately generate enough DR cases to fill a caseload, IR workers may begin to perceive DR workers as having lighter workloads. In the interests of maintaining good relationships between DR and IR workers, and in order to support good casework practice, the SOAR counties have adopted a variety of solutions:

One county had a swing worker who would take both types of cases in order to somewhat reduce the pressures on workers in one track or the other;

Some counties had the DR workers take other related types of cases—dependency or families in need of services (FINS)—when the DR caseload was too low;

Some counties requested that randomizer ratios be increased or decreased over time. The challenge was to not change the ratio so dramatically that it simply shifted the overload to the other track.

None of these practices was perfect; DR workers could quickly become overloaded if a large number of cases happened to be randomized to DR soon after the DR workers had picked up other cases. But any of the solutions was preferable to having the site coordinators arbitrarily choose not to use the randomizer—an understandable reaction by a supervisor but a serious threat to the evaluation. Overall, the randomizer proved a little frustrating at study start because of the unpredictability it caused in caseload numbers for staff.

Technology

Technology has proven to be both a boon and a challenge—helpful when it works correctly, anxiety-inducing and irritating when it does not. The RCT study relies on three separate electronic data systems: the randomizer, the SOAR web-based data collection system (named SOARDS), and the state administrative data system, SACWIS.

Randomizer: Just as the idea of random assignment was difficult for staff to accept, so too was the concept of an electronic process to make that random assignment. The randomizer is seen as a “black box” wherein a decision is made without input from the worker/supervisor who is accustomed to using professional discretion to
decide how a family should be engaged by the child welfare system personnel. The technical process is very simple: Once a case is screened as eligible for DR, the screener logs into the randomizer website; a new screen then pops up with a box in which the study-eligible family’s intake number can be entered. The staffer clicks the “submit” button, and the randomization result appears on the screen: assigned to DR or IR, and selected for a survey or no survey.\(^3\) However, this process initially presented two problems to the SOAR sites. The first problem was the separation of the randomizer from SACWIS. It meant that staff had the extra step of going to an outside web address while working within SACWIS to obtain the correct case ID number. Workers were initially anxious about being able to log in back and forth between systems; this soon proved to be a relatively smooth process. The second challenge was that the randomizer sometimes was out of service and was not available to the staff. Because PCSAs have strict state rules dictating the allowable time between receiving a report of abuse and a worker initiating the DR or IR process, a non-working randomizer threatens to compromise the casework process. This problem also concerned evaluators: If the unreliability of the randomizer reduced sites’ commitment to always using the random assignment process, it would undermine the integrity of the RCT. This problem was resolved early in the study by moving the randomizer to a different type of server. However, while the problem was being addressed, the evaluation team established a Plan B. Whenever the randomizer was not available, the PCSA staff person would use the old-fashioned coin toss to randomize families. This was not ideal but at least maintained a random assignment of families; the decision was then communicated to the appropriate casework staff. At the same time, the evaluators required a notation to be made in SOARDS for any cases in which a coin toss had been used in order to reduce the likelihood of workers making arbitrary decisions to assign cases to one track or the other.

Several benefits come from use of an electronic randomizer. It has enabled the evaluation team to relatively easily control and change DR/IR ratios within each county when caseloads become too unequal. It allows counties to painlessly assign families to each track without having to put substantial additional effort into their work. Finally, it provides an electronic record of the cases that have been entered into the system, along with the historical record of the date the family was randomized and the random assignment result. This gives the evaluators an opportunity to double-check randomizer track assignments when and if data entry errors occur at later points in the process.

**SOARDS:** The initial reason for creating a web-based data system for the SOAR cases was to provide a centralized tracking system to ease the burden county coordinators face when tracking families. In the 2007–2009 DR pilot, Clark County had developed its own spreadsheets to accomplish this task; a centralized, standardized web-based system seemed to be an easier approach, and it has ultimately come to serve an even larger set of purposes. SOARDS is a stand-alone web-based data collection system utilized to varying degrees by PCSA screening staff, DR coordinators, and casework supervisors. It contains a search tool so that counties can check whether a family with a new abuse/neglect report has been previously entered into the randomizer. It includes tabs for the pathway assignment tool and a family characteristics tool, both of which need to be completed for each family. It has a resource page with downloadable copies of surveys, consent

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\(^3\)The randomization is conducted at two levels. The first is to DR or IR. Each case is then randomized again to determine whether it is part of the subgroup receiving a survey (SACWIS data will be used for all cases).
forms, the evaluation manual, and team contact information. And it has a tracking sheet for randomization results—track assignment and survey selection—as well as for dates of survey distribution and completion. In addition, it offers sites the option of running a series of canned reports so they can track their own performance over time, including survey response rates. At the same time, it is invaluable for keeping the evaluation team alert to potential errors and omissions in data; in this way, evaluators can urge counties to keep up with data cleaning as the study progresses.

Despite all its advantages, SOARDS nonetheless represents another level of complexity for county coordinators. Having the two stand-alone systems—the randomizer and SOARDS—can lead to data discrepancies between systems as intake numbers are copied from SOARDS into the randomizer, and randomizer results are copied into SOARDS. Tracking and logging data inconsistencies are laborious and can be hard to resolve. Progress is slowly being made, but the tasks remain burdensome at times to both county staff and the evaluation team.

SACWIS: The state administrative data system is an extremely large, complex system that has recently undergone a series of changes in response to the expansion of DR throughout Ohio. SACWIS will provide much of the data needed to evaluate outcomes. At the time of the study’s rollout, several gaps still remained between what was in the system and what the evaluation would require. As a safeguard, the evaluation team chose to capture additional information in SOARDS. However, this means that the PCSAs now have three unconnected data systems all housing critical evaluation data. The evaluation team knows that data entry discrepancies will emerge among the three systems and these will take some time and additional information to unravel. By the end of data collection for this study, SACWIS will contain information to remedy many of these issues, making it easier for Ohio counties that are implementing DR in the future.

Workload

Workload issues arise whenever a new casework practice or approach is introduced because it takes some time for staff to adjust to the changes. However, the impact of the shift and its duration are very much influenced by the magnitude of the change being sought. In other words, a fundamental change in child welfare philosophy (as in the move to DR) may be harder for workers to embrace and may require a longer transition period. Thus, the stress associated with workload pressures needs to be alleviated promptly rather than being allowed to build up and threaten the longer-term stability of the reform—and, indeed, the viability of the RCT.

The RCT design requires that data is collected on both the experimental and control side. The evaluation team is collecting survey data for a randomly chosen subset of the study families. For each family selected to complete a survey, the caseworker is also asked to complete a survey. The RCT design introduces workload concerns in three main ways. First, because the RCT is a “live experiment,” the evaluation requires some types of data that are not available in state administrative data systems but which are essential to the local evaluation as well as to the cross-site study (see earlier article in this journal). Asking workers and supervisors to complete multiple surveys and to enter information into several different data systems is extra work and there is no easy way to reduce the burden. However, letting staff know early on that they will be required to do extra work on all cases in the study, not just those selected for DR, is essential. This was a problem in some SOAR sites, causing extra resistance to data collection responsibilities. Training and ongoing support to
staff in their data collection tracking tasks has somewhat relieved this stress. Nonetheless, it is also important to note that this extra work is purely due to the evaluation: States that choose to adopt DR will not necessarily have an accompanying evaluation.

A second source of workload pressure for caseworkers is the fluctuation in case assignments. As described briefly above, the random assignment process generates an uneven flow of cases to DR and IR staff. While the numerical inequities can be somewhat ameliorated, there may be an accompanying negative undercurrent that is more difficult to address: Workers on the IR side may begin to feel less valued, interpreting the attention to keeping DR caseloads manageable as a message that their own work is not as important. This feeling may be aggravated by the enthusiasm on the DR side, since these workers have self-selected for the DR track.

The PCSAs sought to minimize this situation through orientation and training messaging, openly explaining the value of both types of practice for families and for evaluation. The evaluation will assess the magnitude of this attitudinal factor through a general survey of caseworkers’ experiences and perspectives of DR; these data may help agencies to fashion an appropriate response (e.g., bringing workers together to give positive feedback to both groups, or giving each group the opportunity to fully vent their anxieties and resentments). It has also been helpful to share with all staff the actual caseload differences, to replace impressions with facts, and to allow a more direct discussion of how best to remedy any genuine inequity.

The third source of workload burden comes from the need to carefully track what happens to cases as they proceed through the randomizer to be assigned to DR or IR staff. Each case is randomly assigned to the IR or DR track, but it is also randomly selected to be surveyed. A surveyed case requires the worker to do two things when the case closes: distribute a paper survey to the family and complete a case report form asking for details about the case. While workers receive formal notification of these random assignments at the time they receive the case, it can be difficult for them to keep on top of the extra tasks that come with a case’s selection for surveying. Some counties initially left these tasks to workers or line supervisors, but subsequently have realized they need clerical support to keep up with reminders, and have thus brought on additional support staff.

**Exposure to the Intervention**

To clearly assess the impact of participation in the DR pathway on child and family outcomes, the evaluation team must ensure that all families included in the study (i.e., all those sent to the randomizer to be assigned to DR or IR) have not had any past experience with DR. The evaluation is testing whether an initial “dose” of DR leads to better outcomes than those that typically occur for families served in the traditional approach. If any family in the current study had been previously involved in DR, that experience could be expected to affect how the family fares during the current case episode (the case episode begins with the initial report of abuse/neglect and ends when the case is closed by the PCSA). If families in either the DR or IR track have such prior exposure to DR, they are different than other families in the study and thus constitute a potential threat to the validity of the random assignment process.

Given Ohio’s earlier involvement in a DR pilot study, the risk is real that current PCSA families may have already been served through DR. This risk stems from two sources: First, Clark County is one of the SOAR sites and was one of the earlier pilot sites; families served a few years ago during the pilot study could very well emerge again with a
Lessons Learned

The evaluation of the SOAR project using an RCT faces challenging but not insurmountable conditions. Careful and thorough preparation is essential, especially in terms of building relationships with the study sites, communicating well throughout the study, and having a pilot period for testing. The research must be seen by all parties as a collaboration and not as something that is being done to the agency; therefore, at the heart of implementing and sustaining a successful RCT is developing a shared vision between community agencies and researchers (Senge, 1990). Agency representatives and researchers must work closely, shoulder to shoulder, to come to a common understanding of the value of the research, and to establish the common path that will achieve the vision. Leaders will then be more willing to advocate for the internal structural and procedural changes necessary to ensure full implementation of DR and success of the RCT study, and to support the research process when worker motivation and enthusiasm for the study begin to waver.

Relationships and Communication

The top priority in preparing to field an RCT is to establish a solid partnership with the study sites and mechanisms for ongoing communication. In the current study, the evaluation team maintains frequent contact with the SOAR counties through individual phone conversations, emails, and monthly all-site meetings; key to these interactions is listening, respecting, and being responsive to the counties’ needs for support. Equally important is that staff in all the sites feel the freedom and security to call the researchers whenever they feel confused, anxious, or have a specific question. Most people want to do the best job they can, but enthusiasm may be quickly lost if external support is not available. Having an on-site evaluator who is readily accessible to troubleshoot as needed has
been invaluable. This person understands the
unique context of each site, can balance this
context against the needs of the evaluation, and is
always available to take a question or visit the
individual site to provide extra support or training.

Regular feedback to the counties has been very
important. This takes the form of monthly data
reports showing, for example, the number of
family participants in the study to date and the
number of surveys received from the selected
families. The reports are delivered electronically to
each site and then given further explanation at the
monthly all-site call. This call provides an open
forum in which the SOAR team and the evaluators
work together to identify any problems that may
be occurring and partner to find solutions to those
problems. For example, researchers were surprised
to discover the workload toll that tracking families
through the study pipeline was taking in one of the
larger counties. Adjustments were made to the
process so that it could be sustained throughout
the duration of the study. Communication of study
progress in the public arena of the monthly
conference call has been positive in that counties
that are relatively successful in their RCT efforts
can provide tips to other counties.

Several aspects of the evaluation require
particular attention, through training and ongoing
support:

- Explaining the how and why of random
  assignment in a very down-to-earth
  way so that workers see their roles as
  integral to the success of the study;
- Adopting user-friendly technology,
  explaining why each piece is needed,
  and being open to making
  modifications to increase worker
  comfort with the processes;
- Ensuring that data collection
  responsibilities are laid out in detail
  from the start, especially the purpose
  of each task in terms of the overall
  integrity of the study, and emphasizing
  that the process will get easier over
time, as staff become accustomed to
the tools and the data entry routine.

Overall, it is essential for the evaluation team to
be attentive to the level of stress workers
experience during the lengthy transition to the
new practice, and to do whatever is feasible to
acknowledge the contribution staff are making and
to try to relieve some of their burden.

Piloting of the RCT

An important complement to nurturing
relationships and communication between the
evaluation team and the sites is having a pilot
period before the study formally begins. This “no-
fault” time period offers researchers and agency
participants the opportunity to conduct a trial run.
During this time, theory becomes practice and
hands-on learning occurs—for everyone. It is a
time when mistakes can be made without fear of
reprimand or criticism, additional trainings or
supports can be put in place, and final
adjustments to procedures and responsibilities
can be made.

Piloting the RCT is a necessary and critical
undertaking in order to identify and address
situations that might threaten the internal validity
of the study. A 2-month pilot period was originally
scheduled for the current study. However, it
quickly became evident that 2 months was too
short a time frame, and the piloting period was
extended by an additional month. Two reasons
drove the extension decision: During the first 2
months of the study, only a very small number of
the study participants had enough time to pass
completely through the study pipeline, so not all
aspects of the study process were adequately
tested; additionally, the pipeline had not had time
to reach full capacity on the intervention or
control side of the study. It was not possible to fully understand how well the procedures for tracking the assignments and collecting data about exiting families were working in practice. Researchers have recently wondered if even the extended period has been long enough.

Even with the best training, when so many different people are involved in the smooth operation of an RCT, there will be misunderstandings. The notion of an RCT is not necessarily an intuitive one for workers who are trained to deal with family problems rather than research design. One of the clear benefits of the pilot period has been to uncover where those misunderstandings lay. The pilot period provided a much-needed window during which follow-up individualized trainings could be provided. These have been welcomed by the agency partners, and ad hoc refresher trainings will continue to be provided as necessary throughout the study.

Conclusion

The study described above is a real world experiment located in a variety of child welfare settings with families that have complex issues. The intervention itself is a shift in philosophy as well as practice, making it more challenging to evaluate. Many factors interact to influence the PCSAs, the workers, the families, and the communities. This first year of implementation has been an intense learning experience for all those involved: It has included learning new language, new practices, and new rules, and it has been an opportunity to establish strong relationships between project staff and evaluators. The enormous progress made by the SOAR sites has established a solid foundation for practice and evaluation, and promises to support the long-term examination of the impact of DR on child and family outcomes. The study team anticipates producing findings in 2013 which will clearly address issues of child safety, subsequent maltreatment, and differences in rates of placement into foster care as they relate to comparable families that have received the traditional approach versus DR.

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References


Making the Case for Chronicling System Change

Carla Carpenter

Introduction

From July of 2008 through December of 2009, the state of Ohio piloted a differential response child protective services framework within 10 counties. Ohio’s differential response (DR) system includes two pathways for responding to screened-in reports of child maltreatment: the traditional response (TR) and an alternative family assessment, or alternative response (AR).

Ohio’s 18-month pilot of DR was rigorously evaluated through a random control study conducted by the Institute of Applied Research. In early pilot planning, the project consultant team encouraged the state to engage in a parallel and complementary research process, distinct from the evaluation. The specific objective of this second research focus would be to capture historical lessons of the pilot experience. This qualitative analysis of the pilot process became known within the state as the “chronicle” and was conducted independently of the pilot evaluation. The chronicle documented project milestones, processes, challenges, successes, and lessons learned from the planning and preparatory stages through implementation of the 18-month pilot and beyond.

This article will discuss the benefits of chronicling child welfare change initiatives such as Ohio’s AR pilot. The article will explore the rationale for writing a chronicle as a piece of qualitative research and will present information on Ohio’s chronicling process, lessons learned, and key considerations for other jurisdictions contemplating a similar research focus.

What is Chronicling?

The term “chronicling,” as utilized by those involved in Ohio’s alternative response (AR) pilot, refers to the documentation of the pilot process and the “behind the scenes” exploration of participants’ experiences over time. Ohio’s chronicling effort was initiated to capture both the “how” and the “why” behind Ohio’s differential response (DR) development.

In its narrowest form, a chronicle may be characterized as an objective and chronological reporting of events (Thomas, 2003, p. 18). Among qualitative research methodologies, narrative inquiry may be most akin to the process utilized in chronicling Ohio’s AR pilot. Constable et al. (2005) define narrative inquiry as “the process of gathering information for the purpose of research through storytelling.”

Where other forms of qualitative research aim to evaluate the effectiveness or fidelity of an intervention or program, chronicling seeks to gain insight from the experiences of those in the midst of development and implementation. Unlike a process evaluation designed to assess whether a strategy or program has been implemented as planned and is achieving the intended outcomes, a chronicle derives meaning from the individual and collective narrative of participants as their experiences unfold.

“It has been a great opportunity to learn how system change works. It has been a good process.”
—Franklin County Administrator
**Why Chronicle?**

As with other forms of qualitative and observational research, chronicling provides an opportunity to explore, describe, and share findings that are not readily quantifiable but are nonetheless meaningful. When chronicling is undertaken during a system change process, it offers a methodology for creating a detailed historical record and documenting lessons learned throughout the process. The voices of participants may be captured and reflected through chronicling, providing first-hand perspectives on the experience. In Ohio’s chronicling effort, for example, perspectives were collected and shared from everyone from front-line staff up to and including the director of the state agency responsible for child welfare in Ohio.

When paired with other types of evaluative research, chronicling can be one piece of a well-balanced research effort that includes both rigorous quantitative and rich qualitative analysis. Chronicling is a complement to quantitative methods and may provide additional context for understanding the outcomes achieved. For example, if a particular quantifiable benchmark is achieved, chronicling may help uncover what worked and why, so that the benchmark may be more easily replicated. Chronicling may also assist in identifying and describing aspects of the process that presented unforeseen challenges or barriers, so that this information may be available to guide future planning. As noted by Borland (2001, p. 5), it is the combination of quantitative and qualitative analyses that, “when used in concert, produce complete or useful knowledge.”

**Ohio’s Chronicling Process**

Effective chronicling requires a comprehensive information-gathering process. In Ohio, a variety of strategies were employed in order to formulate an inclusive history of the pilot and incorporate a wide range of perspectives. Both the process and the final research product were synthesized out of the joint experiences of the chronicler and participants. As Connelly and Clandinin (1990, p. 12) discuss in their explanation of narrative inquiry, the research is “a mutually constructed story created out of the lives of both researcher and participant.”

The foundation of Ohio’s chronicling process centered on shared experiences between the chronicler and project participants. These shared experiences occurred in the forms of opportunities for participant observation and a series of semi-structured interviews at key points in time throughout the project.

**Shared Experience: Participant Observation**

A cornerstone of the process in Ohio was the chronicler’s participation in significant events occurring across the life of the project, including:

- Pre project regional forums convened to provide information to potential pilot counties;
- Meetings of the design work group and all of its task teams, which established the framework for Ohio’s AR pilot;
- Training opportunities provided in preparation for pilot rollout;
- Ongoing technical assistance meetings and conference calls offered for AR workers and supervisors throughout the pilot;
- Ongoing training opportunities provided to pilot counties during the project implementation phase; and
- Meetings of the project advisory and
leadership structure throughout the pilot and beyond.

As a participant observer in these activities, the chronicler documented key discussions and decisions, participant questions, participant reactions, and the chronicler’s own observations about the experience. Chronicling focused not only on creating a record of what happened, but also on documenting observations about how the process unfolded and underlying themes.

**Shared Experience: Semi-Structured Interviews**

The chronicler conducted an extensive series of individual and group interviews with participants at various points in time throughout the life of the project. Interviews centered on themes and expectations at the conclusion of the design phase, early implementation lessons, mid pilot experiences, and end of pilot reflections. Interview subjects included state and county leaders, Ohio Department of Job and Family Services (ODJFS) staff, front-line staff and supervisors in each of the 10 pilot counties, and project consultants.

This series of interviews provided considerable insight regarding:

- The growth of state and county partnerships through the collaborative process initiated during the design phase of the pilot;
- Model fidelity concerns and considerations when balancing county autonomy, flexibility, and the need for a discernable and measurable practice;
- Family and worker responses to the AR approach and changes in services to families resulting from the approach;
- Internal changes in practice and ways of doing business within county agencies initiated as a result of the pilot;
- The impact of DR on community partnerships;
- Practice challenges for workers and supervisors, as well as overall systemic challenges or barriers; and
- Guidance from workers, supervisors, and other key stakeholders to inform the future direction of DR in Ohio.

Interviews were semi-structured, beginning from a framework of planned questions, but participants ultimately shaped and guided the direction of each interview. The interview framework consisted of mostly open-ended questions designed to provide participants the greatest opportunity to share their stories and perspectives. The overarching goal of the interview process was to capture the emerging and changing experiences and perceptions of participants at regular intervals throughout the project.

**Products of the Chronicling Effort**

The end product of the chronicling effort was a comprehensive report entitled *Process Perspectives: Chronicling Ohio’s Alternative Response Pilot Experience*. This report includes:

- A *process timeline* featuring major project milestones;
- An *historical context* section highlighting the collective effort that paved the way for Ohio’s AR pilot;
- Chronological summaries of the process, milestones, successes, challenges, and lessons learned at critical stages, from pre-pilot planning through implementation and beyond;
• A section highlighting family stories that are representative of the work and help to illustrate the impact of the pilot; and

• Final conclusions and recommendations, including key messages from county and state participants as well as observations of the chronicler.

On the journey to creating the final chronicle, several smaller pieces of the story were shared through interim reporting documents. These pieces were developed at key points in time throughout the pilot, frequently following the chronicler’s conversations with project participants. These interim documents ultimately helped to form the foundation for the final chronicle. However, the systematic collection and sharing of the “story” at regular intervals provided an important opportunity to inform planning and decisions on an emergent basis, rather than waiting for the conclusion of the process and a final, comprehensive report.

Lessons Learned Through Chronicling

Through chronicling, a wealth of information was gathered from the experiences of workers, supervisors, agency administrators, and state partners. Chronicling began before the formal pilot evaluation and extended beyond the 18-month implementation period to include post-project reflections. Because the time frame for the chronicling effort was broader than that of the formal project evaluation, chronicling offered a unique opportunity to document the insights of a variety of participants and stakeholders over a greater period of time than would have otherwise been captured.

In the end, several of the themes that emerged through chronicling underscored or aligned with the findings of Ohio’s evaluation. The information gathered through chronicling provided a corresponding narrative that added context to the outcomes data and qualitative analysis conducted by the project evaluators. Beyond providing additional perspective on project outcomes, however, chronicling yielded a vast array of useful guidance to inform future implementation efforts. By tracking a broad variety of participant perspectives over time, the chronicle helped to systematically document what worked and why, as well as specific aspects of implementation that could be strengthened going forward.

The following section contains excerpts adapted from the chronicle and summarizes a few of the most salient themes and lessons learned through Ohio’s AR pilot.

Lessons on Partnership

Like many DR jurisdictions, Ohio is a state-supervised and county-administered child welfare system. Before the first families were ever served in Ohio’s AR pathway, a fundamental transition was underway, resulting in important lessons for county and state partners. A unique aspect of Ohio’s AR pilot was the collaborative planning effort undertaken jointly by county and state partners to design the “nuts and bolts” of Ohio’s AR model in preparation for the pilot. As documented in the chronicle, a significant process shift was required of both the state and the counties to move from a history of primarily state driven initiatives to a collaborative process to
develop the pilot model. As one state administrator said, “Typically, the state introduces an initiative, and the counties react and respond by advocating for their position. The AR design process was much different.”

Creating this process shift required an intentional focus on relationship building between state and county partners and a significant departure from “business as usual.” Lasting nearly a year, the design and planning phase required a considerable investment of time and resources on the part of both state and county representatives. The process was frequently challenging, particularly as stakeholders sometimes brought widely varying visions, expectations, or goals to the table. One of the most significant themes of this process reflected by participants was the vital importance of well defined roles and transparency among all stakeholders as a partnership is formed.

Although the conversations were often difficult, the growth achieved by the group through this process was universally recognized by participants. As one design work group member from Trumbull County stated, “This is the first time in a long time that the state and counties are sitting at the table and making decisions together.” While it may have been more expedient for the state to take the lead in developing Ohio’s AR policy, tools, and practice guidance, the upfront investment of time and resources in a collaborative planning process yielded benefits extending far beyond the pilot. Ultimately, this work proved to be the beginning of an ongoing systemwide alignment with the partnership principles central to DR.

Lessons on Practice and Implementation

Caseworkers and supervisors frequently reflected that seemingly small changes in practice yielded a significant and positive impact on case outcomes. As is true for many jurisdictions, the implementation of an AR pathway in Ohio did not require a wholesale change in practice. As staff received training in preparation for rollout of the pilot, many practitioners struggled with the question, “How is this different?” Throughout the pilot, however, workers and supervisors shared evolving perspectives on the impact of integrating new approaches within their practices. Changes in the way families were approached at the outset, removal of labels, time frames that were more conducive to building rapport, and family driven service planning contributed to enhanced family engagement and partnership around safety and well being concerns. As one worker in Fairfield County explained, “Taking concentration off of the allegation, removal of labels, focusing on the family system, and having longer time frames will take you miles farther with families.”

“We needed to step back and look at how we defined alternative response. It is not dependent on services or resources; it is about openness to having families drive the process.”

—Franklin County Administrator

Challenges experienced by workers, supervisors, and agency leaders throughout the pilot provided some of the greatest opportunities for learning. The chronicle details lessons learned through challenges arising in the forms of:

- Caseload demands;
- Inconsistency in pathway assignment;
- Integration of AR within Ohio’s child welfare information system (SACWIS);
- Implementation during a severe economic downturn; and
- Impact on staff morale and cohesion.

In particular, several counties identified tensions between AR and traditional response (TR) workers as a significant challenge of the pilot.
Often, these tensions were a result of both real and perceived imbalances in workloads, as well as a sense that cases assigned to the AR pathway are the “easy cases” and inherently less demanding. Also impacting the morale of workers in the TR pathway was a sense that their work was underappreciated or devalued by the addition of an alternative track. At the close of the pilot, counties reflected on things they would change or do differently in the implementation process. Staff responses at all levels, from front-line workers to agency administrators, frequently focused on improving communication between AR and TR workers.

A few of the pilot counties provided regular and formalized opportunities for AR and TR units to dialogue about cases, which proved to be an effective strategy for dissipating tensions and increasing understanding between the two groups. In Fairfield County, for example, AR and TR workers regularly met in an intake work group for group case consultation sessions. Fairfield County’s supervisor reported that this practice fostered a better understanding of the AR approach among all workers. By jointly consulting on cases, TR workers gained a better understanding of the amount of time their colleagues in AR spent providing services that are not traditional intake functions, such as service planning, linkages, and follow up.

Several of the pilot counties embraced the concept of clinical case consultation and case mapping to enhance decision making throughout the life of a case. These group decision-making processes were used for a variety of purposes, including screening, case closure decisions, or any point when a worker was feeling stymied about what to do next. Group consultation proved to be a powerful tool in supporting the development of clinical social work skills by increasing focus on the child welfare intervention beyond the service-brokering role. In Trumbull County, a worker reflected, “We discuss and present strengths more, and we discuss cases in a more respectful way.” A supervisor in Franklin County discussed how group consultation supported a shift in thinking and reinforced the focus on engagement over time. At the close of the pilot, a worker from Fairfield County shared, “Workers have progressed in their depth of communication and understanding of families.”

Lessons on Community

“We have found that if you ask for help from your community you will receive it. Through the alternative response initiative, we have expanded our view of community partners.”

—Ross County Supervisor

Several counties reported that, just as families’ perceptions of children services changed as a result of their experiences with AR, community partners also began to see child protective services differently. Screeners in several counties noted that, after learning about AR, reporters would, at times, expressly request AR for families when making a referral. Although those types of requests did not guide pathway assignment, counties were encouraged by the growing awareness of the new approach among reporters. In many instances, community partners developed a better understanding of the AR approach through their conversations with screeners when making a report. This type of one on one education was an effective piece of community outreach in several counties and is an important consideration in preparing screeners for implementation.

The pilot also opened new avenues of collaboration with community partners. Some of these new partnerships were leveraged with pilot funding provided to support counties’ transition to
AR. However, many others were developed out of creativity inspired by the pilot process and required no additional funding. As counties universally noted, flexible funding was an important resource for realizing the goal of family-directed service provision, but it was not the most important factor. Flexible funds provided a much-needed resource for counties to be able to work with families in new ways in a tough economy. However, developing an expanded view of whom potential partners in the community might be was equally, if not more, important. Several examples of how counties creatively engaged partners in their communities are highlighted in the final chronicle report.

Lessons on Leadership

Strong leadership was a key factor in successful outcomes at all levels within agencies. In counties where staff described the most significant practice changes, agency leaders made intentional and purposeful choices to encourage staff to conduct business differently. Changes implemented within agencies were frequently broader than DR and certainly not exclusive to the AR pathway—for example, the integration of clinical case consultation into supervision. Leadership was the critical ingredient among agencies that fully embraced the opportunities provided by the pilot to re-examine practice and procedures from top to bottom and to try new approaches. Agencies that emphasized parallel shifts in supervision and administration that mirrored the practice shifts asked of workers were successful in creating internal cultures of learning and growth.

As has been well documented, supervisors are central to leading and mentoring quality practice within agencies. Workers and supervisors alike recognized the shift in supervisory focus that was needed to support the implementation of an AR pathway. A supervisor from Trumbull County reflected on the change in her supervisory lens that developed throughout the pilot and which ultimately impacted her supervision of staff in both pathways, resulting in greater “integration of strengths-based, solution-focused supervision in investigation.” This supervisor indicated that, early in the pilot, the opposite frame of reference tended to prevail, bringing an investigative focus to AR supervision. For this supervisor, coaching provided during the pilot played a key role in fostering this transition. Although supervisors across the pilot counties were universally positive about the difference AR made for workers and families in their counties, many indicated that additional support and specific opportunities for supervisory professional development would have been helpful prior to implementation.

Lessons on Change

The incremental and developmental nature of a successful change process was another theme that emerged through chronicling. A consistent message among county and state staff was that the change implemented through the pilot experience could not be rushed. County staff emphasized the continuous growth process that had occurred throughout the pilot and stressed that this process was by no means complete after 18 months of implementation experience. During the final set of post-pilot interviews, discussions with county staff reflected significant changes in internal language, agency culture, and practice that had occurred just within the last few months of the pilot and beyond. County and state staff alike articulated that the current DR structure should not be viewed as a “finished product.”

“It’s important to get people invested in any change this big. Stay open-minded and be flexible.”

—Lucas County Supervisor
Pilot participants encouraged a timeline for post-pilot expansion of Ohio’s DR system that would support the same type of developmental change process experienced within the initial 10 pilot sites. As one state-level stakeholder expressed, “The pilot counties had the benefit of the design process and pilot experience—months of foundation; we can’t expect others to flip a switch.” In keeping with these lessons, Ohio has continued with a phased approach to the expansion of DR to additional counties.

Pilot participants reflected on the factors that were the most influential in supporting meaningful system change. Hand-in-hand with strong leadership and supervisory support, opportunities for coaching, mentoring, and cross-jurisdictional site visits, or immersion experiences, were cited as critical tools for fostering change. As one Franklin County supervisor reflected, “Hands-on consultation was one of the most beneficial things we received through the pilot.” Based on the experiences of the pilot counties, Ohio has continued to support quarterly gatherings for caseworkers and supervisors, as well as periodic coaching, in addition to traditional training as DR expands. Additionally, the state has developed an infrastructure to support and encourage peer-to-peer learning opportunities among counties.

As outlined above, chronicling provided an opportunity to formally and systematically capture rich qualitative data through all phases of Ohio’s AR pilot, including those that fell outside of the scope of the project evaluation. Compiled independently of the evaluation, the chronicle ultimately provided important contextual detail that complemented the findings of the evaluation. Perhaps the most important benefit of chronicling, however, was the opportunity to document implementation lessons as a guidepost for future project sites.

All of this was accomplished at relatively low cost to the state, as this endeavor was primarily driven by a single researcher dedicated to the project at approximately half time. While significant time was invested in field research in all of the project sites, which were spread throughout Ohio, travel costs associated with the project were minimal because the researcher was based within the state.

In addition to the investment made in a dedicated, on-the-ground researcher, several other key factors impacted the success of Ohio’s chronicling initiative. The following are suggestions for other jurisdictions considering the use of chronicling as a tool for examining system change:

- **Enlist an independent and neutral party to conduct the chronicling effort.** Although the author has subsequently joined the ODJFS as Ohio’s DR program manager, throughout the chronicling process she worked as a project consultant in her position with the National Center for Adoption Law & Policy (NCALP) at Capital University Law School. Because the chronicler was not
a county or state employee, nor a direct stakeholder in the project, it was easier to establish trust and to facilitate a process that resulted in a balanced narrative. The chronicler came to the project with a social work practice and program background and substantive understanding of DR. This foundation proved to be advantageous, as the researcher was equipped with the necessary knowledge, skills, and experience to organize the process, conduct effective interviews, and synthesize the myriad perspectives and stories shared.

• Begin to compile history as early as possible in the change process being studied. Ohio’s AR pilot was initiated out of the work of the Supreme Court of Ohio’s Advisory Committee on Children, Families, and the Courts and its Subcommittee on Responding to Child Abuse, Neglect, and Dependency. While serving in her role with NCALP, the author had worked as part of a consultant team to the Subcommittee since 2004. This consultant team assisted the Subcommittee’s efforts to research and craft recommendations for child welfare improvement in Ohio, including a recommendation to implement and evaluate an AR pathway. NCALP’s involvement with the Subcommittee from the earliest phases of the project created a natural fit for the author to undertake the work of chronicling and allowed for a fully inclusive history of the pilot process, including foundational work that preceded the pilot. Although a unique set of circumstances positioned Ohio to engage in this comprehensive chronicling effort, other jurisdictions should not be discouraged from pursuing chronicling if a similar individual or group is not readily identifiable. An early commitment to chronicling as a research tool is important, however, so that information is gathered and documented on an emergent basis, rather than purely retrospectively.

• Immerse the chronicler in the system change process. Ohio’s county and state partners were extraordinarily generous in allowing the chronicler full access to significant pilot events and in their participation in interviews throughout the process. While the chronicler approached the process as an objective, outside party, immersion in the participants’ experience over time helped the chronicler to be able to develop an insider’s view in order to effectively communicate that experience to others (Genzuk, 2003, p. 2).

• Create a safe place for participants to share and offer transparency. Being able to ensure some measure of confidentiality and being clear about how information will be utilized and shared are critical to establishing an atmosphere of trust. In this case, individual names were not utilized in chronicling products, but participants were advised that county identifiers may be included. The chronicler did not share participants’ comments with other agency staff; for example, specific worker comments were not shared with supervisors or vice versa. Reintroducing the purpose of chronicling during each interview provided an opportunity to emphasize the goals of the project and to underscore the importance of participants’ contributions.
• **Separate the functions of chronicling and meeting documentation.** It is important to note that, from the very beginning, chronicling was distinguished from the development of meeting minutes. There was early recognition among project consultants and stakeholders that chronicling was a unique function and responsibility separate from documenting meeting content and decisions. Other project staff were charged with taking minutes during project activities, allowing the chronicler to focus on note-taking for the distinct purposes of the chronicle research.

### Closing Thoughts

Upon completion of the pilot, county and state staff were asked to reflect on the messages that they believed would be most important for the chronicle to convey to other stakeholders who had not been deeply involved in the pilot experience. Although the question elicited a wide variety of responses, an underlying and unifying theme was the tremendous learning and growth that had occurred throughout the pilot.

The critical work of sustaining and growing momentum after a successful pilot is underway. The information culled from county and state staff through chronicling has provided insight into the areas of investment required to carry this change effort forward. Ohio has capitalized on these critical lessons by continuing to foster enhanced county and state partnerships through multiple initiatives. As the state brings DR to scale, it has approached expansion at a pace and in a manner designed to provide sufficient time and support to successfully bridge the transition from pilot to statewide practice.

“No matter what perspective individuals came from—administrator, policy, or front-line staff—it has been a learning experience. Everybody had something to learn and something to improve upon.”

—Ohio Department of Job and Family Services Staff Member

**Carla Carpenter, M.S.S.W.,** is the differential response program manager with the Ohio Department of Job and Family Services. Prior to joining ODJFS, Ms. Carpenter served as an administrator for 6 years with the National Center for Adoption Law & Policy at Capital University Law School—initially as the Center’s child welfare programs coordinator and subsequently as associate director. Throughout Ohio’s alternative response pilot, Ms. Carpenter served as the project’s chronicler, researching the experiences of the counties and state. Ms. Carpenter is a licensed social worker. Her professional experience also includes direct practice with children and families in community-based services.
References


Introduction

Differential response (DR) was introduced in Minnesota as a pilot project in 20 of the state’s 87 counties in the latter half of 2000. Counties participating in the project were permitted to employ an alternative response to reports of child maltreatment unless an investigation was statutorily required. The alternative response involved a family assessment that was broad-based and non-coercive and that sought to provide services to families with child maltreatment reports that historically have received limited attention from child protection systems (CPS). For some time, conventional wisdom advised that within the context of severely restricted resources, CPS funds should be reserved for the most serious reports in which the safety of children is at imminent risk (see Lindsey, 1994, for a discussion of the residual approach in traditional CPS). DR rows against the tide of this convention. The hope behind Minnesota’s initiative was that intervening more substantially and in a more supportive manner to less severe reports would have longer-term positive consequences. To the extent that some prevention might be realized, however, this question remained: At what financial cost were any such positive outcomes achieved?

A comprehensive evaluation of Minnesota’s DR pilot was conducted by the Institute of Applied Research from 2001 through 2004 (Loman & Siegel, 2004), with a subsequent extended follow up that spanned 2004-2006 (Siegel & Loman, 2006). The evaluation included an experimentally designed field study in which 14 of the 20 counties participated. In these counties, families that were judged appropriate for an alternative response were randomly assigned either to an experimental or a control condition. Experimental families received a family assessment, while control families received a standard, formal investigation. The experimental study tracked 2,860 families and found a modest but statistically significant reduction in new reports of maltreatment and a small but still significant reduction in subsequent placement of children in foster care. The cost study, which tracked aggregate costs associated with a randomly drawn sample of 598 of these experimental families, consisted of two analyses: 1) a comparative cost analysis, which examined the relative monetary effect of implementing DR over a period of nearly 4 years; and 2) a cost effectiveness analysis, which examined the relationship between costs and outcomes. This is a description of how the cost analyses were conducted and what they found.

Background

When Minnesota developed its DR model, it adopted and adapted an approach that had been tried and tested in Missouri. The Missouri model was commonly referred to as a two-track approach. Investigations remained unchanged, but an alternative to an investigation, called a

1 Minnesota Statutes (Section 626.5551) require an investigative response to any report that alleges “substantial child endangerment.”
2 Pilot counties included urban, suburban, and rural counties. The 20 pilot counties accounted for 64% of the state’s population; the 14 counties in the experimental study accounted for 51% of the state’s population.
family assessment, was permitted when the report received did not allege criminal behavior or suggest that a child was in imminent danger. Unlike an investigation, a family assessment did not focus on whether or not an allegation of maltreatment was true, but whether the well-being of the child and family required some kind of assistance that could be provided. The family assessment response was not to be police-like or stigmatizing in any way, but positive and supportive, identifying problem areas that needed to be addressed. The children’s services worker was to seek to form a collaborative relationship with the family and build on its existing strengths. Child safety remained as important in family assessments as in investigations, and, at any time, the response track could be changed by the CPS worker from a family assessment to an investigation. However, while children’s services workers were asked to reach out to families and to assess their needs across a broad array of areas, no additional funds were authorized to pay for services the families might need. These were to be found, somehow, from pre-existing community resources.

Five findings of the evaluation of Missouri’s two-track approach (see Siegel & Loman, 1997) are worth noting because of their effect on Minnesota’s thinking about DR: 1) child safety was not compromised by family assessments, as some child advocates had feared; 2) caseworkers who conducted family assessments tended to learn more about the circumstances and needs of families than did investigators whose primary focus was the reported allegation; 3) while investigations tended to lead to a larger number of formal case openings so that purchased services, often therapeutic in nature, could be provided, family assessments led to more assistance being provided to more families overall; 4) the recurrence of new reports of child maltreatment was somewhat lower among families that received family assessments than families that had been investigated; and 5) this outcome was strongest among families with lower incomes that had received services that addressed their practical needs, such as emergency food and clothing, housing-related assistance, household needs, and childcare.

The Minnesota Department of Human Services took notice of the Missouri project because it had itself been testing the efficacy of providing services to families that were reported for child maltreatment but that did not typically receive post-investigative services (see Johnson, Sutton, & Thompson, 2005). When Minnesota piloted its own dual-response model, it placed similar emphasis as Missouri on changing the way families were approached in family assessments, but placed greater emphasis on the provision of services to these families. These two core elements—a family-friendly response to child maltreatment reports and an increased emphasis on meeting the service needs of families—formed the core of the practice change in Minnesota that was intended to improve outcomes for children and their families. It was assumed at the start of the Minnesota pilot project that the alternative response could not be implemented without a corresponding increase in funding. This increase in cost was viewed as an investment in the longer-term welfare of children and families.

Investment costs of the Minnesota pilot were provided through a grant from the McKnight Foundation as well as support from the state legislature. Counties participating in the pilot received funds for two purposes: 1) a supplement to defray worker costs for conducting family assessments, since it was expected that these

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For a detailed discussion of the Minnesota DR logic model, see Siegel (2011).
assessments would take longer and absorb more caseworker time than standard investigations; and 2) funds to provide increased services to families. Such services could be purchased by caseworkers, provided directly by caseworkers, or provided through contracts with community agencies. However, a minimum portion (one third) of the services grant had to be spent on what were termed as “hard goods.” These were items that addressed practical and concrete needs of families and included, as one caseworker told evaluators, “some pretty basic things they need for their homes and their children, like blankets, pillows, cribs, vacuums, safety gates, [and] electrical plugs.” Another worker, describing services provided through the alternative response, said, “We can provide many types of services now that we wouldn’t have before: electricity, lamps, refrigerators, rent, utilities—things that take the stress off. We also provide the kinds of things we do with traditional families, but AR [alternative response] allows us to be more creative in working with families.” The alternative response gave workers a great deal of flexibility to provide services that matched the unique needs and circumstances of families. The evaluation found that experimental families were more likely to get a wider variety of services than control families and were more likely to receive the kind of assistance that they themselves said they needed. Such services included traditional interventions such as family counseling, mental health services, and parenting instruction, in addition to practical assistance related to basic and particular needs, such as those described above by caseworkers.

Overall, the impact study of the Minnesota pilot found fewer new reports of child maltreatment among experimental families during the evaluation follow-up period, and also found that experimental families that received services were less likely to have new reports than control families that received services. Not surprisingly, perhaps, with the emphasis on practical and basic needs, services were more often provided to alternative response families that were in greater socio-economic distress. It was among these poorer families that the largest impact of alternative response was found. At the same time, it should be noted that the evaluation also found that experimental families had fewer new reports of child maltreatment than control families, whether or not they received purchased services; this was at least partly due to the method of engagement during family assessments that facilitated the resolution of problems by the family itself and, as available, through assistance from the family’s natural support system. These findings indicated that both elements of the new practice model contributed to positive outcomes. Importantly, the impact effects found in the original evaluation persisted through the extended follow up.4

**Comparative Cost Analysis**

The basic cost analysis conducted as part of the evaluation of the Minnesota pilot was relatively simple and straightforward. It borrowed aspects of both cost neutrality and cost-benefit analyses. In was similar to cost neutrality analysis in that it was concerned ultimately about a single bottom line: the difference over a period of time in monetary costs to CPS between the new alternative response and the traditional investigative response. But it also borrowed the notion of “return on investment” from cost-benefit analysis—although, unlike most cost-benefit studies, it did not examine the full range of client and societal effects, but considered costs only to CPS.

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4 For additional discussion of how and why DR works, refer to Loman (2006 & 2010) and Siegel (2012), in addition to the two program evaluation reports of the Minnesota pilot project already referenced.
Design

The evaluation of the alternative response pilot project was longitudinal in nature. Through surveys and administrative data, families were tracked over a period of years. The cost study involved a random sample of 598 families (299 experimental and 299 control) from the study population of 4,031 families. The sample was selected from cases that opened over an 18-month period, from July 1, 2001, to December 31, 2002. With the extended follow-up time available to evaluators, families were tracked through December 31, 2005, a period that ranged from 3 to 4.5 years.

System costs were examined during two periods of time for each family. The first was the initial contact and treatment period. Each family in the sample had its own start and stop dates for this first period. The starting point was the date of the maltreatment report that brought the family into the study population. The termination point for period 1 was the day on which CPS intervention arising from this report ceased, county supervision and monitoring were discontinued, and all case activity was closed. This period, which typically ranged from 3 weeks to 3 months, always involved either a family assessment or an investigation, and it may have included the provision of ongoing case management or services. Period 1 start and end dates for each family were obtained from the Statewide Automated Child Welfare Information System (SACWIS), which, in Minnesota, is part of the Social Service Information System (SSIS). If new reports of maltreatment were received and addressed before CPS supervision or monitoring had stopped on the initiating report, these reports and any costs associated with them were considered to be part of the initial contact period. Once CPS activity ceased and an end or closing date was entered into the information system by a caseworker, the first period was considered over and the evaluation follow-up period commenced the following day. Any new report or CPS activity and costs from this point forward were considered part of the follow-up period, period 2. The end date for the follow-up period was the last day data could be collected because of the time constraints of the evaluation; this date was the same for all families in the study.

The design for the study can be understood with reference to Table 1. Mean costs associated with the sample of experimental families are represented by $e_1$ for the initial contact period and $e_2$ for the follow-up period. The total of these costs is represented by $e$. Similarly, mean costs

<table>
<thead>
<tr>
<th>Study Group</th>
<th>Period 1 Initial Contact &amp; Treatment</th>
<th>Period 2 Follow-up</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Families</td>
<td>$e_1$</td>
<td>$e_2$</td>
<td>$e$</td>
</tr>
<tr>
<td>Control Families</td>
<td>$c_1$</td>
<td>$c_1$</td>
<td>$c$</td>
</tr>
<tr>
<td>Difference</td>
<td></td>
<td></td>
<td>$c - e$</td>
</tr>
</tbody>
</table>

Table 1: Cost Study Design Matrix
associated with the sample of control families are represented by \( c_1 \) for the initial contact period and \( c_2 \) for the follow-up period. The total of these costs is represented by \( c \). The final cell contains the bottom line: the difference between total mean costs incurred by experimental families and control families \((c - e)\).

**System Costs**

There were two types of system costs included in the analysis: costs for purchased services and costs associated with worker time. Service costs were incurred whenever something was purchased for a family. This included items that were tangible (such as clothing or home repairs) as well as payments for training or therapeutic treatment. Depending on the county, tangible items might be arranged for by a county social worker and paid for with county funds or provided through the case management assistance of a community agency. Training and therapeutic services were nearly always provided through a service vendor and were sometimes part of a broader service agreement with a community agency. In a small but important number of instances, service costs included payments for foster care when a child was removed from the home.

The second type of costs involved those associated with a social worker’s time. This included time spent on the initial assessment, any time spent seeking assistance for a family from other sources, and case management if an ongoing case was opened. As would be expected, a greater portion of a worker’s time was spent in the period immediately following a report and during the assessment or investigation. As a general rule, the longer a case stayed open, the more worker time was absorbed by it.

Table 2 expands on the one above by including the two sources of costs. In this matrix, \( e_s \) and \( c_s \) refer to mean costs incurred while providing services to experimental and control families; \( e_w \) and \( c_w \) refer to mean costs of worker time devoted to experimental and control families. Other symbols remain the same as in the previous table, and the final cell again contains the bottom line: the difference between total mean costs incurred by experimental families and control families \((c - e)\).

**Data Sources**

Data sources utilized were the state’s SACWIS and county accounting systems and quarterly rate reports.

1. **Costs of Services.** When the cost study was conducted, while the state agency’s SACWIS contained a considerable amount of family and case data, it did not contain information on service costs. These had to be obtained from county bookkeepers in each of the 14 counties in the cost study. Accordingly, county bookkeepers were given a list of the families from their counties that had been selected in the sample. The list contained a variety of information to enable bookkeepers to locate the families in their county’s accounting system; this information included the SACWIS case ID, the county case ID, and the name of the head of household along with his or her social security number and birth date, all of which were available to evaluators through SACWIS. Bookkeepers were asked to provide all expenditures related to children’s services that were incurred between the start date of the demonstration and the end date of the tracking period. Children’s services included costs associated with specific system accounting codes and vendor services, including costs related to foster care placement. (Excluded were system codes of other social services that might already have been in place and
that were independent of a family’s involvement in child protection.) Bookkeepers were asked to provide the service code and service date of any service on the children’s services code list for the identified families. If a service date was unknown, bookkeepers were asked to provide the payment date on the designated spreadsheet.

For a majority of bookkeepers, the request was straightforward and the data was provided promptly. However, for certain counties with accounting systems that stretched over multiple databases and computer systems, the task was more complicated and lengthier. Some bookkeepers were able to provide the data in electronic spreadsheets, while others provided paper reports, and some a combination of the two.

The dates attached to service provision for each cost item for each family that were provided by bookkeepers were integrated into the research database. Cost and date data from bookkeepers, when combined with SACWIS data on CPS activity, permitted the separation of costs for individual families into the appropriate study period—initial contact and treatment (period 1) or follow up (period 2).

The service codes attached to the bookkeeper cost data permitted researchers to compare data submitted by bookkeepers with certain data in SACWIS for quality assurance purposes. For example, if SACWIS indicated that out-of-home placement had occurred for a child in a sample case, but data provided by a bookkeeper did not include costs for any such placement over the same dates, bookkeepers were queried about the

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Table 2. Full Design Matrix of the Cost Analysis

<table>
<thead>
<tr>
<th>Cost Type &amp; Group</th>
<th>Period 1 Initial Contact &amp; Treatment</th>
<th>Period 2 Follow Up</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental Families</td>
<td>es1</td>
<td>es2</td>
<td>es</td>
</tr>
<tr>
<td>Control Families</td>
<td>cs1</td>
<td>cs2</td>
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<td>Worker Costs</td>
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<tr>
<td>Experimental Families</td>
<td>ew1</td>
<td>ew2</td>
<td>ew</td>
</tr>
<tr>
<td>Control Families</td>
<td>cw1</td>
<td>cw2</td>
<td>cw</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td></td>
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<td>e2</td>
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<td>c1</td>
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<td>c</td>
</tr>
<tr>
<td>Difference</td>
<td></td>
<td></td>
<td>c - e</td>
</tr>
</tbody>
</table>
lack of consistency. This back-and-forth communication continued with each county bookkeeper until researchers were satisfied that all inconsistencies were accounted for and explained.

2. **Costs of Worker Time.** Costs related to staff time were derived by combining data from two sources. The first was the amount of time CPS workers spent with specific families. Workers logged this time into SACWIS (conversations with county administrators and staff indicated that they considered these data to be reliable and accurate). Through this source, the number of staff hours by family and time period was determined. Costs associated with staff time were obtained through quarterly rate reports that counties submitted to the state’s Department of Human Services. The rate reports were compiled by the Financial Operations Division into a Social Services Expenditure and Grant Reconciliation (SEAGR) report. Hourly rates for staff time, which vary from county to county and quarter to quarter, are typically used in allocating costs across an array of programs. By combining hourly log data and county rates for specific periods, the cost of staff time (and indirect and administrative expenses) for each case in the sample was calculated for each of the two study periods.

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**Cost Data**

Data utilized in the cost analysis can be seen in Table 3. Data in the cells of the table are mean costs associated with the two study groups by cost type and by period. The table shows that mean service costs for the initial contact and treatment period was $342 for experimental cases and $180 for control cases. This means that for every $1 spent for services for control families, $1.90 was spent on experimental families. Costs for staff time were similarly greater for experimental families than for control families during period 1, indicating that caseworkers spent more hours working with alternative response families during this initial period. Total costs for experimental families for period 1 averaged $1,142, compared to $905 for control families. The $237 cost difference may be viewed as the per-family investment price of additional prevention services provided to experimental families.

Costs during the follow-up period and total combined costs show that the investment was worth making. During the follow-up period, including the extension, the mean costs of both additional staff time and purchased services were less for the experimental group. The difference was substantial enough to offset the greater upfront costs invested during the initial contact period. The total mean cost for the experimental families was $3,689, compared with $4,966 for the control families. In cost neutrality analyses, the positive difference between these two mean costs is sometimes referred to as “savings.” In cost-benefit terms, these longer-term savings were the return on investment.

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5 For cost allocation purposes, in which costs are allocated across funding streams, worker time is a typical way of determining indirect and administrative costs. This cost category, therefore, includes costs associated with the salaries of workers, but also office and administrative expenses that can be related to specific cases.

6 In terms of overall workload, a case review sample found that there were more worker contacts with experimental than control families during period 1. This included more face-to-face meetings with families (3.6 on average vs. 2.4) and more total in-person and telephone contacts with the family and on the family’s behalf (12.5 vs. 7.0). All counties used the same assessment tools, but because Minnesota is a county-administered system, there were differences among counties in various procedural aspects of the initial engagement and decision-making process that affected how things were done and how long they typically took (see Loman & Siegel, 2004).
Cost Effectiveness

Within the context of DR, the issue for cost effectiveness is not simply the relative cost of doing things differently, but the cost of achieving desired outcomes using different approaches to CPS (see Haddix, Teutsch, & Corso, 2003). Essentially, a program can be cost effective in one of two ways. Either effectiveness can be improved while costs are maintained at similar levels, or effectiveness may remain unchanged or only slightly changed while costs are reduced.8

A key measure of program impact in the Minnesota evaluation was the reduction in subsequent maltreatment reports. The family assessment was found to be slightly more successful at doing this than traditional investigations in those reports screened for the alternative response. The recurrence of new reports of maltreatment found in the original program evaluation (Loman & Siegel, 2004), in which the follow-up period ranged from 9 to 26 months, was found to be 30.3% for control families and 27.2% for experimental families. Stated positively, for every 100 cases, the goal of recurrence avoidance was achieved in 72.8 of alternative response cases, compared with 69.7 of

Table 3. Mean Costs Associated with Sample Families in Impact Study Counties

<table>
<thead>
<tr>
<th>Cost Type &amp; Group</th>
<th>Period 1 Initial Contact &amp; Treatment</th>
<th>Period 2 Follow Up</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>Service Costs</td>
<td></td>
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<tr>
<td>Experimental Families</td>
<td>$342</td>
<td>$674</td>
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<td>Control Families</td>
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<td>Worker Costs</td>
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<td>Control Families</td>
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<td>$2,527</td>
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</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Experimental Families</td>
<td>$1,142</td>
<td>$2,547</td>
<td>$3,689</td>
</tr>
<tr>
<td>Control Families</td>
<td>$905</td>
<td>$4,061</td>
<td>$4,966</td>
</tr>
<tr>
<td>Difference</td>
<td>-$237</td>
<td>$1,514</td>
<td>$1,279</td>
</tr>
</tbody>
</table>

Cost Effectiveness

Within the context of DR, the issue for cost effectiveness is not simply the relative cost of doing things differently, but the cost of achieving desired outcomes using different approaches to CPS (see Haddix, Teutsch, & Corso, 2003). Essentially, a program can be cost effective in one of two ways. Either effectiveness can be improved while costs are maintained at similar levels, or effectiveness may remain unchanged or only slightly changed while costs are reduced.8

A key measure of program impact in the

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7 These costs were incurred over an average (mean) of 1,450 days.
8 Note that the comparative cost analysis discussed above uses total follow-up costs through the end of the extended evaluation (that is, from July 2001 through March 2006). The cost-effectiveness analysis, which follows, distinguishes costs from the original follow-up (July 2001 to September 2003) from costs during the extended follow-up (September 2003 to March 2006).
the control cases. Total mean costs expended on the two sets of families in the cost sample through the end of the original program evaluation were $1,972 for experimental families and $2,683 for control families. Given these expenditures, the mean cost of achieving the goal of recurrence avoidance for experimental families was $2,660 (1,972/.728) compared with $3,058 (2,683/.697) for the control group, a difference of $398.

During the extended follow-up study (Siegel & Loman, 2006), when costs were tracked a further 30 months, there were additional system costs for both experimental and control group families. This happened because the cases of some families remained open at the end of the original follow-up period and costs continued, while other families had new reports of child maltreatment requiring new assessments or investigations and new case openings. The mean costs incurred during the extended follow-up were $1,716 for experimental families and $2,284 for control families. This brings total expenditures to $3,689 for experimental families and $4,966 for control families.

The percentage of families with any new reports after the initial contact period increased for experimental families from 27.2% in 2004 to 37.5% in 2006, and for control families from 30.3% to 39.8%. Through this longer time period, recurrence avoidance had now been achieved by 62.5% of experimental families and 60.2% of control families.

While the difference in recurrence of new reports between the two study groups shrunk somewhat during the additional 30 months, a larger percentage of experimental families continued to experience positive outcomes. At the same time, the gap in costs between the groups widened. Taking all expenditures into account, the mean cost of achieving the goal of recurrence avoidance with the alternative response through the full tracking period increased to $5,902 (3,689/.625). However, for families that received a standard investigation, the cost per positive outcome rose to $8,249 (4,966/.602), a difference of $2,347.

Discussion

This paper was not meant to show precisely what costs or savings can be expected from the introduction of a DR program, but only to show how costs were analyzed in one study and what was found. The important finding was that the family assessment approach, as implemented in Minnesota, was not more costly than the investigative approach over the longer term. This finding is programatically significant in the same way as the central finding of the original evaluation of Missouri’s dual-track program, that the safety of children was not imperiled through the introduction of family assessments. It does not mean that all DR programs can or should be either cost neutral or produce savings. But it suggests that if the program is implemented in a manner consistent with the logic model and improves outcomes, it should be cost effective and probably will be cost beneficial.

The family assessment approach essentially involves treating parents in a way that is consistent with how society expects parents to treat their children: in a caring, supportive, and respectful manner that provides real help when it is needed and equips them with skills they need to better help themselves. In a very basic way, the evaluation of the Minnesota DR pilot provided confirmation of the program and cost benefits of positive social interaction.

Importantly, both positive outcomes and positive cost differences attributable to the family assessment approach were found in the original evaluation completed in 2004 and in the extended follow up in 2006. This means that the program “has legs,” to borrow a term from theater, where
longer runs are more likely to recoup investments and yield profits. In this case, the beneficiaries are the children and families served by CPS and the taxpayers that fund it.

It would be a mistake to think that the results from the Minnesota experience are easily replicable. They can be reproduced, but not easily; the Minnesota model is not a magic bullet. Preconditions for success include smart planning, close state-local collaboration, sustained training and commitment, and the courage to invest extra effort and money upfront. In a time of mounting fiscal uncertainty, when spending on social programs may be opposed as wasteful, it is important to demonstrate the benefits of effective programs. But there are risks to this as well. The risk is turning priorities upside down when the subject is child welfare and planting the notion that more can be done with less. Child welfare cannot be done “on the cheap,” and it is possible to reduce the cost of an effective program to the point where desired outcomes cannot be achieved. Moreover, while the high price and difficult job of child protection became increasingly evident as the evaluation of the Minnesota project continued, the question that still remains is: How much more could be accomplished with a greater investment in the welfare of families?

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References


The mission of American Humane Association is to ensure the welfare, wellness and well-being of children and animals, and to unleash the full potential of the bond between humans and animals to the mutual benefit of both.

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