National Quality Improvement Center on Differential Response in Child Protective Services

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Evolving Models of Practice and Differential Response Systems

Suzanne Lohrbach, M.S., LICSW

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This product expresses the views of the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR), not the views of the Children's Bureau. This issue brief is the second in a series and was funded by a grant of the Children's Bureau, U.S. Department of Health and Human Services as part of the QIC-DR.

This issue brief focuses on the development of practice models specific to child welfare practice in jurisdictions within the United States where differential response systems are being developed and implemented. Differential response refers to the way a public child welfare system can be organized to respond in more than one way to screened-in reports of child maltreatment, based on such factors as the type and severity of the alleged maltreatment, number and sources of previous reports, and the willingness of the family to participate in child protective services. The number of response options, or pathways and criteria for the different response options, in a differential response-organized Child Protective Services (CPS) system varies based on state policies or protocols. Similar activity is ongoing within the larger international community and specifically in jurisdictions within Canada and the Republic of Ireland.

For the purpose of this brief, the term "practice model" will be defined as the clearly articulated and written explanation of how the agency functions in relationship with families, service providers, and other child welfare stakeholders. A practice model strives to link agency practice, policy, and research with its mission, values, principles, and outcomes. This brief will summarize the various models and draft model components rather than advocate for or evaluate any one particular model.

Background History of Child Welfare in the United States

In 1962, C. Henry Kempe and his colleagues reported on the "Battered-Child Syndrome" in the Journal of the American Medical Association, describing "cases representing hundreds of children under three years of age with broken bones and significant head injuries" (Kempe et al., 1962) in which the explanations presented were discrepant or inconsistent. Subsequent to that publication were the mandated reporting laws enacted in the United States for suspected child abuse and neglect (1974 Child Abuse Prevention and Treatment Act). Child welfare began to become preoccupied with the function of child protection (Lindsey, 1994), and the nature of social work practice with children and their families began a departure from family support and rehabilitation toward a more forensic and investigative function.

Traditional child protection systems have been hindered by challenges of "over-inclusion" of low risk referrals, "under-inclusion" of families who have high needs (Waldfogel, 1998), and have been burdened by a "one size fits all" high resource investigative approach. Differential response now allows for more than one way for an agency to respond to reports of child maltreatment concerns; forensic, investigative resources can be allocated to high risk (for reoccurrence) situations and an alternative (different) response can meet the needs of family support issues (often currently assessed as low or moderate risk). As child welfare systems implement new ways of working in the context of differential response, practice model development, supervision, management, and skill building emerge again as priorities.

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

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

[1] For more comprehensive reports and information on differential response, please visit www.differentialresponseqic.org.

Practice Model Components

Particularly since the development of differential response systems, there has been a desire on the part of child welfare agencies to better articulate their practices in response to both internal and external questions about the differences between working within an investigative pathway and a family assessment pathway. In practice, the components apply across all pathways and any distinctions are specified as procedural guidance and as highlighting the core elements of a differential response system (Merkel-Holguin, Kaplan, & Kwak, 2006). Practice models are important in providing guidance and expectations for improving outcomes for children, youth, and families, standardizing practice across the continuum of service, and implementing evidence-informed practice. A practice model becomes the agency's guide for working with families, and is implemented through supervision, system-wide acceptance and approval, and an organizational culture that supports and promotes the tenets of the specified model.

The practice models reviewed are in draft form and represent the work to date of the states of Colorado, Minnesota, Ohio, and Vermont. These draft models were chosen for general discussion within this brief based on each jurisdiction's implementation of differential response, the development of specific practice models for illustration, and author knowledge and access. All of the models similarly addressed the major components of practice, values, and outcomes; the degree of detail presented varied from approximately three pages of description to thirteen pages. The expanded versions tended to add applied context to the components, giving more specific examples of outcomes and linking practice principles to measurements. Practice skills were also identified and were inclusive of engagement, advocacy, communication, cultural competence, planning, partnership, evaluation, and assessment. One of the models specifically and descriptively embedded the core components of a differential response system as described in the previous National Quality Improvement Center on Differential Response in Child Protective Services Issue Brief 1; this description represented the major difference among the four. The practice models were titled as follows: family services practice model (Vermont), alternative response project practice model (Ohio), child welfare practice model (Minnesota), and practice model for differential response (Colorado).

The three common components of the draft models reviewed were described as practice, values, and outcomes. These components will be described in the following text:

1. Practice:

The specified model provides guidance, training that aligns skills and builds knowledge, and supervision that reinforces research and skills.

The Children's Bureau of the Administration for Children and Families, United States Department of Health and Human Services, has provided federal guidance for practice. According to the Children's Bureau (JBS Child Welfare Review Projects, 2007), ALL child welfare practice ought to be:

- Child-focused
- Collaborative
- Family-centered
- Community-based
- Culturally-responsive
- Individualized to meet the specific needs of children and families
- Enhanced to strengthen parental capacity
- Outcome-oriented

Practice is further described in the various models in the context of service interventions: families are best served through engaging their protective capacities, recognizing and employing their strengths, maintaining cultural and community connections, and addressing immediate safety concerns and ongoing risks of child maltreatment. The phases of work are outlined as engaging for positive change; assessing readiness to change; planning, coordination, and implementation of service plans; support and reassessment; and transfer/closure.

Engagement occurs when someone communicates interest in what someone else has to say; questions arise from interest and allow for a more natural conversation and dialogue. There are types of questions

At least 15 States have either fully implemented DR or have implemented DR in limited localities

that lend themselves to sharing more information; asking someone more open-ended questions that begin with what, when, where, and how tends to expand the conversation. There is recognition that people who need to make changes in their lives may be at different stages of readiness. Meeting someone at his or her stage of readiness tends to build more effective working relationships; moments of crisis often create opportunities for motivating action. Suspending judgment and/or owning each judgment (i.e., locating the judgment with the person who promotes it), in addition to sharing perspectives, open conversations.

Gathering, organizing, analyzing, and sharing information are aspects of planning, assessment, and decision making. Signaling interest, asking good questions, offering choices, engaging in conversation, providing straightforward disclosure of information, and bringing family, extended family, community, and service providers together ensure that all available information is provided and that plan development is enhanced. Where multiple service providers are involved, the development of one plan, or at least clear coordination of all plans, can decrease fragmentation of service delivery and can enhance focus on the prioritized goals regarding child safety. There is ongoing assessment of and modification of plans as needed to ensure that new information is assimilated—both complicating factors and positive progress. Depending on the way different child welfare systems are organized, there may be a transfer point (for example, in some child welfare agencies there is a transfer from investigation or family assessment to ongoing child protective services or other specialized teams that work with domestic violence or situations specific to the presence of alcohol or other drug involvement) or, when child safety concerns are addressed and progress sustained over time, case closure.

2. Values:

Values are expressed through principles, training, and an organization-wide culture of commitment. Common examples within the models reviewed include:

- Child safety is the primary focus and is achieved through family engagement.
- Building constructive, working relationships with families is a primary goal and stems from a belief and assumption that every family has strengths, resources, and assets.
- Collaboration among service providers and community supports are essential to the promotion of positive outcomes for children and strengthening families.
- Family and extended family and community inclusion builds safety for children and enhances the capacity for longer-term success.
- Comprehensive assessment of risk includes both danger/harm and protective capacity.
- Shared understanding of goals and a straightforward sharing of information builds shared risk and accountability.
- Differences are respected and an understanding of different cultures, races, and ethnicities is sought; that knowledge is applied in practice.
- Staff are supported, valued, and receive ongoing supervision and training as well as access to research, evidence, and policy.

Values are integrated into organizational culture in a variety of ways. The following examples are illustrative of such integration:

1. Intentional planning regarding training: Ensuring that all training (internal and external) forwards the organization's values (e.g., prioritizing training on diversity/understanding and respecting differences).
2. Providing access to research: Ensuring that professional practice is informed by current research and knowledge in the field (e.g., staff person or time allocated to updating research information, subscriptions to professional journals, and summaries provided to staff).
3. Access to facilitation and coordination of family meetings to ensure family/extended family inclusion and collaborative practice patterns (e.g., internal staff time or community contracts).
4. Development of critical thinking skills and decision-making processes, and access to valid risk assessment tools (e.g., use of specified frameworks for decision making or comprehensive assessment of risk inclusive of protective capacity).
5. Supervision forums that emphasize clinical case consultation so that critical thinking skills, decision-making processes, and utilization of research are applied (e.g., group supervision).
6. Visible statements of values as reminders of what the organization views as important to communicate to staff, service recipients, and community providers (e.g., posters or pictures reflecting values).

Values that are translated into the organization's day to day operations are clearly linked to practice and

outcomes. The required documentation (case notes, tool completion, court reports, etc.) that accompanies practice reflects the values (inclusion, ongoing assessment, decision making, critical thinking, supervision, etc.) that ultimately support the major outcomes of child safety, well-being, and permanency.

3. Outcomes:

Outcomes are specific and measurable with respect to child safety, child and family well-being, and child permanency. Public child welfare systems operate within practice models with the goal of achieving the common outcomes for all families, children, and youth who are in relationship with the child welfare system. These common outcomes include:

- Children are cared for in safe, nurturing families with security and stability, and are under the charge of caregivers who have the necessary skills and resources to provide for their physical and mental health, behavioral, and educational needs.
- Children are safely maintained in their families and communities with connections, identity, culture, and relationships established and preserved.
- Children, youth, and families who encounter the public child welfare system are supported to achieve equitable outcomes, regardless of race, ethnicity, socioeconomic status, or tribal status.
- The public child welfare staff is a diverse, professionally competent team that supports strength-based practice and demonstrates inclusiveness at all levels.

The three questions being studied by the Quality Improvement Center on Differential Response (QIC-DR) will further add to the body of knowledge specific to how to better achieve the above outcomes:

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?

For additional information regarding outcomes, see the abstract on the QIC-DR website: (www.differentialresponseqic.org).

Outcomes represent the overarching goals of a child welfare/child protective service intervention with families. These goals are further detailed and individualized to each family situation through casework **practice** that is guided by research, principles, supervision, skills, and tools; practice reflects the **values** that the organization is committed to implementing. Making the links between these practice model components and ensuring that they are institutionalized as a way of working from first contact with families through case closure introduces coherence into a system that is often fragmented and anxious.

Conclusion

In preparing this issue brief, it was clear that a number of jurisdictions that are organized as differential response systems employ a practice model that is consistent across all response pathways. In those practice models that differentiate between pathways, the common distinctions specifically incorporated and articulated were the eight core elements that were provided by the Quality Improvement Center on Differential Response models (Merkel-Holguin, Kaplan, & Kwak, 2006) as cited in the Issue Brief 1: "Beyond Investigations: Current Innovations in Responding to Reports of Child Maltreatment." The development of both specified and integrated practice models provide a promising foundation for further refinement of professional supervision practices, organizations as learning institutions, and clear links to policy and research to bring greater coherence to an often fragmented and procedurally driven work environment; social workers/practitioners are searching for the "how-to prompts" as they wade through the historic challenges of a risk averse system that is embracing innovation and moving from primary case management models in order to return to direct practice engaging families. While it would be easy at first glance to address these direct practice needs through numerous trainings on various tools and techniques and to add procedural layers to manage the considerable risks, the greater challenge is how to develop critical thinking skills to guide the practitioner through gathering more meaningful and comprehensive information inclusive of all family/extended family/cultural community views alongside professional views and relevant research. These practice models reflect the movement in the direction of prioritizing an understanding of the considerable depth required in direct service to both prevention and intervention with families where there are ongoing concerns regarding the safety and well-being of children.

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