

National Quality Improvement Center on Differential Response in Child Protective Services

Final Report: QIC-DR Cross-Site Evaluation

Grant #90CA1794



July 2014

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ACKNOWLEDGMENTS

This project has benefited from the efforts of many people who represent not only the administration of child protective services, but also the funding of such services, evaluation of these services, the receipt of such services, and a deep interest in these services. All have expressed their commitment to improving child protective services for children, families, agencies, and communities. In particular, the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR) would like to acknowledge:

- The U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau for funding this project; our Project Officers, Catherine Nolan and Dori Sneddon, for their ongoing guidance; and Jean Blankenship, who was instrumental to the formative years of the QIC-DR.
- Members of the QIC-DR’s National Advisory Committee who, with their ideas and strategic thinking, supported the project over the 5 years, including: Donald Baumann, Saint Edwards University; Deb Conway, Parent Partners of Washington State; Theresa Costello, National Resource Center for Child Protective Services; Chiemi Davis, Casey Family Programs; Lucille Echohawk, Denver Indian Family Resource Center; Eric Fenner, Casey Family Programs; Judge Thomas Frawley, 22nd Judicial Circuit, City of St. Louis; Rita Katzman, Virginia Department of Social Services; Lloyd Malone, Colorado Department of Human Services (retired); Jerry Patton, Southeastern Louisiana University Family Resource Project (retired); Erin Sullivan Sutton, Minnesota Department of Human Services; and Betty Weiser, Nevada Department of Health and Human Services (retired).
- The Program Directors and Evaluation Directors of the three research and demonstration (R&D) sites who worked tirelessly and collaboratively to implement and evaluate differential response, including: Ida Drury and Marc Winokur from the Colorado site; Nancy Mahoney and Julie Murphy from the Ohio site; and Womazetta Jones and Tamara Fuller from the Illinois site.
- The child welfare staff in the three R&D sites who were critical not only to implementation, but also to the evaluation of differential response.
- The many families who were served by child protective services, and who responded to the written surveys and participated in focus groups, providing the child welfare field with greater information and insights from a consumer’s perspective.
- Members of the NCANDS Technical Team, especially Mary Jo Ortiz and Leonard Johnson, who conducted additional analyses using the NCANDS dataset.
- Lastly, former staff from American Humane Association, The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, and Walter R. McDonald & Associates, Inc. who contributed to the QIC-DR during the 5-year time period (in alphabetical order): Brett Brown, PhD; Debra Gilmore, JD, MPP; Anita Horner; Michelle Howard, MS; Caren Kaplan, MSW; Lauren Morley, MSW; Donna Parrish, MA; Gila Shusterman, PhD; and Sonia Velazquez.

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Suggested citation: National Quality Improvement Center on Differential Response in Child Protective Services. (2014). *Final report: QIC-DR cross-site evaluation*. Available from: www.differentialresponseqic.org.

Funder: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Grant #90CA1794.

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Summary

Differential response (DR) is a variation of delivering child protective services (CPS), which includes at least two distinct pathways for responding to screened-in reports of child maltreatment: the investigative response (IR) and the alternative response (AR). DR is also sometimes used to refer to CPS systems that are comprised of only one pathway for responding to screened-in reports, namely IR, but includes a diversion component, which triages screened-out reports to community agencies. This report does not address this latter type of DR system.

Generally, AR, under the dual response pathway version of DR, is intended for low- and moderate-risk maltreatment allegations, while IR is reserved for allegations of child maltreatment that are considered to be of high risk or needing potential involvement of law enforcement. Given the interest and growth of DR throughout child welfare systems in the United States, the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau funded the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR). The American Humane Association received this award, which was later transferred to The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect. The QIC-DR operated between 2008 and 2014.

This QIC was structured to generate and disseminate knowledge on DR and to support the infrastructure at state and local levels to improve outcomes for children and families referred for suspected maltreatment. The QIC-DR included three components aimed at increasing the knowledge base of DR: (1) local evaluations conducted in child welfare systems; (2) a cross-site evaluation; and (3) a dissertation research component for PhD candidates. The local evaluations can be found at www.differentialresponseqic.org.

EVALUATION DESIGN

Three research and demonstration (R&D) sites were selected to implement and evaluate DR. The sites selected were:

- The Colorado Consortium on Differential Response (CCDR), representing five counties (Arapahoe, Fremont, Garfield, Jefferson, and Larimer), with the local evaluation conducted by Colorado State University Social Work Research Center;
- Illinois Department of Children and Family Services, consisting of a statewide implementation of DR, with the local evaluation conducted by the Children and Family Research Center at the University of Illinois Urbana-Champaign; and
- The SOAR Consortium, representing Six Ohio Counties Implementing Alternative Response (Champaign, Clark, Madison, Montgomery, Richland, and Summit), with the local evaluation conducted by the Human Services Research Institute.

The cross-site evaluation team, led by Walter R. McDonald & Associates, Inc., collaborated with the R&D sites and the Kempe Center to design the evaluation study. This design was formulated to

research multiple aspects of DR implementation. It included a 9-month-long needs assessment process, which identified knowledge gaps from the perspectives of various child welfare professionals, partners, advocates, and researchers. Using a framework of studying families who met the eligibility criteria for AR and comparing families from this group who were randomly assigned to AR or IR, the following core research questions were examined.

- 1) Are children in AR families as safe as or safer than children in IR families?
- 2) How is the AR pathway different from the IR pathway in terms of family engagement, caseworker practice, and services provided?
- 3) What are the costs for child protection agencies that implement DR?

To best answer these questions, the QIC-DR cross-site evaluation team took a comprehensive approach to the analyses, employing a variety of data collection and analytic methods. This mixed methods strategy involved collecting and analyzing both qualitative and quantitative data obtained from a variety of sources, including caseworkers and parents through surveys and focus groups, and administrative data systems. Colorado’s and Ohio’s study periods began on December 1, 2010, and ended on February 28, 2012. Illinois’ study period began on November 1, 2010, and ended on May 22, 2012. The cross-site study sample, which differs slightly from each local evaluation sample, is identified below.

<i>Cross-Site Samples</i>									
	Colorado			Illinois			Ohio		
	Total (n=1,667)	AR (n=870)	IR (n=797)	Total (n=4,534)	AR (n=1,706)	IR (n=2,828)	Total (n=846)	AR (n=543)	IR (n=303)
	Response Rates								
Administrative Data	1,667 (100%)	870 (52.2%)	797 (47.8%)	4,534 (100%)	1,706 (37.6%)	2,828 (62.4%)	846 (100%)	543 (64.2%)	303 (35.8%)
Case Report Data	1,667 (100%)	870 (52.2%)	797 (47.8%)	4,534 (100%)	1,706 (37.6%)	2,828 (62.4%)	846 (100%)	543 (64.2%)	303 (35.8%)
Family Survey Data	398 (23.9%)	219 (55.0%)	179 (45.0%)	1,132 (25.0%)	518 (45.8%)	614 (54.2%)	319 (37.7%)	228 (71.5%)	91 (28.5%)
Staff Survey*	Caseworkers: 89/143 (62%) Supervisors: 30/39 (77%) Overall: 119/182 (65%)			Caseworkers: 200/741 (27%) Supervisors: 48/171 (28%) Overall: 248/912 (27.2%)			Overall: 227/378 (60%)		

*Percentages refer to the distribution of AR or IR cases within the total number of cases in each data source type subsample.

KEY FINDINGS

Question 1: Are children in AR families as safe as or safer than children in IR families?

Based on the indicator of re-referrals, the QIC-DR team found that, in Colorado and Ohio, AR families were less likely to be re-referred than IR families, whereas in Illinois, AR families were more likely to be re-referred than IR families. From a cross-site evaluation perspective, the extent to which the high rate of transfer of cases from AR to IR in Illinois contributed to this finding under the intent-to-treat analytical design is not known.

Fewer than 5 percent of children in either the AR or IR sample of families were removed at any time during the 365-day study period. In all three sites, the implementation of AR did not appear to impact—positively or negatively—the entry of children into foster care.

Question 2: How is the AR pathway different from the IR pathway in terms of family engagement, caseworker practice, and services provided?

In all three sites, a statistically significant higher proportion of AR families, in comparison to IR families, received at least one service. When service arrays were examined, there were some statistically significant differences regarding the receipt of specific services. Among all three sites, AR families were more likely than IR families to receive services to meet their material needs. In Illinois, AR families were more likely than IR families to receive services such as social support, educational, parenting, and “other” services. However, IR families were more likely to receive substance abuse services than AR families. With regard to the responsiveness of services, only in Illinois was there a significant difference with AR families receiving services more rapidly than IR families.

Caseworkers in all three sites rated IR parents, in comparison to AR parents, to have more positive engagement attributes (cooperative, receptive to help, and engaged) at their first meetings. Caseworkers also rated their perceptions of parents’ positive engagement attributes and negative engagement attributes (uncooperative and difficult) between their first and last meetings. These results showed that, in Colorado and Ohio, caseworkers perceived the negative engagement attributes of AR parents to decrease, and, in all three sites, caseworkers perceived the negative engagement attributes of IR parents to decrease. There was no significant difference in the amount of change among any of the three sites.

In Illinois and Ohio, when parents responded to how they felt at their first meeting with the caseworker, AR parents, in comparison to IR parents, reported more positive affect (feeling relieved, respected, encouraged, thankful, hopeful, and comforted). In all three sites, IR parents scored higher on the attribute of “worry” at their first meeting with the caseworker in comparison to AR parents. In Illinois only, IR parents, in comparison to the AR parents, scored higher on the attribute of “anger” at the first meeting with the caseworker. Given that AR parents rated themselves as having more positive affect than IR parents, but caseworkers rated IR parents to be more engaged initially at the first meeting, it appears that the two groups had different perceptions of the first meeting.

In Colorado, AR parents and IR parents did not statistically differ in their levels of satisfaction in their treatment by their caseworkers or in the levels of help received from their caseworkers. However, AR parents were statistically more likely to indicate that they would call their caseworkers in the future than were IR parents. In Illinois, AR parents were significantly more satisfied on all three indicators than IR parents (satisfaction with treatment by their caseworkers, level of help received, and likelihood of contacting their caseworkers in the future). In Ohio, there were no statistical differences between AR and IR parents on these same three indicators.

Question 3: What are the costs for child protection agencies that implement DR?

In Colorado, the difference in total costs was not statistically significant. AR cases were slightly more expensive than IR cases (\$1,211.97 compared to \$953.78, respectively). In Illinois, the difference was significant, as AR cases cost much less than IR cases (\$725.29 compared to \$2,737.79, respectively). In both Colorado and Illinois, foster care costs contributed to the difference between AR and IR total costs.

CONCLUSIONS

Differential response restructures the CPS system to offer multiple ways (AR or IR) to assess and possibly serve families. In two of the three QIC-DR sites, the entire CPS system was impacted by the introduction of the new AR pathway. Most of the changes observed in Colorado's and Ohio's implementations of DR were not reserved for AR families, but rather the modifications became embedded into child welfare systems for all CPS families. The AR pathway, like the IR pathway, is guided by procedures and policies, and influenced by the skills and characteristics of caseworkers. This has been demonstrated in the introduction of, for example, revised family service plan documents, group consultation processes to review cases, new screening procedures, and revamped timelines for responding to child abuse and neglect reports. In addition, a number of existing child welfare practice strategies have clearly become part of the AR and IR pathways, influencing how caseworkers approach relationship building and engagement of all families.

It has been noted that DR can result in identifying new service partners, increasing services in the community, and reallocating existing resources to meet emerging family needs. The management of service provision and the development of a more holistic service array will be influenced by: (1) CPS agencies' limited resources, which impact caseworker, supervisor, and administrator decisions on which families receive services; and (2) caseworkers' perceptions of engagement and receptivity of families, along with their understanding of available services and ability to access services for families with whom they work. While the implementation of DR may have revealed the importance of CPS agencies being able to provide or link families to poverty-related services, it also highlighted the surveillance nature of the system, as a high percentage of families who are screened in to CPS receive no or minimal services.

CPS decisions can have short- and long-term impacts on families, including affecting family relationships, future employment possibilities, family members' social standing, and their identities. Many CPS families might be better served by applying the categorization of "in need of services," rather than only having the option of considering whether parents/caregivers are perpetrators or not, and whether children are victims or not. The implications of eliminating a substantiation decision for all CPS cases, and not just AR parents, may impact the relationship among the public agencies, the communities, key stakeholders, and families.

The implementation of DR changes the CPS system, and as such, it can be expected that the key indicator statistics may change as well. This includes: population rates of substantiation decreasing; substantiation rates of IR increasing; possible increase in the number of referrals to CPS if the agency becomes viewed by the community as one that is service-oriented; and a

decreasing number of child maltreatment victims. This could unintentionally portray a message that child abuse and neglect, while an important social or public health issue, is one that is less epidemic than in the past. How the child welfare field re-messages these and other statistics will be important in the years ahead.

It would appear that the end goal in implementing AR may not be to attempt to classify AR as a manual or standardized intervention that could be replicated across jurisdictions. Rather, it may be that AR should be seen as a modification of the CPS system, which also influences how IR is implemented and delivered.

Although AR might be considered to be merely an alternative to IR, as its name implies, a fully implemented DR system may have deep impacts upon the community and its families; the CPS workforce; the policies, practices, and procedures guiding child protection casework; and the child welfare agency mandate. These impacts may not be solely in terms of different outcomes for those who have come to the attention of CPS, but rather may widen the reach and influence of CPS to other families who may be at risk or vulnerable. DR may indeed reshape the core mission of CPS.

Chapter 1. Introduction

The QIC-DR was structured to generate and disseminate knowledge on differential response (DR) in child protective services (CPS) and to support the infrastructure at state and local levels to improve outcomes for children and families referred for suspected maltreatment. The QIC-DR included two components aimed at increasing the knowledge base of DR, (1) local evaluations conducted in child welfare systems and (2) a cross-site evaluation, as well as a dissertation research component for PhD students. Lastly, the QIC-DR was charged with disseminating information through several products that showcase what was learned in this 5-year project.

The purposes of the QIC-DR were to:

- Design and conduct evaluation on the implementation, outcomes, and cost impact of DR in research and demonstration (R&D) sites;
- Determine whether DR is an effective approach in CPS; and
- Build cutting-edge, innovative, and replicable knowledge about DR, including guidance on best practices in DR.

There were two phases to the QIC-DR. Phase I (Year 1) began on October 1, 2008, and concluded on September 30, 2009. Phase I focused on conducting a comprehensive needs assessment that informed the identification of gaps in CPS practice, knowledge gaps, and research priorities, as well as the construction of an evaluation design. The QIC-DR project team and the Children's Bureau drew upon the expertise of diverse leaders in the field at the federal, state, and community levels, as well as the input of families and other participants during this knowledge-gathering phase. The knowledge obtained during Year 1 informed the implementation plan for Phase II. Phase II covered Years 2-5 (October 1, 2009 – September 29, 2013). Through a competitive RFP process, the QIC-DR awarded funding to three sites to support their implementation and local evaluation of DR. The QIC-DR collaborated with the sites in designing the QIC-DR cross-site evaluation. In addition, in this second phase, the QIC-DR produced various products, which are available online at www.differentialresponseqic.org.

QIC-DR Project Staff

The Kempe Center¹ served as the lead agency for the QIC-DR, partnering with Walter R. McDonald & Associates, Inc. to lead the cross-site evaluation. The Institute of Applied Research served in an advisory capacity throughout the project, especially around the evaluation and instrument design. During Phase I of the project, the American Bar Association Center on Children and the Law (ABA) and the National Conference of State Legislatures (NCSL) joined in to contribute their specialized expertise to the project.

¹ The QIC-DR grant was initially awarded to the American Humane Association (AHA), which relinquished the grant to the Kempe Center in 2012.

Research and Demonstration Sites

Three research and demonstration (R&D) sites were selected to implement and evaluate DR. Each site's project director and independent evaluator worked closely with the cross-site team. The sites selected were:

- The Colorado Consortium on Differential Response (CCDR), representing five counties (Arapahoe, Fremont, Garfield, Jefferson, and Larimer);
- Illinois Department of Children and Family Services, consisting of a statewide implementation of DR; and
- The SOAR Consortium, representing Six Ohio Counties Implementing Alternative Response (Champaign, Clark, Madison, Montgomery, Richland, and Summit).

National Advisory Committee

The QIC-DR developed a National Advisory Committee (NAC) with diverse representation from across the United States. Members represented numerous jobs, including a judge, state administrator, county administrator, child welfare consultant, evaluator, tribal leader, parent consumer, and community service provider. The NAC met twice in the first year to help with planning and development of the core research questions. In Phase II of the project, they met on a yearly basis to help advise the sites, doctoral students funded by the QIC-DR, and cross-site team members with respect to implementation and evaluation issues.

Doctoral Students

Using funds from the QIC-DR, five doctoral students were awarded financial support during the dissertation research phase of their doctoral studies. Students were selected through a competitive request for applications process. Three students were funded \$50,000 over 2-year periods, and two students were funded \$25,000 over 1-year periods. More information about the students and their research is available online at www.differentialresponseqic.org.

Academic Scholars Panel

The Academic Scholars Panel was convened by the QIC-DR in Phase II to guide the recruitment and selection of the previously noted doctoral students and to support them as they constructed their dissertations and implemented their research. The panel included Donald Baumann, PhD (also a member of the NAC); Brett Drake, PhD, from Washington University in St. Louis; and Jacquelyn McCroskey, DSW, from the University of Southern California. The panel was invited to attend National Advisory Committee meetings to hear presentations from the students who were selected. When applicable, the panel made recommendations to the students regarding changes to their evaluation plans in order to improve them.

TERMINOLOGY

The terms differential response, alternative response, and family assessment response are often used interchangeably. For this report, we will use the following terms:

Differential Response (DR)

DR is a type of CPS system that includes at least two distinct pathways for responding to screened-in reports, the investigative response (IR) and the alternative response (AR). Generally, AR is intended for low- and moderate-risk allegations, while IR is reserved for more serious allegations of child maltreatment. Each QIC-DR site had clear criteria for determining the initial pathway assignment for cases, which varied across sites (see Chapter 3). In county-administered child welfare systems, there was also variability among counties with respect to the types of cases screened in. Where that line of risk is drawn can vary substantially across jurisdictions implementing DR.

While it is clear that DR has expanded in terms of practice, what is also evident is that there is great variation in definitions of DR, and that more definitions emerge as additional states implement their versions of DR. It is commonplace that, when something is introduced as “new,” it gets distinguished from the “old.” In this case, the investigation response (IR) is the “old” and alternative response (AR) is the “new.” Within states, and across counties and tribes, there is great variability in how AR is defined and operationalized, and the degree to which it differs from the “traditional” response to an allegation of maltreatment. Similarly, IR is not defined or operationalized as a monolithic response across the nation.

Alternative Response (AR)

AR, sometimes also called the family assessment response (FAR), incorporates the following considerations:

- Establishment of AR pathway is formalized in statute, policy, or protocols;
- New information that alters risk level of safety concerns can cause the initial AR pathway assignment to change to IR;
- Families assigned to AR can choose to receive IR;
- AR families can accept or refuse the offered services *if there are no safety concerns*;
- AR families are assessed with no formal determination of child maltreatment; and
- Since no determination of maltreatment is made, no one is named as a perpetrator, and no names are entered into the central registry for those individuals who are served through the AR pathway.

Investigation Response (IR)

The IR pathway requires a formal investigation that includes the assessment of the allegation of child maltreatment and culminates in a finding, such as *substantiated*, *indicated*, or *not substantiated*. An integral part of IR is the identification of perpetrators of maltreatment. The names of these people are generally included in a central state registry.

ORGANIZATION OF THIS REPORT

Chapter 2 provides a summary of the evolution of DR in CPS in the United States. This chapter discusses pivotal, historical moments, state expansion of DR, and some of the rationales given by implementing states. It concludes with the QIC-DR's qualitative answer to one of the main research questions: What is the difference between AR and IR in a DR-organized CPS system?

Chapter 3 summarizes the three QIC-DR sites that were part of this project within a national context. The cross-site evaluation dataset was constructed from these sites. Chapter 4 describes the methodology of the cross-site evaluation. Chapter 5 provides a description of the characteristics of the AR and IR families in the cross-site evaluation, including demographics of the children and caregivers, number of children in the household, types of allegations of maltreatment, and types of safety threats.

Chapter 6 analyzes the concept of parent engagement from the perspectives of parents and caseworkers. Chapter 7 reviews characteristics of services for AR and IR families and discusses assessment for safety, receipt of services, duration of the AR and IR pathways, and ongoing services. Chapter 8 looks at the issue of child safety for AR and IR cases. Chapter 9 examines the costs related to AR implementation. Lastly, Chapter 10 presents the final conclusions of this cross-site evaluation. In addition, there are several supporting appendices (available at www.differentialresponseqic.org).

For other products from this project and the local evaluation reports, please visit www.differentialresponseqic.org.

Chapter 2. The History of DR

CALLS FOR CHILD WELFARE REFORM

In its report, the U.S. Advisory Board on Child Abuse and Neglect, commissioned by the Department of Health and Human Services (1990), concluded:

Child abuse and neglect in the United States now represents a national emergency. The Board bases this conclusion on three findings: (1) each year hundreds of thousands of children are being starved and abandoned, burned and severely beaten, raped and sodomized, berated and belittled; (2) the system the nation has devised to respond to child abuse and neglect is failing; and (3) the United States spends billions of dollars on programs that deal with the results of the nation's failure to prevent and treat child abuse and neglect. (p. vii)

This Board continued with a recommendation for once the emergency was under control:

The nation should commit itself to achieving an equally important goal: the replacement of the existing child protection system with a new, national, child-centered, neighborhood-based child protection strategy. (p. viii)

Numerous reforms to the formal child welfare system have been proposed in the past two decades, with DR being one of them. To set the context for this report, we briefly synthesize some prominent reform concepts that have been suggested. Some have been embraced by policymakers and child welfare administrators to varying degrees of implementation. Others have been noteworthy and, in some instances, controversial, but for various reasons have not gained traction either locally or nationally. All of these ideas have some connection—either philosophically or programmatically—to DR.

Eliminate Child Abuse and Neglect Substantiation

An ongoing theme since the mid-1990s has been the role of substantiation in protecting children. For example, Drake (1996) questioned the usefulness of the child maltreatment substantiation decision. Further research (Drake & Jonson-Reid, 2000) demonstrated that substantiated cases and unsubstantiated cases are similar in many ways. It has been argued, from this research and that of others (Fluke et al., 2001; English, Marshall, Brummel, & Coughlin, 1998), that the substantiation label may not be a useful distinction for child protective services. It has further been suggested by Drake and Jonson-Reid (2000) that the substantiation label could be replaced with other indicators tracked by family or by case, including court involvement, services needed, and possibly a central registry indicator for purposes of employment. Given that the substantiation decision is eliminated for AR cases, this concept has been partially implemented in states with DR.

Separating the Roles of Law Enforcement and Child Protection

For over 30 years, child welfare scholars, foundations, and advocates have discussed the inherent tension for CPS caseworkers who have to play dual functions, that of investigator of harm and helper. For example, Drews (1980) and Hutchison, Dattalo, and Rodwell (1994) noted the inherent tension between CPS simultaneously having investigative and family support/service functions, offering the proposal that law enforcement agencies conduct investigation functions, allowing child welfare to provide family support functions. DR provides the opportunity for child welfare professionals to reclaim a more robust social work philosophy in its work with families.

Increased Role for Community Partners

Waldfoegel (2000) suggested a paradigm in which community-based partners would serve lower risk CPS cases, and the CPS agency would reserve its energies, time, and attention for the most serious cases. Historically, the roots of child welfare programs existed in settlement houses and nonprofit organizations, with a gradual shift to child welfare becoming a government function. Certainly, in the past decade, there are a number of examples of a slightly modified version of this model, with community-based agencies voluntarily serving families screened out from a formal CPS response. In many communities with DR, the role and integration of existing, local resources to address underlying problems of child welfare families has also been woven into the fabric of implementation.

DIFFERENTIAL RESPONSE AS ONE OF THE EVOLVING CHANGES TO CPS SYSTEMS

First introduced in the early 1990s, the adoption of DR has spread nationally and internationally in an effort to address the growing recognition that CPS families' differing circumstances and needs may necessitate distinct responses, and that the front-end of the child welfare system could provide an avenue to make such changes. Given that the majority of families who come to the attention of CPS are deemed to present low or moderate risk of maltreatment, and are not experiencing immediate child safety issues, DR encapsulates the notion that CPS systems could be reorganized to respond to these families differentially in a manner that may support families as unique entities. DR emphasizes a CPS system with two response types: an investigation and/or an assessment. These two pathways respond to different types of and risk levels in child maltreatment reports. In essence, some children are in grave danger and require a response that can meet the legal requirements for removal of the child and pursuit of additional legal action (if necessary), yet the majority of children are in families who may not be maltreating them but may be experiencing difficulty in caring for their children.

The history of DR is quite complex. Pivotal papers, symposia, legislation, advocacy, research, and implementation experiences have collectively contributed to and influenced the ongoing implementation and expansion of DR in CPS systems. Table 2.1 highlights some of the most critical events underlying the adoption of DR as a widely embraced type of child welfare system reform.

Table 2.1. Child Welfare Reform Timeline: Connection to Differential Response

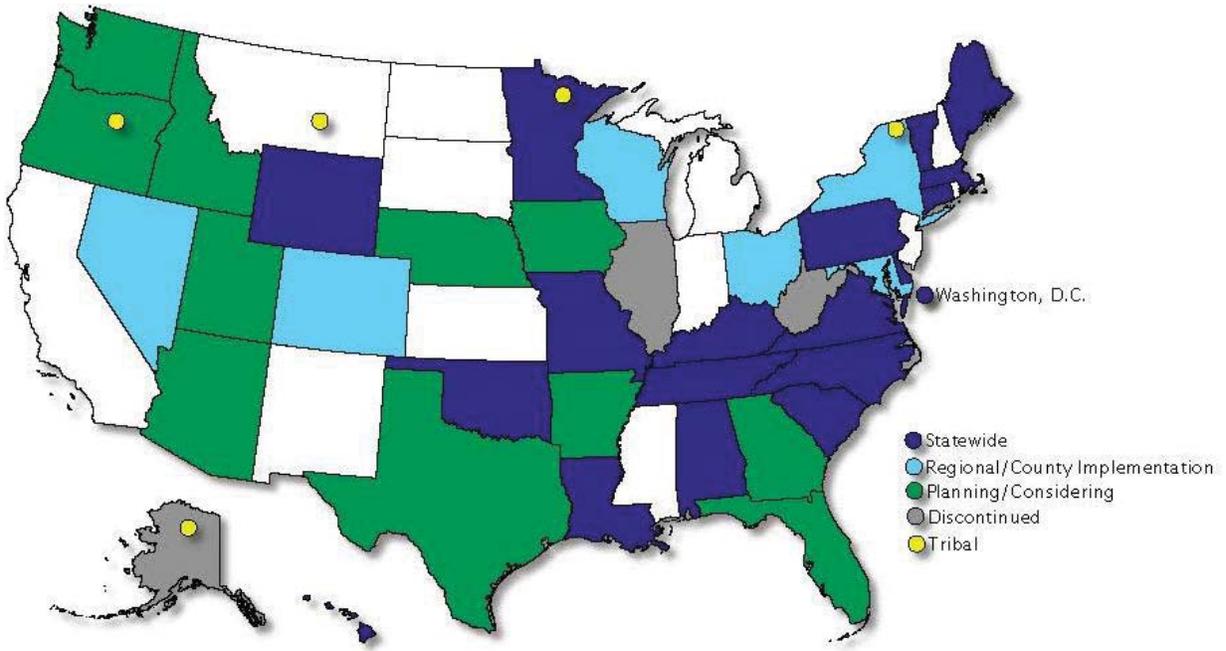
Year	Event or Activity
1990	U.S. Advisory Board on Child Abuse and Neglect issued a report to Congress declaring that the U.S. faces a “child protection” emergency.
1993	Florida and Missouri were the pioneering states implementing DR in an effort to be more efficient in addressing child maltreatment.
1994–1997	Executive Session on Child Protective Services (CPS) at Harvard University’s Kennedy School of Government resulted in a review of the existing recommendations for significant reform.
1998	Waldfoegel, in her book <i>The Future of Child Protection: How to Break the Cycle of Child Abuse and Neglect</i> , suggested that CPS needs a new “differential response” paradigm, with three basic elements: (1) provision of customized response to families; (2) the development of community-based systems of child protection; and (3) the involvement of informal and natural helpers (1998).
2000–2003	U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and the Children’s Bureau initiated the National Study of Child Protective Services Systems and Reform Efforts (Walter R. McDonald & Associates, Inc., 2003), which included a review of state CPS policies, a survey of local CPS practices, and a literature review (Walter R. McDonald & Associates, Inc., 2001).
2003	A follow-up invitational symposium was held to assist the U.S. Department of Health and Human Services in interpreting the implications of the findings of the National Study of Child Protective Services Systems and Reform Efforts for the CPS field.
2004	The Institute of Applied Research published research on Minnesota’s implementation and evaluation of DR, which may have boosted national interest and spread of DR to more states in the past decade (Loman & Siegel, 2004).
2005	The American Humane Association (AHA) and Child Welfare League of America (CWLA) collaborated with programmatic and policy leaders in Minnesota to further define what is meant by the term <i>differential response</i> . This resulted in the identification of the following 7 core elements, ² which states were asked to use in defining the presence of DR in their CPS systems: <ul style="list-style-type: none"> • Use of two or more discrete response pathways for cases that are screened in and accepted; • Establishment of discrete response pathways is formalized in statute, policy, or protocols; • Initial pathway assignment (IR or AR) depends on an array of factors (e.g., presence of imminent danger, level of risk, the number of previous reports, the source of the report, and/or presenting case characteristics such as type of alleged maltreatment and age of the alleged victim); • Initial pathway assignment can change based on new information that alters risk level or safety concerns; • After an assessment, families who receive AR can accept or refuse the offered services if there are no safety concerns; • Families are served in the AR pathway without a formal determination of child maltreatment (no substantiation decision); and • For families served in the AR pathway, no one is named as a perpetrator, and no names are entered into the central registry.

² The language describing the core elements, but not the concepts, was slightly altered for this report.

Year	Event or Activity
2005	The California Evidence-Based Clearinghouse for Child Welfare (2014), using its Scientific Rating scale to evaluate each practice based on the available research evidence, rated “alternative response” as “3. Promising Practice” with a high level of interest for the child welfare field. (In 2009, the scale designation for a “3” was changed to “Promising Research Evidence.”)
2006	AHA and CWLA published the <i>National Study on Differential Response in Child Welfare</i> (Merkel-Holguin, Kaplan, & Kwak, 2006).
2006	AHA held the first annual Conference on Differential Response in Child Welfare in California. Since that time, seven annual conferences have been held, with organization of this event being transferred to The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado Denver, School of Medicine.
2008	U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau released an RFP to fund the National Quality Improvement Center on Differential Response in Child Protective Services. The RFP described DR as follows: Differential response, also referred to as ‘dual track,’ ‘multiple track,’ or ‘alternative response,’ is a service provision approach that allows child protective services to respond differently to various accepted reports of child abuse and neglect. Most often, such a model is designed with two discrete tracks for case intervention. The first track, the ‘investigation track,’ is designed to serve the role of a more traditional child protective services path. In such a model, the focus of the investigatory track is on determining if there is a finding of child abuse or neglect and identifying the responsible party. The alternative, non-investigation track most often consists of a family assessment instead of the traditional forensic investigation and may provide some form of voluntary case management and/or family support/strengthening services. (USDHHS, 2008, p. 6)
2010	Institute of Applied Research released results of another major research study on the implementation of differential response in Ohio (Loman, Filinow, & Siegel, 2010).
2010	In the 2010 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) (CAPTA Reauthorization Act of 2010, P.L. 111-320), statutory changes were made that encourage federal support for state practices intended to access help for at-risk children. Sec. 106 of this new legislation required states to certify that they are operating or enforcing a statewide program that includes differential response as a “triage” for appropriate referrals to a “community organization or voluntary preventive service” for children who are found by CPS not to be at risk of imminent harm. The reauthorization also included a requirement for HHS to provide a clearinghouse on best practices in differential response and options to use funding for research and training.
2014	The QIC-DR cross-site and local evaluations were completed.

The following map, *Differential Response Implementation as of October 2013* (Figure 2.1), shows that implementation of DR is occurring across the majority of states. In general, the rapid expansion of DR has been based on changing values associated with CPS and a limited body of research and evaluative results.

Figure 2.1. Map of Differential Response Implementation as of October 2013



Implementation of DR began in 1998 with Missouri, Florida, and Arizona. Several counties in Louisiana, Virginia, and Texas also implemented in that year. Table 2.2 provides the implementation year for each state, including a few states that implemented more than once. In states/counties that discontinued DR, an end date is provided.

Table 2.2. Chronology of DR Implementation by Year

State	Statewide	Implementation Year	Discontinuation Year
Arizona		1998	2003
Florida		1998 and 2008	1998 and 2008
Louisiana*	X	1998; 2008 (statewide)	-
Missouri*	X	1998	-
Oklahoma*	X	1998	-
Texas (Bexar County)		1998	1999
Virginia *	X	1998; 2003	-
Alaska		1999	2009
Kentucky*	X	2001	-
Minnesota*	X	2001	-
Alabama		2002	-
Maine	X	2003	-
North Carolina*	X	2003	-
Hawaii	X	2006	-
Nevada*		2007	-
Ohio*		2008	-
Massachusetts*		2009	-
New York*		2009	-
Tennessee*	X	2009	-
Wyoming*	X	2009	-
Colorado*		2010	-
Illinois*	X	2010	2012
Vermont*	X	2010	-
Wisconsin*		2011	-
Connecticut	X	2012	-
District of Columbia*	X	2012	-
Arkansas	X	2012	-
Oregon		2013	-
Iowa	X	2014	-
Texas		2014	-
Washington*		2014	-

* Indicates state reports on DR to NCANDS. Georgia and South Carolina report on DR to NCANDS. Their models do not adhere to the core elements of this project, so they are not included on this list.

CREATING THE QIC-DR'S RESEARCH FOCUS

The comprehensive needs assessment process that occurred in Year 1 resulted in the development of considerable knowledge about DR-organized CPS systems. In turn, multiple products were created and disseminated through electronic channels, and the knowledge was synthesized to guide the development of the core research questions for the QIC-DR. The comprehensive needs assessment was designed to include two types of activities. First, document-based reviews included a comprehensive literature review on DR, an analysis of Child and Family Services Review (CFSR) reports, a review of legal and constitutional matters, and an analysis of state legislation. Second, various activities were conducted to collect additional data and perspectives, including four information summits on specific topics, eight focus groups, two listening sessions, dozens of interviews, a web-based survey to state administrators, and sessions with the National Advisory Committee (NAC) of the project. The diverse group of participants identified valuable gaps in knowledge, unresolved questions, and emerging dilemmas.

Table 2.3 showcases some of these research gaps and prospective research areas that were considered for study by the QIC-DR. A full list was generated to enable the evaluation team to select its foci.

Table 2.3. Matrix of Research Gaps and Prospective Research Areas

Outcome Domains	Agency Structure/Model	Practice	Services
Child	What is the effect of a finding or substantiation of maltreatment on child safety?	Is child safety compromised in the implementation of a DR-organized CPS system?	Are rates of removal lower for children in families served by the AR pathway?
Family	Does engagement of families in DR-organized CPS systems result in better child and family outcomes?	Do families assigned to the AR pathway receive more face-to-face contacts with the caseworker?	Do families assigned to the AR pathway receive services sooner than families assigned to the IR pathway?
Worker	Is caseworker satisfaction different in AR and IR pathways?	Are caseworkers' skills and competencies different in the AR and IR pathways? If so, in what ways?	Does service availability and provision impact worker morale?
DR System	What are the structural changes that an agency should make in the implementation of DR?	How are the pathways similar or different in practice approach and execution?	To what extent does the availability of services impact outcomes?
Funding/Cost	What are the sources and levels of funding to implement DR?	In order to implement DR, do caseloads have to be smaller in the AR pathway than the IR pathway? If so, what are the resource implications?	Is there a need for new, additional service dollars in the AR and IR pathways? Can reallocation of service resources sufficiently address the service needs of AR and IR families?
Agency	What are the impacts of implementation of DR on the CPS agency?	What are the skills and competencies required of AR caseworkers and how do they compare with the skills and competencies of the IR caseworkers?	Does DR change the array of services offered to families by the agency?
Community	Is there greater community involvement in the protection of children who receive AR?	What are the practice changes based on the new role of community partners?	Do AR families receive more services from community-based agencies than IR families?

The QIC-DR grant, which funded three local evaluations and a cross-site evaluation, yields insights about the impact of DR. When this project commenced, research knowledge on DR was in its infancy. With the addition of this research, there are now seven studies that involve random assignment. While this body of research fills some of these gaps, additional areas of inquiry have also been unearthed. Undoubtedly, research related to DR outcomes, as well as information on DR

processes associated with the child, family, worker, agency, or community, will continue to benefit from further study.

QIC-DR's Research Focus

Promising evidence-based interventions are ones that have been sufficiently evaluated with significant and positive evidence of efficacy (Centers for Disease Control and Prevention, 2009). Based on the comprehensive needs assessment, it was clear to the QIC-DR team that the design would need to be constructed to research multiple aspects of DR implementation. DR is a relatively new system reform, and is therefore replete with continuously emerging knowledge gaps.

As described more fully in the methodology chapter below, the QIC-DR dedicated 9 months to a needs assessment and the identification of knowledge gaps. Using a framework of comparing families who were eligible to receive AR, but were randomly assigned to either AR or IR, the following core research questions were adopted:

- 1) Are children in AR families as safe as or safer than children in IR families?
- 2) How is the AR pathway different from the IR pathway in terms of family engagement, caseworker practice, and services provided?
- 3) What are the costs for child protection agencies that implement DR?

Research Question 1: Safety

Are children in AR families as safe as or safer than children in IR families?

Most would agree that the foundation of CPS, and the first goal of any CPS response, is to keep children safe from child abuse and neglect (Child Welfare League of America, 1999) and to prevent further child abuse and neglect. Still, definitions of what constitutes harm and when and how systems should respond differ between and even within states (Fluke et al., 2001; Tumlin & Geen, 2000; Wells, Fluke, & Brown, 1995). Some communities and professions have opinions that certain types of cases (e.g., minor neglect, lack of supervision, truancy, runaways) do not require an investigation and perhaps would be better served by a different public or private nonprofit agency.

Given the mandate of child protection, public concerns about the potential for compromised child safety associated with serving families through AR must be addressed. Although Loman and Siegel (2004; 2013) found that the overall safety of children is not compromised by the use of AR, and that children were not at any greater risk for subsequent reports of child abuse and neglect than children who received IR, child safety was a foundational research topic for the QIC-DR, given the different types of participating sites.

Research Question 2: Differences Between the AR and IR Pathways

How is the AR pathway different from the IR pathway in terms of family engagement, caseworker practice, and services provided?

Across all stakeholders who participated in the comprehensive needs assessment, increased knowledge about the practices that are part of serving families in the AR and IR pathways was a

high priority. Some of the most interesting inquiries from the information-gathering processes stemmed from the variability in DR implementation. The project team determined that the most meaningful way to address this knowledge gap would be to examine AR in contrast to IR. In addition to the focus on child safety and cost, the basic questions related to the two pathways were:

- 1) How do the styles and skills of caseworkers differ between the AR and IR pathways?
- 2) Do AR parents feel more engaged and more satisfied than IR parents?
- 3) Do AR families receive more services and more appropriate services than IR families?
- 4) Are relationships between caseworkers and parents different in the AR pathway than they are in the IR pathway?

Research Question 3: Cost

What are the costs for child protection agencies that implement DR?

The most exploratory of the research questions, the issue of cost of implementing DR, was selected as the third research topic. Costs are always a concern in social welfare programs, while the commitment to address the needs of vulnerable children and their families is an overriding objective and context for financial discussions. Any system change will need to address two questions: “How much will it cost?” and “Where will the money come from?” Of course, there is a variety of additional questions, such as those centered on the effectiveness and benefits of the investment. Concerns about cost and funding were frequently mentioned by both key informants and summit participants. These concerns also preoccupied many public officials (legislators) and child welfare administrators, as well as the QIC-DR National Advisory Committee (NAC). One NAC committee member emphasized the insufficiency of funding and questioned how funding could be structured for a collaborative model relying on community-based service providers. The need for flexible funding, giving agencies more authority over how resources are spent, was also mentioned. While some jurisdictions that piloted DR received supplemental funding, there was also an interest in evaluating the outcomes of the approach when there was no infusion of extra dollars.

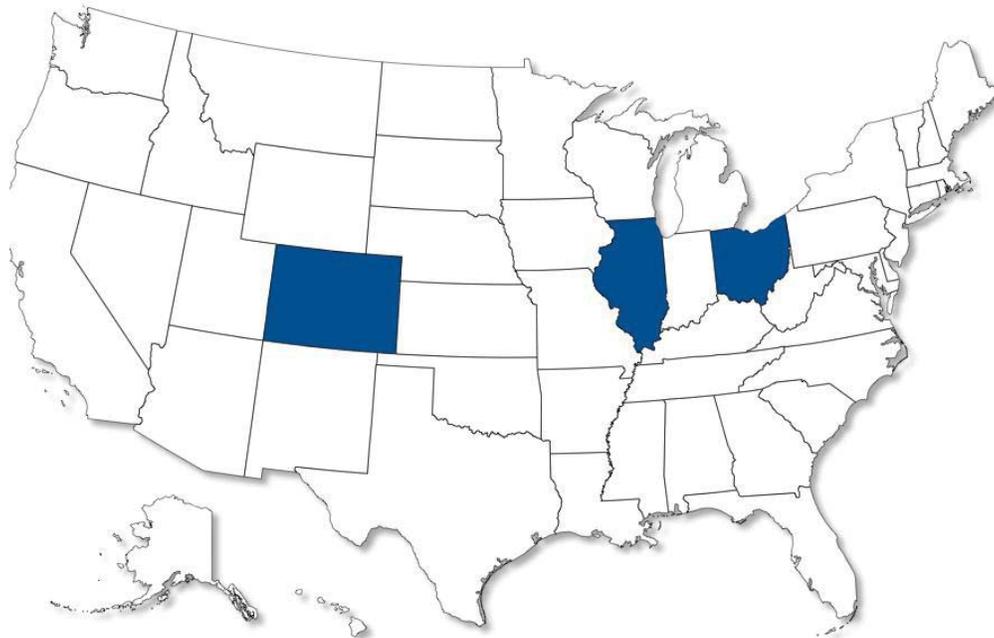
The next chapter provides the reader with the specifics of each site’s DR implementation, set within a national context.

Chapter 3. QIC-DR R&D Sites in a National Context

As mentioned above, projects in Colorado, Illinois, and Ohio were selected as the three research and demonstration (R&D) sites. These three sites were selected through a competitive application process, based on their quality applications, evaluation plans, and oral presentations by the QIC-DR National Advisory Committee and QIC-DR staff. In order to be eligible for the award, the sites had to adhere to certain project requirements and standards.

The first requirement was to implement or expand upon existing implementation of a DR model that adhered to a set of core elements. The core elements for the AR pathway were described in Chapter 2. The second main requirement was to conduct a local evaluation and participate in the cross-site evaluation, which included an AR-IR comparison study of outcomes, a process study, and a cost study. This chapter describes the QIC-DR sites. Figure 3.1 depicts the locations of the QIC-DR's R&D sites.

Figure 3.1. QIC-DR Research & Demonstration Sites



DESCRIPTION OF DR BY SITE

Table 3.1 outlines the characteristics of the three sites. Each site demonstrates unique features of DR implementation, including CPS system design, system reforms predating and coexistent with DR, and project scope.

Table 3.1. QIC-DR Site Characteristics

Category	Colorado	Illinois	Ohio
Child welfare structure	County administered, State supervised	State administered	County administered, State supervised
Previous implementation of DR in the State	No	No	Round 1 (10-county DR implementation starting in 2008) Round 2 was the QIC-DR Ohio site, with Clark County in both Rounds 1 and 2
Scope of implementation as part of QIC-DR	5 counties	Statewide	6 counties
AR staff	AR caseworker; varied between counties as to whether AR caseworkers carried mixed caseloads or only AR cases	Team of public AR caseworker and private Strengthening and Supporting Families (SSF) worker	AR caseworker; varied between counties as to whether AR caseworkers carried mixed caseloads or only AR cases
Safety and risk assessment tools used for IR and AR	Colorado Assessment Continuum	CERAP (Child Endangerment Risk Assessment Protocol)	Comprehensive Assessment and Planning Model – Interim System (CAPMIS) Safety Assessment and CAPMIS Family Assessment
Maximum days cases can be open	AR: 60 days for assessment, can be transferred to post-assessment services that can extend beyond that time IR: 30 days plus the option for unlimited, supervisor-approved 30-day extensions related to completion of paperwork or assessment needs, transferred to ongoing service delivery if needed	AR: 90 days with up to three 30-day extensions allowed IR: 60 days with extensions allowed	AR: No maximum; officially transfers to post-assessment phase at 45 days but most often same worker continues to work with family IR: 30 days with 15-day extension allowed, then transferred if services are needed

Colorado

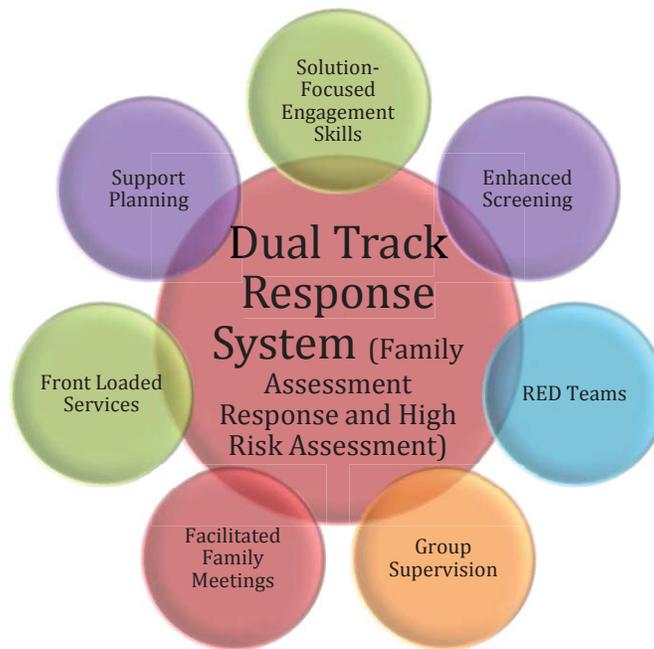
Colorado is a county-administered, state-supervised child welfare system. Counties have flexibility in how they conduct CPS, with the exception of those areas covered by statute and rule. As a result, practices can vary across counties.

The five Colorado counties that together made up the Colorado Consortium on Differential Response (CCDR) were Arapahoe, Fremont, Garfield, Jefferson, and Larimer. The counties ranged in population from 46,824 in Fremont to 572,003 in Arapahoe (U.S. Census, 2010). The rate of screened-in reports in 2012 ranged from 31.6 percent in Larimer to 52.9 percent in Garfield (Colorado Department of Human Services Division of Child Welfare Services, 2012).

The CCDR was led by a dedicated project director, a core group of administrators from each of the five counties, and committed community stakeholders from the local communities. The Social Work Research Center at Colorado State University was selected as the local evaluator, in partnership with Westat. Since DR had not previously been implemented in the State, the CCDR was responsible for the development and design of DR, as well as recommending modifications to the Statewide Automated Child Welfare Information System (SACWIS), known as Colorado Trails.

While allowing for some flexibility, the five counties agreed to implement a model of DR that shared several elements beyond the core elements required by the QIC-DR (Figure 3.2). This model emphasized consistency in the dual track system, meaning that, whether IR or AR, these elements existed.

Figure 3.2. Colorado’s Dual Track Response System Model



Source: Colorado Differential Response Model, 2011

The first shared characteristic among counties was to enhance screening by asking different questions to collect more information from reporters about each incident. Questions focused on protective factors and child vulnerability. A group decision-making model (RED teams) was implemented at the point of screening to decide pathway eligibility to AR or IR, as long as it was not considered a report that required an immediate response (such as concern for child safety). Other elements included a focus on providing services early in the case, support planning with the family to identify friends and relatives who could help, solution-focused engagement skills, group supervision, and facilitated family meetings such as family group conferences and family team meetings. The implementation of this expanded model occurred in both the AR and IR pathways, although implementation at the local level was an ongoing process during the evaluation period. Contextual information regarding these changes and their impact on the process study has been explored in the *Colorado Year 1 Site Visit Final Report (2012)*, accessible online at www.differentialresponseqic.org.

DR in Colorado was largely modeled after Olmsted County, Minnesota. Minnesota is also a county-administered system with variability in local practices. In Colorado, AR caseworkers were selected from existing staff. Each county had its own process for selecting the AR caseworkers. AR caseworkers were volunteers in some counties, while in others they were selected based upon their applications and interviews. While all staff attended a core training provided by the State, caseworkers all possessed different backgrounds, experience levels, and skills.

In larger counties, caseworkers only carried AR cases or IR cases. In some of the smaller counties, AR caseworkers would at times carry both AR and IR cases. IR caseworkers more often carried only IR cases.

Colorado had a moderate threshold for AR eligibility across the five counties, with variation among the counties. The Colorado Department of Human Services Agency Response Guide (2010) instructs that “track assignment [is] 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” (p. 20). Any allegations of serious harm, sexual abuse, suspicious child fatality or homicide, or institutional abuse were required to be referred to IR. In each of the counties, additional discretionary reasons for referring only to IR were also available:

- Currently open IR
- Frequent, similar, and/or recent referrals
- Violent activities in the household
- Caregiver declined services in past
- Caregiver unwilling/unable to achieve child safety
- Past safety concerns were not resolved
- Previous serious child harm offenses
- Credible reporting party alleges high safety concern
- High child vulnerability (i.e., young age or cognitive delay)
- Substance abuse not manageable through AR
- Domestic violence not manageable through AR
- Court-ordered investigation

- Insufficient information to assess for AR eligibility
- Other

In Colorado, the AR and IR pathways became increasingly similar over the course of DR implementation. After a report was screened in, the RED team made a determination as to whether the report was eligible for AR. Eligibility for AR would be decided using the Agency Response Guide developed by the CCDR. The CCDR also made a response time decision, choosing from three options: immediate (within the same day of the report), end of third calendar day, or within 5 working days. The report was assigned to either an IR or AR caseworker who must see the adult and child subject(s) within the response time. If the response time guidance allowed, caseworkers attempted to reach the caregivers by phone to set up an initial meeting. Coordination with law enforcement was also possible for both AR and IR cases.

The same safety and risk assessment was completed in both tracks within 30 days. A safety plan could be completed in both tracks, if necessary. The caseworker also assessed family needs and strengths. If safety was not a concern, services for AR families were voluntary. At that point, if services were not needed, a framework documenting strengths and needs was completed and the child protection team reviewed the decision to close the case. If services were needed, a Family Assessment Response Service Plan was completed. This tool was unique to AR and was considered to be a more flexible tool that families could complete with their caseworkers. A Family Support Plan also had to be completed for any case remaining open longer than 60 days; it was designed to establish an ongoing plan of support for the family after case closure. If lengthy AR services were needed, the AR caseworker attempted to keep the case until it closed, but if a case continued for a long period of time, many counties initiated policies to transfer the case to an ongoing caseworker.

In March 2012, DR expansion legislation was signed into law in Colorado to allow additional counties to implement DR. It is expected that the experiences of the five participating counties and the findings from the Colorado evaluation report will inform the expansion.

Illinois

Illinois CPS is a centralized, state-run system with six administrative regions, three within heavily populated Cook County and three covering the remainder of the state. Outside of Cook County, the regions are urban, rural, or a mixture of both, with the southern region predominantly rural except for East St. Louis. The responsible agency, the Department of Children and Family Services (DCFS), is over 95 percent unionized and has a long history of working in partnership with private agencies for the delivery of services to families.

Over 12.8 million people live in Illinois (U.S. Census, 2010). In fiscal year 2011, the system fielded over a quarter of a million hotline calls and responded to a little over one quarter of these reports (U.S. Department of Health and Human Services [USDHHS], 2012). In fiscal year 2012, 26 percent of child maltreatment reports were indicated, and half of those families were provided services (Illinois Department of Children and Family Services [DCFS], 2012).

Following legislative approval for a 5-year pilot and evaluation of DR, the model was designed by a committee of stakeholders that provided recommendations to the DCFS director. A project director was assigned to the QIC-DR who worked with the local evaluator, Children and Family Research Center, University of Illinois at Urbana-Champaign.

Based on a Memorandum of Understanding (MOU) negotiated between DCFS and the union, the AR caseworkers and supervisors were selected from employees who applied; seniority was the main determinant for acceptance into these temporary positions. AR staff members were only allowed to work on AR cases. The Strengthening and Supporting Families (SSF) workers and supervisors were selected by the 14 private agencies with which DCFS contracted. These workers had to be certified to use the CERAP safety assessment protocol. The SSF workers only carried AR cases and had a maximum of 12 cases. The SSF and AR caseworkers were required to attend a 4-week training on AR. SSF workers received an additional week of online training.

DR in Illinois had many more eligibility restrictions than the other two sites. The eligibility threshold in Illinois was the lowest that was consistently applied among the three sites. Pathway assignment was determined using information provided by the central hotline. Eligibility for AR included:

- Identifying information for the family members and their current address(es) were known at the time of the report;
- Caretakers were birth or adoptive parents, legal guardians, or responsible relatives;
- The family had no prior indicated reports of abuse and/or neglect;
- The children were not in the care and custody of the Department or wards of the court at the time of the report;
- Protective custody had not been previously taken; and
- Current allegations included any combination of the following:
 - Mental and emotional impairment (neglect only), inadequate supervision, inadequate food, inadequate shelter, inadequate clothing, medical neglect, and environmental neglect. The following circumstances involving the allegations of mental and emotional impairment, inadequate supervision, and medical neglect prohibited the report from being assigned to AR.
 - Mental and emotional impairment reports accepted as abuse were ineligible for AR.
 - Inadequate supervision reports involving a child or children under the age of 8, or a child older than 8 years of age with a physical or mental disability that limited his or her skills in the areas of communication, self-care, self-direction, and safety were ineligible for AR.
 - Medical neglect reports that involved a child with a severe medical condition that could become serious enough to cause long-term harm to the child if untreated were ineligible for AR.
 - An additional neglect allegation (substantial risk of physical injuries/environment injurious to health and welfare) was added to the list of AR-eligible maltreatment allegations in July 2011 (Fuller, Kearney, & Lyons, 2012).

Of note in the eligibility criteria is the automatic exclusion of any reports that involved caregivers or children with any prior CPS exposure. If a subsequent report was made on the family after the case was already in AR, the case would have to be rerouted to an investigation. The same was true if any safety issues arose during the AR case.

For AR cases, Illinois implemented a paired-casework approach between a public AR caseworker and a private SSF worker. The public AR caseworker initiated contact with the family members by calling them within 24 hours of case assignment to explain AR and schedule a time for an initial visit within 3 business days between the adult and child subject(s) of the report and the AR and SSF caseworkers. An unannounced home visit was allowed if attempts at telephone contact were unsuccessful. During this initial visit, the AR caseworker was responsible for completing the CERAP safety assessment. If a safety concern was present, the case was reassigned to an investigation. If there were no child safety concerns, the family could voluntarily agree to work with the SSF caseworker. At this point, the AR caseworker's role was complete, and the AR worker passed the case over to the SSF worker.

The SSF worker completed a family assessment as part of the voluntary family enhancement plan. The SSF worker was considered to be a coach, advocate, and broker of services. The SSF worker might help with connecting the caregivers to local food banks, assist them in the development of a resume, teach them about appropriate hygiene or cleaning methods, connect them with resources at school for the child, or transport them to a service provider. Cash assistance, up to \$400, was available for families to meet basic needs. The SSF worker visited the family in the home twice a week unless the family requested fewer contacts. Cases were permitted to stay open for 90 days with the possibility of three 30-day extensions.

In comparison, IR cases in Illinois were conducted by DCFS Child Protection Specialists or investigators. These caseworkers did not carry a mixed caseload and received no more than 12 new investigations per month during 9 months of the year and no more than 15 during the other 3 months of the year. Upon receipt of a new report from the hotline, the investigator checked for prior CPS involvement and contacted the reporter to confirm and gather more information. The investigator initiated a case by making an unannounced in-person contact with the alleged child victim within 24 hours, unless there was an allegation of immediate harm. An interview was conducted with every alleged victim in the household without the alleged perpetrator or other adult members present. Investigators might also have talked with collateral sources and photographed child injuries or the environment with parental consent.

The CERAP safety assessment was completed within 24 hours after interviewing the alleged child victim. Within 60 days, the investigator and supervisor made a determination regarding maltreatment. If warranted, 30-day extensions could be granted. A report was either unfounded or indicated. If indicated, the investigator completed a risk assessment prior to closure or transfer to ongoing services, and the names of the perpetrators were placed on the central registry. Referral to services could be made during or at the conclusion of the investigation.

In June 2012, Illinois DCFS underwent a major budget crisis. Along with several other adjustments, ongoing funding for AR was cut from the budget following the completion of the QIC-DR study period.

Ohio

Ohio is also a county-administered, state-supervised child welfare system. The R&D site in Ohio included six counties: Champaign, Clark, Madison, Montgomery, Richland, and Summit. The consortium was collectively called SOAR, Six Ohio Counties Implementing Alternative Response. The counties ranged in population from 40,097 to 541,781 (U.S. Census, 2010). SOAR was a mix of large metro counties and smaller rural counties. The average rate of screened-in reports in 2011 was 53.3 percent statewide, although this percentage varies in each county (USDHHS, 2012).

In 2008, 10 counties in Ohio implemented DR as part of a pilot project that was evaluated by the Institute of Applied Research. Clark County was part of the pilot project, and thus was the only SOAR county that had prior experience with DR. The State considered the SOAR counties to be its second round of implementation, with a planned phased roll-out to all counties owing in part to the positive results of the pilot evaluation. As a result, SOAR counties implemented DR within the context of an existing state-level infrastructure to support DR, including access to the experience and expertise of the original 10 counties. In Ohio, most of the state-level activities required to implement DR had already been accomplished in establishing the initial 10-county pilot project launched in 2008. The SOAR Consortium, comprised of administrators and supervisors from each of the six counties, focused on training and learning opportunities, joint problem-solving, and the coordination of efforts for the evaluation.

The SOAR counties all attempted to have their AR caseworkers carry only AR cases, although for two of the small rural counties, some caseworkers had to carry both AR and IR cases on a regular basis. Caseworkers for both AR and IR had varying levels of education and experience. Staffing requirements varied, with some jurisdictions requiring bachelor's or master's degrees in social work. Selection of AR caseworkers was done through an interview process of existing staff in Summit County. In Montgomery County, an ongoing unit was switched over to AR.

Differences between IR and AR procedures and practice varied across the six counties. Reports were made to the hotline and each county had a different threshold for accepting reports of maltreatment. The screening process was mostly consistent across counties, with a few minor differences in screening questions, staffing structure, and decision-making authority. Pathway assignment occurred after a report was accepted for a CPS response. Reports were found to be eligible for AR based on criteria set by legislation and departmental rule, and also by considering individual county guidelines. The following types of allegations and case characteristics were not eligible for AR:

- Allegation of serious harm to child
- Allegation of sexual abuse
- Suspicious child fatality or homicide
- Need for specialized or third-party assessment
- Current open investigation response or ongoing case
- Requested or received court-ordered custody or protective supervision order

Anything not on this list was technically eligible for AR, though a discretionary exclusion list was also used during the pathway assignment process:

- Frequent, similar, or recent past reports
- Past custody by Public Children Service Agency
- Two or more children under the age of 5 years
- Past substantiated or indicated child abuse and neglect
- Parent/legal guardian has declined contact in the past
- Previous child harm offenses charged against the alleged perpetrator
- Past maltreatment concerns not resolved at previous closing
- Worker hazards that require law enforcement contacts with family
- Reported intimate partner violence
- Positive toxicology at birth
- Current open AR or ongoing AR case

Counties varied in their use of the discretionary items to assign or not assign to AR. If a case was not assigned to be eligible for AR, an explanation was required in SACWIS.

Once a case was assigned to AR or IR, it had to be initiated within 24 hours, unless it was considered an emergency case, under which circumstance it would be initiated within 1 hour.

- Initiation in IR was defined by contact with the reporter or collateral source with knowledge of the child's safety through telephone or face-to-face contact with the alleged victim. The caseworker must attempt face-to-face contact with the child within 72 hours.
- In AR, the definition of initiation was expanded to allow the caseworker to initiate via letter, though this was rarely used. Telephone initiation was encouraged.
- The same safety assessment was used in both tracks and had to be completed and approved in SACWIS within 4 days for IR and 7 days for AR. Services could be provided any time after the completion of the safety assessment in both tracks. Extra funds were available for AR cases to assist with hard services such as rent, automobile or home repairs, etc. Some counties chose to make those funds available to all cases.
- A family assessment was also completed on all cases. In AR, caseworkers had 45 days, and, in IR, caseworkers had 30 days. At this point, if an IR case had a disposition requiring continued service provision, the case moved to an ongoing caseworker who completed a case plan with the family within 30 days. In AR, if services continued, a family service plan was created with the family.

Summary

The three selected sites for this project provide a unique opportunity to evaluate various models of DR within differing contexts and communities in the United States. Illinois provides the greatest difference due to the unique model implemented across an entire state, use of a privatized system. Colorado implemented numerous changes to its child welfare system while implementing DR

across five very different counties committed to a core set of practice changes. Ohio's project provides the unique opportunity to compare findings from a previous study of DR in a very independent, county-driven system. The next section provides the reader with additional context about CPS in each of these sites.

ADDITIONAL CONTEXT

The national data from 2011³ are provided in terms of referrals screened in for a CPS response, percentages and rates of screened-in referrals, distribution of professional and nonprofessional report sources, and the age, sex, and race of children accepted for a CPS response in the three sites. Since the Colorado and Ohio studies implemented DR in only a sample of counties, the statewide statistics will not reflect their specific counties, but will provide a context for the future implementation of DR statewide.

Screening of Referrals

The CPS flow of cases begins with referrals that are determined to be screened in or screened out. National statistics provide a perspective on the patterns of screening. Based on reporting to the National Child Abuse and Neglect Data System (NCANDS), in 2011, 60.8 percent of reports were screened into CPS, and 39.2 percent were screened out among states that screen out reports. While some states do not screen out any referrals alleging maltreatment, for those that do, the percentage of referrals screened in ranged from a low of 24.4 percent to a high of 98.6 percent. Correspondingly, the percentage of screened-out referrals ranged from 1.4 percent to 75.6 percent (USDHHS, 2012).

Table 3.2 shows the 2011 referral rates of the three states that participated in the cross-site evaluation. Data on the specific counties in Colorado and Ohio participating in the study were not available. The referral rates for Colorado and Ohio were more than double the referral rate in Illinois.⁴

State	Child Population	Total Referrals	Rate of Referrals per 1,000 Children in the Population
Colorado	1,230,088	70,747	57.5
Illinois	3,098,125	63,065	20.4
Ohio	2,693,092	151,732	56.3
<i>National Estimate</i>	74,810,766	3,426,000	45.8

Source: USDHHS, 2012

³ 2011 data were selected for discussion because the sites were operational in 2011.

⁴ The past tense is used throughout this chapter. The period refers to FFY 2011 and the period of the study.

Table 3.3 shows the number of referrals that were screened in, the percentage of all screened-in referrals, and the rate of screened-in referrals per 1,000 children in each state. Illinois accepts all referrals related to child abuse and neglect. The rate of screened-in referrals was 20.5 per 1,000 children to 30.0 per 1,000 children. Table 3.3 shows that the implementation of screening processes in Colorado and Ohio resulted in comparable rates of children who received a CPS response.

Table 3.3. Screened-In Referrals, 2011

State	Child Population	# of Screened-In Referrals	% of All Referrals Screened In	Rate of Screened-In Referrals per 1,000 Children in the Population
Colorado	1,230,088	31,603	44.7%	25.8
Illinois	3,098,125	63,065	100.0%	20.5
Ohio	2,693,092	80,875	53.3%	30.0
<i>National Estimate</i>	74,810,766	2,047,000	59.7%	27.4

Source: USDHHS, 2012

Table 3.4 presents data on the unique counts of screened-in children. In this table, a child is counted only once regardless of how many times the child has been referred during the reporting period. Since a given referral may include more than one child, rates of screened-in children are higher than rates of screened-in referrals. Rates were comparable among the three states, but the rate of CPS involvement with children was lowest in Colorado, with Illinois higher than Colorado by approximately 3 children per 1,000 in the population, and Ohio higher than Colorado by approximately 4 children per 1,000. All three states had rates lower than the national rate.⁵

⁵ This study could not determine if the difference in the rate of children who received a CPS response is a function of the demographics of family size in each state or a result of state CPS response policy, which may require all children in a family to be included in the CPS response.

Table 3.4. Screened-In Children, 2011

State	Population	Screened-In Children (unique)	Rate of Screened-In Children per 1,000 Children in the Population (unique)
Colorado	1,230,088	42,099	34.3
Illinois	3,098,125	114,849	37.1
Ohio	2,693,092	103,554	38.5
51 States ⁶	73,921,000	3,049,871	41.3

Source: NCANDS, 2013⁷

Report Sources

The client population of CPS is based on referrals to the state or local public agency, which will then identify potential issues of child abuse and neglect. These referrals are made by professionals, such as social workers, law enforcement personnel, school teachers, and others who come in contact with children in their professional roles, as well as nonprofessionals such as neighbors, relatives, and others.

In 2011, the national distribution of screened-in referral sources was 57.5 percent professionals, 18.2 percent nonprofessionals (e.g., other relatives, parents, friends, and neighbors), and 24.3 percent unclassified, encompassing anonymous, other, and unknown sources. Among professionals, educational and law enforcement personnel accounted for large percentages, followed by social services and medical personnel.

Table 3.5 shows the percentage distributions for the three sites and the nation based on data from 51 states. In Illinois, nearly three quarters of screened-in referrals came from professionals, while in Colorado and Ohio professionals accounted for 67.9 and 58.9 percent, respectively. The following points are noteworthy insights into the table data:

- Consistent with national patterns, in all three study states, law enforcement and educational personnel accounted for the largest percentages of professional reporters. Law enforcement personnel accounted for 24.3 percent, 23.2 percent, and 18.0 percent in Colorado, Illinois, and Ohio, respectively. Educational personnel accounted for 18.2 percent, 22.2 percent, and 12.5 percent in Colorado, Illinois, and Ohio, respectively.
- Patterns varied in terms of reporting by medical and social services personnel. In Colorado, only 5.7 percent of screened-in reports were made by social services personnel, compared to 12.2 percent in Illinois, 17.1 percent in Ohio, and 10.5 percent nationally. In Ohio, only

⁶ The 51 States include the 50 United States and the District of Columbia.

⁷ Data received by the Children's Bureau for FFY 2011, which were not analyzed in the annual *Child Maltreatment* report, but which were analyzed for this study, are cited as NCANDS, 2013.

5.7 percent of screened-in reports were made by medical personnel, compared to 10.4 percent in Colorado, 13.3 percent in Illinois, and 8.2 percent nationally.

In Ohio, nonprofessionals accounted for more than one fifth of screened-in referrals (22.5 percent), while in Colorado and Illinois nonprofessionals accounted for 19.2 percent and 14.4 percent, respectively (NCANDS, 2013).

Prior child welfare research has indicated that substantiation decisions are related to the report source (Wells et al., 1995), and additional research will be needed to determine if the report source impacts the pool of cases determined eligible for AR.

Table 3.5. Screened-In Referral Sources, 2011

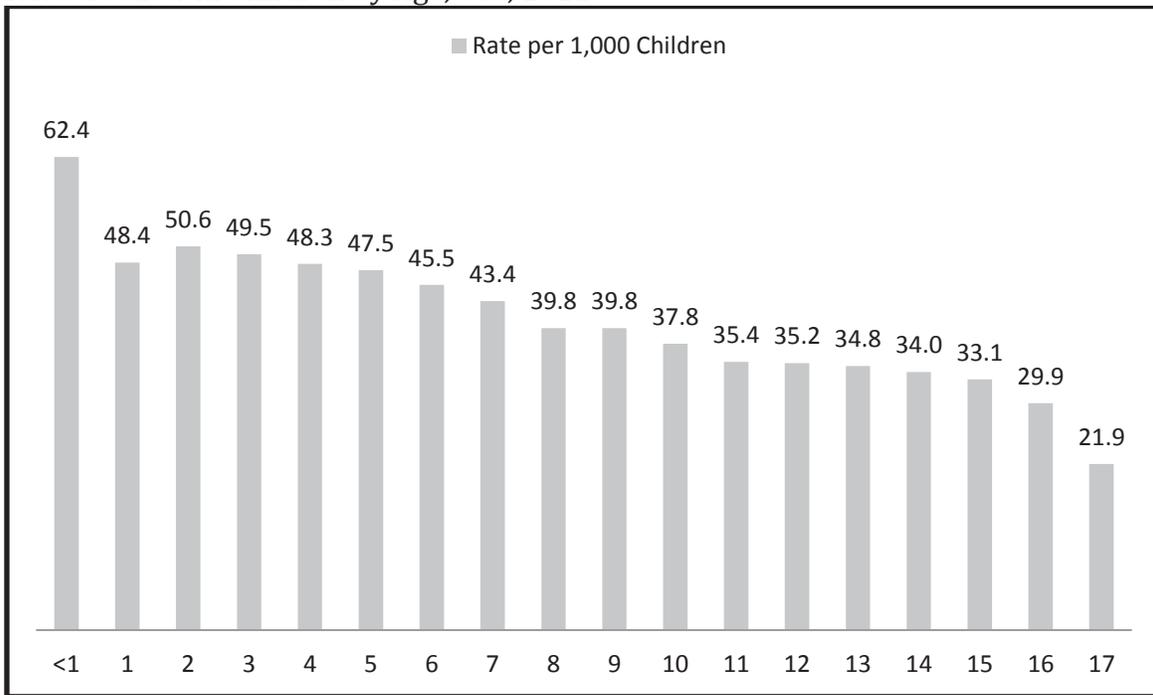
State	Colorado	Illinois	Ohio	51 States
Professional	67.9%	74.0%	58.9%	57.5%
Nonprofessional	19.2%	14.4%	22.5%	18.3%
Unclassified	12.9%	11.6%	18.6%	24.1%

Source: NCANDS, 2013

Ages of Screened-In Children

For 2011, national data indicate that very young children had the highest rates of being screened in for a CPS response. Figure 3.3 shows that children younger than 1 year old were accepted for a CPS response at a rate of 62.4 per 1,000 children. This rate decreased gradually over early, mid, and late childhood. The rate for 17-year-old youths was the lowest at 21.9 per 1,000 children.

Figure 3.3. Screened-In Children by Age, U.S., 2011



Source: NCANDS, 2013

Table 3.6 compares the rates for children younger than 1 year old through 21 years old for Colorado, Illinois, and Ohio. The rates discussed below are for the entire state and therefore may not reflect the rates of the Colorado and Ohio counties that participated in the study. In all three sites, children younger than 1 year of age had the highest screened-in rates. With the exception of the children younger than 1 year of age, Colorado had the lowest rates among the sites. Percentage distributions by age were very similar across all three sites. In each state, children younger than 1 year old accounted for the highest percentage of children who were screened in.

Table 3.6. Ages of Screened-In Children, 2011
(Rate per 1,000 Children in the Population and Percent Distribution by Age)

Age (in years)	Colorado		Illinois		Ohio		51 States	
	Rate	Percent	Rate	Percent	Rate	Percent	Rate	Percent
<1	57.1	8.8	54.2	7.7	69.3	9.1	61.7	8.1
1	41.1	6.5	44.2	6.2	49.4	6.6	47.9	6.3
2	43.1	6.9	44.8	6.4	50.4	6.9	50.0	6.6
3	40.7	6.7	45.6	6.7	49.6	6.9	49.0	6.7
4-7	40.4	27.2	42.1	25.0	43.5	24.7	45.6	24.8
8-11	32.0	21.2	36.1	21.7	33.5	19.6	38.1	20.8
12-15	26.6	16.7	30.7	18.7	29.2	17.4	33.9	18.6
16-17	16.7	5.3	22.6	7.2	22.4	6.9	25.6	7.3
Unknown & 18-21		0.7		0.4		1.9		0.9
Total	34.3	100.0	37.1	100.0	38.5	100.0	40.8	100.0
Mean	7.08	4.92	7.54	5.05	7.25	5.13	7.51	5.10

Source: NCANDS, 2013

Gender of Screened-In Children

The national rate of reporting of boys and girls was 40.0 and 42.0, respectively, per 1,000 children of the same gender in the population. The rate of boys ranged from 6.9 to 125.0 and the rates of girls from 8.5 to 125.0 per 1,000 children. In all three study states, the rate of screened-in girls was slightly higher than the rate of screened-in boys.

Table 3.7. Gender of Screened-In Children, 2011
(Rate per 1,000 Children of the Same Gender)

State	Colorado	Illinois	Ohio	51 States
Boys	33.7	35.6	36.5	40
Girls	34.8	37.8	39.6	42

Source: NCANDS, 2013

Race and Ethnicity

Nationally, African American children had the highest screened-in rates. Among the three study states, the rates of screened-in African American children were the highest compared to other races and ethnicities in Colorado and Ohio, and second highest in Illinois. These rates may be influenced by missing data and the use of the category of *multiple race*. Percentages of children

with missing race and ethnicity data were 19.5 percent, 3.7 percent, and 27.0 percent in Colorado, Illinois, and Ohio, respectively.

**Table 3.8. Race and Ethnicity of Screened-In Children, 2011
(Rate per 1,000 Children of the Same Race or Ethnicity in the Population)**

	Colorado	Illinois	Ohio	49 States
African American	56.8	75.8	57.7	64.2
American Indian/Alaska Native	24.1	24.6	10.9	44.2
Asian	7.2	7.4	3.7	8.4
Hispanic	32.5	17.7	23.3	36.9
Pacific Islander	41.9	112.3	24.2	37.2
White	24.2	35.8	23.1	35.7
Multiple Race	23.1		30.9	36.9

Source: NCANDS, 2013

Table 3.9a and Table 3.9b present the data on race and ethnicity in terms of percentages of all children served by CPS. The underreporting of data on race and ethnicity results in incomplete pictures of the race and ethnicity of screened-in children. The existing data indicate that Colorado had the highest percentage of Hispanic children served by CPS, and Illinois had the highest percentage of African American children (including both Hispanic and non-Hispanic African American children) served by CPS. In all three states, White children (including both Hispanic and non-Hispanic White children) were the largest percentage of children served.

Table 3.9a. Race of Screened-In Children, 2011

	Colorado	Illinois	Ohio	49 States
African American	7.3%	33.4%	22.1%	22.1%
American Indian/Alaska Native	.6%	.1%	.1%	1.1%
Asian	2.9%	.9%	.2%	1.0%
Pacific Islander	.2%	.1%	0.0%	.2%
White	65.6%	59.6%	46.7%	55.2%
Multiple Race	3.5%	0.0%	3.6%	3.7%
Unknown	22.3%	5.9%	27.3%	16.8%

Source: NCANDS, 2013

State	Colorado	Illinois	Ohio	50 States
Hispanic	29.3%	11.3%	3.1%	20.8%
Not Hispanic	46.9%	47.7%	47.6%	59.4%
Unknown	23.8%	41.0%	49.3%	19.8%

Source: NCANDS, 2013

Allegations of Maltreatment of Screened-In Children

In all three states, neglect was the most frequent allegation. The percentage of children with allegations of neglect in Colorado was approximately 50 percent greater than the percentage of children with allegations of neglect in Illinois and Ohio. The percentage of children with allegations of physical abuse was much greater in Ohio than in either Colorado or Illinois. The high percentage of children with unknown or no allegations in Illinois is due to the practice of investigating all children in a family regardless of whether allegations have been made or not.

	Colorado	Illinois	Ohio	51 States
Neglect	70.1%	48.2%	56.5%	64.9%
Medical Neglect	2.6%	2.7%	2.3%	3.0%
Physical Abuse	19.7%	24.1%	45.0%	25.1%
Sexual Abuse	9.4%	12.5%	12.5%	8.7%
Psychological Maltreatment	4.1%	0.2%	6.8%	9.3%
Other	0.0%	2.0%	0.0%	10.3%
Unknown or No Allegation	9.6%	27.2%	0.0%	10.5%

Percentages equal more than 100 percent since a child may have more than one type of alleged maltreatment.

Source: NCANDS, 2013

SUMMARY

This brief overview of key characteristics shows that the population context in which DR was implemented varied among the three sites based on data for FFY 2011. One might anticipate that these differences would influence the implementation of an AR pathway. Some contextual features that might influence the implementation of the programs are briefly discussed below.

- Colorado is the 22nd largest state in the nation with an estimated 2013 population of slightly more than 5 million persons,⁸ with the lowest rate of screened-in children. Almost three quarters of the screened-in children had allegations of neglect, less than 20 percent had allegations of physical abuse, and less than 10 percent had allegations of sexual abuse. Only a small percentage (5.7 percent) of referrals was made by social services personnel.

⁸ All population estimates are from the U.S. Census Bureau (2010).

Given the distribution of allegation types, this may suggest a justification for a new pathway for lower-risk cases.

- Illinois is the fifth largest state in the nation with an estimated 2013 population of nearly 13 million. Unlike Colorado, less than half of screened-in referrals had allegations of neglect, nearly a quarter had allegations of physical abuse, and more than 10 percent had allegations of sexual abuse. Three quarters of screened-in referrals were made by professionals and more than 10 percent by social services personnel. Illinois chose to implement statewide rather than in selected regions or counties. Thus, implementation might be anticipated to be challenging given the types of cases that the Department handled and the scale of the rollout.
- Ohio is the seventh largest state in the nation with an estimated 2013 population of 11.5 million. Although Ohio is smaller in population than Illinois, it had a slightly higher rate of screened-in children than Illinois. Noticeably, the screened-in referrals in Ohio included almost 50 percent related to physical abuse and more than 10 percent related to sexual abuse. Nearly 60 percent (58.9 percent) of referrals were made by professionals, and the remainder were made by nonprofessionals and unclassified sources. Social services personnel accounted for 17.1 percent of referrals. Thus, Ohio presents a mixed picture. Given that 10 counties in Ohio had already implemented DR and that the counties in this study were among the second wave of counties implementing DR, the past experience in conducting AR would certainly be an additional resource for implementation, even with a profile of a service population that might have more serious needs. One could anticipate a high degree of variation among the local counties based on the population usually served and the customs of the CPS staff in addressing this population.

The next chapter discusses the methodology of the cross-site evaluation.

Chapter 4. Methodology

The QIC-DR study, described here and in the site-specific reports, represents a large expansion of information about policies, processes, outcomes, and the overall efficacy of DR. A literature review (National Quality Improvement Center on Differential Response [QIC-DR], 2011) summarized the evaluations to date and noted that, prior to the QIC-DR local evaluations and cross-site evaluation, three DR studies used random assignment, an approach that is commonly considered the gold standard of evaluation. Random assignment removes one potential for bias that influences the decision about which cases get assigned to which pathway (e.g., “easier” cases may be directed to the AR pathway due to fewer perceived safety concerns), and increases the likelihood that the cases assigned to the two tracks are similar. Further, in this design, any differences observed between the AR and IR groups can be more confidently attributed to differences in the treatment—whether it be the nature of the intervention associated with the assigned pathway or the extended influence of the pathway on measures of child safety, service delivery, family engagement, and so forth. Due to other sources of potential bias, the present cross-site evaluation is best described as a comparative study. These sources are described in more detail in the last section of this chapter, Study Caveats.

Each of the chapters in the report includes a brief review of some key findings from other DR evaluations. The discussions focus on a core group of studies, primarily sharing findings from those that employed random assignment. The core reports selected for reference include state- or county-specific studies conducted in Minnesota (Loman & Siegel, 2004); Ohio (Loman & Siegel, 2013); and Onondaga County, New York (Ruppel, Huang, & Haulenbeek, 2011). While there are differences among these studies, some of these evaluation findings and trends set the context and inform our understanding of DR systems.

Occasionally, the current QIC-DR report refers to information from other DR research reports that did not employ experimental methods, but may have used quasi-experimental or qualitative methods. In general, information from these sources was used when counterevidence to common results or unique, parallel analyses replicated in this study were found in these less rigorously designed, but still valuable, DR studies. Thus, data from studies conducted in Nevada (Siegel, Filonow, & Loman, 2010), Texas (Chiple, Sheets, & Baumann, 1999), and a multi-state qualitative study conducted in Kentucky and Oklahoma (Zielewski, Macomber, Bess, & Murray, 2006) are referenced on occasion. Exploring these studies further may aid in understanding the context and content of the information summarized in the chapters that follow.

To best answer the research questions, the QIC-DR cross-site evaluation team took a comprehensive approach to the analyses for this report, employing a variety of data collection methods and analytic methods. This mixed methods strategy involved collecting and analyzing both qualitative and quantitative data obtained from a variety of sources. This chapter describes these mixed methods in detail, including the samples and instruments used, how the sites submitted their data to the cross-site evaluation, and the statistical methodology used to analyze the data.

It is important to note that there are instances where the findings of the cross-site evaluation differ from those of one of the local evaluations (i.e., Colorado, Illinois, Ohio). Some reasons this may have occurred include differences in samples of families who were analyzed or differences in analytical approaches. We do not address differences that are minimal in nature—for example, slight differences in significance levels—but wherever feasible, we do address differences that may have import for administrators, practitioners, and policymakers.

Initial Institutional Review Board (IRB) approval for human subjects research was obtained from American Humane Association in October 2010 for the cross-site evaluation. When the grant was transferred to the Kempe Center in 2012, the QIC-DR cross-site team obtained IRB approval from the Colorado Multiple Institutional Review Board. Each of the three sites applied for, and received, approval from their local IRBs.

QUALITATIVE METHODOLOGY

The cross-site evaluation relied on a range of qualitative methods, including focus groups, structured interviews, and policy reviews. The following section describes those methods, the composition of the qualitative samples, and the methods with which the data were analyzed.

Site Visit Methodology

The cross-site evaluation team conducted two rounds of site visits. The first round took place between April and June of 2011, approximately six months after the start of DR implementation (including the pilot study). The purpose of this first round of site visits was to provide each site with an opportunity for all key people involved in the project (i.e., the program director, evaluation director, financial manager, Statewide Automated Child Welfare Information Systems [SACWIS] lead, county leads, any additional senior-level leadership for the site, caseworkers, supervisors, and community stakeholders) and QIC-DR staff to meet and discuss the major aspects of the evaluation, training, site implementation issues, and budget and financial components. These visits allowed participants to dialogue, explore each aspect of the project in detail, identify successes and challenges, and determine next steps. The basic agenda included: (1) Implementation Overview and Discussion, including legislation/statute/rule/policy status, partnerships with service providers and communities, pre-implementation readiness and activities, and implementation challenges; (2) Training Overview and Discussion, including DR staff training, evaluation and data collection training, and control group training; (3) Evaluation Overview and Discussion, including data collection, worker surveys, caseworker reports, Family Surveys, and family consumer council implementation; (4) SACWIS Overview and Discussion, including system design (functional and technical flow), randomizer, and data collection; (5) Financial Overview and Discussion; and (6) Discussion About Upcoming Activities.

The second round of site visits took place between February and July of 2013, as the end of the study approached. The purpose of the second round of site visits was to elicit county and state perspectives on the project as they prepared for sustainability and replication planning, as well as to better understand important changes since the first site visits that may have impacted the

evaluation findings. Prior to each visit, the cross-site team held teleconferences with each site to develop site visit agendas. While visiting county child welfare agencies that were part of the QIC-DR evaluation, the cross-site team conducted interviews and facilitated focus groups. Below is a description of the site-specific focus groups, structured interviews, and document reviews that were used over the course of the evaluation.

Colorado

As part of Colorado's first site visit, the evaluation team presented the various pre-implementation workgroups, including: Screening and Referral, focusing on the track assignment process and DR response regarding alleged maltreatment; Intake and Services, focusing on the family assessment response process; and the Leadership Team, comprised of Colorado county directors, whose purpose was to listen to other work groups and counties. Colorado participants communicated that the State was developing a child welfare practice model and was planning to work to match policies to practice, including DR practice.

The focus groups and interviews for the first site visit were conducted by evaluation staff and faculty from the Social Work Research Center (SWRC) in the School of Social Work at Colorado State University (CSU). Notes were taken by representatives of the cross-site evaluation team and CSU. The focus groups and interviews were recorded and then were transcribed. CSU used a constant comparative analysis approach to analyze the qualitative data, yielding narratives for each group that participated in the site visits. In addition to focus groups and interviews, documents were reviewed. Colorado's project director assembled documents for the Colorado Children's Code, Colorado Consortium on Differential Response (CCDR) DR model, the practice model for DR in Colorado, the Agency Response Guide, and House Bill 10-1226 (Differential Response to Child Abuse).

The first round of site visits involved 31 focus groups and interviews that were conducted over a 2-day period at each local site. There were a total of ten caseworker focus groups, seven stakeholder focus groups, six supervisor focus groups, five administrator focus groups, two screener interviews, and one administrator interview. Each focus group had between four and ten participants, and lasted between 60 and 90 minutes. In addition to holding interviews and focus groups, the documents provided by the project director (i.e., the Colorado Children's Code, the CCDR DR model, the practice model for DR in Colorado, the Agency Response Guide, and House Bill 10-1226) were reviewed and considered. In early 2013, 2 years into implementation of DR, the QIC-DR cross-site evaluation team conducted six focus groups in three Colorado counties to gain child welfare agency staff perspectives about DR.

Illinois

The first Illinois site visit included a presentation and discussion about the statewide service provider database that was being developed to provide more efficient and effective service that would be easily accessible, readily available, and culturally relevant for families. Illinois participants also shared information about locally developed Parent Cafés, gatherings of caregivers held in early childhood centers and other friendly environments. Led by trained caregivers, these settings were a safe place to talk about the "hard stuff" and explore questions about taking care of oneself, raising strong children, and building strong relationships between parents and children.

Separate focus groups were conducted with public and private agency AR caseworkers and supervisors, as well as with IR caseworkers and supervisors during the first round of site visits. Groups were conducted in each of the four DCFS geographic regions of the State. The majority of the focus groups was conducted by the DR evaluation director and senior analyst, and was also attended by a member of the cross-site evaluation team who assisted with note-taking. All focus groups were recorded and transcribed for analysis. Focus groups were typically held in community-based service agencies or DCFS offices. A focus group was also conducted with the Child Welfare Advisory Committee Differential Response sub-committee. As part of the first round of site visits, separate key informant interviews were conducted with the DCFS director, the DCFS DR project director, and the DCFS deputy director of child protection. Interviews with the director and deputy director were recorded and transcribed. The interview with the QIC-DR project director was not recorded due to technical difficulties, so the interviewer took extensive notes throughout the interview, which were included in the analysis.

In addition, the project director provided a set of documents (legislation related to DR; Illinois DCFS DR-related rules, procedures, and policy documents; assessment and service forms used by AR caseworkers; AR agency program plans; and other materials, such as the MOU between the Department and the state employees union), which were reviewed and analyzed.

In February 2013, the cross-site team conducted a second round of focus groups in the Central and Cook regions with private agency staff who had been the Strengthening and Supporting Families (SSF) workers. Focus groups were also conducted with DCFS supervisors and administrators. The local evaluator in Illinois determined that they would not conduct follow-up site visits in the other regions due to the State's discontinuation of DR.

Ohio

Ohio held its first round of site visits in each of the six participating counties. Each site visit team included one staff member from Ohio's evaluation team and one member of the cross-site evaluation team. During each site visit, Ohio's evaluation team conducted interviews with DR lead staff, administrators, and AR and IR supervisors and caseworkers. Group interviews lasted between 30 minutes and 2 hours. Human Services Research Institute (HSRI), the Ohio site evaluator, compiled and coded all of the notes from the sessions into the qualitative analysis program NVivo. In addition, Ohio's evaluation team provided documentation regarding AR practice.

During the second round of site visits, the cross-site and local evaluators conducted focus groups and interviews in each of the six participating counties. Focus groups were conducted with AR and IR caseworkers, supervisors, parents, and the SOAR leadership team. In addition, six family focus groups were held at the child welfare agency at a time convenient to families in order to explore the experience of AR families in more detail. A total of 14 families participated in one meeting in each county. Hot food was provided at each focus group, and each participant received a gift card. At least 10 of the families had prior involvement with child welfare, either as a parent, minor, or prior foster parent; thus, while this sample of families was not randomly drawn, valuable insight was gained into the difference between these families' prior traditional experience and current AR experience, as well as the aspects of AR that these families found most helpful.

Qualitative Study Instruments

The following section describes the development of the focus group and interview measures.

For the first round of focus groups and interviews administered in all sites, the QIC-DR cross-site team and the local evaluation directors worked collaboratively to develop the protocols. In addition to the standard protocol, the local sites adjusted the terminology of the questions for better alignment with their sites' implementation of DR, and included additional questions that were important to their local evaluations. The focus group and interview protocols were developed in conjunction with the QIC-DR cross-site and local evaluation teams for the first round of site visits. A set of questions was developed to assess both fidelity to the DR core components outlined by the QIC-DR as well as fidelity to the DR practice model described in state legislation, policy, or procedures. The model fidelity questions assessed the topics of DR eligibility determinations, pathway reassignment, assessment, service delivery, and case closure. A second set of questions was developed to assess the early implementation activities and the core implementation drivers (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). The implementation questions assessed the topics of staff selection, training, supervision, coaching, performance evaluation, decision support data systems, facilitative administration, and systems intervention and external stakeholders. The cross-site team developed questions for the second round of questions.

Recruitment of Participants

Below is a discussion of how participants were recruited for the focus groups and structured interviews.

Colorado

For the first visit, the practice leads in each county recruited participants for the focus groups and interviews. They distributed recruitment flyers and e-mails to caseworkers, supervisors, administrators, screeners, and community stakeholders, which included members of multi-disciplinary teams (MDTs), child protection teams (CPTs), RED (review, evaluate, and direct) teams, school district staff, law enforcement personnel, service providers, and judicial representatives. For the 2013 focus groups conducted by the QIC-DR, the local evaluation team asked three Colorado counties to participate in these focus groups and to select staff to attend who were knowledgeable and experienced in DR implementation.

Illinois

In each of the four major DCFS administrative regions, first-round focus group and interview participants were invited from the following groups: AR specialists, SSF caseworkers, SSF supervisors, IR specialists, and IR supervisors. All five AR supervisors in the State were invited to attend the same focus group. For all groups, invitation letters were sent to each person individually via e-mail with an attached letter. One SSF supervisor focus group had to be cancelled because only one supervisor was able to attend on the scheduled date and time. For the second round of focus groups and interviews, Illinois' local project director selected and invited participants.

Ohio

For both the first and second rounds of site visits, focus groups and interviews were conducted with a convenience sample drawn from staff members who happened to be available on the day of the visit. Both rounds included group interviews with SOAR managers, agency administrators, supervisors, and caseworkers. Family focus groups were added for the second round of interviews. Each AR coordinator was asked to invite between five and eight AR families of his or her choosing to participate in focus groups to be held in each of the six counties. The Ohio and cross-site evaluation teams requested that only families whose cases were already closed be invited.

OTHER QUALITATIVE REVIEWS

Aside from the site visits, the focus groups, and the structured interviews, the cross-site evaluation team had other, less formal interactions with sites and evaluators that informed the interpretation of the findings of this study. Interactions and time spent with site evaluators and program staff at site visits, meetings, and conferences provided valuable insights that were crucial to the valid interpretation of findings.

QUANTITATIVE METHODOLOGY

Sample

The three sites used varying definitions of eligibility and conceptually similar but unique operational methods of randomization to select participants. Participation was elicited at the case, or family, level. Broadly speaking, if a case was screened in and determined to be eligible, the case was randomly assigned to either alternative response (AR) or investigative response (IR). Each site's report (accessible at www.differentialresponseqic.org) contains CONSORT diagrams (Schulz, Altman, & Moher, 2010), which represent a standardized method for reporting data from random trials, and show the flow of participants through each site's study. The diagrams include sample sizes at time of study enrollment, pathway assignment, and case closure or end of data collection.

The samples used for the individual site analyses and the cross-site analysis are different. For the purposes of the cross-site evaluation, analytic samples consisted of those families for whom:

- Both Administrative Data and Case Report Data (described in the following section) were available; and
- Data collection spanned at least 365 days (date of pathway assignment + 364 days).

The primary reason the cross-site team chose to implement these restrictions that resulted in slightly smaller sample sizes was to make the datasets consistent in their construction across sites. It was not the goal of the cross-site analyses to enable comparisons of the findings from the three sites, as each site's DR implementation occurred in unique contexts. However, the cross-site team placed great value in having consistent variable definitions across the three sets of analyses to

avoid confusion when interpreting the three sets of findings. For example, there are several derived variables that calculate the proportion of the study period that a given service occurred. Having consistently sized study periods across sites prevents the reader from having to interpret findings from each of the sites in what might be substantively different ways. Note that the Family Survey data was only analyzed for those families who had both Administrative and Case Report data.

Table 4.1 outlines the size of the samples selected for the cross-site analyses, as well as the proportion of the sample each site selected for data collection that was selected by the cross-site evaluation for analysis.⁹ It is important to note that the response rates below apply to responses within the cross-site evaluation sample only, not within the larger site sample. Additional information regarding the selection of cases for inclusion in the cross-site sample for each site is available in the CONSORT diagrams found in Appendix A (available at www.differentialresponseqic.org).

Table 4.1. Cross-Site Samples									
	Colorado			Illinois			Ohio		
	Total (n=1,667)	AR (n=870)	IR (n=797)	Total (n=4,534)	AR (n=1,706)	IR (n=2,828)	Total (n=846)	AR (n=543)	IR (n=303)
Response Rates									
Administrative Data	1,667 (100%)	870 (52.2%)	797 (47.8%)	4,534 (100%)	1,706 (37.6%)	2,828 (62.4%)	846 (100%)	543 (64.2%)	303 (35.8%)
Case Report Data	1,667 (100%)	870 (52.2%)	797 (47.8%)	4,534 (100%)	1,706 (37.6%)	2,828 (62.4%)	846 (100%)	543 (64.2%)	303 (35.8%)
Family Survey Data	398 (23.9%)	219 (55.0%)	179 (45.0%)	1,132 (25.0%)	518 (45.8%)	614 (54.2%)	319 (37.7%)	228 (71.5%)	91 (28.5%)
Staff Survey*	Caseworkers: 89/143 (62%) Supervisors: 30/39 (77%) Overall: 119/182 (65%)			Caseworkers: 200/741 (27%) Supervisors: 48/171 (28%) Overall: 248/912 (27.2%)			Overall: 227/378 (60%)		

*The Staff Survey data reflected caseworkers’ perspectives, but were not related to any particular case. As such, there was no case ID, so the Staff Survey data could not be appended to the analytic dataset, nor were the data related to any case’s pathway assignment. It was decided that these data did not pertain to any of the core research questions, and therefore are not analyzed in this report.

It is important to consider the potential for bias the cross-site team imposed with the decision to use only those cases with information on two instruments and whose data covered 365 days. It is possible that the cases under study are somehow different than those that were excluded. The evaluation team decided that being able to define variables and constructs consistently made the

⁹ Colorado weighted its data for its site-specific analyses in order to account for the differential probability of assignment to AR among counties, as well as changes in those sampling probabilities over time. The cross-site evaluation team was less concerned about making the analytic sample representative of the target population; rather, the cross-site evaluation aimed to describe relationships between variables and constructs. As such, weighting the data was not part of the cross-site evaluation methodology. An informal comparison of a selection of the findings from Colorado’s and the cross-site team’s analyses did not reveal any notable differences.

risk worthwhile. Information about the proportion of cases included and excluded is available in the CONSORT diagrams, and additional findings are presented in each individual site's report.

There is some variation in sample size across analyses, according to the completeness of the data. The cross-site team decided *a priori* not to analyze, for a given site, variables or instruments missing more than 20 percent of potential responses. As a result of the requirement that cases have at least some data for both the Administrative and Case Report instruments in order to be included in the cross-site sample, their de facto response rates were 100 percent for all three sites. Because not all responding cases had complete data for an instrument (e.g., the Case Report noted information about whether services were received, but not what type), the evaluation team only included, in a given analysis, those cases with at least 80 percent of the responses on the associated variables (exceptions are noted). The Family Survey had much lower response rates for several reasons. First, two sites (Colorado and Ohio) administered the survey to a sample of families, rather than to the complete study population (Illinois). Second, even though the sites implemented incentives, reminders, and other strategies to boost Family Survey response rates, only a small proportion of those families who were selected for the Family Survey actually completed it. However, the team decided to analyze the Family Survey data despite low response rates because it was the only source of information directly from families, and was essential for answering key research questions in the area of parent engagement. Where appropriate, characteristics of families who did not complete the survey were compared with those who did. If the populations differed on important characteristics, these results are also reported. Finally, all caseworkers and supervisors were eligible to complete the Staff Survey, but each site returned different rates of completion. This report does not include any data from the Staff Survey.

Study Period¹⁰

Colorado's and Ohio's study periods began on December 1, 2010, and ended on February 28, 2012. Illinois' study period began on November 1, 2010, and ended on May 22, 2012. The cross-site evaluation team restricted its follow-up longitudinal analyses to a 365-day window, or study period, with a start and end date specific to each study family. The first day of the study period for each case was defined as the date of pathway assignment (date of randomization). The last day of the study period was 364 days later.

Quantitative Study Instruments

To support the evaluation goals, instruments were designed to collect data on the process, caseworker and parent perceptions, and outcomes for the families involved in the study. The cross-site team implemented an intentionally inclusive process to develop the instruments for the study. The research team, consisting of the cross-site and local evaluators, and with input from local project directors, developed a core set of instruments to guide the interviews covering all

¹⁰ There was a pilot period in which each site tested randomization software, and prepared its staff for the study. Colorado began its pilot on October 5, 2010; Illinois began its pilot on November 1, 2010; and Ohio began its pilot in early September 2010. All three sites ran their pilots through November 30, 2010, and they launched their studies on December 1, 2010.

aspects of model fidelity and program implementation. First, they identified relevant instruments and measures from previous evaluations—most commonly, instruments developed by Gary Siegel and Tony Loman of IAR for earlier DR evaluations. Then, the combined study team reviewed those measures for quality, ease of use, and relevance to the specific research questions being addressed in the evaluation. Additional items for the caseworker survey were derived from instruments developed by Donald Baumann of the Texas Department of Family and Protective Services, Lenard Dagleish of the University of Stirling, Alan Dettlaff of the University of Illinois, and John Fluke of the Kempe Center. The cross-site evaluators held weekly calls with the local evaluators and project directors to discuss the instruments and make agreed-upon changes. Westat performed cognitive testing of the Family Survey, with Colorado families who had experience with child welfare serving as the review panel. As part of this testing, changes were made accordingly to the items in the Family Survey to increase readability and respondents' understanding of the questions.

Each site was responsible for working with its agency's respective SACWIS system to obtain the required information for the Administrative Data. In addition, each site was responsible for the administration of the Case Report, Caseworker Survey, and Family Survey. Examples of these surveys are found in Appendix B (available at www.differentialresponseqic.org). Sites could expand these instruments with additional questions to meet local needs, as long as the original items remained present and unchanged. While Illinois collected data for all of the randomized families and caseworkers, Colorado and Ohio selected samples of their randomized participating families and caseworkers for data collection. Additional information about their methodologies for sampling for data collection is included in their site-specific reports, accessible at www.differentialresponseqic.org.

Administrative Data Record Extract (Administrative Data)

These data consist of records extracted from state SACWIS and other administrative data systems, and were designed to capture information about both the time before study pathway assignment and the 365-day period starting at pathway assignment. The Administrative Data file included the following topics: IDs and submission dates, study pathway assignment and the report associated with study entry, caregiver characteristics, child characteristics, and re-referrals.

Confidential Case Specific Questionnaire (Case Report)

Caseworkers completed this questionnaire at the close of the case. The Case Report gathered information on contacts with the family, family functioning in multiple domains, threats to safety at first contact and case close, service receipt across multiple areas of need, service effectiveness and match to needs, and caseworker perceptions of family and caregiver engagement and cooperation.

General Caseworker/Supervisor Survey (Staff Survey)

This survey of child welfare caseworkers and supervisors in participating counties across the three sites was fielded during the first year of DR implementation. Ohio conducted a follow-up survey near the end of the evaluation period. Topics covered included tenure and duties, professional skills and approach, job satisfaction, knowledge of AR, attitudes toward AR, AR training, assessment of the availability of services in the community, and demographic

characteristics of the caseworker and/or supervisor. As noted above, this cross-site report does not present any data from this survey.

Confidential Family Survey (Family Survey)

Caregivers completed this voluntary and confidential survey after the initial case was closed. In Colorado and Ohio, a random sample of participating families were invited to complete the survey, while in Illinois, all participating families were invited to complete the survey. The survey covered the following topics: client satisfaction; qualities of the relationship with the caseworker; services received and the adequacy of services to meet family needs; effects of the experience on child safety, parenting, and material well-being; and selected demographic information. The survey was available in both English and Spanish. Caseworkers delivered the surveys to families, either in person or by mail. In Colorado, the survey was mailed to families by the local evaluation team. Also in Colorado, a small percentage of surveys for Spanish-reading families were conducted by telephone. Families then completed the survey and returned it to the local evaluation team by mail. In a small percentage of cases, families responded over the telephone.

Data Submission Process

Each site submitted data six times, inclusive of pilot data submissions. For each data submission, the sites were required to submit:

- One SPSS (a statistical analysis software) data file format (.sav file) per instrument, zipped to reduce file size.
- Only records for completed instruments. For the Administrative Data, only records which exceeded the 365-day follow-up period were considered complete.
- Data files that were cumulative from the start of the study through the end of the particular reporting period.
- Encrypted case IDs.
- Files that matched a record layout (provided by the cross-site evaluation team) with no additional variables.
- A brief memo detailing any problems they encountered in preparing their files for upload.

The schedule for submissions, including pilot submissions, is listed in Table 4.2.

Table 4.2. Schedule of Submissions

Submission Date	Materials Submitted
11/22/2011	Pilot submissions for the Case Report, Family Survey, and Caseworker Survey
12/15/2011	Case Report, Family Survey, Caseworker Survey, and submission memo
5/15/2012	Pilot submission for the Administrative Data
6/15/2012	Case Report, Family Survey, Caseworker Survey, Administrative Data, and submission memo
10/15/2012	Case Report, Family Survey, Caseworker Survey, Administrative Data, and submission memo
3/15/2013	Case Report, Family Survey, Caseworker Survey, Administrative Data, and submission memo

The cross-site evaluation provided a secure website for the data submissions. To enhance the security of the data transmission for each site, the website had a separate section for each site to upload data submissions and access archived submissions.

The cross-site evaluation also provided sites with a variety of resources to facilitate consistent data collection between the sites. The documents described below are included in Appendix C (available at www.differentialresponseqic.org):

- **Data submission instructions:** Instructions on how to prepare and upload data files to the secure website.
- **Data tally form:** Form to track and compare the number of cases entered into the study, and the number of cases submitted to the cross-site evaluation.
- **Mapping forms:** Mapping forms to crosswalk differences between sites' internal data systems and the cross-site evaluation record layouts for each of the four data sources.
- **Record layouts:** Detailed record layouts for the Case Reports, Family Surveys, Caseworker Surveys, and Administrative Data were provided to each site. The layouts included the following for each variable: variable name, variable and value labels, variable type, and length.
- **Table shells:** Table shells matching the record layouts were provided to the sites in the form of SPSS data files.
- **Quality Assurance (QA) documents:** Documents containing QA principles and related procedures to be followed by all sites and by the QIC-DR cross-site team. One example of a QA check is that the date of the first safety assessment had to be on or after the pathway assignment date for the study.

Data Validation

The cross-site team requested that sites run a predetermined set of QA checks on their data corresponding to the data checks listed in the QA documents. When a site submitted a file, the team downloaded the file and assessed its quality. First, the data were checked for structural problems, such as missing variables or an invalid file type, rejecting any files containing structural

problems. Then, the cross-site team ensured that the files without structural problems conformed to the QA checks specified in the QA documents, rejecting files with one or more violations of the QA checks. Examples of the QA checks include: required fields contained valid values, dates were in the correct order, and contingent questions only contained values when appropriate.

Next, the team e-mailed a memo to sites informing them whether a particular file had been accepted or rejected. For rejected files, the memo contained either detailed information on the structural problem or a brief description of each violation of a QA principle. Sites resubmitted rejected files after resolving any problems. The data validation process continued until files met QA standards and were accepted.

Dataset Construction

Using each site's accepted Administrative Data, Case Report, and Family Survey files for a given data submission, an analytic dataset was constructed, with files being merged on a common identifier (Case ID). Because of the cumulative nature of the data, the final data submission contained all records to be included in the cross-site evaluation's analyses. Additional variables were created based on research questions for inclusion in the analytic dataset. A description of all study variables, including those constructed by the cross-site evaluation team, can be found in Appendix E (available at www.differentialresponseqic.org).

ANALYTIC APPROACHES

Intent-to-Treat

There are two approaches used when analyzing data that represent randomly assigned cases: intent-to-treat (ITT, also known as "as-assigned") and as-treated (AT). The ITT strategy preserves the randomized groups, regardless of actual treatment received. In this evaluation, analyses using the ITT approach would compare cases as though they received the treatment condition to which they were initially assigned, regardless of whether the actual services they received were consistent with that pathway. For example, if a case was assigned to the AR pathway, but the caseworker determined that a safety risk was present in the home and transferred the case to the IR pathway (the case received an investigation), the case would still be considered an AR case for the purposes of the cross-site evaluation. When conducting AT analyses, cases are compared using the treatment they actually received, which may be different from the treatment pathway to which they were assigned. In the earlier example, that case would be treated as though it had been assigned to the IR pathway.

As might be expected, each approach has advantages and disadvantages. Findings from ITT analyses are more likely to represent what might happen in the "real world" rather than in a more sterile study environment by allowing for variations in practice that actually occur. Another advantage of the ITT approach is that it preserves the result of randomization; the samples are still quite similar to each other at baseline. A disadvantage of using the ITT approach is that the findings may be diluted, depending on the proportion of "non-adherers/non-compliers" present

(Ten Have et al., 2008). Conversely, AT findings are less likely to result in a diluted estimate of the treatment effect. This equates to an overestimation of effectiveness (Hollis & Campbell, 1999). AT analyses may be subject to bias in that factors that resulted in participants’ reassignment may have independent influences on the outcomes. General statistical protocol recommends that AT analyses be used as explanatory analyses, supplemental to ITT analyses (Irish, 2011).

The cross-site evaluation team decided, as did the local sites, to implement the ITT approach to analysis. Non-adherence, or non-compliance, was defined as pathway changes after randomization. In the context of the cross-site evaluation, those assigned to the AR pathway were able to receive a pathway change to IR, but those assigned to IR could not be changed to AR. So, those cases which were originally assigned to the AR pathway were treated as though they received AR for the purposes of the analyses. As Table 4.3 shows, varying percentages of cases experienced pathway changes.

Table 4.3. Proportion of AR Cases Experiencing a Pathway Change to IR

Colorado (n=807)	Illinois (n=1,706)	Ohio (n=543)
2.0% (16)	11.6% (198)	6.4% (35)

In the cross-site sample of Colorado’s data, 16 (2.0 percent) of the 807 cases randomized to AR (the only pathway that had the potential to change pathways) changed pathways to IR. In Illinois, 198 (11.6 percent) of the 1,706 randomized to AR changed to the IR pathway. Of the 543 cases randomized to AR, 35 (6.4 percent) experienced a pathway change.

Having small proportions of non-compliers is preferred, and Colorado’s and Ohio’s samples had relatively few pathway changes. Illinois, on the other hand, experienced a higher proportion of pathway changes than would be desired. It was important, then, to determine whether, and how, those cases differed from the cases that were assigned to and received AR.

The Illinois evaluation team conducted a set of sensitivity analyses, with the AR sample being subset into four groups: (1) AR “switchers” (switched to IR and received an investigation); (2) AR “refusers” (declined AR services after the initial meeting and received neither AR services nor an IR investigation); (3) AR “withdrawers” (randomized to and accepted AR services, but withdrew before the services were complete); and (4) AR “completers” (families who were assigned to, received, and completed AR services). Illinois examined differences between these groups in the contexts of experiencing a maltreatment re-report and/or whether child removals took place during the 18-month follow-up period. For more information on these specific findings, please see the Illinois final evaluation report, accessible at www.differentialresponseqic.org.

Analytic Strategies

A variety of statistical tests were used for answering the cross-site team’s research questions. These methods were often different from those used by the sites for their analyses. The primary

reason for this was that the cross-site evaluation's specific research questions were often different than the questions addressed by the local sites. When pertinent, those differences are noted in the corresponding chapters. The methods used by the cross-site evaluation included:

Bivariate Logistic Regression

Bivariate logistic regression models the association between a single independent variable and a dichotomous outcome, or dependent, variable. The result is an Odds Ratio (OR). The OR can be interpreted as the expected change in the log odds of the dependent variable for a one-unit increase in the independent variable. These models estimated the association between a range of child, family, allegation, service, and safety characteristics and two separate dichotomous dependent variables—re-referrals and removals.

Chi-Square Tests

Chi-square tests compare the frequencies of observed categorical variables to the frequencies that would be expected under a given hypothesis. Most often, in this study, these were conducted when determining whether a categorical variable differed across pathways.

Cox Proportional Hazards Regression

Also known as time-to-event analysis, and a form of survival analysis, this extension of regression modeling allows for the examination of the likelihood of an outcome, or event, when the potential time for the event to occur varies by participant, and allows for the adjustment of the risk of the event occurring by incorporating covariates in the model. In the case of this evaluation, the length of the assessment period varied by family, but all families only had 365 days in which the outcome (in this case, first re-referral after assessment) was measured. Families with longer assessment periods had fewer days in which to have a re-referral than families whose assessment periods were shorter. This analytic strategy accounts for those differences in time-to-event from the end of the assessment period. The resulting coefficients for the covariates, or hazard ratios, can be interpreted as relative risk associated with a one-unit increase in a given independent variable.

Factor Analysis

When surveys ask respondents multiple items about similar concepts, factor analysis, a multivariate data reduction method, can be used to examine which survey items group together to collectively represent an idea (e.g., positive family behaviors). In this study, factor analysis was used to identify and examine themes in both the caseworkers' case-specific report surveys and the Family Surveys. These themes included caseworkers' reports of positive and negative family engagement, as well as caregivers' reports of positive affect, worry, and anger.

General Linear Modeling (GLM)

This modeling framework allows for mixed modeling for both categorical factors and covariates using link functions. The use of the procedure in this context is for continuous dependent variables or, more specifically, in the analysis of scaled dependent variables for the analysis of family engagement. Like multiple linear regression, the interpretation of a coefficient for a modeled covariate is the change in the value of the dependent variable per unit change in the covariate. Factor coefficients are interpreted as differences in the value of the dependent variable intercepts.

Multivariable Logistic Regression

Multivariable logistic regression models the association between multiple independent variables and a dichotomous outcome, or dependent, variable. The result is an Odds Ratio (OR). The OR can be interpreted as the expected change in the log odds of the dependent variable for a one-unit increase in the corresponding independent variable, holding all other independent variables, or covariates, constant. Multivariable logistic regression estimated the association between a range of child, family, allegation, service, and safety characteristics and two separate dichotomous dependent variables—re-referrals and removals.

T-Tests

Independent samples *t*-tests compare the means of a continuous independent variable across two groups. In this study, *t*-tests were most often used to determine whether the mean continuous measures (e.g., age of caregiver, duration of the assessment period) differed across pathways.

Unless otherwise specified, comparisons of the descriptive statistics were conducted using independent samples *t*-tests and chi-square tests.

For the analyses examining family engagement, the cross-site evaluation first used factor analysis to identify and examine themes in both the Case Report surveys and the Family Surveys. Comparisons of each factor and a set of family characteristics (e.g., youngest child's age, primary caregiver's age) and caregiver reports of family engagement were conducted. This was intended to identify those characteristics that might be associated with non-response, which could then introduce bias in the subsequent analyses.

A series of bivariate and multivariable logistic regression models were fit to determine the association between a range of child, family, allegation, service, and safety characteristics and two separate dichotomous dependent variables: (1) transfer to ongoing services, and (2) the presence of any removals during the study reporting period. Bivariate logistic regression models were first conducted, followed by the multivariable analyses. A second potential outcome—first re-referral after the assessment period—was examined using Cox proportional hazards regression.

When fitting the multivariable and Cox proportional hazards regression models, all of the variables from the corresponding bivariate logistic regression models were retained. Those variables were retained for the multivariable models regardless of the statistical significance of the association between the independent and dependent variables because of (1) the strength of findings in prior research and (2) theoretical support.

Additional Information

Most analyses were conducted in IBM SPSS Statistics, Release 21.0.0.0 (IBM Corp., 2012). Stata/IC 12.1 (StataCorp, 2011) was used to fit the bivariate and multivariable logistic regression models, as well as the Cox proportional hazards regression model. The unit of analysis for all analyses in this report was the family, or case, unless otherwise stated. Missing data for individual analyses were handled using listwise deletion. In general, the discussion of the findings includes only those results for which statistical significance reached the 95 percent confidence level ($p < .05$) and, for

ease of readability, largely omits references to the test statistics underlying the presented findings. However, it was the opinion of the evaluation team that, although a number of findings did not reach statistical significance, they were critical when attempting to answer the core research questions and are therefore included. When a presented finding did not reach statistical significance, the lack of statistical significance is noted in the corresponding text. Select findings are presented in the report chapters, but more detailed information and additional findings are included in the tables in Appendix D (available at www.differentialresponseqic.org).

The QIC-DR cross-site evaluation analytic dataset, including both original and constructed variables, as well as accompanying documentation, will be made available to the public through the National Data Archive on Child Abuse and Neglect (NDACAN). Interested researchers should contact NDACAN to learn about the data, how to access the data as they become available, and what restrictions may apply.

Tables

The tables throughout this report follow several conventions that are described here. *P*-values are denoted by asterisks, with one asterisk indicating $p \leq .05$, two indicating $p \leq .01$, and three asterisks indicating $p \leq .001$. When a table presents the findings from a single comparison, the asterisks are placed beside the site's name at the top of the table. If there are multiple comparisons presented within a single table, the asterisks are placed next to the cell containing the IR value associated with that comparison. A key for explaining the asterisks are only presented below tables that have statistically significant findings at the 95 percent confidence level. In addition, sample sizes are presented in each table. When more than one comparison is included in a table (e.g., Table 5.3), the sample size for a particular comparison is presented in a row above that comparison, for each comparison.

STUDY CAVEATS

There are several overarching issues that bear mentioning prior to the presentation of findings. The cross-site evaluators were concerned about the potential for bias. Specifically, the cross-site evaluators were concerned about five types of bias: blinding, selection bias, response/non-response bias, performance bias, and social desirability bias.

In a blinded study, the intervention to which a participant is assigned (i.e., AR or IR) would not be revealed to either those responsible for implementing the intervention (caseworkers) or the participant (families). It was not possible for the QIC-DR evaluation to blind this study, however, as families were assigned to caseworkers who were aware of the type of service they were providing. The lack of blinding can lead to a strong likelihood of some degree of cross-contamination across the two groups in terms of the intervention offered, a common reality in field-based studies. This bias is especially likely when a worker serves both groups of clients, which was true in some instances in Ohio and Colorado.

Selection bias refers to any systematic error in choosing study participants. In this study, this bias could have been introduced when, in some sites, the ratio of assignment to the AR or IR pathway varied over time. Another opportunity for the introduction of selection bias, even though it rarely

happened, was just after randomization, when families assigned to AR could choose to be reassigned to IR. A third potential opportunity for selection bias involves how caseworkers were assigned to serve either AR or IR families. For example, those who volunteered to work with AR families might have different, and more positive, expectations for their families' outcomes than those who were assigned to work with AR families. As a result, those caseworkers' attitudes, their interactions with families, and their survey responses may be quite different.

Response/non-response bias occurs when the participants who responded to a survey are different than those who did not. For example, those who respond may be more favorable toward their experiences than those who chose not to respond. This is of particular concern for the Family Survey findings, as the response rates for those surveys were quite low. There are a number of possibilities: (1) It is possible that the families who did not respond to the survey were different for some key characteristics, and would have provided different responses to the survey, than the responders; and (2) it is possible that different caseworkers prompted different responses in families.

Performance bias refers to a systematic difference in the treatment of participants, other than the intervention. For example, caseworkers who found their families to be more engaged may have provided them with better service options regardless if the pathway was AR or IR, or the caseworkers may possess characteristics or skills that positively influence relationship building, and thus engagement. We were unable to determine whether this type of bias occurred. In addition, it is not clear whether only one caregiver or the entire family may have been present at the initial point of contact in the case-specific survey. Any assessment of a family's characteristics that reflect behavioral and/or attitudinal elements are likely influenced by the attitudes and experiences of the person making the observation. To increase the transparency of this matter in Chapter 6, the evaluation team labeled "family characteristics" as "family engagement attributes," making the inference that the worker has attributed his or her observations to a description of the caregiver.

Finally, there is some possibility of social desirability bias influencing the caseworker's responses. For example, engaging families is a fundamental part of social work, and positive family engagement could be considered a measure of worker effectiveness. Thus, in the Case Report instrument, it is possible that caseworkers may have overrated families' positive engagement attributes with the understanding that engagement reflects the caseworker's own practice to some degree.

Given these potential sources of bias that occurred during the study, although randomization was used, a more accurate description of this study may be that it is a multi-site comparison study.

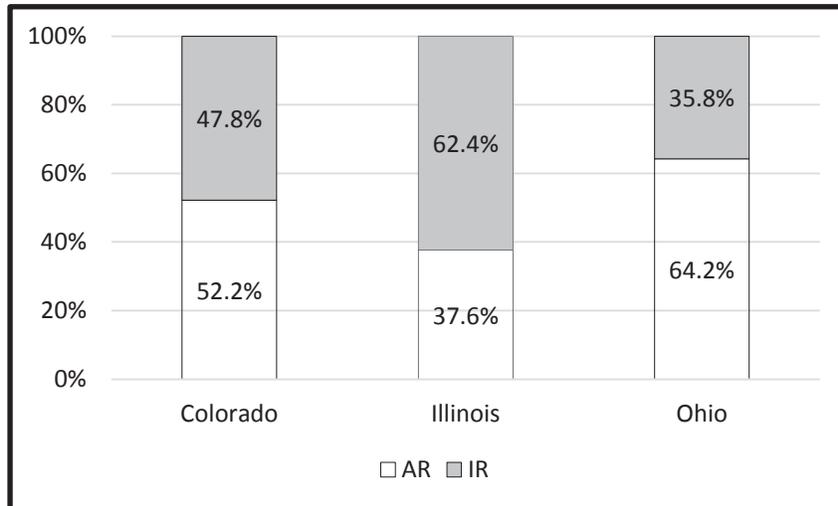
Chapter 5. Characteristics of AR and IR Families

This chapter presents data on the characteristics of families who received AR or IR. These characteristics include demographics of the children and caregivers, number of children in the household, types of allegations of maltreatment, and types of safety threats. The reader is referred to Appendix D (available at www.differentialresponseqic.org), which presents detailed data tables supporting the summary data within this chapter and subsequent chapters.

All of the data tables in this and the following chapters include data from the three sites. The format was chosen to assist the reader in understanding the similarities and differences among the implementations, but it is recognized that each implementation and local evaluation was conducted independently from the others. In addition, as discussed in Chapter 3, each implementation was undertaken within a larger state context, which varied in many ways among the three sites. For some readers, the comparison of similarities or differences will be of less importance than the results of a specific site. For others, the comparisons will provide an understanding of the variation among such programs across the United States.

The number of cases on which data were collected, submitted, and included in the cross-site evaluation is shown in Figure 5.1.¹¹ A case was defined as the family or household unit that was referred to CPS. A case could include more than one child and more than one adult.

Figure 5.1. Percentage of Cases by Pathway



¹¹ In spite of some variation in the numbers of cases that were reported in the local evaluations and the cross-site evaluation, the majority of findings are consistent among all four studies. We note where conclusions may vary on differences in the study populations.

CAREGIVERS

Table 5.1 demonstrates that the three sites were similar in terms of the age and the gender of the primary caregivers. The mean age of primary caregivers was between 31 and 34 years of age. More than 90 percent of all primary caregivers were female.

The sites differed in terms of the number of caregivers in the family. In Ohio, less than 40 percent of cases had two caregivers, compared to Colorado and Illinois, in which more than half of the cases in each pathway had two caregivers. See Appendix D for additional detail.

Table 5.1. Household and Primary Caregiver Characteristics

	Colorado			Illinois			Ohio		
	AR	IR	Total	AR	IR	Total	AR	IR	Total
Number of Caregivers in the Household									
1	40.1% (343)	33.7%*** (265)	37.0% (608)	45.0% (767)	38.4%*** (1,087)	40.9% (1,854)	64.0% (315)	62.2% (171)	63.4% (486)
2 or more	59.9% (513)	66.3% (521)	63.0% (1,034)	55.0% (939)	61.6% (1,741)	59.1% (2,680)	36.0% (177)	37.8% (104)	36.6% (281)
Primary Caregiver's Gender									
Female	93.6% (814)	93.7% (747)	93.6% (1,561)	92.8% (1,582)	93.4% (2,638)	93.2% (4,220)	93.7% (490)	95.9% (279)	94.5% (769)
Male	6.4% (56)	6.3% (50)	6.4% (106)	7.2% (123)	6.6% (187)	6.8% (310)	6.3% (33)	4.1% (12)	5.5% (45)
Primary Caregiver's Age									
Years, mean (SD)	33.6 (9.3)	33.3 (9.5)	33.5 (9.4)	33.5 (9.8)	33.2 (9.5)	33.3 (9.6)	31.1 (9.0)	31.1 (8.9)	31.1 (9.0)
*** $p \leq .001$									

CHILDREN

Table 5.2 shows the mean numbers of children in AR and IR cases in Ohio were slightly lower than in Colorado and Illinois. The mean age of all children ranged from 5.4 years to 6.4 years. The percent of children younger than 1 year of age ranged from 7.4 percent to 10.3 percent. Additional information about the characteristics of the children in this study can be found in Appendix D.

Table 5.2. Child Characteristics

	Colorado		Illinois		Ohio	
	AR (n=870)	IR (n=797)	AR (n=1,706)	IR (n=2,828)	AR (n=543)	IR (n=303)
Number of children in the assessment, mean (SD)	1.9 (1.0)	2.0 (1.2)*	1.9 (1.1)	2.1 (1.3)***	1.5 (0.9)	1.5 (0.8)
	AR (n=1,639)	IR (n=1,599)	AR (n=3,151)	IR (n=5,753)	AR (n=831)	IR (n=446)
Age of children in years, mean (SD)	7.7 (4.9)	7.4 (4.9)	7.6 (5.0)	7.6 (5.0)	6.8 (5.7)	7.1 (5.1)
Percentage of children younger than 1 year old (n)	7.4% (n=122)	7.4% (n=118)	6.8% (n=268)	8.3% (n=478)	9.9% (n=82)	10.3% (n=46)
*p ≤ .05, ***p ≤ .001						

The percentage of children younger than 1 year old in these studies varied slightly from the statewide statistics. The percentage served by AR was slightly lower than the statewide statistics in Colorado, but slightly higher in both Illinois and Ohio. In other words, there may have been a slightly higher likelihood that families with younger children would be found to be eligible for AR in Illinois and Ohio. In Illinois, this is consistent with the policy that families with prior contact with CPS would not be eligible for AR. It is possible that the broader range of case allegations that Colorado accepted as eligible for AR would result in families with older children being considered eligible for AR, but the variation may also be due to the populations in the counties which were a part of the study.

RACE AND ETHNICITY

As indicated in Table 5.3, the majority of children served were White. With the exception of Colorado, a higher percentage of children were Hispanic than were not. Additional information is found in Appendix D.

Table 5.3. Race and Ethnicity of Children

	Colorado		Illinois		Ohio	
Child Race						
	AR (n=1,356)	IR* (n=1,286)	AR (n=3,163)	IR*** (n=5,504)	AR (n=695)	IR*** (n=345)
American Indian/Alaska Native	0.6% (8)	0.5% (7)	0.1% (2)	0.1% (5)	0.0% (0)	0.0% (0)
Asian	1.1% (15)	0.5% (7)	0.7% (23)	1.4% (76)	0.1% (1)	0.3% (1)
African American	6.1% (83)	7.7% (99)	29.4% (930)	34.1% (1,875)	22.2% (154)	35.9% (124)
White	90.1% (1,222)	87.5% (1,128)	67.0% (2,119)	64.2% (3,535)	70.2% (488)	57.7% (199)
Multiracial	2.1% (28)	3.7% (48)	2.8% (87)	0.1% (4)	7.5% (52)	6.1% (21)
Child Ethnicity						
	AR (n=1,237)	IR (n=1,209)	AR (n=3,218)	IR*** (n=5,846)	AR (n=478)	IR (n=234)
Not Hispanic or Latino	65.4% (809)	62.0% (750)	86.2% (2,775)	89.6% (5,238)	97.5% (466)	94.9% (222)
Hispanic or Latino	34.6% (428)	38.0% (459)	13.8% (443)	10.4% (608)	2.5% (12)	5.1% (12)

*p ≤ .05, ***p ≤ .001

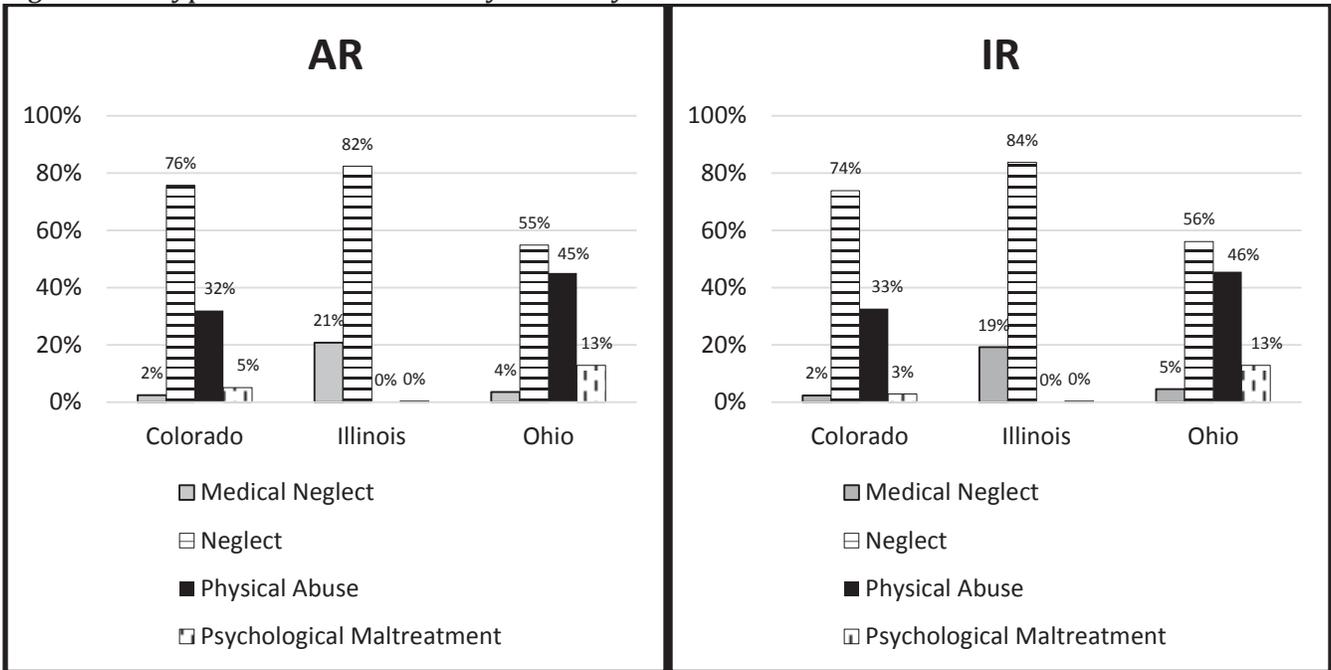
Note: The chi-square tests for race for both Illinois and Ohio had cells with fewer than five children, so the results should be interpreted cautiously.

ALLEGATIONS OF MALTREATMENT

The cross-site team examined the official allegations of maltreatment as recorded in the administrative data systems of each site, which are displayed in Figure 5.2, Types of Maltreatment by Pathway. Highlights of findings on allegations were as follows:

- The most common allegation of maltreatment concerned neglect of one or more children in the family.
- Physical abuse allegations were not eligible for randomization in this study in Illinois. In Colorado and Ohio, physical abuse was the next most frequent type of allegation after neglect.
- Sexual abuse allegations were the least frequent. In Illinois and Ohio, an allegation of sexual abuse would disqualify a case from being eligible for randomization in this study. In Colorado, only 0.5 percent of cases in either AR or IR included allegations of sexual abuse.

Figure 5.2. Types of Maltreatment by Pathway



Percentages may equal more than 100 percent since a case could have multiple allegations. See Appendix D for additional detail.

The comparison of the cases considered eligible for AR in each of the sites with the overall population screened in to CPS was revealing.¹² The percentage related to neglect was similar overall for the states and for those deemed eligible for AR. In Ohio, this was also true for physical abuse allegations, while in Colorado, the percentage related to physical abuse eligible for AR was higher than the statewide percentage. Given the policies in Illinois, it is not surprising that the percentage related to neglect was almost 75 percent higher than for all children served by CPS. No cases had allegations of physical abuse in the Illinois study of DR. These comparative data confirm that different eligibility criteria were used among the sites.

SAFETY THREATS ASSESSED BY CASEWORKERS

Across all sites, statute or rule dictates that there must be a process by which cases are assessed for the safety of children after an allegation of maltreatment is screened in and a case is opened. Within each site, the same child safety assessment instrument was used for AR and IR cases.

- In Colorado, the same safety and risk assessment had to be completed within 30 days for cases in both pathways. A safety plan was completed if necessary.
- In Illinois, the process was different. Under AR, the public agency caseworker initiated contact with the family by calling the family within 24 hours of case assignment to explain

¹² The NCANDS analyses are conducted at the child level, while the cross-site analyses were conducted at the case level. This difference may contribute to the high percentages of cases with neglect compared to the lower percentages of children with allegations of neglect in Illinois, since Illinois conducts investigations on all children in the family, whether or not there were any allegations of maltreatment.

AR and schedule a time for an initial visit within 3 business days between the adult and child subject(s) of the report and the AR and SSF caseworkers. During this initial visit, the AR caseworker was responsible for completing the CERAP. If a safety concern was determined to be present, the case was reassigned to an investigation. If there were no identified child safety concerns, the family could voluntarily agree to work with the SSF caseworker. The assessment of AR families was usually completed within 5 days. At this point, the public caseworker's role was complete and the case was handed over to the SSF worker. Under an investigation, the CERAP was also completed within 24 hours after interviewing the alleged child victim. Within 60 days, the investigator and supervisor were required to make a determination regarding maltreatment. If warranted, 30-day extensions could be granted.

- In Ohio, the safety assessment was required to be completed and approved by a supervisor within 4 days for IR and 7 days for AR. A family assessment was also completed on all cases. In AR, caseworkers had 45 days, and, in IR, caseworkers had 30 days to complete these assessments.

Besides the fact of existence of a safety threat, caseworkers reported their assessments of the type of safety threats present in families in both pathways. In general, caseworkers in the AR and IR pathways did not find that a large percentage of families had any safety threats, which is consistent with the initial review by the hotline or screening groups.

States varied regarding percentage of cases with specific safety threats. It is important to note that what is considered to be a safety threat in one state may not be a safety threat in another state. In Colorado, the highest percentage of cases with a specific safety threat was 10.2 percent of AR cases assessed as having a safety threat of lack of supervision. In Illinois, the highest percentage of cases with a specific safety threat was 38.5 percent of AR cases assessed as having a safety threat of neglect. In Ohio, the highest percentage of cases with a specific safety threat was 17.8 percent of IR cases assessed as having a safety threat of neglect or abandonment. This may be a reflection of varying eligibility criteria across the sites.

With only a few exceptions, IR caseworkers in all states assessed a greater percentage of cases having a specific safety threat than did AR caseworkers. Table 5.4 presents the percentage of cases with a range of caseworker-reported safety threats. More detailed information, including exact *p*-values, can be found in Appendix D.

Table 5.4. Percentage of Cases Assessed as Having Safety Threats

	Colorado			Illinois			Ohio		
	AR (n=870)	IR (n=797)	Total (n=1,667)	AR (n=1,706)	IR (n=2,828)	Total (n=4,534)	AR (n=543)	IR (n=303)	Total (n=846)
Damaging adult-child relationship	4.5% (39)	5.0% (40)	4.7% (79)	4.3% (74)	6.5%** (183)	5.8% (257)	7.4% (40)	8.3% (25)	7.7% (65)
Lack of supervision or proper care	10.2% (89)	9.0% (72)	9.2% (161)	13.7% (233)	13.1% (371)	13.3% (604)	8.3% (45)	10.9% (33)	9.2% (78)
Neglect or abandonment	6.9% (60)	8.4% (67)	7.6% (127)	38.5% (657)	27.5%*** (778)	31.6% (1,435)	14.4% (78)	17.8% (54)	15.6% (132)
Physical, sexual, or emotional abuse	6.2% (54)	8.5% (68)	7.3% (122)	8.8% (150)	8.6% (244)	8.7% (394)	15.7% (85)	17.5% (53)	16.3% (138)
Other	4.4% (38)	8.3%*** (66)	6.2% (104)	8.4% (143)	11.6%*** (329)	10.4% (472)	2.6% (14)	11.2%*** (34)	5.7% (48)
** $p \leq .01$, *** $p \leq .001$									

The low percentage of cases with safety threats confirms that, in general, these cases were screened in appropriately as being of low risk. However, where there are some instances of significant variations, there may be biases that arise during the assessment component of the AR and IR pathways. It will be important for CPS agencies to examine the variations further.

PATHWAY CHANGES

Transfer of Cases From AR to IR

DR systems have usually provided a safety valve when implementing AR and IR pathways. AR pathways are given the option of transferring a family to IR at any point. In this study, some cases were transferred immediately based on what was deemed to be inappropriate assignment to AR. No AR services were provided to these cases, and, in most instances, these cases were considered ineligible for the randomized trial and not included.

- In Colorado, if the case was determined to have been inappropriately considered as eligible for AR and therefore ineligible for randomization, the cases were excluded from the study. Cases that were deemed eligible, were initially received for AR, but then were transferred were retained under the ITT principle.
- In Illinois, a similar principle was applied. If the case was considered ineligible for AR, it was excluded from the analyses. Cases that switched from AR to IR were kept under the ITT principle.
- In Ohio, the same decisions were made as in Colorado.

Other cases were deemed to be inappropriate for AR after some AR services were provided. These cases were included under the ITT design of the evaluation, meaning that they remained as part of the AR experimental group for analyses. Illinois had the highest rate of transfers from AR to IR. This rate was influenced by two of Illinois' eligibility criteria: identification of prior referrals post randomization, which automatically made the case ineligible for AR, and a re-referral that occurred while AR was being provided, which also made the case ineligible to continue receiving AR. Meeting either of these criteria resulted in a pathway change in Illinois. Cases were not able to transfer from IR to AR in any of the three sites. See Table 5.5.

Table 5.5. Pathway Assignment Changes From AR to IR

	Colorado (n=807)	Illinois (n=1,706)	Ohio (n=543)
Transferred from AR to IR	2.0% (16)	11.6% (198)	6.4% (35)

SUMMARY

Table 5.6 summarizes data reported to NCANDS for each of the sites in terms of all screened-in children for the entire state, and children who were eligible for AR and received either AR or IR for this evaluation. Once a program is fully implemented and no evaluation is being conducted, the distribution of each of these factors for those receiving IR would likely differ from the picture below. In that instance, those receiving IR would not include those eligible to receive AR.

Table 5.6. Summary Comparison of the CPS Population to the AR-Eligible Population

	Colorado			Illinois			Ohio		
	NCANDS	AR	IR	NCANDS	AR	IR	NCANDS	AR	IR
Children younger than 1 year old	8.8%	7.4%	7.4%	7.7%	8.5%	8.3%	9.1%	9.9%	10.3%
Children whose race was indicated African American	9.4%	6.1%	7.7%	35.5%	29.4%	34.1%	30.4%	22.2%	35.9%
Children whose race was indicated White	84.3%	90.1%	87.5%	63.3%	67.0%	64.2%	64.3%	70.2%	57.7%
Children who were Hispanic of any race	35.5%	34.6%	38.0%	19.1%	13.8%	10.4%	6.1%	2.5%	5.1%
Cases/children with allegations of neglect	70.1%	75.7%	73.9%	48.2%	82.4%	83.7%	56.5%	54.9%	56.1%
Cases/children with allegations of physical abuse	19.7%	32.0%	32.6%	24.1%	0.0%	0.0%	45.0%	45.1%	45.5%

Race and ethnicity data on all screened-in children were obtained from NCANDS, 2013

Differences found between the NCANDS data on screened-in populations and those eligible for AR and served through AR and IR may be attributable to the samples included in these studies. In all

sites, variation may be attributable to differences in characteristics of those found to be eligible for AR and the greater population receiving a CPS response. Further research is needed in order to understand the significance of these comparisons.¹³

Table 5.7 summarizes differences between the AR and IR cases that were found to be statistically significant at the 95 percent confidence level with respect to a set of case characteristics for each site. Some core characteristics of the AR cases were of significant statistical difference from the characteristics of IR cases in each site. The large sample in Illinois likely contributes to the findings of significant statistical differences. The one common finding across sites was that the races of AR families were different than races of IR families. Variations in outcomes may be influenced by differences other than solely the receipt of either AR or IR.

Table 5.7. Significant Differences Between AR and IR Cases

	Colorado	Illinois	Ohio
Two or more caregivers	More in IR***	More in IR***	NS
Number of children	More in IR*	More in IR***	NS
Race	Different racial distributions*	Different racial distributions***	Different racial distributions***
Ethnicity	NS	More Hispanic/Latino in AR***	NS
Damaging adult-child relationship	NS	Higher in IR**	NS
Neglect safety threat	NS	Higher in IR***	NS
Other safety threats	Higher in IR***	Higher in IR***	Higher in IR***
* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$		NS = Not Statistically Significant	

The next chapter examines parent engagement from the perspective of caseworkers and parents within AR and IR pathways.

¹³ Such research can be carried out using the NCANDS dataset.

Chapter 6. Parent Engagement

INTRODUCTION

The engagement of parents and/or primary caregivers (herein “parents”) who become involved with CPS has been an area of inquiry receiving more attention in recent years. A review of the child welfare literature indicates that the majority of peer-reviewed, published studies on parent engagement have been conducted in Canada, Europe, Australia, and the United States. Most of the existing studies have qualitative designs (interviews and focus groups) that explore parents’ perceptions of engagement and, sometimes, CPS workers’ perceptions of parental levels of engagement. The QIC-DR research, which is predominately based on surveys of caseworkers and parents, as well as a limited number of focus groups, relies on quantitative and qualitative methods, and thus makes a unique contribution to this field of study.

The term *engagement* has been defined by researchers and practitioners alike to mean a variety of things, including compliance, involvement, participation, cooperation, and collaboration between the caseworker and the parent. Clearly, these varying constructs create confusion in teasing out not only what constitutes engagement, but also how it relates to measuring the success of the child protection interventions to engage parents. Generally, client engagement is seen as integral to the achievement of positive CPS outcomes. Strengthening the helping alliance between CPS workers and parents through improved engagement is one of the core objectives of DR-organized CPS systems. Still, although the use of DR by CPS has increased across the United States, there is much to learn about the dynamics underlying parent engagement in DR and whether or not the AR approach yields different or better engagement between parents and caseworkers than IR.

This chapter begins by summarizing the previous research on parent engagement from other DR research. This is followed by the QIC-DR cross-site evaluation findings, in which the data sources are first identified, the process for constructing variables is described, and the results are provided.

PREVIOUS RESEARCH ON DR AND PARENT/FAMILY ENGAGEMENT

Previous studies on DR systems, using case reports completed by caseworkers and surveys completed by families, provide a variety of findings related to engagement. All of these studies and commonly used methods suffer from some methodological limitations, many of which are highlighted in the QIC-DR literature review, accessible at www.differentialresponseqic.org.

Still, the literature review on DR (QIC-DR, 2011) found that client satisfaction reviews in 13 studies indicated uniformly that clients who participated in AR reported higher levels of satisfaction when compared to clients who received IR. AR parents were more likely to express that they were involved in the assessment and service planning processes than IR parents. In most studies, AR parents also had a more favorable attitude toward CPS services and were more likely to report being positively engaged than IR parents. Thus, in spite of the great cross-site variations

in methodology, geography, and implementation, findings related to engagement have been generally consistent.

There have been few studies comparing caseworkers' perceptions of family engagement and families' receptivity to CPS involvement in AR versus IR cases. Four studies (Loman & Siegel, 2004; Loman et al., 2010; Ruppel et al., 2011; Siegel & Loman, 1997) that used an experimental design with random assignment are worth noting (Minnesota, Ohio, New York, and Missouri). Nevada used a quasi-experimental design of matched families, but it is also noted due to the similarity in measures.

In Minnesota, one of the studies that used randomized control assignment for intervention pathways, a sample analysis of 690 caseworkers, found that, compared to IR caseworkers' ratings of IR families, AR caseworkers rated AR families as significantly more cooperative, realistic, and motivated, and as having higher self-esteem. Since the assignment of the cases to AR versus IR was randomized, there should have been no difference between the groups.¹⁴ Thus, this finding suggests that the engagement process in AR between caseworkers and family members may be different and possibly improved over the processes used by IR caseworkers (Loman & Siegel, 2004). In a similar Ohio study (Loman et al., 2010), caseworkers were asked about their perceptions of family reactions to CPS involvement in case-specific surveys. Caseworkers reported feeling that AR families reacted more positively to them, were more cooperative, and were more involved in the decision-making process than did caseworkers who reported these feelings about IR families. Family self-reports through surveys confirmed these caseworker perceptions.

Caseworkers reported that families receiving AR were also more likely to have participated in services, and AR families reported greater satisfaction with how they were treated by their caseworkers and with the services they received, compared to families receiving IR (Loman et al., 2010). Families surveyed in New York's and Nevada's DR pilots who received AR also reported greater satisfaction with caseworker treatment and perceived caseworkers as friendly, supportive, and cooperative (Ruppel et al., 2011; Siegel et al., 2010).

Finally, a seminal study of DR in Missouri (Siegel & Loman, 1997) found that 81 percent of the families in the Missouri AR pilot areas were satisfied with their services, compared with 71 percent of families from the comparison areas who were not implementing DR. Within the pilot areas, 88 percent of the families who received AR were satisfied with the services they received, compared with 57 percent of the families who received IR. Similar client satisfaction results were

¹⁴ Although random assignment of cases to AR versus IR tracks strengthens our ability to interpret significant differences as reflective of the different approaches, there remains the issue of whether AR and IR worker characteristics are the same or different (e.g., self-selection may produce selection biases) and whether such characteristics can explain some of the findings of significance. The counties involved in the Minnesota study employed different approaches to determining whether the same or different caseworkers delivered the AR and IR interventions, the phase during which AR-specific staff members were involved in a case, and whether or not staff could volunteer to serve in an AR staff capacity. No rigorous analysis of the effects of worker assignment processes and the characteristics of caseworkers appear to have been conducted. Since in most studies it appears that the selection of caseworkers assigned to AR was not random, the influence of selection bias on results must be considered.

found in DR studies conducted in West Virginia and North Carolina (Center for Child and Family Policy, 2006; Costello, 1998).

Engagement in child welfare has been explored in numerous evaluations and publications and has been evaluated in the specific context of DR systems. However, there remains a lack of clarity and specificity regarding the mechanics of successful engagement between families and caseworkers. Moreover, since engagement likely has both an attitudinal and behavioral component, it is a complex phenomenon that is challenging to measure and study. Indeed, a review of the DR literature indicates that there is no consistent manner in which engagement has been measured or characterized to date (Siegel & Loman, 1997; Ruppel et al., 2011; Loman & Siegel, 2013).

This chapter presents the methodology used to better understand differences and similarities in engagement, including some limitations (e.g., potential survey response bias). The questions used to guide the analyses, based on the core research question, “Is engagement different for AR and IR parents?” are presented. This is followed by the constructed variables by which caseworkers’ perspectives of parent engagement and parents’ perspectives on their levels of engagement were measured.

QUESTIONS GUIDING THE ANALYSES

The first set of analyses involved caseworkers’ perceptions of family engagement attributes at first meeting, and again at last meeting if there was more than one contact. The QIC-DR team asked two main research questions:

1. What were caseworkers’ perceptions of the positive and negative family engagement attributes at their first meeting with AR and IR families?
2. According to caseworkers’ perceptions, did positive and negative family engagement attributes change between the first and last meeting, and if yes, were there differences between AR and IR families?

The second group of analyses was about parent reports of satisfaction as well as feelings resulting from contact with the caseworker. Here, there were three core research questions:

1. How did parents report feeling after the first time a caseworker came to their home?
2. How satisfied did parents report they were with how they were treated and with the help they received?
3. How did parents report on the likelihood that they would contact the caseworker again if they needed help in the future?

METHODOLOGY AND CONSTRUCTED VARIABLES

As the literature review indicated, while family engagement is a key concern for child welfare agencies, there is little consensus about how to define engagement. To answer the above inquiries, and to define engagement similarly across the sites, two data sources—the Confidential Case Specific Questionnaire (Case Report) and the Confidential Family Survey (Family Survey)—were

used. The Case Reports were completed by the assigned caseworker for each case at the close of the initial case. As with all research methods, these approaches have limitations.

The Family Surveys were completed by parents or primary caregivers after the initial case was closed. As described in Chapter 4, response rates for the Case Report for the cross-site sample were 100 percent, as this was a criterion for inclusion in this study sample. In comparison, only about one quarter to one third of the cases with a Case Report, which was completed by the caseworker, also had a Family Survey. Responding to the Family Survey was voluntary for parents in each of the sites and, as expected, some elected not to respond. Consequently, there is real potential for response bias, that is, the possibility that families did not complete the survey for a reason that would affect the interpretation of the findings.

Since response bias may impact whether the findings can be considered representative, a comparison of data known about respondents and non-respondents was conducted. Factors examined included family characteristics (primary caregiver's age at intake, youngest child age at intake, and number of prior reports [not valid for Illinois, since cases with prior reports were omitted from the study]) and caseworkers' reports on engagement (caseworker report of positive affect at first and last meeting and caseworker report of negative affect at first and last meeting). While the average age of the primary caregivers in Colorado's respondent pool was almost 2 years older than the primary caregiver's age of non-respondents, no other statistically significant differences were noted with respect to family characteristics and prior reports. That said, a comparison of caseworkers' ratings of parents' attributes indicated that parents who had higher levels of positive affect were more likely to return surveys compared to parents at lower levels. However, based on the analysis and with the exception of Illinois, the relative amount of difference is statistically the same for both IR and AR groups.

Another caveat affecting the interpretation of the results below is that caseworkers rated families on measures of engagement at first and last meeting simultaneously. That is, they reported their assessment of a family's engagement for the first and the last meeting in the same survey. The limitations of this approach are discussed in Chapter 4.

Factor analysis, analysis of variance (ANOVA), and general linear modeling (GLM) were the primary methods utilized to examine the concept of engagement. Factor analysis enabled the evaluation team to examine which case-specific survey items grouped together to collectively represent two overarching concepts: the caseworker's perceptions of the family's positive engagement attributes and the caseworker's perceptions of the family's negative engagement attributes. Factor analysis was also employed to determine how best to combine the results from different items from the Family Survey, and yielded three factors: parent reports of positive affect, parent reports of worry, and parent reports of anger. ANOVAs were used to compare scores on caseworkers' initial ratings of family engagement attributes and to compare AR and IR parents' answers to questions about their experiences. GLM was employed to compare changes in caseworkers' descriptions of AR and IR parents' affect between the first and last meeting and to test for interactions. This section briefly explains which survey items were combined to construct the factors analyzed. Further detail about the statistical tests performed that support the item groupings and the results of the ANOVA and GLM analyses can be found in Appendix D.

Caseworker Reports of Positive and Negative Engagement Attributes

Caseworkers reported on five family engagement attributes observed during the first meeting with the family on the Case Report. When the factor analysis was conducted across the five items, it resulted in two factors. As Table 6.1 indicates below, the first factor was “Caseworker Report of Positive Family Engagement Attributes,” including the attributes cooperative, receptive to help, and engaged. The second factor was “Caseworker Report of Negative Family Engagement Attributes,” including the attributes uncooperative and difficult.

<i>Table 6.1. Caseworker Report of Positive and Negative Family Engagement Attributes</i>	
Caseworker Report of Positive Family Engagement Attributes	
<ul style="list-style-type: none"> • Cooperative • Receptive to Help • Engaged 	
Caseworker Report of Negative Family Engagement Attributes	
<ul style="list-style-type: none"> • Uncooperative • Difficult 	

Parent Reports of Positive Affect, Worry, and Anger

The present analyses also included parent reports of engagement from the Family Survey and, as described in Chapter 4, entailed a smaller subsample of cases from the overall study sample. Among other things, the Family Survey asked parents to reflect on and report how they felt after the first time a caseworker came to their home.

The factor analysis conducted on the 12 questions regarding parents’ feelings at the time of initial involvement indicated the items grouped to form three separate factors. As Table 6.2 indicates, the first factor was “Parent Report of Positive Affect,” and included six items: relieved, respected, encouraged, thankful, hopeful, and comforted. The second factor, “Parent Report of Worry,” included three items: worried, stressed, and afraid. The final factor, labeled “Parent Report of Anger,” included three items: angry, disrespected, and discouraged.

Table 6.2. Parent Reports of Positive Affect, Worry, and Anger	
<p>Parent Report of Positive Affect</p> <ul style="list-style-type: none"> · Relieved · Respected · Encouraged · Thankful · Hopeful · Comforted 	<p>Parent Report of Worry</p> <ul style="list-style-type: none"> · Worried · Stressed · Afraid <p>Parent Report of Anger</p> <ul style="list-style-type: none"> · Angry · Disrespected · Discouraged

FINDINGS

Caseworker Report of Family Engagement Attributes

The evaluation team analyzed caseworkers’ perceptions of the family engagement attributes of AR and IR families. There were four possible ratings for each of the positive or negative family engagement attributes measured. Response options, and their associated scores, included (1) Not at All, (2) A Little, (3) Moderately, and (4) Very. The combination of caseworkers’ responses to individual items that were based on the factor analysis results produced an average score across the items that composed each factor. Thus, the data in the tables below correspond to the average score for families assigned to the respective intervention pathway. For example, a score of 3.32 indicates that the average score of the items composing the factor for families on that pathway lay between (3) Moderately and (4) Very. In comparison, a score of 2.88 would indicate that the average score for families on that pathway lay between (2) A Little and (3) Moderately. Overall, for positive engagement scores, higher numbers reflect more positive assessments.

As Table 6.3 reflects, caseworkers’ reports of positive family engagement attributes at the first meeting differed by track, with caseworkers in all three sites reporting statistically significant, higher positive engagement scores for IR families. Across all the sites, however, the average score on positive family engagement attributes for AR families and IR families fell between (3) Moderately and (4) Very.

Table 6.3. Caseworker Report of Positive Family Engagement Attributes at First Meeting

	Colorado		Illinois		Ohio	
	AR (n=865)	IR (n=792)	AR (n=1,655)	IR (n=2,552)	AR (n=462)	IR (n=255)
Average score on positive family engagement attributes at first meeting	3.19	3.32**	3.17	3.50***	3.12	3.38***
** $p \leq .01$, *** $p \leq .001$						

In addition, the evaluation team analyzed whether caseworkers’ perceptions of the level of positive family engagement attributes changed between the first and the last meeting, for those cases in which more than one meeting took place. The analysis also examined whether the amount of change, if any, differed for AR versus IR families. Like the process above, average scores for the items were calculated, and, to identify the amount of change between first and last meetings, the families’ scores for the first meeting were subtracted from their scores for the last meeting.

The notations for statistical significance in every cell in Table 6.4 indicate that caseworkers reported a statistically significant increase in positive family engagement attributes from first to last meeting for AR and for IR families in all three sites. Further, for those families holding more than one meeting, caseworkers’ ratings of families’ positive engagement at the last meeting ranged between (3) Moderately positive and (4) Very positive for both AR and IR tracks. However, interaction tests indicated that there were no statistically significant differences in the amount of change associated with AR families versus IR families at any of the sites. In other words, while Colorado, Illinois, and Ohio AR families were associated with larger average positive changes than IR families, these differences were not statistically significant.

Table 6.4. Average Change in Positive Family Engagement Attributes Between First and Last Meeting Reported by Caseworkers

	Colorado		Illinois		Ohio	
	AR (n=855)	IR (n=767)	AR (n=1,327)	IR (n=1,656)	AR (n=378)	IR (n=167)
Average change in positive family engagement score between first and last meeting	0.09***	0.07***	0.14***	0.11***	0.22***	0.18***
*** $p \leq .001$						

Table 6.5 presents data from caseworkers’ perceptions of the AR and IR families’ negative family engagement attributes at the first meeting. The same scale was used for these items (e.g., options ranged from “Not at All” to “Very”), though, in this case, a lower number can be considered a less negative, or better, finding. As the table indicates, there were no statistically significant differences between AR and IR families for any site on this factor. Further, since all the scores are between 1.0 and 2.0, on average, AR and IR families were generally identified as somewhere between A Little and Moderately negative with respect to negative family engagement attributes.

Table 6.5. Caseworker Report of Negative Family Engagement Attributes at First Meeting

	Colorado		Illinois		Ohio	
	AR (n=865)	IR (n=792)	AR (n=1,583)	IR (n=2,191)	AR (n=460)	IR (n=243)
Average score on negative family engagement attributes at first meeting	1.45	1.44	1.37	1.40	1.48	1.45

The evaluation team also analyzed whether caseworkers' perceptions of level of negative family engagement attributes changed over time for AR and IR families. As Table 6.6 reflects, Colorado and Ohio caseworkers reported a statistically significant decrease in their ratings of negative family engagement attributes from first to last meeting for both AR and IR families. Here, negative numbers indicate that the assessed change was for the better, or that families were less negative on average. In Illinois, according to the caseworkers, the IR families' reported decrease was significant but the decrease associated with AR families was not. Thus, there was a statistically significant interaction between the pathway and the likelihood of a reduced negative engagement rating in Illinois. For further details on this interaction, please see Appendix D (available at www.differentialresponseqic.org).

Table 6.6. Average Change in Negative Family Engagement Attributes by Last Meeting Reported by Caseworkers

	Colorado		Illinois		Ohio	
	AR (n=855)	IR (n=767)	AR (n=1,272)	IR (n=1,386)	AR (n=374)	IR (n=164)
Average change in negative family engagement scores between first and last meeting	-0.06***	-0.06***	-0.01	-0.06**	-0.10***	-0.15***
** $p \leq .01$, *** $p \leq .001$						

Parent Perspectives on Engagement

The previous set of findings looks at engagement from the perspective of the caseworker who completed a survey at the conclusion of the case, recalling family characteristics. This next section transitions to look at engagement from the perspective of the parent, who completed a survey at case closure. The limitations of the survey data are presented in Chapter 4.

Parent Report of Satisfaction

Parental reports of satisfaction with how they were treated by their caseworkers were also examined. Response options for the first two parent satisfaction questions discussed here were (1) Not at All Satisfied, (2) Somewhat Satisfied, or (3) Very Satisfied. As shown in Table 6.7, in Illinois, compared to IR families, AR parents reported greater satisfaction, on average, with the way their families were treated by the caseworkers who visited their homes. The differences on

this measure between AR and IR parents in Colorado and Ohio were not statistically significant. In all sites and across all pathways, the average score from Family Survey respondents indicated that they were between (2) Somewhat Satisfied and (3) Very Satisfied with how they were treated by their caseworkers.

Table 6.7. Parent Satisfaction With Treatment by Caseworker

	Colorado		Illinois***		Ohio	
	AR (n=217)	IR (n=175)	AR (n=503)	IR (n=605)	AR (n=228)	IR (n=90)
Average satisfaction with treatment by caseworker	2.60	2.52	2.91	2.78	2.86	2.84
*** $p \leq .001$						

In addition, the satisfaction of parents with the help they received from their caseworker was also analyzed. As shown in Table 6.8, in Illinois, AR parents reported greater satisfaction with the help their families received from their caseworkers than did IR parents. In Colorado, AR parents were also more likely to indicate that they were satisfied with the help they received from their caseworkers; however, the results only trended toward statistical significance.¹⁵ The difference in the average score ratings by AR and IR parents in Ohio were not statistically significant.

Table 6.8. Parent Satisfaction With Help Received From Caseworker

	Colorado		Illinois***		Ohio	
	AR (n=216)	IR (n=174)	AR (n=499)	IR (n=595)	AR (n=228)	IR (n=89)
Average satisfaction with help received from caseworker	2.46	2.32	2.87	2.70	2.75	2.66
*** $p \leq .001$						

Parents were also asked to state how likely they would be to contact the caseworker again if they needed help in the future. Again, response options ranged from (1) Not at All Likely to (2) Somewhat Likely or (3) Very Likely. Table 6.9 shows that, in Colorado and Illinois, AR parents were more likely than IR parents to indicate that they would call the caseworker or agency if they or their family needed help in the future. In Ohio, AR and IR parents reported no significant differences for this measure. On average, parents at all sites indicated that they were (2) Somewhat Likely or (3) Very Likely to contact their caseworker or the agency in the future.

¹⁵ The term “trend” is intentionally used in this report to identify results from tests for statistical significance that did not reach the traditional value of $p < .05$, but were at least less than $p = 0.1$. Since the selection of $p < .05$ as the threshold for significance is itself an arbitrary choice, findings of statistical significance can be influenced by sample size. As the research presented above represents a unique contribution to the field, the evaluation team opted to highlight those findings that approached but did not meet the traditional definition of statistical significance. While the selection of $p < 0.1$ is also arbitrary, it is a convention for identifying trends that is commonly utilized in research literature. For specific p -values associated with the trends, please refer to Appendix D (available at www.differentialresponseqic.org).

Table 6.9. Parent Likelihood of Calling Caseworker or Agency in Future

	Colorado*		Illinois***		Ohio	
	AR (n=218)	IR (n=175)	AR (n=498)	IR (n=600)	AR (n=226)	IR (n=91)
Average likelihood of calling caseworker or agency in future	2.27	2.08	2.73	2.46	2.62	2.51
* $p \leq .05$, *** $p \leq .001$						

Parent Report of Positive and Negative Affect

At case closure, parents were asked to recall their feelings at the first time a caseworker came to their home. Parents could answer (0) No or (1) Yes for each of the six items composing the positive affect factor in this analysis. Then, once the factor groupings were identified, the average of the responses was calculated. Table 6.10 shows that, in Illinois and Ohio, AR parents reported significantly greater positive affect, on average, than IR parents at the first meeting with the caseworker. In Colorado, the averages for the items composing the factor were not significantly different between AR and IR parents.

Table 6.10. Parent Report of Positive Affect at First Meeting

	Colorado		Illinois		Ohio	
	AR (n=219)	IR (n=179)	AR (n=518)	IR (n=614)	AR (n=228)	IR (n=91)
Average of parent report of positive affect at the first meeting	0.30	0.27	0.43***	0.29	0.27*	0.21
* $p \leq .05$, *** $p \leq .001$						

On the other hand, as identified in Table 6.11, Illinois IR parents reported feeling more worry during their first meeting with their caseworker, on average, compared to AR parents in those sites, and these differences were statistically significant. In contrast, Ohio IR parents reported less worry compared to AR parents, which was also a statistically significant finding. The Colorado data reflected a trend following a similar pattern as Illinois (with IR parents reporting more worry), but the results did not reach traditional statistical significance. Again, ratings were based on the average of items rated on a (0) No and (1) Yes scale.

Table 6.11. Parent Report of Worry at First Meeting

	Colorado		Illinois		Ohio	
	AR (n=219)	IR (n=179)	AR (n=518)	IR (n=614)	AR (n=228)	IR (n=91)
Average of parent report of worry at the first meeting	0.31	0.38	0.21	0.31***	0.43***	0.26
*** $p \leq .001$						

Similarly, with respect to negative affect, Table 6.12 shows that, in Illinois, IR families reported more anger at their first meeting with the caseworker compared to AR families. Once again, the Colorado data trended toward, but did not reach, statistical significance on this measure. In Ohio, the difference between AR and IR families on this measure was not statistically significant.

Table 6.12. Parent Report of Anger at First Meeting

	Colorado		Illinois		Ohio	
	AR (n=219)	IR (n=179)	AR (n=518)	IR (n=614)	AR (n=228)	IR (n=91)
Parent report of anger at the first meeting	0.16	0.21	0.06	0.14***	0.19	0.20
*** $p \leq .001$						

SUMMARY

To summarize these findings, Table 6.13 lists the results, across indicators. The table indicates what the analysis identified as the relationship between the item and the pathways.

<i>Table 6.13. Summary of Engagement Analysis Results</i>			
Item	Colorado	Illinois	Ohio
Caseworker report of positive family engagement attributes at initial meeting	Higher for IR**	Higher for IR***	Higher for IR***
Caseworker report of change of positive family engagement attributes (between first and last meetings)	Equivalent increase for IR and AR***	Equivalent increase for IR and AR***	Equivalent increase for IR and AR***
Caseworker report of negative family engagement attributes at initial meeting	NS	NS	NS
Caseworker report of change of negative family engagement attributes between first and last meetings	Equivalent decrease for IR and AR***	Decrease only for IR**	Equivalent decrease for IR and AR***
Parent report of satisfaction with treatment by caseworker	NS	AR parents more satisfied***	NS
Parent report of satisfaction with the help received from caseworker	NS	AR parents more satisfied***	NS
Parent report of likelihood of calling caseworker/agency in the future	AR parents more likely*	AR parents more likely***	NS
Parent report of positive family affect at first meeting	NS	Greater positive affect for AR parents***	Greater positive affect for AR parents*
Parent report of worry at first meeting	NS	IR parents more worried***	AR parents more worried***
Parent report of anger at first meeting	NS	IR parents angrier***	NS
* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$		NS=Not Statistically Significant	

Chapter 7. Services

This chapter presents data on the two pathways in each study site in terms of similarities and differences, based on a number of characteristics. We discuss receipt of services, duration of the pathway, and receipt of ongoing services. We present an overview of some of the relevant literature on receipt of services as an introduction to the chapter.

SUMMARY OF THE LITERATURE

Most evaluations of AR and IR have examined some aspect of service delivery. The topics include:

- Comparison of proportions of families in each pathway who received services;
- Differences in types of service by pathway among those families who receive services; and
- Comparison of proportions of families who were referred to ongoing child welfare services.

Receipt of Services

In general, previous research has found that AR families are more likely to receive one or more services than IR families. Statistically significant differences in overall proportions of families who received services were identified in Minnesota (Loman & Siegel, 2004); Ohio (Loman, Filonow, & Siegel, 2010; Loman & Siegel, 2013); Onondaga County, New York (Ruppel et al., 2011); and in a multi-state study examining NCANDS data for six states (Shusterman, Hollinshead, Fluke, & Yuan, 2005).

- For example, in Minnesota, 54 percent of AR families indicated they received one or more services compared to 36 percent of IR families. The reports by caseworkers were similar; caseworkers reported 59 percent of AR families and 34 percent of IR families received one or more services (Loman & Siegel, 2004).
- Similar patterns in the relative proportion of cases receiving one or more services by pathway were reported in Ohio (Loman et al., 2010; Loman & Siegel, 2013) and in Onondaga County, New York (Ruppel et al., 2011).
- An exception to these findings was a study conducted in Texas in 1999 (Chipley et al., 1999). There, researchers found that more IR cases were associated with one or more services than AR cases (rates were 17 percent and 9 percent, respectively).

These studies have tended not to discuss the finding that a significant proportion of AR families and IR families did not receive any services. There has been little study regarding the factors associated with receiving services within each pathway.

Types of Services

The Minnesota study (Loman & Siegel, 2004) found that, among those families who received services, AR families received an average of 3.5 types of services and IR families received an average of 2.7 types of services.

Previous research has shown that, among those families who receive one or more services, families in the AR pathway tend to be more likely to receive assistance in meeting basic needs than families in the IR pathway.

- Studies in Minnesota (Loman & Siegel, 2004); Ohio (Loman et al., 2010; Loman & Siegel, 2013); and Onondaga County, New York (Ruppel et al., 2011), found that the proportion of AR cases that received services addressing basic needs (e.g., transportation or housing assistance, help paying utilities, or providing furniture or appliances) was significantly higher than the proportion of IR cases that received such services.

Although a common typology of service types is lacking, several studies have indicated differences in the receipt of specific services.

- Some studies have found that AR families were more likely to receive marital counseling services (Loman & Siegel, 2013) or “help with a difficult relationship with a partner or ex-partner” (Ruppel et al., 2011) than IR families.
- Some studies have indicated that AR families were more likely to receive counseling services for a child (Loman & Siegel, 2004; Loman et al., 2010) than IR families.
- AR families may be more likely to be connected with community resources than IR families (Loman & Siegel, 2004). In Onondaga County, New York, AR caseworkers were more likely to report connecting AR families to community action agencies, support groups, and neighborhood organizations, compared to IR families (Ruppel et al., 2011).

There are some findings indicating that more IR families receive specific types of services than AR families.

- In Onondaga County, New York (Ruppel et al., 2011) and Nevada (Siegel et al., 2010), IR families were more likely than AR families to receive substance abuse treatment. In Nevada, researchers surmised that this distinction was likely due to high rates of families changing from AR to IR tracks once substance abuse issues were identified.
- In Ohio, IR families reported receiving significantly more medical or dental services (Loman & Siegel, 2013).

Ongoing Services

The AR and IR pathways constitute the initial phase of assessment of screened-in referrals by CPS. Upon completing this phase, the family may be referred for ongoing services, most often in-home services. Case openings in ongoing services are usually voluntary, although they can be court ordered. Ongoing services can also include foster care services.

Rather than depending upon the reports of adult members of a case or the caseworker, data on the transfer of a family to ongoing services are available in administrative data. In these systems, it is more complicated to determine whether a family was recommended to receive ongoing services, but refused such services.

- In Minnesota, administrative data indicated that AR cases were two times more likely than IR cases to receive ongoing services (31 percent versus 14 percent, respectively).¹⁶ Additional analysis indicated that, of those cases associated with low- or moderate-risk ratings, a larger proportion of AR cases received ongoing services compared to low- or moderate-risk IR cases (Loman & Siegel, 2004).
- Follow-up analysis, which extended the prior study for another 2 years in Minnesota, indicated that the differences between pathways persisted with respect to the percent of cases receiving ongoing services. At the 2-year point, 38 percent of AR cases were receiving ongoing services, while only 18 percent of IR cases were still receiving ongoing services (Institute of Applied Research [IAR], 2006).¹⁷

QIC-DR FINDINGS

Receipt of Services

Based on some of the earliest DR research (described above), for some states implementing DR, the goal was for AR families to receive services more quickly and more completely during the initial phase of CPS involvement. A counter argument has more recently emerged, which presents the notion that the assessment period was more comprehensive and time-consuming for AR families, and thus they would be less likely to receive services more quickly. Combining these two possibilities, one would expect that AR families would receive more services, with less certainty on the rapidity of those services, than IR families.

Each site had parameters for receiving services and assessment processes to determine service needs for AR and IR families.

- In Colorado, if services were not needed, an assessment of strengths and needs was completed, and the Child Protection Team reviewed the decision to close the case. If services were needed, a Family Assessment Response Service Plan was developed. This tool, unique to FAR, is intended to be co-completed by the caseworker and the family. A Family Support Plan was also completed for any case that remained open longer than 60 days and was designed to establish an ongoing plan of support for the family after case closure.¹⁸ If lengthy services were needed, the AR caseworker attempted to keep the case until it closed, but if a case continued for a long period of time, many counties initiated policies to transfer the case to an ongoing caseworker.
- In Illinois, the SSF worker completed a family assessment as part of the voluntary family enhancement plan. The SSF worker was considered to be a coach, advocate, and broker of

¹⁶ In the Minnesota administrative data system, the simplest proxy for determining if families received ongoing services was to examine whether a “case-management workgroup” was associated with the case. For a discussion of the limitations of this approach, see Loman and Siegel (2004).

¹⁷ From some perspectives, this finding might be considered to be a negative finding, in that two times as many AR cases were still receiving services compared to IR cases. Another perspective is that families in need of services were more likely to obtain such services if they had received AR than if they had received IR. Further study of the impact of such services might be useful to decide which perspective is most relevant.

¹⁸ Subsequent to this study period, this requirement was dropped.

services. The workers might help with connecting the caregivers to local food banks, assist them in the development of a resume, teach them about appropriate hygiene or cleaning methods, connect them with resources at school for the child, or transport them to a service provider. Cash assistance, up to \$400, was available for families to meet basic needs, which SSF workers could access through requesting extra monies from the Illinois DR director. The SSF worker visited the family in the home twice a week unless the family requested fewer contacts. Cases were permitted to stay open for 90 days with the possibility of three 30-day extensions. The decision whether to open an ongoing services case was the responsibility of the department worker.

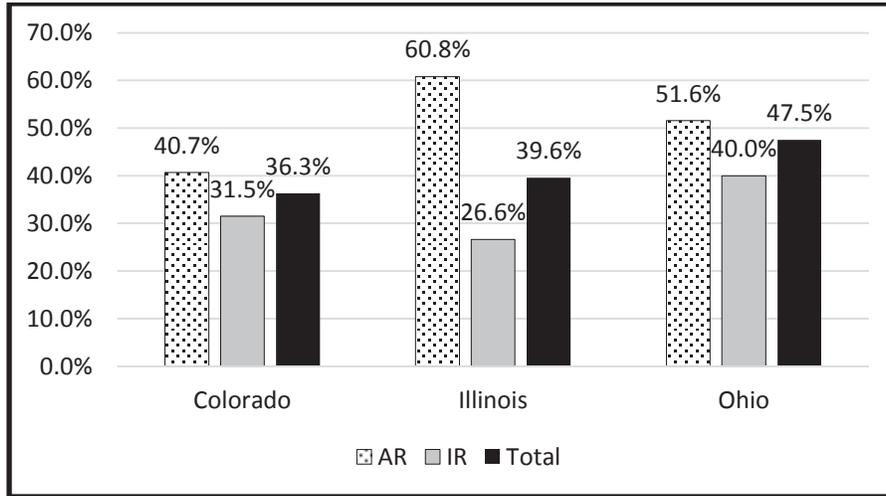
- In Ohio, services and supports could be provided any time after the completion of the safety assessment in either pathway. However, extra funds were available from Casey Family Programs and from the QIC-DR grant for AR cases to assist with concrete services such as rent, transportation, diapers, car seats, home repairs, etc. A family assessment was also completed on all cases. In AR, caseworkers had 45 days, and, in IR, caseworkers had 30 days to complete the assessment. In AR, if services continued, a family service plan was created with the family. If an IR case had a disposition requiring continued service provision, the case moved to an ongoing caseworker who completed a case plan with the family within 30 days.

As noted in Chapter 4, caseworkers were asked at case closure to document services provided to AR and IR families in the study. The evaluation collected data from caseworkers on three aspects of service provision:

- How many families received services;
- How quickly services were provided; and
- The array of services that was provided.

At case closure, caseworkers reported on families' service receipt. They reported whether the family had received any services, the types of services a family received (selecting from a list of options), and how long it took for the family to receive those services. Two findings regarding the receipt of services were common among all three study sites. First, not all AR families received services. Second, IR families were less likely to receive at least one service than AR families. Figure 7.1 shows the percentage of families by pathway who received at least one type of service.

Figure 7.1. Receipt of Services



Timeliness of Receipt of Services

In all sites, a high percentage of AR and IR families who received services received these services within 2 weeks. Specifically:

- In Colorado and Ohio, there was no significant difference in the speed with which AR and IR families received services.
- There was a significant difference in Illinois; a higher percentage of AR families, compared to IR families, received services within 2 weeks. This finding is likely to be related to the distinct model that was used in Illinois, since there was an explicit handover to a service provider under AR. Table 7.1 presents more specific information related to the speed with which services were provided in each site.

Table 7.1. Timeliness of Receipt of Services

	Colorado			Illinois***			Ohio		
	AR (n=332)	IR (n=207)	Total (n=539)	AR (n=980)	IR (n=579)	Total (n=1,559)	AR (n=263)	IR (n=89)	Total (n=352)
Within 2 weeks	69.9% (232)	77.3% (160)	72.7% (392)	89.2% (874)	67.9% (393)	81.3% (1,267)	66.5% (175)	64.1% (57)	65.9% (232)

*** $p \leq .001$

Total cases for which timeliness was reported varied slightly from the total number of cases receiving services. Percentages were computed based upon the number reported. Significance was computed based on the complete range of responses. See the data tables in each site appendix for more detailed information.

Array of Services

Table 7.2 shows the percentage of AR and IR families receiving particular types of services. The consistent, statistically significant finding across all sites was that AR families, compared to IR families, were more likely to receive services to meet their material needs. In addition:

- In Colorado and Ohio, there weren't any additional significant differences regarding service receipt between AR and IR families.
- In Illinois, several service categories were noted as statistically significant, and thus provided more often to AR families than to IR families. These included social support, educational, parenting, and other services. Of interest is that IR cases were more likely to receive substance abuse services than AR cases.

Table 7.2. Array of Services Received

	Colorado (n=605)			Illinois (n=2,611)			Ohio (n=632)		
	AR	IR	Total	AR	IR	Total	AR	IR	Total
Material Needs	29.7% (54)**	13.9% (16)	23.6% (70)	34.1% (430)***	7.6% (103)	20.4% (533)	45.3% (197)***	21.8% (43)	38.0% (240)
Mental Health	25.8% (55)	18.2% (25)	22.9% (80)	9.2% (116)	8.4% (113)	8.8% (229)	18.6% (81)	15.2% (30)	17.6% (111)
Substance Abuse	23.5% (27)	22.8% (18)	23.2% (45)	2.8% (35)	6.9% (93)***	4.9% (128)	12.2% (53)	12.2% (24)	12.2% (77)
Social Support	17.0% (26)	16.8% (160)	16.9% (42)	17.2% (217)***	6.4% (87)	11.6% (304)	11.5% (50)	6.6% (13)	10.0% (63)
Educational	27.4% (17)	20.8% (10)	24.5% (27)	10.3% (130)***	2.2% (30)	6.1% (160)	7.4% (32)	2.0% (4)	5.7% (36)
Domestic Violence	6.7% (6)	9.0% (6)	7.6% (12)	5.6% (71)	5.9% (80)	5.8% (151)	7.4% (32)	10.2% (20)	8.2% (52)
Health	15.2% (15)	11.7% (9)	13.6% (24)	4.0% (51)	3.0% (41)	3.5% (32)	3.4% (15)	4.6% (9)	3.8% (24)
Parenting Classes	21.2% (25)	21.4% (15)	21.3% (40)	7.3% (92)***	3.3% (45)	5.2% (137)	5.7% (25)	6.1% (12)	5.9% (37)
Other	50.0% (30)	35.6% (16)	43.8% (46)	8.4% (106)***	3.9% (53)	6.1% (159)	10.3% (45)	8.6% (17)	9.8% (62)

p ≤ .05; *p ≤ .001

The array of services received is based only on caseworkers' reports of those who received at least one service and for whom it was indicated that they did or did not receive a service. Persons who did not receive any service were not included in this more detailed examination of services. Significance is based on each individual service category. See the data tables in each site appendix for more detailed information. Note that Colorado's response rate was below 80 percent (29.1 percent) for these items.

Duration of AR and IR Assessment Period

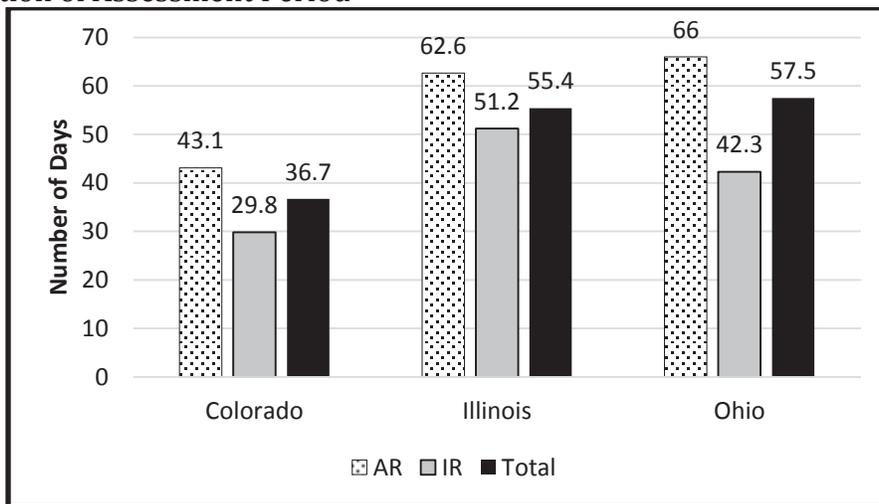
In most states, CPS has established the initial timeframe for an IR case to be approximately 30-45 days. This has become common for several reasons. The primary underlying reason is that, with a limited objective of establishing whether maltreatment has occurred or not, caseworkers should

establish this within a time period that gives them enough time to gather the required evidence but also limits the intrusion into family life. Caseload management is probably also an underlying factor in determining the length of the investigation period. Given the broader perspective of the AR approach, time parameters for AR might be more relaxed, or a similar amount of time might be used in a different way.

- In Colorado, AR cases allowed for a 60-day assessment period, whereas IR cases were allowed a 30-day assessment period with available extensions. A Family Support Plan was completed for any case that remained open longer than 60 days and was designed to establish an ongoing plan of support for the family after case closure.
- In Illinois, the SSF worker was given a specified length of time for service. Any extensions needed to be approved by the Department. The SSF worker visited the family in the home twice a week unless the family requested fewer contacts. Cases were permitted to stay open for 90 days with the possibility of three 30-day extensions.
- In Ohio, AR caseworkers had 45 days and IR caseworkers had 30 days to complete the family assessment. At this point, if an IR case had a disposition requiring continued service provision, the case moved to an ongoing caseworker who completed a case plan with the family within 30 days. In AR, if services continued, a family service plan was created with the family within 30 days, and the case might remain with the AR worker or transfer to an ongoing worker.

In all three sites, as shown in Figure 7.2, AR cases were in the assessment period for significantly longer durations than IR cases. This finding was significant for each site. The difference in mean number of days ranged from 11.4 days in Illinois to 20.2 days in Ohio. In Colorado, the difference was 13.3 days. See Table 15 in each site appendix for additional detail.

Figure 7.2. Duration of Assessment Period



Ongoing Services

In both AR and IR pathways, there is some degree of flexibility in the extension of the timeframe of the AR or IR worker in order to provide short-term services. The national study on CPS systems reform found that, even a decade ago, there was variation in policy and practice concerning the formal end of the investigation phase of a child welfare case (USDHHS, 2003).

Each of the sites provided guidance on when to refer a case to ongoing services. The primary guidance was based on the length of time it was anticipated that a family would need services. In both Colorado and Ohio, there was some variation in how ongoing services were provided to AR families.

- In Colorado, the AR caseworker attempted to keep the case until it closed, but if a case continued for longer than 60 days, many counties initiated policies to transfer the case to an ongoing caseworker.
- In Illinois, the decision to refer a case to ongoing services was made by the Department.
- In Ohio, if an IR case had a disposition requiring continued service provision, the case moved to an ongoing caseworker who completed a case plan with the family within 30 days. In AR, if the length of time that services were needed extended beyond 45 days (or 60 days if an extension for the family assessment had been granted), the case would be technically transferred to ongoing services within SACWIS, but in practical terms would remain with the same caseworker.

In all sites, less than 20 percent of families were referred to ongoing services in either pathway.

As shown in Table 7.3, patterns of transferring families to ongoing services were not comparable among the three sites. In Colorado, a higher percentage of AR cases were transferred to ongoing services even though they had received longer periods of service under AR. In Illinois, a smaller percentage of AR cases received ongoing services than IR cases, which may be consistent with the findings that AR cases had received significantly more services in Illinois than IR cases. Given that both AR and IR cases were considered low risk, in Illinois the upfront investment resulted in lower percentages of families being referred for ongoing services. In Ohio, there was no significant difference, which is an interesting finding given the significant differences found between AR and IR pathways for receipt of material services and for the duration of the assessment period. See each site appendix for additional details.

Table 7.3. Transfer of Cases to Ongoing Services

	Colorado***			Illinois***			Ohio		
	AR (n=870)	IR (n=797)	Total (n=1,667)	AR (n=1,706)	IR (n=2,828)	Total (n=4,534)	AR (n=531)	IR (n=300)	Total (n=831)
Transferred to ongoing services	15.7% (137)	5.9% (47)	11.0% (184)	6.3% (108)	13.0% (369)	10.5% (477)	18.3% (97)	13.3% (40)	16.5% (137)
*** $p \leq .001$									

It is of interest to consider how this subgroup of families served by the sites compared to the overall population served by CPS in the most recently reported year. In Table 7.4, victims include only those who were found to be victims through an investigation. Nonvictims include those who received either AR or IR. The data report on the percentage of cases that received post-response services, namely, were transferred for ongoing services.

Table 7.4. Receipt of Services Reported to NCANDS

	Colorado		Illinois		Ohio	
	Duplicate Victims (11,072)	Duplicate Nonvictims (38,273)	Duplicate Victims (27,907)	Duplicate Nonvictims (107,677)	Duplicate Victims (33,509)	Duplicate Nonvictims (91,269)
Received post-response services	26.3% (2,910)	9.3% (3,544)	45.6% (12,727)	12.8% (13,830)	44.5% (14,924)	17.4% (15,863)

Source: USDHHS, 2012

Compared to the overall population of CPS, the cases in this study were those of low risk and, therefore, one might anticipate that a smaller percentage of AR or IR cases should have received services than those found to be victims. This assumption is confirmed by the comparison of the two sets of data.

Since very few of the families who received IR in this study were substantiated and they were of low risk, one might assume that their rates of receipt of ongoing services would be lower than the percentage of nonvictims who received services. This assumption is confirmed by the comparison of the two sets of data, with Illinois being an exception. Both groups have comparable rates.

A third assumption is that, given the emphasis on providing services during the AR response, a lower percentage of AR families would be referred for ongoing services than nonvictims. This was demonstrated in Illinois but not in either Colorado or Ohio.

A number of findings were found to be significant. In Colorado, AR families were more than twice as likely to be referred to ongoing services as IR families. In Illinois and Ohio, those families who were assessed by the caseworker as being engaged at their first meeting were 50 percent and 15 percent, respectively, less likely to be referred for ongoing services than those who were not. While one might posit that this is because engaged families received more services, this hypothesis was not demonstrated. In Ohio, families who had one or more prior screened-in referrals were nearly 60 percent more likely to be transferred to ongoing services. In Illinois, several additional factors were found to be related to the transfer to ongoing services when adjusting for other independent variables. First, AR cases were 55 percent less likely than IR cases to be transferred. Households with two or more caregivers were about 30 percent more likely to be transferred to ongoing services. In addition, cases with an allegation of neglect were 47 percent more likely to be transferred to ongoing services, cases with shorter assessment periods were more likely to be transferred to ongoing services, and families with older children were more likely to be transferred than those with younger children.

Summary of Findings

Table 7.5 summarizes the statistically significant findings by site on the practices of AR compared to IR.

<i>Table 7.5. Summary of Findings Comparing AR and IR</i>			
	Colorado	Illinois	Ohio
Receipt of services	More likely in AR***	More likely in AR***	More likely in AR***
Percentage of cases receiving services within 2 weeks	NS	Greater in AR***	NS
Material needs services provided	More in AR**	More in AR***	More in AR***
Mental health services provided	NS	NS	NS
Substance abuse provided	NS	More in IR***	NS
Social support provided	NS	More in AR***	NS
Educational services provided	NS	More in AR***	NS
Domestic violence services provided	NS	NS	NS
Health services provided	NS	NS	NS
Parenting classes provided	NS	More in AR***	NS
Other services provided more in AR than IR	NS	More in AR***	NS
Duration of assessment period	Longer in AR***	Longer in AR***	Longer in AR***
Transferred to ongoing services	AR more likely than IR***	AR less likely than IR***	NS
Regression Model Results			
Type of maltreatment	NS	Families with a neglect allegation more likely to be transferred to ongoing than those without a neglect allegation*	
Two or more caregivers	NS	Families with two or more caregivers more likely to be transferred to ongoing than those with fewer than two caregivers*	NS
Prior screened-in referrals (one or more, Ohio only)	NA	NA	Families with prior referrals more likely to be transferred to ongoing than those with no prior referrals**

Longer duration of assessment period	NS	Families with longer assessment periods less likely to be transferred to ongoing services than those with shorter assessment periods***	NS
Families with older children	NS	Families with older children more likely to be transferred to ongoing services than those with younger children***	NS
Very engaged families at first meeting with caseworker	Engaged families less likely to be transferred to ongoing services than less engaged families***	Engaged families less likely to be transferred to ongoing services than less engaged families***	Engaged families less likely to be transferred to ongoing services than less engaged families**
* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$		NS=Not Statistically Significant	

The next chapter examines the safety of children of AR and IR families.

Chapter 8. Child Safety: Re-Referrals and Removals

INTRODUCTION

As part of the formulation of the Children’s Bureau response to the Adoption and Safe Families Act of 1997, three main goals for children were enunciated: safety, permanency, and well-being. These goals reflect the core concerns of child welfare services in meeting the needs of children who come to the attention of the public system due to allegations and findings related to child abuse and neglect. The Children and Family Service Review (CFSR) operationalized safety by establishing an indicator that measures repeat victimization. The CFSR also recognizes that there are contextual issues that underlie this measure. The “Safety Profile” of the CFSR collects information on whether cases were opened for services and whether services were received, based on data reported to the National Child Abuse and Neglect Data System.

In most states, the majority of referrals to CPS involve cases of neglect. Neglect covers a range of actions and results, but is often caused by lack of foundational supports available to the family. The development of DR has partially been in response to thinking about how best to serve such families who may not have access to resources that meet their needs. Since these cases are unlikely to be referred for judicial action, it has been thought that a determination of substantiating the neglect or risk of neglect may not serve any useful purpose.

Both the proponents and challengers of adopting a DR system of child protection recognize that any adjustments to CPS should not endanger a child or fail to identify risk factors that may endanger a child. As a result, AR pathways also assess the situation for safety. In this demonstration, the same instruments were sometimes used for both the AR pathway and the IR pathway to assess safety. Furthermore, each of the sites provided the ability to easily transfer a case from AR to IR to ensure that the appropriate response of the agency would be provided.¹⁹

This chapter first sets the context for the cross-site evaluation findings by summarizing relevant findings from prior research. It then compares AR and IR processes in terms of child safety, and examines the outcomes of both groups of children in terms of re-referrals and removals of children in the cross-site evaluation sample, which, as previously noted, is different than the three local evaluation samples.

LITERATURE REVIEW: PRIOR RESEARCH ON SAFETY MEASURES AND OUTCOMES IN DR

Several common outcomes tend to be examined when researchers evaluate the efficacy of child welfare interventions. These include whether cases are opened for ongoing services, re-referrals to CPS, and placement in out-of-home care. Some studies have compared safety and risk assessment findings for AR and IR cases, but differences between safety and risk assessment instruments, the timing, and the methods of their use make it difficult to generalize across studies. A number of DR evaluations have focused on some or all of these safety outcomes for AR, and sometimes IR, cases. This literature review focuses on the three key evaluations (Minnesota, Ohio,

¹⁹ It may be noteworthy that, to date, no DR system, other than Minnesota, provides for the transfer of IR cases to AR.

and Onondaga County, New York) that employed random assignment when determining which AR-eligible cases received AR versus IR.

Safety and Risk Assessments

Two of the three studies compared AR families with IR families on measures associated with safety and risk assessment ratings. The Onondaga County, New York, study did not examine safety assessments (Ruppel et al., 2011).

Initial Safety Assessment Ratings

The Minnesota study, conducted by Loman and Siegel (2004), examined results of initial structured decision making (SDM) safety assessments for both the AR and the IR pathways and found that the families assigned to the two tracks were similar with respect to the proportion of families with at least one safety item checked. Both the AR families and IR families were identified as low risk in general, as only 15.8 percent of AR families and 15.3 percent of IR families had at least one safety item checked; the difference between them was not statistically significant. That almost 85 percent of cases did not have a safety threat indicated suggests that, in general, the DR study sample in the Minnesota study was relatively low risk.

Number of Safety Problems at Case Closure and Degree of Change on Safety Problems

The Minnesota study compared AR and IR families whose safety status was known at the end of the study and who had at least one safety item checked at the outset of the study. There were no statistically significant differences between AR and IR families on the number of safety problems at case closure. However, because families could be associated with either one or multiple types of safety problems during the course of the case, in order to assess whether pathways differed with respect to the degree of change in safety status by case closure, the Minnesota evaluators calculated the average change in safety status. The results indicated that AR families were associated with statistically significant larger improvements with respect to their overall safety status, compared to children in IR families (Loman & Siegel, 2004).

Number of Safety Assessments and Types of Safety Threats

In Ohio (Loman & Siegel, 2013), researchers examined the results of safety assessments conducted after initial involvement ended and up to at least 3.5 years thereafter. They found that comparable proportions of AR families and IR families received subsequent safety assessments, with 48.1 percent of AR families receiving at least one assessment in the follow-up period, compared to 51.1 percent of IR families. However, distinctions between AR and IR families emerged when individual safety factors were examined in the groups that had received additional safety assessments. Specifically, although very few families had any risk factors, families originally assigned to AR were significantly less likely than families originally assigned to IR to be associated with a few specific safety concerns, including:

- A child in the family received serious inflicted harm (4.3 percent of AR compared to 5.5 percent of IR);
- Caregiver refusal of access to child or indication that the family was likely to flee (1.4 percent compared to 2.2 percent, respectively); and

- Failure to meet serious physical or mental health needs (2.9 percent compared to 3.9 percent, respectively).

Re-Referral Rates

Re-referral rates are another measure of safety commonly used to assess CPS intervention efficacy. Studies have examined re-reports during the initial involvement, and vary with respect to the stage of the case and the length of time periods examined; therefore, generalizations are difficult.

The Minnesota (Loman & Siegel, 2004) and Ohio (Loman & Siegel, 2013) studies did not find statistically significant differences between the rates of re-referrals during the assessment or investigation phase for AR versus IR cases. However, the Minnesota study found that AR cases with no prior history of CPS involvement had a longer time to re-referral compared to IR cases with no prior history. This finding was statistically significant. There was no significant difference in the number of days to a re-referral for AR or IR families with a prior history. The Ohio study replicated the findings regarding longer times to re-referral for AR cases with no prior history of CPS involvement.

In contrast, but using a much shorter 6-month follow-up time period, the Onondaga County, New York, study found that AR families were over three times as likely to have a subsequent report before their focal report (the one that made them eligible for the study) was closed, compared to IR families (rates were 12.4 percent and 4.2 percent, respectively). Still, the research did not find statistically significant differences between pathways with respect to re-reports within 6 months of the focal report (Ruppel et al., 2011).

In Ohio, following the agency's final contact with the family, AR families were significantly less likely to be the subject of additional accepted reports during the assessment or investigation phase than IR families (rates were 3.8 percent and 4.8 percent for AR and IR, respectively).

Moreover, when Ohio study families with a prior history of CPS involvement were examined separately from those with no prior history, the researchers found that the results above were generally replicated and, in some cases, even strengthened. AR families with a prior CPS history were significantly less likely than IR families with a prior history to be associated with:

- A child receiving serious inflicted harm (4.4 percent of AR cases versus 6.9 percent of IR cases);
- An adult with a mental or physical illness who poses danger to a child (4.4 percent versus 6.3 percent, respectively);
- Household environmental hazards (3.0 percent versus 4.5 percent, respectively); and
- Failure to meet serious physical or mental health needs (3.6 percent versus 5.4 percent, respectively).

Given these results and considering additional factors that fell just short of reaching statistical significance, the Ohio researchers concluded that long-term safety improvements appeared to be

more pronounced for those AR families who had a prior history of CPS involvement (Loman & Siegel, 2013). When the Ohio analysis took prior history with CPS into consideration, AR cases with no prior history were significantly less likely to be re-reported post case closure than IR cases with no prior history (35.8 percent versus 39.2 percent). In contrast, no statistically significant differences were observed when AR and IR cases had prior reports to CPS.

Placement in Out-of-Home Care

Research in Minnesota (Loman & Siegel, 2004) and Ohio (Loman & Siegel, 2013) suggest that AR families are generally associated with lower rates of out-of-home placement. In Minnesota, 10.9 percent of AR families and 13.1 percent of IR families had children placed in out-of-home care, although time-to-removal analyses did not reveal differences by pathway. However, when prior CPS involvement and the receipt of ongoing services were controlled in the analysis, there were significantly lower rates of placement over time for AR families compared to IR families.

In Ohio (Loman & Siegel, 2013), AR families were significantly less likely than IR families to be associated with placements both while the case was active and in the interim period between case closure and the follow-up study conducted in that state. No analyses regarding out-of-home care placements were included in the Onondaga County, New York, study (Ruppel et al., 2011).

RESEARCH QUESTION

As might be expected, safety was a main emphasis for the cross-site evaluation team, which was tasked with answering the following research question:

Are children in AR families as safe as or safer than children in IR families?

FINDINGS

The QIC-DR study sample is a complex one, and a clear understanding of the sample is useful when interpreting the findings. In order to facilitate that understanding, the safety-related findings are organized as follows. Because safety is the key outcome of interest, there are discussions of two separate outcomes, post-assessment re-referrals and removals during the study. Two sets of analyses were conducted for each outcome. One describes simple relationships between the outcome and each of a selected set of case characteristics (independent, or explanatory, variables). The second describes more complex, interactive relationships between multiple variables at one time.

Sometimes, the findings of the simpler and more complex analyses do not agree with each other. This disagreement indicates that the additional independent variables have an effect on the relationship of interest. In these cases, interpretation can become a challenge. The first set of findings capture simple relationships, set the stage, and provide context. But relationships in the real world are not simple. And so, the second set quantifies each of those relationships, controlling for the effects of additional independent variables, providing a more “real world” perspective.

While the findings of the second set of analyses are often considered more reliable and more valued, the first set of analyses can help decide which independent variables to include in that more complex model.

Because of differences in policy and implementation, each site defined terms differently. As described in Chapter 4, the cross-site evaluation team did not necessarily define terms in the same ways local sites did. The goals of the evaluation team were to have a single definition across sites and to ease interpretation for the reader of this report. A set of definitions used by the cross-site team are presented in Figure 8.1. Note that this means that some findings will differ from those in the sites' individual reports. Please refer to their reports for additional findings, which are accessible at www.differentialresponseqic.org.

Figure 8.1. Definitions

Case Initiation: For the purposes of this study, this is the date that the case was assigned to either the AR or IR pathway.

Assessment Period: This is the time period that starts at pathway assignment and ends when the case is transferred to ongoing services or is closed, or when the 365-day study period ends, whichever occurs first.

Re-Referral: This is a screened-in re-referral. This study only examined re-referrals that occurred after the end of the assessment period, but before the end of the 365-day study period. Note that this could be a re-referral that leads to the closing of an AR case and the immediate opening of an IR case. These are also referred to as “post-assessment re-referrals.”

Removal: This is an out-of-home placement. Removals could take place at any time during the study, including during the assessment period.

The sections below are organized as follows. First is a presentation of two sets of findings related to re-referrals. The first set examines descriptive statistics related to re-referral and specific variables. The second set of analyses examines the relationship of re-referral to each variable while controlling for other variables. After the section about re-referrals, those same two sets of findings, but related to removals, are presented. This chapter presents some findings which do not reach statistical significance at the 95 percent confidence level, generally meaning that there is a 95 percent probability that the findings are not a result of chance alone. However, there is some value in presenting findings that do not reach statistical significance if there is an understanding that they may be clinically significant or have some meaning regardless of their statistical significance. As such, this chapter presents findings on small, but meaningful, numbers of re-referrals and removals.

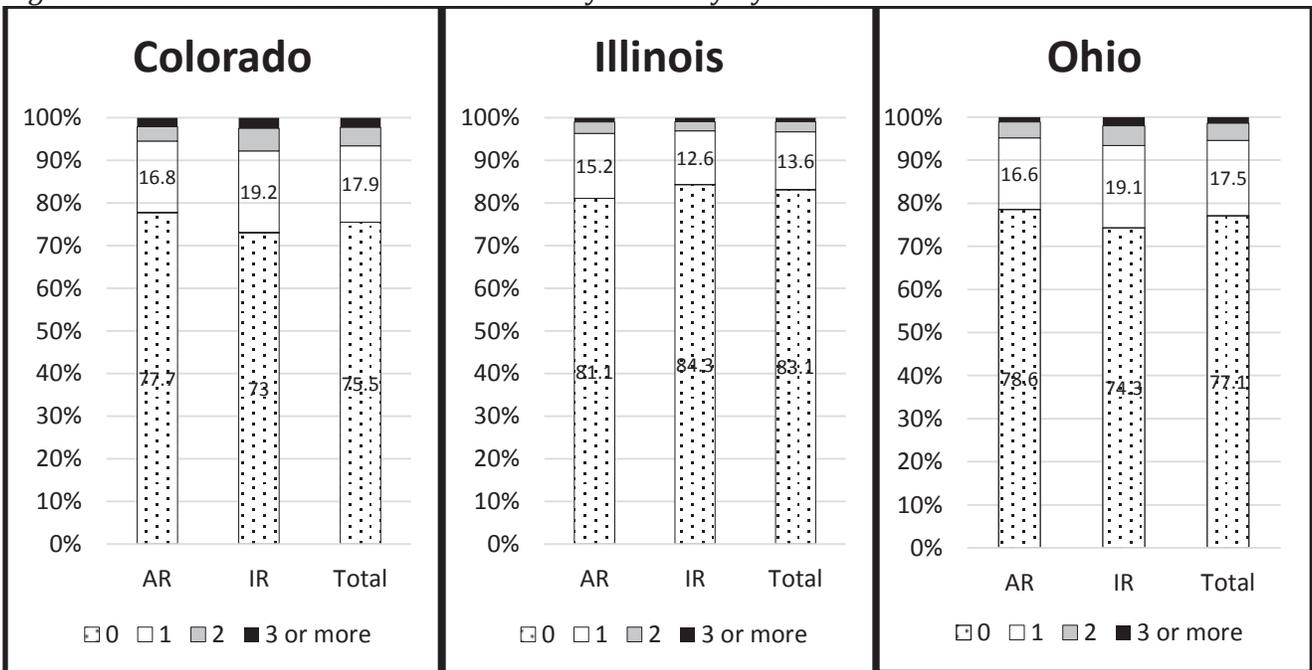
Re-Referrals

One indicator of safety is whether a family is re-referred to the child welfare agency. This reflects, to some degree, whether the issues facing a family have been resolved. This section presents

simple relationships between re-referrals and the results of cases' safety assessments at case initiation and the end of the assessment period. The examination of the number of screened-in re-referrals was focused on the time from end of the assessment period to the end of the 365-day study period.

Figure 8.2 shows the number of post-assessment re-referrals for each pathway by site. It shows that all three sites had a similar pattern of post-assessment re-referrals, with the vast majority having no re-referrals, between 13 percent and 20 percent having one re-referral, and then dramatically smaller proportions having two or more re-referrals after the assessment period. Note that the findings for Illinois are the only ones that reached statistical significance, possibly driven by their larger sample size, which provides increased statistical power to find differences if they exist.

Figure 8.2. Post-Assessment Re-Referrals by Pathway by Site²⁰



²⁰ While we strive to use consistent terminology, in Colorado, re-referral actually means cases that received a re-assessment.

Table 8.1 presents the proportion of cases experiencing a re-referral after the end of the assessment period, but within the 365-day study period, by the results of their initial safety assessments. Illinois’ findings are the only ones that reached statistical significance. In Illinois, about 20 percent and 15 percent of AR and IR cases determined to be safe at case initiation, respectively, had a post-assessment re-referral. About 70 percent and 15 percent of AR and IR cases in Illinois determined to be unsafe at case initiation, respectively, had a post-assessment re-referral. Generally, in Illinois, cases with an original safety assessment result of “unsafe” were considerably more likely to have one or more re-referrals than cases initially determined to be safe.

Table 8.1. First Safety Assessment Results and Post-Assessment Re-Referrals									
# of Re-Referrals	Colorado			Illinois***			Ohio		
Safe at Case Initiation									
	AR	IR	Total	AR	IR	Total	AR	IR	Total
0	78.4% (649)	72.8% (541)	75.7% (1,190)	81.5% (1,379)	84.3% (2,291)	81.2% (3,670)	78.3% (403)	74.0% (219)	76.7% (622)
1 or more	21.6% (179)	27.2% (202)	24.3% (381)	18.5% (313)	15.7% (427)	16.8% (740)	21.7% (112)	26.0% (77)	23.3% (189)
Total	100% (828)	100% (743)	100% (1,571)	100% (1,692)	100% (2,718)	100% (4,410)	100% (112)	100% (77)	100% (189)
Not Safe at Case Initiation									
	AR	IR	Total	AR	IR	Total	AR	IR	Total
0	63.4% (26)	73.7% (28)	68.4% (54)	28.6% (4)	84.2% (80)	77.1% (84)	80.0% (12)	75.0% (3)	78.9% (15)
1 or more	36.6% (15)	26.3% (10)	31.6% (25)	71.4% (10)	15.8% (15)	22.9% (25)	20.0% (3)	25.0% (1)	21.1% (4)
Total	100% (41)	100% (38)	100% (79)	100% (14)	100% (95)	100% (109)	100% (15)	100% (4)	100% (19)
Total									
Total	100% (869)	100% (781)	100% (1,650)	100% (1,706)	100% (2,813)	100% (4,519)	100% (530)	100% (300)	100% (830)
*** $p \leq .001$									

Note: All cases with an assessment at case initiation are included in this analysis.

In addition to the above analyses, the evaluation team conducted more complex multivariate analyses to examine the simultaneous effect of multiple factors associated with post-assessment screened-in re-referrals. These factors included child, family, allegation, service, and safety characteristics, and similar factors were used for each site (see Appendix D for a list of variables, or covariates, included for that site). The type of regression model used (Cox proportional hazards

model) also took into account the variation in amount of time that cases had for re-referral within the 365-day window. The following findings reached statistical significance at the 95 percent confidence level ($p \leq .05$). Additional findings can be found in Appendix D of the cross-site evaluation. Next to each site's name below is the size of the sample for which outcome and covariate data were complete, as well as the proportion of that site's total sample it represents.²¹

Colorado ($n = 1,346$; 80.7 percent)

The Cox proportional hazards analysis found that, in Colorado, AR families were 20 percent less likely to have a re-referral during the time between the end of the assessment period and the end of the 365-day study period than IR families. Cases with an allegation of medical neglect were 61 percent more likely to experience a re-referral than those without. Families identified as multiracial (not all children in the family were of the same race) were 3 percent less likely to have a re-referral during this time period. Families were 3.2 percent less likely to have a re-referral for every one-year increase in the age of the youngest child associated with the original report.

Illinois ($n = 3,770$; 83.1 percent)

AR families in Illinois were 23 percent more likely than IR families to have a re-referral between the end of the assessment period and the end of the study period. Families whose original report included an allegation of medical neglect were 46 percent more likely to have re-referral than those whose cases did not have a medical neglect allegation. Likewise, families whose original reports included a neglect allegation were 52 percent more likely to have a re-referral than those whose reports did not include a neglect allegation. Families with two or more caregivers in the household were 15 percent less likely to have a re-referral. Families who identified their ethnicity as Hispanic or Latino, and those who reported their race as African American, were less likely to have a re-referral (than White families)—29 percent and 32 percent, respectively. Families with younger children had about 5 percent less risk of having a re-referral. Families perceived by caseworkers to be very engaged were 25 percent less likely to have a re-referral than those who were perceived to be less engaged.

Ohio ($n = 823$; 98.0 percent)

Cases assigned to the AR pathway were 42 percent less likely to have a re-referral between the end of the assessment period and the end of the study period than IR families. Families who had screened-in referrals prior to participation in this study were 84 percent more likely than those who did not have prior referrals to have a re-referral between the end of the assessment period and the end of the study period.

Removals During the 365-Day Study Period

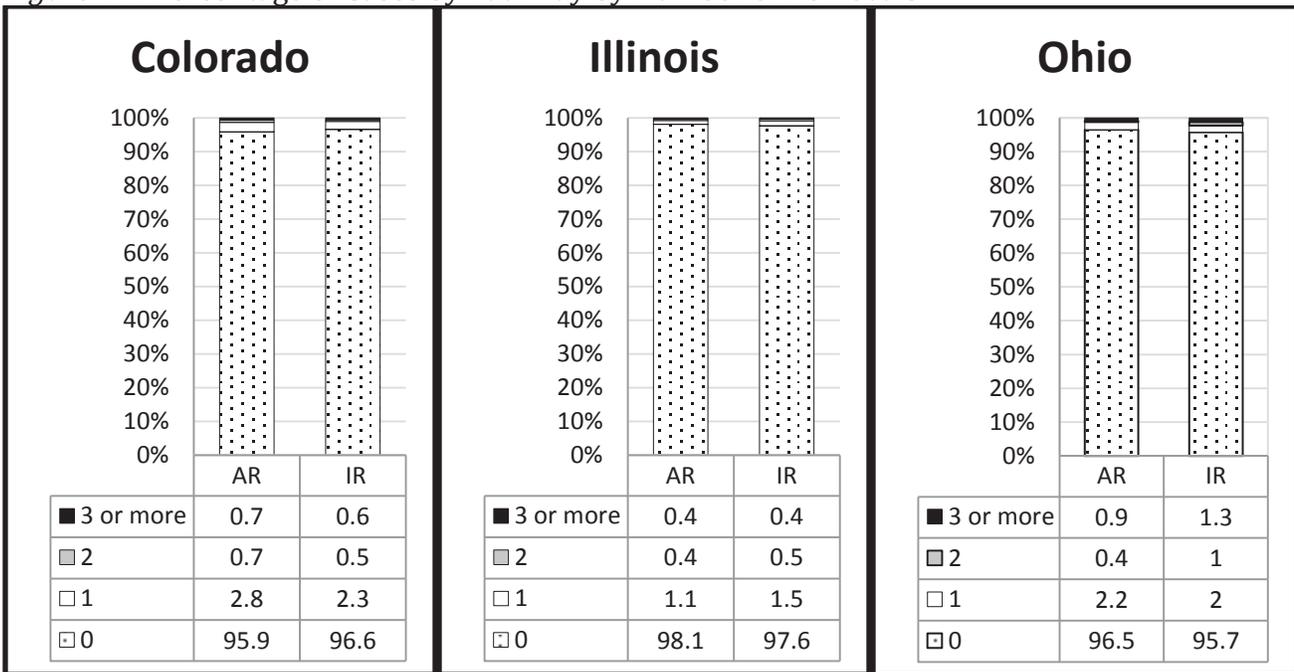
Another indicator of safety is whether or not a child needs to be removed from the home. Data on removals was obtained but without dates of removal, due to concerns related to burden, as well as

²¹ When conducting any regression analysis, listwise deletion is imposed; the analytic dataset for a given model becomes limited to only those cases with complete (non-missing) data on all of the variables in that model. This deletion applies to those missing on either the outcome variable or any of the covariates. These analytic datasets vary across models.

the expectation that, given the characteristics of the population, removals would be a rare event. Therefore, we do not know if the removals occurred before or after the children were served in one of the two pathways. Below is a presentation of the simple relationships between removals during the study period and each of a set of explanatory variables. Not all findings reached statistical significance (as noted by the absence of asterisks), but the cross-site team determined that those findings were important for context. Additional findings can be found in each Appendix D (available at www.differentialresponseqic.org).

In Colorado, 4.1 percent ($n = 63$) of IR and AR families experienced one or more removals. In Illinois, 1.9 percent ($n = 99$) of IR and AR families experienced a removal. In Ohio, 3.5 percent ($n = 32$) of IR and AR families had one or more removals over the course of the 365-day study period. Figure 8.3 presents more detailed findings regarding the number of removals. None of the findings regarding removals reached statistical significance for any of the sites. In other words, in all three sites, the implementation of AR did not appear to impact—positively or negatively—the entry of children into foster care. Additional information can be found in Appendix D.

Figure 8.3. Percentage of Cases by Pathway by Number of Removals



We also examined the proportions of cases that experienced a removal during the 365-day study period that had either a “not safe” finding for the first safety assessment (Table 8.2) or a pathway change (Table 8.3). Because of the small cell sizes, no statistical comparisons were made for the analyses presented in Table 8.4. Because cases assigned to IR were ineligible to change pathways, there are no statistical comparisons in Table 8.5. Likewise, these findings should be interpreted with caution because of the overall low number of removals. Analytic sample sizes are provided in

each table.²² Table 8.2 highlights that only a relatively small proportion of cases experienced a removal, regardless of the result of the first safety assessment.

Table 8.2. Association Between Results of the First Safety Assessment and Removals During the Study Period									
# of Removals	Colorado			Illinois***			Ohio		
Safe at Case Initiation									
	AR	IR	Total	AR	IR	Total	AR	IR	Total
0	96.9% (828)	96.5% (717)	96.7% (1,519)	98.6% (1,669)	98.3% (2,671)	98.4% (4,340)	96.4% (511)	95.7% (287)	96.1% (798)
1 or more	3.1% (26)	3.5% (26)	3.3% (52)	1.4% (23)	1.7% (47)	1.6% (70)	3.6% (19)	4.3% (13)	3.9% (32)
Total	100% (833)	100% (743)	100% (1,571)	100% (1,692)	100% (2,718)	100% (4,410)	100% (530)	100% (300)	100% (830)
Not Safe at Case Initiation									
	AR	IR	Total	AR	IR	Total	AR	IR	Total
0	75.6% (31)	97.4% (37)	86.1% (68)	35.7% (5)	78.9% (75)	73.4% (80)	66.7% (10)	75.0% (3)	68.4% (13)
1 or more	24.4% (10)	2.6% (1)	13.9% (11)	64.3% (9)	21.1% (20)	26.6% (29)	33.3% (5)	25.0% (1)	31.6% (6)
Total	100% (41)	100% (38)	100% (79)	100% (14)	100% (95)	100% (109)	100% (15)	100% (4)	100% (19)
Total									
Total	100% (874)	100% (781)	100% (1,655)	100% (1,706)	100% (2,813)	100% (4,519)	100% (530)	100% (300)	100% (803)

The data below suggest that cases experiencing a pathway change were more likely to have one or more removals during the study period. Similarly, the cases with “not safe” results of the first safety assessment (shown in Table 8.3) were more likely to have a removal than those with “safe” results. It is important to recognize that the pathway change may have been the result of the removal.

²² Sample sizes vary across tables for sites because cases having incomplete data on one or more of the variables in the table were removed for the analysis (listwise deletion).

Table 8.3. The Association Between Pathway Changes and Removals During the Study Period			
	Colorado	Illinois	Ohio
Number of Removals	AR	AR	AR
No Pathway Change			
0	96.1% (821)	99.0% (1,493)	98.0% (498)
1 or more	3.9% (33)	1.0% (15)	2.0% (10)
Total	100% (854)	100% (1,508)	100% (508)
Pathway Change			
0	31.3% (13)	91.4% (181)	74.3% (26)
1 or more	18.6% (3)	8.6% (17)	25.7% (35)
Total	100% (16)	100% (198)	100% (35)
Total			
Total	100% (870)	100% (1,706)	100% (543)

It is also apparent that AR cases assessed at case initiation as unsafe were more likely to change pathways, and subsequently receive an investigation, than those deemed safe (Table 8.4).²³ This suggests that there was a core group of particularly high-risk cases in these samples, and those cases were more likely to experience a removal as a safety-related outcome.

²³ Only AR cases are presented here, as IR cases were ineligible for pathway change.

Table 8.4. The Association Between Pathway Change and First Safety Assessment Results for Cases Initially Assigned to AR			
	Colorado	Illinois	Ohio
	AR	AR	AR
Safe at Case Initiation			
No pathway change	98.4% (815)	89.1% (1,507)	94.6% (487)
Pathway change	1.6% (13)	10.9% (185)	5.4% (28)
Total	100% (828)	100% (1,692)	100% (515)
Not Safe at Case Initiation			
No pathway change	92.3% (38)	7.1% (1)	60.0% (9)
Pathway change	7.3% (3)	92.9% (13)	40.0% (6)
Total	100% (41)	100% (14)	100% (15)
Total			
Total	100% (869)	100% (1,706)	100% (530)

To gain a more “real world” perspective, the team conducted more complex multivariate analyses to examine the relationship of removals with each of a set of explanatory variables. These analyses assessed the relationship between removals during the study and a range of child, family, allegation, service, and safety characteristics. Highlighted findings were determined to be statistically significant at the 95 percent confidence level, with one exception. The findings regarding pathway assignment are presented for all three sites, regardless of the statistical significance of the associated hazard ratios. It is noted when those associations did not reach statistical significance. Additional findings can be found in Appendix D.²⁴

Colorado (n = 1,322; 79.9 percent)

In Colorado, cases assigned to the AR pathway were 11 percent more likely to experience a removal during the study period (this finding did not reach statistical significance). For every additional day of ongoing services received, there was a slight increase (0.5 percent) in the likelihood of removal. While this may not seem to be a practically (versus statistically) significant increase, this translates to a 4 percent increase in the likelihood of removal for cases with 90 days

²⁴ As with the re-referral analyses, listwise deletion has limited these analyses to only those cases with complete (non-missing) data on all of the variables of interest. Next to each site’s name below is the size of the sample for which all variables of interest were complete and available for analysis, as well as the proportion of that site’s total sample it represents.

of ongoing services. Families who were identified by their caseworkers as very engaged during the first meeting were 70 percent less likely than those characterized as less engaged to experience any child removals during the reporting period.

Illinois (n = 3,733; 82.3 percent)

Families assigned to the AR pathway were 47 percent more likely than families assigned to the IR pathway to experience any removals during the reporting period. Note that this finding did not reach statistical significance. Cases with longer duration of ongoing services had an increased likelihood of experiencing a removal. Families who identified themselves as Hispanic or Latino were 88 percent less likely than their non-Hispanic or non-Latino counterparts. Families who identified as multiracial were nearly 3 times more likely to experience a removal during the study period than White families. Families whom caseworkers identified as very engaged at the first meeting were 61 percent less likely to have a removal during the assessment period than families whom caseworkers identified as being less engaged.

Ohio (n = 569; 67.3 percent)

Families who were assigned to the AR pathway were 28 percent less likely to experience a removal than their IR counterparts, although this finding did not reach statistical significance. Having an allegation of neglect was associated with a four-fold increase in the likelihood of having a child removed during the reporting period. For every additional day of ongoing services received, there was a slight increase (0.7 percent) in the likelihood of removal.

In addition to factors associated with removals, we noted that the number of days that children were in out-of-home placement varied widely within and across sites. In Colorado, the shortest length of placement was 2 days, and the longest was 365 days. The average length of placement was 166.8 days for the 102 children who were removed. In Illinois, the shortest placement was 1 day, and the longest was 364. The average number of days in placement for the 166 children removed was 186.5. In Ohio, the shortest out-of-home placement was 1 day, and the longest was 356. The average length of placement was 121.4 days for the 61 children removed.

SUMMARY

Table 8.5 summarizes the findings regarding safety by site.

Table 8.5. Summary of Safety Differences Between AR and IR			
	Colorado	Illinois	Ohio
Number of post-assessment re-referrals	NS	* IR has slightly fewer "0," AR has slightly more "1," both decrease at "2" and "3 or more"	NS
Number of post-assessment re-referrals by safety at case initiation	NS	*** Safe at initiation: Slightly more for AR than IR Not safe at initiation: More for AR than IR	NS
Number of children removed	NS	NS	NS
Number of removals by safety at case initiation	NS	NS	NS
Number of removals by pathway change	NS	NS	NS
* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$		NS=Not Statistically Significant	

Chapter 9. Cost Analysis

INTRODUCTION

Early in the cross-site evaluation, it was recognized that state and local variations in both the receipt and the expenditure of funds were such that this evaluation could not enforce a common methodology without a large investment in studying each child welfare system as a whole. The diversity of financing and the complexity of unraveling the fiscal aspects of child welfare services and programs have been cited in the following report from the Urban Institute (Scarcella, Bess, Zielewski, & Geen, 2006):

Collecting and comparing child welfare expenditures across states is difficult for two reasons. First, child welfare agencies do not always serve the same populations. . . . Second, states may not be able to document all the spending from the various funding streams available for child welfare. Federal funding for child welfare activities includes block grants that multiple agencies may use for multiple purposes, and states cannot always determine what portion was used for child welfare. . . . Some states also have difficulty reporting local spending accurately because localities may not be required to report spending to the state.

Therefore, the cross-site evaluation worked together with the sites to establish some core principles for analyzing the costs of implementing DR and the potential cost benefits of DR. Three main categories of data were agreed upon: level of investment in startup of DR, case costs during implementation, and possible cost savings related to the outcomes of the cases served by AR compared to those served by IR. Colorado and Ohio examined the investment in startup. All sites examined costs associated with providing AR and costs derived from the subsequent involvement of cases with the child welfare agency. Each local site evaluator worked closely with the child welfare agency to determine what data were readily available and instituted supplementary data collection procedures, as needed and as was possible. This chapter examines the findings related to implementation of DR in two of the study sites, Colorado and Illinois. The study undertaken by Ohio was of two counties and could not represent all SOAR counties.

PRIOR RESEARCH ON COST ANALYSIS OF DR

The evaluation of Minnesota's AR program conducted by the Institute of Applied Research examined costs at two points. The initial final report (IAR, 2004) and the subsequent follow-up study (IAR, 2006) both included analysis of the costs of AR and IR.

In the initial study, a sample of 752 cases was used to examine the costs of the initial contact with the family until CPS was discontinued, as well as a subsequent follow-up period. The mean length of time for the first period was 85 days, and the mean length of time for the second period was 453 days. The follow-up period ranged from 9 months to 26 months. Two categories of costs were examined: service costs as recorded by the local agency and staff costs as estimated based on time spent on a case.

The basic findings were as follows:

- Both service costs and worker costs were higher for AR families than IR families during the initial CPS response. AR families cost almost twice as much as IR families (\$1,131.80 compared to \$593.45, respectively).
- During the follow-up period, AR families incurred almost half as much in service costs compared to IR families (\$562.62 compared to \$1,209.97, respectively) and almost a third less in staff costs (\$241.82 compared to \$327.71).
- The difference in total estimated average costs for 14 counties was approximately \$200, with AR families costing \$1,936.24 and IR families costing \$2,131.13. AR families cost less in service costs but more in staff costs.

In the follow-up study, the researchers found that lower recurrence rates among AR families resulted in still lower costs compared to IR families. Data on nearly 600 families in 13 counties²⁵ were used in this study. This study added 30 months to the follow-up period. The main findings were as follows:

- During the initial period, service costs were higher for AR families than IR families, as additional funds were available for AR families. Staffing costs were also slightly higher, resulting in AR costs of \$1,142 compared to \$905 (for IR).
- During the follow-up period, service costs and staffing costs were lower for AR families compared to IR families, resulting in overall follow-up costs of \$2,547 compared to \$4,062, respectively.

The evaluation of the initial Ohio experience in implementing AR (IAR, n.d.) included a discussion of the direct service costs and indirect or administrative costs associated with implementing AR. Data on a sample of cases, 190 experimental families and 236 control families, were collected for a period of 10 months through 15 months. No actual time records were used for experimental families. Some of the basic findings were:

- An estimated average of 8.55 hours was spent with AR cases compared to 6.73 hours with IR cases.
- For the initial assessment or service case, this resulted in an average of \$940 for indirect worker costs for AR cases and \$732 for IR cases. Additional indirect costs and placement costs were estimated, which resulted in estimated indirect costs of \$1,085 for AR cases and \$998 for IR cases.
- Additional estimates of direct service costs indicated a total of approximately \$242 spent on AR cases and \$235 spent on IR cases.
- Although the total costs for AR cases (\$1,325) were higher than the total costs for IR cases (\$1,233), the authors posit that, over time, the total costs for AR cases would be less than for IR cases if they were to continue to have lower costs with increased follow-up time.

²⁵ Ramsey County was not included in the follow-up study.

METHODS

The QIC-DR evaluation worked together with the local evaluators to establish common objectives for the cost analysis component of their studies. Each local evaluator decided how best to meet these objectives. Table 9.1 presents a comparison of the methods for each of the study sites.

<i>Table 9.1. Comparison of Methods</i>		
Feature	Colorado	Illinois
Sample	Used full 4,996 cases, but weighted data to account for county-level differences in assignment to pathways. Transformed the data to minimize the impact of high out-of-home placement costs.	Randomly selected 200 AR and 200 IR cases from those that had report dates between April 1 and September 30, 2011. Stratified the sample by service region. The sampling frame for DR cases was restricted to those that accepted AR services and were not switched to IR. The eligibility period was selected to assure that there was a full 365 day follow-up period.
Data collection tools for startup analysis	Used a form to keep track of meetings conducted during startup.	Did not analyze startup costs.
Data collection sources for case and services data	Used client contact data available in Colorado Trails with an expert panel to verify accuracy. Included child welfare services and out-of-home placement costs. Used salary data from the county financial management system (CFMS). Used loaded salary.	Obtained contact information from the department information system. Used experts to estimate duration of contact. Collected salary information from Department and agencies. Used loaded annual salary. Obtained ancillary service costs, including cash payments for DR families, from administrative information system.
Data parameters	Did not collect data on contracted services paid by non-child welfare funding streams. Did not collect data on caseworker time spent in nondirect client activities.	Did not collect data on caseworker time spent on nondirect client activities.
Data collection sources for follow-up data	Used administrative data.	Used administrative data.
Total study period	Initial involvement period plus 365 days.	365 days, including the initial service period.

This summary of the methods used by Colorado and Illinois highlight some caveats to these studies.

- The primary source of costs associated with client services was the state administrative data system. Because neither state system uses a standardized unit of service approach to recording time, additional inferences about length of time per client or case were made by the evaluators, with input from program administrators and other personnel.
- The cost analysis did not use a workload methodology approach, which would require workers to keep track of all activities per case or randomly report on their activities.
- The cost estimates that are presented are conservative, since additional costs associated with services—whether cash payments, ancillary services, or costs to other agencies—are sometimes undercounted or not counted at all.
- Although the sites may be compared with respect to their high-level interpretation of the difference in investments in time and costs between AR and IR, they cannot be compared across sites in terms of dollar costs, given the differences in the salary ranges in each site and the different methodologies.

Startup Costs

While it may seem reasonable to ask what it costs to initiate a new program, this is an extremely difficult question to answer since it depends upon such factors as how familiar the jurisdiction is with the new program and what the infrastructure accommodates in terms of systems or program redesign. For example, a jurisdiction might have a policy unit that is very familiar with the policy ramifications of a new program, or a jurisdiction may need to hold many meetings with many different persons to determine the policy implications. At the other end of the continuum, relatively little attention may be given to updating policy and procedures and orientating staff.

Other factors that influence the estimate of the cost of implementing a new program, and which may not be able to be part of the data collection effort, include the following:

- New programs often require adjustments or workaround processes in terms of ongoing case management and financial management systems. Each of the study sites found that the new programs ideally would result in adjustments to these administrative systems. These adjustments were not made during this study but may be likely candidates for future investments of each agency if the programs continue.
- New programs may require establishing new fee-for-service contractual arrangements, which are difficult to track in terms of the cost of establishing these contracts.
- If fee-for-service contracts are not established, then either new staff members are hired or are realigned. Both strategies have hidden costs. Such costs may be determined to be cost neutral to the agency, but how cost neutrality is obtained may not be examined.
- New programs require the support of key leaders and stakeholders. Information about their time expenditures may not be readily accessible, and therefore the costs may not be determined.

- Costs may be absorbed under “normal” agency evolution of services. All agencies are constantly adapting and adjusting their service mixes, providers, and service eligibility. These costs are often part of administrative costs that support the whole agency and not distinguishable at the level of a specific program or initiative.

Colorado undertook to estimate the costs of startup by using a method to keep track of all cross-county meetings, presentations, and trainings, including travel time for participants. Updates to policies and procedures were also considered, and information flow was facilitated by the program plan, which included a new project director for the initiative. Since the time spent was captured by the new State director, State level investments were also captured; however, county-specific investments that occurred solely within a county were not. The results can therefore be considered conservative estimates of what it took Colorado to initially implement the new program.

Over a 10-month startup period, the five counties spent 1,557 hours in joint meetings and 13,012 hours in trainings, including travel, for a total of 14,569 hours. This is equivalent in Colorado to 8.5 FTE. Colorado used 1,720 hours for a FTE for a 10-month period. This might be considered overgenerous, since it is based upon a computation that includes vacation, sick, and holiday leave. If a more realistic estimate of the FTE hours available for work during a 10-month period were computed to be 1,567 hours, then the total FTE in Colorado would be 9.3 FTE over the 10-month period.

In addition, the State spent 968 hours of both recurring and nonrecurring project meetings, presentations, training and training development, and updating policies and procedures. One can establish FTE equivalencies of either .56 FTEs or .62 FTEs.²⁶

Another way to look at the cost of investment is that the State spent a total of 15,537 hours in meetings, trainings, and other activities in order to implement AR in Colorado. Since 3,194 AR cases were served, this investment equaled approximately 5 hours per AR case. As more AR cases are served, even though training will still be needed, the per case time investment to implement AR will decrease.

Initial Case Costs

Both Colorado and Illinois conceptualized the initial case costs as those costs incurred while providing AR or IR, including the assessment and any initial services. Both primarily used the costs of the estimated contacts with the families during AR and IR or with other persons for whom contacts were recorded in the administrative data system. Both were able to include in-person contacts and phone and other non-face-to-face contacts that were recorded by caseworkers into the administrative data systems.²⁷ In addition, both were able to obtain service costs, including out-of-home placement costs, from their administrative data systems.

²⁶ Costs of these hours were not investigated due to the wide array of salary ranges for the different types of people.

²⁷ Illinois included collateral contacts, while Colorado did not.

Table 9.2 presents the estimated hours and costs of caseworker involvement in the cases and total initial case costs. In Colorado, caseworker costs represent public agency worker hours; in Illinois, they represent for the AR cases both the public service worker and the nonprofit service provider.

<i>Table 9.2. Initial Case Cost</i>				
	Colorado ²⁸		Illinois	
	AR	IR	AR	IR
Average contact hours per case	678.6 min 11.3 hours	634.1 min 10.6 hours	828.8 min 13.05 hours	208 min 3.5 hours
Average cost per worker per hour	\$25.40-\$33.60	\$25.40-\$33.60	\$19.86-\$59.70	\$60.36
Average case cost	\$309.90	\$283.87	\$348.35	\$208.85
Average additional service costs	\$496.95	\$256.54	\$90.00	\$0
Total Average Initial Case Cost	\$806.85	\$540.41	\$439.16	\$208.85

The number of hours provided to an AR family ranged from an average of 11.3 hours in Colorado to 13.05 hours in Illinois. In both study sites, the amount of time spent with AR families was greater than that spent with IR families. However, the difference was most striking in Illinois, where investigations averaged 3.5 hours. This finding is related to the type of model that was used in Illinois, which added community-based service workers in nonprofit agencies to the AR pathway.

Since services were provided by nonprofit agencies with lower hourly salaries than the public agency workers, the resulting costs reflect not only the hours spent but also the salary rates within Colorado and Illinois. Public agency child protective worker salaries were reported as being almost twice as much in Illinois compared to the salaries in the more rural counties of Colorado. If the appropriate qualifications for service provision can be found in the nonprofit sector and those salary rates are lower, then clearly more hours of service can be provided using contracted services in some environments. In both Colorado and Illinois, the costs of providing initial AR caseworker services were slightly greater than the costs of providing initial IR.²⁹

In both Colorado and Illinois, the costs of other services could also be identified as relevant to the initial case cost estimate. However, the differences in the service models make comparisons inappropriate.

²⁸ Colorado presented its data in terms of mean weighted contacts. The initial case period included the uninterrupted time from the report through the assessment or investigation and an ongoing services case, if applicable.

²⁹ Tests for significance of the difference in initial costs between AR and IR were conducted in Colorado, and these differences were not found to be significant. Differences among counties were found to be statistically significant ($p < .001$).

- In Colorado, a few cases received additional services, including out-of-home placements, paid for by the Department. Ten percent of AR cases and 5 percent of IR cases received additional pay for services; moreover, 1.6 percent of AR cases and 0.9 percent of IR cases were actually removed during the initial case and incurred extensive out-of-home costs. When these costs were averaged among all AR and IR cases, the additional costs added \$496.95 to AR cases and \$256.54 to IR cases. The resulting total initial costs for AR cases and IR cases were \$806.85 and \$540.41, respectively. This difference was not statistically significant.
- In Illinois, only the AR cases received any additional services. Furthermore, due to the way cases were defined in Illinois, any out-of-home costs were ascribed to the follow-up period. Service costs for AR families averaged \$90.81 and zero dollars for IR families. The total average initial case costs were \$439.16 for AR families and \$208.85 for IR families. This difference was significant at $p < .0001$.

Follow-Up Costs

The follow-up periods were slightly different between Colorado and Illinois. In Colorado, the initial service period included the transfer to ongoing services if there was no service interruption. In Illinois, caseworker contact costs, whether related to new referrals or referrals to ongoing services, were counted as follow-up costs. In both sites, service and out-of-home placement costs were also counted. The data are not comparable due to their differences in definitions in terms of the period being tracked. Colorado tracked the period of the initial involvement plus 365 days. In Illinois, a total period of 365 days was used.

Table 9.3 presents the follow-up contact and cost information within the parameters of each study site’s definitions and total follow up costs.

	Colorado		Illinois	
	AR	IR	AR	IR
Average contact minutes and hours	378.6 minutes	426.5 minutes	Not provided	Not provided
Average salary per hour	\$25.40–\$33.60	\$25.40–\$33.60	\$19.86–\$59.70	\$60.36
Average case cost	\$171.70	\$188.68	\$62.89	\$45.52 plus
Average additional service costs	\$106.78 service costs and \$126.64 out-of-home placement costs	\$120.32 service costs and \$104.37 out-of-home placement costs	\$223.24 for intake family services	\$990.97 for intact families and \$1492.45 out-of-home placement costs
Total Average Follow Up Case Cost	\$405.12	\$413.37	\$286.13	\$2,528.94

In Colorado, the low service costs are also related to the small number of cases that received additional services during the follow-up period. Only 4 percent of the AR cases and 4 percent of the IR cases received any pay for services, and most cases did not receive additional services. The percentage of cases receiving intake family services in Illinois was 5 percent for AR but 9 percent for IR.

Removals were also a relatively rare event in both study sites for both groups. In Colorado, 1.4 percent of AR cases and 0.9 percent of IR cases received out-of-home placements. In Illinois, no AR cases entered into out-of-home services, while four children in the IR sample were removed, two from the same family. The differences in follow-up costs between AR and IR were found to be statistically significant. It is unclear whether this finding would hold up if a larger sample were used, given the rarity of out-of-home placement for low-risk families. The out-of-home costs were included when computing total service costs for both the Colorado cases and the Illinois cases. (The reader is reminded that the Colorado study timeframe is approximately 45 days longer than the Illinois timeframe.)

In Table 9.4, total costs were computed considering both initial costs and follow-up costs.

	Colorado		Illinois	
	AR	IR	AR	IR
Total Average Case Costs	\$1,211.97	\$953.78	\$725.29	\$2,737.79

The Colorado results, based on nearly 5,000 cases across both AR and IR, show that there is a slightly higher cost to providing AR than for providing IR. This is primarily due to the early investment in services during the initial service period. However, the difference is not significant.

One of the interesting analyses conducted by Colorado indicates that the number of children in the home and the age of the youngest child are related to costs of a case.

- There was a statistically significant positive relationship between the number of children in the family and the initial costs, the follow-up costs, and the overall costs.
- There was a statistically significant negative relationship between the age of the youngest child and follow-up costs and overall costs.

The Illinois data appear to demonstrate that total costs for AR is far less expensive than for IR, but certain methodological issues require that further study be conducted to confirm this finding. In Illinois, as soon as an AR case involved a removal, it was reclassified as an IR case. Furthermore, no AR cases in the relatively small sample had a new removal during the follow-up period. What is evident throughout both sets of data is that the removal of a child, no matter how rare an event, will seriously impact the overall costs of a program. Rare events such as these pose many challenges for analysts in both quality assurance programs as well as cost analysis studies. Further analysis and research techniques will be needed to appropriately adjust findings in meaningful ways for such events.

CONCLUSION

The administrative and programmatic infrastructure of child welfare does not easily support cost analysis of specific programs, especially those that are in a demonstration mode. For example, it is usually not possible to ascertain the costs of services provided by other agencies, and it is often difficult to obtain costs of caseworker activities or services that are not normally tracked in some systematic way. Workload studies are usually needed to ascertain the amount of effort that workers may use in documentation of a case, as well as in training and non-case activities, which nevertheless are a cost to the agency.

Although the actual costs in Colorado and Illinois cannot be directly compared, there are two important findings which arise from these studies:

- The two studies show that the more common the initial service model and the staffing pool used between AR and IR, such as in Colorado, the more comparable the initial costs. The more distinct the two models are, such as in Illinois, the more likely there will be differences in costs.
- The two studies also show that, even among low-risk families, if a removal occurs, the costs of such removals will have a disproportionate impact upon the average case cost.

Chapter 10. Conclusions

This chapter presents the conclusions of the cross-site evaluation based on data submitted by the local evaluators to the QIC-DR and qualitative data collected in 2013 by the QIC-DR. The fuller results and data are presented in the previous chapters and are not repeated here. In addition, it is important to note that there is some variation between the cross-site evaluation and local evaluations, due in part to different samples and analytical approaches. All of the local evaluations are available at www.differentialresponseqic.org.

With the three local evaluations and the cross-site evaluation, there are now seven evaluations of DR in the United States with a random assignment design of similar cases receiving either AR or IR. While these studies cannot predict the impact of DR implementation in other states and communities, they do contain important information that program administrators and policymakers may want to consider in the design of such systems.

TESTING THE HYPOTHESES

This chapter is organized around the study hypotheses that were the foundation of the evaluation work. The findings from the cross-site study, the caveats related to the data, and the implications for future directions for CPS programs are discussed under each hypothesis. The hypotheses are discussed in the same order as presented in the report—parent engagement, services, safety, and cost. The focus is primarily on findings that were consistent among all three sites, or at least two sites, but we do mention some that were unique to one site. This chapter concludes with a discussion of the implications of DR for changing the nationwide landscape of CPS and child welfare programs as a whole.

Hypothesis 1: Caseworkers Are Better Able to Engage With AR Families Than With IR Families

Findings

The Case Specific Questionnaire, completed by the caseworkers; the Family Survey, completed by the parents or caregivers; and stakeholder focus groups in the local sites were used to answer the questions related to engagement. Measuring attributes is a complex endeavor. In this study, respondents were asked to rate whether they believed parents expressed certain attributes at the first meeting and the last meeting. These were classified as positive or negative. Both the responses of caseworkers and of families were analyzed. The statistically significant findings are summarized below.

Caseworkers' Perceptions of Parent Attributes at the First Meeting

- Caseworkers in all three sites rated IR parents to have more positive engagement attributes (cooperative, receptive to help, and engaged) at their first meetings than AR parents.

Parent Responses to First Meeting With the Caseworker

- In Illinois and Ohio, when parents responded to how they felt at their first meeting with the caseworker, AR parents, in comparison to IR parents, reported more positive affect (feeling relieved, respected, encouraged, thankful, hopeful, and comforted).
- In all three sites, IR parents scored higher on the attribute of “worry” at their first meeting with the caseworker, in comparison to AR parents.
- In Illinois only, IR parents, in comparison to the AR parents, scored higher on the attribute of “anger” at the first meeting with the caseworker.

Caseworkers’ Perceptions of Family Attributes From First to Last Meeting

- In all three sites, caseworkers rated AR and IR parents’ positive engagement attributes (cooperative, receptive to help, and engaged) to increase between the first and last meeting, but there was no significant difference in the amount of change between the two groups.
- In Colorado and Ohio, caseworkers perceived the negative attributes of AR parents to decrease, and, in all three sites, caseworkers perceived the negative attributes of IR parents to decrease from the first to last meeting.

Differences in Caseworker and Parent Perceptions at First Meeting

- Given that AR parents rated themselves as having more positive affect than IR parents, but caseworkers rated IR parents to be more engaged initially, it appears that the two groups had different perceptions of the first meeting.

Caveats

Both caseworkers and parents rated the parents’ emotions and engagement attributes that they recalled from the first meeting, but not until case closure. Moreover, the Family Survey response rates were low. In addition, because a definition of engagement was not provided on either survey, the QIC-DR evaluation team created an engagement construct that created proxies to capture engagement-like data from various perspectives.

Possible Underlying Factors

The concept of family engagement has permeated training and practice strategies, with the expectation that CPS caseworkers will be able to engage families. This may have influenced caseworkers’ self-reports. These results may also reflect a different paradigm that caseworkers and parents use to think about engagement. It may be that caseworkers view compliance as engagement, while families view engagement in terms of partnership or collaboration. In addition, AR and IR caseworkers may also have different engagement paradigms. For example, if AR caseworkers view engagement as collaboration, it may be reasonable to conclude that, at their initial meetings with parents, they would rate engagement attributes lower than IR caseworkers who may hold more of a compliance construct.

In addition, in Colorado and Ohio, it was difficult to determine whether the AR approach is markedly different than the IR approach, other than the maltreatment substantiation decision that accompanies IR. In the Colorado and Ohio focus groups, CPS workers and supervisors agreed that, generally, caseworkers used similar engagement practices with AR and IR families. These included calling families to set up appointments, making suggestions to families rather than telling them what to do, using solution-focused questioning strategies, and communicating in a respectful tone.

Implications for Future Directions

The majority of CPS families are reported to CPS by other persons, and families cannot refuse an investigation or assessment. Several authors have discussed the underlying attitudes of families who come in contact with CPS. Dumbrill (2006) has written that most families are unwillingly thrust into a relationship with a caseworker, who represents a government system that often possesses an ill-defined power over those being investigated or assessed. Some aspects of this perspective were found in the QIC-DR (2013) focus groups. Lonne, Parton, Thomson, and Harries (2009) underscored the view that it is important to minimize policing and coercive interventions in child protection work, and that there is a need for “rebalancing of child protection work to include both child protection and family support and to inquire” rather than enforcing “a forensically determined power to investigate” (p. 42).

Dumbrill (2006) concluded the following from his research:

[DR] rests on the premise that coercion and casework can be separated in child protection intervention, a notion that findings from this study do not support. Separation into policing and helping cases may be possible from the perspective of those delivering service, but not from the perspective of parents on the receiving end of service. Indeed, many of the parents in this study who described power being wielded over them were voluntary clients. From a parental perspective, a differential response may not separate intervention that uses power over them from one that employs power with them. (pp. 35-36)

Future implementation of DR and of evaluations of DR may wish to consider the following points.

- What is the underlying hypothesis about the need to engage a parent and/or family in order to achieve specific outcomes in CPS? Which specific outcomes need to be considered?
- Given that “engagement” may vary according to the eyes of the beholder, can specific aspects of engagement be measured with greater consistency and replication, particularly between the two groups who are part of the relationship? How should engagement be defined in future studies?
- CPS systems in general may be providing training to their caseworkers, regardless of pathway, to help them better relate to families and caregivers. If AR and IR caseworkers receive the same training and use similar engagement practices, should one still expect differences in family or caseworker perceptions of engagement?
- Are there specific micro-practices that should be examined in more depth to determine if they make a difference for parents and families? As examples: Does setting an appointment to visit a family make a difference in engaging a family in early stages of relationship

building? Does solution-focused casework result in parent willingness to engage with caseworkers?

Hypothesis 2: AR Parents Report Greater Satisfaction With Their CPS Experience Compared to IR Parents

Findings

The Family Survey data were used to answer the questions related to family satisfaction with CPS. Three indicators were studied: satisfaction with the treatment by the caseworker, satisfaction with help received from the caseworker, and likelihood of calling the caseworker in the future if the family needed help.

- In Colorado, AR parents and IR parents were not statistically different in their levels of satisfaction in their treatment by their caseworkers or the level of help received from their caseworkers. However, AR parents were statistically more likely to indicate that they would call their caseworkers in the future than were IR parents.
- In Illinois, AR parents were significantly more satisfied on all three indicators than IR parents.
- In Ohio, there were no statistical differences between AR and IR parents on these three indicators.
- Even though the statistical differences were not frequent between AR and IR parents' perspectives on some indicators, in general, their self-reported feelings were above average on the 3-point Likert scale of (1) Not at All Satisfied, (2) Somewhat Satisfied, or (3) Very Satisfied. This may suggest that AR and IR parents were generally satisfied.

Caveats

Three broad questions were used to measure a complex relationship between a parent and a caseworker. The QIC-DR did not measure parents' expectations of the CPS system or of a specific worker, and thus do not have a baseline on expectations of families for their caseworkers. In addition, as previously mentioned, the Family Survey had a fairly low response rate.

Possible Underlying Factors

Over time, with the implementation of DR in Colorado, the AR and IR pathways converged to be more similar than disparate. While there were differences in AR and IR procedures and timeframes, after 2.5 years of implementation, Colorado administrators, supervisors, and caseworkers who participated in focus groups (only held in 3 of the 5 counties) clearly stated that the only consistent difference between the two pathways was the substantiation decision remaining in IR (QIC-DR, 2013).

In Illinois, these results may be due to the AR caseworker being located outside of the public agency. This relationship may be perceived by the parents as less threatening. In Ohio, the results differ from previous evaluations of DR in Ohio (Loman et al., 2010), and may reflect variation in county practices. In Colorado and Ohio, the implementation of DR may be changing the relationship between CPS agencies and all families, independent of the family's receipt of AR or IR.

Implications for Future Directions

It is interesting that, in two sites, AR parents were more likely than IR parents to be willing to contact their caseworkers again in the future. This may be indicative that, indeed, families felt that caseworkers were responsive to their own needs and could be responsive in the future. If CPS is able to meet needs as identified by families, parents may become proactive service recipients, and may also be more inclined to seek help as needed from either CPS or community-based agencies. This may occur either informally (based on previous relationships) or formally if CPS systems decide to encourage families to reconnect with the agency. For the latter to occur, CPS agencies will likely need to be perceived by recipients as having non-punitive yet formal mechanisms for families to seek assistance. Without such a framework, it may be unlikely that families would self-refer into the CPS system.

In addition, if CPS decides to encourage families to reconnect with their caseworkers or with the agency as a whole, the implications for this “open door” policy will need to be assessed from a policy, workload, and outcome measurement perspective. Such reconnections should be examined to determine if these contacts should count as re-referrals.

Such policies could have major impact upon CPS as a whole, not solely the AR pathway. IR could also intentionally encourage caseworkers to consider families as clients whose satisfaction is an important aspect of the agency’s policies and practices.

Hypothesis 3: Service Patterns Are Different for AR Families Than IR Families

Findings

This study examined three features of service patterns in AR and IR pathways based on Administrative Data and data from the Case Report survey completed by caseworkers at case closure.

Quantity of Service

Although jurisdictions may have different reasons for adopting DR, there are several competing perspectives concerning the quantity of services that AR families may receive, compared to IR families.

- Some jurisdictions suggest that AR families, in comparison to IR families, will receive more services because AR caseworkers approach these cases with the intention to find or access services.
- Others argue that it cannot be assumed that more services will be provided to AR families or IR families, since this will depend upon the service resources that exist in the community.

The cross-site evaluation findings do show differences in service receipt between AR and IR families.

- In all three sites, a statistically significant higher proportion of AR families, in comparison to IR families, received at least one service. When service arrays were examined, there were some statistically significant differences regarding the receipt of specific services.

- Among all three sites, AR families were more likely than IR families to receive services to meet their material needs.
- In Illinois, AR families were more likely than IR families to receive services such as social support, educational, parenting, and “other” services. However, IR families were more likely to receive substance abuse services than AR families.

Responsiveness of Service

Two competing perspectives have been offered regarding the responsiveness of services:

- Some jurisdictions posit that AR families, in comparison to IR families, will receive services more quickly, given that AR caseworkers will not need to meet all the requirements of conducting a formal investigation and reaching a disposition decision.
- Others argue that services may not be able to be provided more quickly to AR families than IR families, given that more time is spent conducting assessments with families.

The cross-site evaluation shows no consistent findings among the sites. Across all three sites, among the AR and IR families who received services, more than half of those in each group received services within 2 weeks of opening the case. In Illinois, there was a significant difference between AR and IR families in the rapidity of receiving services. This difference may be related to the use of private, nonprofit agencies serving AR families. The model employed allowed AR caseworkers to begin services as soon as possible after the safety assessment was completed, and in relationship with the family, to meet the family’s service needs.

Continuity of Service

In both AR and IR pathways, there is some degree of flexibility in the extension of the timeframe of the AR or IR worker in order to provide short-term services. The national study on CPS systems reform found that, even a decade ago, there was variation in policy and practice concerning the formal end of the investigation phase of a child welfare case (USDHHS, 2003).

Throughout the nation, a family can be opened in ongoing in-home services after having been the recipient of a CPS assessment or investigation. In some communities, this may be done with the voluntary agreement of the family, although in others this may require a court order. In general, the decision-making processes for opening a services case after the initial CPS response varies throughout the country and is not well understood (Fluke, personal communication, 2014).

There are competing perspectives about the opening of a case for ongoing services once AR is introduced as a CPS response.

- One perspective is that the introduction of an alternative to investigation will result in more ongoing services being offered to families as a positive and responsive action of child welfare and that more families will agree to such services due to the positive relationships which have been built.
- A second perspective is that new alternatives for CPS, such as AR, may reduce the necessity of opening an ongoing services case in that more services may be offered during AR as compared to what can be provided during IR.

- Another perspective that was shared by focus group participants is that caseworkers would be more likely to transfer AR cases to ongoing services because they had developed relationships with these families, understood the underlying issues which brought them into the system, and were actively pursuing services to meet those needs.

This study examined how many cases were opened as ongoing services cases in the AR and IR pathway in each site based on Administrative Data on case openings. Patterns for opening services cases were not consistent among the three sites.

- In Colorado, a higher percentage of AR cases, compared to IR cases, were transferred to ongoing services even though they had received longer periods of service under the initial portion of AR.
- In Illinois, a smaller percentage of AR cases received ongoing services than IR cases. AR cases, in comparison to IR cases, had received significantly more services during the initial pathway.
- In Ohio, there was no significant difference between AR and IR families being opened in ongoing services.

Caveats

While this study was able to obtain data on types of services that were provided to families, and used a common services taxonomy, data on the duration and intensity of services were not collected. Some services might have been relatively short. Others could have been continued without opening an ongoing case. In addition, in Illinois and Ohio, the AR caseworkers had access to flexible dollars to meet service needs of some AR families.

Possible Underlying Factors

Several factors may underlie the service patterns of low- to moderate-risk families. The relative lack of differences among the families in the AR and the IR pathways indicate that other factors not related to pathway assignment are important in order to determine the patterns of service delivery. Some factors may include accessible service array, funding of services and budgetary constraints, and the willingness of families to engage in government-supervised voluntary services.

Implications for Future Directions

CPS is the entry point for the majority of families into the child welfare system. There is a general agreement based on field experience and research that families who come to the attention of CPS are likely to need some type of assistance, whether or not maltreatment is substantiated (Burns et al., 2004). Consistently, national data has shown that only small percentages of families receive services (USDHHS, 2012). Most families do not receive more than a CPS assessment or investigation, especially as the majority of CPS referrals for investigation are not substantiated. The commonality of service patterns that occur across both AR and IR pathways may have implications for CPS as a whole. The vast majority of families in this study did not receive any service. Among those receiving at least one service, the service rates were very low for each specific service. Data from all three sites indicate that caseworkers provided services to meet the material needs of some AR families, which may be due to the added resources which they had for that particular group. Concerted additional resources may need to be invested into the system if

the overall goal is to provide higher levels of services receipt, since the existing baseline of service provision is low across both AR and IR. This suggests that the concept of services extends beyond bolstering the caseworkers' skills in finding and providing needed services to include expanding the formal and informal service network available in the community.

If the services are to increase under either an AR or IR pathway, several topics may need to be addressed by local CPS agencies.

- The agency may need to invest in determining which are the most effective and appropriate services for families referred to CPS.
- Service needs assessments may be important in order to ensure that the service resources are appropriately allocated.
- The role of CPS as a screener for referral to community-based services may need to be contemplated. A model that may be consistent with community concerns for protecting children would be to adopt a short assessment for low-risk families and then to offer them community-based services on a voluntary basis. This approach would result in a system whereby families would not be diverted from child welfare without an assessment, an assessment would be conducted in a brief and intensive manner, and the locus for services for many families would be community-based agencies.

These findings also raise some additional questions: (1) How can the service array be expanded to meet the needs of more families? (2) What is the role of caseworkers in accessing needed services? (3) If there is a limited number of services, how do caseworkers and agencies prioritize them for the many families who present needs? (4) Does providing greater access to services for one set of families (i.e., AR versus IR) come at the expense of providing services to the other group? (5) Is there an effective service taxonomy that can be tied to producing better outcomes for families? and (6) Who should be responsible for funding these services?

Hypothesis 4: Children in Families in the AR Pathway Are as Safe or Safer Than Children in Families in the IR Pathway

Findings

The primary concern of CPS is to ensure that children who are reported as maltreated are safe and remain safe. Safety is a concept with multiple facets and can be measured in various ways. One facet is the timing of the condition; in other words, are children safe during the intervention and safe after the intervention? A second facet is whether a child is removed from the home, which indicates that a child would not be considered safe if he or she was to remain with the parents.

In this study, the families who were assigned to either the AR or IR pathway were classified as families for whom there were no immediate safety concerns. If the hotline or screening staff determined that there were immediate safety concerns or a number of risks for safety, the family was considered ineligible to be part of the study. Thus, this study does not address safety concerns that might apply to other families who were not considered eligible for this study. Further

research is needed if jurisdictions wish to consider that all families who are referred to CPS would be eligible for AR or if jurisdictions wish to develop different standards of eligibility.

Safety at Referral

- In general, very few families were found to have safety threats as rated by the AR or IR caseworkers. This, along with the low percentage of cases transferred between pathways, indicates that hotline and screening processes, with relatively minimal information, adequately assessed those who were defined as eligible for this study. Exceptions included approximately 13 percent of both AR and IR cases in Illinois found to have lack of supervision as a concern; 38.5 percent and 27.5 percent of AR and IR families in Illinois, respectively, found to have concerns related to neglect; 14.4 percent and 17.8 percent of AR and IR families in Ohio, respectively, found to have concerns of neglect; and 15.7 percent and 17.5 percent of AR and IR families in Ohio, respectively, having concerns related to physical, sexual, or emotional abuse.
- Significant differences between AR and IR were found in Colorado and Ohio concerning other unspecified types of safety threats. Significant differences between AR and IR were found in Illinois, related to damaging adult-child relationship, neglect or abandonment, and other unspecified types of safety threats.

Relatively few families who were assigned to AR were transferred to the IR pathway (1.8 percent in Colorado, 11.6 percent in Illinois, and 6.4 percent in Ohio).

Re-Referral to CPS

One way of examining if a child was considered to be safe was to examine whether the family was subject to further referrals that were accepted by CPS. Approximately three quarters of all AR and IR cases in each of the sites were not re-referred during the 12-month period after randomization/referral. In general, between 15 and 20 percent in either pathway among all sites were re-referred once during the follow-up period. A very small percentage of families in all sites were re-referred more than once.

Regression analyses were used to examine which factors impacted the possibility of re-referral among the cross-site evaluation subsample. Statistically significant findings that were consistent among at least two sites are mentioned below.

- In Colorado and Ohio, AR families were less likely to be re-referred than IR families, whereas in Illinois, AR families were more likely to be re-referred than IR families.
- In Colorado and Illinois, families with older children were less likely to be re-referred than families with younger children, when the age of the youngest child was considered, regardless of pathway.
- In Colorado, Illinois, and Ohio, the longer families received services, the more likely that there would be a re-referral.

Removals

Fewer than 5 percent of children in either the AR or IR sample of families were removed at any time during the 365-day study period. In all three sites, the implementation of AR did not appear to impact—positively or negatively—the entry of children into foster care.

Regression analyses examined the factors related to the small number of removals. Statistically significant findings consistent among at least two sites are mentioned below. In all three sites, the longer families received ongoing services, the more likely that there was a removal.

- In Colorado and Illinois, children whose families were characterized by their caseworkers as being “very engaged” were less likely to be removed than children whose families were characterized as being less engaged.

Caveats

There are many different ways of measuring safety, and it can be argued that re-referrals and removals are proxies for measures of safety. Moreover, given that the population that was served was low risk, safety issues concern small numbers of children.

Possible Underlying Factors

The regression analyses considered several factors in addition to pathway. As indicated above, these included age of child, length of ongoing services, and engagement, among other factors. Neither re-referral rates nor removal rates are dependent solely upon family or child characteristics. Re-referral depends upon community tolerance or intolerance of behaviors by parents, as well as the extent to which a family is visible in the community. Some have posited that re-referrals may actually increase if the community views CPS as being able to provide more helping services to families. Removals depend not as much on community standards, but the standards of the workforce and the judicial system, as well as the availability of resources where children can be placed. If kinship care is used for the child, the child welfare agency must be able to recruit relatives. If non-kinship care is used, then the child welfare agency must have such resources already licensed with openings for the child.

An additional issue is that some variation exists in how re-referrals are counted. In some jurisdictions, if a case is already being investigated or assessed, another referral would not be counted. In other jurisdictions, each referral by a mandated reporter must be counted regardless of when it is received. Re-referrals in Illinois and Ohio count only those referrals that are screened in for a CPS response, whereas Colorado counts all re-referrals, independent of whether they are screened in or screened out. Therefore, there may be an undercount in two of the sites of the number of families who may need some type of help or may be vulnerable in some fashion.

Lastly, while the cross-site evaluation team did not conduct additional analyses on the families that were part of the AR group in Illinois, Fuller, Nieto, and Zhang (2013) in the Illinois site evaluation did complete such analyses. They separated AR families into 4 groups: (1) Switchers (those who switched between AR and IR, but remained classified as AR families for the evaluation); (2) Quitters (those who did not finish the AR intervention); (3) Completers (those who completed AR); and (4) Refusers (those who declined to voluntarily participate with the AR

caseworker/agency). The analysis of re-referral outcomes by AR grouping are found in the report at www.differentialresponseqic.org.

Implications for Future Directions

The adoption of AR for low-risk families did not appear to impact the safety of children either negatively or positively when compared to families who received IR. Based on these findings, it is difficult to infer whether child welfare agencies will realize the anticipated or desired impacts from wider-scale DR implementation, particularly in the area of significantly reducing re-referrals and entries into foster care. In addition, this raises a number of questions for jurisdictions implementing DR:

- Should all low-risk families receive AR?
- Should the threshold for providing a family with AR be raised?
- Should CPS caseworkers also have the discretion to reassign IR families to AR?
- If families are encouraged to build relationships with their CPS caseworkers and are encouraged to contact them in the future, should re-referral still be considered a proxy for lack of safety?

Hypothesis 5: Cost Savings Can Be Obtained by Providing AR Instead of IR

While states have not primarily adopted DR as a cost savings approach, examining costs is relevant given the investment made in introducing a new approach to CPS. Previous evaluations have shown that the estimated average cost of an AR case can be less than the estimated average cost of an IR case, especially when costs are considered over longer periods of time (IAR, 2006). Ohio data are not included in this analysis due to small sample size and limited data availability.

Findings

The findings regarding incurred costs related to the implementation of DR included two types of costs that were analyzed by the Colorado and Illinois local evaluators: initial case costs and follow-up costs. Initial case costs are costs identified by each site within the period of time served in either AR or IR pathway. Follow-up costs were defined by each site as costs that were incurred after completion of the AR or IR pathway.

Initial Case Costs

Initial case costs are the result of three factors: amount of time spent with a family, cost of the worker who is assigned to the case, and the cost of any additional services, out-of-home placement, or material assistance provided. In Colorado, the initial case costs include the time spent by caseworkers with cases during the assessment phase, as well as the ongoing services phase if the case was transferred without interruption. The difference in costs was not significantly different between the AR and IR pathways.

In Illinois, AR cases received significantly more service hours than IR cases and received some additional services. The cost of caseworkers involved with AR cases was significantly lower than the cost of caseworkers involved with IR cases. However, the large differential in hours of service resulted in AR cases costing approximately twice as much as IR cases.

Follow-Up Case Costs

The impact of follow-up costs is directly related to the amount of service that is provided. Higher rates of re-referral and removals will influence the costs incurred. In both Colorado and Illinois, even relatively infrequent removals impacted follow-up costs. In Colorado, the difference was significant, while in Illinois it was not.

Total Costs

In Colorado, the difference in total costs was not statistically significant. (AR cases were slightly more expensive than IR cases, \$1,211.97 compared to \$953.78, respectively. As previously noted, this is likely because of the very high costs of out-of-home placements for a few outlier AR cases.) In Illinois, AR cases cost much less than IR cases due to some very expensive placement costs among IR families (\$725.29 compared to \$2,737.79, respectively).

Caveats and Possible Underlying Factors

Although the study sought to make the cost studies as comparable as possible, it is quite clear that larger contextual issues for each system play significant roles in estimating costs of specific programs. Costs of new and existing programs are impacted by the agency's use of nonprofit agencies with lower salaries than public agency unionized caseworkers and the amount of time typically expended in performing standard responsibilities. Other factors that may have influenced the findings on costs include the availability of data in each jurisdiction and the philosophy and practices underlying the use of foster care.

Implications for Future Directions

The cost analysis clearly indicated that, given the high costs of foster care, even a few cases of families that result in the removal of one or more children will impact the average costs of programs. Child welfare's most likely target for reducing costs lies with reducing the number and cost of placements. DR, as an adjustment at the front end of the child welfare system, is unlikely to impact such costs in a major way without additional programmatic changes. This may be an important finding for states considering the implementation of DR as part of their Title IV-E Waiver demonstration efforts.

Furthermore, if the future of CPS depends in part on understanding the cost of each phase of working with a family or with a child, a great deal of attention needs to be given to collecting consistent data on the workload of the agency staff, the costs of services on a case by case basis, as well as the costs of services that are not recorded as case-specific costs under normal circumstances. For example, many agencies do not track the costs of parenting classes and other group services. Foster care costs are monitored at the child level and are therefore among the easiest to obtain.

The ability to gather more consistent data on the costs of providing services rests not only upon methodologies for collecting data, but also on the actual practices of child welfare. Workload studies have routinely showed that caseworkers do not spend the majority of their time in direct contact with families; however, we do not have standards for how much time should be spent with clients. If CPS as a whole considered the amount of time individual service components take, costs

could be better monitored and perhaps reduced. As the current system operates, it is very difficult to control costs in any intentional manner.

Another factor is that, with the increased ability for caseworkers to maintain their own data files, enter data directly into the information systems, and retrieve data, work functions have greatly changed from the days when there were file clerks and dictation transcribers. Child welfare agencies will need to consider whether automation can reduce costs of staff work.

Clearly, the highest cost savings to CPS will occur when cases are screened out or triaged from the formal CPS system. This approach must be reconciled with the mandate to protect children and a determination of whether there are necessary services available from other agencies. Thus, from a societal perspective, the costs of CPS could be examined from a broader perspective of the costs of public and private sectors in supporting families whose children are at risk of maltreatment.

DR AND SYSTEMS REFORM

During the 6-year span of the QIC-DR (2008-2014), as illustrated in Table 2.2, the implementation of DR has spread across and within states. There is variability in the language used to describe AR, IR, and DR across the nation, with multiple terms being used simultaneously, but not mutually exclusively, to describe DR and its components. It appears from the literature that oftentimes DR is mischaracterized as only the AR pathway. Similarly, the rationales and goals provided by states for the implementation of DR are inconsistent. All of these terms and rationales result in a language conundrum and policy confusion, and contribute to a lack of consistent understanding of the differences and similarities between AR and IR in each jurisdiction and nationwide.

In the last several decades, the CPS system has become more bureaucratized and has adopted complex and somewhat rigid policies and procedures, in large part due to an emphasis upon forensic evidence. As noted by Lonne et al. (2009), child protection and child welfare reform attempts have been dominated by managerialistic approaches that emphasize sophisticated systems, assessment, demands, and outcome frameworks.

Whether DR creates systematic changes to CPS that minimize bureaucratic and rigid procedures and that emphasize relationship-building with families will most likely reflect the desires and intentions of the administrators and policymakers who are the driving forces behind implementation in a particular site. Moreover, if more individualized approaches are adopted, then agencies must be careful to balance individual responses with equality of responses for all families. An individualistic response that results in inequities in terms of government intervention or judicial action will not be acceptable.

What is clear from the QIC-DR experience is that restructuring the CPS system to offer multiple ways to assess and serve families may also result in numerous changes to the IR pathway as the newly introduced AR pathway gets created and installed. It would also appear that the end goal in implementing AR may not be to attempt to classify AR as a manual or standardized intervention that could be replicated across jurisdictions. Rather, it may be that AR should be seen as a modification of the CPS system which also influences how IR is implemented and delivered.

Re-Organization or Meaningful Change?

In two of the three QIC-DR sites, the entire CPS system was impacted by the introduction of the new AR pathway. Most of the changes observed in Colorado's and Ohio's implementations of DR were not reserved for AR families, but rather the modifications became embedded into child welfare systems for all CPS families. The AR pathway, like the IR pathway, is guided by procedures and policies, and influenced by the skills and characteristics of caseworkers. This has been demonstrated in the introduction of, for example, revised family service plan documents, group consultation processes to review cases, new screening procedures, and revamped timelines for responding to child abuse and neglect reports.

In addition, a number of existing child welfare philosophies and practice strategies have clearly become part of the AR and IR pathways, influencing how caseworkers approach relationship building and engagement of families. Solution-focused casework and family engagement techniques are two of the more commonly identified child welfare practices associated with DR-organized CPS systems (Murphy, Kimmich, & Newton-Curtis, 2012; Winokur et al., 2012) that are intended to permeate caseworkers' interactions with both AR and IR families. A parent with a positive experience with CPS summed it up this way:

All workers should be compassionate. You don't know what families have been through. Don't judge them. Don't befriend them. Sit down and try to understand them. (QIC-DR, 2013)

There may be some signs from this study that DR, particularly from the perspective of system professionals, is changing the relationships between caseworkers and families. Glisson (2010) discusses the interplay and tension between casework and organizational structures:

Timely, appropriate care requires that an individual caseworker assumes responsibility for each maltreated child's well-being and establishes a relationship with the child and the family that helps the caseworker identify the child's unique needs . . . and ensure that the child and family receive needed services. Although several factors affect the caseworker's performance, studies indicate that the caseworker's success is in part a function of the work environment of the child welfare agency in which the caseworker is employed.

While the quantitative data from the surveys did not suggest marked differences between AR and IR experiences, themes emerging from focus groups with AR caseworkers and families who received AR surfaced additional insights. AR caseworkers discussed such strategies as setting appointments, spending more time with families, and sitting down and having conversations at times that are convenient for families as ways to build respectful relationships. AR families who clearly had positive experiences with CPS and who were recruited to participate in focus groups in Ohio confirmed this notion. They noted that their caseworkers provided them guidance; allowed them to make some decisions; returned their phone calls; were direct, honest, and empathetic in their communication; and helped them access assistance. At the same time, one of the themes emerging from IR caseworkers was the notion that the policies, procedures, and limited services

restricted them from being able to serve families in the same way as AR caseworkers. While there was a slight pattern in IR caseworkers suggesting that they manage their caseloads by limiting their contact with parents and children and completing all of the necessary paperwork and assessments in one visit, many others noted what one IR caseworker so succinctly verbalized (QIC-DR, 2013): “AR workers are getting to do the social work that we all want to do.”

Revisiting Substantiation as a Policy?

CPS decisions can have short- and long-term impacts on families, including affecting family relationships, future employment possibilities, family members’ social standing, and their identities. Many CPS families might be better served by applying the categorization of “in need of services,” rather than only having the option of considering whether parents/caregivers are perpetrators or not, and whether children are victims or not. The difficulty in this approach is that child welfare will need to come to consensus on which cases should be classified as such and which should include the determination of a perpetrator who may be subject to sanctions by CPS and/or the legal systems. To date, this issue has not been considered, since low- or medium-risk families have been assigned to AR.

The implications of eliminating a substantiation decision may impact the relationship among the public agencies, the communities, key stakeholders, and families. It is possible that not having to “substantiate” may have practical implications of changing the conversation between caseworkers and parents. Eliminating terms of alleged perpetrators and alleged victims for a large percentage of families who come to the attention of CPS may reframe the community perspectives of CPS and child maltreatment, but may also have unintended consequences which are not known.

Strengthening the Service Array?

As Lonne et al. (2009) cautioned,

... there is a clear danger that all that is achieved (by instituting DR) is a reshuffling of cases into different categories in order to work within limited resources, rather than working to reduce the incidence of child abuse and neglect. (p. 42)

Some child welfare administrators have noted that DR has resulted in identifying new service partners, increasing services in the community, and reallocating existing resources to meet emerging family needs (Drendel, personal communication, 2014). As discussed previously, the management of service provision and the development of a more holistic service array will be influenced by: (1) CPS agencies’ limited resources, which impact caseworker, supervisor, and administrator decisions on which families receive services; and (2) caseworkers’ perceptions of engagement and receptivity of families, along with their understanding of available services and ability to access services for families with whom they work.

Will the Statistics Tell A Different Story?

As the CPS system changes, one would also expect that key indicator statistics may change. For example, the population rates of substantiation are likely to continue to decrease, as some cases are diverted from the investigation pathway. Indeed, one might expect that, even as the population-based rates decrease, the percentage of IR cases that are substantiated may increase, given that low-risk cases are handled by AR. Another area of key indicators which may change is the number of referrals that are made to CPS. If CPS becomes more service-oriented, the community may feel more comfortable and responsible for referring more families to CPS to receive needed services. This would also impact the mission of the CPS agency and the workload of the CPS staff. Lastly, with diversion of a fairly significant number of cases to the AR pathway, it is likely that the national statistics will reflect a decreasing number of child maltreatment victims. This could unintentionally portray a message that child abuse and neglect, while an important social or public health issue, is one that is less epidemic than in the past. How the child welfare field re-messages these and other statistics will be important in the years ahead.

Final Thoughts

Although AR might be considered to be merely an alternative to IR, as its name implies, a fully implemented DR system may have deep impacts upon the community and its families; the CPS workforce; the policies, practices, and procedures guiding child protection casework; and the child welfare agency mandate. These impacts may not be solely in terms of different outcomes for those who have come to the attention of CPS, but rather may widen the reach and influence of CPS to other families who may be at risk or vulnerable. DR may indeed reshape the core mission of CPS.

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