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PROTECTING CHILDREN Volume 23, Numbers 1 & 2, 2008

*Exploring Differential Response:
One Pathway Toward Reforming Child Welfare*

PROTECTING CHILDREN

A Professional Publication of American Humane

Volume 23, Numbers 1 & 2, 2008



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Caren Kaplan, ACSW, joined American Humane's Children's Division in 2007 as the director of Child Protection Reform. She is expanding the scope of American Humane's differential response initiative, launching and leading a national chronic neglect initiative, and managing several efforts that will examine and refine the assessment of child safety, risk, and comprehensive family functioning by child protection agencies. Ms. Kaplan also participates in national coalitions and allied organizations that are committed to strengthening the federal response to the protection of children and the prevention of child abuse and neglect. She has more than 25 years' experience in child welfare policy and practice with a goal of implementing and sustaining systemic change through family and community engagement and investments. Ms. Kaplan has specialized expertise in alternative response, chronic neglect, maltreatment in foster care, the child protection-housing connection, and interdisciplinary collaboration and service integration.

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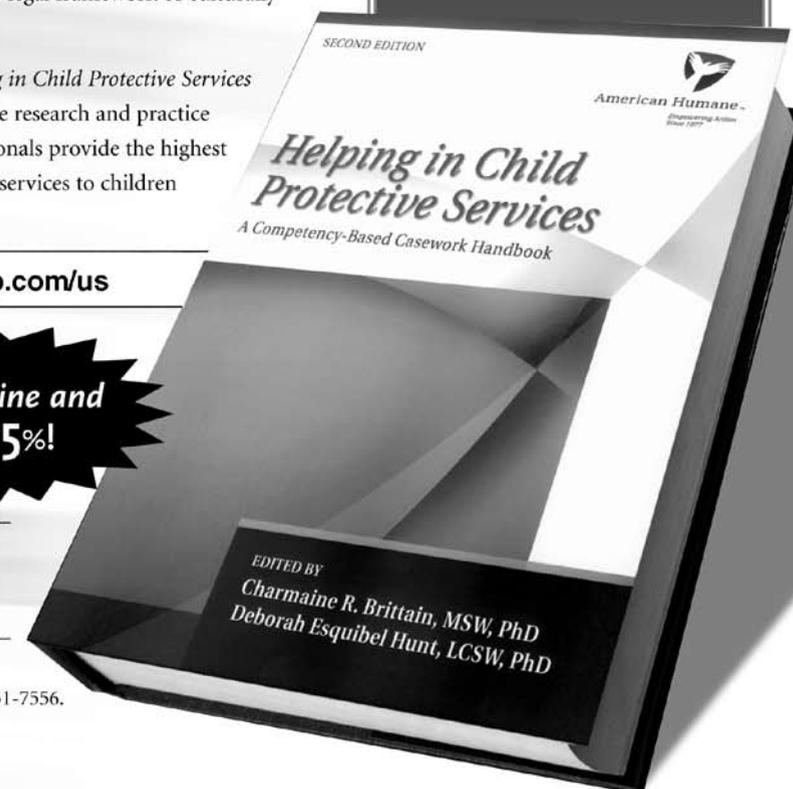
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Differential Response: Progressive Child Welfare

Amy Rohm

Amy Rohm, MSW, is a program specialist in the Children's Division of American Humane, Englewood, Colorado.

Differential response is an alternative to the traditional investigations in child welfare for accepted reports of abuse or neglect. In most states, for low- to moderate-risk accepted reports of child maltreatment, differential response focuses on partnering with families to provide services that meet their needs while dismissing the labels of perpetrator and victim and removing the determination or finding. Many communities are using differential response as a way to enhance their child welfare system to avoid creating adversarial relationships with families and increase their voluntary engagement in services.

Inside this Issue

This second double issue of *Protecting Children* on differential response encompasses a broad range of experiences. The volume's authors discuss practice, policy, and research related to understanding and implementing differential response to provide further information to the child welfare field and other systems. Caren Kaplan and Lisa Merkel-Holguin begin by summarizing the key findings from the 2006 *National Study on Differential Response in Child Welfare*. They highlight the core components, values, and similarities and differences of multiple communities using differential

response. David Thompson, Dr. Gary Siegel, and Dr. L. Anthony Loman share the initial findings from the Parent Support Outreach Program, a pilot project in Minnesota that created a preventive pathway for families. Amy Conley and Dr. Jill Duerr Berrick then summarize evaluation findings from the Another Road to Safety program based in Alameda County, California. The article focuses on replication across the state system and specific neighborhood implications for the program. To further explain the California experience, Dr. Sofya Bagdasaryan, Walter Furman, and Dr. Todd Franke discuss the implementation of differential response in 11 rural counties in Northern California, with findings from their evaluation. Focusing on the importance of safety in child welfare, Mary Jo Ortiz, Dr. Gila Shusterman, and Dr. John Fluke examine the NCANDS data to determine if children served through differential response pathways are as safe as children receiving traditional investigations. Dr. Raymond Kirk follows by presenting findings related to the use of the North California Family Assessment Scale for General Services, a family assessment instrument designed for differential response. To broaden the discussion of differential response, Betty Christenson, Scott Curran, Kelli DeCook, Scott Maloney, and Lisa Merkel-Holguin illuminate the possible intersections and common values between differential response and family involvement strategies, using Olmsted County, Minnesota as an example. This issue concludes with Daniel Comer and Deborah Vassar's article



focusing on the importance of partnering with families in order to successfully sustain system changes such as differential response.

Supporting the Implementation of Differential Response

American Humane is committed to supporting states and jurisdictions as they implement differential response in child welfare. This initiative is growing around the country and internationally and American Humane is proud to be a part of this very meaningful shift for families in the child welfare system. Differential response is a progressive approach to child welfare and American Humane will continue to support the field in using this approach.

Acknowledgments

Many people deserve acknowledgement for their role in this issue of *Protecting Children*. American Humane would like to thank all the authors for their thoughtful contributions to this topic, and the reviewers, Theresa Costello and Caren Kaplan, who contributed both time and expertise to strengthen this substantive collection of articles. American Humane would also like to give special thanks to the American Legion Child Welfare Foundation for its dedication to the betterment of all children and its commitment to print and disseminate this issue of *Protecting Children*. The Child Welfare Information Gateway also deserves gratitude for helping disseminate this issue. Its continued support allows broader access to this valuable information.



Another Look at the National Study on Differential Response in Child Welfare

Caren Kaplan and Lisa Merkel-Holguin

Caren Kaplan, ACSW, joined the American Humane Association's staff as the director of child protection reform in June 2007. Kaplan is expanding the scope of American Humane's special initiative in differential response, launching and leading a national initiative on chronic neglect, and managing several efforts that will examine and refine the assessment of child safety, risk, and comprehensive family functioning by child protection agencies. Caren works out of Washington, D.C.

Lisa Merkel-Holguin, MSW, is the director of practice and systems advancement at the American Humane Association in Englewood, Colorado. Since 1997, she has also directed American Humane's family group decision making initiative.

Background

Over the past 40 years, child protective services intervention has expanded rapidly. This growth is principally due to an increase in reports in response to poverty, disparate access to resources, economic conditions, social isolation, and insufficient information of vulnerable families and their children. The volume of reports, the complexity of family situations, and the limited resources available to child protective services systems to assist families, coupled with the infusion of family-centered practice and strengths-based values, provided the platform

to support differentiated system responses to accepted reports of maltreatment.

Since the mid-1990s, beginning in Missouri and Florida (National Conference of State Legislators, 2000), an increasing number of states have been implementing a differential response in their child protective services systems. Differential response, also referred to as "dual track," "multiple track," or "alternative response," is an approach that allows child protective services to respond differently to accepted reports of child abuse and neglect, based on such factors as the type and severity of the alleged maltreatment, the number of previous reports, the age of the child, and the willingness of the parents to participate in services. While there is great variation among the states' implementation of differential response, it generally is applied to low- and moderate-risk cases with no immediate safety concerns. Those cases are provided a family assessment and offered timely, strengths-based services without a formal determination or substantiation of child abuse or neglect.

Historically, accepted maltreatment reports have received one traditional response – an *investigation* – with a primary focus on substantiating the allegations in the report. In the practice of differential response, the child protection investigative response is reserved for accepted reports that are high-risk and may involve egregious harm to children. While the ability to offer choices in how agencies respond to reports of child maltreatment is intuitive,



this burgeoning practice is frequently embraced without a comprehensive understanding of its elements and the essential commitment and support required to (a) ensure that workers are both comfortable with and skilled in working with families as partners, (b) be aware of and prepared for the resulting organizational transformation, and (c) possess the political will to sustain this approach.

In a comprehensive effort to detail the reform efforts of both state and local child protection systems, the Administration for Children and Families conducted a 3-year effort to describe the child protection policies in place in all 50 states and the District of Columbia. The resulting *National Study of Child Protective Services Systems and Reform Efforts* (U.S. Department of Health and Human Services [USDHHS], 2003) provided an initial baseline of differential response practices as identified by agency response. This 2003 study defined differential response as a response in which the agency assessed the needs of the child or family without requiring a determination that maltreatment had occurred or that the child was at risk of maltreatment. In the years following the publication of this study, innovation abounded in multiple child protection systems, including differential response practices and other transformations in the front end of these systems.

Building on the federal government's 2003 national study, American Humane and the Child Welfare League of America (CWLA) collaborated to conduct a national study of differential response in child welfare in 2005-2006 (Merkel-Holguin, Kaplan, & Kwak, 2006). The purposes of the American Humane-CWLA study were fivefold: (1) to provide greater specificity of the

practice elements of differential response and thus, increase definitional clarity; (2) to provide states with the opportunity to describe their practice innovations and determine whether their approach was differential response; (3) to describe the national landscape of this approach once the characteristics were catalogued and summarized; (4) to make a significant contribution to the literature; and ultimately (5) to support communities in implementing differential response.

Striving for Clarity in Murky Waters

Since the formal inception of differential response with the first state statute to codify the practice of the Family Assessment and Response System (Child Protection and Reformation, 1993), a clear understanding of this approach has been challenged by the lack of common terminology and definition.

As has been the case with other child protection reforms, such as family preservation, states have embraced

a significant change in the way in which they relate to families and their needs, using different terminology, definitions, models, services, and service providers, all while shaping the evolution of the approach.

As mentioned previously, differential response is referred to by a variety of names. Regardless of the specific terminology used by states, the rationale for this approach is to offer flexibility to tailor the child protection response to the needs and circumstances of the family, to collaborate with families early rather than waiting for serious harm to occur, and to remove faultfinding in order to increase the possibility of parent engagement and, ultimately, child safety.

**Historically, accepted
maltreatment reports have
received one traditional
response – an *investigation*.**



Developed by the AIM team (American Humane, Institute of Applied Research, and Minnesota consultants¹) in 2007, a number of core values that guide the development, implementation, and evaluation of differential response are consistent across the previously mentioned differences. These values include:

- *Engagement versus adversarial approach.* The shift from an adversarial approach in which parents are “investigated” in a quasi-law enforcement method to an approach in which parents are partners in maintaining child safety is a significant change for most child protective services agencies.
- *Services versus surveillance.* Families receiving the noninvestigation assessment response are more likely to be receptive to and engaged in the receipt of services when approached in a nonadversarial, nonaccusatory way, resulting in better outcomes.
- *Label of “in need of services/support” versus “perpetrator.”* When individuals are not labeled as perpetrators, the stigma of being associated with child protective services decreases.
- *Encouraging versus threatening.* For the majority of reports, exposing families to an often intrusive and threatening investigation is unnecessary, especially when for many, this may be the first and only contact with child protective services. The intent of the assessment pathway in differential response systems is to encourage families who come into contact with child protective services to seek assistance when they are in crisis. When the fear of family members is not unnecessarily aroused, they may be more willing to seek assistance in the future because of the supportive nature of the intervention.

- *Identification of needs versus punishment.* By proactively engaging families in strengths discovery and also their identification of needs, while still attending to any precipitating concerns that led to the report, workers are able to switch the perception of the role of the child protective services agency to one of providing support and assistance rather than punishment.
- *Continuum of response versus one size fits all.* Child protective services responses to child abuse and neglect should more accurately correlate to and reflect the presenting risk, safety, child vulnerability, protective factors, and other essential criteria. Alternative response systems apply this value by providing low- to moderate-risk reports with a family assessment and high-risk reports with an investigation.

These core values highlight the contrast between the traditional investigative approach and that of a family assessment response. The traditional response approach, an investigative model, is rooted in the determination of whether a child has been harmed, a child is at risk of being harmed, and an individual is culpable for this conduct. The family assessment pathway in a differential response approach focuses on meeting the protective services needs of a child and the support and engagement of the family.

Commonalities Between the Family Assessment and Investigative Response Pathways

There are numerous philosophical and pragmatic commonalities between the two pathways. These include: (a) the three major outcomes which all child welfare responses and interventions target and strive to achieve – a focus on child safety, promotion of permanency, and attunement to child well-being, (b) an overt value of building partnerships with and

¹Our Minnesota partners include Carole Johnson, Suzanne Lohrbach, Robert Sawyer, and David Thompson.



leveraging community services to support child and family needs, (c) a recognition of the child protection agency's authority to make decisions about placement and court involvement, and (d) creating system flexibility so that child protection systems can rapidly respond to changing family circumstances and meet families' needs (Schene, 2005).

National Study Methodology

Given the variation among states' and counties' definition and implementation of alternative response, the *National Study on Differential Response in Child Welfare* (Merkel-Holguin, Kaplan, & Kwak, 2006) attempted to achieve definitional clarity and distinguish among the multitude of child protection reforms across the nation's state and county child welfare systems. States were surveyed in order to obtain a national "snapshot in time" of differential response. In conducting the qualitative survey, American Humane and CWLA identified a group of key informants as survey respondents based on published and unpublished literature on differential response and the network of state and county leaders engaged in this approach. Twenty-seven states and two counties participated in the survey. The qualitative profiles contained information on the title of model or referent, contact information, origins, description, evaluation and results, plans for the future, impact on front-line practice, and implementation challenges.

The majority of the qualitative profiles presented a snapshot of differential response in the summer and early fall of 2005. In an effort to ensure comprehensiveness, American Humane sent letters to the child welfare offices in the states that had not been profiled, inquiring if their state or any counties were engaged in differential response. Because the implementation of differential response and other innovative practices in child protective services is a dynamic

process and the majority of the profiles were finalized in summer 2005, some of the profiles may contain "outdated" information.

The profiles were completed in one of two ways. For the majority of profiles, CWLA interviewed the state or county respondents, requested background material on their work, and drafted the profiles, using the categories listed previously. The respondents, CWLA, and American Humane staff then reviewed the profiles. Modifications to the profiles were made with the respondents' approval of the final versions found in the compilation. Alternatively, a few states drafted their own profiles, based on the survey categories, and a similar process of review and modification ensued.

The quantitative survey, based on the American Humane-CWLA definition of the core elements of differential response and the qualitative profile responses, was sent to 20 states and counties in April 2006. Fifteen states and counties responded. Four states and one county deemed that their innovative practices did not meet the majority of the core elements, and therefore, opted out of the quantitative survey.

The quantitative survey was composed of 17 nominal and mutually exclusive questions. The purpose of this survey component was to provide a national portrait of differential response, using consistent, categorical information complementing the profiles. Core elements identified in the following paragraphs were used not only as a guide to determine the categorization of practices for the qualitative listing, but also to support the quantitative survey questions. A copy of the survey responses can be found at www.americanhumane.org/differential.

Key state informants were asked to respond to the 17-item survey if their practice approach was consistent with the following definition of differential response established for this survey:

Differential response is an approach that allows child protective services to respond differently to accepted reports of child abuse and neglect. Differential response is “a formal response of [the] agency that assesses the needs of the child or family without requiring a determination that maltreatment has occurred or that the child is at risk of maltreatment” (USDHHS, 2003, Chapter 5)

Core elements were identified in an attempt to achieve definitional clarity and distinguish among the multitude of child protection reforms across the nation’s state and county child welfare systems. Selected core elements, as identified in the *National Study of Differential Response in Child Welfare* (Merkel-Holguin, Kaplan, & Kwak, 2006) included:

- The use of two or more discrete responses to reports of maltreatment that are *screened-in and accepted* by the child protection agency for response. Typically, this would include the traditional approach – an investigation pathway – and the nontraditional approach – a family assessment pathway.
- Multiple responses for reports of maltreatment that are screened-in and accepted for response.
- Pathway assignment determined by presence of imminent danger, level of risk, the number of previous reports, the source of the report, or presenting case characteristics such as type of alleged maltreatment and age of the child reported.
- A possible decrease or elevation in original pathway assignments based on additional information gathered during the investigation or assessment phase. An increase or decrease in threats of harm or risk level can trigger a change in pathway assignment.

- Establishment of multiple tracks codified in statute, policy, or protocols.
- The ability of families who receive a noninvestigatory response to accept or refuse the offered services after a family assessment, as long as child safety is not compromised.
- No formal determination that child maltreatment occurred (i.e., no substantiation or finding of abuse or neglect). Labels of perpetrators and victims are not used when alleged reports of maltreatment receive a noninvestigation family assessment response.
- A differential use of the central registry, depending on the type of response. Given that there is no identification or labeling of a perpetrator, the names of the individuals served through a noninvestigation family assessment pathway are not entered into the central registry.

Summary of Findings

Table 1 summarizes the complete responses to this survey. Respondents from 15 states (Alaska, Florida, Hawaii, Kentucky, Louisiana, Minnesota, Missouri, North Carolina, Oklahoma, Pennsylvania, Tennessee, Virginia, Washington, West Virginia, and Wyoming) indicated that their child protection system incorporated an alternative response to reports of suspected maltreatment, and 11 of these (Hawaii, Kentucky, Minnesota, Missouri, North Carolina, Oklahoma, Pennsylvania, Tennessee, Virginia, Washington, and Wyoming) indicated that there is statewide implementation of their alternative response approach.

The survey found that in all 15 states there are policies or practice protocols which formally guide the implementation of and child welfare practice in a differential response system. All respondents indicated that assignment to either the traditional investigation response or the



noninvestigation family assessment response is based on specific criteria, including the type of alleged maltreatment, the age of the child, and the number of previous reports. All states indicated that there could be reassignments of the initial response from noninvestigation family assessment to investigation based on additional information gathered during the assessment phase or situation changes during the life of the case. (Reassignment is less likely if the initial assignment has been made to an investigative response pathway.) All but one of the state respondents indicated that the name of the alleged perpetrator is *not* entered into the central registry for individuals served through a noninvestigation assessment response.

State respondents identified their use of various criteria (such as precipitating factors, exposure to domestic violence, or substance abuse) to determine a child's risk level and the response pathway assignment. The source of the report was not a factor in any of the states in determining whether an accepted report could be assigned to the assessment response pathway. All 15 state respondents indicated that reports of sexual abuse, serious physical injury or abuse, or cases where there has been a child death connected to a report of abuse or neglect *cannot* be assigned to the noninvestigation assessment response pathway. Ten states also identified serious neglect as a type of maltreatment that cannot be assigned to the noninvestigation assessment response. With the exception of three states that require investigation for maltreatment allegations involving young children, the age of the child does not preclude the assignment to the assessment response pathway in states that implement a differential response.

The survey found additional variation among the states in terms of whether the differential response system includes a formal pathway for reports of child maltreatment that are screened out of child protective services,

whether assignment to the noninvestigation assessment response was limited by the number of the family's previous reports of alleged child maltreatment, or whether an assessment response can be provided when a child is placed in foster care or when the case is involved in the juvenile dependency court.

While the general differential response approach nationwide embraces key values of family engagement and service provision, jurisdictions vary in their conceptual delineation of who should receive which options. As noted in several studies, there is additional variation in the length of the service, the amount of service provided to the family, the service provider, and whether the service option is voluntary or mandatory.

Highlighting Unique Practice Issues

In conducting the national study, several practice issues were unearthed that require additional examination to gain sufficient understanding of differential response practice, support the intentions of the practice, and attempt to eliminate that which is unintended and not desired.

Case assignment. All respondents indicated that assignment to either the traditional investigation response or the noninvestigation assessment response is based on specific criteria, including the type of alleged maltreatment, the age of the child, and the number of previous reports.

State respondents identified their use of various criteria (child's age, number of previous reports, precipitating factors, or exposure to domestic violence) to determine a child's risk level; it is the risk level that is a determinant in the response pathway assignment. In most states, cases of low to moderate risk are eligible to be served through the noninvestigation family assessment response. The states also reported that families' voluntary

requests for services are served through the assessment response. For example, in Kentucky, when a social worker receives a voluntary request for assistance from an individual with a previous case history and there is a low risk for abuse, neglect, or dependency, the social worker may take the request as an assessment. Conversely, high-risk cases and cases of imminent danger are served through the traditional, investigatory pathway.

Maltreatment categories. Some types of maltreatment categories are excluded summarily from the assignment to assessment response. There are frequent case-specific determinations in which particular types of maltreatment may be precluded from assignment to the assessment response given the level of risk, worker discretion, and consultation with the supervisor. This circumstance highlights the complexity inherent in any assignment schema as well as the importance of flexibility in making these determinations, given the specific circumstances of any particular family and their children.

All 15 state respondents, with qualifications noted where applicable, indicated that sexual abuse reports *cannot* be assigned to the noninvestigation assessment response. Similarly, all 15 states indicated that serious physical injury or abuse or cases where there has been a child death connected to a report of abuse and neglect *cannot* be assigned to the noninvestigation assessment response pathway. Ten of the 15 respondents (Florida, Hawaii, Kentucky, Louisiana, Missouri, Oklahoma, Pennsylvania, Virginia, Washington, and West Virginia) identified serious neglect as a type of maltreatment that cannot be assigned to the noninvestigation assessment response. Slightly less than one half of the state respondents (7 out of 15: Hawaii, Kentucky, Pennsylvania, Tennessee, Virginia, Washington, and Wyoming) indicated that there can be no assignment to the noninvestigation assessment response where

there is serious mental injury. Slightly more than one half of state respondents (8 out of 15: Hawaii, Kentucky, Minnesota, North Carolina, Pennsylvania, Virginia, Washington, and West Virginia) reported that cases of abandonment cannot be assigned to the noninvestigation assessment pathway. Six states (Florida, Kentucky, Minnesota, North Carolina, Pennsylvania, and West Virginia) preclude cases of medical neglect, and four (Kentucky, Oklahoma, Tennessee, and West Virginia) prohibit cases that involve drug-exposed infants from being assigned to the noninvestigation assessment response.

Import of Worker Discretion

Based on conversations with numerous state respondents and explanatory notes provided by these respondents, it became readily apparent that workers' clinical judgment and discretion were of great importance in the implementation of differential response. There are few *hard and fast rules* that cannot be altered given the practice wisdom of a specific worker and the approval of a supervisor.

Much like the decisions that workers make at different points in the life of the case, there is a unique set of decisions associated with differential response in which the worker's discretion is of significance. These include:

- Initial pathway assignment
- Pathway response reassignment
- The use of assessment response when the child is in care
- The ability to respond to family issues that workers previously had no means to address

While intake and screening systems have discrete guidelines for assigning cases to the response pathways, many of these systems also support case-level decision making in determining the appropriate response.

Missouri, as cited previously, is one example where three reports constitute a significant risk factor; but based on other case characteristics, staff have latitude to determine the pathway. Another example is Kentucky, where if a report alleges injuries to an adolescent as the result of altercations between child and custodian, the report may be accepted for an investigation or a Families In Need of Service Assessment (FINSA). In making that determination, the social worker specifically focuses on the age of the child, precipitating factors, the degree and appropriateness of force used by the caretaker, and the need for further services to assist in eliminating the violent behavior in the home.

The worker is able to redress multiple objections to involvement in the child welfare system as well as make greater strides in working with families. Workers believe that they are better able to engage families earlier in the case process, services are provided sooner, and the stigma of involvement in the child welfare system is diminished. Social workers report that families are more receptive and less resistant and that they are performing “real” social work practice. Several studies by Loman and Siegel (2004a, 2004b) indicated increased satisfaction of both families and workers. It is interesting to note advocates for or recent adopters of differential response provided benefits related to workforce issues – retention, reduced workload, reduced recidivism, and caseload management – as impetus for change.

Voluntary Services

Whenever possible, it is important to engage families in a manner that promotes the voluntary selection of and participation in services. This is true regardless of whether a family is assigned to a traditional response pathway or a differential response pathway.

The specific level of risk to the child influences the degree to which services are voluntary. When the child is determined to be at high risk of imminent harm, services are most likely to be mandated and families who are in the differential response pathway are likely to be reassigned to the investigation pathway. When the child is assessed to be at moderate risk of imminent harm, services may be voluntary or they may be mandatory. Different states deal with the reassignment issue differently. In many instances, such a determination would be made in response to specific case characteristics.

The opportunity for families to engage in services *voluntarily* is a core element of the differential response approach. It has been suggested that when the child protective services agency offers families the choice to elect and participate in services, the family is more likely to develop a constructive partnership with service providers, experience greater satisfaction with service delivery, and perhaps, improve the outcomes associated with service provision.

In the quantitative, categorical survey on differential response, state respondents were asked whether services were voluntary for families who receive a noninvestigation assessment response. This question did not specify the level of risk to the child determined by the assessment process and thus, the interplay between the level of risk and the opportunity to engage in services voluntarily was not captured. Therefore, states responded to the question in disparate ways. Given the complexity of the issue and the lack of comparable data across states, the authors opted not to categorize the responses or report these findings in the response table.

However, with the collection of additional information from state respondents, it is apparent that the specific level of risk to the child influences the degree to which services are



voluntary. When the results of an assessment indicate low levels of risk of maltreatment, the majority of state respondents indicate that service provision is voluntary. As the continuum of risk moves from low to high, the need for mandated services also increases. For example, a number of states noted that if the assessment indicates that the child is at high risk of maltreatment, the provision of *voluntary* services is no longer an option. In such instances, some states reassign high risk cases to the investigation pathway. Some states, on the other hand, mandate services through court involvement, but do not require an investigation.

In addition, a number of states noted that if parents or caregivers decline to address the risk factors and cooperate with services that are deemed essential to reduce the high level of risk, this refusal triggers a more coercive response. When families receiving the assessment response reject services, some states reassign the case to the investigation pathway while others mandate services. With any of these more coercive and adversarial reactions to refusal, we must question whether the opportunity to participate in services is indeed *voluntary*. In Hawaii, for families offered voluntary case management services, an investigation response is triggered if services that would decrease risk or impact child safety are refused by the family. Similarly, in Minnesota, if the assessment reveals that the child is not safe or is at high risk of maltreatment, services are not optional. If the parents refuse to resolve the issues, a juvenile court petition would be filed to order the actions necessary to make the child safe.

While there appears to be consistency that the concept of voluntary service provision is no longer an option when children are determined to be at high risk, there is some variability on this question with moderate-risk cases. Although not all state respondents provided clarifying

information, in Louisiana, there are cases in which voluntary services are available to families who are receiving a noninvestigation assessment response and whose children are determined to be at moderate risk of maltreatment. In Minnesota, services are voluntary for families whose children are at moderate risk of maltreatment. In some of the other states, moderate risk determination results in either reassignment to the investigation pathway or mandated services. Because the issue of voluntary services is a core component of differential response, more in-depth study is required to fully understand the complexity of states' policies and protocols related to this issue.

Variations on a Theme: Selected Child Protective Services Innovations

Table 2 highlights various innovations, including differential response, that are being implemented in the United States. As it shows, many states have implemented child protective services innovations that are related to, and yet are not, differential response. Many of these state respondents indicated that they were indeed carrying out this reform, when in reality, based on the federal and American Humane-CWLA definition of differential response, this was not the case. Examples of states with these notable innovations include California, New Mexico, and Wisconsin, which have multiple response pathways. None of the pathways are dedicated to screened-in and accepted reports of alleged child abuse and neglect as would be the case in differential response. All three of these states have a dedicated community pathway for screened-out cases. Families are connected with services in the community for which there is voluntary participation and no formal involvement of the child welfare agency.

Iowa also has a formal pathway to refer the family to a community-based agency and has four formal response levels that allow the agency's

workers to consider an array of factors in making a determination as to the best way to respond.

North Dakota and South Dakota have a single nonadversarial response to all reports of alleged maltreatment. The Dakotas use many of the characteristics of the differential response pathway in their single-track systems.

These and the many other innovations that exist to refine our encounters with families when they are first involved in the child welfare system demonstrate the struggle and the desire to respond more appropriately to vulnerable families and their children.

Growth of Differential Response Practices

Currently, the landscape of differential response is rapidly evolving and spreading in child protection. Soon after the completion of the *National Study of Differential Response in Child Welfare*, the authors acquired additional information related to the pursuits of other states in this arena. In the year that followed the publication of the national study, at least five states passed legislation or adopted policy that enabled the use of differential response approaches to screened-in and accepted reports of suspected child abuse and neglect. These six states were Massachusetts, Nevada, New Jersey, New York, Ohio and Vermont. Given the rate of growth, it is important to remain vigilant and monitor the following issues as the approach evolves and expands.

The child welfare field is actively pursuing, through diversified experience, evaluation, and research, more knowledge about differential response implementation. Many questions regarding differential response remain unanswered to date, including but not limited to:

- In county-administered systems, what degree of variation will be implemented?
- Are changes in law needed to allow for both an alternative response and an investigatory response? If so, what changes are necessary?
- As one changes the definition of child abuse and neglect, as anticipated in Ohio, what will be the impact not only on alternative response but also on investigations?
- What sector of the workforce is best suited to providing alternative response?¹
- If child welfare staff is best suited to provide alternative response, what knowledge, skills, and expertise are best to work with families in an alternative response system? How are they different from those that are best suited for an investigation approach?
- What are the key factors that make a difference? Is it the amount of service provided to families, the attitude of workers who seek to “empower and strengthen” families rather than “punish” families, or other factors?
- Can alternative response exist as a viable response for child protective services and not just an alternative? In other words, is it a response that all cases with certain characteristics should receive or only those for whom there are enough “slots”?

Conclusion

With the data from the *National Study on Differential Response in Child Welfare* as a foundation from which to base future inquiry, as well as the questions they raise, there is much opportunity as well as need to gain additional

¹ An early version of alternative response implemented in Washington state essentially diverted such cases from the child protective services system to community providers. Alternative response cases were not considered part of the child protective services workload. In other communities, including Minnesota, alternative response is provided by the same workers who provide investigation services.

understanding about the impacts of differential response on child welfare systems, including front-line practice, outcomes for children and families, and impact on worker and family satisfaction. Attempting to identify the stressors to the system and the solutions to the presenting difficulties will allow for the growth of a practice innovation that celebrates our ability to make a positive difference in the lives of families who come to the attention of the child protection system.



Table 1. Summary of State Survey Responses

State	Number of response pathways for accepted reports of child abuse/neglect	Differential Response System includes formal response for screened-out reports	Scope of implementation	Assignment of case to assessment or traditional response depends on various criteria	Assignment to assessment response limited by:				Assessment response can be used when child placed in foster care	Assessment response can be used in cases involved with juvenile dependency court	Initial response assignments can be reassigned from non-investigation to investigation
					maltreatment category	source of reporter	age of child	number of previous reports			
AK	2 ^a	No	Multiple sites	Yes	Yes	No	No	No	Yes	Yes	
FL	2	Yes	Multiple sites	Yes	Yes	No	No	No	No	Yes	
HI	3	No	Statewide	Yes	Yes	No	No	No	Yes	Yes	
KY	2	Yes	Statewide	Yes	Yes	No	No	Yes ^c	Yes	Yes	
LA	2	No	Multiple sites	Yes	Yes	No	No	No	No	Yes	
MN	2	Yes ^d	Statewide	Yes	Yes	No	No	No	Yes	Yes	
MO	2	Yes	Statewide	Yes ^e	Yes	No	No ^f	Yes ^g	Yes	Yes	
NC	2	No	Statewide	Yes	Yes	No	Yes ^h	No	Yes	Yes	
OK	2	No	Statewide	Yes	Yes	No	No	Yes ⁱ	No	Yes	
PA	2	No	Statewide	Yes	Yes	No	No	Yes	Yes	Yes	
TN	2	Yes	Statewide	Yes	Yes	No	No	Yes	Yes	Yes	
VA	2	No	Statewide	Yes	Yes	No	No	Yes ^k	No	Yes	
WA	2	Yes	Statewide	Yes ^m	Yes	No	No	No	No	Yes	
WV	2	Yes	Multiple sites	Yes	Yes	No	Yes ⁿ	No	Yes	Yes	
WY	3	No	Statewide	Yes	Yes	No	Yes ^o	No	Yes	Yes	

State	Initial response assignments can be reassigned from investigation to noninvestigation	State mandates differential response (DR) in statute	State has practice/policy protocols that formally guide implementation or practice of DR	No substantiation of alleged maltreatment for families in non-investigation assessment response	Name of alleged perpetrator entered into central registry for those served through noninvestigative assessment response
AK	No	No	Yes	Yes	No
FL	Yes	No	Yes ^a	Yes	Yes ^b
HI	No	No	Yes	Yes	No
KY	No	Yes	Yes	Yes	No
LA	No	Yes	Yes	Yes	No
MN	Yes	Yes	Yes	Yes	No
MO	Yes	Yes	Yes	Yes	No
NC	Yes	Yes	Yes	Yes	No
OK	No	Yes	Yes	Yes	No
PA	No ^c	Yes	Yes	Yes	No
TN	No	Yes	Yes	Yes	No
VA	No	Yes	Yes	Yes	No
WA	Yes	No	Yes	Yes	No
WV	No	No	Yes	Yes	No
WY	Yes	Yes	Yes	Yes	No

Note. From *National Study on Differential Response in Child Welfare*, by L. Merkel-Holguin, C. Kaplan, and A. Kwak, November 2006, Denver: American Humane Association and the Child Welfare League of America.

^aOnly in the communities that have differential response grantees.

^bAs of 2005, the Florida Department of Children and Families began a 2-year process of designing and developing its alternative response system. Therefore, the responses to the survey reflect the implementation team's thinking in October 2005.

^cWhile it is not the specific number of reports that triggers an investigation, typically multiple reports enhance risk and safety concerns, and previous reports are used as one factor in determining the appropriate pathway.

^dMinnesota has a third pilot response pathway in 38 of 87 counties for screened-out reports.

^eReports other than those of sexual abuse go to the "family assessment response" if the allegations, if found to be true, would not constitute a law violation.

Table 1 notes continued.

^f Age is only one criterion that influences pathway selections.

^g If a report is screened as a “family assessment” and has three or more prior calls to the hotline with the same abuse or neglect type, staff have the option to upgrade to the investigation response pathway. This decision is made on the basis of how the agency can best serve the family.

^h Only true for children under the age of 1 who have allegedly been shaken or subjected to corporal punishment.

ⁱ Three previous reports disqualify assignment to a noninvestigation assessment response.

^j The only exception is corporal punishment when it does not involve injury to an older child or older children who do not have adequate supervision.

^k Three previous reports within the year disqualify assignment to a noninvestigation assessment response.

^l Except if the case was taken into protective custody.

^m Low-risk referrals go to alternative response and moderate- to high-risk referrals are assigned to traditional investigation.

ⁿ Any child under 6 is not eligible to be served through the noninvestigation assessment response.

^o Under development as of October 2006.

^p Currently, the workgroup recommends the name of the individual to be entered in the system, but not be indicated in an “alleged perpetrator” role.

^q After completion of the investigation, it can be assigned as a general protective services case if it has been determined that child abuse was not committed.



Table 2. Differential Response (DR) in Child Welfare by State

State	DR Statewide	DR multiple jurisdictions <i>not</i> statewide ^a	DR formal pathway for screened-out reports ^b	DR in development ^c	Other innovation ^d	DR non-operational ^e
AK		X				
AZ						X
CA ^f					Differential response	
CO					Child welfare and TANF implementation for prevention purposes	
CT					Hartford Community Partnership	
DC					Community collaboratives	
DE						X
FL		X	X	X	Community partnerships for protecting children	X
GA					Community partnerships for protecting children	
HI	X					
IA ^g					Child abuse assessment & community partnerships for protecting children	
IL					Integrated assessment program	
IN					Community partners for child safety	
KY	X		X		Community partnerships for protecting children	
LA		X		X		
MA				X	Connecting families	
MD				X		
MI					SDM: 5-category disposition	
MN	X		X			



Table 2 continued.

State	DR Statewide	DR multiple jurisdictions not statewide ^a	DR formal pathway for screened-out reports ^b	DR in development ^c	Other innovation in CPS ^d	DR non operational ^e
MO	X		X		Community partnerships for protecting children	
NC	X					
ND					Safety strength risk assessment	
NJ				X	Child welfare service/assessment	
NM ^h					Differential response	
NV ⁱ				X		X
NY ⁱ					Differential response	
OH				X		
OK	X					
OR					Family support and connections	
PA	X					
SD					Initial family assessment	
TN	X		X			
TX					Community partnerships for strengthening families	X
UT					Domestic violence pilot project	
VA	X					
WA	X		X			
WI				X		
WV		X	X			
WY	X					



Table 2 notes

Note. Data from *National Study on Differential Response in Child Welfare*, by L. Merkel-Holguin, C. Kaplan, and A. Kwak, November 2006, Denver: American Humane Association and the Child Welfare League of America. Source data was provided by states in spring 2006. Supplemental information is captured from community-based child abuse prevention applications. Alabama, Arkansas, Idaho, Kansas, Maine, Mississippi, Montana, Nebraska, New Hampshire, Rhode Island, South Carolina, and Vermont did not provide information for the study and thus, information is needed. Differential response is defined as “a formal response of the agency that assesses the needs of the child or family without requiring a determination that maltreatment has occurred or that the child is at risk of maltreatment” (USDHHS, 2003).

^a Contractual arrangements may or do exist with other service providers; authority for the implementation of this approach resides with the child welfare agency.

^b In addition to two discrete responses, there is at least one formal track or pathway that diverts screened-out reports to community-based agencies and/or other service providers.

^c Differential response, under the authority of the child welfare agency, is in the stages of development or initial implementation with the intent to establish a formal system either statewide or in multiple jurisdictions.

^d Practice innovations that provide a comprehensive, countywide or statewide approach respond to and assess the needs of vulnerable children and their families in a nontraditional manner without conducting a formal investigation. Such approaches may be provided under the auspices of the child welfare agency or another service provider.

^e Differential response was previously implemented by the child protection agency statewide or in selected jurisdictions and the approach is no longer in existence.

^f California Department of Social Services has established three pathways that are implemented by the county child welfare agencies. None of these pathways correspond to the definition of differential response (USDHHS, 2003). Therefore, although the pathways have some of the essential criteria, the approach is characterized as an innovation.

^g Iowa’s response system, although not an alternative response, provides a formal pathway to refer the family to a community-based agency.

^h New Mexico’s differential response is dedicated to meet the needs of families not screened-in to the child protective services system.

ⁱ Nevada has enabling legislation that allows for statewide use of formal alternative response. There are no broad efforts to initiate the system and lack of organizational capacity has resulted in limited success. (Reclassified for this table; the National Study characterizes Washoe County, NV as having an alternative response system.)

^j New York’s child abuse statute requires that a determination of suspected maltreatment be made and the perpetrator’s name be entered into the central registry. Nonetheless, Westchester County is attempting to implement the other characteristics and elements of an alternative response county-wide.

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The Parent Support Outreach Program: Minnesota's Early Intervention Track

David Thompson, Gary L. Siegel, and L. Anthony Loman

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Minnesota has invested considerable time, energy, and resources in developing a differential response system for accepted reports of child maltreatment (Johnson, Sullivan Sutton, & Thompson, 2005). Within this system, the family assessment response has demonstrated the benefits of responding to a broad set of needs of families at all risk levels rather than focusing on a narrow set of interventions for the most serious reports. If families are engaged respectfully and become partners in achieving child safety, they are less likely to experience child maltreatment in the future and they demonstrate significant improvement in both child and family well-being (Institute of Applied Research, 2006). Both the emotional trauma and the financial costs associated with child neglect and abuse can be avoided or diminished.

Although encouraged by the impact of differential response on families reported and *screened in* for a child maltreatment response, Minnesota policymakers recognized that an even larger number of reported families were screened out of the system and received no formal response. Of all child maltreatment reports in Minnesota, approximately 60% (36,956) were

screened out in 2006. Nationally, approximately 38% of reports were screened out in 2005, the most recent year for which national data are available (U.S. Department of Health and Human Services, 2007). Screened-out reports lack either a specific incident of child maltreatment or sufficient information to support a formal response, and therefore, counties determine no formal child protection response, either family assessment or investigation, is required.

Minnesota child welfare services are administered by counties and supervised by the state. County child welfare agencies seldom offer services to screened-out families because limited resources force most counties to confine interventions to cases of alleged current and immediate threat to children's safety. This practice foregoes the opportunity to respond early to a broader set of families and prevent conditions that are harmful to children.

Some communities in Minnesota have developed family service and children's mental health collaboratives that offer education, counseling, child development, and other services for families. When families are successfully connected with these programs, the outcomes for their children, such as the ability to succeed at home and at school, improve. Unfortunately, many at-risk families are so overwhelmed with the task of meeting basic needs or responding to periodic crises, they are unable to independently seek out available services. Struggling families often require proactive engagement and targeted supports to effectively make use of community resources.



The Parent Support Outreach Program: Minnesota’s Prevention Response

With the support of a grant from the McKnight Foundation, the Minnesota Department of Human Services elected to begin addressing this underserved and at-risk population by piloting the Parent Support Outreach Program (PSOP). PSOP is a prevention and early intervention program focused on families who have children under the age of 6 and who have been reported for child maltreatment concerns but screened out from a formal child protection response. This pilot program, begun in April 2005 and continuing through 2008, tests the impact of early intervention on families at risk of child maltreatment by joining public sector case findings with the community-based delivery of family support services. A total of 5,000 families are expected to be enrolled during the pilot period.

Project County Selection

Counties interested in piloting the Parent Support Outreach Program responded to a request for proposals by the Minnesota Department of Human Services. The interest level was high and ultimately, all 38 counties submitting proposals (out of a total of 87 Minnesota counties) were selected to participate. Those 38 counties represented a wide variety of urban, suburban, and greater Minnesota settings and generated the vast majority of child maltreatment reports. Results from this large pilot program could easily be generalized to the whole state. Service models varied from county service provision to the use of contracted

community service providers. Proposals paid attention to strengths-based engagement efforts and included creative strategies such as the use of “asset baskets” containing information about community resources and small gifts.

Project Description

During the pilot, counties have been directed to identify reports of child maltreatment in families with at least one child aged 5 or under that are not accepted for a child protection response. These reports may be further screened for the existence of child maltreatment risk factors including but not limited to:

- Past reports of child maltreatment;
- Poverty;
- Domestic violence;
- Substance abuse;
- Homelessness; or
- Cognitive, emotional, or behavioral disabilities of the child or parent.

For most pilot counties, engagement of at-risk families entails an initial contact and service offer by the county child welfare agency, with services delivered by community social service providers. County social workers make the first contact with families and are encouraged to make the service offer through a face-to-face contact whenever possible. It is hoped that personalized contacts employing strengths-based and parent-affirming engagement strategies will increase participation rates. Some low-population density counties do not have convenient access to community-based social service providers and the county social

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service agency is the direct provider of services.

The Parent Support Outreach Program is voluntary. Families choose whether or not to participate and are expected to largely direct the service plan and delivery. County outreach to these families is based on respectful engagement, collaborative practices, and the provision of services identified by the families as needed by the family. Families assess their concerns and needs with the community provider or county agency and identify services they want to engage. Families are assisted by the service provider in completing a structured decision making strengths and needs assessment and a child well-being assessment. These tools are used to assist the family in developing the service plan. The service provider acts as a resource coordinator for the family. Typical services may include parenting education, family counseling, child development assistance, crisis counseling, and emergency help meeting basic needs. Pilot counties receive state grants averaging \$1,000 per family to assist in covering the cost of services to PSOP families.

An additional program goal is to guide families in making use of the available community supports and learning how to access them in the future if necessary. Pilot counties are to make at least one follow-up contact with families 6 months after the service case has been closed. This check-in with families is intended to ensure that families are continuing to access community services if needed.

Training

Before the program was implemented, service providers attended training provided by the Minnesota Department of Human Services regarding project guidelines, best practices concerning family engagement, and collaboration and the use of strengths-based interventions. Course offerings available to service providers through the Minnesota Child Welfare Training System also include:

- Attachment - Past and Present: Framework and Strategies for Breaking Intergenerational Cycles of Abuse and Neglect;
- Family Assessment Orientation;
- Family Group Decision Making (FGDM) Orientation;
- Understanding Poverty and The Role of Child Welfare;
- How Our Potential Explodes (HOPE);
- Solution-Focused/Brief Therapy; and
- Co-Occurrence of Child Maltreatment and Domestic Violence.

Periodically, pilot counties participate in all-pilot conference calls, and are brought together for specialized training and to share lessons learned.

Project Evaluation

The Institute of Applied Research has been selected to evaluate the Parent Support Outreach Program. The alternative response program evaluation demonstrated the importance of tracking program outcomes such as subsequent reports of child maltreatment, indicators of child and family well-being, and the reduction or elimination of child maltreatment risk factors. The significant benefits to families documented in the alternative response evaluation strongly influenced public policy, county and community investment, and sustainable funding. Similar documentation of the Parent Support Outreach Program is considered critical if outcomes support the value of statewide implementation.

Program Modifications

Several modifications have been made to the program since its inception in April 2005. The first change was to expand eligibility to families with at least one child aged 10 or under. Based on the demographics of screened-in



reports, it was thought that approximately 35% of screened-out reports would involve at least one child aged 5 or under. Pilot counties found that screened-out reports were not producing the expected number of referrals. One explanation may be a bias by child protection programs to respond to this vulnerable population by screening in most reports involving preschool-aged children.

The second change was to allow families to self-refer to the program or, with the permission of the family, to be referred by a community professional or their Temporary Assistance for Needy Families (TANF) program worker. Screened-out reports were still to be given priority but the expanded eligibility group could be enrolled in the program when time and resources allowed. With service acceptance rates at approximately 38%, it made sense to accommodate other families seeking assistance.

Participant Demographics

Through the first 24 months, 4,042 families in the 38 participating counties have been offered services through the Parent Support Outreach Program. Of these families, 38% have accepted the offer of assistance. Typically, these are young families who are very poor, often headed by single women who have limited education and who rely on various types of public support.

Over half (63%) of the households who have accepted the offer of PSOP services consisted of single mothers and their children, with no adult males present. The households had an average of 2.3 children with a mean age of 5.6 years. While some of the households included teenagers, a majority (57%) of all children in these families were younger than 6. The median household

income from all sources was less than \$13,000. Fewer than a third (30%) of the household heads had full-time jobs. Nearly two in three of the households received food stamps, over half (55%) benefited from the Women, Infants, and Children program, and 37% received public assistance from TANF. More household heads were high school dropouts (16%) than college graduates (4%).

Significantly, many PSOP families (47%) have had prior reports of child maltreatment, whether neglect or physical abuse. It is significant because a prior report is one of the most highly correlated factors to future reports (Loman & Siegel, 2004). In addition, a number of PSOP families have had contact with other parts of the counties' human services system. For instance, 24% have had a prior child welfare case open, 10% had an adult household member with a prior chemical dependency case and 10% have had some other type of adult services case opened.

Compared with families who were offered PSOP services but declined, acceptors were more likely to have had prior contact with the county human services system, including child protection, developmental disabilities, child welfare, child care, and chemical dependency services.

PSOP family respondents to surveys ($N = 250$; 49.3% response rate) often reported the presence of child-related problems. One in five (20.5%) reported some emotional problems among their children, such as acting as if they were depressed, exhibiting anxiety, or feeling unsafe. About the same percentage told us that their children were experiencing health problems, often felt unwell, or complained about headaches or stomachaches, and 10% reported their children had a serious illness. Those with older children often reported

Over half (63%) of the households who have accepted the offer of PSOP services consisted of single mothers and their children.



that they were difficult to control (31%) and acted aggressively toward family members (22%). Parents also frequently reported that their children had trouble learning in school (21%) and 12% reported a child with a developmental disability.

Another window into the lives of families participating in the Parent Support Outreach Program is being provided by their case managers. For purposes of the evaluation, county social workers complete an extended assessment of each family’s case once it is closed. These assessments (*N* = 763) are providing confirmation for much of what families themselves report: high incidences of child behavior problems (33%), chronic emotional problems among children (32%), chronic ill health (12%), and developmental disabilities (11%). It is the further judgment of social workers that the well-being of the children is seriously impaired due to the presence of these conditions in two out of three cases. Additionally, in one third (33%) of the PSOP families served thus far, social workers have found a level of poverty that impairs the care of the children.

PSOP Intervention

The families reached through the PSOP often have needs that are intensive and multi-faceted, and frequently complicated by the limited ability of the head of household to address them in an adequate way. In keeping with the purpose and goals of the program, social workers are seeking to assess the strengths and needs of families across a broad spectrum of socio-economic, health, personal, and interpersonal dimensions, and to address serious needs when they find them. They do this through the provision of services funded

by the program as well as referrals to a broad array of community resources. According to the families themselves, 88% have received some type of funded services and 72% report also being given referrals to various community resources for other, nonfunded assistance. In addition, 50% of the families report receiving some type of assistance directly from social workers, and nearly half (47%) say they have become aware of resources in their communities they had not known about before.

Services provided to PSOP families tend to fall within four general types: basic needs (e.g., food, clothing and other needs affected by poverty); general needs (e.g., child care or needs independent of a family’s economic situation); enabling assistance (e.g., job- or school-related information); and interpersonal or therapeutic assistance (e.g., counseling, parenting

instruction, or substance abuse treatment). Because of the high incidence of poverty among these families, many have received services that address basic needs; for example, 30% have received food or clothing assistance, others have received help paying rent (21%) or utility bills (17%), and some have received health care (14%) or

housing assistance (12%). Others have received help obtaining or paying for child care (15%) and assistance finding employment (10%). And many have received counseling services (31%), parenting classes (22%), and other mental health and substance abuse treatment services (20%).

In addition to providing these services, social workers have referred PSOP families to a wide array of community organizations and agencies through which other assistance is often available. These organizations include emergency food and

Two out of three families that received PSOP services reported that they felt more able to care for their children than they did a year ago.



childcare providers, community action agencies and health providers, employment and training agencies, support groups, legal services providers, domestic violence shelters, alcohol and drug rehabilitation agencies, schools, recreational facilities, churches and religious organizations, neighborhood organizations, developmental disabilities agencies, and youth organizations.

Most (92%) of the families served through the program reported that the services they received were what they needed. About one family in four (24%) said they needed additional services they did not get, and often these needs arose from the intensity of their poverty and limited household resources. Two out of three families that received PSOP services reported that they felt more able to care for their children than they did a year ago and expressed more confidence in their ability to deal with serious issues in their lives.

Additionally, a large majority of families served through the program expressed satisfaction with how they were treated (92%), and with the help they were offered and received (93%). A significant majority (80%) of the families said that they are better off because of PSOP.

Conclusions

Classic assessments of child protection in the United States describe a system able to provide services only to the most severely abused and neglected children (Kamerman & Kahn, 1990b; Lindsey, 1994). In a study conducted for the Annie E. Casey Foundation, Kamerman and Kahn found that other children and their families tend to be turned away. They wrote, “Chronic multi-problem cases in troubled families often are overlooked. In fact, if a case is not marked by dramatic events, it may receive only token processing and response” (1990a, p. 10).

The alternative response pilot project in Minnesota was a programmatic response to this situation. It was an attempt to attend to cases at the less critical end of the maltreatment spectrum

in a noncoercive way, providing services when needed, where services have infrequently been provided before, in the hope the problems would not become more acute. The evaluation of the alternative response pilot validated the expectation that more could produce less – that is, that greater investment in effort and service dollars up front would thin the stream of families reappearing in the child protection system (Loman & Siegel, 2005). Families most affected by the alternative response were those with very limited means and difficulty meeting basic needs. Families like these often presented chronic neglect cases that clogged the system, inflated the caseloads of social workers, and used up a disproportionate amount of available service dollars.

The concept of the Parent Support Outreach Program grew out of these findings and the experiences of state and county administrators and social workers who became convinced that the new approach was indeed a better way. The question became: Could even more be done and better results be obtained if the approach were pushed back to an earlier point; if the focus was placed on families found to benefit most from alternative response intervention; and if the program concentrated on younger families who, because of the age of their children, represented the greatest potential long-term cost to the system?

The surprising interim finding of the evaluation of the Parent Support Outreach Program is just how similar these families are to those whose reports require a family assessment. This finding supports the underlying concept of the program – that some offer of assistance is warranted and beneficial. But as the evaluation continues to track these families and monitor the assistance they receive, the outstanding and critical questions remain: To what effect? How successful is PSOP in thinning the stream of cases coming into the child protection system? How successful is it in reducing long-term risk to children and

in making them safer? Are families better able to parent their children and improve the well-being of their children with the receipt of needed supports and services? These are questions still to be answered.

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Implementation of Differential Response in Ethnically Diverse Neighborhoods

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Alameda County is the pilot site of California's first differential response program, Another Road to Safety (ARS). The ARS program uses a differential response model to screen risk at the county child maltreatment hotline and to offer services to families who are screened out of traditional investigation; have a child aged 0-5 or a pregnant mother in the home; and reside in designated neighborhoods selected due to high rates of child maltreatment reporting. The program is currently undergoing expansion to serve families with children above the age of 5. ARS clients receive up to 9 months of intensive home visiting and case management, concrete services, and referrals to local service providers. The ultimate goals of ARS are to promote family safety and stability, and to ensure positive child development. Staff experiences in implementing this program model in diverse community settings are described, with implications for clients' experience.

In California, differential response, a relatively new initiative in child welfare, changes the structure of front-end services by offering early intervention to families who traditionally would be screened out of investigation and services. Under the differential response paradigm, agencies typically assess child risk and safety levels of cases reported to the child abuse hotline and offer voluntary services to those deemed at low to moderate levels of risk. The differential response approach is characterized by the voluntary nature of services, respect for the unique needs of individual families, and community involvement in service delivery (Waldfoegel, 1998). This new way of doing business is catching the imagination of policymakers and child welfare administrators throughout the country.

In 2006, a survey by the American Humane Association and the Child Welfare League of America identified 15 states engaged in differential response implementation and another nine implementing other child protective services innovations that resemble differential response (Merkel-Holguin, Kaplan, & Kwak, 2006). California is a relative newcomer to implementing the differential response model¹. The California Child Welfare Redesign, a 3-year planning effort by a wide range of stakeholders, recommended inclusion of differential response in child welfare practice (Child Welfare Services Stakeholders Group, 2003).

¹ California's definition of differential response varies from the national definition. In California, families whose reports are screened out are served in Path 1, whereas nationally, the differential response approach refers to screened in and accepted low- and moderate-level reports that receive an assessment response. No maltreatment determination (substantiation) is made in California's Path I or nationally in the assessment pathway. California does not have a central registry for perpetrators of child maltreatment, but for those states that do, parents served in the assessment pathway would not be registered.

The predominant version of differential response currently being implemented in California involves three “paths” or service responses. Path assignment is based on an assessment using an evidence-based standardized safety and risk assessment tool. The California Child Welfare Services Stakeholders group has recommended two assessment tool options to ensure fairness and equity in case decisions on a statewide level: the Comprehensive Assessment Tool Safety and Risk Assessment System, and Structured Decision Making (Child Welfare Services Stakeholders Group, 2003). Path 1, *community response*, is designed for cases that do not meet the statutory definition of child maltreatment, yet involve families who are experiencing problems which might be addressed by community-based providers. Path 2, *child welfare services and community response*, involves a partnership between the county child welfare agency and a community organization. Services are offered to families whose referral meets the legal definition of maltreatment but whose risk of future child maltreatment is low to moderate. Families must agree to participate voluntarily. *Child welfare services response*, or Path 3, is the traditional approach to cases, in which the county agency provides voluntary or court-mandated services to families at moderate to high risk of future maltreatment (Schene, Oppenheim, & Senderling, 2005).

Pre-dating the California child welfare services reform movement, Alameda County has, since 2002, provided a two-track differential response approach. Track 1, known as the Another Road to Safety (ARS) program, serves cases screened out of the public child welfare system and diverted for community services, while Track 2 serves cases which indicate the need for court-mandated services. ARS offers voluntary services to those families who are screened out of traditional investigation; have a child aged 0-5 or a pregnant mother in the home; and reside in designated neighborhoods where a high proportion of child

maltreatment referrals originate. The program was expanded in 2005 to a third neighborhood and serves families with children aged 0-18. ARS clients receive intensive home visiting, with a host of concrete services, support, and referrals to other formal service providers.

The ARS program is funded and managed through a cooperative agreement between the Alameda County Social Services Agency and Alameda County First 5 (described in more detail later). The ARS program is currently in a period of transition, and these functions are being transferred exclusively to Social Services, with First 5 remaining involved in training and data management. Three community-based organizations operate the program in South Hayward, East Oakland, and West Oakland.

When a family is referred for services to one of the agencies, a paraprofessional home visitor is assigned to the case. The home visitor maintains a caseload of 7-13 families and sees each family for a minimum of 1 hour a week. The community-based organization staff maintains records of client contacts, assessments, and progress toward goals. After the home visitor conducts child development, mental health, and substance abuse screens, he or she and the family jointly outline goals and steps to achieve them in a “family care plan.” Guided by the family care plan, the home visitor has the responsibility of connecting the family to resources in the community (such as child care or employment assistance), checking in with clients and ensuring follow-up on referrals, and forming a therapeutic relationship with the parents which helps provide emotional support and parenting skills education. Each family receives services for up to 9 months, with 3 month extensions granted on a case-by-case basis.

Literature Review

Evaluations of differential response have been conducted in Minnesota (Loman & Siegel, 2004b), Missouri (Loman & Siegel, 2004a), North Carolina

(Center for Child and Family Policy, 2004), Virginia (Virginia Department of Social Services, 2004), and Washington (English, Wingard, Marshall, Orme, & Orme, 2000). All of these evaluations observed the outcomes of a group of clients over time, and several supplemented this methodology with surveys and interviews to assess the qualitative experiences of workers, supervisors, community members, and families. With the exception of Virginia, each of these states developed comparison groups, either through matching a pilot and business-as-usual county or community (Missouri, North Carolina, Washington), or through random assignment of low- to moderate-risk families whose reports are screened in, meeting the statutory threshold of abuse and neglect, to receive a differential response or traditional response (Minnesota).

Each of the studies considered outcomes for children and families. Several states also included qualitative studies which assessed organizational, behavioral, and attitudinal change in the child welfare agency; community reactions; and family responses to differential response. A cost analysis was also conducted in Minnesota (Loman & Siegel, 2004b). The main outcome measures assessed by these studies were improvement in perceived child safety (based on observations by workers, community stakeholders, and families), reductions in child abuse and neglect report recurrence, reductions in rates of investigation, and reductions in out-of-home placements. With reference to the comparison group, families receiving differential response were statistically less likely to be re-referred in Minnesota (Loman & Siegel, 2004b) and Missouri (Loman & Siegel, 2004a), while no difference was observed in North Carolina (Center for Child and Family Policy, 2004) and Washington (English, et al., 2000). Findings for placement in out-of-home care were more mixed, with families who received differential response less likely to have

their children removed in Minnesota (Loman & Siegel, 2004b), more likely in Missouri (Loman & Siegel, 2004a), and neither more nor less likely in Washington (English, et al., 2000) (this outcome was not measured in North Carolina). Researchers in two studies highlighted possible limitations of differential response. In Missouri, families with chronic child abuse and neglect appeared unaffected by either differential response or traditional services and, according to researchers, may have needed sustained intervention beyond the capacity of the child welfare system (Loman & Siegel, 2004a). Researchers in Washington observed that the risk level and severity of some of the cases referred to differential response was inordinately high, and cautioned that voluntary community services are not designed to address severe problems (English, et al., 2000).

Qualitative studies conducted in Minnesota, North Carolina, and Virginia found largely positive perceptions of differential response. Agency staff were surveyed or interviewed in each state, families were interviewed in Minnesota and North Carolina, and community partners were surveyed in Virginia. In all three states, a majority of workers and administrators reported that the differential response system was better than traditional child welfare services, though differential response was frequently reported to increase workload and costs (Virginia) or present other initial challenges to staff (North Carolina). Minnesota also reported initial cost increases, but found that differential response was more cost-effective and resulted in a cost savings in the long-term. Families reported high levels of satisfaction with how they were treated and the services they received from differential response workers (Minnesota and Virginia). Responses from community providers in Virginia were mainly positive but sometimes mixed.

There is a gap in information about the neighborhood context of differential response.

Mixed results from these studies of differential response programs make it difficult to summarize results across jurisdictions. This may be because the term “differential response” encompasses a range of intervention models. Case management may be provided to low-risk families through public child welfare agencies (Florida, Missouri, North Carolina, Virginia) or community-based agencies contracted by child welfare (Michigan, South Carolina, Washington), or may be mixed in the state and may depend on the county (Louisiana, Minnesota) (Schene, 2001). One worker may stay with a case from the assessment through service delivery phases, or a case may be reassigned after assessment.

Knowledge about the ARS model can contribute to the growing literature base. ARS is a mature model with highly-trained paraprofessionals offering home-visiting services – a promising practice in the prevention of maltreatment (McCurdy, 2000). Lessons learned about the Another Road to Safety program model have important implications for policy and program development in the area of differential response for several reasons. First, ARS is the first pilot differential response program implemented in California and reflects the context of the California child welfare system, with its unique regulatory structure. ARS clients are screened with the Standardized Decision-Making Tool, a risk assessment instrument which is becoming commonly implemented across the state. Second, because ARS is conducted by a different agency in each community, it is highly tailored to each neighborhood. There is a gap in information about the neighborhood context of differential response, with most of the extant research focusing on the state or county, not neighborhood, level. Third, the model is thoughtfully designed and more service-rich than the basic casework model being used in many California counties. Further evaluation of the model is necessary to determine its efficacy and validity for replication in other sites.

Methods

Data collection to inform the development of this article took place over two time periods: the first, in 2004, to learn about the development of the public-private partnerships; and the second, in 2006, to learn about the influence of the neighborhood context on the program model. In 2004, data collection involved in-person interviews with all administrators ($n = 12$) and line staff ($n = 9$). Questions focused on revealing the processes involved in building collaboration, designing the ARS model, and implementing services. In 2006, data were collected through in-person interviews with administrators ($n = 16$) and focus groups with all direct line staff ($n = 12$). In both cases, interviews and focus group questions were guided by scripts developed in collaboration with the ARS partner agencies. Data were transcribed and entered into a computer for data management and coding. Transcripts were coded for emergent themes, using inductive and deductive processes.

Findings

Establishing Public-Private Partnerships

A number of factors converged at the state and county levels in the creation of the Another Road to Safety program. In 1998, indication of increased concern for the welfare of children came from the state government in the form of augmented investment in child welfare services and from the voters of California in the passage of Proposition 10. The California state legislature granted additional state funding to child welfare services in response to a policy paper issued by the County Welfare Directors Association (Bermack, 1998). This policy paper described the need for increased financial support in order to provide workload relief for child protective services departments struggling with new state mandates and increasingly complex cases. California voters were similarly moved to devote more resources to children through the passage of Proposition 10. This initiative created a new funding stream through tobacco taxation and

dedicated the revenue to enhancing services for children under 5 and their families. Each county established a First 5 commission and received a funding allotment based on its birth rate.

Concern for children was mirrored on the local level by the residents of Alameda County, who demanded that the county board of supervisors make improvements in child welfare services.

Issues raised by residents included poor communication between those involved in child welfare; lack of prevention and early-intervention services; and poor quality of services provided to minority children and families. The board responded by inviting the Child Welfare League of America (CWLA) to evaluate the child protective services system and to make recommendations for its improvement.

As with many child welfare agencies across the nation, CWLA staff found that the prevention and early intervention end of the continuum of services in Alameda County was lacking. Consequently, many children did not receive services that would prevent future harm and subsequent contact with the child protective services system. A study of child maltreatment reporting in Alameda County indicated that a high percentage of calls (60%) were screened out at the hotline and never resulted in services. Research in that same county suggested approximately 62% of families screened out at the hotline had prior reports, and many had multiple prior reports. Of cases closed after an investigation without services, 71% had prior or subsequent reports of abuse or neglect (Karski, Gilbert, & Frame, 1997). To ensure better outcomes for families and children, CWLA recommended the development of a “first responder” community-based system of child maltreatment prevention and early intervention

that would address problems in families when first identified.

With support from CWLA, the Alameda County Social Services Agency launched an agency-wide effort to improve practice. Differential response was identified as a strategy with the potential to help at-risk families before they reached a crisis point. By engaging community providers,

the services were also likely to be perceived as less stigmatizing and more culturally sensitive than traditional child welfare services. Having found a promising model, the agency now looked for resources and partners to bring their vision to reality.

Elsewhere in the county, the Alameda County First 5 Commission became the first in the state to approve

its strategic plan, thus launching the work of Every Child Counts. Every Child Counts provides direct services and grants to improve the health, development, and well-being of children aged 0-5 in their home environment, in child care, and in the community. To help effect systems change, Every Child Counts formed partnerships with each of the major public agencies in the county as well as community-based organizations that serve children and families.

Alameda County Social Services and Every Child Counts had complementary goals and strategies that lent themselves to partnership. At the same time, both organizations also had to make certain compromises in order to jointly create a program that fit within their organizational structures and cultures. Management of both organizations agreed on the basic structure of the model, but needed to work out the crucial details. The first hurdle was how to handle the population served. Every

By engaging community providers, the services were also likely to be perceived as less stigmatizing and more culturally sensitive than traditional child welfare services.



Child Counts could only spend its funds on children under 5 and pregnant mothers. It was agreed that the ARS program would be primarily funded by Every Child Counts and would serve their target population, until flexible funding could be secured to expand services to children up to age 18. Length of services was a point of contention for the two agencies. Most Every Child Counts programs were of an extended duration, up to 5 years in some cases. Social Services, on the other hand, provided services generally of shorter duration but with great intensity. As a compromise, the two agencies chose 9 months for the length of service, with case-by-case extensions of 3 months when more time is needed to work with families toward meeting their goals. It was determined that the content of services would be tailored to the needs of each family, rather than a one-size-fits-all approach typical to court-mandated child welfare services. Families would jointly develop their “family care plans” with their worker, drawing primarily on formal support from community service providers to meet family needs, such as those for employment, adequate food, and child care, among others. Less emphasis is placed on informal sources of support, with the assumption that families will use these resources if they are available to them.

The choice of whether to staff the program with professionals or paraprofessionals was a decision with a range of implications including quality of service delivery and cultural competence. The ARS planning team chose a model with paraprofessionals because having a background match between the helper and the client was seen as crucial for achieving acceptance by families. The paraprofessional model made proper clinical supervision, employee selection, and training especially crucial to the program’s success.

Planning to Work in Neighborhoods

The implementation plan for ARS began with a two-site pilot phase, and is now in a phase of gradual countywide expansion. In 1999, when planning for ARS began, the Eastmont

neighborhood of Oakland and the Harder-Tennyson neighborhood of Hayward had some of the highest rates of child maltreatment referrals. The ARS planning team invested time in studying these communities to form an understanding of their strengths and problems. One source of information was “no investigation needed, close file” data drawn from the California child welfare database. This data offered zip-code-specific demographic information on families referred for child welfare services. To assess client interest in voluntary ARS services, the Social Services Agency and Every Child Counts staff conducted in-home surveys with clients who met eligibility criteria. Despite the staff showing up at homes without prior announcement and identifying families’ prior CPS reports as criteria for the study, the refusal rate was remarkably low. Families surveyed expressed a strong interest in voluntary, in-home services. Parents who attended community forums held in each neighborhood showed similar interest in ARS program services. In addition to piloting the work with eligible families, staff planned to launch the model with an understanding of the neighborhoods in which the model would be delivered. High school students were hired to walk the streets of the communities and develop asset maps. This effort produced geo-coded maps of community resources in each of the three neighborhoods.

Tailoring Services to Diverse Neighborhoods

Although the general program approach is the same in each of the three communities, service providers indicate that they have customized the ARS model to meet the unique needs of their communities. Both the demographic characteristics of community members and the range of services available to families are distinctive by community. For example, the South Hayward community is heavily populated by Latino immigrant families (Barnett, 2002). The majority of families in West Oakland, however, are African-American (Harvey, et al., 1999), and East

Oakland, a community historically dominated by African-American families, has recently grown more diverse with Latino and Asian immigrant families moving into the neighborhood (Younis, 1998).

The resource context. South Hayward has sustained a long-standing community collaborative composed of service providers that represent a wide spectrum of agencies and supports. Faith-based organizations and mental health, medical health, food, cash assistance, employment, and parental support services are all available to some degree in this community. The executive director of the ARS program has long been viewed as a strong community leader, and has developed a close working relationship with the majority of the service providers in the surrounding area. A neighborhood family resource center serves as the hub for these services, providing a kind of community living room for neighborhood residents, and a haven from daily hassles and stress. In this community context, ARS workers feel confident that they can refer families directly to needed services, and that families can access those services quickly and easily. ARS staff also sees this program as a neighborhood-based intervention with the potential to serve as one component of a larger effort to strengthen the community as a whole. By connecting ARS family members to neighborhood resources, families become more embedded in the community, and parents will know how to secure assistance from within the community, should future needs arise.

In West Oakland, efforts to develop a collaborative of service providers have proceeded unevenly. Waves of philanthropic and public initiatives have been attempted in an effort to re-vitalize this community, but many of these efforts have floundered. In recent months, however, efforts to draw community agencies together in order to coordinate services seem to have born more fruit; ARS staff is optimistic about several new opportunities to refer families to neighborhood-based services.

In the third ARS neighborhood, East Oakland, the resource context differs markedly. At the center of this community stands an old shopping mall, once the home of large department stores and specialty shops. The mall closed some years ago when it was no longer economically viable in the neighborhood, and the public social service agency has since converted several of the large stores into offices. An array of public benefits is now available to community residents at this location, including Temporary Assistance for Needy Families, Medicaid, food stamps, and adult services. This “service mall” offers a centrally-located resource for neighborhood residents in need; however, the sheer size of the building and its institutional image convey a different message from the community living room suggested by a neighborhood-based family resource center such as that in South Hayward. In addition to the mall there are a large number of smaller nonprofit and faith-based services and programs, but these are not coordinated in any fashion and they are not necessarily widely visible to community residents. ARS staff does not have designated liaisons at the public agencies, nor do they have regular contact with the smaller service providers in the community. As a result, when ARS staff works with parents, they must determine the availability and accessibility of services, along with the eligibility requirements for parents, slowing their work considerably.

Beyond these challenges, the agency housing ARS services in East Oakland is not located in the community it serves. The extent to which the location influences service delivery is unknown, but staff clearly exhibits a developing knowledge of community resources that might be enhanced if all of their work occurred within the neighborhood. These combined factors contribute to a view held by East Oakland ARS staff that their service is largely a family-based intervention (rather than a neighborhood-based intervention) wherein individual workers connect with individual parents within the privacy of their own home to offer services, support, and referrals. The difference is subtle; all of the ARS providers

view their work as individually based, with individual families, but West Oakland and South Hayward staff also views their work as layered and having additional impact and import to the neighborhoods in which families reside.

The family context. When asked how ARS staff adapts the program to the unique needs of the neighborhood, they indicate that the demographic context is a critical factor driving their program model. In West Oakland, for example, staff recognizes the extreme poverty of the community, relative to the other two neighborhoods. In this setting, staff first assesses families' basic needs and attend to these well before attempting to alter parent-child relationships. According to one staff member in this agency:

One thing about this neighborhood, with the poverty, you respond to the community's needs and pay attention to basic needs. We're talking about basic needs, being able to get the family to that point where we have food on the table today.

Staff is mindful of the history of their community and makes special efforts to honor their commitments to families. Because previous programs have been offered, but have failed, West Oakland staff is attempting to grow its program methodically and to offer concrete services to families, so that community members can experience tangible benefits from program participation.

In East Oakland, staff is aware of the community's attitude toward child protective services and its mistrust of the system. Community suspicion is well-founded, as evidence from some research in California suggests that more than one third of all African-American children in that state will have contact with the child welfare agency through a child maltreatment referral before kindergarten. One in 10 African-American children are placed in foster care – a rate approximately double that for children of other ethnic groups (Magruder & Shaw, 2007). To alleviate some of parents' doubts

about ARS providers' intentions, ARS staff in this neighborhood attempts to gain access to families by offering concrete supports, such as gift cards to local grocery stores. Using concrete supports as their initial lever of intervention, ARS staff hopes to gain sufficient trust so it can then work on developing a relationship that will support family change. In their early interactions with parents, staff members acknowledge the challenge of parenting, and suggest that they can help improve parents' capacities to care for and provide for their children. Staff member in both East Oakland and West Oakland are direct with parents about the reason for their visit and their goals. A staff member states:

We say, "Did you know that someone called to report you?" Some say, "Yes, I know who did it." We say, "Let's try to keep them from calling again." We say, "Our goal is to keep CPS out of your house. Give us an opportunity so that someone won't call CPS again, and there's a possibility of them taking the kids away." We tell them that we are not tied to CPS. "We're here to keep you out."

Staff in South Hayward also distances itself from the public child welfare agency, but its approach to parents is subtly different. Therefore, staff focuses less on the parents as access points to the family, and instead concentrates on the young child, the child's development, and the child's need for a safe and healthy environment in which to grow. ARS staff in South Hayward acknowledges the cultural value placed on children in the Latino community, and uses this as a tool for gaining access to and trust with parents.

Conclusion

ARS is a well-designed, well-considered model grounded in research findings regarding the effects of home visitation, provision of resources tailored to families' needs, and relationship-based services (for more information, see Conley, in press). Each of the three ARS providers set about to implement its program according to

the tenets of the program's originators, with administrative and training support from Every Child Counts and the Social Services Agency of Alameda County. Their experience along the way has shown that adaptation is essential in order to work within the context of existing resources and the cultural, geographic, and economic milieu of families. Efforts to better understand which agency approach may be more effective in assisting families and ensuring the safety of children are the next important steps to take in determining the promise of this model on a larger scale.

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Implementation of California's Differential Response Model in Small Counties

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The purpose of this article is to describe the implementation of differential response¹ programs in 11 small, mostly rural, counties in Northern California, where small is defined as having a population of less than 70,000. Differential response in California is designed to provide multiple response options in reports of maltreatment so that families with problems that do not rise to the level of statutory definitions of child abuse or neglect can receive services to prevent maltreatment. The “Small-County Initiative” was sponsored by the Office of Child Abuse Prevention of the California Department of Social Services and designed to strengthen child abuse prevention systems in these counties.

As part of a larger evaluation of the initiative, the current study used rich qualitative data gathered from site visit interviews with county administrators, program managers, direct service providers, and community partners. In addition, the study analyzed quantitative data from annual prevention system inventories completed by teams of county workers and community representatives, and incorporated information from quarterly reports submitted by Small-County Initiative program directors.

This article examines three specific elements within the differential response model as it is being formulated or implemented in the 11 counties: (1) case identification and risk assessment, (2) components of differential response systems and referral methods, and (3) system response and service delivery². Methods of case identification and risk assessment are reviewed in the context of volume and case visibility across county departments. The discussion regarding differential response systems and case referral methods focuses on methods used by small counties to refer clients to other agencies and partners and the adequacy, accessibility, flexibility, and information-sharing parameters of partnerships and community networks. The system response and service delivery discussion reviews the models of therapeutic and community-based interventions used by the small counties when families are

¹ California's definition of differential response varies from the national definition. In California, families whose reports are screened out are served under Path 1, whereas nationally, the differential response approach refers to screened in and accepted low- and moderate-level reports that receive an assessment response. Nationally and in California, for cases served through an assessment pathway, there is no maltreatment determination (substantiation) or use of the central registry.

² All data and descriptions in this paper are true as of the period of data collection in 2004-2005.

referred out under differential response programs to other agencies or community services, such as family resource centers, in-home visiting, peer support, and mentoring. This article highlights the challenges of implementing California's differential response model within small counties, as well as strategies used and resources available in these settings to achieve program success. The lessons learned from this evaluation are discussed within the context of policy implementation and system change.

Background

California's state-supervised, county-administered child welfare services³ system is undergoing several reforms, known collectively as the Child Welfare Services Outcome Improvement Project⁴, to improve both the experiences of children and families while in contact with the system and their subsequent outcomes. In 2000, the Child Welfare Services Stakeholders Group was formed to study California's child welfare system. The Stakeholders Group reported that every year, about 650,000 cases of suspected child maltreatment were reported to child welfare agencies in the state, and that of these, the vast majority (about 92%) were closed after initial contact, without receiving services (Child Welfare Services Redesign, 2004). In addition, about one-third of telephone hotline referrals involved the same families referred in the previous year. These patterns were comparable to those at the national level, where less than 30% of reports were substantiated, with even fewer being opened for ongoing services. These facts, combined with frequent, multiple re-referrals of families, led to a "growing level of dissatisfaction with traditional CPS [child protective services] practice," with reverberations across the states (Schene, 2005,

p. 4). The concern was that there were families not receiving needed services because screening or investigation indicated a low risk for child abuse or neglect, and the problems which led to the initial referral could worsen, leading to maltreatment and future referrals (Waldfoegel, 1998).

To address concerns in California regarding recidivism and prevention of maltreatment, statewide efforts over the past several years to reform the child welfare system have focused on development, improvement, and expansion in three areas: (1) standardized assessment of child safety when a report of maltreatment is filed, (2) ensuring that children referred to child welfare services have permanent homes, and (3) collaboration between county departments and the communities they serve in providing alternative options for response and service delivery in cases of reported maltreatment (Schene & Oppenheim, 2005). The latter strategy, known formally as differential response in California, represents a nascent shift in the child welfare system. Families are no longer categorized as perpetrators or non-perpetrators of maltreatment; instead, finer distinctions are drawn. In this changing practice model, the potential role of the immediate and extended family is becoming more important in solving the family's problems. An enhanced role for community partners, either local contracted service providers or informal community supports, is also an element of the differential response service model.

Differential response is designed to provide multiple response options to reports of maltreatment. In California, the differential response model offers three pathways (Child

³ Although we refer to child welfare departments as "child welfare services," informants from the study and sources cited often used "child protective services." The terms are considered interchangeable here.

⁴ The reforms were formerly known as Child Welfare Services Redesign and were mandated by the Child Welfare System Improvement and Accountability Act of 2001 (Assembly Bill 636).

Welfare Services Stakeholders Group, 2003; Schene & Oppenheim, 2005):

- Path 1 involves a community response. When the county child welfare agency receives a report of suspected maltreatment and determines that the allegations do not meet statutory definitions of abuse or neglect, that the child is at relatively low risk of harm, and that the family needs support, then that family is formally referred to agencies in the community. Under the traditional system, families such as these would not receive services and may or may not be referred to community agencies. Under differential response, however, if a worker feels a family could use support, the family can voluntarily accept services from community partners.
- Path 2 involves a team approach with response from both child welfare services and community agencies. When the county child welfare agency receives a report of suspected maltreatment that meets statutory definitions of abuse or neglect, but the child is at low to moderate risk of harm and the family is willing to work on the problems leading to risk for the child, then the family is approached by a child welfare worker, in partnership with (and sometimes accompanied by) a community agency worker such as a public health nurse or home visiting program staff. The requirement for this path is the family's willingness to work with child welfare services and community partners to address identified problems. Although families such as these may or may not have received services under the traditional system, often, court involvement would be necessary in order to engage the families. With differential response, however, families voluntarily⁵ work

with staff from community agencies and child welfare services to address the problems that led to the report of maltreatment.

- Path 3 involves a traditional child welfare services response. These are cases in which the child welfare agency determines that the children are unsafe, the risk of continued maltreatment is moderate to high, and action is necessary to protect the child, with or without the involvement of the parents. But, to avoid the adversarial approach of automatic court involvement, stringent time frames, and county mandates, the county agency makes an effort to engage the family and others in the child's life in order to preserve the relationships between the child, the family, and the community and to provide needed services to address identified problems.

California's three-path model is most comparable to Oklahoma's alternative response system, which has three priority levels, and Iowa's child abuse assessment model with four response tracks (Merkel-Holguin, Kaplan, & Kwak, 2006). Elements of California's model are also similar to Hawaii's differential response system, which assigns cases with "low risk of harm" to Family Strengthening Services and cases of "moderate risk of harm" to Voluntary Case Management Services. The three-path model is different, however, in that child welfare workers and community partners work together in Path 2 cases while community partners are solely responsible for Path 1 cases. This Path 1 and Path 2 differentiation appears to be unique to California, although it should be noted that other states also use private agencies and community providers for low-risk cases referred or screened out under various alternative response tracks, such as in West Virginia (Merkel-Holguin, et al.).

⁵ It could be argued that some families referred under Path 2, while considered voluntary in the model, can sometimes be "involuntary clients cooperating under threat of court involvement," an issue raised by Drake and Jonson-Reid (2000) in discussing the substantiation process in child welfare (p. 231).

Working with communities broadens resources to support families before problems worsen. For example, of the more than 650,000 annual reports of suspected maltreatment received in the state, 25% are screened out over the telephone with no in-person contact, 46% are screened out after one in-person visit with a social worker, and 21% receive up to 30 days of services. However, under differential response, there is the potential to serve and support many of the families in these cases (Schene & Oppenheim, 2005).

Currently, 11 pilot counties are receiving funds to test the implementation of various practice changes such as differential response. The Small-County Initiative was developed because smaller⁶ counties in the state face unique challenges in their efforts to secure funding and provide services to families in need of support. For example, these counties may have limited administrative infrastructure, limited budgets, lack of community agencies and service providers, and geographic isolation of families. The Small-County Initiative provides financial and technical assistance for strengthening child abuse prevention systems (Child Abuse Training and Technical Assistance Center, 2006). There are 11 counties participating in the Small-County Initiative program: Alpine, Amador, Calaveras, Del Norte, Glenn, Plumas, Siskiyou, Tehema, Trinity, Tuolumne, and Yuba. Of these, only Glenn, Tehema, and Trinity are part of the 11 original differential response pilot counties. In 2003, the Small-County Initiative program was extended as “Small-County Initiative-II” to provide additional funding for capacity building and integration of

prevention systems, including the development of differential response programs as envisioned by the Stakeholders Group.

With the exception of an evaluation of Missouri’s family assessment and response system that included small, rural counties in the study (Siegel & Loman, 2000), the authors know of no other studies that focused on differential response implementation in small, rural counties. Using both quantitative and qualitative data, this article provides information regarding differential response programs in such environments.

Method

The Small-County Initiative-II evaluation used a prevention system assessment tool designed to collect data annually about important aspects of prevention systems and services in each of the 11 small counties. The instrument has three major sections, each with subsections and sets

of items to assess system elements. The first major section assesses “community capacity development,” such as neighborhood partnerships and public education about abuse and prevention. The second section pertains to “differential response and service availability to vulnerable families,”

including in-home services, parent education, health and mental health services, and the availability of services to at-risk families. The final section covers “organizational culture change,” or the structure and functioning of the governing collaborative and system coordination. Although the assessment tool contains 86 different elements, only relevant data on differential response elements were analyzed in this study.

Working with communities broadens resources to support families before problems worsen.

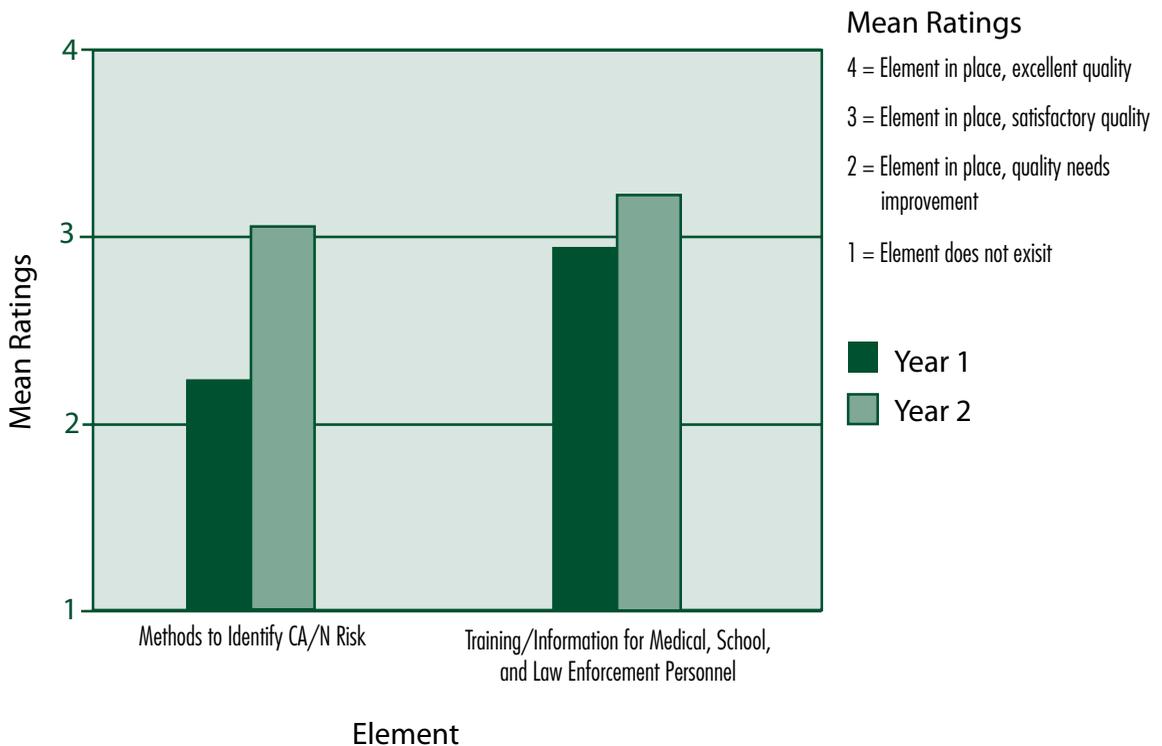
⁶ While the participating counties in the Small-County Initiative program had populations of less than 70,000, many of them are fairly large in land size. The 11 range in size from 593 to 6,287 square miles, totaling approximately 22,500 square miles all together. The number of people per square mile ranges from 1.6 to 95.5, with an average of 27.8. In addition, the counties are mostly rural with mountainous regions that cover large areas.

Counties self-reported their assessment tool measurements, making the assessment a subjective measurement of the state of their prevention systems. In assessing the status of the elements, counties rated each item on a scale of 1 to 4. The ratings were: 1 = element does not exist; 2 = element in place, quality needs improvement; 3 = element in place, satisfactory quality; and 4 = element in place, excellent quality. Using this data, averages were calculated for each element. The ratings were assigned by substantial teams in each participating county – usually four or five people, including both child welfare and program staff. This process should lead to a consensus view of strengths and weaknesses rather than representing an individual’s perception. In addition, the probability of skewed results that are socially desirable should be lessened, but not perhaps eliminated.

Counties completed the year 1 assessment tool in fall 2004 and the year 2 assessment tool in fall 2005. Year 1 is considered the initial start-up period, or baseline, before the programs and services of Small-County Initiative-II were in effect, while year 2 data represent the first full year most programs were operational. Comparing ratings from the year 2 assessment tool to the baseline allows for examination of early changes.

In addition to this information, qualitative data are available from site visits conducted in nine of the 11 counties in fall 2005. Site visits were not conducted in two counties because they had only just begun program activities related to Small-County Initiative-II at the time. The visits to counties involved in-depth interviews with administrators from county social services departments, child welfare agencies, and community partner organizations. A total of

Figure 1. Status of Case Identification Methods and Training of Professionals



71 people were interviewed, including program managers and line staff at the community agencies. An interview protocol was developed to guide the interviews and the following topics were analyzed for this article: (a) overview of differential response and other system changes, (b) description of client direct service programs and related issues such as capacity, (c) inter-organizational issues such as collaboration, and (d) integration of differential response and prevention services with child welfare services. Finally, this article uses information from quarterly reports submitted by the Small-County Initiative-II program directors, which provided updates regarding progress toward meeting the goals of the Small-County Initiative-II program.

Findings

The counties participating in the Small-County Initiative-II program are all in various stages of planning and executing their respective differential response systems. It should be noted that the findings from this study are reflective of early implementation efforts. At the time of data collection, three counties were in the formulation phase; two had been piloting differential response for 1 to 3 years, although the formal system had not been fully implemented; three had protocols in place and were in the early stages of implementation; and three had implemented differential response within the 2 years prior to the site visits.

Case Identification and Risk and Safety Assessment

Identification of families at risk for child maltreatment requires that: (a) a system be in place to help child welfare workers and other community professionals become aware of such cases, (b) training be provided to such workers in how to identify at-risk families, (c) agencies and community programs have sufficient capacity to meet the demands of the additional volume of risk assessments that result from increased awareness, and (d) procedures are used to effectively assess

risk. In addition, risk assessment throughout the life of a case, whether formally with tools or informally, is a consideration that requires appropriate training of both child welfare and community program staff to achieve continuing child safety.

Case identification methods. All of the counties now have methods available to identify children at risk of maltreatment (see Figure 1). Assessment tool data reveal that in year 1, only two counties did not have such methods in place and the average scale rating across counties was 2.27 (standard deviation = 0.91). By year 2, the average scale rating was 3.09 (SD = 0.70). In fact, only two counties cited the need for improvement, six assigned ratings of satisfactory, and three assigned ratings of excellent. This represents a large improvement across counties.

Informants in several of the counties said that geographic isolation of families and communities in rural parts of the counties makes it difficult to identify issues that may lead to child maltreatment. Although many informants noted that isolation is sought by a portion of residents, a few also noted that weather can isolate entire communities during winter months. Program managers and direct staff in several counties stated that for these reasons, it is important to have community agency workers who live in the communities be the ones to provide outreach to families, as they have more immediate and consistent access to families.

A second theme that emerged from the interviews involved developing strong public-private partnerships that can facilitate identification of cases, given that the small nature of the counties often translates into high visibility of cases across agencies and departments. For example, one social worker at a child welfare agency remarked on the high visibility caused by having just one community-based organization in the county: “our families are not just known to [child protective services]. I know in some of

the bigger areas, the CBOs [community-based organizations] wouldn't even know them, the families. But we have [only] one CBO." In three counties, child welfare services places staff at community-based organizations such as family resource centers to serve as a bridge or liaison between the community agency and the county, facilitate communication, and strengthen partnership. Also, some informants noted that stationing county child welfare workers at community agencies allows those agencies to draw upon the workers as resources in assessing safety and risk in an ongoing manner.

The family resource centers in three counties are located on school grounds, providing further opportunity for close collaboration and case identification. This type of collaboration in co-locating staff was also observed by other studies (Siegel & Loman, 2000; see also Walter R. McDonald & Associates, 2001). Of particular relevance for the current study, Siegel and Loman conducted an evaluation of Missouri's family assessment and response system, which included some small and rural counties. The researchers reported that in "six predominantly rural counties, some child welfare workers were assigned to specific school districts" and that "[some] schools let workers use office space in school buildings, on a daily to weekly basis" (p. 23). Co-locating staff specifically at schools has implications for case identification. A study of local child welfare practices across the country found that schools are a frequent referral source to child welfare services; 28% of child welfare agencies cited schools as the most common referral source and 33% cited them as the second most common (U.S. Department of Health and Human Services [USDHHS], 2003).

Public-private partnerships in the Small-County Initiative counties were also reported to be part of broader networks that involve multiple agencies and public systems coming together to identify families at risk for maltreatment. Many

counties mentioned three particular systems as being part of their networks: behavioral health, education, and law enforcement. One informant's comments were typical of those from other counties regarding the usefulness of partnerships with law enforcement agencies:

[If] the police went out on a call to a family, and they saw that there were situations there that weren't quite something they should report to CPS, but if they had an organization that was available, they could call and have volunteers that could go to the family and say, "Hey, it was noted that these situations are here and these are the things that are available in the community that we can work with to help you or whatever." It's an up-front program. So we have early intervention and prevention.

Networks of agencies and programs are currently used to identify cases even in counties where differential response is not fully implemented, which is likely due to collaborations that existed prior to Small-County Initiative-II and the current reform efforts under the Child Welfare Services Outcome Improvement Project. For example, an informant in one county remarked:

At this time, the Path 1 pilot program is in a planning phase. Nevertheless, the family resource centers are already informally, through outreach efforts, identifying at-risk families. In addition, the family resource centers are collaborating with different agencies – primarily the schools and law enforcement – to identify at-risk families.

Administrators and program managers in a majority of the counties also spoke of regular meetings among child welfare services staff and representatives from other organizations such as schools, mental health agencies, family resource centers, and the public health department.

In one county, for example, the community agency meets with child welfare and other programs once a month to discuss current cases and staff newly identified cases.

The presence of child welfare services in community meetings can be important in facilitating communication with community partners and other county departments regarding case identification. Although this collaboration is quite different from larger counties where child welfare services has historically remained separate, there have been some problems that parallel those found in larger counties. For example, conflict can arise as a result of the different mandates under which different agencies are governed, such as the child protection mandate of child welfare services versus the family-centered focus of family resource centers or the focus on women of some domestic violence services. In such cases, however, informants indicated that situations are eventually resolved through dialogue at meetings or in trainings where roles and responsibilities of each department are delineated and there is rationale provided for decisions made on both sides. Sawyer and Lohrbach (2005) found that this type of dialogue was also helpful in reducing “tensions” in Olmsted County, Minnesota; the inclusion of workers and supervisors from other agencies in the formal group assessment process that facilitates differential response pathway selection provided those workers a “view of how decisions are reached” (p. 48)⁷.

Informants in several counties in the current study remarked on the numerous trainings provided within their agencies and programs, to

other professionals and paraprofessionals, and to the broader community. Counties are using training to increase knowledge of risk assessment methods adopted for differential response. In addition to continuing to provide mandated reporting training, counties are also raising public awareness through a variety of public education campaigns. Many informants considered training and education for the community as being an integral component of their case identification and risk assessment process. This opinion is evidenced in the assessment tool ratings of the element “training and information about abuse, neglect, and preventive services is readily available to medical practitioners, teachers, and law enforcement personnel” (see Figure 1). The average rating on this element in year 1 was high at 2.91 (SD = 0.54) and improved by year 2 to 3.27 (SD = 0.79).

Risk assessment. Informants in all counties noted the importance of accurate risk assessment both initially and ongoing. Out of the nine counties visited, four reported using structured decision making as an assessment tool when reports of suspected maltreatment are received and one had chosen the comprehensive assessment tool⁸. Both structured decision making and the comprehensive assessment tool are standardized risk and safety assessment tools that can be used at intake. Since the site visit, all counties have decided on one of these two tools, but only four are currently fully implementing the tools. The lag in implementation of standardized assessment is attributed by some informants to cost and administrators’ hesitancy to add one more new system on top of the changes brought by differential response.

⁷ Olmsted County is larger and more urban than the Small-County Initiative counties, with an estimated population of 135,000 in 2005, according to the U.S. Census Bureau (2007a). However, about 20% of the county is rural, according to the Office of Social and Economic Trend Analysis (2007), which makes comparison reasonable.

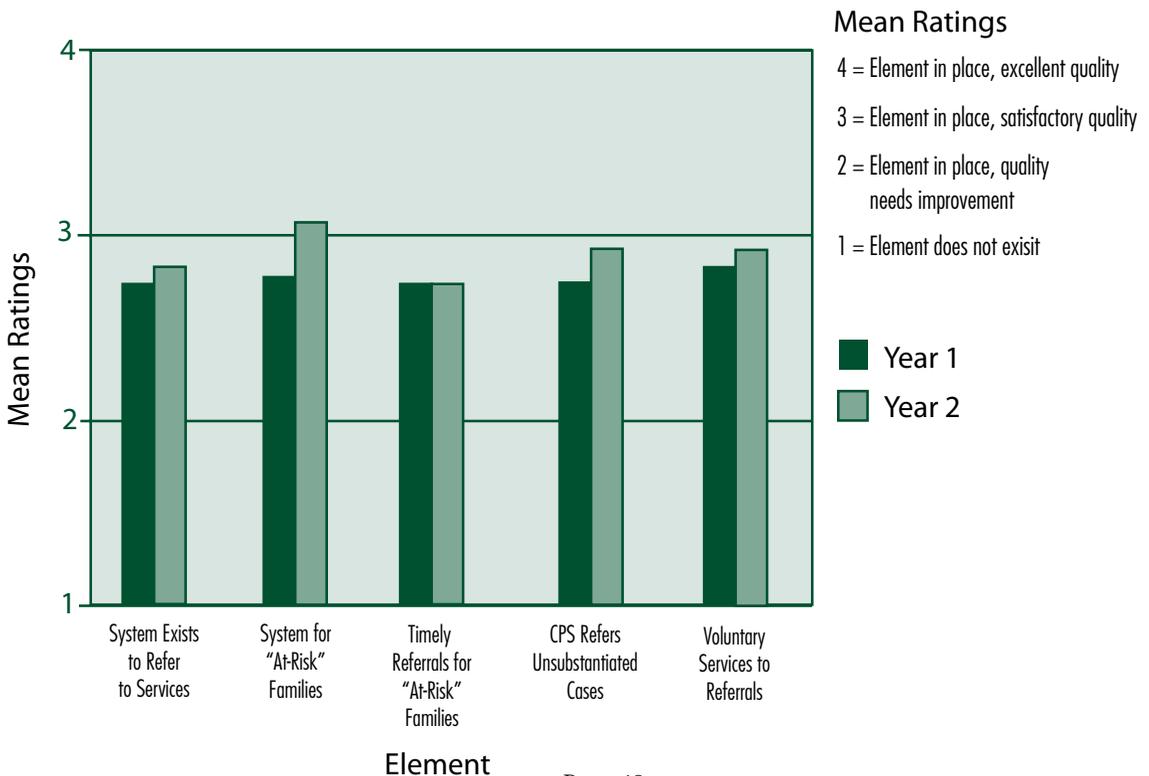
⁸ California mandated that all counties in the state choose a standardized risk and safety assessment tool. For more information on structured decision making, see http://www.childsworld.ca.gov/Structured_352.htm. For more information on the comprehensive assessment tool, see <http://www.sphereinstitute.org/cat.html>.

Some of the counties have also instituted strengths-based questioning. The value of asking such questions is reflected in the following representative quote from an informant:

[Child welfare services] started asking the reporting party about what strengths they saw in that family, trying to get what good things are coming out of that . . . Sometimes people will say “oh I can’t think of anything good,” but the workers are being trained . . . to ask other questions to hopefully come up with some strengths so that when [the home visitors] go out on their case, instead of saying “Oh we’ve gotten this report and you’re this bad parent,” . . . they can say, “Well I understand that your kids are going to school, that’s a real positive, you’re doing these things really good but we have some concerns in this area.” So it gives them a nicer way of approaching parents.

In three out of the 11 counties, one to two specific screeners conduct assessments of all referrals and assign families to one of the three differential response paths after conferring with a supervisor. Most of the remaining counties rotate child welfare case workers who also serve families to screen referrals. In one county, two screeners are assigned to handle all referrals but they also carry cases. These different staff utilization systems have arisen in response to both the counties’ limited availability of staff and their existing referral systems. This type of variability reflects the national picture. For example, a study of local child welfare practices across the country found that 33% of all agencies had different workers for screening and intake than for investigation (USDHH, 2003). Yuan (2005) notes that “smaller agencies, that rotate the screening function among their social workers may have staff members who have experience with both [alternative response] and investigations and are therefore better able to make informed decisions”

Figure 2. Status of Differential Response Referral Methods



(p. 24). In the Small-County Initiative counties that use specific screeners, those workers were once case workers.

Informants in all of the counties visited expressed concern regarding the ability of child welfare and partner agencies to meet the demands of risk assessment brought by increased public education about child maltreatment and training provided to professionals in systems outside of child welfare. Despite this concern, it appears that counties have more capacity to identify cases and assess risk than to provide services at this time. The concern expressed was related mostly to future staff turnover, given past problems with turnover. Staff turnover and difficulty in recruiting qualified candidates is an issue in child welfare agencies all over the country, but it is particularly problematic for small counties that may have only a handful of workers.

Components of Differential Response Systems and Referral Methods

All of the counties in the Small-County Initiative program are committed to implementing a differential response model similar to that of California's three-path model. Assessment tool data reveal that although much progress has been made by many of the counties in a short time, there is room for improvement in some of the elements of their differential response systems. For example, counties rated the status of the element "a system exists within our county to refer vulnerable families for family support services" during years 1 and 2 (see Figure 2). All the counties had systems in place in both years and there was some improvement in quality; the average rating in year 1 was 2.73 (SD = 0.65) and the average in year 2 was 2.82 (SD = 0.75).

Counties also rated whether they had a system of referrals in place for "at-risk" families, those assessed to be at risk for maltreatment but who can be referred under differential response to

community agencies. The average rating for year 1 was 2.73 (SD = 0.65) and for year 2 was 3.09 (SD = 0.70). All counties had this element in place both years. However, ratings regarding the timeliness of such referrals suggested need for improvement; the average in both years was 2.64 (SD = 0.51 and 0.67 in years 1 and 2, respectively).

Because actually using a differential response system is different from merely having the elements of such a system in place, counties rated the status of "child welfare services refers unsubstantiated cases of abuse to appropriate agencies for follow-up." The average ratings were 2.64 (SD = 0.92) and 2.82 (SD = 0.87) for years 1 and 2, respectively, indicating that this is an area that can be improved. Counties also rated voluntary services being offered to unsubstantiated referrals, to make sure that the elements on the assessment tool regarding differential response were capturing service referrals considered as voluntary to families. Average ratings were near "satisfactory" at 2.82 (SD = 1.17) in year 1 and 2.91 (SD = 0.83) in year 2. In summary, it is clear that these small counties either have systems in place by year 2 to refer cases under formal differential response or at least a system to refer families to support services aimed at prevention of maltreatment. This reflects a major accomplishment on the part of small counties toward implementation of differential response, though the ratings suggest a perceived need for improved quality.

Public-private partnerships are the cornerstone of the differential response model being implemented in the small counties. As Connolly (2005) notes, "The success of the differential model relies, in part, on the creation and development of strong community support agencies that are willing and able to become partners with the state to protect the interests of children" (p.15). Interviews with county administrators and program managers indicated that public-private partnerships were in place

in all the counties prior to the initiation of differential response, but these collaborations have strengthened and grown as county child welfare agencies work with private community-based organizations in setting up differential response referral systems. Informants from several counties remarked that because of the small size of their counties, “everyone knows everyone,” and this helps not only in day-to-day communications but also in working on relationships over time because everyone from administrators to line staff see each other at various meetings or committees. For example, a program administrator in one county mentioned how child welfare services has a “high profile” at their family resource center meeting; a child welfare services manager is a vocal leader at the meeting, and two social workers also participate in the meeting.

In general, these types of collaborations are difficult to establish and maintain (Connolly, 2005) and one of the challenges mentioned by informants in some of the Small-County Initiative counties involved the negative image that child welfare services sometimes has in the community. For example, one child welfare services administrator noted that community agencies may hesitate to partner with them because:

“If you’re knockin’ on the door with us are we going to look like the bad guys too?” You know, “Are we going to be associated with them?”. . . . I think we have pretty good relationships with the agencies we work with, but I know that it’s hard to overcome that community stereotype.

In an effort to address such concerns, many of the counties reported using public education campaigns (e.g., county fairs and school

functions, sending flyers home with children, advertising in local media) aimed at altering the image of child welfare services and informing the community about differential response and reform efforts underway. Child welfare agencies have also tried to build

bridges with community partners by engaging in joint training and dialogue regarding their new role in the community. This type of collaboration has been cited as being the key to the success of differential response systems in other states as well (e.g., Hawaii as reported in Merkel-Holguin, et al., 2006).

The trainings mentioned by some informants also help define the respective roles of child welfare services and community partners as they work together under differential response, particularly with Path 2 cases. In fact, one informant remarked that having family resource center staff attend training regarding structured decision making along with child welfare services staff allowed workers to discuss the different roles staff play under differential response. As mentioned earlier, an informant in another county noted that at times, the various mandates under which different agencies operate can create tension when agencies work together on Path 2 cases. The informant stated that in such instances, bringing agencies together to discuss issues and define roles has helped ease conflicts over time. All of these efforts are in recognition of the need for community partners as collaborators in preventing maltreatment and supporting families.

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Barriers to implementation of referral system.

The biggest barrier cited by most of the counties regarding implementation of differential response systems involved confidentiality. Although the counties are at various stages of resolving this issue by using universal release forms or including community partners under California's Welfare and Institutions Code definition of multi-disciplinary team members (WIC Section 18951), it took over a year for county counsels to draft memorandums of understanding between counties and their community partners. Even in cases where the multi-disciplinary team definition is used, there is the question of whether paraprofessionals can be categorized under that definition. This becomes especially relevant when considering that the core of differential response involves child welfare staff working hand-in-hand with community agencies, many of whom employ paraprofessionals as home visitors.

Another barrier cited by informants in many of the counties was changing the agencies' culture and staff's attitudes toward "a new way of doing business." County child welfare staff were not the only workers mentioned who needed to change their attitudes and accept differential response. A child welfare services administrator in one county, for example, noted that it would take time to get community agency staff "used to 'This is the way we're going to be doing it now.'" The difficulty of shifting agency cultures and the time required to do so has also been cited by other states (Kentucky, Michigan, Minnesota, Oklahoma, and North Dakota) in their differential response implementation efforts (Merkel-Holguin, et al., 2006). For example, Merkel-Holguin and colleagues noted that for Kentucky, "large organizational change is not always readily accepted and it is a slow process" (p. 34). In Minnesota, researchers noted that as workers grew more experienced with using alternative response, their feelings about the system grew more positive (Loman & Siegel, 2004).

Most informants in the Small-County Initiative counties believed that these challenges could be overcome with time, training, and continued collaboration. In addition, the small size of the counties was considered a strength, as noted by a child welfare services program manager:

I have 12 workers here, and if you told me tomorrow that I need to do something completely different, I would walk out into the center there, and say, "hey guys, tomorrow this is what we do now." And they're all going to do it. . . . If you have 300 employees, really, how do you know which workers are buying into the process or not? Which are invested? Which care, and which don't care? I have 12 people here, and all they want to do is help families, and I know that, because I look at them and I see them every day.

System Response and Service Delivery

The initial conceptualization of differential response systems involved inclusion of a "wide range of informal and formal potential supports in service planning and delivery" (Walter R. McDonald & Associates, 2001, p. 4). Interviews and quarterly reports indicate that the small counties are in fact using a broad range of community resources, as available. Out of the 11 counties, eight use or plan to use family resource centers as the primary agencies of service provision for families referred under differential response. Most informants considered family resource centers as necessary for having an effective prevention system in place for differential response.

One of the core services that family resource centers provide is home visiting. All of the counties have home visiting programs and all but two use or plan to use these programs as part of differential response. Many of the programs follow the California Safe and Healthy Families model, which combines family support home visiting and center-based services for



at-risk families with children up to 3 years old (Legislative Analyst’s Office, 1999). A direct staff member explained the rationale for home visiting:

It gets you out to the people. We don’t want to wait for the mountain to come to us The home visitors, when they’re in the home, they can detect unhealthy conditions. . . . The more you’re out there with the people, the more you know what’s going on.

A few informants noted that it was especially important that the home visitors are members of the communities the programs serve because of trust issues. For example, one program manager stated, “When you’re an outsider coming in to provide services, some communities are more open than others. . . . It’s always been our desire to have [a home visitor] who lived in the community.”

In addition to home visiting programs, counties also have a number of other support services available to families once they are referred to community agencies. For example, parent education programs are used by a majority of the counties. These programs range from support and mentoring groups to skills-based programs. As a support services system, it is important that differential response programs offer specialized services for vulnerable populations; thus, counties offer case management for at-risk families and families with vulnerable children such as infants and children with special needs. Respite care and youth development programs are also available in some areas. Differential response programs also involve referral to other available services after community agency staff conduct assessments on health, mental health, domestic violence,

substance abuse treatment, and economic self-sufficiency.

A key component of service delivery is knowledge of available resources. Many informants noted that because of the small size of their counties and the fact that service providers often meet regularly for various committees, boards, and coalitions, workers commonly know about county resources and their availability. These findings are similar to those reported by Siegel and Loman (2000) in their evaluation of Missouri’s family assessment and response system, which involved both demonstration counties piloting the system and comparison counties. The researchers found that “overall, there was greater use of community resources in pilot areas”; in addition, “child welfare workers in pilot areas were more likely to know the names of contact persons in a broader range of community

organizations that were potential sources of assistance to families and were more likely to have met with them” (p. 21).

For the counties in the current study, several themes emerged regarding challenges to service provision, specifically in small, rural counties. The first concern involved

issues of capacity, especially as community agencies are increasingly relied on to provide support services. Informants in the counties that have implemented differential response reported increases in referrals to community agencies, and those in the counties in the formulation stage all expected such increases. As mentioned earlier, it appears that counties have sufficient capacity to identify cases and conduct assessments, but there are limited resources and sometimes substantial barriers to delivering needed services. For example, informants in

As a support services system, it is important that differential response programs offer specialized services for vulnerable populations.



some counties reported not having the same variety of service providers as found in larger counties. Administrators from several counties also noted that simply keeping staff levels up is an ongoing challenge. Funding to hire staff appears to be the biggest barrier to building capacity for community partners. Specifically, there is insufficient funding to hire full-time permanent staff, so many programs operate with part-time staff. These types of funding and resource issues have also been cited by other states implementing differential response and similar initiatives (e.g., West Virginia and South Dakota, as reported in Merkel-Holguin et al., 2006). For example, Merkel-Holguin and colleagues reported “Washington state has heavily populated urban centers and also rural communities that are remote and sparsely populated. Finding qualified providers in rural areas is sometimes challenging” (p. 65).

In some cases, lack of capacity led to waiting lists for the Small-County Initiative counties, and some had to phase in differential response more slowly. For example, one county is currently still in the pilot stage of implementation of Path 1 referrals only, due to such concerns of “overloading the family resource centers.” A child welfare services administrator from this county stated:

The FRC [family resource center] priority is in providing core services, particularly to populations not traditionally served. This is our minimum requirement for the FRCs, and we want them to have success with this first before we load them up with more responsibility.

A few informants mentioned that they “have to be really creative” in terms of sharing resources, a finding that is similar to that of Siegel and Loman (2000), who noted that in “smaller, more rural pilot counties.. .where there are fewer formal

service providers, the demonstration caused workers to seek out and develop a wider variety of informal resources” (p. 21).

Another common barrier cited by informants in all the counties visited involved geographic accessibility, not only structurally, in terms of transportation issues, but also culturally, in self-isolation by residents. The counties are, in many cases, very large in land size but small in population. For example, Siskiyou County is 6,287 square miles but contains just seven people per square mile (U.S. Census Bureau, 2007b). The land in many of these counties is undeveloped, with dirt roads and mountain trails. Out of the nine counties visited, seven cited transportation as a major barrier. The following quote illustrates the difficulty of transportation faced by clients in many of the counties:

The transportation system. . . stops running at about 5:00 or 6:00 at night, so if you run an evening class that starts at 5:30 to accommodate work and it ends at 7:30 you’ll have people stranded. . . . The site we had before this was six blocks off the closest transit with no sidewalks. And you’re talking people who can have three kids, two of them in a stroller. . . and we’re not even talking about the foothills where the average travel to the main road can be two miles.

Many informants also noted that physical distance or separation is often sought by individuals who move to these counties: “Then of course, you’ve got your rugged individuals, ‘I don’t need the government, I don’t want the government helping me’.” Out of the nine counties visited, six reported a culture of isolation as a barrier to service delivery. The following quote by a program administrator reflects others’ comments on the issue:



Rural counties in general. . . are kind of spread out. . . and there are isolated pockets of population that aren't very trusting of governmental agencies and it's hard to engage them in services or get them involved even though they may desperately need them.

It should be noted, however, that informants in some counties made it clear that the challenges faced by small counties are not necessarily unique to small counties, but the rural nature of these counties makes them different. A quote by a county administrator highlights this subtle difference:

[There is] a difference between small counties and large counties. Urban-based counties . . . they've got big problems, big numbers, but that doesn't mean that those problems don't exist in huge intensity in the small counties, just in small numbers. The intensity is the same, the problems are the same, just small numbers. . . . [However,] the smaller numbers don't mean that they should be treated differently in terms of resources. . . . Small counties need the resources to accomplish goals such as those in SCI [Small-County Initiative] and their own goals as much as big counties.

Conclusion and Future Directions

The counties involved in the Small-County Initiative program are moving toward implementation of California's three-path model of differential response. This represents major systemic change for many of the counties. Evidence for rapid system change in elements related to differential response is found in ratings from the prevention system assessment tool as well as in interviews with county and community personnel. These data also indicate that system change is not caused by any one agent or program. Statewide initiatives, including the Small-County Initiative and the Child Welfare Services Outcome Improvement Project, in response to federal

accountability, all play a role in moving small counties to engage community-based prevention services with child welfare services, which is a decided change from past system development.

Methods of case identification have improved dramatically from year 1 to year 2. Development of strong public-private partnerships facilitates identification of cases, especially when, as is often the case, workers from community programs live in the communities being served. There is also high visibility of cases across agencies and departments and public-private partnerships are used in discussing potential cases of families at risk for maltreatment. In some counties, family resource centers have stationed child welfare workers in community locations, which aids in identifying cases and making child welfare services' new preventive services role more visible to clients.

The data suggest that, in general, systems are in place regarding referral methods and there have been improvements in these systems. Families are being referred to community agencies under Path 1, while those under Path 2 are being seen by a child welfare services worker and community partner together as a team. Although public-private collaborations existed prior to differential response implementation, these partnerships have become much more formalized as counties work to implement differential response. Child welfare services is more involved in front-end cases, and the increased communication and integration of services with community agencies has resulted in more seamless service delivery. An additional benefit of these partnerships, according to informant reports, is that communities are starting to see child welfare services in a different light – not as adversaries, but as partners supporting their efforts to address conditions putting children at risk for maltreatment.

The two primary issues identified regarding implementation of differential response referral methods are confidentiality and change in agency culture. Confidentiality was described as a major stumbling block to implementation because there was concern regarding the privacy of families referred to community agencies. Counties are addressing this issue of confidentiality either by including community partners under the multi-disciplinary team definition or by using universal release forms, which families sign before they are approached by community agencies. The issue of organizational culture change involved the “new way of doing business” that comes with differential response. Informants mentioned that some workers, especially those with seniority, need more time to adjust to the new system. However, many informants noted, that the shift to preventive services and collaboration between private and public agencies has been facilitated in the small counties because “everyone knows everyone.” In addition, because small counties have few staff, practice changes can be readily introduced by managers.

Concerns about staffing resources at both community agencies and county departments were raised. Informants in many community agencies noted that their programs are at maximum capacity and that additional, full-time staff are needed. Still, community agencies are responding to Path 1 and Path 2 referrals in counties that have implemented differential response. Most counties are using family resource centers as the primary community organizations to provide services. All the counties have home visiting programs and most counties are using these programs to support families under differential response. Shortfalls in county child welfare services staffing are noted as undermining attempts to go beyond the minimum basic requirements and toward the system reforms embodied in the differential response approach.

Geographic accessibility issues continue to be a challenge in service delivery. There are small, remote communities that are difficult to serve and that can become isolated during winter. In addition, some individuals choose self-isolation by living in such areas. Informants reiterated the importance of having satellite offices in different areas of the county rather than centralized centers, and having workers living in the communities so that isolated communities could receive services.

Overall, it appears that counties have made much progress in implementing California’s differential response model. While lack of administrative capacity makes responding to all outside demands difficult, the extra resources from the Small-County Initiative (and the Child Welfare Services Outcome Improvement Project) have been used well in filling in system gaps. Capacity for family assessment and engagement will be tested in the future as differential response is fully implemented in all the small counties. A commitment to evaluate system development, including tracking cases and case outcomes in the three differential response paths, will be necessary to ensure that families actually benefit from this policy change.

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Outcomes for Children with Allegations of Neglect Who Receive Alternative Response and Traditional Investigations: Findings from NCANDS

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This study sought to determine whether children in alternative response systems were kept as safe as children receiving traditional investigations. Using NCANDS data, this study examined patterns of rereporting of alleged child maltreatment among children who received assessments and those who received traditional investigations following allegations of neglect. Two forms of event history analysis were

conducted: trajectory pattern analysis, which diagrams patterns of rereporting of alleged child maltreatment, and proportional hazards analysis, also called Cox regression, which presents the projected risk of a second report occurring after controlling for specific factors.

The trajectory analysis demonstrated little difference between the rereporting rates of children who received an assessment following neglect allegations and children who received traditional investigations. The proportional hazards analysis revealed that children in the assessment track had a somewhat decreased risk of rereporting compared with children receiving investigations.

Traditional investigations into reports of child abuse or neglect typically involve a forensic approach to determine whether child maltreatment occurred. Cases with sufficient evidence of maltreatment, based on statutory definitions, are called substantiated. When a case is substantiated, adults and children in the family are commonly referred to services, and sometimes ordered by the courts to obtain services. Nationally, services were provided following investigation to approximately 36% of children with maltreatment reports in 2004, regardless of disposition, while 59% of children found to be victims received services (U.S. Department of Health and Human Services [USDHHS], 2006). Sometimes children are removed from the home and placed in foster care. Families who are the subject of traditional investigations may experience this as an adversarial process in which they are threatened



with punitive action and instructed to participate in services (Schene, 2005). Alternative response, sometimes known as “differential response,” “multi-track” or “dual track,” is a less adversarial approach to responding to accepted reports of child maltreatment. Alternative response focuses on family assessments without a formal determination of whether the maltreatment occurred or the child is at risk of maltreatment (USDHHS, 2003). Assessments are strengths-based and comparatively service-rich. In assessments, perpetrators are not identified and children are rarely removed from the home. Services are voluntary, and offered in a constructive and helpful way, resulting in greater engagement and satisfaction of families and a higher service delivery rate for families in assessment tracks (Loman & Siegel, 2004; Merkel-Holguin, Kaplan, & Kwak, 2006). If deemed necessary for child safety reasons, services can be mandatory even within an alternative response track. However, if a family refuses services or if the agency feels a more authoritative approach is needed, a family can be moved to an investigative track (Virginia Department of Social Services, 2004). Services provided within an assessment track are not usually linked to the determination of victimization since no such determination is made.

Alternative response is becoming more widely used across the nation; Merkel-Holguin, et al. (2006), in a survey of differential response policies, reported that 15 states now use differential response with reports of child maltreatment. Several of these states have implemented alternative response systems statewide. In 2005, 10 states with differential response systems reported data to the National Child Abuse and Neglect Data System (NCANDS), an increase over the eight states that reported data in 2004.

Using NCANDS data, this study tracked children in five states¹ implementing alternative response programs statewide during 2004 and 2005, and with sufficient data on all the variables of interest, examined patterns of re-entry into the child protective services system among children who received assessments and those who received traditional investigations. The primary research question was: Are children in alternative response systems being kept as safe as children receiving a traditional investigation? For the purpose of this study, safety was defined as lack of re-entry into the system within 12 months for a child who had previously come to the attention of child protective services due to neglect or neglect with other maltreatment. Child and maltreatment factors were studied to examine any connections to the child’s risk of re-entry.

Background

The federal government recognizes recurrence or repeat maltreatment as a measure of child safety. In response to the Social Security Act Amendments of 1994, the Administration for Children and Families developed regulations for reviews of state child and family services programs under titles IV-B and IV-E of the Social Security Act. Based on these regulations, states were required to report rates of recurrence as a safety outcome measure for the Child and Family Services Reviews (USDHHS, 2000) beginning in 2001. Recurrence is any subsequent substantiated or indicated maltreatment occurring in a six-month period after an initial substantiated or indicated maltreatment. During the first six months of federal fiscal year 2004, 8.1% of children in the United States with substantiated or indicated maltreatments were rereported to the child protective services system with findings of at least one subsequent substantiated or indicated maltreatment (USDHHS, 2006).

¹ Kentucky, Minnesota, Oklahoma, Washington, and Wyoming.



Researchers studying recurrence (DePanfilis & Zuravin, 2002; Drake, Jonson-Reid, Way, & Chung, 2003; Fluke, Shusterman, Hollinshead, & Yuan, 2005), have employed a variety of methods to examine recurrence of maltreatment within periods ranging from 15 days to 5 years. Studies that used survival analysis, which calculates the proportion of a population surviving, or not experiencing an event past a certain time, showed that child maltreatment is less likely to occur as time increases after the initial or index event (Drake, et al., 2003; Fluke, et al., 2005).

Because investigations have been the dominant response to allegations of child maltreatment, there is much concern about the impact of assessment on safety outcomes. Alternative response systems do not include determination of victimization, so recurrence of substantiated maltreatment, which is

often considered to be an indicator of safety, cannot be calculated for children receiving an assessment.

Researchers have therefore used rereporting, an indication of recidivism (Drake, et al., 2003), as a measure of safety for children receiving an assessment (Loman & Siegel, 2004; Shusterman, Hollinshead, Fluke, & Yuan, 2005). Rereporting is defined

as any subsequent report of child maltreatment following an initial report of maltreatment regardless of the finding on each case. Studies have varied on the length of time a child is followed to determine re-entry into the child protective services system. Fluke, et al., (2005), followed children for 5 years in their study of recurrence and rereporting and found rereporting to be associated with risk factors consistent with those for recurrence in the study population.

Prior research demonstrates that re-entry into the child protective services system is not substantially influenced by the decision to place a child in an assessment track. Rates of rereporting and recurrence are comparable for children receiving assessments and children receiving traditional investigations and in some cases, are lower for children receiving assessments (Loman & Siegel, 2004; Schene, 2005).

Studies within a single state, using an experimental design, showed that children who received an assessment had fewer subsequent child abuse reports and continued for longer periods without a new maltreatment report than did children receiving traditional investigations (Institute of Applied Research, 2006). A broader study of children in six states using the NCANDS 1998-2002 data found no difference in the

6-month recurrence rate between children receiving an assessment and children receiving traditional investigations (Shusterman, Fluke, Hollinshead, & Yuan, 2005; Shusterman, Hollinshead, et al., 2005). The present study used data from five states to examine the rereporting trajectories of children in families with allegations of neglect for 12 months, and presents comparative rereporting rates

for groups of children who received assessments and investigations.

The relatively high rates of repeat victimization help justify neglect as an important focus for intervention and prevention of subsequent maltreatment.

Factors Related to Rereports

Many factors are associated with a higher likelihood of multiple referrals into the child protective services system. They include prior victimization or involvement with the system (Hamilton & Browne, 1999; Littell, 1997), younger children, the presence of a disability, the presence



of neglect or multiple types of maltreatment (USDHHS, 2006), and larger family size (National Resource Center on Child Maltreatment, n.d.). Several studies cite neglect as the type of maltreatment most likely to be repeated (Jonson-Reid, Drake, Chung, & Way, 2003; Fluke, et al., 2005). Children in families with allegations of neglect in their first report of child maltreatment are 30% more likely to experience a second report of confirmed child maltreatment than are children who were physically abused (Fluke, et al., 2005). Because neglect is often associated with chronic conditions related to poverty and caregiver behavior, it is understandably likely to be more chronic in nature (Child Welfare Information Gateway, 2001). Nevertheless, the relatively high rates of repeat victimization help justify neglect as an important focus for intervention and prevention of subsequent maltreatment.

Fluke, Yuan and Edwards (1999) also found a correlation between the receipt of post-investigative services and recurrence, and hypothesized that this may be due to use of services for higher risk situations or to the surveillance of families by child protection agencies. At least one other study reports decreased risk of recurrence being related to receipt of specific services while the case is active (DePanfilis & Zuravin, 2002).

Services

Service delivery rates varied across states and across jurisdictions within a state (Virginia Department of Social Services, 2004), yet overall, families in the assessment track received services at least as often as families with substantiated investigations. In Virginia, 32% of families in the alternative response track were identified as having one or more service needs and most of them received at least one service. In Minnesota, 54% of alternative response families received some specific service other than case management, compared with 36% of families

in the control group that received traditional investigations. Ortiz and Shusterman (2006), using 2004 data from NCANDS, reported that children in the alternative response track were 13% more likely to receive services following their assessments than were children in the investigation track. However, the nature of the service delivery may differ considerably between families in the assessment track and those receiving investigations. For example, as part of the practice model in some jurisdictions, families in the assessment track are encouraged to become engaged in identifying their own service needs and requesting services, while in the traditional investigative track, jurisdictions may simply refer to or recommend services.

Characteristics of Children in Alternative Response

When surveyed about the criteria for determining the response provided to a maltreatment report, state respondents indicated that risk level is the primary determinant for this decision (Merkel-Holguin, et al., 2006). Cases of low to moderate risk are typically eligible for alternative response, while high-risk cases and cases of imminent danger are served through traditional investigations. State policies differ in the case characteristics and criteria used to determine level of risk. In Minnesota, assessments are typically provided to families at low to moderate risk of physical abuse. These families may have allegations of neglect, including lack of necessities, unattended medical needs, absence of supervision, or educational neglect. Traditional investigations in Minnesota are typically provided in response to allegations of serious physical, medical, or emotional abuse involving a referral for law enforcement, child sexual abuse, children in licensed childcare or out-of-home placement, serious violations of criminal statutes, or serious conditions within the home leading to removing a child from the home (Sawyer & Lohrbach, 2005).

While an age-based track assignment is not mandated by policy in most states, studies consistently indicate that older children are more likely to receive an alternative response than are younger children (Chipley, Sheets, Baumann, Robinson, & Graham, 1999; English, Wingard, Marshall, Orme, & Orme, 2000; Shusterman, Fluke, et al., 2005; Shusterman, Hollinshead, et al., 2005). Other than age, researchers have found few differences between those children and families who experienced traditional investigations and those who received assessments in case characteristics and demographics such as gender, race, and ethnicity (English, et al.; Siegel & Loman, 2000); prior contact with child protective services; type of maltreatment; report source; identity of the perpetrator; family structure; parental unemployment; or size of family (Siegel & Loman).

Methodology

Case-level data from the 2004 and 2005 NCANDS were used as the basis for this study. Children in families with allegations of neglect have been shown to have higher recidivism rates than children in families with allegations of other types of maltreatment (Fluke, et al., 1999). Therefore, these analyses focused entirely on children in families with allegations of neglect, who represented a majority of children in maltreatment reports. Among states that reported alternative response in sufficient numbers (at least 1% of records) during 2004 and 2005, five states also reported allegations of neglect that were referred to alternative responses. These five states, Kentucky, Minnesota, Oklahoma, Washington, and Wyoming, reported 93,576 unique children with maltreatment report dispositions during federal fiscal year 2004, of which, 32.4% received an alternative response. Descriptive statistics

were obtained for all unduplicated children² with reports of maltreatment during 2004 who received either traditional investigations or alternative response. Variables related to child demographic factors included age groups, race, and sex, and report characteristics such as report dispositions and report sources.

Trajectory pattern analysis was conducted on a sample of children in families with allegations of child neglect during federal fiscal year 2004 ($N = 93,576$), to identify the patterns of rereporting within 365 days among children who received either an assessment or an investigation. Rereports within 1 day were excluded, due to the possibility that these were reports of the same incident. All NCANDS reports with alternative response dispositions were coded as an alternative response, while reports with all other dispositions were coded as investigations. This technique determined the prevalence of rereporting by track as well as the track assignment of subsequent reports.

Proportional hazards analysis, a form of survival analysis controlling for multiple variables (Hosmer & Lemeshow, 1999), was also performed, using the same sample of children ($N = 93,576$), with rereports tracked through the end of federal fiscal year 2005. Data were analyzed to examine the relationship between the risk factors and the hazard of a child experiencing a subsequent report. The outcome variable of interest was the risk of children experiencing a subsequent report of maltreatment within a period of time. The time variable was the time it took for each child to have a second report of maltreatment. The time index event for this study was the date of the first report.

² For the descriptive statistics, children who experience multiple reports of maltreatment were counted for their first report during 2004.

Risk factors in the analyses included:

- *Child's Sex.* Children were reported as male or female.
- *Child's Age at Initial Report.* The child's age at the time of report was grouped into a categorical variable: age 3 or younger, 4-7 years old, 8-11 years old, 12-15 years old, and 16 years or older.
- *Child's Race and Ethnicity.* A single variable with mutually exclusive categories was created based on data in the NCANDS record reflecting the primary race or ethnicity with which the individual identifies.
- *Child's Prior Victimization Status.* This variable indicates whether the child had previously experienced a report with a substantiated or indicated disposition prior to the first report during this fiscal year.
- *Child With Indication of Disability.* A child is considered to have a disability if one or more of the following risk factors has been identified: mental retardation, emotional disturbance, visual impairment, learning disability, physical disability, behavioral problems, or some other medical problem.
- *Source of Initial Report.* A variable included in the NCANDS record reflecting the category or role of the person who notified a child protection agency of alleged child maltreatment. For this analysis, parents, friends, neighbors, and victims were combined into a single category designated "nonprofessional."
- *Response.* This variable indicates whether the child received an investigation or an assessment.
- *Disposition.* For children receiving investigations, this variable indicates whether the report of maltreatment was

substantiated or indicated, so the child is considered a victim, or whether the report was not substantiated, so the child is considered a nonvictim.

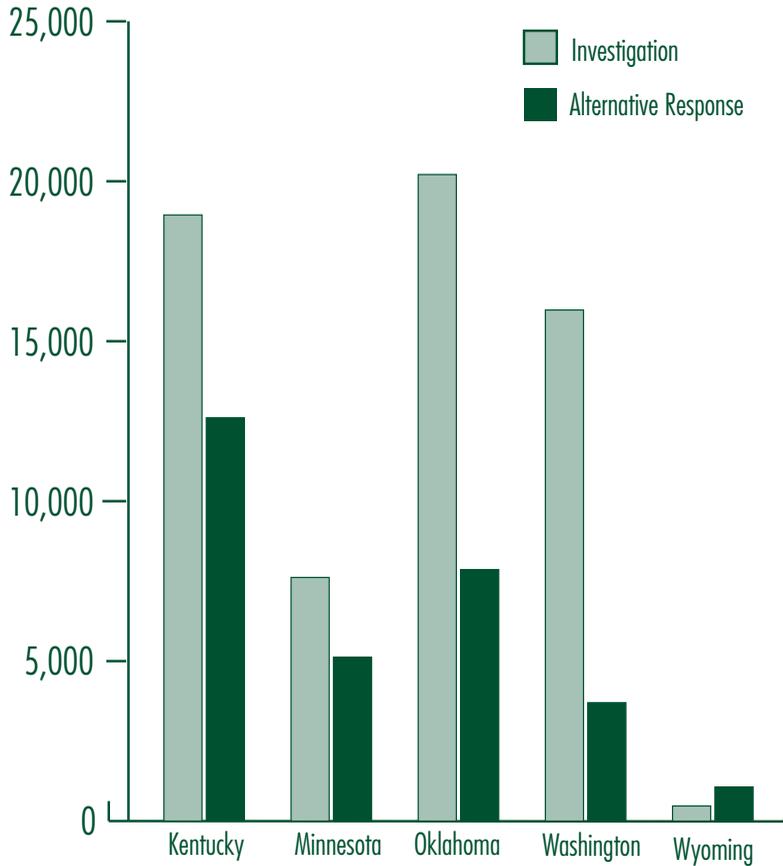
- *Post-Investigation Services Provided.* A child is considered to have received post-investigation services if the record indicates that any of a list of services, including family preservation, family support, and foster care, were provided. Post-investigation services are entered into the child's record if they were provided or arranged by the child protection agency, social services agency, or child welfare agency for the child or family because of needs discovered during the course of an investigation, and delivered within the first 90 days after the disposition of the report.
- *Child's Placement in Foster Care.* This variable included in the NCANDS record reflects the child's placement away from his or her parents or guardians, and the responsibility of the state title IV-A/IV-E agency for placement, care, or supervision of the child.

The state variable was also treated as covariate in the model to act as a control for state level variation. For this type of analysis, once a child is reported, he or she is considered at risk for a subsequent report, and the probability of that rereport occurring is considered the hazard probability. Proportional hazards analysis adjusts for the bias associated with estimating hazards with observational periods of different lengths.

Findings

Figure 1 shows the unduplicated number of children in families with allegations of neglect who received investigations and those who received an alternative response in their first report during 2004 in each of the five states. Wyoming, with the smallest number of allegations of child neglect during 2004 ($n = 1,538$), referred 69% (1,066) of the children

Figure 1. Unique Children in Maltreatment Reports by State, 2004. (N= 93,576)



to an assessment track, while Kentucky, with the largest number ($n = 31,551$), referred 40% (12,605) for an assessment. In Minnesota, with 12,739 children entering the system with reports of neglect, 40% (5,124) of children received an assessment. Oklahoma and Washington referred much smaller proportions of their children to assessment tracks. In Oklahoma and Washington, 28% (7,862) and 19% (3,700) respectively, were referred for assessments. Across all states in this study, 32% of children in the child welfare system with allegations of neglect received assessments.

Descriptive analyses were conducted to identify similarities and differences between the groups

of children who received investigations and those who received assessments. Both groups had an equal distribution of boys and girls. Race and ethnicity did not appear to be relevant in the decision to refer a child to either an investigative or assessment track.

As seen in previous literature (Chiple, et al., 1999; English, et al., 2000; Loman & Siegel, 2004; Shusterman, Fluke, et al., 2005), children receiving assessments in various states were somewhat older than children in the investigative track. In Kentucky, 51% (6,414) of children referred to the assessment track were aged 8 or older, compared with 40% (7,504) of children receiving



investigations. A similar finding was also seen in Wyoming, where 46% (492) of children receiving alternative response were 8 or older, compared with 34% (162) of children in investigations. Also, in Wyoming, which by policy focuses its alternative response system on older children (Merkel-Holguin, et al., 2006), 27% (295) of children referred for assessments were older than age 12, while only 15% (74) of children in this age group received investigations.

Children who received assessments were more likely to be referred by nonprofessional reporters than were children who received traditional investigations. Nonprofessional reporters included parents, friends, the alleged perpetrator, anonymous reporters, and other or unknown reporters. This finding was particularly true in Oklahoma and Wyoming, where a greater percentage of referrals received from nonprofessionals were assigned to assessment tracks. Among children who received an assessment in Oklahoma, 59% (4,680) were referred by nonprofessional report sources. This number is much lower for children assigned to the investigation track, of which, 44% (8,975) were reported to child protective services by nonprofessional sources. In Wyoming, nonprofessionals referred 54% (572) of children in the assessment track, and 36% (172) in the investigative track. In Minnesota, 23% (1,191) of children in the alternative response track were referred by educators, compared with 12% (882) of children in the investigative track. Prior studies (English, et al., 2000; Shusterman, Fluke, et al., 2005; Shusterman, Hollinshead, et al., 2005) suggested that alternative responses more often resulted from referrals from schools or social service personnel.

While foster care placement may seem incongruous with an alternative response approach, two states in this study indicate that

by policy, the assessment track pathway can be used when a child is placed in foster care (Merkel-Holguin, et al., 2006). The data from this study suggest that being in the assessment track does not exclude the possibility of foster placement. Of children in the assessment track, 2.1% received foster care services relative to a report of neglect, compared with 11.8% of children in the investigative track who were placed in foster care. Due to limitations of the dataset, it is unknown whether these placements were voluntary.

Trajectory Pattern Analysis

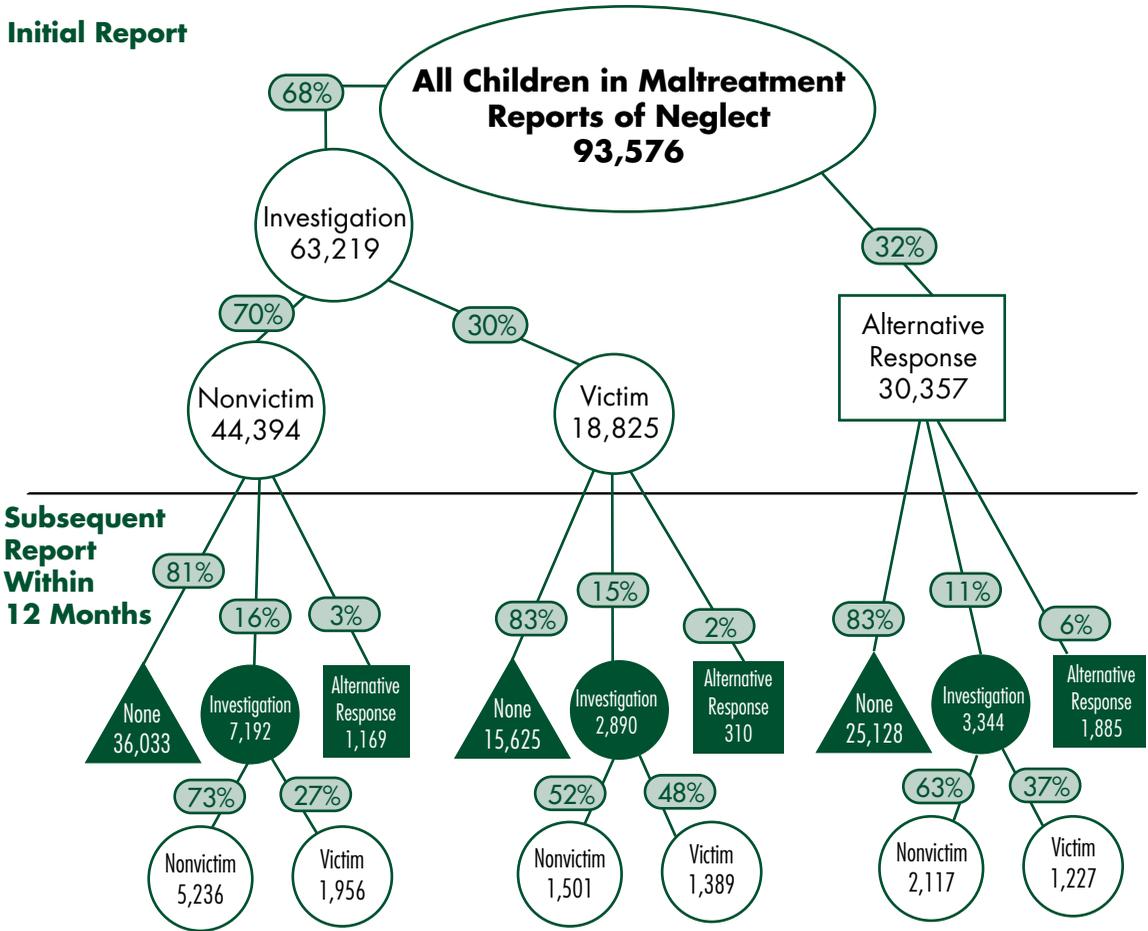
The objective of the trajectory pattern analysis was to describe patterns of rereporting for two groups of children entering the child protective services system with allegations of neglect – one that received alternative responses and one that received traditional investigations. Subsequent reports may include allegations of other types of maltreatment.

For this analysis, the data were arrayed in patterns of assessments and investigations including the determination of victimization during each investigation. These patterns show rates of re-entry into the system and provide information regarding the track assignment and disposition of subsequent reports.

Figure 2 illustrates patterns of reporting for the initial report of alleged maltreatment during federal fiscal year 2004 and any subsequent reported maltreatment within 12 months. Both children whose initial reports were assessed and children who received an investigation may receive either a second assessment or an investigation upon re-entry into the system. The patterns illustrated in this figure display the percentage of children in each group receiving either assessments or investigations upon re-entry into the system. Squares represent assessments and circles represent investigations. Triangles

Figure 2. Subsequent Reports Within 12 Months by Initial Response, Children with Initial Reports of Neglect, 2004

Initial Report



represent the percentage of children receiving no further reported maltreatments.

Of the 93,576 unique children in maltreatment reports involving neglect during federal fiscal year 2004, 68% (63,219) initially received traditional investigations, and 32% (30,357) received alternative responses. There was very little difference in the rereporting rates between children in the assessment track and children in the investigative track. The likelihood of not re-entering the system was marginally better for children receiving assessments (83%) and for children who received investigations and were found to be victims (83%), than for those found in an investigation to not be a victim (81%). These

findings are similar to those of other researchers (Loman & Siegel, 2004; Shusterman, Fluke, et al., 2005) who found that child safety was not compromised for children receiving assessments. A second allegation of abuse or neglect can also result in an assessment. Among children who received an assessment following their first report during the year, 6% received a second assessment upon re-entry into the system. A subsequent referral to an assessment track was less likely for children who received an investigation following their first report of the year, but not impossible. Of children whose cases were initially investigated, 2% of victims and 3% of nonvictims received assessments upon re-entry into the system. Upon reinvestigation, children in the assessment group

Table 1. Factors Related to Rereporting for Children Receiving an Alternative Response or an Investigation, 2004. (N=93,576)

Factor Categories	Risk ratio associated with rereporting	
Child's sex	Male	1.00
	Female	1.04 ***
Child's age	0-3 years	1.00
	4-7 years	0.94 ***
	8-11 years	0.81 ***
	12-15 years	0.70 ***
	16 years or older	0.38 ***
Child's race/ethnicity	Caucasian/white	1.00
	American Indian/Alaska native	0.99
	Asian/Pacific islander/native Hawaiian	0.64 ***
	African-American/black	0.84 ***
	Hispanic	0.94 *
	Other/multiple race	1.37 ***
	Unknown/unable to determine	0.65 ***
Prior victim	No	1.00
	Yes	1.50 ***
Presence of child disability	No	1.00
	Yes	1.26 ***
Report Source	Social Services/mental health	1.00
	Medical personnel	0.92 **
	Law enforcement or legal personnel	0.88 ***
	Educational personnel	1.24 ***
	Child daycare or foster care providers	0.92
	Nonprofessional, other, or unknown	1.15 ***
Disposition	Nonvictim	1.00
	Victim	0.84 ***
Type of response	Investigation	1.00
	Alternative response	0.92 ***
Post-investigation services	No	1.00
	Yes	1.59 ***
Foster care services	No	1.00
	Yes	0.93 *
Interaction: alternative response & foster care	Not alternative response and foster care	1.00
	Alternative response and foster care	1.50 ***
Interaction: victim disposition & foster care	Victim in foster care	1.00
	Nonvictim in foster care	2.02 ***

Data source: NCANDS 2004-2005 Child File

*p<0.01, **p<0.001, ***p<0.0001



were found to be victims less often than children found to be victims from the investigation group and more often than nonvictims in the investigation group. Among children in the assessment group, 37% were found to be victims in a subsequent report. In the investigation group, 48% were found to be victims and 27% were found to be nonvictims in subsequent investigations.

Proportional Hazards Analysis

A proportional hazards analysis was conducted to determine whether the distinction between alternative response and investigation, as well as factors such as age, sex, report source, and victim disposition, were associated with the likelihood that a child would be rereported within 12 months. As seen in Table 1, the distinction between alternative response and investigation was a significant predictor of rereporting, indicating that children who received an assessment were somewhat less likely to be rereported than children receiving an investigation, as indicated by a risk ratio of 0.92. Other factors that predicted rereports were similar to findings from earlier research. Older children were less likely to be rereported than younger children. African-American, Asian, American Indian and Hispanic children were all less likely to be rereported than Caucasian children.

Children reported by educational or nonprofessional sources were more likely to be rereported and children reported by legal or law enforcement sources were less likely to be rereported than children reported by social services or mental health professionals. Children who were found to be victims were less likely to have a subsequent report than were children not found to be victims. Similar to what has been found by earlier researchers, children who received services were more likely to be rereported.

In this study model, children placed in foster care were less likely to experience a rereport, which is different from findings in earlier studies (Fluke, et al., 2005). However, when foster care was tested in interaction with alternative response as well as with a nonvictim finding, a strong interaction effect was found between alternative response and foster care. Children who both received assessments and were placed in foster care were 1.5 times more likely to be rereported than were children who had only one or neither of these conditions. Children who were not found to be victims but were placed in foster care were 1.7 times more likely to be rereported than were children with only one or neither of these conditions.

Discussion and Conclusions

These findings suggest that overall, children in alternative responses are kept about as safe as children receiving traditional investigations. Trajectory analysis demonstrates that approximately 17-19% of children experience a rereport within 12 months regardless of whether they receive an investigation or an assessment following their first report of maltreatment during the year.

While proportional hazard analysis establishes a significant difference between the risk of rereporting for children in an alternative response track and children in an investigation track, the risk ratio approaches 1.0. This ratio shows that despite the fact that children receiving assessments are at somewhat less risk of rereporting, the difference in relative risk is small, amounting to about 9% increased relative risk for children in the investigation track.

While not many children in alternative response tracks are placed in foster care, the risk ratio for those who are shows that they are at 50% greater risk of rereporting, compared with children receiving traditional investigation



and not placed in care. Likewise, the interaction between nonvictims and foster care demonstrates that children in foster care who are initially investigated and not found to be victims are at nearly twice the risk of being rereported than children not in this category. Due to limitations in the dataset, the exact timing of foster care placement relative to the initial allegation is not known. For example, a second allegation of maltreatment occurring within 90 days of an initial allegation could possibly trigger a child's placement in foster care. Further study matching the NCANDS dataset with the Adoption and Foster Care Analysis and Reporting System dataset would allow for a better understanding of the relationship between foster care placement and rereporting.

The absence of repeated maltreatment reports has been used in the Child and Family Service Reviews and in research as an indicator of safety (Drake, et al., 2003; Loman & Siegel, 2004). However, it is important to note that this measure may not fully represent a child's subjective experience of safety. An investigation is conducted with the purpose of identifying the perpetrator, determining guilt, and assigning a child the status of "victim." An assessment engages families in a strengths-based process that ultimately aims to reduce or eliminate the risk of further abuse and improve the well-being of all family members. Once engaged in an assessment, a child's experience is already qualitatively different from that of a child engaged in an investigation. Therefore, a subsequent report of maltreatment may have a different meaning to each of these two groups of children. While it may appear to reflect a setback, the rereport does not necessarily undo the progress that the family has already made or the willingness to engage constructively in services. The surveillance effect resulting from the receipt of services may increase the likelihood of rereporting for both

groups of children. Controlling for the prior receipt of services may show greater disparity in the likelihood of rereporting between children receiving assessments and those receiving investigations. However, we are unable to determine the existence of other intervening conditions between the receipt of prior services and the rereport, making analysis in this particular area difficult.

Study Limitations

The objective of this study was to utilize NCANDS data to inform the field about the relationship between rereporting and the two response tracks, assessments and investigations. The results of this data analysis raise some points:

- This study shows the receipt of services to be related to an increase in the likelihood of rereporting, which may be explained by the surveillance effect (Fluke, et al., 1999). Yet, active participation in services has also been demonstrated to reduce the likelihood of rereporting while a child protective services case is open (DePanfilis & Zuravin, 2002), emphasizing the importance of the alliance with parents developed during alternative response. The effects of intervening events between the onset of services and the rereport or the timing of the rereport relative to the receipt of services cannot be discerned through the present study.
- These data do not capture the dynamic nature of assessments and investigations. When an assessment is elevated to an investigation, it may be rolled into an investigation and reported as a single event or it may be considered as a separate event, and therefore constitute a rereport.



Future research may more clearly resolve these points. A study of the nature of services provided as part of the alternative response and the timing of the rereport would prove fruitful. Potentially, the rereport may actually result in improved safety for the child in the long term. A detailed study of the nature of the alternative response assessment, the services provided to the family, and the timing of the rereport would provide additional insight into the connection between rereporting and safety for families who receive alternative response assessments.

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Development and Field Testing of a Family Assessment Scale for Use in Child Welfare Practice Settings Utilizing Differential Response

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The North Carolina Family Assessment Scale for General Services (NCFAS-G) was developed in collaboration with the National Family Preservation Network (www.nfpn.org), with funding from the Department of Social Services, San Mateo County, California. Portions of the findings presented in this article were previously presented to the County of San Mateo as part of the final project report in November 2006.

Information about obtaining permission to use the NCFAS-G and training materials on its use are available from the National Family Preservation Network (NFPN) at www.nfpn.org, or from the executive director of NFPN at director@nfpn.org.

This article presents the results of a project undertaken to develop and field test the North Carolina Family Assessment Scale for General Services (NCFAS-G), a comprehensive family assessment instrument designed for differential response practice settings. The NCFAS-G assists workers to assess families in eight domains of family functioning. A field test was conducted in a large, urban county using a voluntary, 90-day, DR model. Over a period of six months in 2006, 123 families including 252 children were assessed using the NCFAS-G.

The NCFAS-G was found to exhibit good psychometric properties, particularly for reliability, expressed as Cronbach's Alpha.

The results of the assessments are in line with expectations for the target population of low- to moderate-risk families, with respect to both the assessment ratings at intake, and the direction and magnitude of changes in ratings following services. The NCFAS-G holds promise in assisting workers and agencies implementing differential response and needing case practice tools to support the differential response approach.

Differential response is a service alternative to traditional investigations in child abuse and neglect situations (Schene, 2005). Historically, the response to child abuse and neglect reports has been that child protective services workers conduct an investigation with the intention of determining the veracity of the report. If the report was substantiated, the child protective services agency exercised its child protection mandate, often by legally compelling the family caregiver to participate in services. Sometimes the child or children would be removed and placed in out-of-home care if the abuse or neglect was serious or if the caregiver was not receptive to services. This method of response is, by its very nature, judgmental, legalistic, and adversarial. By contrast, differential response can be applied in cases where the immediate risks to children are determined to be low, the alleged abuse or neglect is not serious, and the family can be engaged to voluntarily receive services (Schene, 2001, 2005).

One of the overarching policy objectives of differential response is to develop a cooperative, caring, and voluntary relationship with families who may benefit from services such that the risk of future abuse or neglect is reduced.



Waldfoegel (1998) estimated that 50% of all child protective services reports are screened out prior to investigation (based on intake screeners' determination of low risk) and an additional 20% are closed after investigation without services. An estimated 20% receive monitoring alone or monitoring with some other services, and the remaining 10% progress to court and court involvement. Waldfoegel pointed out that some families are reported to child protective services who should not be (i.e., there is no substance to the allegation) and that these reports should be screened out at the point of intake. However, if Waldfoegel's estimates are accurate, as many as 70% of reports to child protective services may represent vulnerable families who are at some degree of risk (low to moderate, if risk assessment processes are functioning adequately) but who do not receive services of any kind after being screened out at intake or having their case closed after investigation. Schene (2005) suggested that child protective services should treat low- to moderate-risk families as vulnerable families who could benefit from voluntary services, and that these families' needs should be assessed with the intention of developing service plans.

Can such an approach be successful without leaving children at undue risk? Results from a review of innovative practices conducted by Walter R. McDonald and Associates (2001b) suggest that it can. They reviewed articles published in the late 1990s in an effort to identify reform efforts in child welfare and reforms resembling differential response (also known as "multiple response," "dual track," and "alternative response"). Referencing evaluations conducted in Florida, Iowa, Missouri, and Virginia, they reported that the number of investigations decreased by as much as one third, the duration of case involvement in the system decreased by one fifth, and the number of services used by families increased by one tenth or more. These changes in system involvement and

service utilization were not associated with any increase in future child maltreatment reports. A more recent study by Loman and Siegel (2005) of Minnesota's differential response system generally supported the findings of Walter R. McDonald and Associates, noting that families randomly assigned to differential response received more services (both funded and non-funded, such as worker contact) than did control families, and that child safety did not appear to be jeopardized.

Why should this new approach succeed? The answer may be as simple as that proposed by Dumbrill (2006), who studied parents' perceptions of relationships with social workers in child protective services practice settings. Dumbrill noted that parents were much more likely to cooperate with workers and engage in services if they perceived that the worker was using the agency's legal and authoritative power to assist rather than control the parent. Regardless of a worker's predisposition to help a family, if after an evidentiary investigation the nature of the relationship has been established as controlling rather than helping, it may be difficult or impossible to change the nature of that relationship.

These types of evaluation findings and philosophical discussions reinforce both the logic and the benevolent approach of differential response and help explain the surge in the number of differential response programs throughout the United States. At this writing, differential response and similar programs are operating in more than 20 states (Loman & Siegel, 2005; Merkel-Holguin, Kaplan, & Kwak, 2006; Walter R. McDonald and Associates, 2001a), and the United States is not alone in moving toward family engagement and voluntary service plans for low- to moderate-risk families. Similar programs have been implemented in Canada (Trocme, Knott, & Knoke, 2003),

Australia (Hetherington, 1999), and New Zealand (Waldegrave & Coy, 2005). Interestingly, New Zealand's model is being developed expressly for the purpose of counteracting a recent narrowing of the legal standard defining investigations by focusing on evidentiary activities rather than family engagement and service outcomes (Waldegrave & Coy). Workers and administrators alike felt that their preferred approach of engagement, assessment, and service was being supplanted by legal requirements, because the law required them to investigate cases forensically even when they felt that such a response was not in the families' best interest. New Zealand's model comprises an attempt to reintroduce benevolence into social work.

Administrators in the United States also have struggled with the distinctions between investigation and assessment, and even different types of assessments. In 1999, the National Association of Public Child Welfare Administrators (NAPCWA) revised its *Guidelines for a Model System of Services for Abused and Neglected Children and Their Families* (NAPCWA, 1999) and specified the following distinctions: (1) safety assessment (undertaken to determine the immediate safety needs of the child); (2) investigation (undertaken to determine whether the allegation of maltreatment is true, in an evidentiary sense); (3) risk assessment (undertaken to determine the likelihood of future maltreatment, particularly in the absence of intervention); and (4) family assessment (undertaken to determine dynamic aspects of family functioning that resulted in the family being brought to the attention of child protective services, as well as family strengths, conditions that need to be remedied, cultural issues, and other issues that should contribute to the construction of a successful service plan). In the context of the mid- to late 1990s, the NAPCWA guidelines made sense, because family assessment would follow investigation

and risk assessment in sequence, in order to provide a responsive service plan to families who had abused or neglected their children. But in the context of differential response, family assessment should be available prior to investigation, and perhaps even prior to risk assessment, although various risk assessment models (e.g., Structured Decision Making) may be useful in determining which families are investigated and which families are served by differential response (Loman & Siegel, 2005).

There remain unresolved issues relating to which families are investigated or assessed, just how "voluntary" the assessment process is, and whether there are sufficient services available to those families who would receive them voluntarily. Whatever processes result in families entering assessment as opposed to investigation, there is an implicit requirement that assessment strategies and supporting instrumentation are available to social workers to help them conduct broad-based family assessments. Walter R. McDonald and Associates (2001a) stated that better information would likely result in better family assessments focusing on dynamic aspects of family interaction, rather than investigation.

Although the preceding literature review is by no means exhaustive with respect to differential response, the large majority of existing literature focuses on the theory and philosophy of differential response. Preliminary results from some evaluation endeavors suggest that public policy changes endorsing differential response may accrue benefits to low- to moderate-risk families by increasing the use of voluntary services and decreasing future risk of child maltreatment. Virtually all of the articles rest their findings, assertions, and assumptions on the central importance of comprehensive family assessment as an integral part of differential response. However, in those articles, information is scant with respect to how to conduct those

assessments, or to case practice tools to support comprehensive family assessment. Other than Waldegrave and Coy (2005), who reference an instrument used in New Zealand that was developed in the United Kingdom, and Loman and Siegel (2005), who reference the use of risk assessment models (Structured Decision Making) that might be used to determine which families progress from risk assessment to investigation or from risk assessment to family assessment, the literature is fairly silent on assessment processes and instruments to support case practice.

The United States Department of Health and Human Services, Administration for Children and Families recently released a comprehensive set of guidelines for family assessment (2005), but though they are instructive, they are largely limited to the defining of terms and promoting the philosophy and value of comprehensive family assessment.

In response to the need to support the promise of differential response with practice tools for workers, this article presents the results of an initiative to develop and field test a family assessment instrument for use in public child welfare environments employing differential response.

Methods

Development of the NCFAS-G

The idea to develop a broad-based family assessment tool grew out of the frustration of the program managers and practitioners in San Mateo County, California, over the lack of family assessment instruments that supported the social work practice model of differential response. A review of instruments being used throughout the jurisdiction offices and programs revealed that the content of the instruments did not relate closely to practice concerns and was not designed to be capable of detecting or assessing changes that occurred in families as a result of service.

Furthermore, the instruments tended to focus on individuals rather than families, and were deficit-based with no capacity to assess strengths or protective competencies.

During scale development, information was gathered about practice needs from practitioners, managers, and administrators representing child welfare, mental health, temporary assistance to needy families, alcohol and other drug services, and domestic violence. This research occurred over an 18-month period in 2004 and 2005. The information gathered was used to inform the process of development of the NCFAS-G so that the scale would be appropriate and responsive to the changing practice environment in the agency and to the implementation of differential response, in particular.

The existing North Carolina Family Assessment Scale served as the basis for the new NCFAS-G instrument. The NCFAS had been developed for high-risk family services cases, had undergone extensive reliability and validity testing, and exhibited good psychometric properties in that practice environment (Reed-Ashcraft, Kirk, & Fraser, 2001; Kirk, Kim, & Griffith, 2005). The NCFAS had been used as a practice tool by thousands of workers in numerous practice environments throughout the United States and abroad, and included five of the eight assessment domains identified by study-site workers as necessary for the NCFAS-G and the differential response practice environment. The assessment domains of the NCFAS included environment, parental capabilities, family interactions, family safety, and child well-being. To complete the content required for the NCFAS-G, three additional domains were developed, along with appropriate subscales and scale definitions. These domains included social/community life, family health, and self-sufficiency. In its final form, the NCFAS-G includes eight domains and 51 subscales.



Table 1. Basic Scale Structure for the NCFAS-G

Domain/ subscale title	Clear strength	Mild strength	Baseline/ adequate	Mild problem	Moderate problem	Serious problem
Intake	+2	+1	0	-1	-2	-3
Closure	+2	+1	0	-1	-2	-3

Some subscales from the original NCFAS were realigned into existing or new domains so that the NCFAS-G would address the general service needs of all families, focusing on low- and moderate-risk families who are the intended recipients of differential response as well as families in crisis. Each of the domains and subscales is structured to assess both family strengths and family problems, using a 6-point Likert-type scale. The structure of the scale provides for ratings to be recorded at both the intake stage and the closure stage of case activity. See Table 1 for the basic scale structure.

During the assessment process, workers using the differential response model assigned ratings to the families on each of the subscales and overarching domains using guiding language in a set of scale definitions. The definitions provided were derived from the literature, the experience of the scale authors and authors of other scales, conceptual and legal thresholds and definitions, and the practice wisdom of social workers using the scales. The intention is that the language of the definitions should be guiding rather than literal, in order to accommodate local contextual adjustments based on worker and supervisor judgment or legal and policy requirements.

Of the 6 points on each scale, three levels of functioning are defined by guiding language to assist workers to assign ratings. The defined scale points are (+2) clear strength, (0) baseline/adequate, and (-3) serious problem. Intermediate levels of functioning (+1, -1, -2) are left undefined in order to encourage worker inquiry and

judgment when assigning ratings. The NCFAS-G is designed to encourage worker judgment. The baseline/adequate level of functioning is defined as “the threshold above which there is no legal, moral or ethical reason for public intervention.” The level of functioning described by this definition is intended to reflect the community and legal standards in which the scale is applied in practice. This definition does not preclude the offer or acceptance of voluntary services, regardless of assigned rating.

Once ratings are assigned, they can be used for a variety of purposes. At intake, the ratings are used to develop a case service plan, and provide a framework for team meetings, case staffings, or case reviews as the case progresses through the period of service. They also focus resource allocation on specific problem areas and help prioritize those areas for service. Intake ratings help identify existing strengths for inclusion in case planning. The NCFAS-G form provides a picture of family functioning at intake for periodic reassessment of key issues and problems. Since assessment is an iterative process, the time intervals between reviews of the ratings and the family’s progress are not specified by the instrument, but are determined by the family’s level of need and the worker’s discretion or the agency’s practice model.

Closure ratings may be assigned at the end of a time-limited period of service (e.g., at the end of a 90-day period of eligibility for service), or at the point at which the worker and agency feel that sufficient progress has been made to



close the case. Alternatively, if, for example, a family deteriorates or risk to children rises, closure ratings could be assigned at the time that the differential response program finds it necessary to transfer the case to more intensive or mandatory services. Whenever they are assigned, closure ratings may be conceptualized as outcome measures of service efficacy and an indication of unresolved issues, perhaps indicating the need for additional services or referral to other service organizations. Closure ratings can also be compared to intake ratings by computing change scores that indicate the magnitude of change evident on each of the domains.

The Study Site and the Differential Response Model

The NCFAS-G was implemented concomitantly with the implementation of a new differential response system in San Mateo County, California, in July 2006. At the time of implementation, the differential response program was new and still evolving as workers learned the new system and as the policies and procedures were being tested on the basis of experience.

The majority of differential response cases in the study were managed and served through a contract with a private community service provider. The provider employed about a dozen workers to handle the expected caseload of referrals. The workers received two weeks of training on the differential response program. The training included child development, responsibilities of mandated reporters, available services, substance abuse, the NCFAS-G assessment tool, a local administrative database, safety, and home visiting. Each worker carried a personal computer to use for recording case data including the NCFAS-G ratings. The local administrative database was modified to accommodate the NCFAS-G, using a structured template.

The differential response case managers received referrals from the child welfare system. Hotline calls were screened and rated by intake workers using the county's standardized risk assessment instrument. The policy objective expressed by county administrators was that the differential response program would respond primarily to moderate-risk cases. Policy required that moderate-risk cases be investigated by a social worker. The social worker generally interviewed age-appropriate children separately from parents and then interviewed the parent(s) with the differential response worker present. If the social worker decided not to open a child welfare case, the parents were informed of this decision and the differential response worker offered the family voluntary services. If the family accepted the offer, a case was opened and the differential response worker then began working with the parents. The NCFAS-G was completed over the course of two or three home visits. Differential response workers used the results of the assessment to help develop a case service plan.

It should be noted that not all differential response models being tested throughout the country begin with an investigation that may or may not lead to the case being transferred to the differential response program. In many cases, the differential response program receives the referral immediately from the intake screeners based on some form of safety and risk assessment. These differing mechanisms of case assignment may affect families' willingness to engage voluntarily, and should be studied as a covariate in differential response as more studies are conducted. However, in the study site reported on herein, an investigation appropriate for moderate-risk cases commenced, and at the social workers' discretion, the case could be transferred to differential response.

The differential response program was designed as a 90-day service program, but cases could stay open for as long as necessary, with supervisory approval. Differential response workers acted both as brokers for services and as direct service providers in areas such as parenting education. Typical referrals made by differential response workers on behalf of families included legal aid, health insurance, food, and immigration services.

Policy required that supervisors review the NCFAS-G ratings with the differential response workers. Differential response workers then generally developed three to four goals with the family. A typical goal might be to improve parenting skills, with a parent education component to help the parent achieve the goal. Due to the voluntary nature of differential response, it is permissible in San Mateo's model to close a case when a family is connected to resources. Closing a case at this juncture, however, does not always permit the observation by the differential response workers of meaningful changes in the family.

Program managers from the contract service provider met twice monthly with the study site's differential response program managers to discuss needs and problems. Implementation of a new differential response program and the NCFAS-G presented the typical challenges of system reform initiatives, but study site administrators considered the implementation to have been successful, based on their observations of case activities and reports from staff.

Field Testing the NCFAS-G in the Study Site

Participants. Study participants comprised 123 families including 252 children (47% male, 53% female), who were served directly or indirectly via the family service plan. Families also comprised a broad range of ethnic identities (18% White, 18% Black, 48% Hispanic, 16% other). Children from all ages were also represented in the sample (5% less

than 1 year old, 32% 1-5 years old, 35% 6-12 years old, 28% 13-19 years old).

Family assessment procedures. Differential response workers began using the NCFAS-G immediately after training that occurred in conjunction with the implementation of differential response. Intake and closure ratings were obtained in accordance with the practice model; intake ratings were obtained after two to three home visits (although some families were not contacted that frequently), and closure ratings were assigned at the point that the differential response worker decided to close the case. Intake and closure ratings were obtained on 123 families, and limited service data were obtained on 67 families. A total of 157 services were offered to 67 families, upon whom these data were available. The most frequently offered services included mental health services (25%), food or clothing (12%), and parent education (10%) adolescent services (7%). All other categories were infrequently offered, suggesting that a wide variety of services was offered under differential response.

Nearly three quarters (72%) of all cases were closed within the 90-day service period envisioned by the practice model. The complete breakdown of case durations was as follows: 30 days or less, 18%; 60 days or less, 27%; 90 days or less, 27%; 120 days or less, 10%; and 200 days or less, 18%.

Results

Results of Family Assessments

The figures in this section present the findings of the analyses of the field test data. Figures 1 through 8 present the intake and closure ratings assigned by workers using the NCFAS-G. In all cases, the figures display the proportion of 123 families rated at each of the six levels of family functioning (clear strength to serious problem) at intake and closure.



Figure 1. Aggregate Intake and Closure Ratings on the Domain of Environment

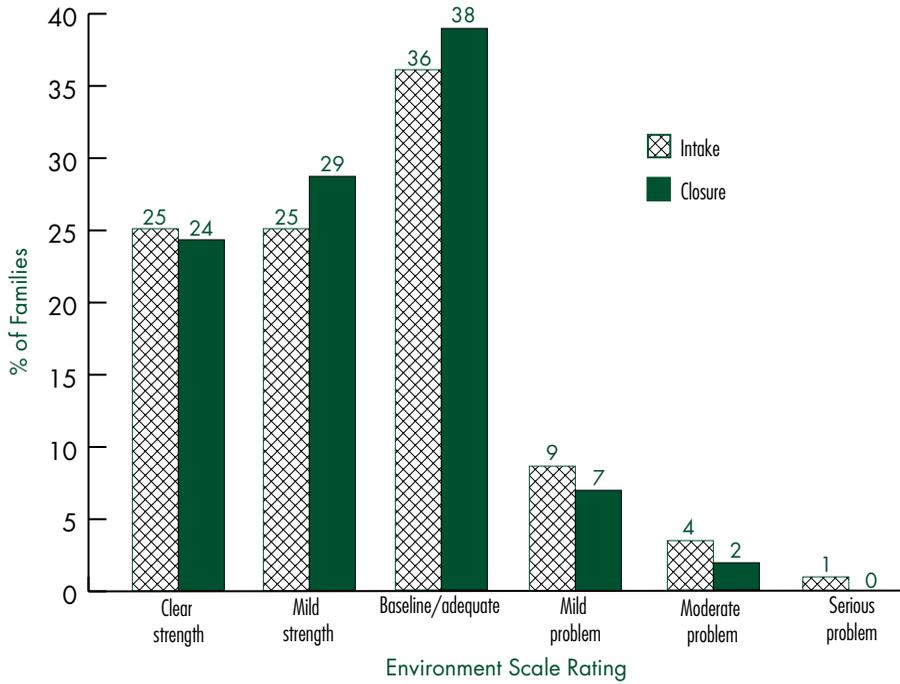


Figure 2. Aggregate Intake and Closure Ratings on the Domain of Parental Capabilities

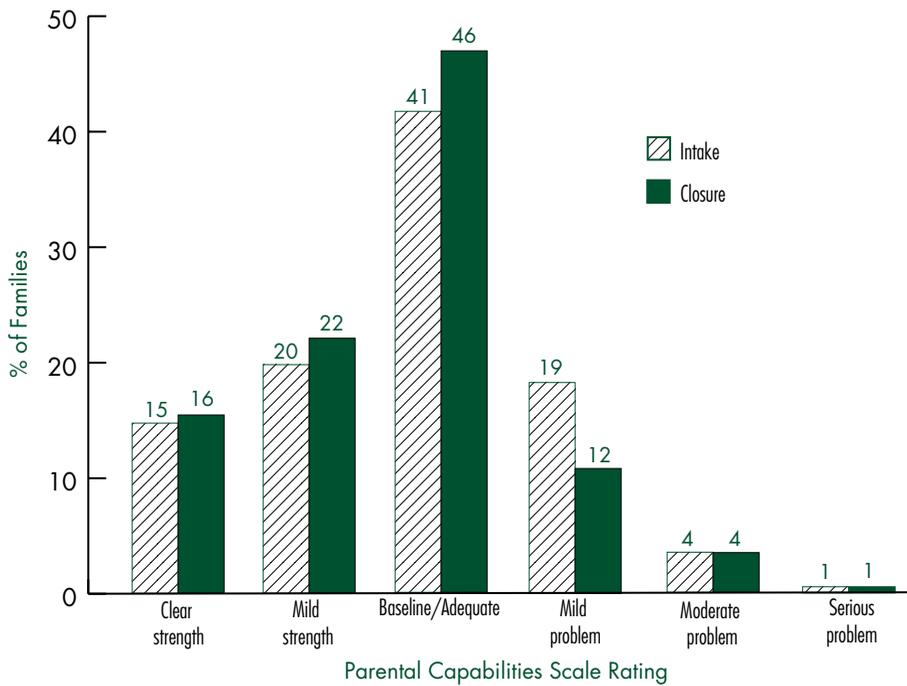


Figure 3. Aggregate Intake and Closure Ratings on the Domain of Family Interactions

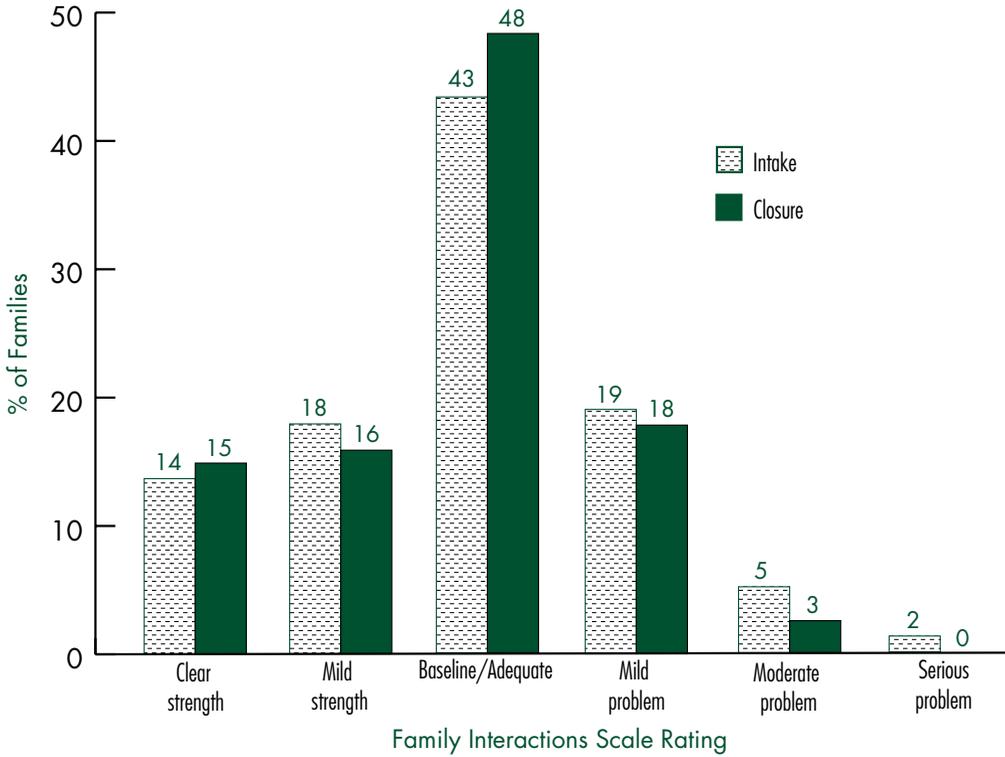


Figure 4. Aggregate Intake and Closure Ratings on the Domain of Family Safety

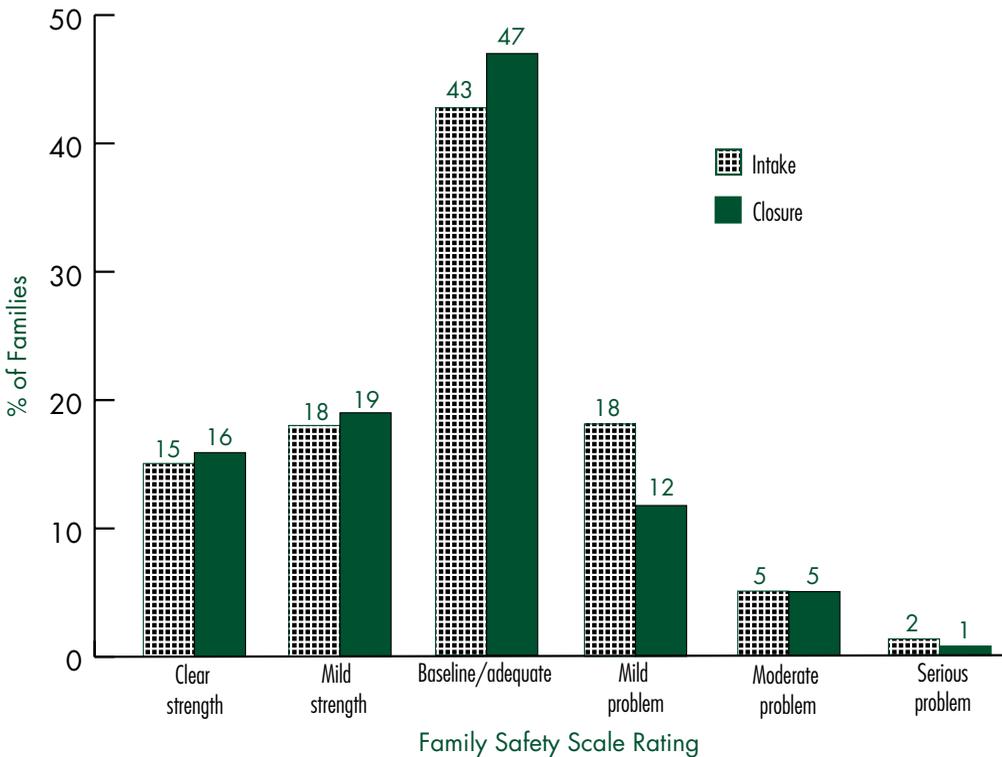


Figure 5. Aggregate Intake and Closure Ratings on the Domain of Child Well-Being

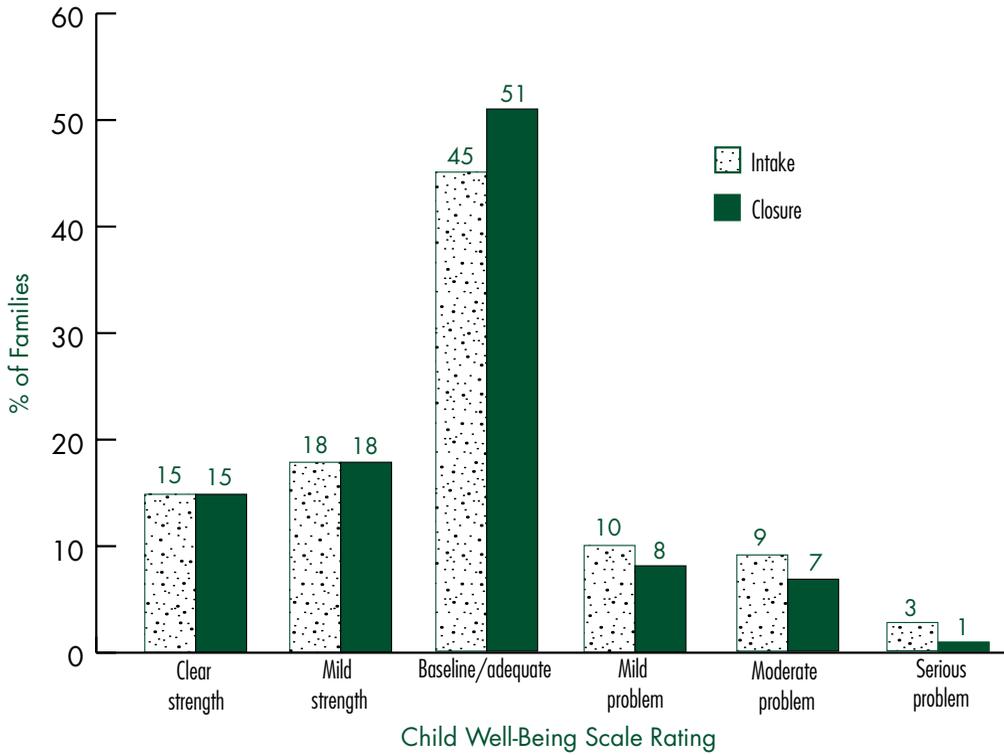


Figure 6. Aggregate Intake and Closure Ratings on the Domain of Social/Community Life

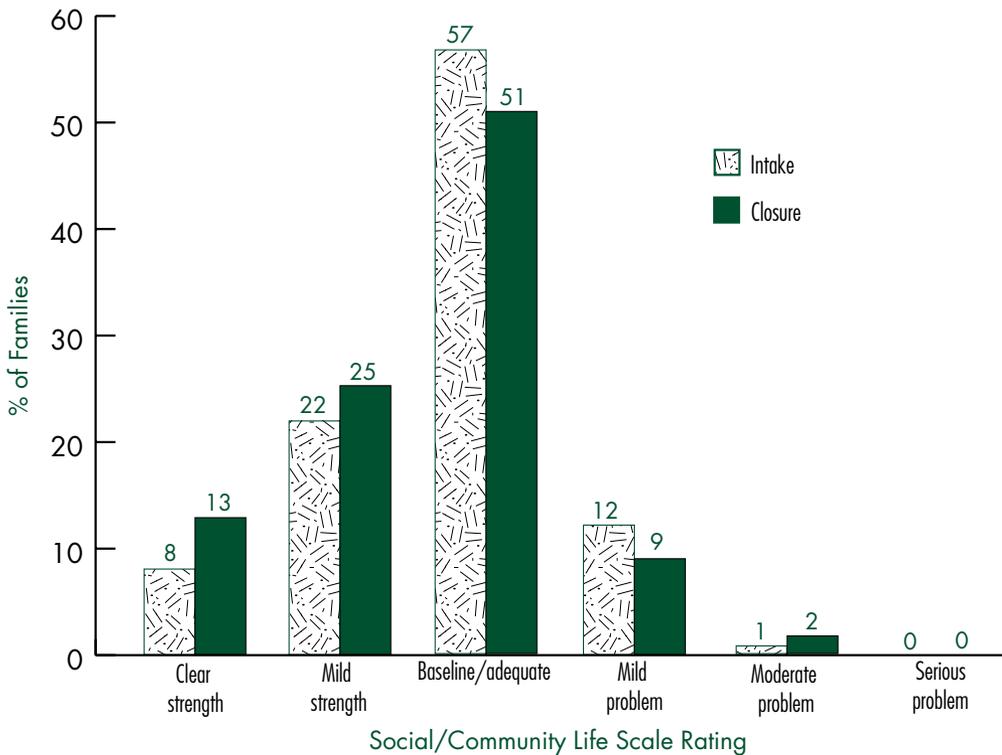


Figure 7. Aggregate Intake and Closure Ratings on the Domain of Self-Sufficiency

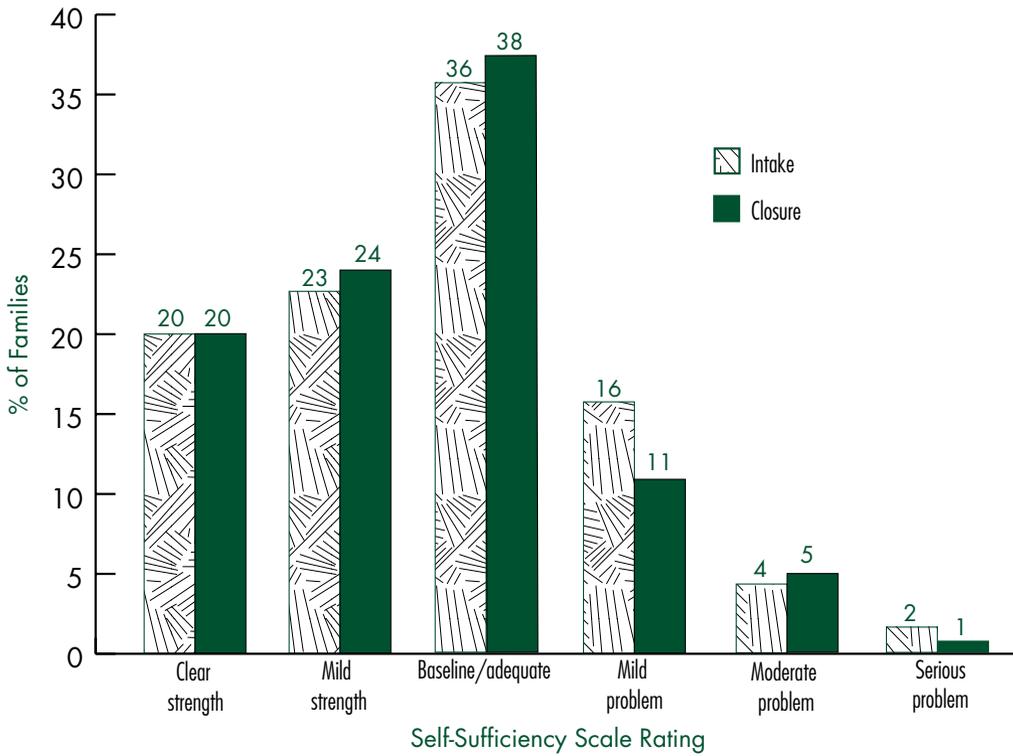
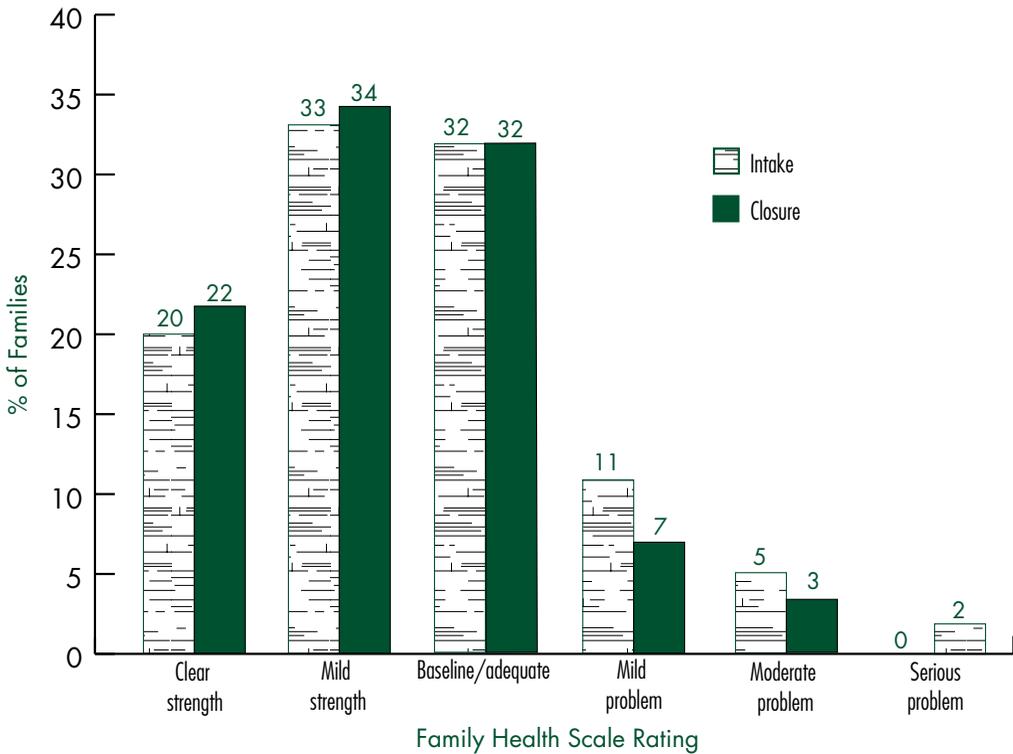


Figure 8. Aggregate Intake and Closure Ratings on the Domain of Family Health



Between 12.7% and 25.9% of families were assessed as being in the problem range of ratings on each of the eight assessment domains. However, very few cases were rated at the moderate (1-9%) to serious (0-3%) problem levels. These ratings are in keeping with the types of cases expected to be served by differential response.

In order not to have to deal with negative numbers during the analysis of frequencies, the six ordinal scale ratings were assigned a positive numerical value such that 1 = clear strength, 2 = mild strength, 3 = baseline/adequate, 4 = mild problem, 5 = moderate problem, and 6 = serious problem. The mean ratings across all domains at intake ranged from 2.5 to 3.1 (approximately mild strength to baseline/adequate), with the standard deviations ranging from 0.8 to 1.3. These statistics indicate a reasonable spread of scores about the mean ratings, without numerous high (problematic) scores which would indicate large numbers of moderate- to serious-problem or higher-risk cases requiring more intensive or even mandatory services.

At closure, the mean assigned ratings were slightly lower, which is not unexpected and reflects progress made by families receiving differential response services. The domain mean ratings at closure ranged from about 2.3 to 2.8, with standard deviations ranging from 0.9 to 1.1, about the same as those for the intake ratings. This array of ratings and dispersion of ratings suggests a modest population shift away from the problem range of ratings toward the baseline and strength ratings. Similar to, but slightly better than at intake, the number of families rated in the problem range of ratings at closure was 9.1-20.7%, across all domains, with 2-7% in the moderate problem category and 0-2% in the serious problem category.

Although the dynamics of the NCFAS-G ratings are somewhat subdued when compared to the types of changes observed with high-risk families, these observations are not unexpected given that the service population comprised moderate-risk cases (96% of cases were moderate-risk on the risk assessment). Deterioration was infrequent, and in no cases were more than two increments of negative change observed on the 6-point rating scale. Deterioration occurred in only 3.5%-7.3% of cases, depending on the domain. In contrast, improvement occurred in 9.3%-16% of cases. Although these numbers are a modest reflection of positive change, they are as expected given that the large majority of moderate-risk families are likely to be rated in the problem ranges on only one or a few domains and therefore are likely to improve on only one or two domains. Furthermore, since an even larger proportion of families are not rated at the moderate or serious problem levels, the amount of possible improvement is limited to two or three increments at the maximum. Improvements of one or two increments appear to be the norm for moderate-risk families served by differential response.

Reliability of the NCFAS-G

Reliability of the NCFAS-G was estimated using the measure of internal consistency yielding the Cronbach's Alpha statistic, which ranges from 0 to 1.0. By statistical convention, alphas above 0.4 are acceptable for scale development and research purposes. The standards are higher for scales used in practice settings. Alphas above 0.7 are considered to be acceptable, alphas above 0.8 are considered to be high, and alphas above 0.9 are very high. The alphas obtained on all eight domains of the NCFAS-G are quite respectable. Table 2 presents the alphas obtained for both intake and closure ratings.

The alphas for all domains are above 0.83, and in 10 of 16 instances, they are above 0.9. These alphas support the reliability of the NCFAS-G with

Table 2. Cronbach's Alphas for Each Domain on the NCFAS-G at Intake and Closure

Domain	Intake	Closure
Environment	.92	.94
Parental capabilities	.91	.92
Family interactions	.90	.93
Family safety	.87	.89
Child well-being	.95	.95
Social/community life	.83	.88
Self-sufficiency	.91	.93
Family health	.86	.88

this population of cases, and the alphas would be expected to be even higher with a larger sample size and if the differential response workers were more experienced both with the NCFAS-G and the practice model (recall that the field test and differential response implementation occurred simultaneously).

Sensitivity of the NCFAS-G to Changes in Functioning

Families receiving services under differential response may appear to change in the direction of improved functioning, stay at the original level of functioning, or deteriorate from the original level of functioning. Furthermore, they may change in small or large amounts (depending on the direction of change and the original rating), and they may change on more than one domain

or none. The change data presented in Table 3 represent only the direction of change (positive, negative, or no change), not the magnitude, and multiple domain changes within families are not expressed.

Between 9% and 16% of the families experienced positive change on one or more domains and between 3% and 7% experienced deterioration on one or more domains. The balance of families, 79-85%, did not change on one or more domains. However, recalling that these are moderate-risk cases, it is likely that most families were rated in the problem ranges on only one domain or a few domains, and change would not be expected to occur on domains not rated in the problem ranges (although those changes do sometimes occur). The data from Table 3 suggest

Table 3. Percent of Families Experiencing Positive Change, No Change, or Negative Change on the NCFAS-G Following Services

Domain	Positive change (%)	No change (%)	Negative change (%)
Environment	9.3	85.2	5.6
Parental capabilities	13.2	82.1	4.7
Family interactions	13.3	81.9	4.8
Family safety	16.0	79.2	4.7
Child well-being	11.9	82.2	5.9
Social/community life	12.1	81.3	6.6
Self-sufficiency	11.5	85.0	3.5
Family health	11.9	80.7	7.3



Table 4. Changes Relative to the Baseline/Adequate Level of Functioning Experienced by Families on the NCFAS-G Following Services

Domain	Proportion at or above baseline		χ^2	df	p
	Intake (%)	Closure (%)			
Environment	86.8	90.9	73.99	1	<.001
Parental capabilities	76.6	83.6	57.25	1	<.001
Family interactions	74.1	79.3	57.64	1	<.001
Family safety	75.5	82.7	54.33	1	<.001
Child well-being	78.3	83.5	48.19	1	<.001
Social/community life	87.4	89.0	54.71	1	<.001
Self-sufficiency	78.0	82.6	71.10	1	<.001
Family health	84.1	88.3	47.00	1	<.001

Note: The χ^2 values relate to eight cross-tabulations of possible baseline/adequate conditions (“at or above” or “below” baseline/adequate) at both time periods (intake and closure). The table only presents the percentages “at or above baseline/adequate” at intake and closure.

that the majority of changes experienced by families receiving differential response services are in the “positive” direction; that is, lower mean ratings indicate movement away from the problem range of ratings toward the strengths range of ratings.

Table 4 presents the confidence estimates of changes experienced by families that received differential response services, relative to the baseline/adequate level of functioning, using the chi-square statistic. Recall that the definition of the baseline/adequate scale point is “the legal, moral, ethical threshold for intervention.” Thus, Table 4 presents the proportion of families at or above baseline/adequate at intake, compared with the proportion at or above baseline/adequate at closure. It is evident that on all domains, the proportion of families at or above baseline/adequate at closure was higher than the proportion at that level at intake. For every domain, the ratings at intake are cross-tabulated with the ratings at closure, and in each case, the changes are statistically significant, suggesting that the changes are reliable and due to services rather than due to random variation.

Discussion

The NCFAS-G was designed specifically for use in child and family service agencies using a differential response service model in which low- to moderate-risk families are invited and encouraged to voluntarily receive services in order to improve overall family functioning, resource management, safety, health, and self-sufficiency, and to reduce the likelihood of future maltreatment of children. This field test of the NCFAS-G, conducted in such an agency serving the described population, indicates that the NCFAS-G exhibits good psychometric statistical properties and can assist workers to assess families and construct broad-based service plans for them. The results of assessments conducted on the families being served are in line with expectations for the population, both with respect to the magnitude of assessment ratings at intake, and to the direction and magnitude of changes of ratings following services offered under differential response.



It is important to note the difference between the results of the field test with respect to the NCFAS-G per se and the results of the services to families served under the differential response model. Recall that the differential response model in the test site and the use of the NCFAS-G as the assessment instrument were implemented simultaneously. Thus, the influences of the use of the instrument and the implementation of the differential response treatment model are commingled and possibly confounded in unknown ways. However, the use of the NCFAS-G during differential response implementation is likely to have assisted that implementation process by offering a common family assessment framework for differential response workers.

To its credit, the study site agency went to great lengths to train differential response staff and host agency staff on the differential response practice model and the NCFAS-G prior to implementation. During implementation they experienced some of the same things that other agencies implementing differential response have experienced. Among them are that families refuse services and that available services frequently fall short of the needs of these families after their needs are assessed. McDonald and Associates (2001b) noted that not only could families improve if services were offered that related to the assessed needs, but also that better information on families' needs could be used to improve the array of services available to them.

In the study site, it became clear that affordable child care was an urgent need, but the only child care agency in the jurisdiction offering

subsidized care had a 2-year waiting list. Other than the shortage of subsidized child care, services were generally available for the 0-5 age

In the study site, it became clear that affordable child care was an urgent need, but the only child care agency in the jurisdiction offering subsidized care had a 2-year waiting list.

group, but there was a shortage of services for adolescents, especially mentoring programs. It is frustrating to workers and families to identify needs for which services do not exist if the information is not quickly used by agency administrators to address those service shortages. Furthermore, changes in family functioning based on voluntary receipt of services cannot be expected to occur in the absence of those services.

Differential response workers also received a substantial number of referrals that involved divorce cases with allegations by one parent against another. Often these allegations are groundless, but still require an investigative response. Many are screened out early in the investigation, but in other cases there may be reason to believe that the family could benefit from voluntary services (e.g., mediation). Even when deemed to be appropriate for a differential response referral, however, differential response workers said that they often found themselves in the middle of legal battles between the parents unrelated to child safety (although the stress of divorce can place children at risk in those families).

Family engagement has also been a problem in other studies (e.g., Loman and Siegel, 2005). It is not known how many families in the present study refused services prior to assessment, but about one third refused services or refused to continue at early stages of the case. The reluctance by families to engage may have been exacerbated by being subjected to an investigation prior to referral to differential response, since

the differential response workers were present during parent interviews by the investigating worker and may not have been viewed by parents as being truly independent of traditional child protective services. If services are to be truly voluntary, then improved family engagement is a necessary component of differential response. Perhaps differential response workers should be trained in motivational interviewing in addition to the other aspects of differential response and family assessment. Along the same lines, recall that differential response workers in the study site could close cases at the time that families were connected to voluntary services. This type of agency disengagement from families may have suppressed observations or measures of family improvement because those improvements might occur after the differential response case was closed but the family was still receiving services.

Less-than-optimal family engagement, premature disengagement, service shortages, and some questionable referrals are all likely to have deleterious effects on the apparent success of a differential response program, regardless of the logic and benevolence of the model. These issues, in turn, are likely to result in less observed change on closure assessments conducted using the NCFAS-G or any other reliable assessment instrument. Thus, it is important to view the use of comprehensive family assessment information not only for planning services for families, but also for agency program planning, program evaluation, and resource allocation.

To summarize the findings from this study, the NCFAS-G appears to be reliable when used by trained differential response workers serving moderate-risk families. The baseline/adequate- to mild-problem ratings at intake are commensurate with low- to moderate-risk families and differential response alternatives to mandatory child protective services involvement, or to no services at all. Incremental improvements

on NCFAS-G ratings at closure are commensurate with services offered to address a limited number of goals. Although population shifts observed on domain ratings were modest, they are in the “right direction” and are statistically reliable. Overall service population changes are likely to have been diminished by families refusing services and by differential response workers sometimes closing cases when the family was connected to voluntary services, rather than later when the services may have resulted in greater observed change.

Concurrent validity is tentatively established (based upon the proportion of families at or above baseline at closure), but stronger concurrent validity needs to be established and requires additional research. In the present study, data were not available on reasons for closure, nor were complete data available on services offered or accepted by differential response families. This type of service information is essential not only for further reliability and validity testing of the NCFAS-G, but also for testing the efficacy of the differential response model as an alternative to legally exercising the child protective services mandate in low- to moderate-risk child welfare cases or leaving those at-risk families to fend for themselves. In addition to service and closure data that are related to concurrent validity, predictive validity needs to be established in relation to rereferral rates over time. This type of research is needed independently of other research focusing on the NCFAS-G per se as it relates to the long-term efficacy of differential response. However, the NCFAS-G is responsive to the identified need for a comprehensive family assessment instrument to support differential response case practice, and may assist efficacy research efforts. The observed psychometric properties of the NCFAS-G suggest that it holds promise as a comprehensive family assessment practice tool for agencies and workers serving families with differential response practice models.



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The Intersection Between Differential Response and Family Involvement Approaches

Betty Christenson, Scott Curran, Kelli DeCook, Scott Maloney, and Lisa Merkel-Holguin

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Overview

A Snapshot of Differential Response

Differential response in child welfare, also referred to as “alternative response,” “multiple response systems,” and “dual-track,” is a reform approach that enables child welfare systems to respond differentially to accepted reports of child abuse and neglect. As described by Kaplan and Merkel-Holguin (2008), the rationale for the differential response approach is to offer flexibility to tailor the child protection response to the needs and circumstances of the family, to partner with families early rather than waiting for serious harm to occur, and to remove faultfinding in order to increase the possibility of family engagement and child safety.

While there is great variation among the states’ implementation of differential response, generally, those cases with low to moderate

safety concerns are provided a family assessment instead of an investigation, are offered timely services to meet their needs, and are engaged in a partnering relationship with the social worker, which begins with the assessment. It can be argued that this level of partnership is more easily attainable because there is no formal determination or substantiation of child abuse or neglect for families who receive an assessment response. Under a differential response paradigm, the investigative, forensic response is retained for the most egregious reports of child abuse and neglect with high child safety concerns. In some states, like Minnesota, differential response systems add an additional family support pathway, enabling the public child welfare agency, in collaboration with its community partners, to respond to screened-out reports of child abuse and neglect, meaning those that do not meet the legal threshold for a formal response.

A Snapshot of Family Involvement in Child Welfare Decision Making

In the past 10 years, public child welfare and community-based organizations have been implementing numerous family involvement and case decision-making models as a way to provide inclusive and culturally-respectful processes when critical safety and permanency decisions are being made about children. These models include front-end, time-sensitive, decision-making approaches (e.g., case planning conferences, team decision meetings, and family team meetings) that occur within 24 to 72 hours of children coming into care, before placement



changes can occur, or to prevent the need for children to enter foster care; and forms of family group decision making meetings (e.g., family group conferences and family conferences) that can occur at any decision-making juncture. The latter require sufficient planning and preparation time to assemble the largest support network available of family members, friends, and other informal supports, community members, and representatives from the service provider network to ensure that the most thorough decisions are made in a noncrisis-oriented framework. International and national scholars have documented the unique features, processes, and implementation challenges of both types of family involvement and case decision-making processes. These types of processes, particularly when they build on each other, “increase the effective participation of families in matters relating to their children” (Doolan, 2005, p. 1).

Front-end case decision-making processes serve multiple purposes, such as changing the structure of child welfare decision making to be group process-oriented rather than solely vested with a social worker and his or her supervisor, thereby reducing unnecessary placements; and serving as the first opportunity to engage the extended family and community in the concern that prompted the public agency or community’s involvement with them. The front-end case decision-making approaches can lead to other family involvement strategies, demonstrating a clear commitment to wider family involvement throughout the life of a case. Across the United States, communities are successfully using family meeting models at various case decision-making junctures. Research shows that family group decision making models result in increased child safety, expedited permanency for children, improved child and family well-being, and enhanced family and community support networks.

The purpose of this article is to explore the possible connection of these two significant reforms – differential response and family involvement approaches in decision making – that are being internationally adopted by child welfare systems. The article analyzes the underpinning values of these reforms; discusses the practical and philosophical connections between them; profiles Olmsted County, Minnesota’s work in this area; and highlights some practice and policy issues for future consideration.

The Connection Between Differential Response Systems and Family Involvement Strategies in Decision Making

Values

In order to determine whether there is a “good fit” in the intersection of differential response systems and family involvement strategies, it is essential to determine whether the values of these two domains are consistent and complementary, or in contradiction with each other.

Before the inception of differential response and family involvement approaches in the mid-1990s, traditional child welfare practice operated primarily as professionally driven processes and decision-making practices with the underpinning ideology of the “system knows best.” Families entering the child welfare system and receiving case management and oversight were prescribed a list of programs and functions to complete. They were also invited to, but not actively involved or engaged in, meetings where professionals shared their conclusions about the families and their children. While frequently disguised behind the drape of family-centered and family-friendly language, professionals made the decisions and families were informed. There was an entrenched belief that as the entity ultimately responsible for the safety of children involved in a child welfare case, the professionals were most qualified to make the decisions. Characteristics of these



decision-making processes typically included investigations for all screened-in reports, closed or nontransparent social work practice, dictation or documentation of goals and objectives, and court involvement for many of the more serious cases of abuse and neglect. These practices or professionally driven processes were amplified when families tried to assert themselves into the case and quickly became labeled as resistant and adversarial by child welfare workers or agencies. In effect, these professionally driven processes, when challenged, became more restrictive, with less accommodation for the family's culture, strengths, or preferences. Successful outcomes of these cases were routinely gauged by how "compliant" a particular family was, as measured by the agency's specific yardstick of goals and objectives for that family.

Following the implementation of differential response and family involvement approaches, child welfare practice reflects a different philosophical paradigm that guides the interaction between families and child welfare system personnel. Both of these system advances share the value that child safety is paramount, with the engagement of the extended family system and broader community as essential partners with child welfare in achieving and sustaining child safety. Boldly stated, both embrace that it is the role of child welfare to create safety *with* families as opposed to *for* families. Under both paradigms, the family voice and commitment for child and family safety and well-being is leveraged, underscoring the notion of child protection as a shared concern and responsibility. However, if safety is at risk of being compromised and family involvement strategies are not materializing, a broader family system and professionally driven processes are employed.

Another complementary value of differential response systems and family involvement approaches is the respectful and transparent

communication between child welfare system personnel and families. For example, during a family assessment response, when the social worker is engaging the family in partnership, the social worker and family members discuss together the social worker's concerns, expressed in a clear, respectful way, and the family's abilities to address the agency's concerns. In various family involvement approaches, the social worker also communicates with the broader assembled family group, sharing concerns, risks, dangers, and protective factors. In many family involvement approaches, like the family group conference, family team meeting, and case planning conference, an independent coordinator or facilitator maintains an impartial role holding as balanced a standpoint as possible while coordinating the process. These family involvement approaches compel open communication in child welfare cases, and provide workers the opportunity to articulate their concerns and work through difficult cases, sharing the responsibility of decision making within the larger family group. This exemplifies the new practice approach of operating by sharing the same information with families, and drawing on their abilities to address the concerns of the agency.

Table 1 identifies some generalizable characteristic differences between the traditional medical model value system and differential response systems and family involvement approaches.

Implementation Connection

Both differential response and family involvement approaches recognize the importance and strength in an increased involvement of the broader family/kinship group in child welfare cases. This is achieved through comprehensive family assessments and the use of myriad family involvement approaches. These strategies are a means of achieving safety,



Table 1. Characteristic Differences Between Traditional Systems and Differential Response Systems

Traditional Medical Model	Differential Response and Family Involvement Approaches
Information is held by the professionals.	Professional knowledge and information is openly shared with families and balanced with family expertise, wisdom, and knowledge.
Agencies use compliance as the primary measure of safety and maintain that child safety is only their concern.	Families can, and typically will, create safety within the context of their family's style of operation.
Agencies rescue children.	Agencies support families.
The focus is on risks.	Risk and safety factors are balanced with solutions and protective capacities.
Societal values drive practice.	Evidence and research promotes best practices.
There is a standard prescription of services.	Specific service planning is responsive to the family's needs.
Agencies use stranger care/foster care.	Agencies immediately search for and engage extended family and kin.
Families are not typically involved in decisions made by placement providers.	Families are involved in the selection of a foster family, in placement transitions, and in lifelong permanent connections.
There is a package of standard services and system monitoring.	There is a system-family partnership in monitoring; services are driven by family needs.

measuring goals, sharing responsibility, and partnering with the family to address the child welfare concerns.

There are a number of states and counties implementing family involvement approaches as part of their differential response systems. For example, North Carolina has directly intertwined these two reforms in policy and practice. Child and family teams are one of the seven core strategies for North Carolina's multiple response system, and are a deliberate attempt to facilitate partnership between formal agencies and informal supports in case decision making. Child and family teams convene within 30 days of a case decision, and quarterly thereafter, to develop and review case plans. Within the child and family team structure, risk assessments and re-assessments are completed with all participants. By policy, families that receive an investigative response and whose reports are substantiated receive a child and family team meeting, as do the families deemed to be "in need of services." A core component of these teams is the extended family's and informal supporters' participation in case planning.

Olmsted County Specific Example

Olmsted County Child and Family Services adopted the differential response approach to accepted reports of child maltreatment in 1999. At the center of this new approach was the premise that setting aside the finding of maltreatment would be beneficial to the family-social worker partnership. Families who were subjects of a valid report of child maltreatment by the Child Protection Division began receiving a family assessment through a team of social workers rather than a traditional, forensic, incident-based investigation. If social work services were deemed appropriate, families would be offered services with the goal of increasing child safety and well-being.

In 1997, the agency introduced family group conferencing as a way of family reunification for children in placement and a means of placement prevention. This later developed into a practice of infusing family involvement approaches into the development of plans to safeguard children. At the time, family group conferencing was seen as an alternative strategy to a traditional, more paternalistic practice. Differential response



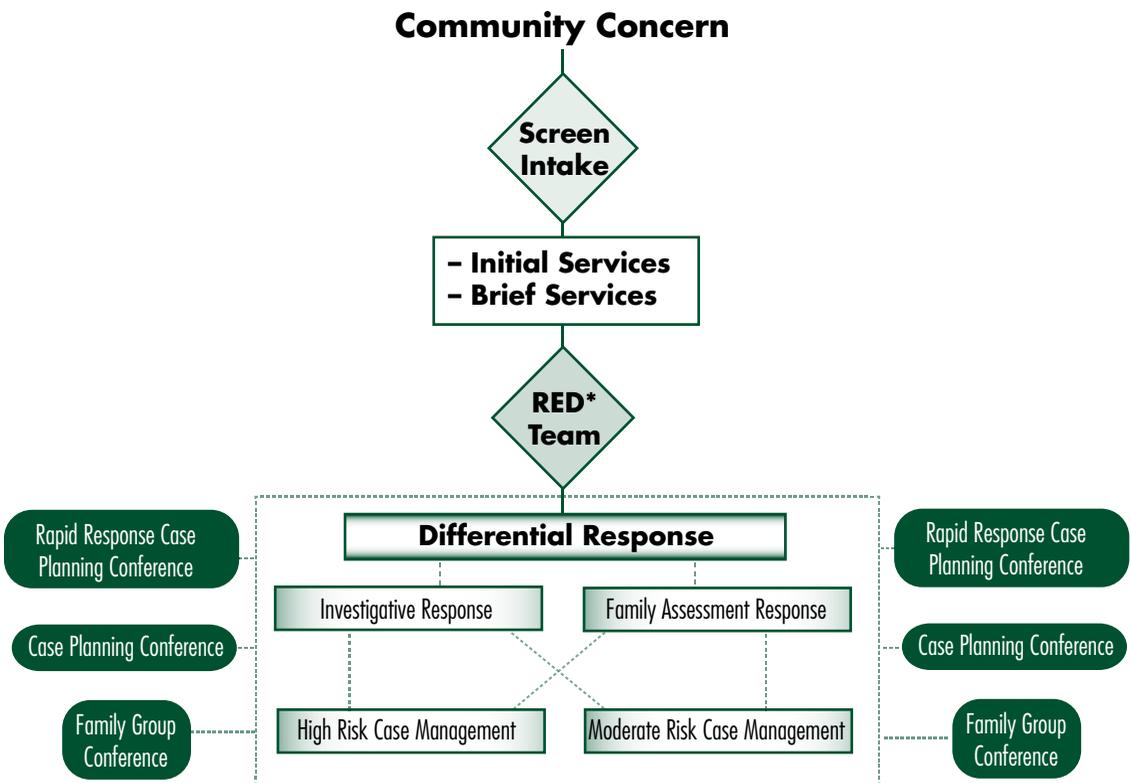
offered a structural opportunity for increased partnership with families. Family assessments were used with lower-risk child maltreatment concerns, while higher-risk situations tended to remain under a more traditional approach until after the year 2000. Differential response was seen as a way to bring the voices and commitment of families into safety planning for their children. At that time, both differential response and family involvement approaches, like family group conferencing, were seen as strategies rather than an agency-wide way of practice, as they are viewed today.

Processes such as family group conferences, case planning conferences, and rapid response case planning conferences are consistent with the differential response systems focus on using the wisdom of the family, partnering with the family, and endeavoring to involve family, kin, and extended family in every aspect of planning and decision making. Family assessment is the preferred response in all situations except for reports of child sexual abuse, licensed facility reports, and egregious or serious harm to a child for which an investigation response is required by legislation.

This agency-wide practice shift of building partnerships with families, focusing on strengths and existing safety factors, and collaborating with other professionals is a principle recognized as paramount to child safety and well-being regardless of which pathway the case has taken.

As shown in Figure 1, there are three family involvement approaches used to support case decision making. The type of conference process used is typically determined by the level of imminent risk and the amount of time available before a decision or plan needs to be made. In

Figure 1. Olmsted County Child and Family Services “Critical Pathways”



*RED - Review, Evaluate, Direct

some of the approaches, such as the family group conference, more preparation time is needed to adequately position the broadest family group to lead decision making.

In Olmsted County, surveys offered to families post-conference as a way of measuring their involvement in case planning showed highly positive results. Ninety-two percent of the family members who participated in a conference reported being able to express themselves, 90% of family members reported feeling as if they were listened to, 89% of family members felt respected, and 89% of families felt part of the solution. Given the emphasis of involving families in case planning as underscored in the Child and Family Service Reviews, these data suggest these conferencing processes as mechanisms to achieve positive outcomes for this indicator.

The following are some examples of how a multitude of family involvement approaches can be used, regardless of the risk level. These are offered to demonstrate the flexibility of the various approaches in meeting families' unique needs.

Front-end agency involvement, moderate risk of harm. Social services receives a report from a teacher concerned for a diabetic student who is not receiving her insulin regularly. A family group conference could be convened to bring together the child's family and support system to hear information and develop a family-driven plan to meet the child's ongoing medical needs.

Front-end agency involvement, high risk of harm. A rapid response case planning conference could be called within hours of a baby being born, with both the infant and the parents testing positive for an illegal substance. Family, medical personnel, law enforcement, and social services would gather to develop safety plans in order for the baby to be discharged from the hospital and, if possible,

remain safely in the family. This could be followed by a family group conference, where the extended family is engaged more fully in decision making, at a point where a crisis is not propelling the need for an immediate decision or to further develop a safety plan.

Midway agency involvement, high risk of harm. A family group conference could widen the circle of support and develop concurrent plans when a child is placed outside of her home. After hearing relevant information from service providers and resource persons, the extended family would plan for reunification and creating lifelong connections for the child, including placement possibilities, creating as many alternative plans as possible.

Midway agency involvement, moderate risk of harm. Ongoing case planning conferences could be held monthly to pull together family, financial workers, and social services to coordinate services for a family that is working toward self-sufficiency.

Closing of agency involvement, high risk of harm. After termination of parental rights, a case planning conference or family group conference may be organized to pull together biological and adoptive family and service providers to determine strategies to assist the child in the transition to adoption.

Future Directions

Differential response and family involvement approaches are still sometimes viewed within the U.S. child welfare sector as a team or specified program delivering a different type of child welfare services. Family involvement approaches impart full consideration of the family perspective and knowledge in child welfare decision making across the length of a case, regardless of whether the family has gone through the investigative or assessment process, or has been served preventively through a family support pathway.

The authors suggest that a shift is required so that these complementary reforms are viewed more as organized sets of attributes, or a way of organizing the agency function which leads to the agency's provision of services. The attributes of differential response and the need to use processes that involve families in decisions are not unique to low-risk cases, but are also applicable to high-risk cases.

The goals of family involvement approaches will likely vary based on the differential response pathway in which the family is being served, which is connected to the level of safety and risk concern. For example, for families served through the family support pathway (screened-out cases, prevention), the purpose of the family meeting would be to generate informal and formal resources and supports, both at the family and community level, with the intention of meeting the family's needs to decrease the likelihood of rereports. For those families served through the family assessment pathway, the goal of the family meeting mirrors that of meetings that occur in the family support pathway. In addition, at these meetings, risk and safety assessments and comprehensive case plans are developed collaboratively. Families served through the investigation pathway are typically those with the highest level of identified risks. Given the complexity of the issues presented by these families, the knowledge, resources, and wisdom of the broader family group is essential to comprehensive decision making. A significant investment in finding family members and preparing the family group is not only beneficial to producing positive outcomes for the children and their families, but also essential to ensuring

that these children do not languish in the foster care system, where too many children experience multiple moves and leave foster care without any permanent connections. Clearly, when family meetings are implemented throughout the

different pathways available in a differential response system, this becomes a way of practice with children and families, rather than a uniform and specified program for a particular type of case or client population.

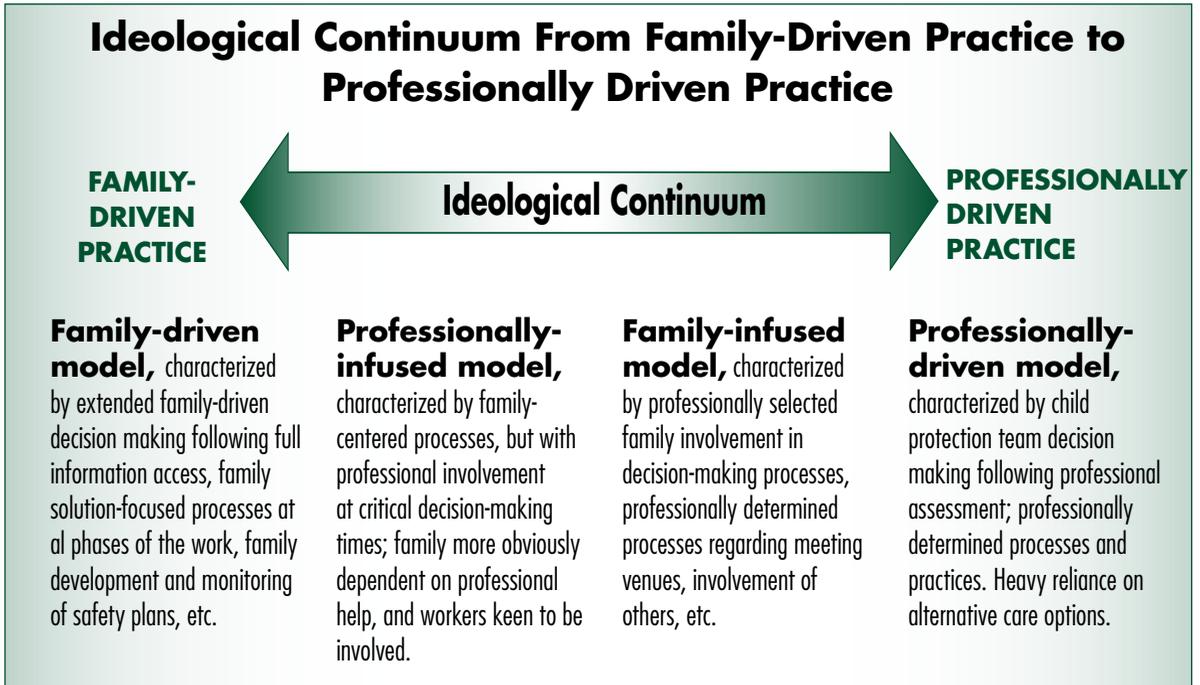
The goals of family involvement approaches will likely vary based on the differential response pathway in which the family is being served.

Yet, with the plethora of family involvement

approaches used in child welfare systems, it is important to reflect on an ideological continuum to assess the level of authentic engagement and voice of the extended family system in decision making, under all differential response system pathways. Connolly (2004), as shown in Figure 2, describes an ideological continuum from family-driven practice to professionally driven practice. Family-driven models, like family group conferences, demonstrate family leadership and are characterized by decision making that is conceptualized and implemented by the extended family. The family group arrives at a decision within a context of organizational support that provides full access to relevant information, a coordinated family solution-focused process at all phases of the work, recognition of family development issues, and oversight of safety plans. At the other end of the ideological continuum, professionally driven models tend to limit family involvement to minimal family group participation in a process that is orchestrated and dominated, either overtly or covertly, by professionals.



Figure 2. Connolly's Continuum from Family-Driven Practice to Professionally Driven Practice



(Connolly, 2004).

In the United States, professionally driven, family-infused processes dominate the landscape, compromising the opportunity for the wider family group to be positioned as leaders or full partners in decision making. Given the core, shared value of extended family involvement in both of these reforms, how can differential response systems be organized to maximize family involvement and leadership? At what point on the Connolly continuum will differential response architects and system reformers be satisfied that they have achieved family leadership? Will the intensity of family involvement and leadership depend on the differential response pathway in which the family is served? Moving into the future, these are a few of the questions that child welfare system professionals, in partnership with families, can wrestle with as they pursue the implementation of differential response and family involvement approaches as significant reform measures.

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Six Principles of Partnership: Building and Sustaining System-Wide Change

Daniel P. Comer and Deborah Vassar

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Is partnership possible? How does the child welfare system share power with families, and what does that look and feel like? Is partnership the same as collaboration? Partnership is indeed possible, although difficult, to achieve and maintain. No matter the difficulty, the benefits are well worth the effort for individual families, workers, and the child welfare system itself.

In 2000, when the North Carolina Division of Social Services adopted six Principles of Partnership as the philosophical and practice foundation for the Multiple Response System (MRS) reform, most system professionals engaged in MRS supported the notion that better partnership with clients should be the focus for the dual track approach. The North Carolina Division of Social Services soon realized, however, that for this reform to be successful, a more sincere partnership had to occur within *every* level, including state, county, community, and agency, *and* with the people served.

The six Principles of Partnership are:

1. Everyone desires respect
2. Everyone needs to be heard
3. Everyone has strengths
4. Judgments can wait
5. Partners share power
6. Partnership is a process

Appalachian Family Innovations originally created the principles as the foundation for a county-wide social service agency effort to improve communication, collaboration, and morale, both internally and externally, with the agency's community partners. These principles created a common language, benchmarks, and an easily understood belief and behavior system that permeated the county agency and its work at all levels. Because of the inherent power and flexibility of the Principles of Partnership, they have now been incorporated as part of the statewide child welfare system reform effort in North Carolina. These principles continue to become infused throughout the human services field in North Carolina.



The Multiple Response System in North Carolina

The following four paragraphs are excerpted from “National Study on Differential Response in Child Welfare” (Merkel-Holguin, Kaplan, & Kwak, 2006, pp. 49-50).

The primary driving force that led to the creation of the Multiple Response System (MRS), the name given to the statewide reform effort, was the dual focus of North Carolina’s family support and child welfare system and its 100 county Department of Social Services partners to ensure safe, permanent, nurturing homes for children while improving the lives of their families.

In May 2005, the North Carolina general statutes were revised to statutorily define a “family assessment response” and an “investigative assessment response.” This revision effectively allowed all 100 county departments of social services to implement the MRS in their counties. The revised statutes were fully implemented in January 2006.

In both tracks, the family actively participates in the completion of a series of structured decision-making tools that provide a comprehensive evaluation of the family’s strengths and needs. These strengths and needs, as well as the child’s safety and risk for future maltreatment dictate service provision.

MRS provides a system that (1) engages families in their own assessments and service planning; (2) provides for consistency of decision-making in all service areas, by all social service agencies throughout the state; (3) addresses the underlying needs of individual families as well as the reported incident; (4) uses existing personnel and fiscal resources to their greatest capacity; (5) accurately identifies a family’s unique needs and provides the necessary services as quickly as possible; and (6) provides for community and interagency collaboration.

Multiple Response System Implementation

Multiple Response System implementation represented a concerted effort to reform child welfare by the individual county departments of social services, and the North Carolina Division of Social Services and its partners, including the North Carolina Association of County Directors of Social Services, universities, private agencies, and child advocates.

North Carolina’s model of a dual track system is designed to result in systemic reformation through an integration of seven key strategies:

1. A strengths-based structured intake process
2. A choice of two approaches to accepted reports of child abuse, neglect, or dependency
3. Coordination between law enforcement agencies and child protective services for the investigative assessment approach
4. A redesign of in-home services
5. Implementation of child and family team meetings during the provision of in-home services
6. Implementation of shared-parenting meetings in child placement cases
7. Collaboration between the Work First Family Assistance and child welfare programs

Appalachian Family Innovations (AFI), as a member of the North Carolina statewide training collaborative, was involved in the development and implementation of MRS reform efforts in the state. During the development process, it became clear how the six Principles of Partnership could lead to more effective family-centered practice and could serve as the guiding framework for how child protection workers could not only better serve their cases, but also aid in the implementation of these seven strategies for systematic reform.

Training Plan

Four years prior to North Carolina's multiple response system implementation, a county department of social services director requested that Appalachian Family Innovations provide teambuilding and collaboration training for the entire agency.

The original curriculum was designed to embody a set of beliefs that when put into actual practice would lead to improved relationships and outcomes for all levels. The six Principles of Partnership were the building blocks created to achieve this outcome. The participants were asked to explore how they could improve utilizing each principle with clients, co-workers, supervisors, the director, and the community partners with whom they work.

While training for the multiple response system was designed to meet the complex needs of line staff, supervisors, and program administrators, it also may serve to assist other agency programs and their county partners as they strive to implement family-centered practice.

Training Implementation

After the training collaborative assessed the training needs for the multiple response plan initiative, a series of courses was designed for various audiences, including the community as a whole, agency supervisors and management, and front-line workers. The six principles served as the foundation, or cornerstone, for each class:

- *Cornerstone One: Multiple Response is System Reform* – Key strategies for the future of child welfare in North Carolina
- *Cornerstone Two: What's Good for Families is Good for Workers* – Training for child welfare supervisors

- *Cornerstone Three: Partners in Change* – A new perspective on children's protective services
- *Cornerstone Four: Working with Others, Working with Outcomes* – Training for supervisors

A 4-day training was held, spread out over several consecutive weeks, until all employees had completed the curriculum. The intervention included a "transfer of learning" component that involved supervisors talking about the six principles at staff meetings, bulletin board reminders of the principles, website listing of the principles, and newsletter articles about "seeing the principles in action." Employee comments were encouraging and enlightening:

- "We now have a common language."
- "I never knew that what I was doing/saying felt disrespectful to someone else."
- "Since I'm looking for strengths, I no longer feel like I'm burning out."
- "I'm seeing my co-workers *and* clients with new eyes."
- "The principles are easy to remember but difficult to do – it's a challenge."
- "We thought we were already acting this way – being respectful, nonjudgmental, but realize through the training that we have a lot of work to do."
- "When I give my attention to these principles and actually practice them, I see magical things happen."
- "My partnerships at home with my spouse and children have improved."

The AFI consultants knew that this intervention would have died without the continued effort of management keeping the momentum alive, but



Figure 1: Respect Ideas: Suggestions for Working Respectfully with Families**Suggestions for Working Respectfully with Families**

- Use family-friendly, everyday language, a soft tone, and neutral words. Listen for the way the family talks – the words they use to describe their problems. Try to match the language of the family when appropriate. If they say their son is “too rowdy in school” use their terms instead of professional jargon.
- Give honest, factual answers. Be upfront about what you and the agency expect from them. Tell them what requirements you will make of them and give them time estimates for completion. If you do not know an answer, say so, but also agree to find out the answer.
- Acknowledge upfront that no matter why they have come in contact with social services (voluntarily or not), they may feel very uncomfortable about being here. Assure them that you will do everything in your power to minimize their discomfort.
- Inform the family of the policies regarding consent and confidentiality, have them sign appropriate release forms, and assure them you see confidentiality as a high priority.
- Be willing to apologize to the client for any mistake or misunderstanding on your part or by a social worker who preceded you. It takes strength and confidence to apologize. Paradoxically, apologizing gives you power in the relationship. You can be a powerful role model by accepting responsibility and apologizing for a mistake.
- If a client becomes agitated, acknowledge his or her feelings, maintain a polite and respectful attitude, do not take angry statements personally, and ask for the client’s recommendations for answers or changes.
- If you work with a family from another culture, try to learn about their customs, rituals, methods of parenting, etc. Show respect by asking them to teach you. You can also ask co-workers to educate you and read pertinent literature to strengthen your knowledge and help you avoid alienating your client.
- Be aware of whether a client maintains eye contact. In some cultures it is disrespectful to look someone directly in the eye. Give the client an opportunity to turn away.
- Ask the family for their opinions, their description of the problems, and what they would like to change or improve. Ask them for possible solutions, what has worked in the past, etc.
- Keep in mind that family members are the experts in the family. Ask the family to teach you about the family, to work with you to find solutions, and to tell you when your suggestions will not work for them.

also realized that the creation of the six principles had struck a chord within this particular department of social services. Consultants were asked to return the next year for a 1-day refresher course to deepen the understanding and implementation of the six principles. This practice has continued annually to this date, as an effort to keep the Principles of Partnership in focus for all employees at this county agency.

Cornerstone Three

Even though all the Cornerstone classes are based on the six principles, *Cornerstone III: Partners in Change* is specifically designed around each principle. In each module of the class, the trainer actively demonstrates the principles from the warm-up to the application plan. Though trainers mention the positive impact of partnering with co-workers, other units, supervisors, and the community, the emphasis in this class is on partnering with client families.

The training uses what AFI calls an “inside-out” approach. In this training, each activity and exercise is designed primarily to allow participants to see, and more importantly, *feel*, at an internal, personal level, the effects of each of the six principles. Then, participants discuss how the principles of partnership can be applied externally to their clients, practice the use of new “tools,” and develop a personal plan on how they want to more deeply apply the concepts in their daily work. This approach follows the experiential learning model of concrete experience, reflection, abstract conceptualization, and application.

A variety of active and passive learning methods are used throughout the training. These include structured warm-ups and closings, “fish bowl” practice sessions, questionnaires, reflection, readings, video clips, case studies, scaling, and many forms of hands-on activities.

Participants are encouraged to take risks and stretch their learning styles as well as their ideas and beliefs. Realizing that risk-taking may be difficult, trainers set the stage for safety at the very beginning of the training and continue to ensure safety throughout the class.

Every component has an underlying theme and recognition of parallel process (modeling what you teach as you teach it). The recognition that client families experience events in similar ways or have similar feelings as the training participant often leads to a deeper understanding of client families and of the benefits of partnership, and thus, to a change in worker beliefs and behavior.

Although not a policy class, the first day of the training includes a brief background of the state’s multiple response system reform and the resulting shift toward partnership with families. This background includes the vision, beliefs, and strategies of the family assessment approach to child protective services. During the remainder of the first 2 days, participants explore the Principles of Partnership in depth. The third day’s focus is on skills practices using actual child protective services cases, in which participants practice the application of the tools and the new approach to families.

Even though many participants are inhibited by, or even dread, role plays, the AFI version has received praise for both its comfort and applicability to the actual work that a child protective services case requires. The skills practices, which take up the majority of the third day, are carefully designed to create a level of safety and willingness in participants to take risks, stretch, and try a new way of working.

The following is a brief overview of the modules for each specific Principle of Partnership.



Everyone Desires Respect

All people have worth and a right to self-determination and to make their own decisions about their lives. Acceptance of this principle helps us treat others with respect and honor their opinions and worldview.

The experiential activity called, “The Symbol,” calls for participants to make a personal symbol out of clay or dough. After making their symbol, participants exchange seats with another participant and are requested to change the symbol where they are now sitting by “making it better,” or “improving it.” When participants reflect on the activity afterward, they discuss their feelings about leaving their symbol in someone else’s hands, improvements made to their symbol, improving someone else’s symbol, and the parallel process of how this experience is like working with their clients. Participants are generally surprised at the intensity of their feelings about their clay symbols and how the instruction to “change someone else’s symbol,” affected them. This act of perceived improvement or change may have felt invasive and intrusive and to change someone’s symbol without talking to them and asking permission was disrespectful. Participants may conclude that these feelings are the origin or birthplace of respect. Trainers and participants create the “Respect Ideas” list as one of the tools for this module (see Figures 1 and 2 for examples).

Everyone Needs to Be Heard

This principle asks us to “seek first to understand” and is accomplished primarily through empathic listening. Empathic listening is motivated by the listener’s desire to truly understand another person’s point of view, or enter that person’s frame of reference, without a personal agenda. When one feels heard and understood, defensiveness and resistance begin to melt away and it becomes easier to look for solutions.

Figure 2: Respect Ideas Specific to Home Visiting

Showing Respect When Home Visiting

- When you schedule the initial home session, ask, “When would be the most convenient time to meet between now and _____ (indicating your time frame)?”
- Set the tone of the home visit so that it is friendly, positive, polite, and supportive. Assume you are accepted; be casual and relaxed. Family members will likely take their cues from you.
- Enter the client’s home as a guest, and show the same respect and courtesy you would want guests in your home to show you. Introduce yourself in a friendly manner and ask to be introduced to every person in the home.
- Use clients’ names to personalize and humanize the interaction, but do not use the parents’ first names unless they invite you to do so. Try to begin building a positive, supportive relationship with everyone in the family.
- Ask where they want you to sit. Avoid taking someone’s favorite chair. Observe the seating arrangement of the family members; this may give you some insight into family relationships, roles, and hierarchy.
- Be aware of physical proximity to clients, especially when the client is anxious. Being too close may escalate the client to aggression. Also, be sensitive of physical distance and body language with people from other cultures.
- While it is tempting to try to control such distractions as TV, telephone, children, or neighbors coming in and out, these elements can reveal much about the family routines, relationships, and the home atmosphere. It is always important to respect the family’s choices regarding the operation of their own home.

In this module, the focus is on the intention of the listener. According to Stephen Covey (1989), everyone has a powerful need to be not only heard but also understood. In fact, most people, including ourselves, are unwilling to listen unless we feel we have been understood first. So for partnership to occur, there must first be the intention to put aside our own agenda(s) and concentrate on seeking to understand our client (or any other partner) first. By using a video example, participants discover how our intention to understand creates a different set of questions than if we are following our own agenda, and that it is the questions we ask that determine if our partner will feel understood.

Once someone does feel his or her own view has been acknowledged, he or she becomes more willing to hear our ideas (agenda), and our work is accomplished much more quickly. Using video clips and practice sessions, participants learn how the tool, “seeking first to understand” can be accomplished by inquiring to learn, paraphrasing, and acknowledging feelings. Parallel process is a key point in this module and participants understand that frustrations with both client and worker are the same. Practice sessions reveal an additional realization: taking the time to seek first to understand does not take that much time.

Everyone Has Strengths

All people have many resources, past successes, abilities, talents, and dreams that provide the raw material for solutions and future success. However, others’ problems sometimes can become a filter that obscures the ability to see strengths. Acceptance of this principle does not mean that we, as social services workers, ignore

When one feels heard and understood, defensiveness and resistance begin to melt away and it becomes easier to look for solutions.

or minimize problems; it means that we work to identify strengths as well as problems so that we have a more balanced and hopeful picture of the present and future.

Because the term “strengths-based” has long been used and emphasized in human services work, participants often say

that this is one principle that they practice fairly well. Therefore, the focus for the third module is to demonstrate how clients’ issues are often overpowering, and their problems drive our search for the intervention instead of allowing the specific family strengths and needs to drive the intervention. Participants generate a list of “ways to find strengths,” and with the use of a case study, practice using strengths to address the problems and concerns of the family. Participants also practice the art of asking exception-finding questions. These questions imply that the client already has the skills necessary to do something in a more successful way, and by exploring the questions in detail, clients are often able to discover their own strengths.

Judgments Can Wait

Once a judgment is made, people have a tendency to stop gathering new information or interpret new information in light of the prior judgment. Since a case worker’s judgment can have an immense impact on another’s life, it is only fair to delay judgment as long as possible, then to hold it lightly while remaining open to new information and willing to change our minds. Acceptance of this principle does not mean that decisions regarding safety cannot be made quickly; it simply requires that ultimate judgments be very well considered.



In this module, while reading case studies and viewing video clips, participants personally experience the swiftness of their judgments as they immediately look for reasons and solutions, often without asking any questions. The tool “not-knowing stance” reminds participants to slow down and ask, “what else could it be?” and “even though it looks this way or sounds this way, could it be something else?”, and acknowledge, “I really don’t know what happened.” The reasons for our quick judgments – time pressure, caseloads, paperwork, and personal prejudices – are examined. The second tool taught in this module, scaling questions (questions which ask a person to rate something on a scale), also assists in delaying judgment. Similarly to the exception-finding question in which clients discover their own strengths, when clients answer scaling questions they are self-evaluating and assessing their situation. Because of the versatility of scaling, the questions can be used as an assessment tool, to set goals, to evaluate the usefulness of a resource, and to measure progress.

Partners Share Power

Power differentials create obstacles to partnership. The person with the perceived power may need to step forward and initiate a conversation with his or her partner or friend to discuss the balance of power and together find ways to share the power.

Power differentials are a roadblock to partnership inherent in the work of a child protective services worker. In this module, participants engage in an experiential activity with personal reflection and a discussion on trust, connections, communication, caretaking, creativity, dependence, independence, and lessons learned. Lists are generated on ways to share power and participants are often surprised at the simplicity and power of ideas such as suggesting to clients that they include notes in

their files, asking clients for their suggestions, allowing the client to be the expert, and asking instead of telling. When there is a power differential, the person with the perceived power is the one with the responsibility to initiate the equality status. And as with all the other principles, the desire and intent has to be present first. Participants discuss and list reasons why this kind of relationship is the vehicle that helps move the client family in a helpful direction. Child and family team meetings, where families name their own resources (often informal services) and generate their own plans, are explicit examples of sharing power.

Partnership Is a Process

Even though each principle has its own merit, all of the principles are necessary for partnership. Each principle supports and strengthens the others.

The experiential activity “try another way” reminds participants that successful partnerships take patience, communication, skillful use of all the principles, and constant attention. Without effective communication, looking for strengths, delaying judgments, sharing power, and being respectful of partnerships are ineffective. The six principles appear easy and we often think or say that we “do all this already.” If a worker accepts this kind of thinking, he or she is likely to lose the necessary focus on the partnership. Consistently applying the principles is difficult and requires both intention and attention. Participants in this module generate lists on creative ways to keep the principles in mind.

Expansion of the Training

The six Principles of Partnership are truly universal principles, applicable to any type of partnership. They have almost taken on a life of their own in North Carolina, spreading across



all levels of child welfare administration from the state level to individual counties, and are beginning to provide a framework and language for good practice in other systems as well.

All four Cornerstone trainings, though designed for different audiences, are based upon the Principles of Partnership and how those particular audiences can improve the partnerships required in that setting. In addition to the Cornerstone series, the North Carolina Division of Social Services has incorporated the principles into preservice training for all social work staff. Perhaps most reflective of the state's awareness of the significance of parallel process, AFI has also designed and facilitated a curriculum based upon the principles for state-level administrative staff to improve their relationships both internally and with their partners at the county level. Most recently, the state has asked AFI to adapt training specifically for all employment services and eligibility staff across the state.

Other county social service agencies continue to use AFI to provide collaboration and teamwork training based on the Principles of Partnership, for reasons similar to why the principles were developed in the first place. The six Principles of Partnership have come full circle as a result of their universality, applicability, and "simple complexity." Outside of North Carolina, programs in Idaho, Washington, and Calgary have received training on the Principles of Partnership from AFI staff.

The Impact of a Training Curriculum

The return on investment of any training program, in any industry, is difficult to determine. This may be even truer in human services training because behavior change, especially in "soft skills," is notoriously difficult to measure. Yet behavior change, or a new way of practice,

is exactly the expected impact of a training curriculum. So, perhaps the best that can be done, without an unlimited supply of money and time, is to design and facilitate training using known and tested methods that are most likely to lead to "real change" in the workers and in the system itself.

The Principles of Partnership and all training designed and facilitated by AFI that support the Principles is based upon methods of curriculum design which motivate behavior change. The key components are a common structure and language (the principles); a respectful, safe training environment, acute awareness to parallel process, experiences that allow participants to make emotional connections to the material, opportunities for reflection and application of all main teaching points or tools, skills practice, and adherence to the most powerful techniques known to increase transfer of learning from the classroom to the real world of work. With the training evaluations indicating that the participants learned something new and have plans to behave or work differently based on their learning, it is evident in North Carolina that careful attention to the training system and curriculum design is paying dividends toward building and sustaining system-wide change.

References

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