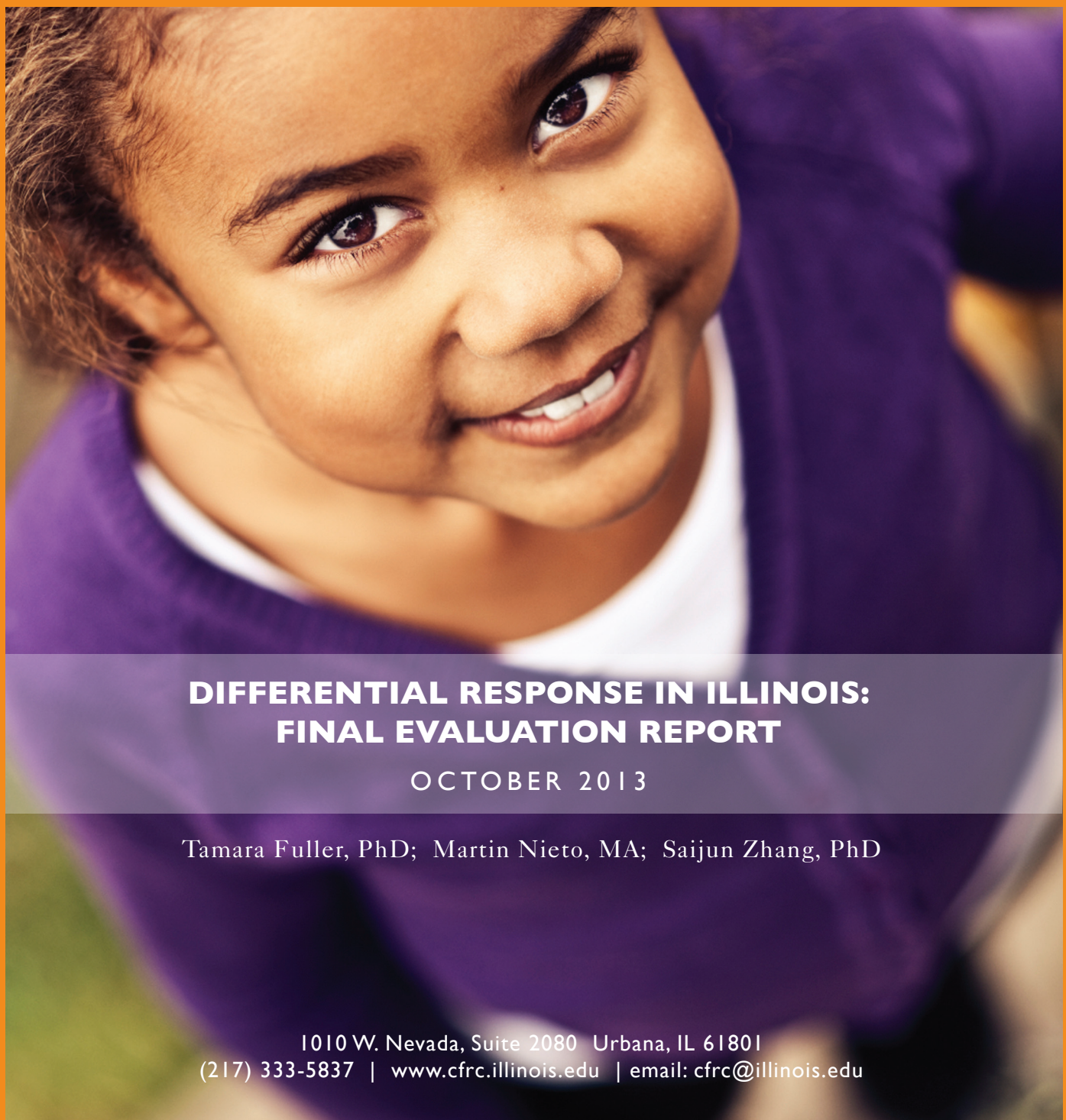
CHILDREN AND FAMILY
| RESEARCH | CENTER

UNIVERSITY OF ILLINOIS | SCHOOL OF SOCIAL WORK



DIFFERENTIAL RESPONSE IN ILLINOIS: FINAL EVALUATION REPORT

OCTOBER 2013

Tamara Fuller, PhD; Martin Nieto, MA; Saijun Zhang, PhD

1010 W. Nevada, Suite 2080 Urbana, IL 61801
(217) 333-5837 | www.cfrc.illinois.edu | email: cfrc@illinois.edu

Differential Response in Illinois: Final Evaluation Report

October 2013

Tamara Fuller, PhD
Director and Research Associate Professor
School of Social Work
University of Illinois at Urbana-Champaign

Martin Nieto, MA
Saijun Zhang, PhD

Submitted to:
Illinois Department of Children and Family Services
Denise Gonzales, Acting Director

Acknowledgements

An evaluation the scope and magnitude of the Illinois Differential Response evaluation does not get completed without numerous individuals and organizations working together in a collaborative manner. The authors would like to take this opportunity to acknowledge the contributions of those who made the evaluation possible.

First and foremost, we wish to acknowledge the parents who participated in the evaluation and generously shared their experiences and time with us. Next, we acknowledge the support of the staff at the Children's Bureau throughout the life of this evaluation, including Catherine Nolan, Dori Sneddon, and Jean Blankenship. In addition, individuals from the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR) and its partner organizations (the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, Walter R. McDonald & Associates, Inc., and the Institute of Applied Research) have provided countless hours of consultation and wisdom related to research methodology and data collection, and made detailed comments on earlier versions of this report that have greatly improved its clarity and impact. We would also like to acknowledge the support and collaboration that developed among the evaluation directors at the three research and demonstration sites (Colorado, Illinois, and Ohio); special thanks to Marc Winokur at the Social Work Research Center at Colorado State University and Julie Murphy, Madeleine Kimmich and Linda Newton-Curtis at Human Services Research Institute for their openness and collegiality over the past four years.

There were also numerous individuals within the Illinois Department of Children and Family Services who facilitated the evaluation efforts or participated in the evaluation in critically important ways. Former DCFS Director Erwin McEwen placed tremendous value on gathering evidence to inform child welfare practice and invested the resources to make the Differential Response evaluation as rigorous as possible. Project Director Womazetta Jones was a champion of both DR and its evaluation from the beginning, and is directly responsible for the successful completion of many of the evaluation's components. Numerous others at the Department, including Deputy Director William Wolfe and his staff, Royce Kirkpatrick and his staff, and former Deputy Director George Vennikandam and his staff all assisted in the evaluation efforts in essential ways.

Very special thanks goes to the DCFS investigators and supervisors, Differential Response (DR) Specialists and supervisors, and Strengthening and Supporting Families caseworkers and supervisors who asssited in the data collection efforts by completing the surveys and reports. The evaluation would not have succeeded without their help, for which they received no compensation other than our gratitude and the hope that its results will improve the lives of children and families in Illinois.

The Illinois Differential Response evaluation is supported by the Illinois Department of Children and Family Services (IDCFS), through a grant from the National Quality Improvement Center on

Differential Response in Child Protective Services, which is funded by the Children's Bureau, Administration for Children and Families (ACF), U.S. Department of Health and Human Services. The findings and opinions expressed in this report do not necessarily represent those of the IDCFS, QIC-DR, or ACF.

Fuller, T., Nieto, M., & Zhang, S. (2013). *Differential Response in Illinois: Final Evaluation Report.* Urbana, IL: Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign.

Table of Contents

Executive Summary

In December 2009, the State of Illinois was selected by the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR) as one of three research and demonstration sites to implement and rigorously evaluate Differential Response (DR). The Children and Family Research Center (CFRC, the Center) at the School of Social Work at the University of Illinois at Urbana-Champaign (UIUC) was chosen by Illinois Department of Children and Family Services (IDCFS) to evaluate the Illinois Differential Response program. This report presents the final findings of the outcome evaluation and cost analyses, which compared the newly implemented family assessment CPS response to maltreatment reports (known as "DR" in Illinois) to the traditional investigation CPS response to answer the following research questions:

1. How is the assessment response different from the investigation response in terms of family engagement, caseworker practice, and services provided?
2. Are children whose families receive an assessment response as safe as or safer than children whose families receive an investigation?
3. What are the cost and funding implications to the child protection agency of the implementation and maintenance of a differential response approach?

Differential Response in Illinois

After DR was implemented in Illinois in November 2010, there were two CPS responses that were available for screened-in reports of child maltreatment: an investigative response (IR) and a non-investigative response known as differential response (DR). However, only a very small subset of screened-in reports (about 8%) was eligible to receive DR in Illinois; reports were eligible if they met all of the following criteria:

1. Identifying information for family members and their current address was known at time of report;
2. Caretakers were birth or adoptive parents, legal guardians or responsible relatives;
3. Family had no prior indicated reports of abuse or neglect;
4. Children were not in the custody of the IDCFS or wards of the court;
5. Protective custody had not previously been taken; and
6. Allegations in the current report were limited to any combination of the following: inadequate supervision (children 8 years and older only; not including children with physical or mental disabilities), inadequate food, inadequate shelter, inadequate clothing, medical neglect, environmental neglect, mental and emotional impairment, and substantial risk of physical injuries.

Reports that did not meet all of these eligibility criteria were mandated to receive an investigation response.

Worker practice and service provision differed in substantial ways between the two types of CPS response. Prescripted elements of investigation practice include an initial in-person contact with the family within 24 hours (or sooner if immediate harm to a child is alleged), during which the investigator is required to interview every alleged victim in the household (out of the presence of the caretaker and alleged perpetrator, if possible) as well as the alleged perpetrator and other adult members of the household. Investigators complete a structured safety assessment within 24 hours of interviewing the alleged victims and must decide whether they can remain safely in the home or are in immediate danger of moderate to severe harm and require a safety plan or protective custody. Within 60 days of the report, investigators make a determination about whether the available evidence suggests that abuse or neglect occurred, and the report is either indicated (i.e., substantiated) or unfounded (i.e., unsubstantiated). Families with indicated reports can be referred by the investigator to informal community resources for services, or can be referred to formal child welfare services, which can involve in-home "intact family" services or out-of-home "placement" services.

In contrast to investigation practice, families provided with a family assessment response (DR), received an initial in-person visit from a paired team of workers, a DR Specialist employed by IDCFS and a Strengthening and Supporting Families (SSF) caseworker employed by a private agency through a purchase of service contract with IDCFS. During the initial home visit, which was scheduled with parents in advance via telephone, the DR Specialist assessed child safety using the same structured safety assessment instrument used by investigators. If there were no immediate safety concerns, the SSF caseworker explained to the parents that participation in DR services was voluntary and described the program to parents. Families could either decline services without consequence or agree to participate in services and work with the SSF caseworker to develop and implement a service plan (the DR Specialist did not have continued contact with the family after the initial visit). SSF caseworkers met with families twice a week to provide a mix of services based on their individual needs for a period of up to 90 days. In addition to these supportive services, cash assistance up to $400 was available to families. Families receiving DR services could be reassigned to an investigation at any time if the DR Specialist or SSF caseworker believed that a child was being maltreated or was at risk of harm. In addition, if an additional maltreatment report on the family was accepted at any point during assessment or service provision, the DR case was immediately closed and an investigation was opened.

Evaluation Design and Methodology

The Illinois DR evaluation used an experimental design in which families with screened-in maltreatment reports who met the eligibility criteria for DR services were randomly assigned to the treatment group (DR) or the control group (investigation/IR). All eligible family reports within the State of Illinois were included in the evaluation. Random assignment of families began on November 1, 2010 and ended on May 22, 2012; during this period, 7,584 families were randomly assigned to either DR (3,101 or 41%) or IR (4,483 or 59%). Although slightly over 22% of the families that were randomly assigned to DR were switched to an investigation

due to safety concerns or new maltreatment reports at some point during their initial case, the analyses in this report (other than the cost analyses) used an intention-to-treat (ITT) approach in which all families randomly assigned to the treatment group, regardless of whether they received it or not, are compared to all families randomly assigned to the control group. In the current study, this means that outcomes for the 3,101 families that were randomly assigned to DR are compared to outcomes for the 4,483 families assigned to Investigations, despite the fact that 22% of the 3,101 families assigned to DR were switched to an investigation at some point after case assignment.

Three primary sources of data were used in the evaluation. Administrative data from the Illinois Statewide Automated Child Welfare Information System (SACWIS) were collected to measure family demographics, safety assessments, and subsequent maltreatment re-reports, substantiated re-reports, and child removals. A case specific report was completed by DR and IR workers at the conclusion of each case and contained information on family needs, services and referrals provided to the family, and ratings of family receptivity, cooperation, and engagement (see Appendix B for a copy of the measure). A family survey was also distributed to parents at the conclusion of the case; it contained questions about the parents' satisfaction with their caseworker and the help they received; their emotional response to the first visit and relationship with their worker; their engagement with their worker; the services they received and the helpfulness of those services; and their assessment of their families' well-being after services.

Parent Perceptions of Child Protective Services

On the family survey, parents responded to several questions related to their CPS experience. Although the low response rate for the family survey suggests that the results should be interpreted cautiously, there were significant differences between the responses of parents who received an investigation and those that received a DR family assessment on nearly every measure included in the parent survey. Compared to parents who received an investigation, significantly higher percentages of parents who received DR reported feeling hopeful, comforted, encouraged and thankful after their initial visit with their worker; and significantly smaller percentages of parents who received DR reported feeling angry, worried, stressed, disrespected, and discouraged. A significantly higher percentage of parents in the DR group, compared to those in the investigation group, reported that their worker listened to them very carefully, that their worker understood their families' needs very well, and that their worker always considered their opinions before making decisions that concerned their families. In addition, parents who received DR reported significantly higher levels of engagement with their worker and satisfaction with services and their overall experience compared to those that received an investigation.

Service Provision

There were large differences in the amount and types of services that were provided to families during the initial DR or investigation service period, although these differences were not surprising given the fundamentally different DR and investigation practice models in Illinois. DR cases had a mean duration of 55.6 days, which was slightly but significantly longer than the mean duration of the investigations. According to both worker and parent reports, families in the DR group were more likely to receive at least one service during their initial case when compared to parents in the investigation group. They also received a greater number of services, and were more likely to receive most of the individual services listed on the parent survey, such as car repair or transportation; housing assistance; food or clothing; appliances, furniture, or home repairs; help paying utilities; welfare/public assistance services; medical or dental care; other financial help; help for a family member with a disability; legal services; assistance in the home such as cooking or cleaning; help getting mental health services; parent support groups; help getting educational classes; counseling; help looking for employment; and educational services. Parents in the DR group were significantly more likely to report that the services they received were the kind they really needed and enough to really help their families. Although families in the DR group were much more likely to receive services during their initial case, families in the investigation group were significantly more likely to receive formal child welfare services (e.g., intact family services) after the initial case was closed.

Child Safety

Within the context of the current evaluation, child safety was measured as the percentage of families that experienced maltreatment re-reports, substantiated maltreatment re-reports, and child removals from the home subsequent to the initial DR or investigation case closure. Using the ITT approach in which all families randomly assigned to DR were compared to all families randomly assigned to investigation, survival analyses revealed higher accumulated risk of a maltreatment re-report and substantiated re-report during the 18-month follow-up period for families in the DR group. There were no differences between the two groups in risk of child removal during the 18-month follow-up period.

However, because almost a quarter of the families that were randomly assigned to the DR group were switched to investigation after random assignment, additional survival analyses were conducted that compared the child safety outcomes among four mutually exclusive subgroups of DR families created based on their DR service experience:

- DR “switchers” consisted of families that were randomly assigned to DR but were switched to an investigation due to either safety concerns or a new maltreatment report (n=718). These families did not actually receive DR services (or received very little) and did receive an investigation.
- DR “refusers” were those families that declined DR services after the initial meeting and safety assessment with the DR caseworker (n=590). These families did not receive any DR services nor an investigation.

- DR "withdrawers" were those families that were offered and initially accepted DR services but then voluntarily withdrew before services were complete (n=322).
- DR "completers" consisted of families who accepted and completed the DR services outlined in their service plans (n=1,389).

When the cumulative risk of a first re-report was examined among these DR sub-groups, both the DR switchers and DR withdrawers had significantly higher cumulative risk than families that received an investigation, but risk of re-report among families that refused DR services were similar to that of investigated families. A similar pattern emerged when the cumulative risk of a substantiated re-report over the 18-month follow-up period was examined: the families who withdrew from services before completion and who switched to an investigation were at significantly higher cumulative risk compared to investigated families, while families that refused or completed DR services were not significantly different from investigated families. Examination of the risk of child removal over the follow-up period revealed that the families that switched from DR to IR had significantly higher risk of child removal compared to all the other DR subgroups and families that were investigated.

Cost Analysis

A cost analysis was completed that examined and compared the average total cost of serving a family through DR and through an investigation, both during the initial case and during a standard follow-up period. Due to the difficulty of obtaining cost data for the entire sample, 400 cases (200 DR and 200 IR) were randomly selected for the cost analysis; DR cases that immediately switched to an investigation and did not receive DR services were ineligible for selection into the cost analysis sample. Costs were divided into two time periods: initial case costs were those that occurred between the initial report date and through the initial DR case or investigation close date OR the date that the case is transferred to ongoing child welfare services, whichever happens first; and follow-up costs were those that occurred the day after the initial case period through 365 days after the initial report.

Two types of costs during the initial case were examined: the costs of the worker's time spent on direct services to the family and the costs of services provided to the families that were paid for by the Department. Costs not included in the analysis include those associated with supervisors' time, caseworker time associated travel and case documentation, and services provided to the family through agencies other than IDCFS (e.g., services provided through the school or other public or private agencies). On average, DR cases had slightly higher costs of worker time during the initial case as well as higher direct services costs, which resulted in higher overall initial case costs. In addition, DR cases had slightly higher costs associated with subsequent investigations during the follow-up period when compared to investigation cases. However, the DR cases in the cost analyses had significantly lower costs associated with intact family services and placement services during the follow-up period. When the initial and follow-up costs for the DR and investigation cases were combined, the magnitude of the costs for child welfare services among the investigation cases during the follow-up period led to significantly higher overall costs for these cases compared to DR cases.

Chapter 1: Introduction

In August 2009, the Illinois General Assembly enacted the Illinois Differential Response Program Act (Public Act 096-0760), which amended the Illinois Children and Family Services Act and the Abused and Neglected Child Reporting Act and gave the Illinois Department of Children and Family Services (IDCFS; the Department) the authority to implement a 5-year demonstration Differential Response (DR) program. This legislation outlined the core elements of the DR program and required an independent evaluation to determine whether it was meeting the program goals outlined in the Act. Shortly after, in December 2009, the State of Illinois was selected by the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR) as one of three research and demonstration sites to implement and rigorously evaluate DR. The Children and Family Research Center (CFRC, the Center) at the School of Social Work at the University of Illinois at Urbana-Champaign (UIUC) was chosen by IDCFS to be the evaluator for the Illinois Differential Response Evaluation. The Illinois evaluation has three major components:

1. A process evaluation, which examines the DR program that was designed and implemented in Illinois; agency practices that were put into place to institute and maintain the program; attitudes of agency staff toward the program; and community involvement during the design, implementation, and sustainability phases. Detailed findings of the process evaluation can be found in the *Differential Response in Illinois: 2011 Site Visit Report*, which is available on the Children and Family Research Center website.[1]

2. An outcome evaluation, which examines the characteristics of the families and children who were assigned to the experimental (DR) and control (investigation response or IR) groups; the amount and types of service that they received; and the outcomes – both initial and intermediate – that result from their receipt of these interventions. The current report presents the results of the outcome evaluation.

3. A cost analysis, which provides a comparison of the average cost incurred for serving a family in the investigation and DR pathways during the initial service period and during a follow-up observation period. The methodology and results of the cost evaluation are presented in Chapter 7 of the current report.

This introductory chapter describes the goals and practices associated with both traditional child protection services (CPS) systems and those that have implemented DR. The practices described in this chapter are generalized across systems and not descriptive of CPS and DR practices *in Illinois*, which are described in detail in the following chapter. This chapter also provides a brief summary of prior DR outcome evaluations. Both of these topics have been extensively covered in other sources, including a literature review conducted by the QIC-DR

[1] http://cfrc.illinois.edu/pubs/rp_20120327_DifferentialResponseInIllinois2011SiteVisitReport.pdf

(National Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR], 2011)[2] and a book chapter on Differential Response in the *Handbook on Child Maltreatment* (Fuller, in press). Readers wishing for a more comprehensive review of the history of DR, the different DR practice models that have been implemented in the United States to date, or the results of previous DR evaluations are encouraged to obtain and read these resources.

Subsequent chapters of this report will more thoroughly describe the DR program that was implemented in Illinois (Chapter 2), the evaluation methodology and sample (Chapter 3), differences and similarities in caseworker approach and family engagement (Chapter 4), service provision (Chapter 5), and child safety and family well-being (Chapter 6) of families who receive DR and IR, the cost analyses (Chapter 7), and the implications of the findings (Chapter 8).

A note about terminology: The term Differential Response was originally used to refer to a child protection system with more than one response track and it is still used in this context within child welfare and in this report. In some States that have implemented DR, including Illinois, the term "DR" is also used to refer to specific practice in the non-investigation pathway that is added to the child protection system. For instance, families in Illinois were randomly assigned to either the DR or Investigation Response (IR) pathways, caseworkers were known as DR workers, etc. The current report adopts this vernacular and refers to the non-investigation pathway *in Illinois* as DR and the investigation pathway as IR. However, when discussing non-investigation CPS practice *in general*, the more commonly-used terminology of "family assessment response" or "assessment response" is used.

1.1 An Overview of Traditional and Differential Response CPS Systems

1.1.1 Traditional Child Protective Service Systems

All child protective service (CPS) systems are designed to screen and respond to reports of alleged child maltreatment. Reports are first screened to determine if the allegations meet the State's statutory threshold for a formal CPS response. Until recently in most States, there was only one type of formal CPS response to screened-in reports – a maltreatment investigation. Similar to criminal investigations, traditional maltreatment investigations focus on the collection of evidence regarding specific allegations through interviews with the alleged victims, perpetrators, and collateral informants, in addition to other data collection activities such as physical exams, drug or alcohol assessments, domestic violence assessments, and background checks. An investigator's primary purpose is to determine whether the child is safe in the home and ensure the child's current safety, to determine whether abuse or neglect occurred, whether there is a high risk of future maltreatment, and whether additional services or child removals are necessary. Once sufficient evidence is collected, the investigator decides if the allegations can be substantiated, meaning the credible evidence exists that the abuse or neglect

[2] Also available at www.differentialresponseqic.org

took place.[3] Nationally in 2011, 18.5% of the reports that received an investigation were substantiated (U.S. Department of Health and Human Services [DHHS], 2012).

A number of additional actions may occur when a report is substantiated, although their likelihood of occurrence varies significantly among CPS agencies (DHHS, 2003, 2012). In nearly all States, the names of the maltreatment perpetrators are entered into a central registry so that reports can be tracked over time and used for background checks. Some families receive post-investigation services. Decisions about services depend on a number of factors, including State policy; results of safety, risk, and needs assessments; and local service availability. If there is little to no risk of future maltreatment or few family needs, the case may be closed without services or the family may be provided with referrals to community-based services. If there is moderate-to-high risk of future maltreatment or many family needs, post-investigation child welfare services may be provided to the family. Voluntary services may be provided to the family while the children remain at home, or, if the family refuses to participate, a court petition may be obtained to mandate participation with in-home services. If the child has been seriously harmed or is considered at risk of serious harm, the court may order the child's removal from the home and mandate the family's participation in services. Post-investigation services may be provided to families with unsubstantiated maltreatment reports as well, although this occurs less frequently than among families with substantiated reports. In 2011, 61.2% of the children in substantiated reports in the U.S. received post-investigation services, compared to 30.1% of children in unsubstantiated reports (DHHS, 2012).

1.1.2 Development of Differential Response in Child Protective Services[4]

Pressures began to mount on the traditional child protection system as the number of annual reports made to hotlines increased from fewer than 10,000 in 1967 to more than 2.6 million in 2010 (DHHS, 2011). As a wider range of child welfare concerns were included in State definitions of child maltreatment, "reports concerning relatively low-risk families unnecessarily add to the volume of cases flooding the CPS system" (Waldfogel, 1998, p. 107). In 1990, a U.S. Advisory Board on Child Abuse and Neglect concluded that child maltreatment was a "national emergency" and that "the system the nation has devised to respond to child abuse and neglect is failing. It is not a question of acute failure of a single element of the system; there is chronic and critical multiple organ failure" (U.S. Advisory Board on Child Abuse and Neglect, 1990, p. 2).

Although the primary goal of a traditional CPS investigation is to protect children from additional harm due to maltreatment, annual outcome reports suggest that many State child welfare agencies struggle to meet performance goals related to repeat maltreatment (see the full series of federal Child Welfare Outcomes reports from 1998 through 2010 here: http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/cwo). In addition to high rates of repeat maltreatment, many public child welfare systems have a subset of families who are chronically re-reported to CPS, typically with allegations of neglect (Loman,

[3] States vary in the level of evidence required for substantiation (credible, preponderance, clear and convincing) as well as whether they will substantiate "threats of harm" in the absence of current abuse or neglect (DHHS, 2003).
[4] Portions of this chapter were adapted from Fuller (in press).

2006). Traditional CPS systems are often ill-equipped to respond to these chronically-reported, lower-risk cases.

Another source of dissatisfaction with traditional child protective services stemmed from accounts of families who had been investigated for abuse or neglect. Interviews with these parents suggest that receiving a visit from a CPS investigator elicits feelings of fear, anger, shame, or humiliation (Buckley, Carr, & Whelan, 2011; Gallagher et al., 2011; Harris, 2012; Platt, 2001; Schreiber, Fuller, & Paceley, 2013). Many parents find the investigation process coercive and intrusive, and respond by overtly resisting the intervention, hiding important information or concerns, or feigning cooperation out of fear of being negatively perceived by the worker and agency (Dumbrill, 2006; Forrester, Westlake, & Glynn, 2012; Harris, 2012; Thoburn, Lewis, & Shemmings, 1995).

Although some parents report feeling coerced into accepting services (Dumbrill, 2006; Forrester, Westlake, & Glynn, 2012; Harris, 2012; Thoburn, Lewis, & Shemmings, 1995), most are not offered any services at all. The vast majority of reports made to CPS are unsubstantiated, and rates of service provision even among substantiated cases are low in many States (DHHS, 2011). This does not mean that investigated families have no service needs; many have underlying problems such as unstable housing, severe poverty, chronic physical and mental health conditions, and issues with substance abuse (Ringeisen, Casanueva, Smith, & Dolan, 2011). Yet, contact with the traditional child protection system does little to alleviate these problems (Campbell, Cook, LaFluer, & Keenan, 2010). As a result, many families come into repeated contacts with the child protection system while their needs and problems go unresolved.

Combined, these mounting dissatisfactions with the limitations of the single-pronged approach to child protective services led several States to reorganize their CPS systems to allow for a *differential response* to maltreatment reports. Loosely defined, Differential Response allows child protection systems the option of responding to screened-in reports of maltreatment in more than one way. Moderate-to-high risk cases are typically given a traditional investigation response, while low-to-moderate risk cases, defined in a variety of ways, can be provided with a non-investigative response, often called a family assessment response.

Practice in a family assessment response differs from that in an investigation response in several ways (summarized in Table 1). Instead of approaching the family in an adversarial manner to collect evidence, the CPS worker attempts to involve them as active partners in the assessment process, which includes not only safety assessment but strengths and needs assessments as well. Extended family members, friends, and community professionals may be included in the assessment process, but as sources of support rather than as collateral contacts. If the initial assessments change the worker's view of the level of risk present in the family, cases can be re-assigned from the assessment pathway to an investigation pathway. If the risk level remains low-to-moderate and needs are identified, services can be offered to the family following the assessment. Families may choose to accept these services, at which point an

ongoing service case is opened. Alternatively, no service needs may be identified by the family or they may choose not to accept the offered services, and the case would be closed.

Table 1. Comparison of Investigation and Family Assessment Approaches to Child Protection

	Investigation	Family Assessment
Focus	To understand what happened to the child in the reported incident, who was responsible, and steps to ensure child safety in immediate future	To understand underlying conditions and factors that jeopardize child safety as well as areas of family functioning that can be strengthened
Goal	Determination of findings related to maltreatment allegations, identify maltreatment perpetrators and victims	Engage parents, children, extended family, and community partners in identifying problems and participating in services and supports that address family needs
Disposition	Substantiation of maltreatment allegations	No substantiation decision is made; families identified as "in need of services or supports" or "services recommended"
Central Registry	Perpetrators' names are entered into a central registry in accordance with State statutes and policies	No names are entered into the central registry
Services	If case is opened, service plan is written by the worker and services are provided; families can be ordered by the court to participate in services	Voluntary services are offered; if family declines and there are no safety concerns, the case is closed; if safety concerns exist, case can be reassigned to investigation
Adapted from Schene (2005)		

1.1.3 Evaluation of Differential Response Systems

Early implementers of Differential Response were faced with concerns that a de-emphasis on forensic fact-finding and substantiation of maltreatment allegations would lead to decreases in child safety. To quell these concerns, evaluators have compared the safety of children in families who receive a family assessment response versus an investigation. The results of randomized controlled trial (RCT) outcome evaluations in Minnesota, Ohio, and New York refute the notion that children who receive a non-investigative CPS response are less safe – not a single study found higher rates of maltreatment recurrence among families who receive an assessment compared to similar families who receive an investigation (Loman, Filonow, & Siegel, 2010; Loman & Siegel, 2004a; 2004b; 2012; Ruppel, Huang, & Haulenbeek, 2011). In addition to being at least as safe as those who are investigated, families provided with an assessment describe their experiences in more positive terms and are provided with a wider variety of services, especially poverty-related services, than families who are investigated

(Loman, Filonow, & Siegel, 2010; Loman & Siegel, 2004a; 2004b; 2012; Ruppel, Huang, & Haulenbeek, 2011).

1.1.4 Research Questions

As the number of States implementing DR continues to climb, administrators need additional information about the effectiveness of the approach. The three research and demonstration sites (Colorado, Illinois, and Ohio) funded by the QIC-DR have completed rigorous evaluations to answer the following questions developed by the QIC-DR (Nolan, Blackenship, & Sneddon, 2012):

1. How is the assessment response different from the investigation response in terms of family engagement, caseworker practice, and services provided?
2. Are children whose families receive an assessment response as safe as or safer than children whose families receive an investigation?
3. What are the cost and funding implications to the child protection agency of the implementation and maintenance of a differential response approach?

The current report attempts to answer these questions using data from the Illinois DR evaluation. Readers are also encouraged to refer to the final evaluation reports from the other two sites as well as the cross-site evaluation report completed by Walter R. McDonald and Associates (WRMA) and partners.

Chapter 2: The Illinois Differential Response Program

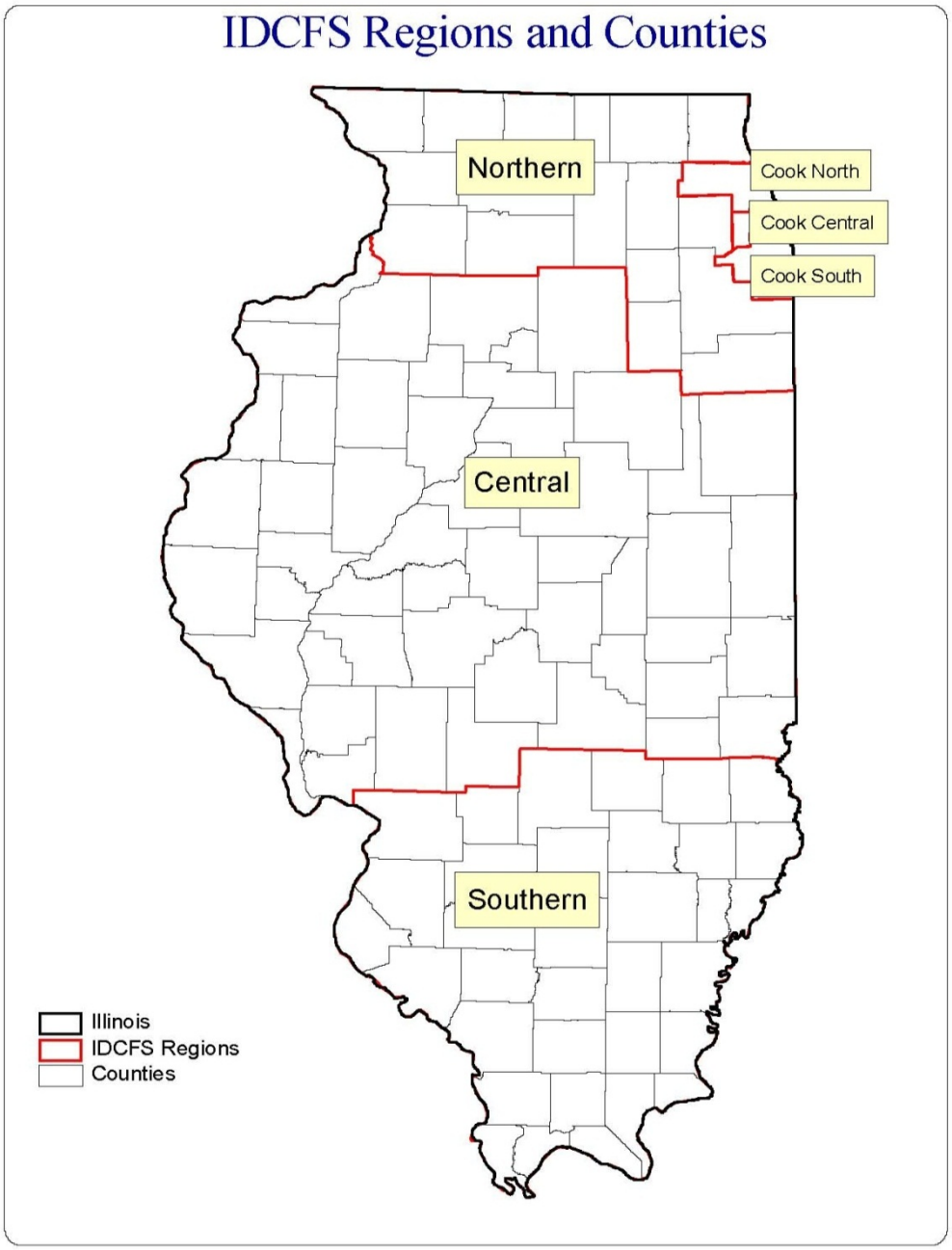
This chapter provides a description of the Differential Response program that was implemented and evaluated in Illinois. It begins by providing an overview of the Illinois child welfare system at the time the DR program was implemented in 2010. Next, the child protective services (CPS) system is described, including an examination of caseload volume and trends over the past decade. Since the DR evaluation involved a comparison between families provided with a traditional investigation response (IR) or a non-investigation response (DR), the practices in both responses are described so that results in later chapters can be understood in the appropriate context.

When examining a program's implementation and impact, it is important to keep in mind that social service programs often change and adapt to the current political and social policy contexts. As a result, the CPS practice described in this chapter may no longer reflect current IDCFS operations. The most obvious example of this is the discontinuation of the Illinois DR program in June 2012, but several other changes in IDCFS programs and practices have also occurred since the evaluation data was collected. However, the current chapter describes DR and IR practices that were in place during the evaluation period (November 2010 through June 2012) so that the evaluation results can be understood in context.

2.1 The Illinois Department of Children and Family Services

Child protective services in Illinois are administered through one State agency, the Illinois Department of Children and Family Services (IDCFS). Operationally, the Department is divided into six administrative regions, with three located in Cook County (the greater Chicago area) and three in the balance of the State (see Figure 1). The Northern and Central regions are less populous than Cook County regions but contain moderately sized cities. The Southern Region, with the exception of East St. Louis, is predominantly rural.

Figure 1. Illinois Department of Children and Family Services Regional Map

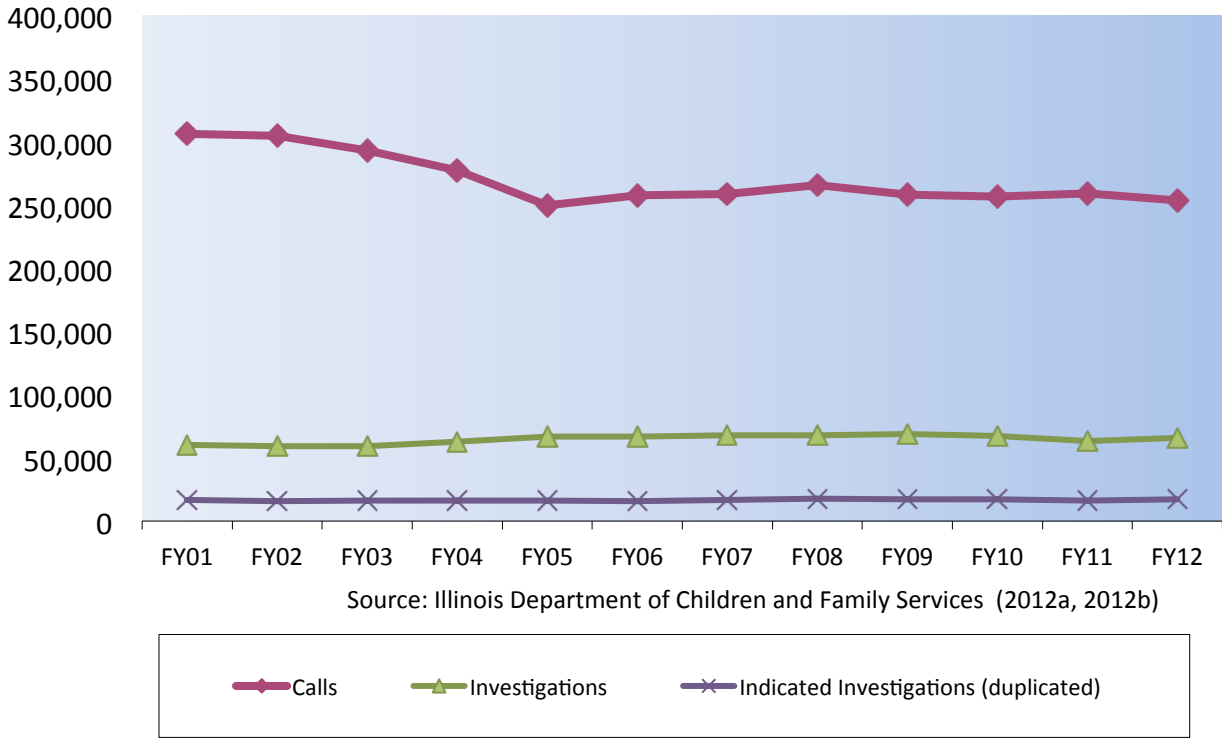


Map produced by: *Agency Operations Analysis, Division of POS Monitoring/QA*

2.2 Child Protective Services in Illinois

The Illinois child protection system is one of the largest in the nation. In FY2012, approximately 253,000 calls were made to the Illinois State Central Register (SCR; commonly referred to as "the hotline") and screened for potential abuse and neglect. Each year, slightly more than a quarter of these calls meet the statutory criteria for a CPS response as defined in the Illinois Abused and Neglected Child Reporting Act (ANCRA). For example, in FY2010, the last year prior to the introduction of Differential Response in Illinois, 26.2% of the calls taken by the SCR were screened-in as reports. The percentage of Illinois referrals that are screened-in for response is quite low when compared to the national average of 60.8% in FFY2011 (DHHS, 2012). In slightly more than one of every four child reports of maltreatment (25.2% in FY2010), CPS workers in Illinois found credible evidence that a child was maltreated and substantiated the report. This percentage has remained consistent for the past several years (Figure 2).

Figure 2. Illinois Child Protective Services (CPS) caseload volume



Source: Illinois Department of Children and Family Services (2012a, 2012b)

Prior to the introduction of Differential Response in 2010, IDCFS had not made substantial changes to its child protection system since the introduction of the Child Endangerment Risk Assessment Protocol (CERAP) safety assessment in 1995. Although the CERAP has been associated with significant improvements in both short-term (within 60 days) and 6-month maltreatment recurrence rates over time (Fuller & Nieto, 2010), IDCFS failed to meet the federal standard for maltreatment recurrence in both the first (2003) and second-round (2009) Child and Family Service Review (CFSR). Few of the families that were investigated received

services through the public child welfare system: less than half of the families with substantiated maltreatment received any type of post-investigation services in 2010 and an even smaller percentage (11.4%) of the families with unsubstantiated maltreatment received services (DHHS, 2011). In addition, in 2009 Illinois had the lowest child removal rate in the nation (Fuller & Kearney, 2010).

Figure 3 displays the process through which maltreatment reports were taken and CPS responses were assigned during the DR evaluation period. The process began with a call to the State Central Register from a maltreatment reporter. The SCR intake worker screened the information provided by the reporter to determine whether the call met the criteria for a maltreatment report. The criteria for accepting or screening-in a report included:

- The reporter must have reasonable cause to believe that a child has been abused or neglected; and
- The alleged victim(s) must be less than 18 years of age; and
- The alleged victims(s) either must have been harmed or must be in substantial risk of physical injury; and
- There must be a specific abusive or neglectful incident that falls within the description of an allegation and that caused harm to the child or a set of circumstances that leads a reasonable person to believe that a child is at risk of harm; and
- If the allegations presented were true, the situation would constitute abuse or neglect as defined in the Abused and Neglected Child Reporting Act (ANCRA);
    - For abuse, the alleged perpetrator must be the child's parent, immediate family member, any individual who resides in the same home as the child, any person who is responsible for the child's welfare at the time of the incident, or a paramour of the child's parent;
    - For neglect, the alleged perpetrator must be the child's parent on any other person who was responsible for the child at the time of the alleged neglect.

Figure 3. Maltreatment report screening process in Illinois

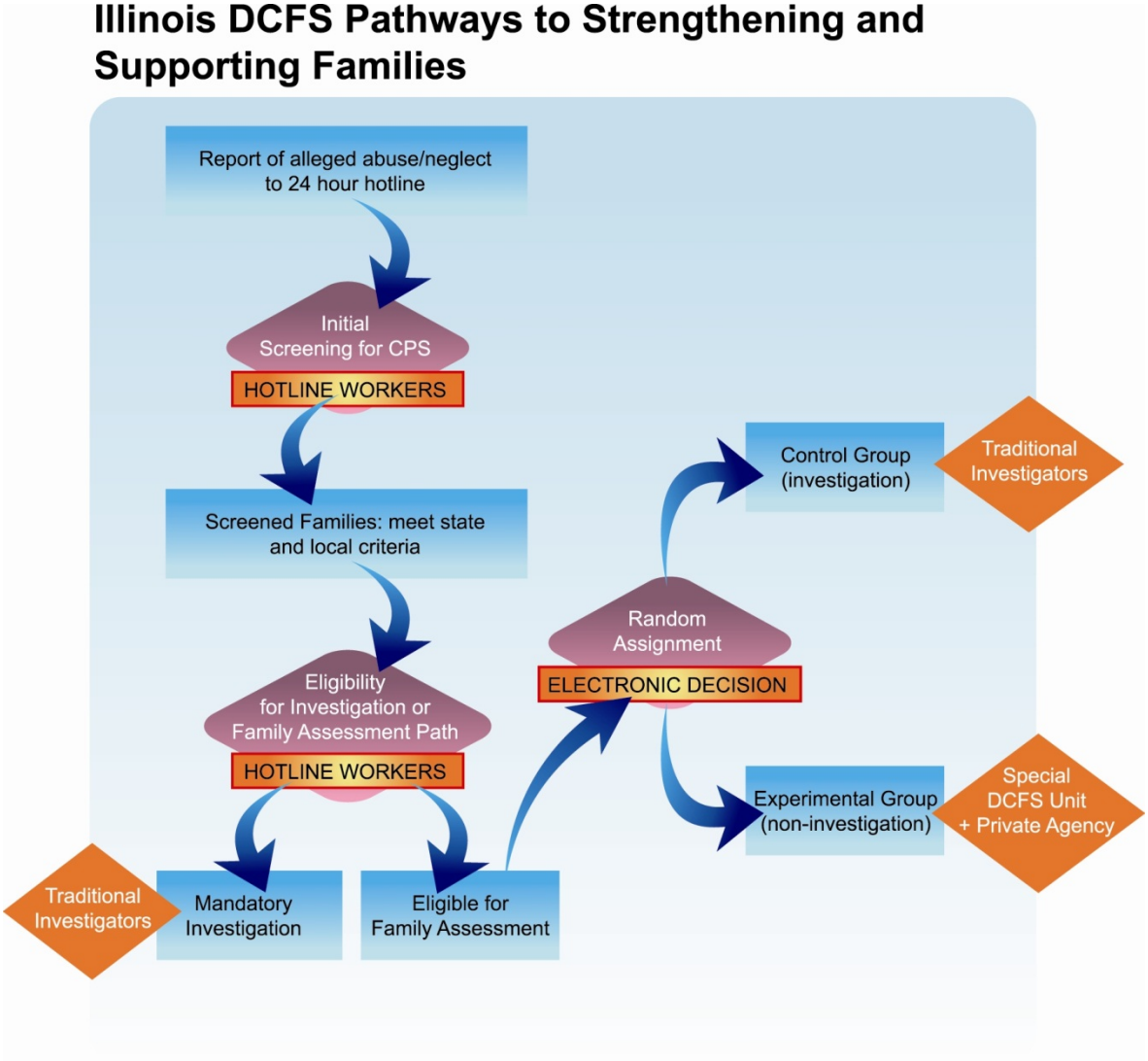


Table 2 shows the child abuse and neglect allegations assigned to screened-in reports in Illinois. The allegation definitions focus on the harm or the risk of harm to the child. Many of the allegations of harm can be categorized as resulting from either abuse or neglect. Abuse allegations are coded with a 1- or 2-digit number under 30; neglect allegations are coded with a 2-digit number greater than 50.

Table 2: IDCFS Allegations of Abuse and Neglect

Abuse Allegations	Neglect Allegations
Death (1)	Death (51)
Head Injuries (2)	Head Injuries (52)
Internal Injuries (4)	Internal Injuries (54)
Burns (5)	Burns (55)
Poisons/Noxious Substances (6)	Poisons/Noxious Substance (56)
Wounds (7)	Wounds (57)
Bone Fractures (9)	Bone Fractures (59)
Substantial Risk of Physical Injuries/ Environment Injurious to Health and Welfare (10)	Substantial Risk of Physical Injuries/ Environment Injurious to Health and Welfare (60)
Cuts, Bruises, Welts, Abrasions, or Oral Injuries (11)	Cuts, Bruises, Welts, Abrasions, or Oral Injuries (61)
Human Bites (12)	Human Bites (62)
Sprains/Dislocations (13)	Sprains/Dislocations (63)
Tying/Close Confinement (14)	
Substance Misuse (15)	Substance Misuse (65)
Torture (16)	
Mental and Emotional Impairment (17)	Mental and Emotional Impairment (67)
Sexually Transmitted Diseases (18)	
Sexual Penetration (19)	
Sexual Exploitation (20)	
Sexual Molestation (21)	
Substantial Risk of Sexual injury (22)	
	Inadequate Supervision (74)
	Abandonment/Desertion (75)
	Inadequate Food (76)
	Inadequate Shelter (77)
	Inadequate Clothing (78)
	Medical Neglect (79)
	Failure to Thrive (81)
	Environmental Neglect (82)
	Malnutrition (non-organic) (83)
	Lock-out (84)
	Medical Neglect of Disabled Infants (85)

While *all* screened-in reports were eligible for an investigation, only a small subset of reports were eligible to receive DR. Determinations about DR eligibility were made simultaneously with the decision to screen-in the report for CPS response, meaning that this decision was made using only the information known to the SCR intake worker at the time of the initial hotline call. Reports that met **all** of the following criteria were eligible for DR:

1. identifying information for the family members and their current address was known at the time of the report;
2. caretakers were birth or adoptive parents, legal guardians or responsible relatives;
3. the family had no prior indicated reports of abuse and/or neglect;
4. the children were not in the care and custody of the Department or wards of the court at the time of the report;
5. protective custody had not been previously taken; and
6. current allegations included any combination of the following:
    a. Mental and Emotional Impairment (neglect only), Inadequate Supervision, Inadequate Food, Inadequate Shelter, Inadequate Clothing, Medical Neglect, and Environmental Neglect. The following circumstances involving the allegations of Mental and Emotional Impairment, Inadequate Supervision, and Medical Neglect prohibited the report from being assigned to DR.
        i) Mental and Emotional Impairment reports taken as abuse (Allegation #17) were ineligible for DR.
        ii) Inadequate Supervision reports involving a child or children under the age of eight, or a child older than eight years of age with a physical or mental disability that limits his or her skills in the areas of communication, self-care, self-direction, and safety were ineligible for DR.
        iii) Medical Neglect reports that involved a child with a severe medical condition that could become serious enough to cause long-term harm to the child if untreated were ineligible for DR.
    b. An additional neglect allegation (substantial risk of physical injuries/ environment injurious to health and welfare) was added to the list of DR-eligible maltreatment allegations in July 2011.

Reports that did not meet the eligibility criteria for DR were automatically directed to an investigation team; these reports are not included in the evaluation. During the evaluation period, DR-eligible reports were randomly assigned to either a traditional investigation response or a differential response assessment.[5] The practice and procedures associated with the traditional investigation response (the control group) and the differential response (the

[5] The randomization procedures are described in more detail in Chapter 3.

treatment group) are described in the following sections. Table 3 summarizes the differences in practice between the two CPS responses.

2.3 Investigation Response (IR)[6]

2.3.1 Staffing and Caseloads

Investigations in Illinois were conducted exclusively by IDCFS (i.e., public agency) workers called Child Protection Specialists or Investigators, in consultation with their Investigation Supervisors. Minimum qualifications for an IDCFS Investigator were a bachelor's degree in social work or related human service field[7] and four years of directly-related professional experience; a master's degree in social work or related human service field was preferred. All IDCFS direct service supervisors, including Investigation Supervisors, were required to have a master's degree in social work or related human service field and a minimum of three years of experience in social welfare services. Investigators did not carry mixed caseloads; they only conducted investigations.

IDCFS operates under a number of active consent decrees, one of which (*B.H.*) specifies that Investigators should be assigned no more than 12 new investigations per month during nine months of the year and no more than 15 new investigations per month during the remaining three months of the year. Although a formal caseload study was not conducted in Illinois, qualitative data from focus groups with Investigators conducted as part of the DR implementation evaluation suggests that Investigator caseloads in many parts of the State were more than double the recommended size (Fuller, Kearney, & Lyons, 2012).

2.3.2 Initial Contact and Assessments

Once the SCR intake worker transmitted information on a screened-in maltreatment report to the local investigative team, an Investigator initiated the investigation by making an unannounced in-person contact (or made a good faith effort to do so)[8] with the alleged child victim(s) within 24 hours (or sooner if immediate harm was alleged). Prior to the initial visit, the Investigator conducted a data check to determine if the alleged victims or perpetrators had prior involvement with IDCFS or law enforcement. The Investigator also contacted the maltreatment reporter to confirm and gather as much information as possible about the alleged maltreatment.

---

[6] Information on investigative procedures was gathered from the IDCFS Procedures 300: Reports of Child Abuse and Neglect, available online at http://www.state.il.us/dcfs/policy/pr_policy_procedure.shtml

[7] Related human service degree refers to psychology, psychiatric nursing, psychiatry, pastoral counseling, sociology, social services, social science, public administration, pastoral care, Master of Divinity, human service administration, human development counseling, home economics – child and family service, guidance and counseling, early childhood development, child, family and community services, and human services. Information on job titles and requirements obtained from http://www.state.il.us/dcfs/library/CommonTitles.asp

[8] Although good faith efforts to contact the family through an unannounced visit were required, not all families could be reached within 24 hours. In these instances, Investigators could leave their business card in an effort to contact the family and the first visit would therefore not be unannounced.

During the initial visit, the Investigator was required to interview every alleged victim in the household, out of the presence of the caretaker and alleged perpetrator, if possible. The Investigator was also required to interview the alleged perpetrators and other adult members of the household. The Investigator could also interview neighbors or other collateral sources, as necessary. In addition, the Investigator could obtain photographs or videos of the child's injuries or environment. Other activities that typically occurred during an investigation included: documentation of the identities of alleged perpetrators, adult household members, and frequent adult visitors to the home; and observations of any areas of the home that were reasonably related to the allegations.

Investigators completed a structured safety assessment protocol, known as the Child Endangerment Risk Assessment Protocol (CERAP), within 24 hours after they interviewed the alleged child victim (see Appendix A for a copy of the CERAP instrument). To complete the CERAP, the Investigator gathered information to assess the presence (Yes) or absence (No) of 14 safety threats in the home, such as "caretaker has not, will not, or is unable to provide sufficient supervision to protect child from potentially moderate to severe harm." If the Investigator checked "Yes" to a threat, the response could be mitigated by family strengths or other circumstances. Based on the information about the safety threats, mitigating circumstances, and any other pertinent facts about the case, a safety decision of safe or unsafe was made. A decision of "safe" indicated that the Investigator believed that there were no children likely to be in immediate danger of moderate to severe harm. A decision of "unsafe" meant that one or more children were likely to be in immediate danger, and required the Investigator to either develop a safety plan with the caretakers designed to keep the child safe or remove the unsafe children from the home. Investigators had the ability to take temporary protective custody of a child if he or she was in imminent danger.

Within 60 days of the initial report date, the Investigator, in consultation with his or her supervisor, was to make a determination about whether the available evidence suggested that abuse or neglect had occurred, although one or more 30-day extensions could be granted. In Illinois, Investigators could make one of two determinations at the conclusion of the investigation: a report could be *unfounded*, meaning there was no credible evidence that the child was abused and/or neglected, or it could be *indicated*, meaning credible evidence existed that the child was abused and/or neglected.[9] If the report was indicated, the names of the perpetrators were placed on a central registry and retained according to a schedule based on the seriousness of the maltreatment. In addition, if the report was indicated, the Investigator completed a risk assessment prior to closing the case or transferring to ongoing services.

[9] The use term "indicated" in Illinois is identical to the more commonly used term "substantiated" in other states and in most national reports. Therefore, the more commonly used terms "substantiated" and "unsubstantiated" are used in later chapters of this report.

2.3.3 Services

The Investigator, in consultation with his or her supervisor, decided whether or not to refer the family to formal child welfare services. Referrals to child welfare services could be made either during the investigation or at its conclusion. In Illinois, there were two types of formal child welfare services that investigated families could be referred to: intact family services or child placement services. Intact family services consisted of case management and referrals to supportive services provided to families in their homes, usually on a voluntary basis although the family could be referred to the State's Attorney for court-ordered services. If a child was removed from the home, child placement services were provided to the child and family while the child was in substitute care. The same family could receive both intact family services and child placement services if one or more children remained at home following the placement of one or more children into substitute care.

2.4 Differential Response (DR)

2.4.1 Staffing and Caseloads

DR cases were staffed by a two-person team comprised of an IDCFS employee (titled "DR Specialist") who assessed initial safety and a private agency employee (titled "Strengthening and Supporting Families [SSF] caseworker") who provided ongoing services to families. For the public agency (i.e., IDCFS) positions, a Memorandum of Understanding (MOU) was negotiated between the IDCFS and the public employee union that outlined the specifications of the DR positions.[10] DR Specialists and DR Supervisors were selected from current IDCFS employees who applied for the positions. Only current employees with job titles of child welfare specialist, child protection specialist, and day care licensing representative were eligible to apply for the DR positions, to ensure that appropriate minimum job requirements were met. In keeping with the master contract between IDCFS and the union, employee length of service (seniority) was the prevailing factor in determining which applicants were selected for the DR Specialist and DR Supervisor positions.[11] The IDCFS DR positions were considered temporary "details" that were filled for 12- or 18-month periods for DR specialists and 24-month periods for DR supervisors. After the detail period was over, the employee returned to their prior assignment within the Department. The MOU did not specify a maximum caseload for DR specialists or DR Supervisors but stated that "the Department may set monthly case assignment goals…consider an employee's availability, as well as the geographic locations of the case assignments…and will adjust the number of monthly case assignments accordingly." DR Specialists and DR Supervisors could only work on DR cases; they were not allowed to conduct investigations, conduct ongoing child welfare casework, or perform the job duties of any other IDCFS worker classification.

The Department contracted with 14 private agencies throughout the State to hire SSF workers and supervisors. Per contract specifications, SSF Caseworkers were required to have a

[10] A copy of the MOU is included in the *Differential Response in Illinois: 2011 Site Visit Report*, which is available on the CFRC website: http://cfrc.illinois.edu/pubs/rp_20120327_DifferentialResponseInIllinois2011SiteVisitReport.pdf

[11] Employees with more seniority were given preference in selection.

bachelor's degree acceptable by Council on Accreditation (COA) standards, documented experience working with youth and families, knowledge of the child welfare system, and certification to use the CERAP safety assessment protocol. SSF Supervisors were required to have a master's degree and extensive experience working with at-risk families (Illinois Department of Children and Family Services, 2011). Agency contracts also specified a maximum caseload of 12 cases per SSF Caseworker, who were not allowed to carry mixed caseloads within the agency (i.e., they could only carry DR cases).

2.4.2 Initial Contacts and Assessments

The DR Specialist contacted the family by telephone within 24 hours of case assignment to explain DR, schedule an initial in-home family visit within 3 business days of the report date, and verify the names and birthdates of all family members and other persons living in the household. Although attempts were made to contact the family via telephone prior to the initial visit, if the family could not be reached within 3 business days, the initial visit was unannounced. The visit occurred in the family's home and was attended by both the DR Specialist and the SSF Caseworker.

During the initial in-home meeting, the DR specialist assessed the safety of the child(ren) in the home using the CERAP safety assessment. If there were no safety concerns, the DR Specialist and SSF Caseworker explained DR to family members, including the fact that participation was voluntary. If the DR specialist determined that a child was unsafe, that there was an immediate need for intervention, or if the allegations were outside the scope of DR, he or she contacted the regional DR Supervisor, who transferred the DR case to an investigation.

2.4.3 Reassignment from DR to Investigations

Although reports that were randomly assigned to investigations could not be reassigned to DR, reports that were randomly assigned to DR could be reassigned to an investigation in several ways:[12]

1. Prior to assigning reports to DR teams, the regional DR Supervisors reviewed each report to determine its appropriateness for DR services. If the DR Supervisor determined that the report did not fit the criteria for DR, he or she could redirect the report to the SCR for assignment to an Investigator.

2. During the initial visit, if a DR Specialist determined that a child was unsafe, that there was an immediate need for intervention, or that maltreatment allegations were not within the scope of DR, they discussed the information with their DR Supervisor, who could use their discretion to reassign the case to an Investigator by contacting the SCR.

[12] Although *in practice* cases could be reassigned from the treatment group (DR) to the control group (investigation), for the analyses reported in later chapters, all cases that were randomly assigned to DR remained in the DR group. Chapter 3 provides additional information on the numbers of cases that were reassigned from DR to IR at each stage, and describes the ITT analyses in more detail.

3. If the DR Specialist could not contact the family within six business days after case assignment, the DR Supervisor contacted the SCR to transfer the report to an Investigator.

4. If the SSF Caseworker (or supervisor) had reasonable cause to believe that a child was being abused or neglected or was at risk of harm at any time during the service delivery period, they contacted the SCR to make a new report. If the report was accepted by the SCR as a new report, the DR case immediately closed and an investigation was conducted.

5. If a subsequent maltreatment report on the family was accepted by the SCR at any point during DR service delivery, the DR case was immediately closed and an investigation was opened.

2.4.4 Services

After the initial assessment visit and if there were no safety concerns that warranted reassignment, families could decline DR services without consequence (i.e., without reassignment to an investigation). If the family agreed to participate in services, the SSF Caseworker worked with them to complete a family assessment as part of their voluntary family enhancement plan.[13] The SSF Caseworker provided comprehensive case management through a mix of services tailored to meet the needs of the family and delivered in their homes. The SSF Caseworker's role was similar to that of a family coach or advocate: providing crisis intervention and short-term interventions; identifying services available in the community; transporting clients to critical appointments; apprising the family of available Federal, State, and local benefits; linking families to community support groups; assisting with proper infant care and parent education; and assisting in creating and maintaining a safe home environment. Twice weekly in-home visits were required unless the family requested fewer contacts. Services could be provided for up to 90 days, and three 1-month extensions could be approved by the DR Project Director, based on the child's safety and well-being, the family's needs, and the amount of progress made. In addition to these supportive services, cash assistance up to $400 was available to families; assistance over $400 was available in certain circumstances with DR Project Director approval. Since services were voluntary, the family could choose to end them at any time without consequences (i.e., without being re-assigned to an investigation).

[13] This was the term used in Illinois for the DR service plan.

Table 3. Summary of Illinois Investigation and Differential Response Practice Elements

	Investigation Response (IR)	Differential Response (DR)
Staffing	Single publically-employed investigator	Two-person team: one public agency and one private agency employee
Recommended caseloads	No more than 12 new investigations per month	Public worker: none Private worker: 12:1
Workers carry mixed caseloads	No	No
Timeframe for initial contact	In-person contact within 24 hours (sooner for certain allegations)	Telephone contact within 24 hours; In-home visit within 3 business days
First visit unannounced	Yes, if possible	No, if possible
Children interviewed separately	Yes	Yes
Safety assessment completed at first visit	Yes (CERAP)	Yes (CERAP)
Other assessments completed	Risk assessment (at investigation conclusion for indicated reports only) Substance abuse assessment Domestic violence assessment	Family assessment (strengths, protective factors)
Cases can be reassigned to other pathway	No	Yes
Families can decline services after initial safety assessment	No	Yes
Families can voluntarily end additional contacts after safety assessment	No	Yes
Ability to take protective custody	Yes	No
Maltreatment substantiation	Yes	No
Perpetrators entered into central registry	Yes	No
Service completion timeframe	60 days; 30-day extensions possible	90 days; 3 30-day extensions possible
Services provided by workers	No services provided by investigators; family can be referred to ongoing child welfare services, either intact family services or substitute care	Case management; crisis management; advocacy; service referrals; parent education; transportation; cash assistance up to $400 (or higher amounts with director approval)

Chapter 3: Evaluation Design and Methodology

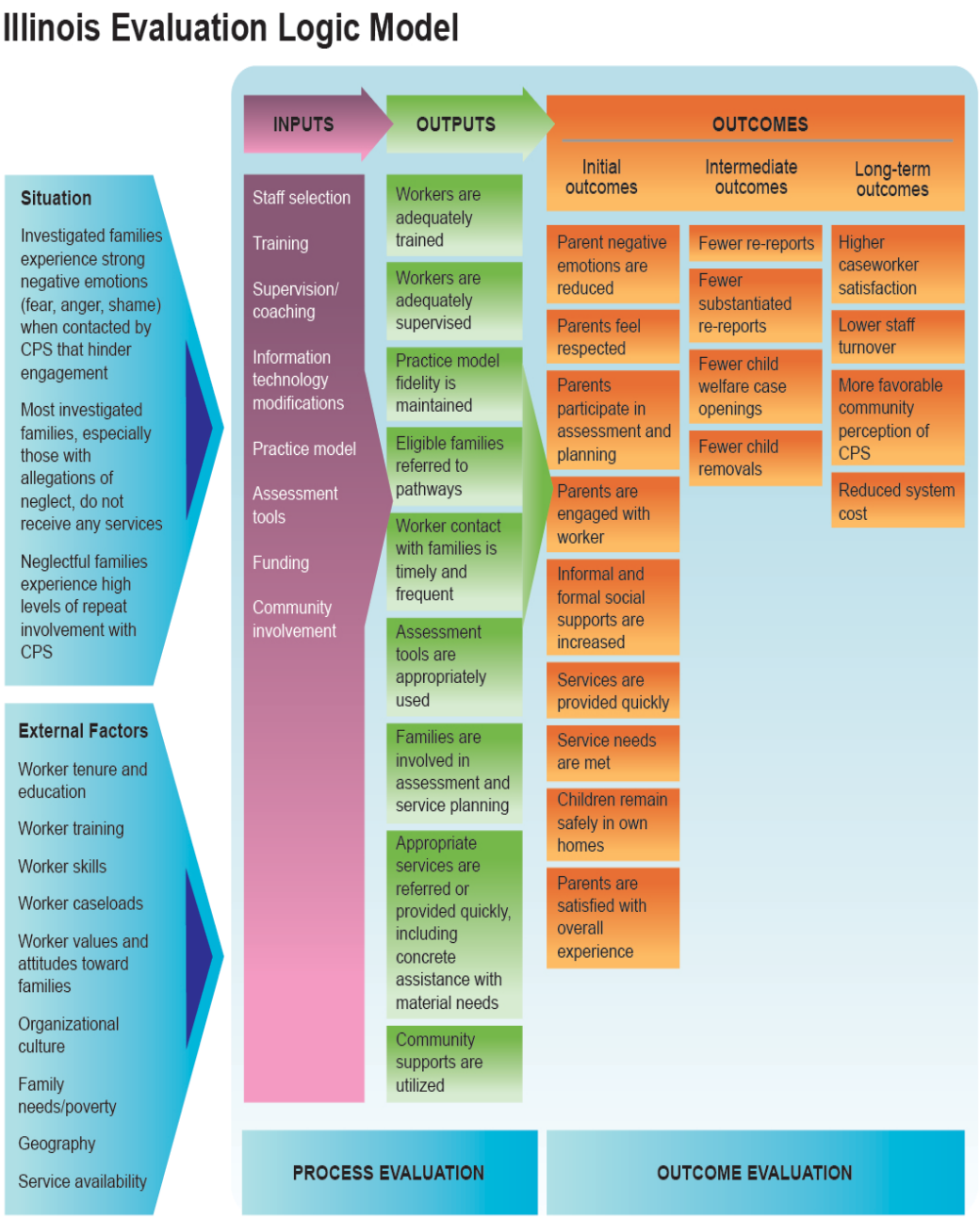
Researchers at the Children and Family Research Center at the University of Illinois at Urbana-Champaign worked collaboratively with those at the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect and Walter R. McDonald & Associates, Inc., as well as the two other local evaluation teams in Colorado and Ohio to develop the methodology used in the evaluation. All methods were approved by the Institutional Review Boards at the University of Illinois at Urbana-Champaign and the Illinois Department of Children and Family Services.

3.1 Research Questions and Logic Model

The Illinois evaluation logic model displays the assumptions that are tested in the Illinois Differential Response evaluation (Figure 4). Previous research and monitoring within Illinois and other states[14] has documented the unfavorable conditions that prompted the Illinois Department of Children and Family Services to implement Differential Response: 1) families investigated by CPS describe their experience in predominantly negative terms such as fear, anger, and shame; 2) the majority of investigated families, especially those with allegations of neglect, do not receive any services or support from CPS agencies, even if their allegations are substantiated; and 3) a sizeable portion of investigated families, especially those with allegations of neglect, experience repeated contacts with CPS. The Illinois Department of Children and Family Services sought to change these conditions by investing several inputs into the implementation of DR: selecting appropriate staff, developing a new DR practice model, training new and existing caseworkers and supervisors to implement the practice model, providing supervision and coaching to caseworkers, modifying existing information technology systems to accommodate the practice changes, developing new assessment tools to guide worker interactions with families, soliciting community input about the program, and leveraging funding for these activities. Information on these program inputs and their associated outputs was collected as part of the process evaluation and described in the *Differential Response in Illinois: 2011 Site Visit Report* (Fuller, Kearney, & Lyons, 2012).

[14] Described in Chapter 1

Figure 4. The Illinois Differential Response evaluation logic model



The Illinois DR logic model shows the hypothesized relationship between the DR program outputs and the initial, intermediate, and long-term outcomes for families, CPS workers, and CPS agencies. The hypothesized outcomes of DR are grouped into three categories that will each be described in subsequent chapters:

- Parent engagement (Chapter 4):
    - Parents who receive DR will have reduced negative emotional responses and increased positive emotional responses following the initial visit from the CPS worker compared to parents who receive an investigation
    - Parents who receive DR will have higher levels of involvement and participation in the assessment and treatment planning process compared to parents who receive an investigation
    - Parents who receive DR will have higher levels of engagement with their worker than parent who receive an investigation
    - Parents who receive DR will have higher levels of overall satisfaction with their worker and with services than parents who receive an investigation
- Service provision (Chapter 5)
    - Families who receive DR will receive their first service more quickly than families who receive an investigation
    - Families who receive DR will receive a higher number of face-to-face contacts with their worker than families who receive an investigation
    - Families who receive DR will receive a larger number of services and supports than families who receive an investigation
    - Services provided to families who receive DR will be better matched to their needs than the services provided to families who receive an investigation
    - Services provided to families who receive DR will be sufficient to meet their needs
- Child safety and family well-being (Chapter 6)
    - Families who receive DR will have fewer subsequent re-reports than families who receive an investigation
    - Families who receive DR will have fewer subsequent substantiated re-reports than families who receive an investigation
    - Families who receive DR will have fewer subsequent child removals than families who receive an investigation
    - More parents who receive DR will report that their children are safer than parents who receive an investigation
    - More parents who receive DR will report that they are better parents than parents who receive an investigation
    - More parents who receive DR will report that they are better able to meet their families' material needs than parents who receive an investigation

The remainder of this chapter will describe the research design of the Illinois Differential Response evaluation, including procedures used to select the study sample and randomly assign eligible families, the demographic characteristics of the sample, and the data collection procedures and instruments.

3.2 Research Design and Sample Selection

This evaluation used an experimental design, in which families with screened-in maltreatment reports who met the eligibility criteria for DR services were randomly assigned to the treatment group (DR) or the control group (IR). All eligible family reports within the entire State were included in the RCT. Random assignment of families began on November 1, 2010 and ended on May 22, 2012.

Reports that were eligible for DR and included in the RCT were those that met *all* of the following criteria:

1. identifying information for the family members and their current address was known at the time of the report;
2. the caretakers were birth or adoptive parents, legal guardians or responsible relatives;
3. the family had no prior indicated reports of abuse and/or neglect;
4. the children were not wards of the State at the time of the report;
5. protective custody had not been previously taken; and
6. current allegations included any combination of the following: inadequate supervision (children 8 years and older only); inadequate food; inadequate shelter; inadequate clothing; medical neglect; environmental neglect; and mental and emotional impairment (neglect only). An additional neglect allegation (substantial risk of physical injuries/environment injurious to health and welfare) was added to the list of DR-eligible allegations in July 2011.

It should be noted that according to the DR eligibility criteria, children with prior substantiated maltreatment reports or current allegations of physical or sexual abuse were not eligible for DR, and were therefore not included in the RCT.

3.3 Random Assignment Procedures

In Illinois, maltreatment reports are received at the State Central Register (SCR) and screened by intake workers to determine if they meet the statutory criteria for a CPS response. As part of their screening process, intake workers collect identifying information on all family members and other adults involved in the report and use this information to determine if any of the individuals have prior indicated maltreatment reports, or prior or current child welfare service cases. If the circumstances reported in the call meet the statutory criteria for a CPS response, the intake worker uses the information collected from the maltreatment reporter to assign one or more allegations to the report (please refer to Table 2 in Chapter 2 for a list of the allegations), which determines the time frame required for the CPS response. The information collected during the intake call is entered into SACWIS and transmitted to the CPS unit responsible for the report.

During the evaluation period, the information collected by SCR intake workers was also used to determine a family's eligibility for DR. After the intake worker entered the report information into SACWIS, if it met all of the DR eligibility criteria outlined above, it was *automatically* entered into a random assignment program built into SACWIS and assigned to either the local DR team or investigative unit. The initial ratio for random assignment to DR and IR groups was set at 50:50, but the statewide DR Project Manager could modify the ratio in any region of the state as needed to accommodate local agency workloads. Staffing issues at the private agencies providing DR services resulted in the adjustment of the randomization ratio to 40:60 or 30:70 (DR:IR) for much of the evaluation period. Between November 1, 2010 and May 22, 2012, intake workers screened-in approximately 101,183 family reports, of which 7,880 (7.8%) were eligible for DR and randomly assigned to the evaluation. Of the 7,880 families that were randomly assigned, 3,240 were randomly assigned to DR (41%) and 4,640 (59%) were randomly assigned to IR (see Figure 5).

A few families with prior indicated maltreatment reports or allegations of physical or sexual abuse were incorrectly included in the RCT, even though they were ineligible to receive DR. These ineligible families were excluded from the sample after randomization but before data analyses occurred:

- 161 families had prior indicated reports of maltreatment and were excluded from the sample
    - 69 families assigned to DR (2% of DR sample) were excluded due to prior indicated reports
    - 92 families assigned to IR (2% of the IR sample) were excluded due to prior indicated reports.
- 135 families had allegations of either physical or sexual abuse and were excluded from the sample
    - 70 families assigned to DR (2%) were excluded
    - 65 families assigned to IR (1.4%) were excluded.

After excluding these ineligible families, 7,584 families were allocated to the DR treatment group (3,101; 41%) or the IR control group (4,483; 59%).

3.3.1 Deviations from Random Assignment

Random assignment rarely results in perfect adherence to the assigned treatment group. Typically, some cases assigned to the treatment group will fail to receive the treatment ("no-shows") and some cases in the control group will receive the treatment ("cross-overs"). In Illinois, investigated families were not allowed to switch to DR, so there were no "cross-over" families. However, there were multiple ways in which a family that was randomly assigned to the DR treatment group could be reassigned to the IR control group ("no-shows"):

1. Immediately after random assignment, a DR Supervisor reviewed the case information for each case that was randomly assigned to the DR treatment group, to determine if the case was appropriate for DR services. Cases that the DR Supervisor deemed inappropriate for DR could be redirected to an investigation at their discretion. These

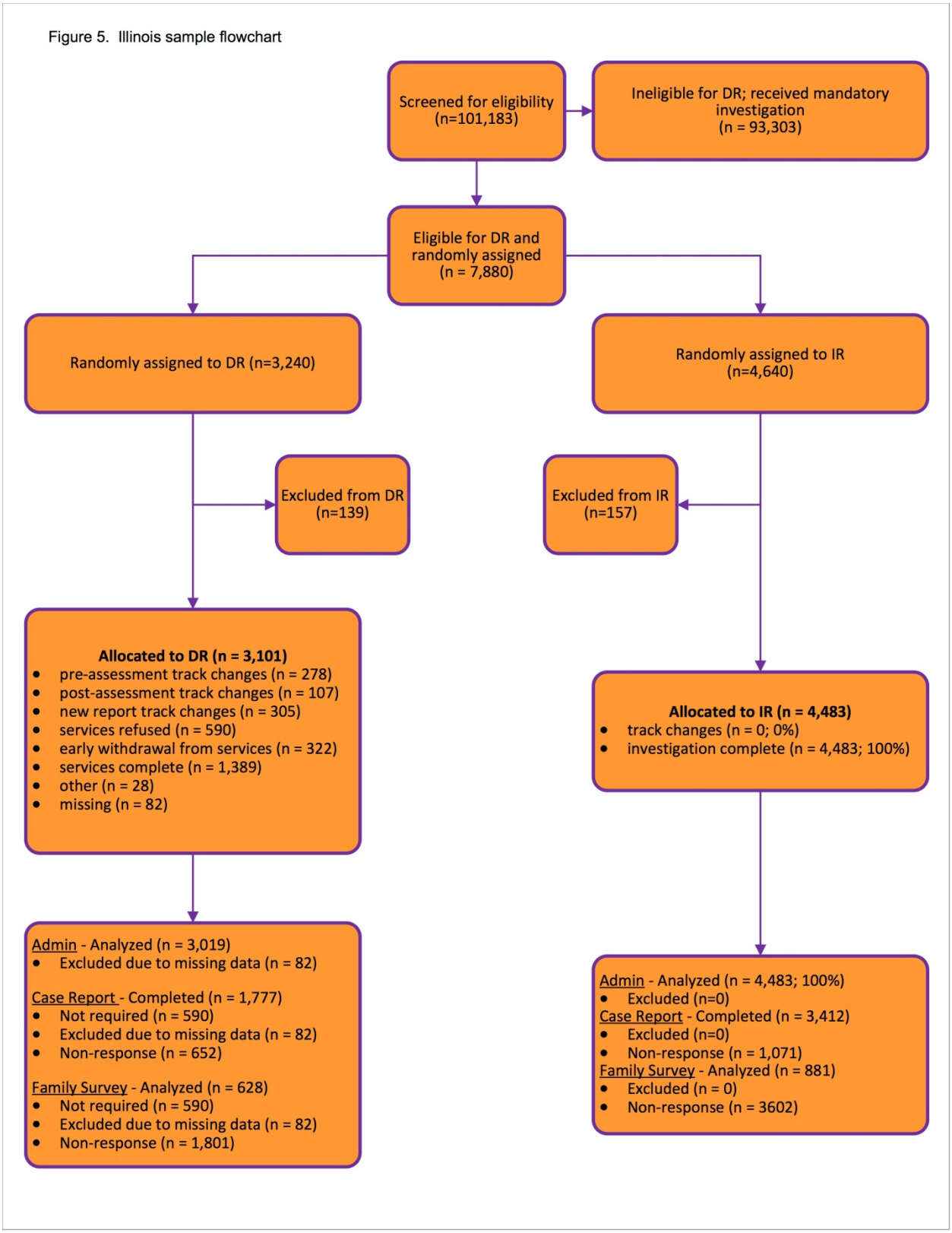
cases therefore received no contact from a DR Caseworker, no DR assessment, and no DR services. There were 278 of these "pre-assessment" track changes, or 9.0% of the families randomly assigned to DR (see Figure 5).

2. Once a DR Caseworker had been assigned to the case and met with the family, the caseworker could report the family to the SCR if they felt that any child in the home was in immediate danger of moderate to severe harm. This could occur during or immediately after the initial assessment or at any other time during service provision. There were 107 of these "post-assessment" track change cases, or 3.5% of the families randomly assigned to DR (see Figure 5).
3. If an additional screened-in maltreatment report was accepted at the SCR on the family at any point during the DR case, the case was immediately closed and an investigation was opened. There were 305 of these "new report" track change cases, or 9.8% of the cases in the DR group (see Figure 5).

In total, 690 of the 3,101 families (22.2%) that were randomly assigned to the treatment group deviated from their randomly assigned group (DR) and received an investigation.
In addition to families that switched from the treatment group to the control group due to safety concerns or new maltreatment reports, families in the DR group could also refuse to accept DR services following the initial assessment. These families received neither DR services nor an investigation. Of the 3,101 families randomly assigned to the DR treatment group, 590 (19.0%) declined to receive services.[15] In addition, some families withdrew from services before their service plans (known as "voluntary family enhancement plans") were complete (322 or 10.4% of the DR group). Of the 3,101 families that were randomly assigned to the DR treatment group, 1,389 completed services (44.8%; see Figure 5).

[15] Information was not collected from families on the reasons they declined DR services.

Figure 5. Illinois sample flowchart



3.3.2 Demographic Characteristics of the Sample

If random assignment was successful, the treatment group and the control group should be equivalent at baseline. Table 4 provides a comparison of the demographic characteristics of the families randomly assigned to the DR and IR groups. There were no significant differences between the two groups on most variables, including: caregiver age, age of the youngest child, age of the oldest child, caregiver gender, youngest child's gender, oldest child's gender, and maltreatment reporter. Statistically significant differences were observed on race and the number of children in the household (highlighted in bold).

A close examination of the differences between the two groups reveals that they are small in magnitude; the very large size of the sample gives it a tremendous amount of power to detect even slight differences between groups as statistically significant. For instance, the average number of children in families randomly assigned to DR was 1.9, compared to 2.1 children in families randomly assigned to IR. The difference between the two groups (.2 children) is meaningfully insignificant, but was statistically significant because of the large sample size. Likewise, the racial differences between the two groups were small in magnitude, but statistically significant due to the large power of the sample size: 56.4% of the youngest children in DR families were White compared to 55.7% of the children in IR families (a .7% difference); 26.8% of the youngest children in the DR families were Black compared to 31.2% of the children in IR families (a 4.4% difference); 13.8% of the youngest children in the DR families were Hispanic compared to 11.7% of the children in IR families (a 2.1% difference); and 3.0% of the youngest children in the DR families were of another racial/ethnic group compared to 1.4% of the children in IR families (a 1.6% difference). Because the magnitude of the baseline differences between the two groups was small, we do not adjust for baseline differences in race-ethnicity or number of children in the home in later analyses.

Table 4. Comparison of DR and IR Characteristics at Baseline			
	Total Sample (n=7,502)	**DR (n=3,019)**	**IR (n=4,483)**
	%/Mean (SE)	%/Mean (SE)	%/Mean (SE)
Caregiver age (years)	34.1 (9.7)	34.2 (9.9)	34.1 (9.6)
Youngest child age (years)	6.6 (5.1)	6.8 (5.2)	6.3 (5.1)
Oldest child age (years)	9.4 (5.3)	9.2 (5.4)	9.6 (5.3)
Caregiver gender (% female)	92.7%	92.1%	93.2%
Youngest child gender (% female)	52.1%	52.0%	52.2%
Oldest child gender (% female)	49.0%	49.0%	49.1%
Caregiver race			
White	**58.6%**	**60.2%**	**57.6%**
Black	**26.9%**	**24.2%**	**28.7%**
Hispanic	**12.7%**	**13.1%**	**12.4%**
Other	**1.8%**	**2.5%**	**1.3%**
Youngest child race			
White	**56.0%**	**56.4%**	**55.7%**
Black	**29.4%**	**26.8%**	**31.2%**
Hispanic	**12.5%**	**13.8%**	**11.7%**
Other	**2.1%**	**3.0%**	**1.4%**
Oldest child race			
White	**55.8%**	**56.6%**	**55.2%**
Black	**29.5%**	**26.7%**	**31.3%**
Hispanic	**12.6%**	**13.6%**	**11.9%**
Other	**2.2%**	**3.1%**	**1.6%**
Maltreatment reporter			
Medical staff	13.7	14.2	13.4
School staff	19.5	19.5	19.5
Social service staff	8.6	8.5	8.7
Law enforcement	21.2	19.8	22.2
Day care providers	.5	.4	.6
DCFS staff	.5	.6	.5
Court personnel	1.3	1.5	1.2
Family	13.1	12.7	13.3
Anonymous	14.9	15.7	14.3
Other non-mandated	6.7	7.2	6.4
Number of children in the household	**2.0 (1.2)**	**1.9 (1.1)**	**2.1 (1.3)**

3.4 Data Sources

There were three primary data sources for the evaluation: Illinois SACWIS, a Case Specific Report (CSR) that was completed by workers on each family at the conclusion of the initial case, and a family survey that was completed by a parent at the conclusion of the initial case.

3.4.1 Illinois' Statewide Automated Child Welfare Information System (SACWIS)

SACWIS contains information on all screened-in maltreatment reports, CPS investigations, and DR cases in Illinois. SACWIS data collected during the initial case included: family members' demographic information, CERAP safety assessments, case notes, substantiation decisions (investigations only), and service plans (DR only). During the follow-up period, SACWIS data were used to collect information on subsequent maltreatment reports, substantiations, child removals, and child welfare case openings. SACWIS data were available for all IR cases and for the majority of the DR cases assigned to the RCT. A small number of DR cases (n=82 or 2.6%) had missing case ID variables and could not be analyzed.

3.4.2 Case Specific Report (CSR)

To obtain more detailed information about the family than is included in SACWIS, investigators and SSF caseworkers were asked to complete a Case Specific Report (CSR) on each family. The CSR collected information about: the number of contacts with the family; family needs (material needs, substance abuse, physical health, mental health, parenting skills, domestic violence, education, social support) at case opening and amount of improvement during the initial case; "safety threats" due to neglect, lack of supervision, damaging adult-child relationship, and physical, sexual, or emotional abuse at initial contact and case close; specific services and referrals provided to family; and worker ratings of family receptivity, cooperation, and engagement (see Appendix B for a copy of the Illinois Case Specific Report). The CSR was completed online via a secure website maintained on the Children and Family Research Center server.

SSF Caseworkers were not required to complete the CSR for families who declined services following the initial assessment. Since families could not decline an investigation, Investigators were required to complete a CSR for each family in the control group. Investigators also completed the CSR for all cases that switched from DR to IR, since they were assigned to the family at case closure. Case specific reports were completed for 70.8% of the DR families and 76.1% of the IR families. Analyses that compared the families that did and did not have a CSR revealed that there were no statistically significant differences between the two groups.

3.4.3 Family Survey

The family survey contained questions about the parents' satisfaction with their caseworker and the help they received; their emotional response to the first visit and relationship with their worker; the services they received and the helpfulness of those services; their assessment of their families' well-being after services; and demographic characteristics. The Illinois version of the family survey also contained a modified version of the Yatchmentoff (2005) measure of client engagement in child welfare services (see Appendix C for a copy of the Illinois family survey).

On the last in-home visit prior to case closure, Investigators and SSF Caseworkers were instructed to give each family in the RCT a packet that contained a paper-and-pencil survey, a cover letter explaining the purpose of the survey as well as the risks and benefits of participation, a consent form, and a self-addressed return envelope to the Children and Family Research Center. All families included in the RCT were to be given a survey packet, with the exception of the families in the DR group that declined services after the initial visit. Investigators and caseworkers were given a suggested script to use when handing out surveys that informed caregivers that they were being asked to participate in a study conducted by the University of Illinois (not IDCFS) and that their decision to participate would not affect their case in any way. Workers were instructed not to complete the survey with the caregiver, as their presence could affect the caregivers' answers to some of the questions. Caregivers were mailed a $15 retail gift card when they returned their survey, and their names were entered into a monthly drawing for a $100 retail gift card. Family surveys were received from 25.0% of the DR families and 19.7% of the IR families.

Because the percentages of parents that returned the parent survey was low, it was important to examine whether the parents that completed and returned a survey were different from those who did not, in other words, if there was a non-response bias. If such a bias were present, it would limit our ability to generalize the results obtained from the family survey to the entire population of families in the study. We therefore compared the demographic characteristics of the family survey responders and non-responders and found that they did not differ on caregiver age, child age, or number of children in the household. Differences were discovered on two characteristics: a higher percentage of women responded (94.8%) than did not respond (92.2%), and a higher percentage of White parents responded (64.5% in the responders versus 53.9% in the non-responders) and a lower percentage of Hispanic parents responded (8.8% versus 13.8%, respectively).

There are several potential strategies for dealing with the non-response bias in the family survey results. One solution is to not utilize the results of the family survey because of the potential to misinterpret findings based on a non-representative sample. A second solution is to develop and apply weights so that the distribution of observable characteristics in the family survey response sample matches the distribution of observable characteristics in the larger sample. A third solution is to analyze the survey data without corrections or weights, with an awareness of the potential limitations or biases in the results when making interpretations. There are drawbacks to each of these strategies; therefore, when selecting a solution to the

problem of survey non-response bias, it is important to consider both the purpose of the survey as well as the size of the discrepancy in response rates (Mandell, 1974). Given that the differences in response rates on observed characteristics in the current study were relatively small and the purpose of the family survey was to examine the relationships between family engagement in services, service provision, and family outcomes, rather than generate population estimates, we present the results from the family survey without weights. In doing so, we acknowledge that the results from the family survey may not be reflective of the entire population of families that received DR or IR, but we believe that the potential knowledge gained from examination of the family survey results outweighs this limitation.

3.5 Data Analysis

3.5.1 Analytic Approach

Other than the cost analyses, all data analyses in this report use an intention-to-treat (ITT) approach to evaluating the outcomes associated with the DR and IR approaches. In an ITT analysis, all participants assigned to the treatment group, regardless of whether they received it or not, are compared to all participants assigned to the control group, regardless of whether they received it or not. In the current study, this means that outcomes for all 3,101 families that were randomly assigned to the DR treatment group are compared to the outcomes for all 4,483 families that were randomly assigned to the IR control group. This is despite the fact that 22% of the 3,101 families that were randomly assigned to the DR group were reassigned to the control group and received an investigation, and less than 50% of the 3,101 DR families completed services.

The benefit of using an ITT approach to the analysis is that it provides an unbiased estimate of the effect of being assigned to the treatment and control groups. However, to the extent that there are large percentages of participants that deviate from their randomly assigned group, ITT analyses will generally underestimate intervention effects. Thus, by using an ITT approach in the current study, we can be relatively certain that any significant differences that are found between the DR and IR groups are meaningful and true, but we can be less certain that all meaningful differences will be revealed.

3.5.2 Defining the Initial Case and Follow-up Periods

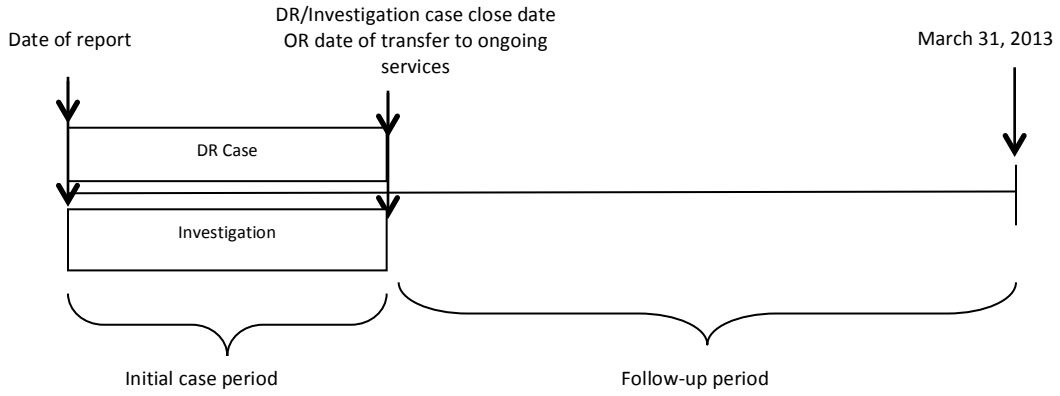
Several of the measures used in the analyses include the terms “initial case” and “follow-up period.” For cases assigned to the IR group, the “initial case” was defined as the period beginning on the date the report was accepted at the SCR (the report date) and ending on the date that the investigation closed in SACWIS. If an investigated family was referred to ongoing child welfare services (intact family services or child placement) during the investigation, the initial case period ended on the date the child welfare case opened (see Figure 6).

The definition of an initial case varied among the families randomly assigned to DR:

- for families who refused DR services, the initial case began on the report date and ended on the date the DR case was closed in SACWIS (after the initial visit)
- for families who either completed service or withdrew from services before completion, the initial case began on the report date and ended on the date the DR case was closed in SACWIS
- for families who switched from DR to IR, the initial case began on the report date and ended on the investigation closing date.

For all families, the "follow-up period" began on the initial case close date and ended on March 31, 2013.

Figure 6. Initial case and follow-up period definitions



Chapter 4: Parents' Perspectives on Their Experience with Child Protective Services

For most families, the initial visit from child protective services (CPS) is an unwelcome surprise that typically elicits negative feelings of fear, anger, or shame from parents (Ayon, Aisenberg, & Erera, 2010; Buckley, Carr, & Whelan, 2011; Dale, 2004; Diorio, 1992; Dumbrill, 2006; Harris, 2012; Kriz, Slayter, Iannicelli, & Lourie, 2012). CPS workers have the difficult task of overcoming parents' initial fears and reluctance to reveal details of their lives so that they can effectively assess child safety, determine family needs, and make decisions about ongoing child welfare services. Research with CPS workers confirms that parent fears have "major implications for the worker-client engagement process at the beginning and intermediate points in any given CPS case" (Kriz et al., 2012, p. 321).

Differential Response represents an attempt to modify several of the forensic elements of traditional investigations that elicit negative emotional responses from parents and hinder engagement (e.g., the involuntary nature of the services, substantiation of maltreatment allegations, labeling family members as "perpetrators" and "victims"). In addition, casework practice in the non-investigation pathway typically emphasizes the use of "family-centered" interviewing, assessment, and service provision. Although the term "family-centered practice" has held numerous meanings over the past two decades, common elements of this approach to working with families include: a focus on the family as the unit of attention; strengths-based assessments and services; and an emphasis on fully-informed family choices in all aspects of planning and care (Madsen, 2009). Decreased emphasis on the forensic aspects of a traditional CPS investigation and an increased emphasis on family involvement in assessment and planning are thought to increase parent engagement with the worker and with child welfare services. This chapter examines several aspects of the parents' experiences with CPS, including their initial emotional responses to CPS intervention, their caseworkers' use of family-centered practice, their engagement with their worker and services, and their satisfaction with their overall experience.

4.1 Measuring Parent Perceptions of CPS

Despite growing interest by both researchers and practitioners in capturing various dimensions of parents' experiences with child protection and child welfare services, little consensus exists about the best methods or measures to utilize. The terms engagement, involvement, participation, retention, and compliance are often used interchangeably, although they may have different underlying meanings. Most recent conceptualizations of parent engagement in services suggest that it consists of both a *behavioral* component (attendance, compliance, participation) and an attitudinal component (perceptions about their worker and the services offered), both of which are influenced by a variety of internal (cognitive and affective) and external (worker and intervention) determinants (see Platt, 2012; Staudt, 2007).

This lack of conceptual clarity about engagement has resulted in inconsistent attempts at operationalization. Many studies have focused only on the behavioral aspects of engagement, measured as enrollment or retention in services, attendance at meetings, or compliance with service plan components (McCurdy & Daro, 2001; Platt, 2012), and have failed to measure the attitudinal dimensions of the construct. In addition, much of the research on parent engagement in child welfare has relied on caseworker ratings of parent engagement, despite findings from related fields (home visiting, psychotherapy) showing that client reports of engagement are much better predictors of client outcomes than clinician reports (Horvath, 2000; Korfmacher, Green, Spellmann, & Thornburg, 2007; Wen, Korfmacher, Hans, & Henson, 2010).

The Illinois DR evaluation gathered information from both parents and workers to assess several different aspects of parents' experiences with CPS:

- Parents' emotional responses following the initial visit from the CPS worker[16]
- Parents' ratings of their worker's use of family-centered practices including
    - listening to parents' concerns
    - understanding parents' needs
    - considering parents' opinions
    - recognizing parents' strengths
- Other aspects of family-centered service provision including
    - the ease with which parents could contact their worker
    - the provision of services in the parents' preferred language
- Parents' ratings of their engagement with their worker and with CPS services, as measured by their responses to Yatchmenoff's (2005) measure of parent engagement in CPS
- Workers' ratings of parents' level of receptiveness, cooperativeness, uncooperativeness, difficultness, and engagement
- Parents' ratings of satisfaction with their treatment by the worker and the services they received

4.2 Emotional Responses After Initial Worker Visit

Investigators and DR caseworkers approach the first face-to-face visit with parents from different perspectives. Although some of the tasks that need to be accomplished are the same, such as the completion of the CERAP safety assessment, notable differences in DR and IR practices and procedures exist that may impact parents' emotional reactions to the first visit and set the stage for their entire experience with CPS.

[16] Throughout this chapter, CPS worker is the general term that is used to refer to the three types of CPS workers in Illinois: Investigators, DR Specialists and SSF Caseworkers. On the parent survey, parents were asked to answer the questions about the worker that they saw "the most." For parents who received IR, this would be their investigator and for parents who received DR, this would be the SSF Caseworker rather than the DR Specialist.

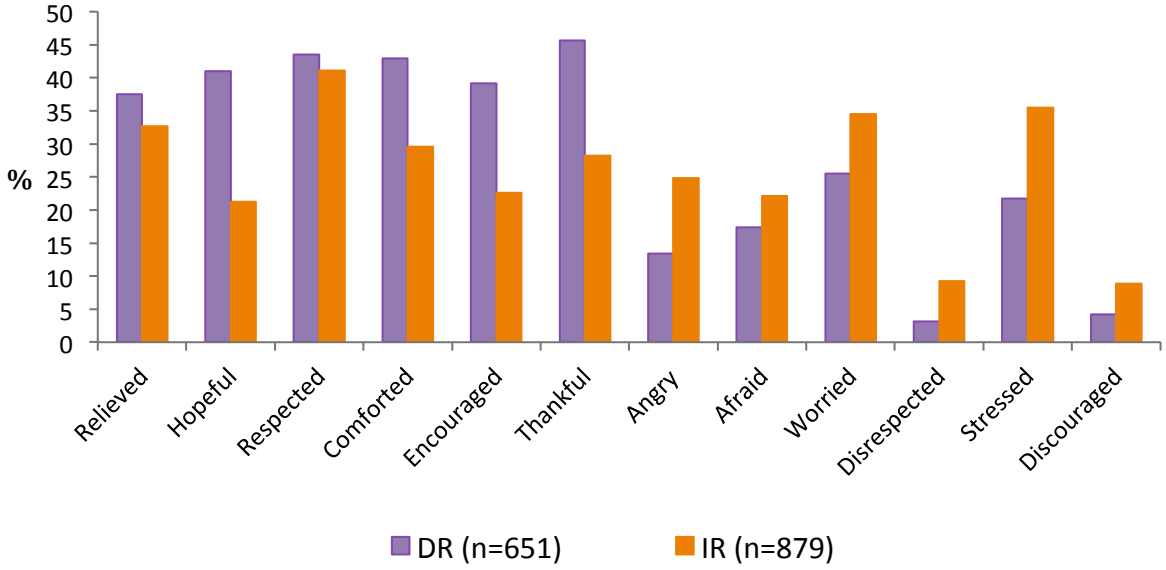
Parents' emotional responses to the first visit were captured on the family survey. Parents were asked "how did you feel after the first time the caseworker came to your home", provided with a list of 6 positive and 6 negative emotional responses that might occur following an initial visit from CPS, and asked to check as many as applied. It should be noted that parents were given the family survey at case closure, which for some parents was two or three months after the first visit. Thus, parents' recall of their emotional responses to the first visit may have been colored by later positive or negative interactions with their worker, so responses to this question may be better interpreted as capturing parents' emotional responses to their entire experience with CPS. It should also be noted, as mentioned in Chapter 3, that response rates for the parent survey were low (25% of the DR parents returned surveys and 20% of the IR parents returned surveys), which raises uncertainty about the representativeness of the findings. However, additional analyses[17] revealed minimal differences between the parents that did and did not return surveys, which lessens (but does not eliminate) the concern.

Figure 7 displays the percentages of parents assigned to the DR and IR groups that reported feeling each of the 6 positive and 6 negative emotional responses after the initial visit. Looking first at the positive emotional reactions, 37% of the parents who received DR felt relieved, 41% felt hopeful, 43% felt respected, 43% felt comforted, 39% felt encouraged, and 46% felt thankful. Similar percentages of parents who received IR felt relieved (33%) and respected (41%); these were not statistically different from those in the DR group. The differences between the DR and IR parents for each of the other positive emotions were statistically significant ($p < .0001$), with smaller percentages of the IR parents reporting feeling hopeful (21%), comforted (30%), encouraged (23%), and thankful (28%).

The reverse pattern was true for each of the 6 negative emotions: significantly smaller ($p < .0001$) percentages of DR parents than IR parents reported feeling angry (13% versus 25%), worried (26% versus 35%), stressed (22% versus 35%), disrespected (3% versus 9%), and discouraged (4% versus 9%), and a non-significantly smaller percentage of DR than IR parents reported feeling afraid (17% versus 22%).

[17] These analyses are described in Chapter 3.

Figure 7. Parent emotional responses after the first CPS visit



4.3 Family-Centered Practice

On the family survey, parents were also asked to rate their worker's use of family-centered practices, such as listening to and understanding their concerns, including their opinions in decisions, and recognizing their family's strengths. A significantly higher percentage of parents in the DR group reported that their worker listened to them "very carefully" (93%) when compared to parents in the IR group (85%) ($p < .0001$; Figure 8). Likewise, a significantly higher percentage of parents in the DR group reported that their worker understood their families' needs "very well" (88%) compared to parents in the IR group (79%) ($p < .0001$; Figure 9). A significantly higher percentage of parents in the DR group reported that their worker "always" considered their opinions before making decisions that concerned their families compared to parents in the IR group (89% versus 77%; $p < .0001$; Figure 10).

Figure 8. How carefully did the caseworker listen to what you and your family had to say?

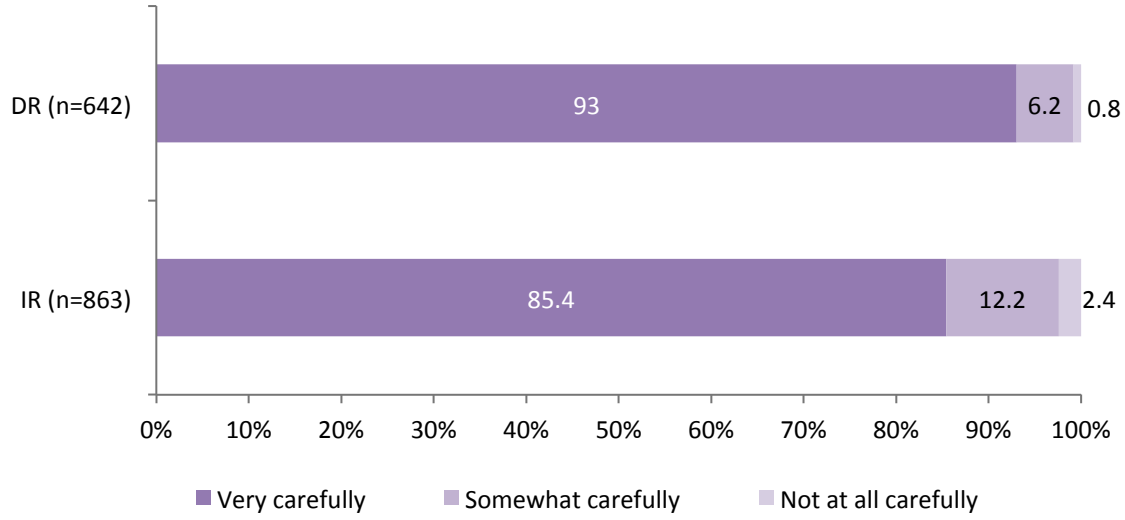
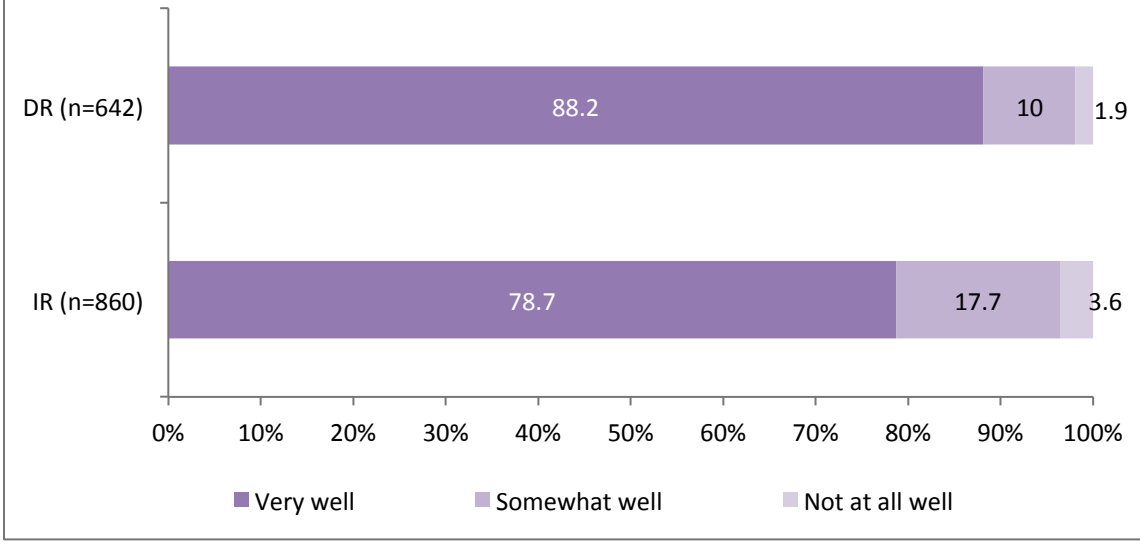
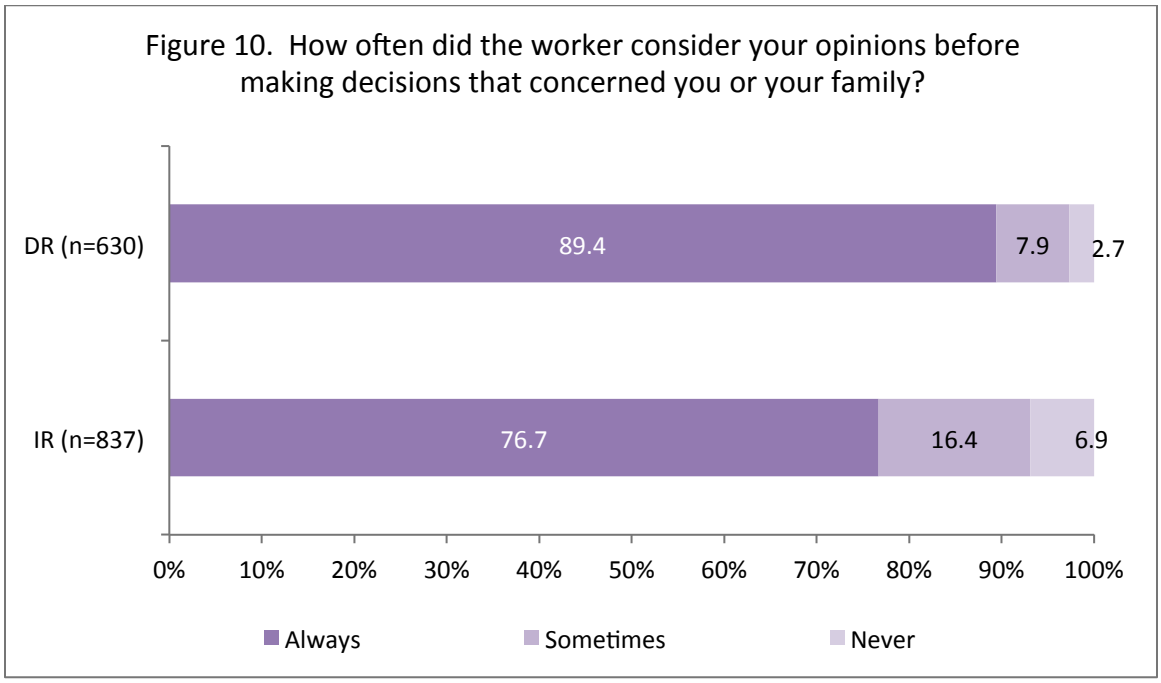
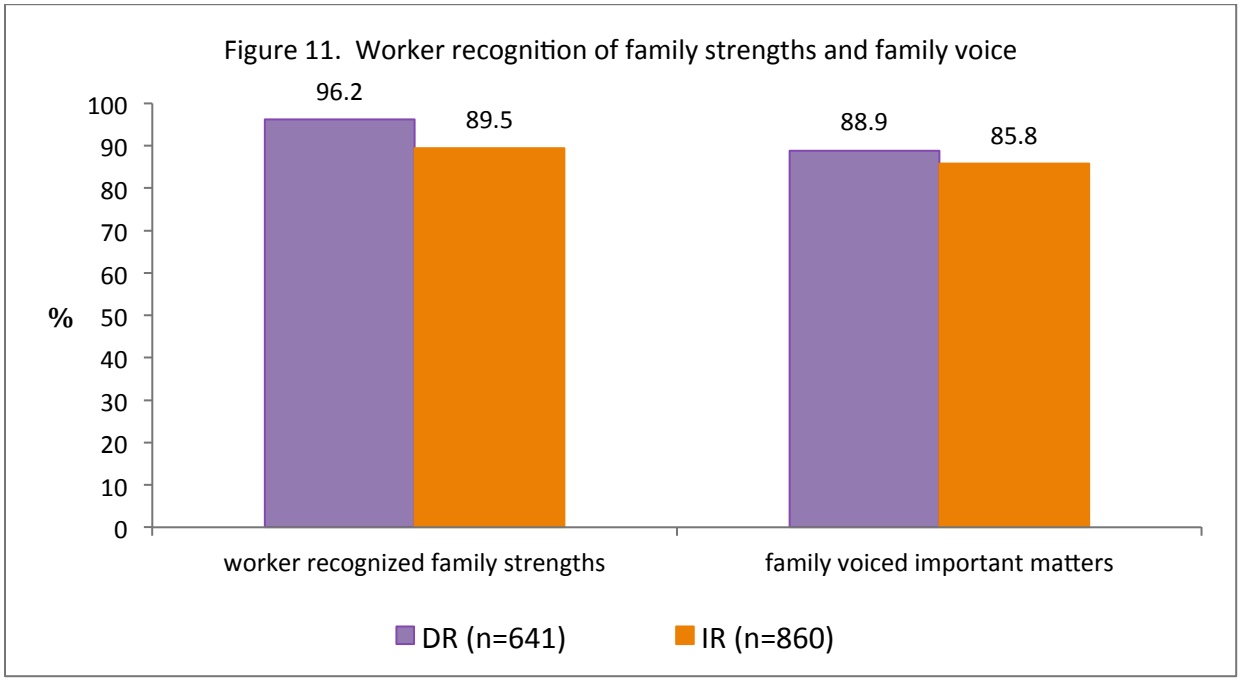


Figure 9. How well did the caseworker understand you and your family's needs?

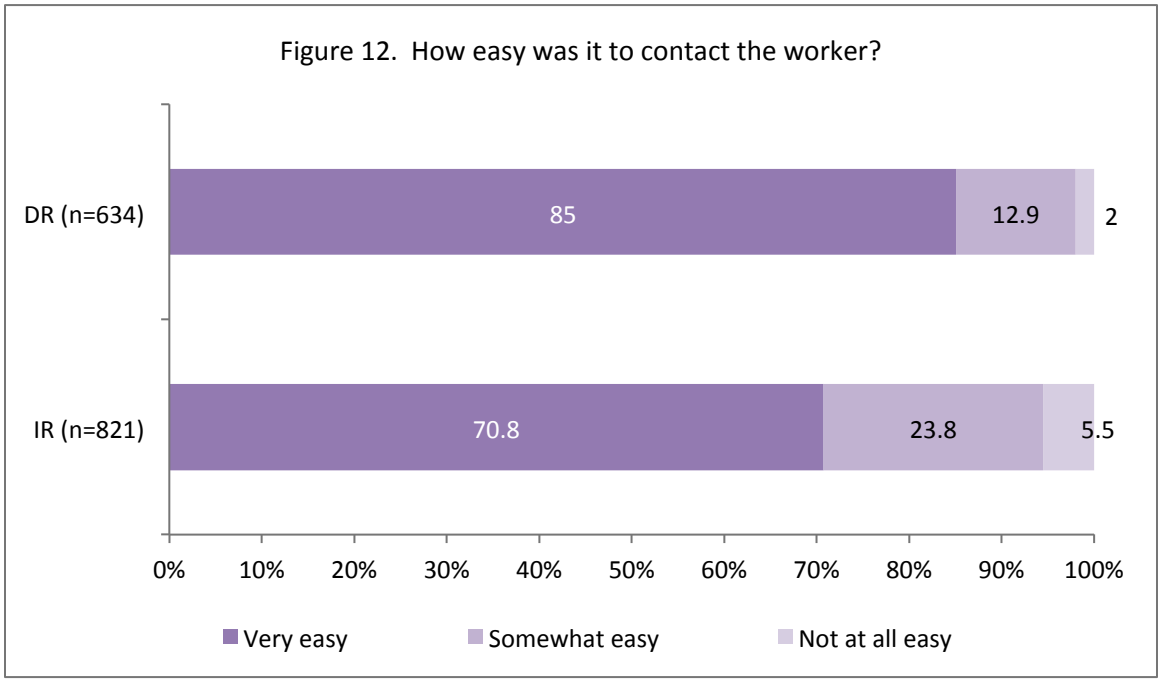




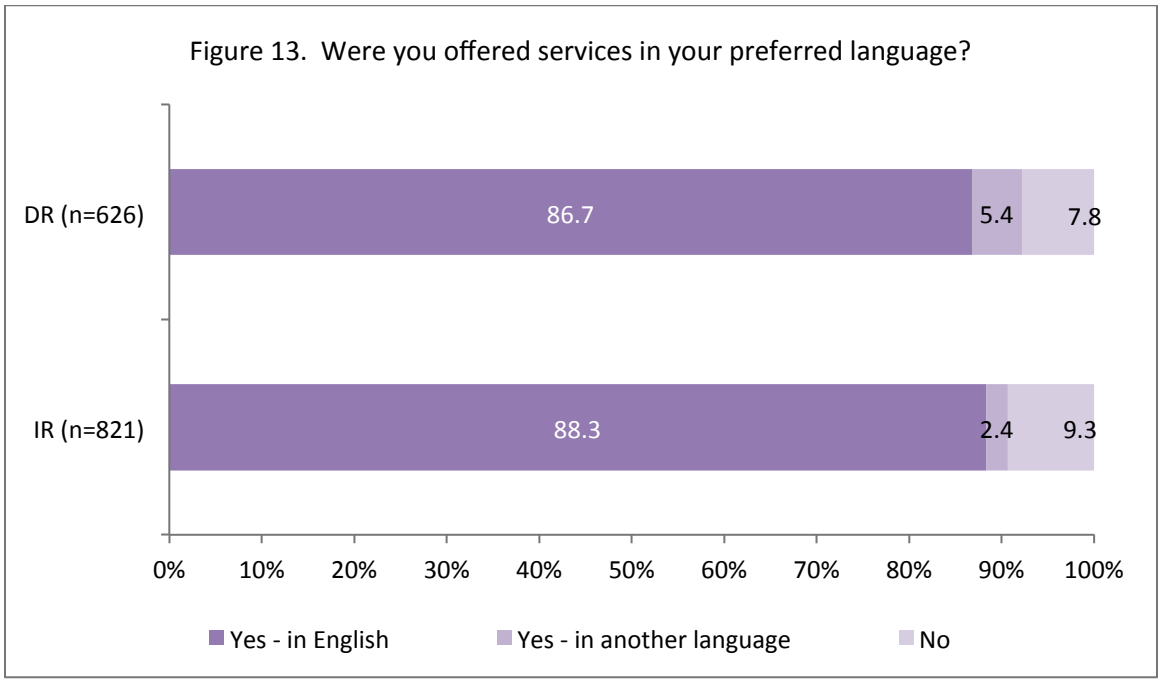
A small, but significantly higher percentage of parents who received DR felt that their worker recognized the things that they and their families did well, compared to parents who received IR (96% versus 89.5%; $p < .0001$; Figure 11). The difference in the percentages of DR and IR parents who felt that they were able to discuss important matters with their worker (89% versus 86%) was not significantly different (Figure 11).



Previous research with parents who have received child protective and child welfare services reveals that a common complaint is not being able to contact their worker. The majority of the parents who completed a family survey felt that it was very easy (85% of DR parents and 71% of IR parents) or somewhat easy (13% DR and 24% IR) to contact their worker (Figure 12). Only small percentages reported that it was not at all easy to contact their worker (2% DR and 5.5% IR). However, the differences in percentages between DR and IR parents were statistically significant, with parents in the DR group reporting greater ease in contacting their caseworker when compared to parents in the IR group ($p < .0001$).



A fundamental aspect of communicating with parents is offering services in their preferred language. Although the majority of parents in both the DR and IR groups were offered services in their preferred language (92% and 91%, respectively), higher-than-expected percentages reported that they were not (8% and 9%, $p < .01$; Figure 13).



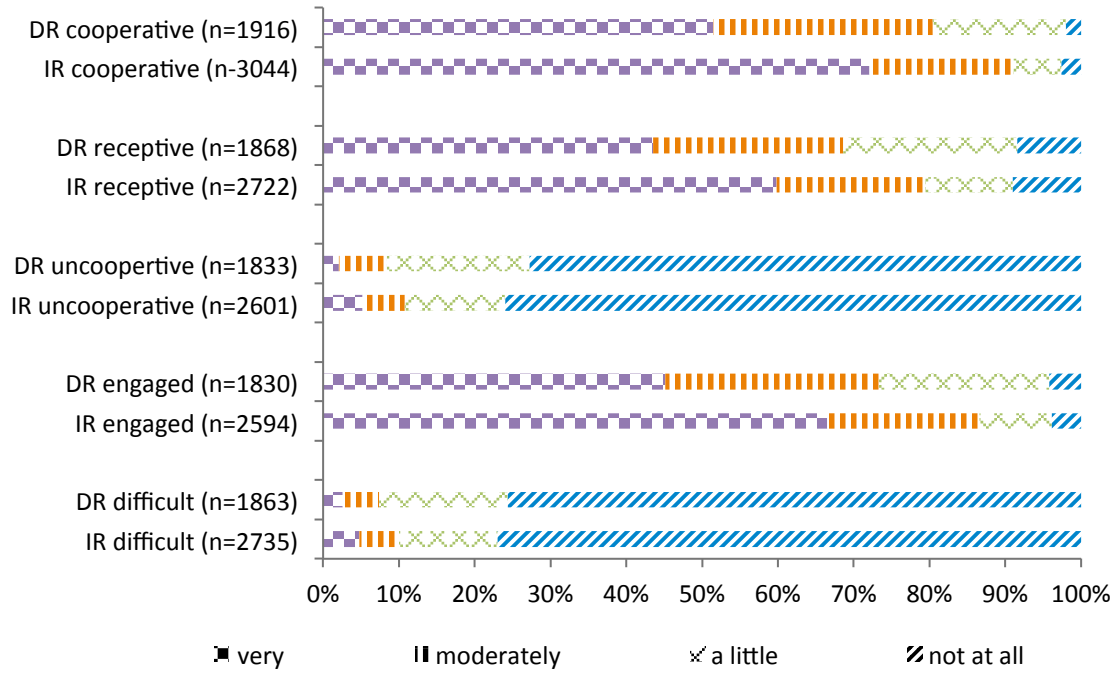
4.4 Parent Engagement with CPS

Parent engagement with their worker and their services was measured from both the parents' and workers' perspectives. Parents completed a modified version of Yatchmenoff's (2005) measure of parent engagement with child protective services.[18] In the modified version of the scale, parents responded to 17 items on a 3-point Likert scale (strongly agree = 5, agree = 3, do not agree=1). After reverse scoring 4 negatively-worded items, the possible scores on the total engagement scale ranged from 17 to 85. Mean engagement scores for DR (n=609) and IR (n=781) parents were significantly different ($p < .0001$): the average score for DR parents was 66.2 (sd = 13.0; minimum = 23 and maximum = 85) versus 57.5 for IR parents (sd = 13.4; minimum = 17 and maximum = 85).

Worker ratings of parent cooperativeness, receptiveness, uncooperativeness, engagement, and difficulty at the first meeting were significantly different. DR workers rated parents as less cooperative, less receptive, less engaged, less uncooperative, and less difficult after the first visit compared to IR workers ($p < .0001$; Figure 14). It is interesting to note that the direction of the relationship between treatment group (DR versus IR) and engagement was different based on parent ratings of their own level of engagement versus worker ratings of engagement. DR parents rated their own engagement significantly higher than IR parents, while DR workers rated parents' initial engagement significantly lower than IR workers. The opposition of these engagement ratings suggests that they may not be measuring the same construct.

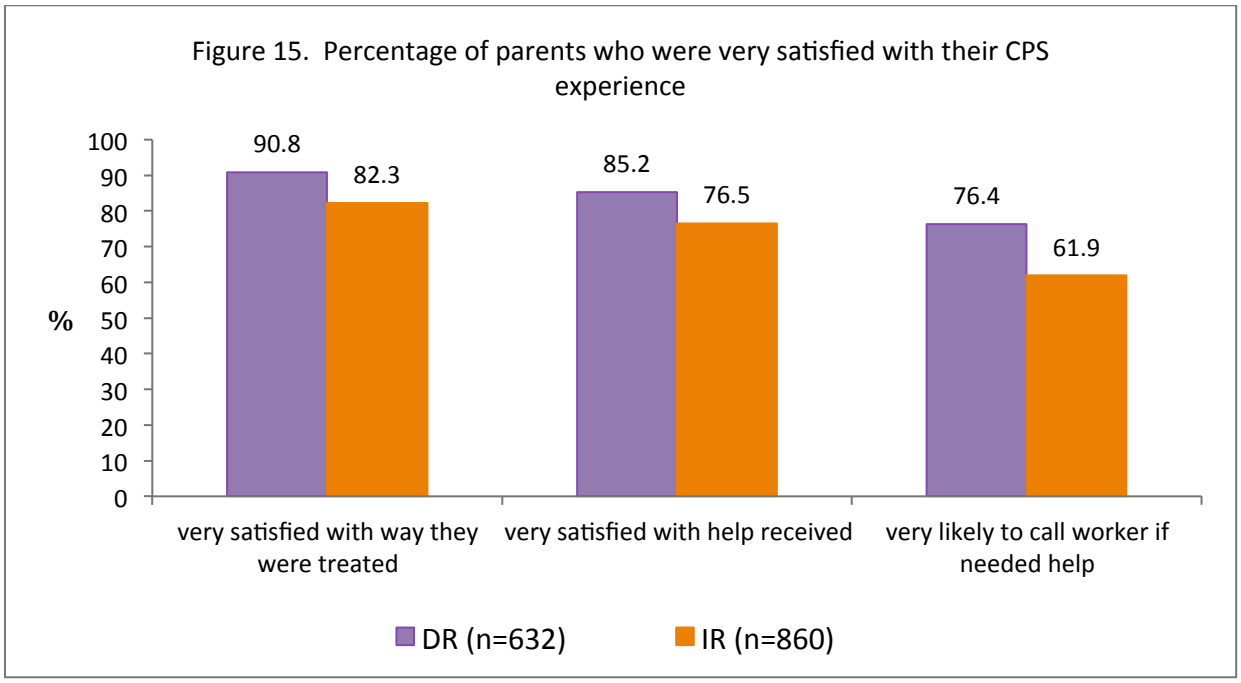
[18] Because parents completed the Illinois family survey after their case was closed, two of the items from Yatchmenoff's original scale did not make sense within this context: "I'm not just going through the motions. I'm really involved in working with CPS." and "Anything I say they're going to turn it around to make me look bad."

Figure 14. Worker ratings of parent attitudes after initial visit



4.5 Parent Satisfaction with CPS

Parents were asked three questions related to their satisfaction: 1) "how satisfied are you with the way you and your family were treated by the worker who visited your home?" (possible answers were very satisfied, somewhat satisfied, and not at all satisfied); 2) "how satisfied are you with the help that you and your family received from the worker" (very satisfied, somewhat satisfied, not at all satisfied); and 3) "how likely would you be to call the worker or the child welfare agency if you or your family needed help in the future?" (very likely, somewhat likely, not at all likely). Responses to all three questions indicated that satisfaction was very high among parents who received both DR and IR services, with large majorities responding that they were very satisfied with their treatment and services and were very likely to call the worker or agency if they needed help in the future (Figure 15). Although satisfaction in both DR and IR groups was high, it was significantly higher on all three items among parents who received DR ($p < .0001$).



4.6 Summary of Findings: Parent Experiences with CPS

Prior qualitative research with parents who have received child protective services suggests that the majority react to the initial CPS intervention with a mixture of fear and anger. Results of the current analyses suggest that in Illinois, about a quarter of the parents who received DR felt worried (26%) and stressed (22%) following the first visit, compared to about a third of the parents who received an investigation (35% for both). Even smaller percentages of parents felt angry following the first visit – 13% of the parents who received DR reported this emotion as did 25% of the parents who received an investigation. There is also evidence to suggest that both DR and IR workers treated parents with respect during the initial in-home visit: 43% of the DR parents and 41% of the IR parents reported that they felt respected and very few felt disrespected (3% and 9%, respectively). Although the negative emotional responses to a traditional CPS investigation were smaller than those reported in prior research, there was also clear evidence that negative emotional responses were significantly lessened among parents receiving DR compared to those receiving an investigation.

In addition, large majorities of parents in both groups reported that their workers listened to them very carefully, understood their families' needs very well, either always or sometimes considered their opinions before making decisions, and recognized their strengths. Although use of these family-centered practices was high in both groups, it was reported significantly more often by parents who received DR compared to those who received an investigation. One important aspect of parent involvement with services is providing services in their preferred language. Almost 10% of parents in both groups reported that they were not offered services

in their preferred language, which suggests that there is additional need for bilingual CPS workers.

Parents and workers differed in their assessments of parents' engagement with CPS. Using a validated self-report measure of engagement in CPS services, parents in the DR group reported significantly higher levels of overall engagement compared to parents in the IR group. Conversely, private agency DR workers rated parent engagement, cooperation, and receptivity following their initial meeting significantly lower than did IR workers. The low correspondence between worker and parent ratings of parent engagement *suggests* that they may be measuring different underlying constructs. Previous research confirms this notion and suggests that workers place a much heavier emphasis on parent compliance with tasks as an indicator of their motivation for treatment than parents do (Smith, 2008). However, further analyses are needed to better understand the relationships between parent and worker ratings of engagement and other aspects of their overall CPS experience.

Chapter 5: Service Provision

Prior to the implementation of Differential Response in Illinois, very few families received formal child welfare services (either intact family services or child placement services) following an investigation, even if their allegations of maltreatment were substantiated. For example, in FY2012, only 26% of families with substantiated allegations of maltreatment were provided with post-investigation child welfare services (Children and Family Research Center, 2013). This was especially true for families investigated for allegations of environmental neglect and lack of supervision, two of the most commonly reported types of maltreatment. One of the goals of Differential Response in Illinois was to provide short-term services and concrete supports to families reported to CPS that most likely would not have received services if they had received a traditional CPS investigation.

5.1 Measuring Service Provision

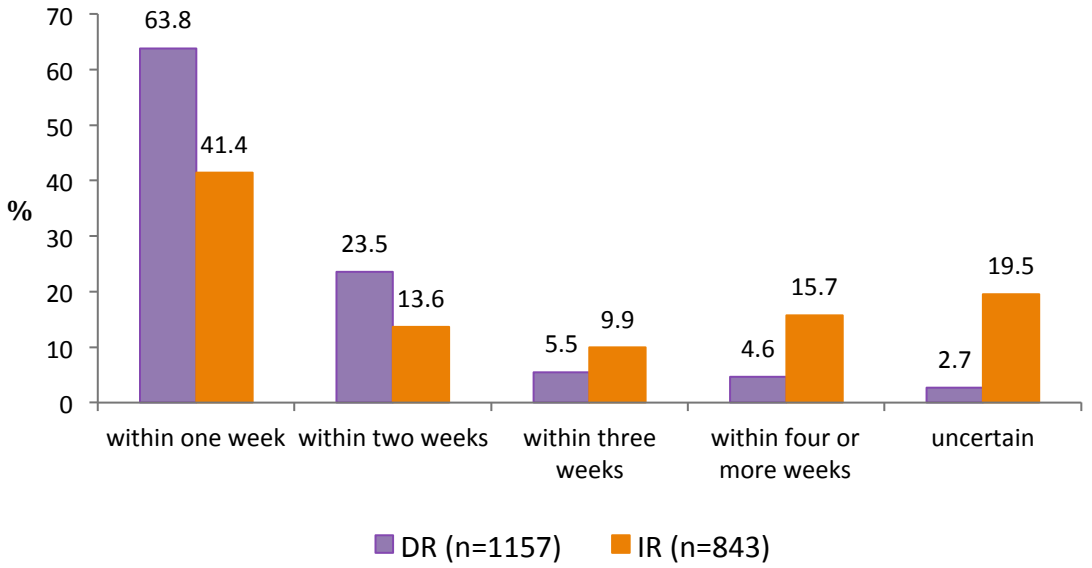
This chapter compares the service experiences of families assigned to the DR and IR groups using information from SACWIS, the worker-completed Case Specific Reports (CSR), and the parent-completed family survey (FS). Several aspects of service provision were measured and will be reported in this chapter, including:

- Time to first service was reported by workers (CSR)
- Initial case duration was computed by calculating the number of days from the initial report date through the initial investigation/DR case closure date (SACWIS)
- Number of face-to-face contacts between the worker and family during the initial case was reported by both workers (CSR) and parents (FS)
- Percentage of families that received any services (i.e., at least one) during the initial case was reported by both workers (CSR) and parents (FS)
- Provision of different types of services during the initial case was reported by both workers (CSR) and parents (FS)
- Workers reported the types of service referrals that were provided to the family (CSR)
- Workers reported on the involvement of friends and relatives outside the household in service provision (CSR)
- Workers reported on the use of community resources in service provision (CSR)
- Service effectiveness and match-to-needs was rated by both workers (CSR) and parents (FS)
- Workers reported on the barriers to effective service provision, such as caseload size, limited staff time, other pressing cases, family problems outside scope of CPS, and limited funds for services (CSR)
- SACWIS data were used to determine the percentage of families that had an intact family service case opened following the initial DR or IR case

5.2 Time to First Service, Case Duration, and Number of Worker Contacts

On the CSR, workers[19] were asked to report the length of time between the initial report and when the family received services ("Were any services (traditional or non-traditional) or supports provided to this family? If yes, how soon after the initial report date did the family receive services?"). A significantly higher percentage of DR workers than IR workers reported that services were provided quickly – within one or two weeks ($p < .0001$; see Figure 16). In addition, a much larger percentage of IR workers reported that they were uncertain when families received services (19.5%) compared to DR workers (2.7%), most likely because IR workers were able to refer families to services but were unable to confirm if or when services were received.

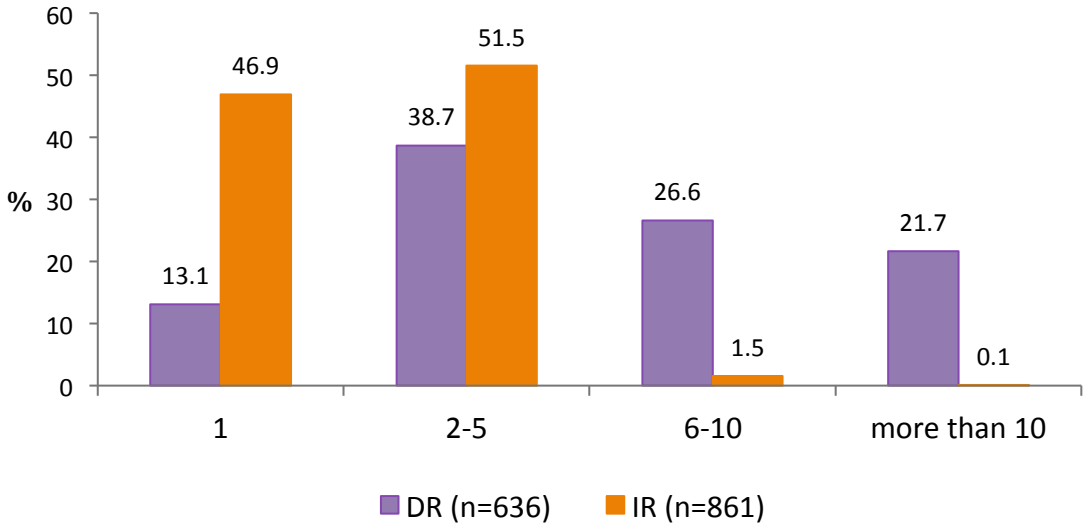
Figure 16. Timeliness of service provision



DR cases (n=3,014) had a mean duration of 55.6 days (sd=33.5; median = 57 days), which was slightly but significantly ($p < .01$) longer than the mean duration of 53.6 days for an investigation (n=4,480; sd=32.2; median =58). Both workers and parents reported on the total number of face-to-face contacts that occurred during the initial case. On average, DR workers (n=1,963) reported significantly more face-to-face contacts with families than IR workers (n=3,374) – 7.8 versus 2.3, respectively, $p < .0001$. Parents who received DR also reported a significantly higher number of face-to-face contacts with their worker than parents who received IR ($p < .0001$, see Figure 17). This difference in the number of face-to-face contacts between DR and IR is not surprising, due to the requirement that SSF workers meet twice a week with families.

[19] For DR cases, the private agency SSF worker completed the CSR, since they were the ones that worked directly with the families for the entire case. For IR cases, the Investigator completed the CSR.

Figure 17. Parent reports of number of face-to-face contacts with workers

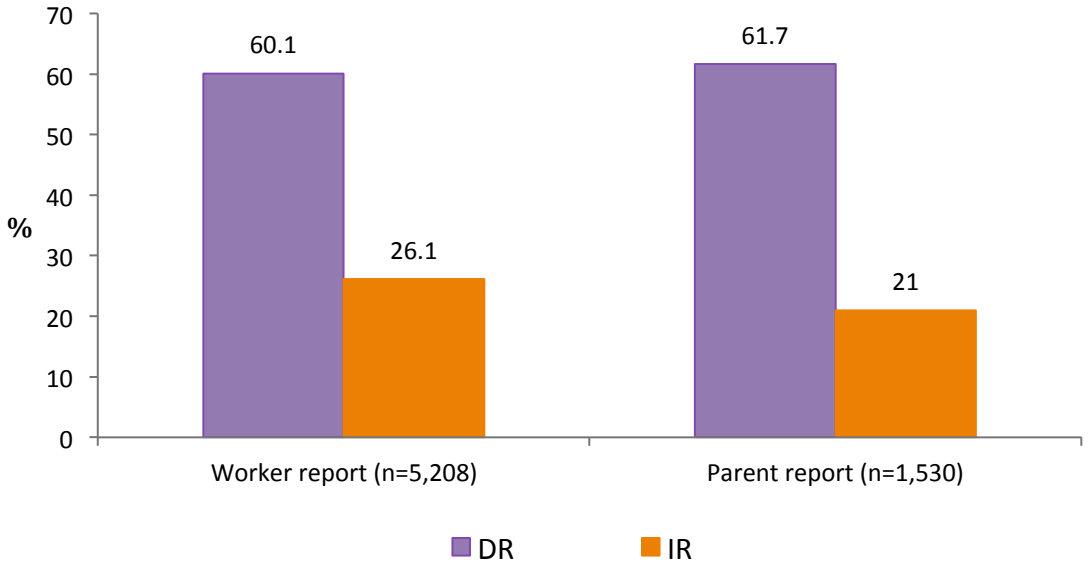


5.3 Number and Types of Services and Referrals Received

Both the Case Specific Report (completed by workers) and the Family Survey (completed by parents) contained a list of services that could have been provided to or received by parents during the initial DR case or Investigation.[20] One measure of service receipt is to examine the percentage of families who received at least one service during the initial case versus those that received no services. Both workers and parents reported that families in the DR group were significantly more likely than those in the IR group to receive at least one service ($p < .0001$; see Figure 18).

[20] The initial case period is defined as the period of time beginning with the initial maltreatment report date and ending with the DR case *or* investigation close date or the date the case is transferred to ongoing services, whichever came first.

Figure 18. Families who received at least one service during initial case



To examine the number and types of services that were provided, the parent survey included a checklist of 25 different services that may have been provided during their case or investigation, and parents were asked to check all that they received. Figure 19 displays the number of different services that families in the DR and IR groups reported receiving during the initial case. Families who received DR were significantly more likely than those who received an investigation to get one, two, three, and four or more individual services ($p < .0001$).

Figure 19. Parent reports of number of services received during initial case

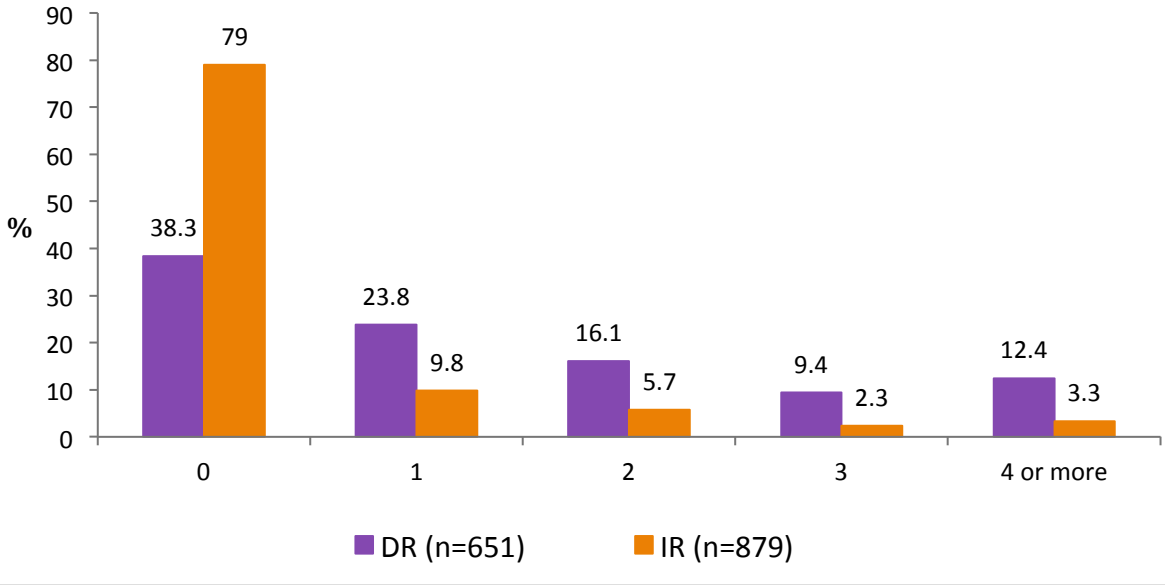


Table 5 presents the list of services that parents in each group reported receiving. The most frequently provided services among parents in the DR group were:

- food or clothing (16.6%);
- help looking for employment (15.5%);
- counseling (13.8%);
- car repair or transportation assistance (9.4%);
- appliances, furniture, or home repairs (8.1%); and
- help getting into educational classes (7.1%).

The most commonly received services among parents in the IR group were:

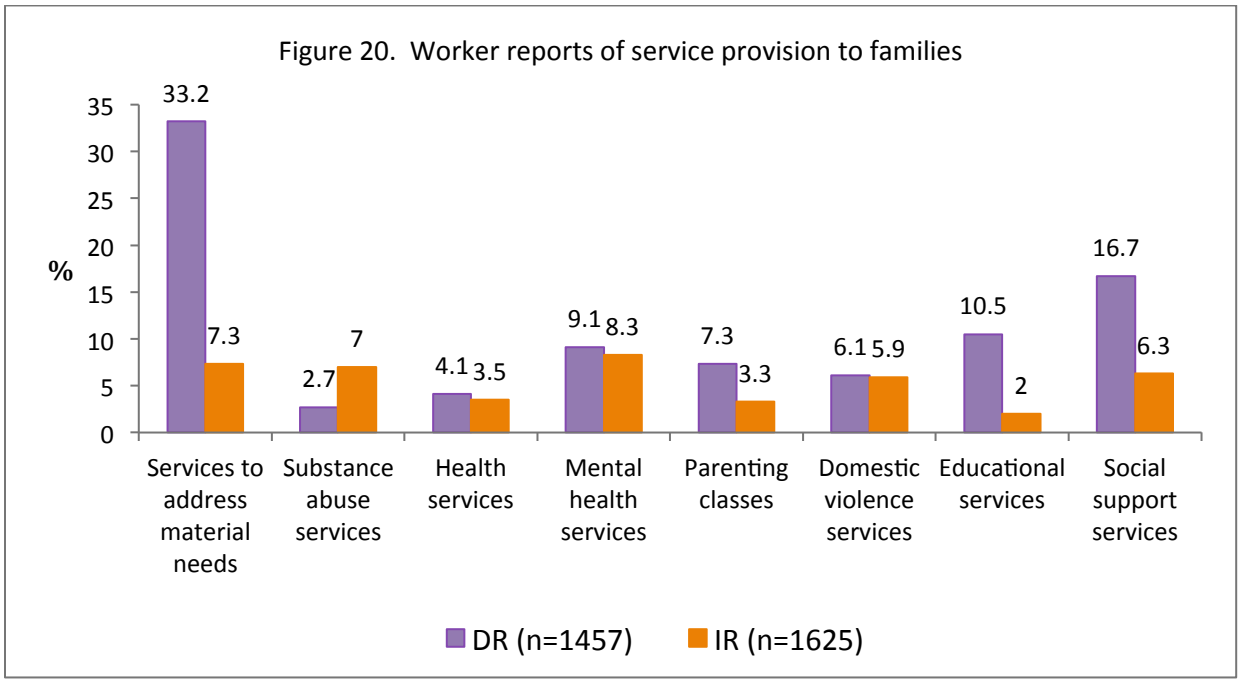
- counseling (6.4%);
- domestic violence services (4.1%);
- parenting classes (3.2%),
- help getting mental health services (3.1%);
- food or clothing (3.0%); and
- medical or dental care (3.0%).

Of the 25 individual services listed, parents in the DR group were significantly more likely than parents in the IR group to receive 17 of them, including: car repair or transportation; housing assistance; food or clothing; appliances, furniture, or home repairs; help paying utilities; welfare/public assistance services; medical or dental care; other financial help; help for a family member with a disability; legal services; assistance in the home such as cooking or cleaning; help getting mental health services; parent support groups; help getting educational classes; counseling; help looking for employment; and educational services. Although parents in the IR group were more likely to receive emergency shelter services than parents in the DR group (2.1% versus 1.5%, respectively) the difference was not statistically significant.

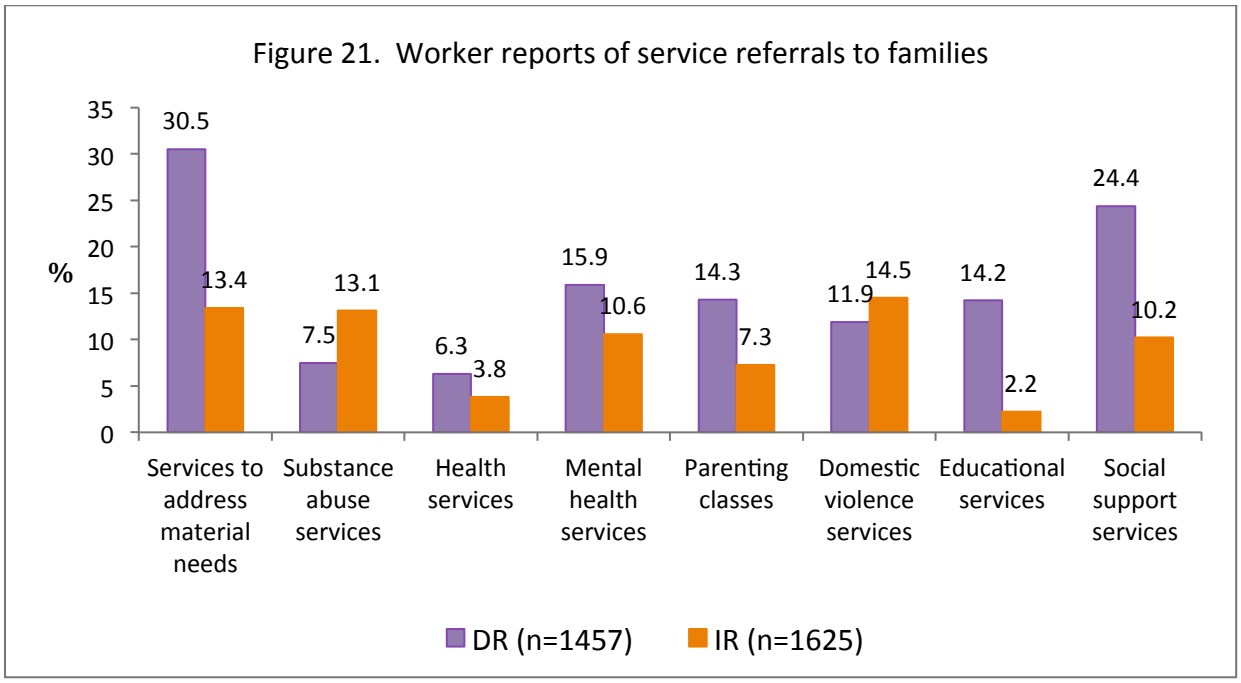
Table 5. Parent Reports of Services Received During Initial Case		
	DR (n=651)	IR (n=879)
Emergency shelter	1.5%	2.1%
Car repair or transportation assistance	9.4%	1.0%***
Housing assistance	5.4%	2.5%*
Food or clothing for family	16.6%	3.0%***
Money to pay rent	2.6%	1.1%
Appliances, furniture, or home repairs	8.1%	1.9%***
Help paying utilities	6.1%	1.5%***
Welfare/public assistance services	6.6%	2.7%**
Medical or dental care	6.5%	3.0%*
Other financial help	6.0%	1.7%***
Help for a family member with a disability	4.0%	1.6%*
Legal services	5.7%	1.7%***
Assistance in the home, such as cooking or cleaning	1.8%	.2%*
Help with child care or day care	4.8%	2.6%
Help getting mental health services	6.8%	3.1%*
Respite care	.9%	.5%
Help getting alcohol or drug treatment	2.3%	2.2%
Parent support groups	4.5%	.5%***
Parenting classes	5.1%	3.2%
Help getting into educational classes	7.1%	.9%***
Counseling services	13.8%	6.4%***
Help looking for employment or changing jobs	15.5%	1.3%***
Domestic violence services	5.8%	4.1%
Job or vocational training	1.7%	.9%
Educational services	6.1%	2.2%***
*p < .01 **p< .001 *** p<.0001		

On the CSR, workers reported whether they provided or referred families to several different categories of services, including services to address material needs, substance abuse services, health services, mental health services, parenting classes, domestic violence services, educational services, and social support services. Figure 20 shows the percentages of DR and IR workers who reported providing these types of services to families. The most frequently-provided services by DR workers were services to address material needs (provided to 33.2% of DR families), social support services (16.7%), and educational services (10.5%); the most frequently provided services by IR workers were mental health services (8.3%), services to address material needs (7.3%), and substance abuse services (7.0%). DR workers reported providing significantly more services to address material needs, parenting classes, educational services, and social support services than IR workers (each difference was significant at p <

.0001). Substance abuse services were more frequently provided to IR families than DR families ($p < .0001$).



Workers also reported whether they referred families to these same types of services (Figure 21). The most frequently referred services by DR workers were services to address material needs (provided to 30.5% of DR families), social support services (24.4%) and mental health services (15.9%); the most frequently referred services by IR workers were domestic violence services (14.5%), services to address material needs (13.4%), and substance abuse services (13.1%). DR workers reported referring significantly more services to address material needs, health services ($p < .01$), mental health services, parenting classes, educational services, and social support services than IR workers (each difference was significant at $p < .0001$). Substance abuse services were more frequently referred to IR families than DR families ($p < .0001$).



Workers were asked two additional questions about service provision during the initial case: if "relatives and friends outside the household" were involved in providing needed support to the family, and if "no-cost neighborhood/community resources (i.e., churches)" were used to assist the family. About half of both DR workers and IR workers reported that they involved relatives and friends to provide support to the family during the initial case (49.7% and 46.3%, respectively). A larger percentage of IR workers than DR workers reported that they did not involve friends or family members at all in service provision (39.6% versus 29.2%; $p < .0001$; see Figure 22). DR workers were much more likely than IR workers to report that they utilized community resources to assist the family ($p < .0001$; see Figure 23).

Figure 22. Involvement of friends and relatives in service provision

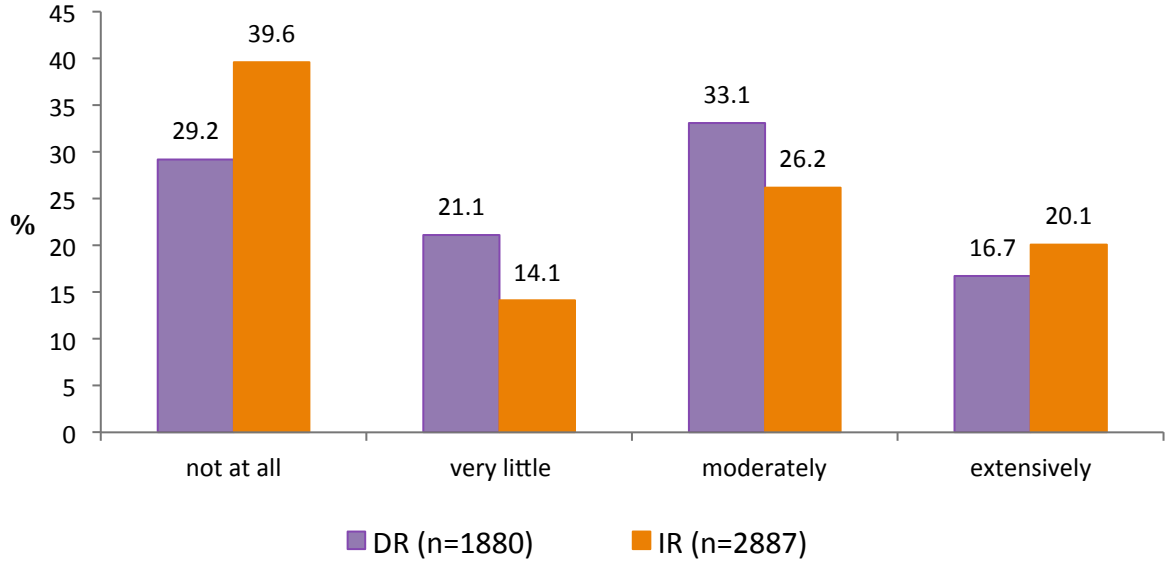
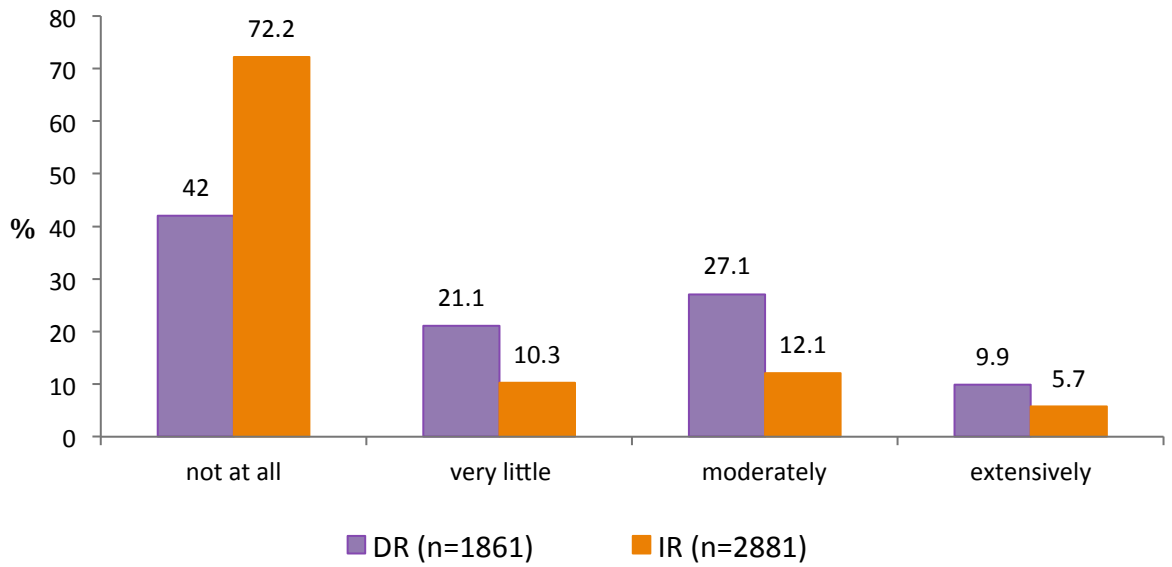


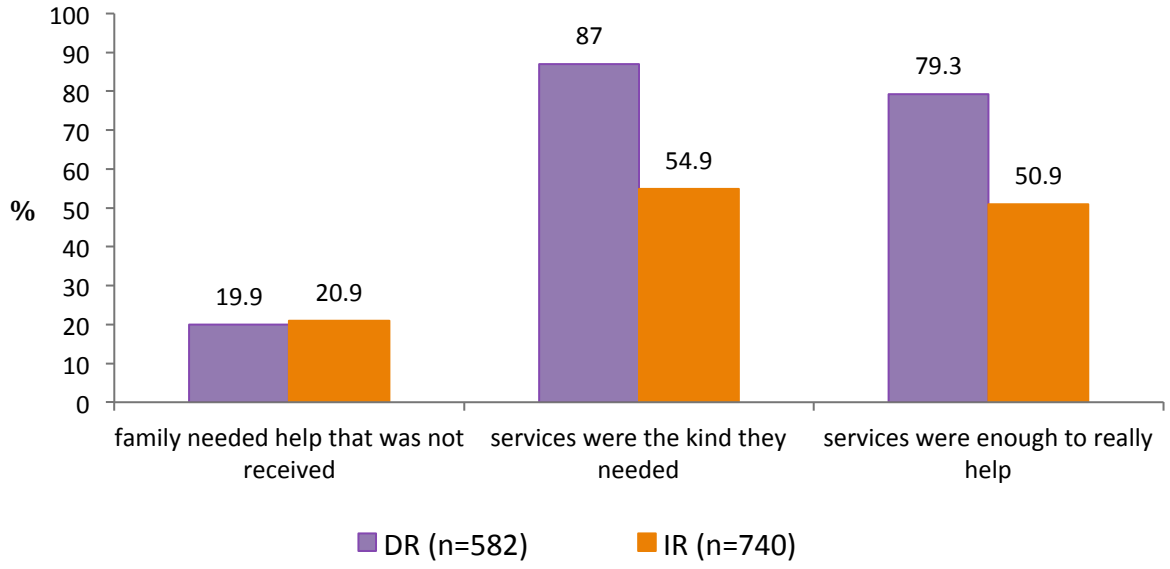
Figure 23. Community resources used in service provision



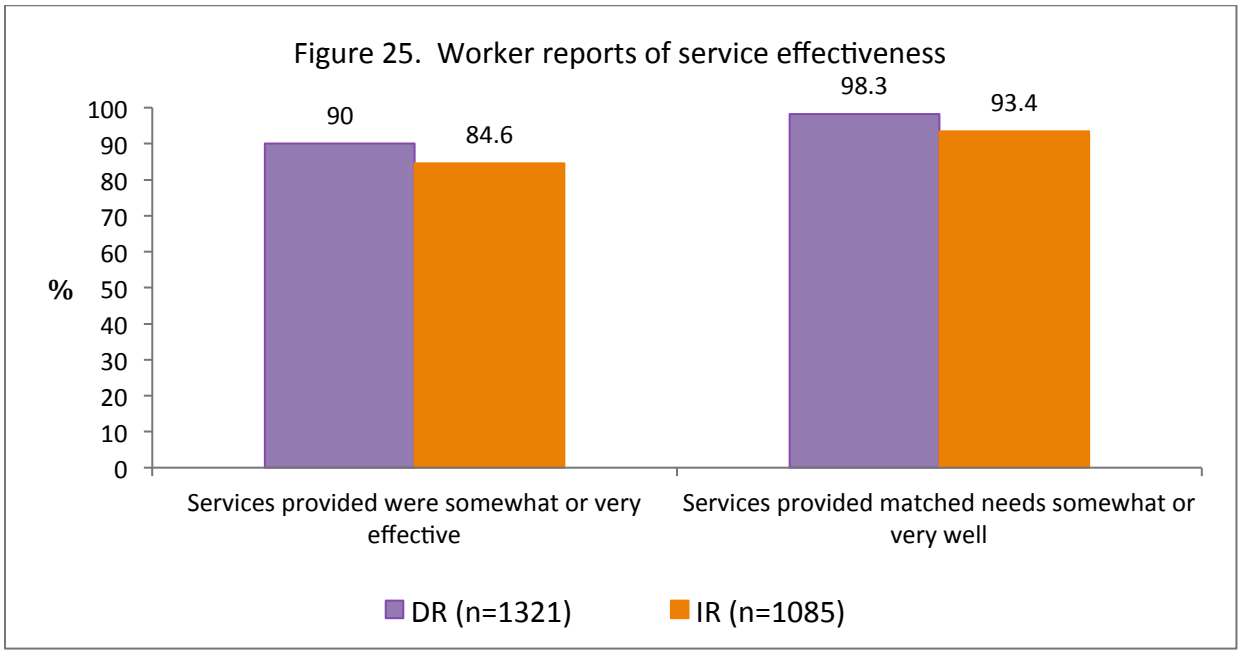
5.4 Service Effectiveness and Match-to-Needs

Families answered several questions about the effectiveness of the services they received in their initial case. Specifically, they were asked: if there was any help they needed but did not receive, if the services they received were the kind of help they needed, and if the services received were enough to really help them (Figure 24). There was no difference in the percentage of families receiving DR and IR that needed help that they did not receive. However, families that received DR were significantly more likely to report that the services they received were the kind they really needed and enough to really help ($p < .0001$).

Figure 24. Family reports of service effectiveness



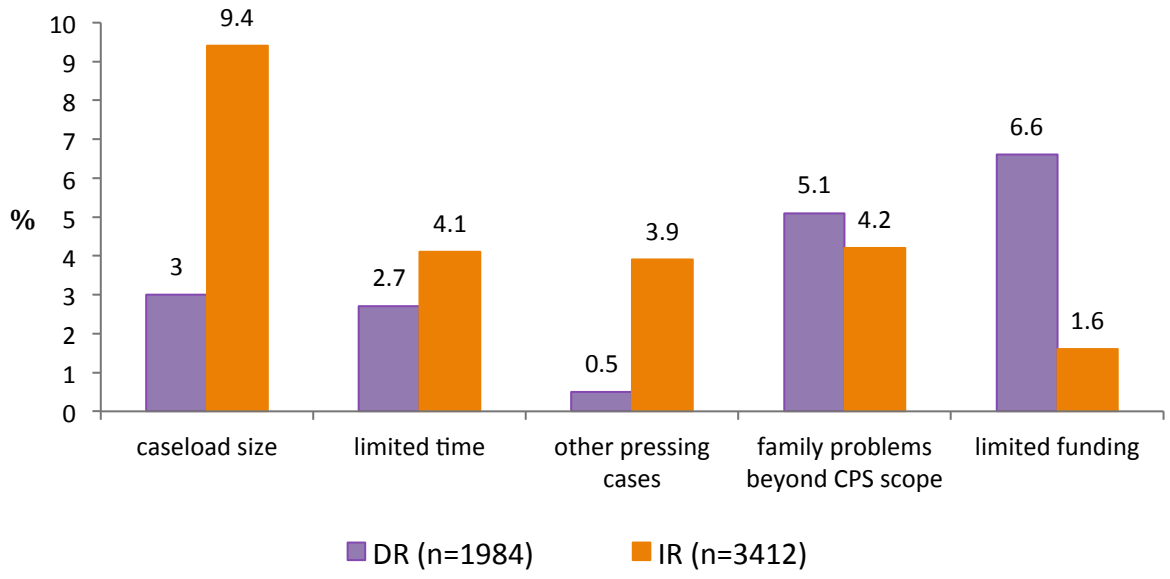
Workers answered two questions related to the overall effectiveness of the services provided in "solving their problems or in producing needed changes" and the overall match between the family needs and services provided (Figure 25). DR workers were slightly, but significantly, more likely than IR workers to report that the services they provided were (somewhat or very) effective in solving the families' problems (90.0% versus 84.6%, $p < .0001$) and that the services were (somewhat or very) well-matched to the families' needs (98.3% versus 93.4%, $p < .0001$).



5.5 Barriers to Service Provision

On the CSR, workers were asked to indicate if the family was not "fully served" because of the following reasons: size of current caseload, limited time to work with family, other pressing cases on caseload, family problems were beyond the scope of CPS to remedy, or limited funds available for needed services. IR workers were significantly more likely to report that families were not fully served due to their high caseloads ($p < .0001$), time limitations ($p < .01$), and other more pressing cases ($p < .0001$); while DR workers were more likely than IR workers to cite funding limitations as a reason that families were not fully serviced ($p < .0001$; Figure 26).

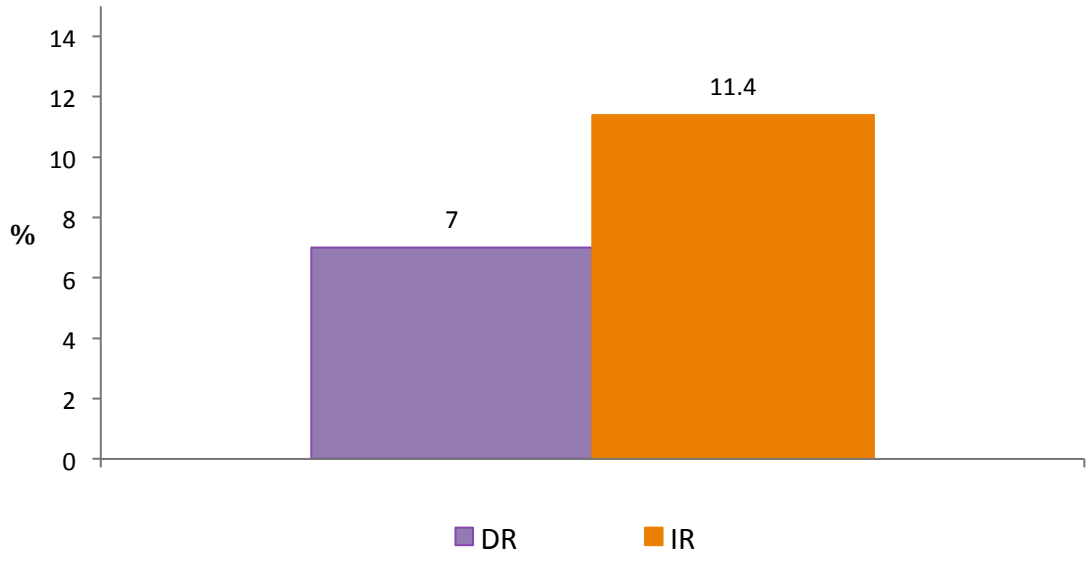
Figure 26. Worker-reported barriers to service provision



5.6 Child Welfare Case Openings Following Initial Case

SACWIS data were used to track whether an intact family child welfare case was opened following the initial case (Figure 27). The percentage of DR families that had a child welfare case opened was significantly smaller (7.0%) than the percentage of IR families (11.4%, $p < .0001$).

Figure 27. Child welfare case openings following initial case



5.7 Summary of Findings: Service Provision

As described in Chapter 2, practice requirements for service provision in the DR and IR pathways in Illinois are very different. Investigators do not provide direct services to families during the initial case, but may refer families to community resources or offer services to the families through an intact family child welfare case. Conversely, SSF workers were considered to be the primary agent of change for the family and were required to meet with them in their home at least twice weekly to directly provide a variety of concrete and supportive services. Given these practical differences in policy and procedures, it is not surprising that DR and IR parents and workers reported vast differences in service provision during and after the initial case.

For instance, parents in the DR group reported that they received at least one service during their initial case about three times more often than parents in the IR group (62% versus 21%, respectively). Parents in the DR group were also more likely to report that they received various kinds of supports during the initial case, including car repair, food or clothing, appliances or home repairs, help with utilities, welfare assistance, medical or dental care, legal services, help getting mental health services, homemaker services (cooking or cleaning), parent support groups, help looking for employment, counseling, and transportation. In addition to receiving more services and a wider variety of services, families assigned to the DR group also received their first service much more quickly than those assigned to the investigation control group: 64% of DR families received services within a week of case assignment compared to 41% of IR families.

Of the families that received any services at all during the initial case, 87% of the DR parents felt that the services were the kind they needed, compared to 55% of the IR parents. Although only 55% of the parents in the IR group felt that the services they received were the kind they needed, 93% of the IR workers felt that the services they provided to families were somewhat or very well matched to family needs. Among IR workers, the most frequently cited barrier to effectively serving families was caseload size, which was mentioned in about 10% of cases. Among DR workers, the most frequently cited barrier to effective services provision was limited funding, which was mentioned in 6.6% of DR cases.

Chapter 6: Child Safety and Family Well-Being

The DR logic model proposes that engaging parents from the initial CPS contact, involving them in the assessment and service planning process, and providing them with well-matched services in a timely manner will result in improved child safety and family well-being. The previous two chapters examined the similarities and differences in family engagement and service provision of families who received DR and IR. This chapter examines the similarities and differences between the two groups on child safety and family well-being outcomes.

6.1 Measuring Child Safety

There are numerous ways to measure child safety, but in child welfare research it is most commonly measured as a subsequent screened-in report of maltreatment (i.e., a re-report) within a certain period of time following an initial report. Although this indicator of child safety is fairly well-established, there are numerous ways that it can be operationalized, each of which can vary along several dimensions:

- Safety can be measured at the child, perpetrator, or family level, depending on which member(s) of the family are followed over time.
- The follow-up period of observation for subsequent maltreatment can vary from short-term (60 days or less) to long-term (2 years or more). It is unclear if there is an ideal length of time to track re-reports, or if it should be expected that a child welfare intervention will have effects on child safety that persist several years.
- Some measures of child safety include any subsequent screened-in report to CPS, regardless of whether or not it is eventually substantiated, while others include only additional substantiated reports.
- Some studies track the types of subsequent maltreatment reports (e.g., neglect, physical abuse, sexual abuse) to examine whether they are the same as the initial report, or if they become more or less "serious" over time.
- Some families will have more than one incident of repeat maltreatment over time (see Loman, 2006; Zhang, Fuller, & Nieto, 2013). Most studies count only the first incident of repeat maltreatment during the follow-up period, but some gather information on the total number of repeat contacts over a specified period of time.

In addition to child safety indicators based on maltreatment re-reports or substantiated re-reports, some studies examine whether families experience other types of child welfare involvement over a follow-up period, such as a child placement into substitute care. These events are used as proxy measures for child safety, under the assumption that child placement into substitute care occurs due to safety concerns. Other safety measures incorporate parent perceptions of the child's safety.

In response to the limitations posed by each of these different measures of child safety, the Illinois DR evaluation takes an inclusive approach and incorporates several different measures using administrative data and parent reports. Specifically, the following measures were used:

- Maltreatment re-reports
    - the percentage of families that had a maltreatment re-report (on any child) within 60 days, 6 months, 12 months, and 18 months of initial case closure
    - the cumulative risk of a first re-report over the 18 month follow-up period (survival analysis)
    - of those families that experienced at least one re-report, the number of re-reports they experienced within 18 months
    - of those families that experienced at least one re-report, the length of time between initial case closure and first re-report
    - of those families that experienced at least one re-report, the percentage that had new allegations of neglect, physical abuse, and sexual abuse
- Substantiated maltreatment re-reports
    - the percentage of families that had a substantiated maltreatment re-report (on any child) within 60 days, 6 months, 12 months, and 18 months of initial case closure
    - the cumulative risk of a first substantiated re-report over the 18 month follow-up period (survival analysis)
    - of those families that experienced at least one substantiated re-report, the number of substantiated re-reports they experience within 18 months
    - of those families that experienced at least one substantiated re-report, the length of time between initial case closure and first substantiated re-report
- Child removals
    - the percentage of families that had at least one child removed from the home following initial case closure
    - the cumulative risk of a first child removal over the 18-month follow-up period (survival analysis)
    - of those families that had at least one child removed, the length of time between case closure and first child removal
    - of those families that had at least one child removed, the mean number of days spent in substitute care
- Parent perceptions of child safety
    - the percentage of parents who reported that their children were safer because of their experience with CPS

Only re-reports and substantiated re-reports that occurred *after* the initial case (or investigation) close date are counted in the analyses. This definition is used to accommodate two important differences in practice between DR and IR that skew the re-report rates between the two groups. According to DR procedures, if the DR Specialist or SSF Caseworker had reason to believe that a child was being abused or neglected or was at risk of harm at any time during the initial assessment or service delivery period, they were required to redirect the case to investigations by calling the SCR and making a new report on the family. This situation occurred in about 12.5% of the cases assigned to the DR group. There was no similar procedure in place for investigators; if they discovered new allegations of abuse or neglect during the course of their investigation, they were not required to call the SCR and make an additional report.

The second source of discrepancy in policy between the two groups involved additional screened-in reports on the same families that were received by the SCR during the initial case or investigation. If a subsequent report was received on a family receiving an investigation within a week or two of the initial report, it was usually "consolidated" with the earlier report rather than opened as a new investigation with a new case number. Thus, these additional reports would not be counted in measures of re-reports among investigated families. The same is not true of families assigned to DR services. If additional reports were screened-in for families receiving DR services, they could not be consolidated with existing reports. Instead, they were counted as a subsequent report and families were immediately re-assigned from DR to IR. An additional 10% of families in the DR group fell into this category. By measuring only re-reports that occurred after the initial investigation/case close date, we were able to avoid the bias that would have occurred if re-reports that occurred after the initial report date (i.e., during the initial case) were included in the safety outcome measures.

Random assignment began in November 2010 and ended in May 2012, and follow-up data on re-reports, substantiated re-reports, and child removals were collected through March 31, 2013. This means that cases that were randomly assigned early will have a longer follow-up period than those randomly assigned later. To deal with the differences in the follow-up periods, two approaches were used. The first compared the percentages of families that experienced the outcome of interest within 60 days, 6 months, 12 months, and 18 months. These cross-tabulations provide a simple method for comparing outcomes of the DR and IR families across different time periods and are intuitive to understand. However, they do not take into account the fact that some families did not observe the full observation period: all families had an observation period of at least 6 months, but 1,581 cases had an observation period less than 12 months, and 4,957 cases had an observation period less than 18 months. The second approach, survival analysis, estimates the probability of an event (such as a first re-report, substantiated re-report, or child removal) by taking into account both the occurrence of the event and the timing of its occurrence. The time to the event is computed using the strategy of "censoring" cases that do not encounter the event based on the lengths of their observational periods. Survival analysis results can be plotted to show the probability of "surviving" (i.e., not experiencing the event) over time; conversely, a "risk" curve can be constructed that shows the probability of experiencing the event over time. Statistical tests can be conducted to compare the survival or risk curves of two or more groups (such as a treatment and control group) and see if they are equivalent.

6.2 Measuring Family Well-Being

In Illinois, there is little administrative data on family well-being. Although well-being indicators exist in other administrative datasets (developmental and educational outcomes, health and mental health outcomes), these data could not be linked to the DR evaluation data. Therefore, several questions related to family well-being were added to the family survey to assess:

- Material well-being: Parent responded to a yes/no question that asked "Are you better able to provide necessities like food, clothing, shelter, or medical services because of your experience?"
- Parenting skills: Parents responded to a yes/no question that asked "Are you a better parent because of your experience?"
- Overall well-being: Parents answered the question "Overall, are you and your family better off or worse off because of your experience?" by choosing one of three responses (we are better off/we are the same/we are worse off)

6.3 Maltreatment Re-reports

Table 6 compares the percentages of families assigned to the DR and IR groups that had a re-report on any child in the family within 60 days, 6 months, 12 months, and 18 months after the initial case closure. At each time point, the percentage of DR families who had a re-report was higher than that among IR families, and the differences became larger over time. Within 18 months of the initial case closure, 18.8% of the DR families experienced at least one screened-in re-report compared to 14.7% of the IR families ($p < .0001$).

Table 6: Maltreatment Re-reports Following Initial Case Closure

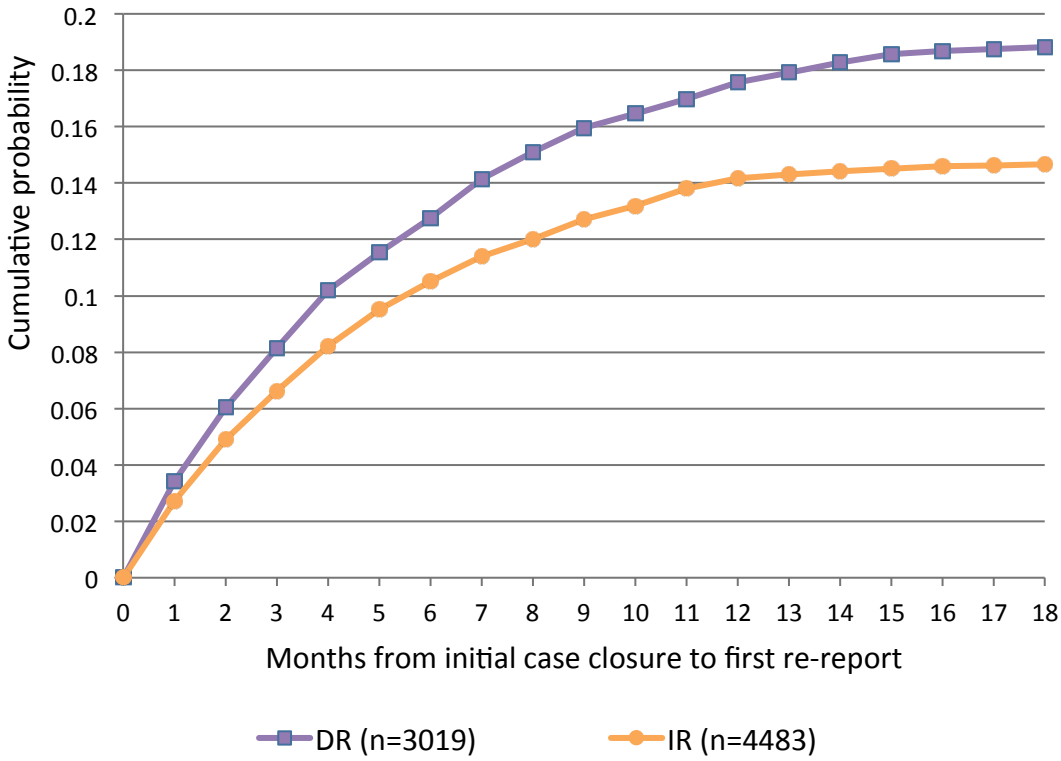
	DR (n=3019)	IR (n=4483)
	%	%
% families with re-report (on any child) within 60 days of initial case closure date	6.1%	5.0%
% families with re-report (on any child) within 6 months of initial case closure date	13.1%	10.7%*
% families with re-report (on any child) within 12 months of initial case closure date	17.7%	14.2%***
% families with re-report (on any child) within 18 months of initial case closure date	18.8%	14.7%***

*p < .01 **p< .001 *** p<.0001

Figure 28 displays the cumulative probabilities of families in the DR and IR groups being re-reported over the 18-month follow-up period. Results of the survival analysis indicate that families in the DR group had a higher accumulated risk over time compared to families in the IR group ($p < .0001$). The risk curves for the two groups are similar during the first few months after case closure, but then begin to diverge. For both groups of families, the slopes of the risk curves are steepest in the first six months after case closure, indicating that this is the riskiest time for a re-report. For families who received an investigation, the curve becomes nearly flat at 12 months after case closure and after, meaning that the cumulative risk of a re-report does not increase after 12 months. For families who received DR, their risk curves continue to

increase until about 15 months after case closure. Thus, rather than decrease over time, the difference in risk of re-report between the two groups actually increases over time.

Figure 28. Cumulative probability of maltreatment re-report within 18 months



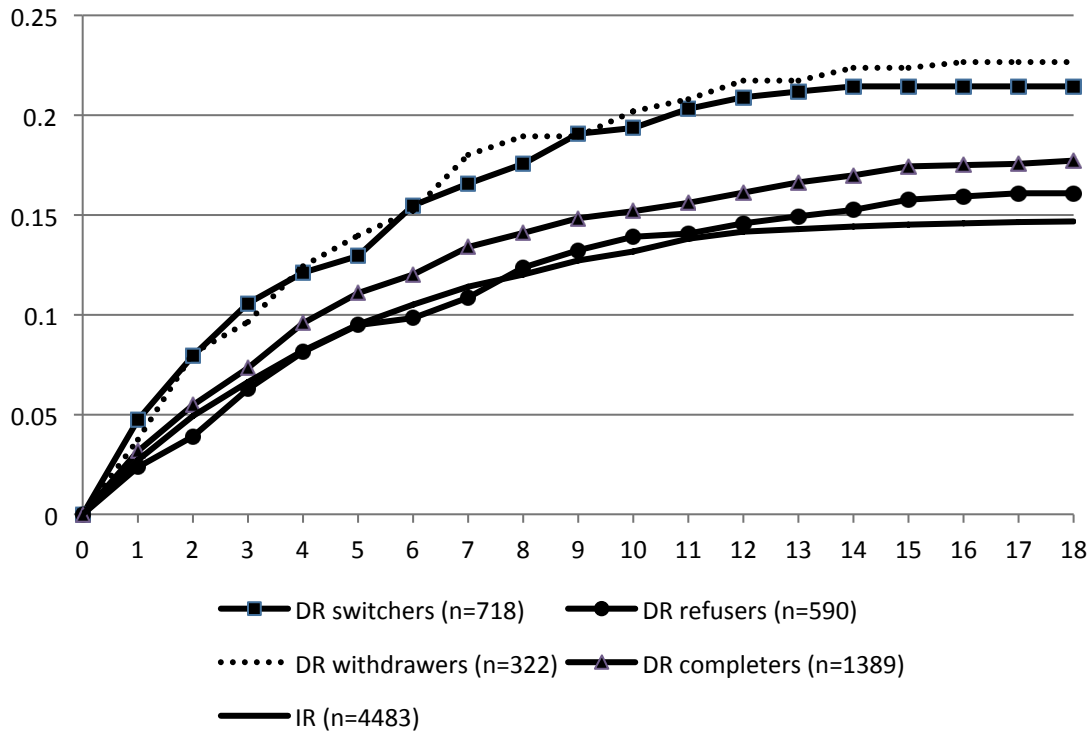
Since the results showing increased risk of re-reports among the DR families were contrary to expectations and previous research, additional analyses were completed to clarify the relationship between DR treatment and maltreatment re-reports. The families included in the DR group in the ITT analyses included many families who did not actually receive DR services or received only partial services, either because their cases were switched to an investigation, because they declined services after the initial visit from the DR Caseworker, or because they withdrew from services before they were completed. Additional analyses compared outcomes among four mutually exclusive DR subgroups:

- DR "switchers" consisted of families that were randomly assigned to DR but were switched to an investigation due to either safety concerns or a new maltreatment report (n=718). These families did not actually receive DR services (or received very little) and did receive an investigation.
- DR "refusers" were those families that declined DR services after the initial meeting and safety assessment with the DR Caseworker (n=590). These families did not receive any DR services nor an investigation.

- DR "withdrawers" were those families that were offered and initially accepted DR services but then voluntarily withdrew before services were complete (n=322).
- DR "completers" consisted of families who accepted and completed the DR services outlined in their service plans (n=1,389).

When the cumulative risk of a first maltreatment re-report was examined for these four DR subgroups separately, the results show a very interesting pattern (Figure 29). The two DR subgroups with the highest risk of re-report throughout the entire 18-month follow-up period were the DR withdrawers and the DR switchers. These two subgroups had significantly higher cumulative risk than families who received an investigation ($p < .0001$). Families who completed DR services had lower risk than either DR switchers or withdrawers, but were still at significantly higher risk than investigated families ($p < .01$). Risk of re-report among families that refused DR services was not significantly different than that of investigated families.

Figure 29. Cumulative probability of maltreatment re-report among DR subgroups



Of the families that had at least one re-report, additional analyses compared the mean numbers of re-reports that occurred within 18 months, the mean numbers of days from initial case closure to the first re-report, and the types of allegations included in the first re-report (Table 7). There were no significant differences between the two groups on any of these measures.

Table 7. Characteristics of First Maltreatment Re-reports		
	DR (n=568)	**IR (n=658)**
	mean (sd)	mean (sd)
Of families with at least one re-report, number of re-reports within 18 months	1.4 (.78)	1.3 (.73)
Of families with at least one re-report, the number of days from initial case closure date to first re-report	142 (123)	133 (114)
	%	%
Of those families with at least one re-report, the percentage with new allegations of neglect	76.5%	77.8%
Of those families with at least one re-report, the percentage with new allegations of physical abuse	10.0%	10.1%
Of those families with at least one re-report, the percentage with new allegations of sexual abuse	4.2%	3.3%
***p < .01 **p< .001 *** p<.0001		

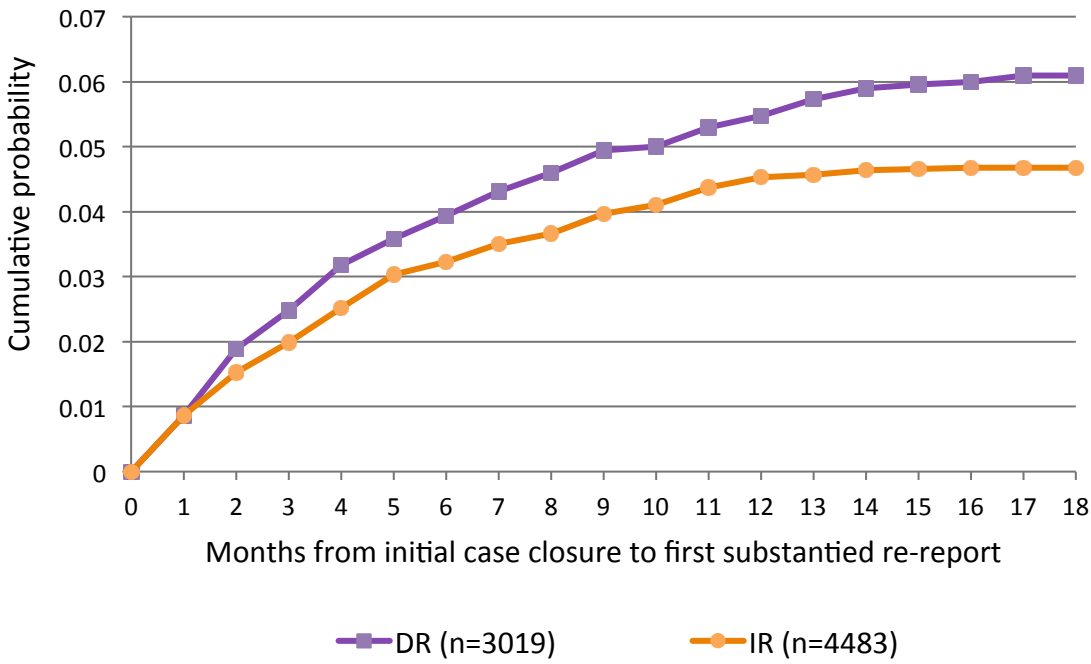
6.4 Substantiated Maltreatment Re-reports

Not all re-reports during the follow-up period were substantiated. Administrative data were used to determine if any of the allegations included in the re-reports on DR and IR families were substantiated (Table 8). The only statistically significant difference between the two groups was the percentage of families with substantiated re-reports within 18 months following initial case closure: DR families were more likely than IR families to have a substantiated re-report within 18 months (6.1% versus 4.7%, $p < .01$). Of the families that had at least one substantiated re-report, there were no differences between DR and IR families in either the total number of substantiated reports that occurred over the follow-up period or the number of days to the first substantiated re-report (Table 8).

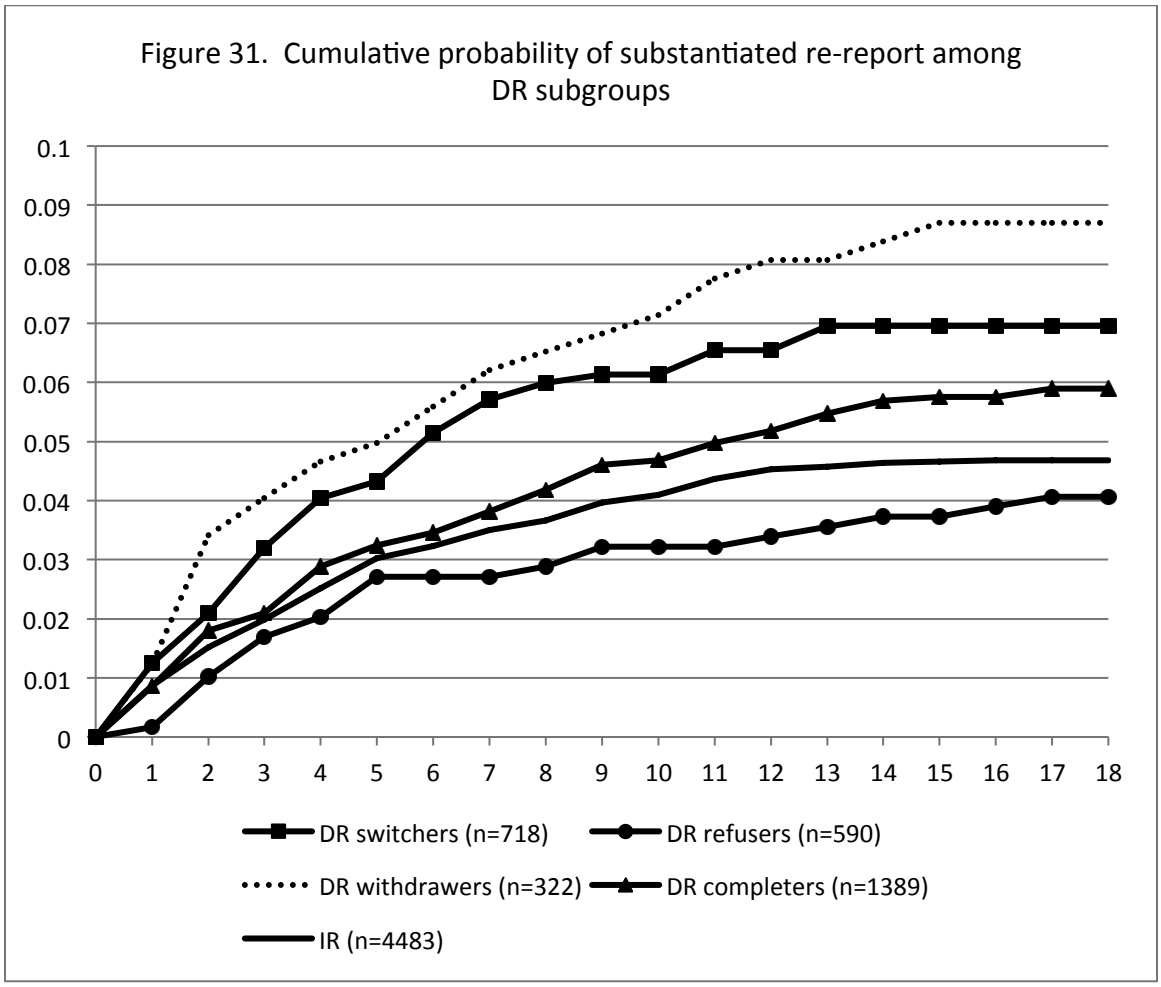
Table 8. Substantiated Maltreatment Re-reports Following Initial Case Closure		
	DR (n=3019)	**IR (n=4483)**
	%	%
% families with substantiated re-report (on any child) within 60 days of initial case closure date	1.9%	1.6%
% families with substantiated re-report (on any child) within 6 months of initial case closure date	4.0%	3.3%
% families with substantiated re-report (on any child) within 12 months of initial case closure date	5.5%	4.5%
% families with substantiated re-report (on any child) within 18 months of initial case closure date	6.1%	4.7%*
	DR (n=184)	**IR (n=210)**
	Mean (sd)	Mean (sd)
Of families with at least one substantiated re-report, number of substantiated re-reports within 18 months	1.2 (.5)	1.1 (.5)
Of families with at least one substantiated re-report, number of days from initial case closure date to first re-report	161 (138)	138 (116)
***p < .01 **p< .001 *** p<.0001		

Figure 30 shows the cumulative risk curves for substantiated re-reports for families assigned to the DR and IR groups, which are statistically different ($p < .01$). Similar to the results for re-reports, the riskiest period for a substantiated re-report for both groups was the first six months after the initial case closed. The difference between the curves for the two groups starts off small and widens over the last 6 months of the observation period.

Figure 30. Cumulative probability of substantiated re-report within 18 months



When the risk curves for a substantiated re-report among the four DR subgroups are examined (Figure 31), the families who withdrew from services before completion and who switched to an investigation were at significantly higher cumulative risk compared to investigated families ($p < .01$). Families that refused or completed DR services were not significantly different from investigated families.

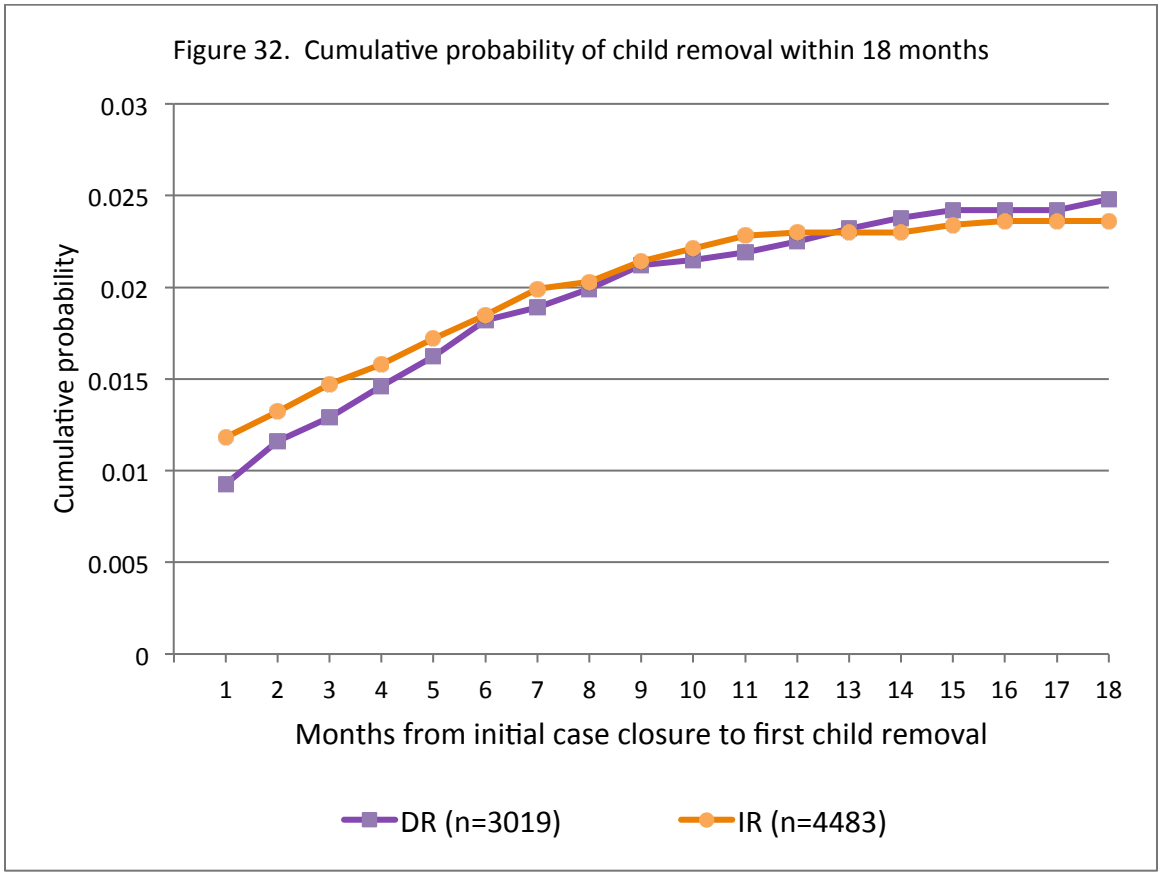


6.5 Child Removals

Administrative data were also used to track whether any child was removed from the family and placed into substitute care following the initial case (Table 9). The percentages of families that had a child removed were low for both groups and not significantly different: 2.6% among DR families and 2.4% among IR families. Among the families that had a child removed, there were no significant differences between the DR and IR families in either the number of days from the initial case closure to the first child removal or the number of days the removed child remained in substitute care.

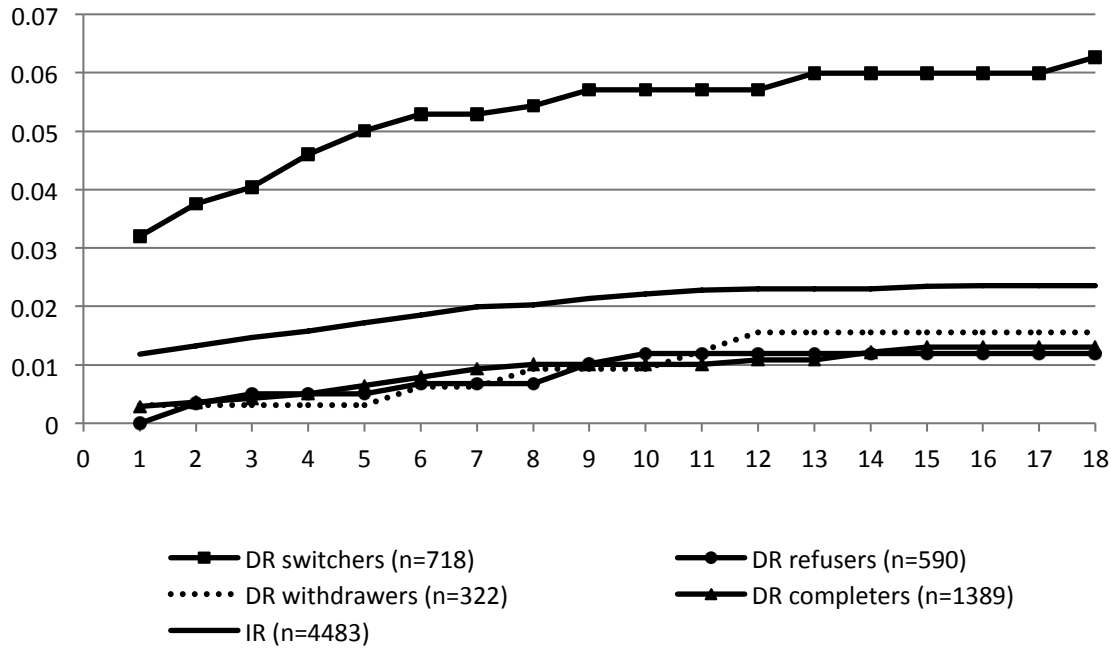
Table 9. Child Removals Following Initial Case Closure		
	DR (n=3019)	**IR (n=4483)**
% families with any child removed during follow-up period	2.6%	2.4%
	Mean (sd) (n=79)	Mean (sd) (n=108)
Of families with at least one child removed, the number of days from initial case closure to date of first removal	150 (173)	101 (137)
Of families with at least one child removed, the mean number of days spent in substitute care	331 (197)	319 (208)
***p < .01 **p< .001 *** p<.0001**		

Figure 32 shows the cumulative risk of DR and IR families experiencing a child removal over the 18 month follow-up period. The two curves are not significantly different.



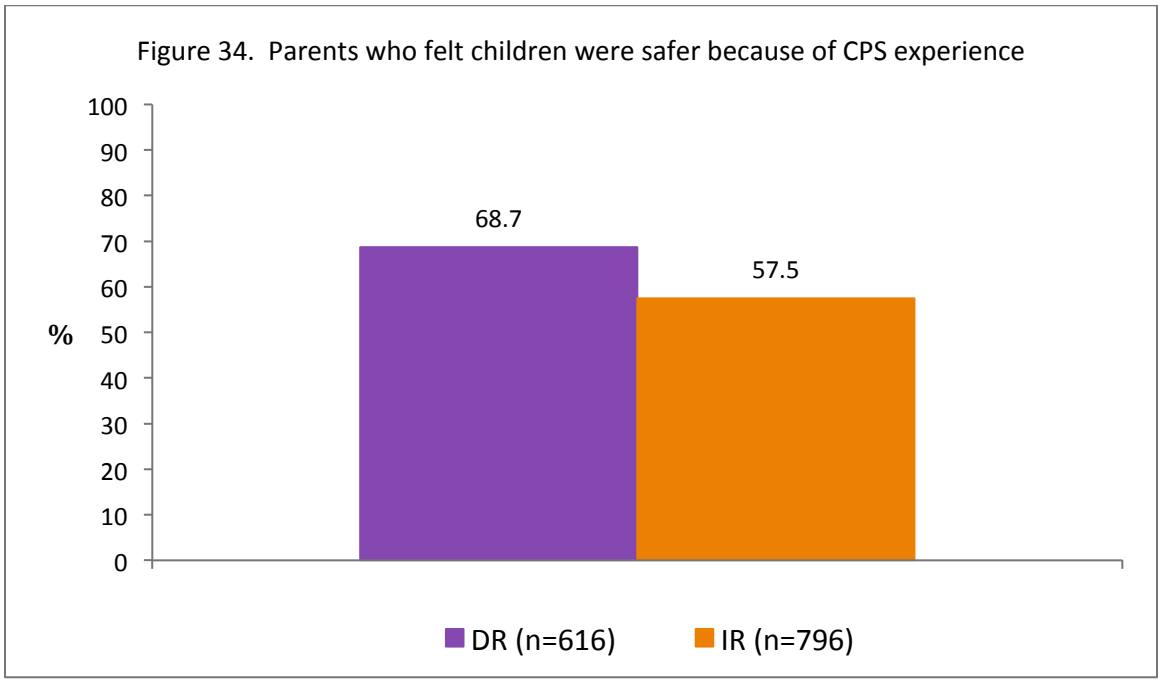
Examination of the risk curves for the DR subgroups reveals that the families that switched from DR to IR had significantly higher risk of child removal compared to all the other DR subgroups and families that were investigated ($p < .0001$; Figure 33).

Figure 33. Cumulative probability of child removal among DR subgroups



6.6 Parent Perceptions of Child Safety

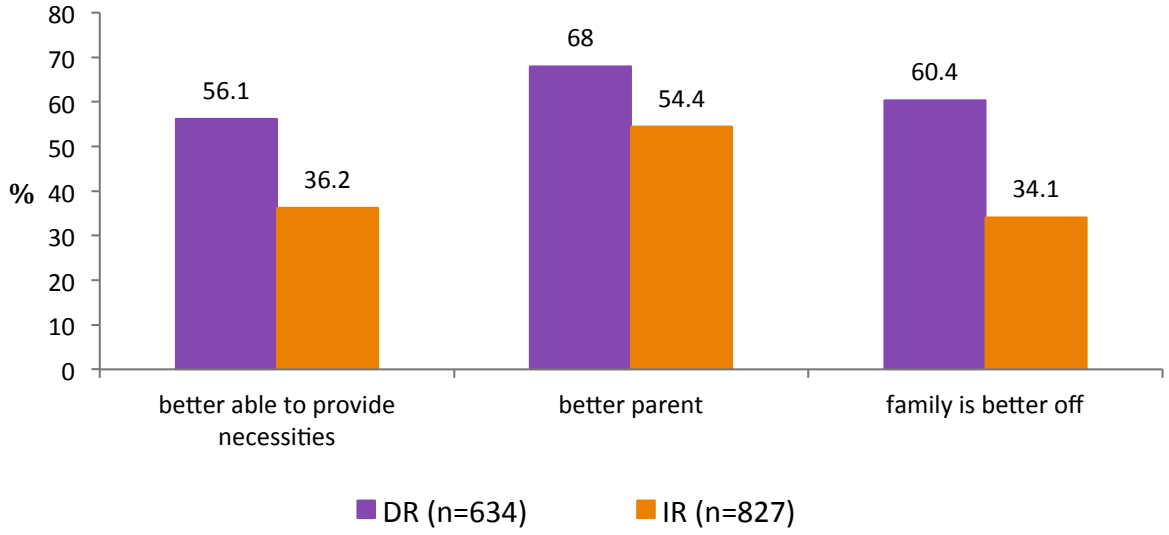
Parents responded to a question on the family survey that asked "Are your children safer because of your experience with the child welfare agency?". As shown in Figure 34, almost 69% of the parents in the DR group responded "yes" to the question, compared to 57.5% of parents in the IR group, a statistically significant difference ($p < .0001$).



6.7 Parent Perceptions of Family Well-Being

Parents were also asked several questions about their family's well-being following their experience with the child welfare agency. More specifically, they were asked if they were "better able to provide necessities like food, clothing, shelter, or medical services," if they were "better parents," and if they and their families were "better off or worse off" because of their experience with the child welfare agency. Figure 35 compares the percentages of parents assigned to the DR and IR groups who responded affirmatively to each of these three questions. The differences between the two groups on each question were statistically significant ($p < .0001$).

Figure 35. Parent reports of improvements in family well-being following CPS experience



6.8 Summary of Findings: Child Safety and Family Well-Being

This chapter examined several indicators of child safety and family well-being following the treatment (DR) or control group (IR) intervention. Results indicated that at the time their initial case was closed, a larger percentage of parents who received DR believed their children were safer, that their families were better off, that they were better parents, and that they were better able to provide necessities for their family. However, the results from analyses using administrative data to track additional family contacts with the child welfare system told a more complicated story. For these indicators of child safety (additional maltreatment reports, substantiated reports, child removals), families that received DR and IR had similar levels of risk for the first few months after the initial case closed. Differences in risk between the two groups grew over the follow-up period so that by 18-months after the initial case had closed, families that received DR were at significantly higher risk of a re-report and substantiated re-report. There were no differences between the two groups for the risk of child removal over the 18-month follow-up period.

Since these findings were contrary to both expectations and previous research conducted in other States, additional analyses were completed to explore potential differences in child safety among DR subgroups. For these analyses, families that were randomly assigned to the DR group (and used in the ITT analyses) were divided into four mutually exclusive groups based on their exposure to DR services:

1. *DR switchers* consisted of families that were randomly assigned to DR but were switched to an investigation due to either safety concerns or a new maltreatment report. These

families did not actually receive DR services (or received very little) and actually received an investigation.
2. *DR refusers* were those families that declined to accept services after the initial meeting and safety assessment with the DR Caseworker. These families did not receive any DR services or an investigation.
3. *DR withdrawers* were those families that initially accepted DR services but then voluntarily withdrew before services were complete.
4. *DR completers* consisted of families who accepted and completed the services outlined in their service plans.

Risks for additional child welfare contacts (re-reports, substantiated re-reports, child removals) were highest among the families that initially accepted services and then dropped out (DR withdrawers) when compared to those who received an investigation. This finding raises some interesting questions about the reasons that families withdraw from services: Is it because they perceive services as ineffective? Or perhaps additional stressors occur in their lives that make participation in services more difficult and increase their risk for additional child welfare contacts? Additional information about the context of these service withdrawals would help in understanding the increased risk observed in these families.

The risks for additional child welfare system contacts among the families that refused DR services after the initial assessment and those that completed DR services were very similar to those families that received an investigation. This result is very similar to the findings from the previous evaluations of DR that have used an experimental design with random assignment of families to treatment (DR) and control (IR) conditions (Loman et al., 2010; Loman & Siegel, 2004a, 2004b).

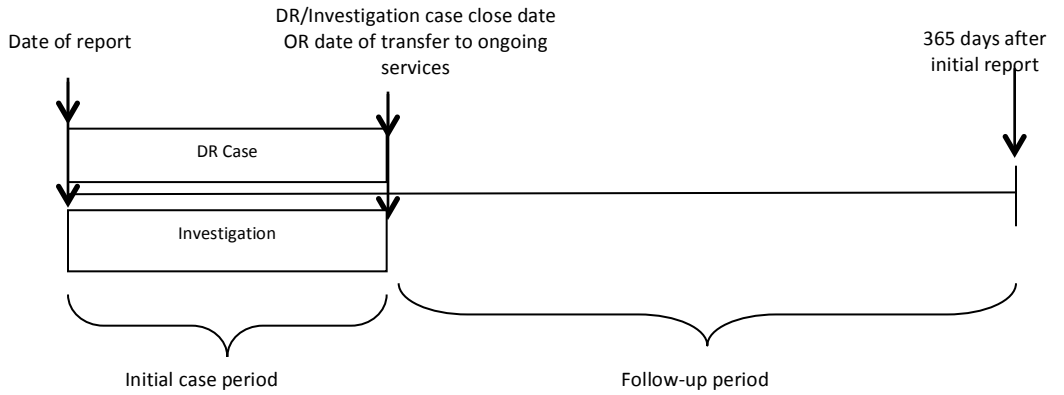
Although they can provide useful information, a generous amount of caution should be used when interpreting outcome analyses that do not use an ITT design. By removing a subset of the families that were randomly assigned to the treatment group (i.e., those that switched from the treatment to the control group), the benefits of random assignment are nullified, and the two treatment groups may no longer be equivalent. This is especially true if the cases that were dropped from the treatment group are systematically different from the cases that remain in the analyses, as was the case in this evaluation as well as the previous DR evaluations. Despite these cautions, the results of the DR subgroup analyses provide additional context for understanding the higher levels of risk among the overall DR group compared to the IR group, and suggest some directions for additional analyses in the future.

Chapter 7: Cost Analysis

Prior to the introduction of Differential Response in Illinois, the majority of families with substantiated maltreatment allegations received no post-investigation services – around 74% in 2012.[21] Of the families that received formal child welfare services, 12% received "intact family services" while their children remained at home and 14% had a child removed from the home and received placement services. One of the goals of Differential Response in Illinois was to provide services to a wider array of families reported to CPS, and the results presented in Chapter 5 confirm that a greater percentage of families in the DR group received at least one service and received a greater total number of services compared to those in the IR group. The rationale for providing short-term, concrete services to families during their initial contact with CPS was to prevent repeated CPS contacts, such as additional investigations, lengthier (and more expensive) intact family services, and child placement into substitute care. It was therefore expected that in Illinois, the initial costs of providing DR services to families would be greater than those of providing an investigation, but that the longer-term costs to the child protection system would be reduced as fewer families had additional child welfare contacts.

To test this hypothesis, a cost analysis was completed that examined and compared the average total cost of serving a family through DR and through an investigation, both during the initial case and during a standard follow-up period. Similar to the analyses in the previous chapters, the initial case period was defined as the time from the initial report date through the initial DR case or investigation close date OR the date that the case is transferred to ongoing child welfare services, *whichever happens first*.[22] Unlike previous analyses, the follow-up period was defined as the period beginning the day after the initial case period and ending one year (365 days) after the initial report date (see Figure 36). Thus, the cost analysis considers the costs to serve a family during the one year period following their initial report date.

Figure 36. Initial case and follow-up service periods for the cost analyses



[21] Children and Family Research Center. (2013*). Conditions of Children in or at Risk of Foster Care in Illinois: 2012 Monitoring Report of the B.H. Consent Decree*. Urbana, IL: Author.
[22] Not all cases are transferred to ongoing services. Most cases are closed after the initial investigation or DR case.

7.1 Cost Analysis Sample

Samples of DR and IR cases were randomly selected for the cost analysis from the populations of cases that were randomly assigned to DR and IR in the larger outcome evaluation (described in Chapter 3). Four hundred cases – 200 DR and 200 IR – were randomly selected from cases with initial report dates that occurred between April 1 – September 30, 2011. Selecting cases during this time frame ensured that all cases in the cost analysis had a complete 365 days of follow-up data. Selected cases were stratified by region, based on the overall distribution of cases in the State during that period of time. DR families that switched to an investigation or that refused services following the initial meeting (i.e., families that did not actually receive DR services) were not eligible for inclusion in the DR sample.[23] Thus, unlike the outcome analyses conducted in chapters 4 – 6, the cost analyses do not use an ITT approach and include only those DR families that actually received DR services.

7.2 Initial Case Costs

Two types of costs during the initial case were examined: the costs of the worker's time spent on direct services to the family and the costs of services provided to the families that were paid for by the Department. Costs not included in the analysis include those associated with supervisors' time, caseworker time associated travel and case documentation, and services provided to the family through agencies other than IDCFS (e.g., services provided through the school or other public or private agencies).

7.2.1 Costs of Worker Time

Data on the number and types of worker contacts (e.g., in-person contacts, telephone, email, mail) with families were available in SACWIS for both DR and IR cases. Types of worker contacts with families were organized into five categories and counted:

- Initial in-person contact with family
- Subsequent in-person contact with family
- Court appearance with family
- In-person collateral contact (school, hospital)
- Telephone, email, or other non-face-to-face contact

Table 10 shows the mean number of worker contacts during initial case period for the 200 DR and 200 IR cases in the cost sample. There are two types of workers for each DR case: the public agency DR Specialist and the private agency SSF Caseworker. Both the DR Specialist and SSF Caseworker were present for the initial in-person contact with the family, and subsequent DR case contacts were made by the SSF Caseworker alone (i.e., the DR Specialist had no further

[23] The purpose of the cost analysis was to estimate the actual costs to provide services to families through a traditional investigation or DR. The decision was therefore made to drop those families that were randomly assigned to DR but did not actually receive DR services and were switched to an investigation. The majority of these families were switched to an investigation within a few days of random assignment and therefore received no DR services at all.

contact with the family). As expected, SSF Caseworkers completed more in-person visits with families than did Investigators (8.2 contacts versus 2.4 contacts) and had a greater number of in-person collateral contacts (1.7 versus .9). Court appearances were very rare for families in both the DR and IR samples.

Table 10. Mean Number of Worker Contacts During Initial Case

	DR Specialist (n=200)	SSF Caseworker (n=200)	Investigator (n=200)
Initial in-person contact	1	1	1
Subsequent in-person contacts		7.22	1.39
Court appearances		0.06	0.03
In-person collateral contacts		1.5	0.87
Telephone, email, or other non-face-to-face contact		5.17	3.44

Data on the duration of each type of contact were not available in SACWIS. An estimated duration for each type of contact was derived by polling an expert panel of SSF Caseworkers and Investigators.[24] Their estimates were averaged to derive an average number of minutes spent on each type of contact (see Table 11).

Table 11. Mean Estimated Duration of Worker Contacts with Families (in minutes)

	DR		IR
	DR Specialist	SSF Caseworker	Investigator
Initial in-person contact	111	111	48
Subsequent in-person contacts		61	31
Court appearances		78	173
In-person collateral contacts		57	41
Telephone contacts		13	22

The number of contacts that occurred in each case in the cost sample was multiplied by the duration of the contact to compute the total amount of time spent by workers during the initial case. For DR cases, the amount of time spent by the DR Specialists and SSF Caseworkers was combined. As shown in Table 12, the average (median) number of minutes that workers spent in direct contact with families was much higher among DR cases than IR cases (757 minutes

[24] DR Specialists were not polled. In the Illinois DR model, the DR Specialist and the SSF Caseworker attend the first in-person meeting with the family together and both workers remain present for the entire meeting. Therefore, the number of minutes spent during the first contact with families will be the same for both DR Specialists and SSF Caseworkers.

versus 195 minutes).[25] In other words, on average DR workers spent about 12.5 hours in direct contact with families during the initial case while investigators spent about 3.25 hours in direct contact with families during the initial investigation.

Table 12. Worker Time Per Case (in minutes)

	Min	Max	Mean	25%	50%	75%	95%
DR (n=200)	222	2722	828.3	518.5	757	1038.5	1656.0
IR (n=200)	48	1122	208	133.0	195	256.5	335.5

To translate the amount of worker time into cost data, an average hourly rate for DR Specialists, SSF Caseworkers, and Investigators was needed. Information on worker salaries and fringe benefits rates was collected from the Department (for the DR Specialists and Investigators) and from the private agencies (for the SSF Caseworkers). Once a "loaded" annual salary (i.e., salary plus benefits) for each type of worker was obtained, a loaded hourly rate was computed by dividing the annual salary by 2080 (the number of hours in a 40-hour per week work year). The loaded hourly rates for each type of worker were:

- DR Specialists -- $59.70
- SSF Caseworkers – $19.86
- Investigators – $60.36

Finally, the cost of worker time during the initial case was then calculated by multiplying the number of hours per case for each type of worker by their hourly rate. Table 13 shows the range and average costs associated with worker time for DR and IR cases.

Table 13. Costs of Worker Time Per Case (in dollars)

	Minimum	Maximum	Mean
DR (n=200)	147.26	978.43	348.35
IR (n=200)	48.00	1122.00	208.85

7.2.2 Initial Service Costs

Direct service costs during the initial case were expected to be low for both DR and IR cases. For DR cases, the SSF Caseworker provided the majority of the services directly to the family rather than through purchase of service agreements with other agencies.[26] The exception to this guideline was the provision of cash assistance payments. The exact amounts of any cash assistance funds provided to the family were included in the initial case costs for DR families. Services are almost never provided during an investigation. If the investigator determines that a family has a need for child welfare services, the family is referred to either intact family services

[25] Both the DR and IR samples had one or two extreme outlier cases that had more direct contact with workers than the others. Therefore, the median (50th percentile) is a better measure of central tendency.
[26] Please refer to Chapter 2 for a description of the services provided to families by the SSF Caseworker.

or the child(ren) is removed and placed into substitute care. If either of these events occurred, the costs associated with these services were included in the follow-up period.

Service costs during the initial DR and IR case were extracted from DCFS administrative data systems. Of the 200 DR cases in the sample, 39 received cash assistance payments, which ranged in amount from $50 to $600 and averaged $320.94.[27] In addition, 9 of the 200 DR families[28] in the sample received additional services (counseling, homemaker services) that were purchased by the Department during their initial DR case. The cost of these services ranged from $174.93 to $1458.35 and averaged $627.24. As expected, there were no service costs associated with any of the 200 IR cases in the sample during the initial investigation.

7.2.3 Total Initial Case Costs

The total initial costs for each of the 400 cases in the cost sample were computed by adding their worker costs and service costs. As shown in Table 14, the average initial cost for DR cases ($439.16) was greater than that for IR cases ($208.85; $p < .0001$).

Table 14. Total Initial Costs Per Case (in dollars)

	Worker Costs	Services Costs	Total Initial Costs
DR (n=200)	348.35	90.81	439.16
IR (n=200)	208.85	0	208.85

7.3 Follow-up Costs

A family could incur three types of costs during the follow-up period:

a. Costs associated with subsequent investigations following the initial case closure[29]
b. Costs associated with intact family services
c. Costs associated with child substitute care placement

7.3.1 Costs of Subsequent Investigations

Administrative data were used to determine how many of the DR and IR families experienced additional investigations during the follow-up period:

- 45 of the families in the DR sample were investigated during the follow-up period (38 families had one investigation, 6 families had two investigations, and 1 family had three investigations)
- 25 of the families in the IR sample were investigated during the follow-up period (19 families had one investigation, 5 families had two investigations, and 1 family had three investigations)

[27] Cash assistance payments were not available to investigated families.
[28] One DR family received both cash assistance and other services.
[29] All families that were re-referred to CPS after the initial case received an investigation rather than a DR assessment.

The costs associated with subsequent investigations were calculated using the same methodology used to compute the costs of the initial investigations:

- the number of contacts was multiplied by the average duration of time for that type of contact to determine the total amount of worker time that was spent during the investigation;
- the total amount of time was multiplied by the hourly rate for an investigator to determine the costs of worker time; and
- administrative data were used to pull any direct service costs provided during the investigation.

The average cost per family of additional investigations during the follow-up period was $62.89 for the DR sample and $45.52 for the IR sample.

7.3.2 Costs of Intact Family Services

Administrative data were used to determine how many of the DR and IR families received intact family services during the follow-up period:

- 10 of the families in the DR sample received intact family services during the follow-up period
- 18 of the families in the IR sample received intact family services during the follow-up period

Costs associated with intact family child welfare cases were pulled from DCFS administrative data and included:

- Case management
- Direct services (counseling, homemaker services, toxicology tests)
- Financial assistance to the family such as rent, housing advocacy, utilities, and kitchen appliances.[30]

The average cost of intact family services for the 10 families in the DR sample was $3,804.00, and the average cost of intact family services for the 18 families in the IR sample was $7,928.13. Not only did a greater number of families in the IR sample receive intact family services during the follow-up period, they received them for longer periods of time, which resulted in higher costs. When averaged across all 200 families in the DR and IR samples, the average cost per family of intact family services during the follow-up period was $223.24 for the DR sample and $990.97 for the IR sample (Table 15).

[30] The services provided to families through an intact family service case are somewhat similar to those provided by the SSF Caseworker through a DR case: case management and concrete assistance to the family. Differences between the two types of cases exist in the case duration (DR cases are limited to 90 days or less while many intact family service cases last for 12 months or longer) and the purchase of direct services such as counseling (not provided in DR cases).

Table 15. Intact Family Service Costs Per Case (in dollars)			
	Minimum*	Maximum*	Mean^
DR (n=200)	225.98	8,474.25	$223.24
IR (n=200)	263.64	13,747.12	$990.97

*Of the families that received intact family services. ^Averaged across all 200 families.

7.3.3 Costs of Substitute Care Placements

Administrative data were used to determine how many of the DR and IR families received substitute care services during the follow-up period:

- None of the families in the DR had children placed into substitute care during the follow-up period
- Three of the families in the IR sample[31] had children placed into substitute care during the follow-up period

Costs associated with substitute care cases were pulled from DCFS administrative data and included:

- Case management;
- Board payments (foster home, institutions, shelter placements)
- Direct services (counseling);
- Child travel expense for parental visits; and
- Other costs not classified in the above items.

Table 16 shows the costs per case for providing placement services to families in the DR and IR samples during the follow-up period. When averaged across all 200 families in the DR and IR samples, the average cost per family of placement services during the follow-up period was $0 for the DR sample and $1,492.45 for the IR sample.

Table 16. Placement Service Costs Per Case (in dollars)			
	Minimum*	Maximum*	Mean
DR (n=200)	-	-	$0
IR (n=200)	12,610.62	219,311.08	$1,492.45

*Of those families that received placement services.

7.3.4 Total Follow-up Costs

The total follow-up costs for each of the 400 cases in the cost sample were computed by adding the costs of any additional investigations, intact family services, and substitute care services. As shown in Table 17, the average follow-up cost for DR cases was significantly less than that for IR cases. The large differences between the DR families and IR families in total follow-up costs are

[31] One of the families had two children removed and placed into substitute care.

partially due to the large differences in substitute care costs, however, even if the costs for substitute care are ignored, the follow-up costs (additional investigations plus intact family services) for the IR families are still significantly greater than those for the DR families ($1,036.49 versus $286.13, respectively).

Table 17. Total Follow-up Costs Per Case (in dollars)

	Investigations	Intact Family Services	Substitute Care Services	Total Costs
DR (n=200)	62.89	223.24	0	286.13
IR (n=200)	45.52	990.97	1,492.45	2,528.94

7.4 Total Costs

The total costs to serve a family from the initial report date through 365 days after the report date were computed by adding all costs incurred during the initial case and the follow-up period for each family and then averaging. Table 18 displays the average costs for the 200 DR and 200 IR cases included in the sample.

Table 18. Total Costs Per Case (in dollars)

	Initial Costs	Follow-up Costs	Total Costs
DR (n=200)	439.16	286.13	725.29
IR (n=200)	208.85	2,528.94	2,737.79

7.5 Summary of Findings: Cost Analysis

Differential Response in Illinois was designed to provide caseworker support and direct services to families during the period immediately following an accepted CPS report. As expected, the costs associated with the initial case period were greater for DR cases ($439.16) when compared to Investigations ($208.85). This was due primarily to the greater amount of time that DR workers (both the public and private agency DR caseworkers) spent in direct contact with families compared to IR workers.

It was predicted, however, that a greater investment in services immediately following an initial CPS report would prevent additional costs associated with subsequent CPS investigation, intact family services, and child placement into substitute care. The results of the cost analysis partially support this prediction. A greater number of families in the DR subsample (45) had additional investigations during the follow-up period compared to that in the IR subsample (25), which resulted in greater costs in the DR group associated with additional investigations ($62.89 per DR family versus $45.52 per IR family). However, fewer families in the DR sample

were provided with intact family services during the follow-up period compared to families in the IR sample (10 versus 18), and when DR families were provided with intact family services, they were less expensive on average than those provided to IR families ($3,804.00 versus $7,928.13, respectively).

Substitute care costs in the randomly-selected DR and IR families included in the cost analyses were significantly different. This was due to the fact that none of the children in the randomly-selected DR families were removed from their homes during the 365-day follow-up period, while four children from three of the IR families were placed into substitute care. Because substitute care is very expensive, small differences in the numbers of children placed into substitute care translated into big differences in costs during the follow-up period. Different randomly-selected groups of DR and IR families may have had equal numbers of children placed into substitute care, which would have resulted in substitute care costs that were more comparable. Unfortunately, it was impossible to obtain cost data for the entire population of families that were randomly assigned into the DR and IR groups in the overall evaluation, which would have provided a more complete picture and avoided any type of selection bias in the cost analysis.

Since the differences between the two groups in substitute care costs are so large, they mask any differences between the two groups in other costs during the initial and follow-up periods. Another way to examine the data is to ignore the substitute care costs and compared the two samples on their totaled initial case costs, additional investigation costs, and intact family service costs. Even after subtracting the costs of substitute care, the average costs per DR case are slightly more than half as much as those of an average IR case ($725.29 versus $1,245.34). In conclusion, the results of the cost analysis suggest that although the costs during the initial case period are higher for DR cases compared to investigations, service costs during the follow-up period were lower, due in part to 1) fewer families receiving intact family services, 2) lower costs among the families that did receive intact family services, and 3) fewer families receiving placement services.

Chapter 8: Discussion and Conclusions

In the fall of 2008, the Children's Bureau awarded a five-year cooperative agreement to create the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR). The QIC-DR was created in response to the need to generate and disseminate new knowledge and robust evidence about Differential Response systems and strategies (Nolan et al, 2012). As one of the three research and demonstration sites selected by the QIC-DR to implement and rigorously evaluate a Differential Response system, the State of Illinois completed a statewide field experiment that began in November 2010 and concluded in May 2012. Almost 8,000 families were included in the evaluation, making it the largest child welfare experiment in Illinois to date. The goal of the Illinois evaluation was to collect valid and reliable data to answer the three research questions outlined by the QIC-DR:

1. Are children whose families receive an assessment response (DR) as safe as or safer than children whose families receive an investigation?
2. How is the assessment response different from the investigation response in terms of family engagement, caseworker practice, and services provided?
3. What are the costs to the child protection agency of the differential response approach?

Before discussing the results of the evaluation in relation to these three questions, a brief discussion of the overall validity of the findings and the limitations of the research methodology is offered.

8.1 Limitations of the Evaluation

The Illinois DR evaluation utilized an experimental design in which eligible families were randomly assigned to either a treatment group or a control group (a random control trial or RCT). Families in the treatment group (DR) received a family-centered assessment (which included both a safety assessment as well as a needs assessment) and up to 90 days of services and supports provided by a private agency caseworker in their homes. Families in the control group (IR) received a traditional child protective services investigation, which consisted of safety assessment and information collection to determine whether or not the alleged abuse or neglect occurred. Services are not provided during a traditional investigation in Illinois; families with a level of need that requires intervention can be provided with referrals to community-based services, or may be referred to formal child welfare services provided in the home (intact family services) or after the child is placed into substitute care (placement services). Although RCTs are regarded as the most scientifically rigorous design for determining the efficacy of treatments, RCTs that are implemented in the field often face threats to their internal or external validity. The Illinois DR evaluation was a field experiment, and as such, could not achieve the level of control that might be expected in a true clinical trial. On the whole, the limitations associated with the evaluation are minor and do not impact our ability to draw conclusions about the effectiveness of the DR approach in comparison to a traditional investigation approach.

If done correctly, randomization results in balance of all known and unknown confounders. In Illinois, the random assignment was achieved through a computerized program that was built into the Statewide Automated Child Welfare Information System (SACWIS), so there was virtually no way to manipulate the random assignment process. In addition, although the DR program in Illinois was discontinued in June 2012, random assignment of families to the treatment and control groups ended in May 2012 and was therefore not affected by the discontinuation of the program. Comparisons of baseline characteristics of the treatment and control groups demonstrated that the randomization process achieved an acceptable amount of balance between the two groups.

A separate source of concern with RCTs is treatment contamination, which refers to the situation when participants cross-over from one study group to the other, thereby contaminating the initial randomization process (Reeves, 2008). In the Illinois DR evaluation, no families crossed-over from the control group (investigation) to the treatment group (DR) – once a family was randomly assigned to an investigation, they always received a complete investigation and were never allowed to receive DR. However, a significant percentage of families (over 22%) that were randomly assigned to DR were switched to an investigation either before receiving DR services or at some point during service provision. Families were switched from the treatment to the control group for a variety of reasons, all of which were related to potentially increased risk of harm to the child: DR Caseworkers or Supervisors could switch a family to an investigation if they had concerns related to child safety, families were switched to an investigation if the caseworker discovered that they had prior indicated reports or service provision, and families were switched to an investigation if a new screened-in maltreatment report was received during service provision. In previous evaluations of DR in other States, the percentages of families that switched from DR to an investigation were considerably smaller, typically less than 5% (Loman et al., 2010; Loman & Siegel, 2004b; Ruppel et al., 2011), and these families were dropped from the evaluation analyses.

Many federal agencies that sponsor or conduct RCTs, including the Food and Drug Administration (FDA) and the National Institutes of Health (NIH), advise that the most rigorous method for analyzing data from RCTs is through the use of Intention-to-Treat (ITT) analyses, which compare outcomes of participants based on the original treatment group to which they were randomly assigned, regardless of later treatment contamination or non-compliance (Atkins, 2009; Lachin, 2000; Reeves, 2008; Ten Have et al., 2008). By preserving the balanced groups produced by randomization at the outset of the study, ITT analyses result in the most valid but conservative estimates of the true treatment effects. Other analytical approaches, such as Per Protocol (PP) analyses, in which participants in the treatment group who did not receive treatment and participants in the control group who did receive treatment are dropped from the analyses, introduce bias into the results to the extent that deviations from random assignment are associated with the outcome of interest. Although some researchers have proposed alternative methods for analyzing data from randomized field trials (see Brown et al., 2008 for an example), the Illinois evaluation utilized an ITT approach to the outcome analyses

for several reasons.[32] The alternative strategy, using the Per Protocol approach, would have resulted in dropping 22% of the families in the DR sample from the analyses and none of the families from the IR sample, introducing an unacceptable level of bias into the findings. In addition, the families that would have been dropped from the DR sample (those that switched to an investigation because of safety concerns or new maltreatment reports) were those at highest risk of negative outcomes (re-reports, substantiated re-reports, and child removals), which also would have introduced bias into the findings. The ITT analyses adopted in the evaluation represent the most conservative approach to evaluating the effectiveness of DR, and likely under-estimate the effectiveness of the approach. However, great confidence can be placed in the significant differences between the two groups that were found using the ITT approach.

Although the internal validity of the Illinois DR evaluation is very high, an additional concern relates to the external validity of the findings. DR programs vary widely in their eligibility criteria as well as the services provided, and characteristics of the Illinois DR program may impact the generalizability of the findings to other jurisdictions. In Illinois, the eligibility criteria for DR were quite restrictive compared to most other jurisdictions that have implemented DR – approximately 8% of the screened-in reports that occurred during the evaluation period were eligible for DR. By restricting the families that were eligible for DR to those with no prior indicated reports of maltreatment and those with current allegations of neglect or "mental injury," the results of the evaluation may not be generalizable to CPS agencies that are considering DR for other types of maltreatment. Although the expansion of the DR-eligibility criteria to additional types of maltreatments and families with prior reports was intended to occur after the initial implementation period (see Fuller et al., 2012), the discontinuation of the DR program in Illinois in 2012 prevented this from happening.

An additional source of concern in any evaluation is the validity of the measurement of key constructs. The three outcomes of primary interest in the evaluations funded by the QIC-DR were child safety, services, and family engagement. Similar to the federal definitions of child safety used in child welfare outcome reports (DHHS, 2013), the DR evaluation used administrative data to define safety outcomes as screened-in re-reports, substantiated re-reports, and child removals from the home. Measures that rely on administrative data have the advantage of being available for nearly all of the 7,880 families in the sample and can also be tracked longitudinally over time. However, it is widely acknowledged that safety measures based on CPS administrative data and other "official" reports are a rather crude measure of child safety, as many instances of unsafe child conditions go unreported. Therefore, additional questions related to child safety were asked of both caseworkers and parents.

The next construct, service provision, was measured through administrative data, as well as caseworker and parent reports. In Illinois, administrative data capture basic information about dates of services and caseworker contacts but do not adequately capture the types of services or referrals that families receive during an investigation or DR case. Therefore, additional data

[32] Note that the cost analyses did not utilize an ITT approach.

collection methods were needed to obtain useful information about services. Although response rates for both the caseworker report and family survey were lower than anticipated, the findings obtained from these two data sources told a similar story vis-à-vis service provision, which bolsters our confidence in their validity.

The third construct of interest in the evaluation, parent engagement, cannot be measured with administrative data. Recent models of parent engagement in child welfare services (see Platt, 2012; Staudt, 2007) suggest that engagement consists of both a behavioral component (measured as attendance, participation, retention in services) as well as an attitudinal component (measured as parent perceptions of the worker and services). Although parent engagement is best measured through parent self-reports, the low response rates of the parent survey introduce doubt about the validity of the findings regarding engagement. It is possible that those parents who were highly engaged with their worker were also more likely to complete the parent survey, which would result in biased findings. However, we felt that the benefits of including the parents' perspectives in the outcome evaluation outweighed the potential pitfall of response bias.

Although RCTs are widely considered the most rigorous method for determining the effectiveness of new interventions, experiments conducted in the field can be fraught with impediments that can invalidate the findings. On the whole, however, the impediments faced by the Illinois DR evaluation were minor, and should not decrease our confidence in the findings to an unacceptable degree. The following sections discuss the results of the evaluation in relation to the three research questions.

8.2 Child Safety

Contrary to the results of previous DR evaluations (Loman et al., 2010; Loman & Siegel, 2004a, 2004b), results from the Illinois DR evaluation found that families randomly assigned to the DR group had significantly *higher* rates of re-reports and substantiated re-reports following initial case closure when compared to families randomly assigned to the IR group. Specifically, 18.8% of the families originally assigned to DR experienced a re-report within 18 months of their initial case closure, compared to 14.7% of families assigned to an investigation ($p < .0001$). This analysis using the ITT approach provides the most conservative estimate of the effectiveness of DR on child safety. However, since 22% of the families randomly assigned to the DR group were switched to an investigation and may have received little to no DR services, additional analyses were completed that separated the larger DR population into four distinct subgroups based on their DR service "dosage" (i.e., those that received the recommended program services, those that received partial services, and those that received little or no services). Among the DR subgroups, cumulative risk of a re-report during the 18 months following initial case closure was greatest for the families that withdrew from services early (22.7%) and those that switched to an investigation (21.5%) and lower for families that completed services (17.7%) or refused services after the initial in-home visit and safety assessment (16.1%). With the exception of the

families that refused DR services, risk of re-report was still significantly higher among each of these DR subgroups and families that received an investigation.

When child safety was measured as substantiated re-reports following the initial case closure, differences between the families assigned to the DR and IR groups were not significantly different until 18 months after the initial case closed. At 18 months post-initial case, 6.1% of the families originally assigned to DR had experienced a substantiated re-report, compared to 4.7% of the families assigned to an investigation ($p < .01$). However, the additional DR subgroup analyses revealed that the risk of substantiated re-reports was significantly higher among those families that withdrew from services early (8.7%) or were switched to an investigation (7.0%). The cumulative risk of a substantiated report among families that completed services (5.9%) or refused services (4.1%) was not significantly different from that of investigated families.

When child safety was measured as child removals from the home within 18 months of the initial case closure, there were no differences in the safety of children whose families were assigned to DR (2.6%) and investigations (2.4%). The DR subgroup analysis revealed that the risk of child removal was significantly higher among the families that were switched from DR to an investigation (6.3%) than any other DR subgroup as well as families that received an investigation. The risk of child removal among the other DR subgroups was not significantly different to that of families that received an investigation: those that withdrew from services early (1.6%), those that completed services (1.3%) and those that refused services after the safety assessment (1.2%).

When taken as a whole, the results of these analyses indicated that children within families who actually received DR or who made the decision to decline DR services after the initial visit by the DR caseworkers were as safe as those children who received an investigation. Following the initial visit and safety assessment, the paired-team of DR workers had the option of switching the case to an investigation if there were safety concerns, or allowing the family to accept or decline additional services if there were no safety concerns. The fact that the risks of re-reports, substantiated re-reports, and child removals were higher among families that were switched to investigations and lower among families that were allowed to refuse services suggests that the DR caseworkers were doing a satisfactory job of assessing which families had safety concerns and redirecting them to an investigation as required. The elevated level of risk among families that withdrew from services early deserves further scrutiny, however. It might be that the additional re-reports and substantiated re-reports seen among this group originated from the DR workers themselves, if they had concerns about the family's early withdrawal from services. However, an alternative explanation could be that increased risk factors prompted families to withdraw from services to avoid additional scrutiny from the child welfare system. Additional analyses will more closely examine the timing of the re-reports of this group of families (i.e., their proximity to case closure), as well as the source of the maltreatment report (i.e., caseworker, teacher, medical staff, family member, etc.).

8.3 Parent Engagement, Caseworker Practice, and Service Provision

One of the most consistent findings to emerge from the Illinois DR evaluation is that parents who received DR felt more strongly positive about all aspects of their child protective services experience when compared to parents who received an investigation. No matter how the questions were phrased or what underlying construct was being measured (engagement, satisfaction, emotional responses), a significantly greater percentage of parents who received DR had more positive emotional responses and fewer negative ones, were more highly engaged, and were more highly satisfied with their worker and the services they received. In terms of caseworker practice, parents who were assigned to DR were also significantly more likely than those assigned to an investigation to report that their worker listened to what they had to say, understood their family's needs, considered their opinions before making important decisions, and recognized their family's strengths. Actual differences in parent reports of engagement and caseworker approach were most likely even higher than those reported, because the analyses conducted using the ITT approach included the responses of parents who switched from DR to an investigation with those that actually received DR.

DR in Illinois represented a distinct shift in service provision to families reported to IDCFS for neglect. Prior to the implementation of DR, very few families received child welfare services following the conclusion of their investigation, and the only options available to investigators were offering families intact family services in their home or placing one or more children into substitute care. In the majority of investigations, the Investigator had one or two face-to-face contacts with the family and then closed the investigation following the substantiation decision. Through DR, it was possible for workers to spend a greater amount of time with families and offer a variety of supportive and concrete services to them in their homes. The findings related to service provision in the two groups are largely reflective of these differences in practice. Families assigned to the DR group had a higher number of face-to-face contacts with their worker compared to those assigned to the IR group (8 versus 2, respectively), received services in a more timely fashion, were more likely to receive at least one service, and received a significantly higher number of services during the initial case. The types of services that parents in the DR group received were different as well – the top five most reported services were provision of food or clothing, help looking for employment, counseling, car repair or transportation assistance, and home repair, furniture, or appliances. The top five services reported by parents who received an investigation were counseling, domestic violence services, parenting classes, referral to mental health services, and food and clothing. When asked about the services provided to them during their initial case, families who received DR were much more likely to report that the services were the kind they really needed and enough to really help them. Although families assigned to DR were more likely to get services provided to them during the initial case, families assigned to an investigation were more likely to receive formal child welfare services through an ongoing intact family service case after their initial case was closed: 11.4% of investigated families had an intact family case opened compared to 7.0% of DR cases.

8.4 Program Costs

Previous DR cost analyses have concluded that costs to provide services through a family assessment approach are higher during the initial case period compared to an investigation, but are recouped during the follow-up period when fewer DR families have additional contacts with the child welfare system and accrue additional costs (Loman & Siegel, 2004b; Loman et al., 2010). The results of the Illinois DR cost analyses were similar to those of previous studies.[33] DR caseworkers spent a significantly greater amount of time in direct contact with families than investigators – 12.5 hours (on average) compared to 3.25 hours. However, by hiring DR caseworkers through private agency contracts rather than through the unionized State agency and by having the private agency DR caseworkers provide most services themselves rather than purchase additional services, the overall costs to provide services through DR were kept low, although they were significantly higher than those accrued during an investigation.

Although Investigators in Illinois do not provide direct services to families during an investigation, if families need services they can be referred to formal child welfare services known as intact family services. Intact family services consist of many of the same services as DR, although services are provided through private agencies through purchase of service (POS) agreements and tend to last much longer than DR cases (which are limited to 90 days). In the larger evaluation sample, 11% of investigated families received intact family services, and the majority of these referrals were made immediately following the investigation. A smaller percentage of families that received DR services also received intact family services, and results of the cost analyses also revealed that intact services for DR families were significantly less costly than those for investigated families. In addition to increased costs for intact family services, placement services were also significantly more costly among investigated families compared to families that received DR. The results of the cost analysis suggest that when measured at the family level, the average total costs to provide services to families from the report date through the first year are lower for families provided with DR services compared to families provided with an investigation. However, these analyses did not take into account several types of costs, such as travel to and from family homes and worker time spent doing case documentation. There are also additional system-level costs to consider when implementing DR, such as the costs associated with modifying existing training, policies, and data systems, that are not included in the current cost analyses.

8.5 Future Directions for DR Research

The addition of the three DR evaluations funded by the QIC-DR in Illinois, Colorado, and Ohio brings the total number of RCT evaluation of Differential Response to 6. The totality of all available evidence from these six rigorous studies seems to indicate that children who receive DR are at least as safe as those who receive an investigation. In addition, an abundance of

[33] By sampling only those DR families that actually received DR services, the cost analyses did not employ an ITT approach.

findings now suggest that parents who receive DR feel more positive about their CPS experience than parents who receive an investigation. However, beyond these general conclusions, many questions remain about *which aspects* of practice in the assessment response are most effective with which families: Do certain strategies for engagement produce better outcomes than others? Which service array produces the best results? Are both engagement and services necessary for improved outcomes or is one more critical than the other? Which families are most likely to benefit from receiving child protective services through an assessment response as opposed to an investigation? Although the emphasis on documenting the differences in outcomes between investigations and assessment approaches should not be abandoned, the next phase of Differential Response evaluation should also focus on the identification of the core components of successful interventions.

Concerns about the best way to respond to child maltreatment stimulated a national discussion about child protective services in the early 1990s. By implementing DR, many States are now experimenting with alternative approaches to intervening with families reported to CPS. Some States, like Illinois, may choose to discontinue DR after a short implementation, while others will expand the use of DR to become the preferred CPS response to most allegations of maltreatment. Regardless of its eventual life span as a CPS reform, discussions about Differential Response have reinvigorated the national discussion about the mandates of public child protective services and the means through which services to families get allocated:

> "Having raised such questions, Differential Response may have identified a more fundamental issue. Perhaps the future of Differential Response is not solely a different response to the investigation of allegations of abuse and but rather an alternative way to understanding the needs of families in contemporary society and the interaction of public and private responses to those needs. Differential Response, therefore, is an example of a current child welfare reform effort that may thrive and grow, or be replaced by the next reform effort, depending on how much child welfare and other human service professionals engage in debates on the broader social policies related to improving the lives of children and their families" (Yuan, 2005, p. 31).

Although DR in Illinois was discontinued in 2012, the results of the Illinois DR evaluation can inform and improve practice with all families who come into contact with the child protection system.

References

Atkins, D.C. (2009). Clinical trials methodology: Randomization, intent-to-treat, and random-effects regression. *Depression and Anxiety, 26,* 697-700.

Ayon, C., Asienberg, E., & Erera, P. (2010). Learning how to dance with the public child welfare system: Mexican parents' efforts to exercise their voice. *Journal of Public Child Welfare, 4*, 263-286.

Brown, C.H., Wang, W., Kellam, S.G., Muthen, B.O., Petras, H., Toyinbo, P., Poduska, J., Ialongo, N., Wyman, P.A., Chamberlain, P., Sloboda, Z., MacKinnon, D.P., & Windham, A. (2008). Methods for testing theory and evaluating impact in randomized field trials: Intent-to-treat analyses for integrating the perspectives of person, place, and time. *Drug and Alcohol Dependence, 95S,* S74-S104.

Buckley, H., Carr, N., & Whelan, S. (2011). 'Like walking on eggshells': Service user views and expectations of the child protection system. *Child & Family Social Work, 16*, 101-110.

Campbell, K.A., Cook, L.J., LaFluer, B.J., & Keenan, H.T. (2010). Household, family, and child risk factors after an investigation for suspected child maltreatment. *Archives of Pediatric and Adolescent Medicine, 164,* 943-949.

Children and Family Research Center. (2013). *Conditions of Children in or at Risk of Foster Care in Illinois: 2012 Monitoring Report of the B.H. Consent Decree.* Urbana, IL: Author.

Dale, P. (2004). "Like fish in a bowl': Parents' perceptions of child protective services. *Child Abuse Review, 13*, 137-157.

Daro, D., McCurdy, K., & Nelson, C. (2005). *Engagement and retention in voluntary new parent support programs: Final report*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.

Diorio, W. D. (1992). Parental perceptions of the authority of public child welfare caseworkers. *Families in Society, 73*, 222-235.

Dumbrill, G.C., (2006). Parental experience of child protection intervention: A qualitative study. *Child Abuse & Neglect, 30*, 27-37.

Forrester, D., Westlake, D., & Glynn, G. (2012). Parental resistance and social worker skills: Towards a theory of motivational social work. *Child & Family Social Work, 17*, 118-129.

Fuller, T. (in press). Beyond investigations: Differential Response in child protective services. In J.E. Korbin & R.D. Krugman (Eds.), *Handbook of Child Maltreatment*. New York: Springer.

Fuller, T.L. & Kearney, K.A. (Eds.) (2010). *Conditions of children in or at risk of foster care in Illinois: An assessment of their safety, stability, continuity, permanence and well-being.* Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

Fuller, T., Kearney, K.A., & Lyons, S. (2012). *Differential Response in Illinois: 2011 site visit report.* Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

Fuller, T.L. & Nieto, M. (2010). *Illinois Child Endangerment Risk Assessment Protocol: FY 2010 annual evaluation.* Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

Gallagher, M., Smith, M., Wosu, H., Stewart, J., Hunter, S., Cree, V. E., & Wilkinson, H. (2011). Engaging with families in child protection: Lessons from practitioner research in Scotland. *Child Welfare, 90*, 117-134.

Harris, N. (2012). Assessment: When does it help and when does it hinder? Parents' experiences of the assessment process. *Child & Family Social Work, 17*, 180-191.

Horvath, A.O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology, 56*, 163-173.

Illinois Department of Children and Family Services (2011). *FY 2011 Differential Response Services Program Plan*. Springfield, IL: Author

Illinois Department of Children and Family Services. (2012a). *Child abuse and neglect statistics: December 2012.* Springfield, IL: Author. Available online: http://www.state.il.us/DCFS/docs/canstat.pdf.

Illinois Department of Children and Family Services. (2012b). *Executive statistical summary: December 2012.* Springfield, IL: Author. Available online: http://www.state.il.us/DCFS/docs/execstat.pdf.

Kempe, C.H., Silverman, F.N., Steele, B.F. Droegemueller, W., & Silver, H.K. (1962). The battered child syndrome. *Journal of the American Medical Association, 181,* 17-24.

Korfmacher, J., Green, B., Spellmann, M., & Thornburg, K.R. (2007). The helping relationship and program participation in early childhood home visiting. *Infant Mental Health Journal, 28*, 459-480.

Korfmacher, J., Green, B., Staerkel, F., Paterson, C., Cook, G., Roggman, L., Faldowski, R.A., & Schiffman, R. (2008). Parent involvement in early childhood home visiting. *Child & Youth Care Forum, 37,* 171-196.

Kriz, K., Slyter, E., Iannicelli, A., & Lourie, J. (2012). Fear management: How child protection workers engage with non-citizen immigrant families. *Children and Youth Services Review, 34,* 316-323.

Lachin, J. (2000). Statistical considerations in the intent-to-treat principle. *Controlled Clinical Trials, 21*, 167-289.

Loman, L.A. (2006). *Families frequently encountered by child protection services: A report on chronic child abuse and neglect.* St. Louis, MO: Institute of Applied Research.

Loman, L.A., Filonow, C.S., & Siegel, G. (2010). *Ohio alternative response evaluation: Final report.* St. Louis, MO: Institute of Applied Research.

Loman, L.A., & Siegel, G.L. (2004a). *Differential response in Missouri after five years: Final report.* St. Louis, MO: Institute of Applied Research.

Loman, L.A., & Siegel, G.L. (2004b). *Minnesota alternative response evaluation: Final report*. St. Louis, MO: Institute of Applied Research.

Loman, L.A., & Siegel, G.L. (2012). *Ohio alternative response evaluation extension interim report.* St. Louis, MO: Institute of Applied Research.

Madsen, W.C. (2009). Collaborative helping: A practice framework for family-centered services. *Family Process, 48,* 103-116.

Mandell, L. (1974). When to weight: Determining nonresponse bias in survey data. *The Public Opinion Quarterly, 38*, 247-252,

McCurdy, K., & Daro, D. (2001). Parent involvement in family support programs: An integrated theory. *Family Relations, 50*, 113-121.

National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR). (2011). *Differential response in child protective services: A literature review (Version 2).* Englewood, CO: Author.

Nolan, C., Blankenship, J., & Sneddon, D. (2012). Research and practice advancements in differential response. *Protecting Children, 26*, 4-6.

Platt, D. (2001). Refocusing children's services: Evaluation of an initial assessment process. *Child and Family Social Work, 6,* 139-148.

Platt, D. (2012). Understanding parental engagement with child welfare services: An integrated model. *Child & Family Social Work, 17*, 138-148.

Reeves, M. (2008). *EPI-546 fundamentals of epidemiology and biostatistics course notes Lecture 7 The RCT.* East Lansing, MI: Michigan State University.

Ringeisen, H., Casanueva, C., Smith, K., & Dolan, M. (2011). *NSCAW II baseline report: Caregiver health and services.* Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Ruppel, J., Huang, Y., & Haulenbeek, G. (2011). *Differential response in child protective services in New York State: Implementation, initial outcomes and impacts of pilot project.* Albany, NY: New York State Office of Children and Family Services.

Schene, P. (2005). The emergence of differential response. *Protecting Children, 20,* 4-7.

Schreiber, J.C., Fuller, T.L., & Paceley, M. (2013). Engagement in child protective services: Parent perceptions of worker skills. *Children and Youth Services Review, 35,* 707-715.

Seigel, G.L. (2012). *Lessons from the beginning of differential response: Why is works and when it doesn't.* St. Louis, MO: Institute of Applied Research.

Siegel, G.L. (2010). *Differential Response in Nevada Final Evaluation Report*. St. Louis, MO: Institute of Applied Research.

Smith, B.D. (2008). Child welfare service plan compliance: Perceptions of parents and caseworkers. *Families in Society, 89*, 521-532.

Staudt, M. (2007). Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. *Journal of Child and Family Studies, 16*, 183-196.

Ten Have, T.R., Normand, S.T., Marcus, S.M., Brown, C.H., Lavori, P., & Duan, N. (2008). Intent-to-treat vs. non-intent-to-treat analyses under treatment non-adherence in mental health randomized trials. *Psychiatric Annals, 38*, 772-783.

Thoburn, J., Lewis, A., & Shemmings, D. (1995). Family participation in child protection. *Child Abuse Review, 4*, 161-171.

U.S. Advisory Board on Child Abuse and Neglect. (1990). *Child abuse and neglect: Critical first steps in response to a national emergency.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, Administration for Children and Families/Children's Bureau and Office of the Assistant for Planning and Evaluation. (2003). *National study of child protective services systems and reform efforts: Review of state CPS policies*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). *Child Maltreatment 2010.* Available from http://archive.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2012). *Child Maltreatment 2011*. Available from: http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2013). *Child Welfare Outcomes 2008-2011: Report to Congress.* Available from http://www.acf.hhs.gov/sites/default/files/cb/cwo08_11.pdf.

Waldfogel, J. (1998). Rethinking the paradigm for child protection. *The Future of Children, 8,* 104-119.

Wen, X., Korfmacher, J., Hans, S.L., & Henson, L.G. (2010). Young mothers' involvement in a prenatal and postpartum support program. *Journal of Community Psychology, 38*, 172-190.

Yatchmenoff, D.K. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Research on Social Work Practice, 15,* 84-96.

Yuan, Y.T. (2005). Potential policy implications of alternative response. *Protecting Children, 20,* 22-31.

Zhang, S., Fuller, T., & Nieto, M. (2013). Didn't we just see you? Time to recurrence among frequently encountered families in CPS. *Children and Youth Services Review, 35*, 883-889.

Appendix A: Illinois Child Endangerment Risk Assessment Protocol

State of Illinois
Department of Children and Family Services

CHILD ENDANGERMENT RISK ASSESSMENT PROTOCOL

SAFETY DETERMINATION FORM

Case Name	Date of Report	Agency Name
RTO/RSF	Date of this Assessment Date of Certification	SCR/CYCIS #
Name of Worker Completing Assessment		ID#

When To Complete the Form:

CHILD PROTECTION INVESTIGATION (check the appropriate box):

☐ 1. Within 24 hours after the investigator first sees the alleged child.

☐ 2. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

☐ 3. Every 5 working days following the determination that a child is **unsafe** and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe, the investigation is completed or all children assessed as unsafe are removed from the legal custody of their parents/caregivers and legal proceedings are being initiated in Juvenile Court. This assessment should be conducted considering the child's safety status as if there was no safety plan, (i.e., would the child be safe **without** the safety plan?).

☐ 4. At the conclusion of the formal investigation, unless temporary custody is granted or there is an open intact case or assigned caseworker. The safety of all children in the home, including alleged victims and non-involved children, must be assessed.

PREVENTION SERVICES (CHILD WELFARE INTAKE EVALUATION) (check the appropriate box):

☐ 1. Within 24 hours of seeing the children, but no later than 5 working days after assignment of a Prevention Services referral.

☐ 2. Before formally closing the Prevention Services referral, if the case is open for more than 30 calendar days.

☐ 3. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

INTACT FAMILY SERVICES (check the appropriate box):

☐ 1 Within 5 working days after initial case assignment and upon any and all subsequent case transfers.
Note: If the child abuse/neglect investigation is pending at the time of case assignment, the Child Protection Service Worker remains responsible for CERAP safety assessment and safety planning until the investigation is complete. When the investigation is completed and approved, the assigned intact worker has 5 work days to complete a new CERAP.

☐ 2. Every 90 calendar days from the case opening date.

☐ 3. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

☐ 4. Every 5 working days following the determination that a child is **unsafe** and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe, the investigation is completed or all children assessed as unsafe are removed from the legal custody of their parents/caregivers and legal proceedings are being initiated in Juvenile Court. This assessment should be conducted as if there was no safety plan (i.e., would the child be safe **without** the safety plan?).

☐ 5. Within 5 work days of a supervisory approved case closure.

PLACEMENT CASES (check the appropriate box):

- ☐ 1. Within 5 working days after a worker receives a new or transferred case, **when there are other children in the home of origin.**
- ☐ 2. Every 90 calendar days from the case opening date.
- ☐ 3 When considering the commencement of unsupervised visits in the home of the parent or guardian.
- ☐ 4. Within 24 hours prior to returning a child home.
- ☐ 5. When a new child is added to a family with a child in care.
- ☐ 6. Within 5 working days after a child is returned home and every month thereafter until the family case is closed.
- ☐ 7. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

For any Safety Threat that was marked "Yes" on the previous CERAP that is marked as "No" on the current CERAP (indicating the Safety Threat no longer exists), the completing worker will provide an explanation as to what changed in order to eliminate the Safety Threat on the next page.

SECTION 1. SAFETY ASSESSMENT
Part A. Safety Threat Identification

Directions: The following list of threats is behaviors or conditions that may be associated with a child being in immediate danger of moderate to severe harm**. NOTE: At the initial safety assessment, all alleged child victims and all other children residing in the home are to be seen, and if verbal, interviewed out of the presence of the caretaker and alleged perpetrator. If some children are not at home during the initial investigation, do not delay the safety assessment. Complete a new safety assessment on the children who are not home at the earliest opportunity only if the safety assessment changes. If there is no change, indicate so in the "Reclassify Participant" box in PART B.2. For all other safety assessments, all children residing in the home are to be seen, and if verbal, interviewed out of the presence of the caregiver and alleged perpetrator.** When assessing children's safety, consider the effects that any adults or members of the household who have access to them could have on their safety. Identify the presence of each factor by checking "Yes," which is defined as "clear evidence or other cause for concern."

1.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household whose behavior is violent and out of control.
2.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household is suspected of abuse or neglect that resulted in moderate to severe harm to a child or who has made a plausible threat of such harm to a child.
3.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household has documented history of perpetrating child abuse/neglect or any person for whom there is reasonable cause to believe that he/she previously abused or neglected a child. The severity of the maltreatment, coupled with the caregiver's failure to protect, suggests child safety may be an urgent and immediate concern.
4.	**Yes** ☐	**No** ☐	Child sex abuse is suspected and circumstances suggest child safety may be an immediate concern.
5.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household is hiding the child, refuses access, or there is some indication that a caregiver may flee with the child.
6.	**Yes** ☐	**No** ☐	Child is fearful of his/her home situation because of the people living in or frequenting the home.
7.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household describes or acts toward the child in a predominantly negative manner.
8.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household has dangerously unrealistic expectations for the child.
9.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household expresses credible fear that he/she may cause moderate to severe harm to a child.
10.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household has not, will not, or is unable to provide sufficient supervision to protect a child from potentially moderate to severe harm.
11.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household refuses to or is unable to meet a child's medical or mental health care needs and such lack of care may result in moderate to severe harm to the child.
12.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household refuses to or is unable to meet the child's need for food, clothing, shelter, and/or appropriate environmental living conditions.
13.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household whose alleged or observed substance abuse may seriously affect his/her ability to supervise, protect or care for the child.
14.	**Yes** ☐	**No** ☐	A caregiver, paramour or member of the household whose alleged or observed mental/physical illness or developmental disability may seriously impair or affect his/her ability to provide care for a child.
15.	**Yes** ☐	**No** ☐	The presence of violence, including domestic violence, that affects a caregiver's ability to provide care for a child and/or protection of a child from moderate to severe harm.
16.	**Yes** ☐	**No** ☐	A caregiver, paramour, member of the household or other person responsible for a child's welfare engaged in or credibly alleged to be engaged in human trafficking poses a safety threat of moderate to severe harm to the child .

For any Safety Threat that was marked "Yes" on the previous CERAP that is marked as "No" on the current CERAP (indicating the Safety Threat no longer exists), the completing worker shall provide an explanation in a contact note as to what changed in order to eliminate the Safety Threat(s).

PART B.1. Safety Threat Description

Directions: **IF SAFETY THREAT(S) ARE CHECKED "YES":**

- Note the applicable safety number and then briefly describe the specific individuals, behaviors, conditions and circumstances associated with that particular threat.

IF NO SAFETY THREATS ARE CHECKED "YES"

- Summarize the information you have available that leads you to believe that no children are likely to be in immediate danger of moderate to severe harm

PART B.2. List Children and Adults Who Were Not Assessed and the Reason Why They Were Not Identify the timeframes in which the assessment will be done.

RECLASSIFY Participant: **Indicate below if no change in the assessment has occurred due to the assessment of the above persons.**
If a change has occurred, complete a new assessment

Worker's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

PART B.3. Family Strengths or Mitigating Circumstances

For each safety factor that has been checked "yes", describe any family strengths or mitigating circumstances. This section is not to be completed if no safety factors are checked "yes".

Safety Factor #	1. Family Strengths	2. Mitigating Circumstances

SECTION 2: SAFETY DECISION

Directions: Identify your safety decision by checking the appropriate box below. (Check one box only.) This decision should be based on the assessment of all safety factors and any other information known about this case.

A. SAFE ☐ There are no children likely to be in immediate danger of moderate to severe harm at this time. No safety plan shall be done.

B. UNSAFE ☐ A safety plan must be developed and implemented **or** one or more children must be removed from the home because without the plan they are likely to be in immediate danger of moderate to severe harm.

SIGNATURE/DATES

The safety assessment and decision were based on the information known at the time and were made in good faith.

Worker _____ Date _____

Supervisor _____ Date _____

Appendix B: Illinois Case Specific Report

Illinois Differential Response Case Specific Report

Caregiver Name: _____

Your Name:_____

Your Agency or Field Office:_____

Part One

1. Was this: ☐ a Differential Response case CYCIS NUMBER:_____

☐ an Investigation case SCR NUMBER:_____

2. Are you the original investigator OR caseworker assigned to this family?

☐ yes
☐ no

3. How well did the primary caregiver speak English?

☐ very well
☐ well
☐ not well
☐ not at all

4. Number of contacts with family (*estimate if necessary*):

	# contacts
a. Face-to-face meetings with members of the family?	_____
b. Telephone contacts with members of the family?	_____
c. Other contacts with family members (court visits, etc.)?	_____
d. Contacts with others on behalf of this family?	_____
e. Face-to-face contacts between other agency providers and family?	_____

5 Family Functioning

Check all family needs present at case opening ⇩	**Then for every need checked, complete (2) and (3)** ⇨	**(2) Condition addressed while the case was open?**		**(3) Improvement (check one)**			
		No	Yes	None	Little	Moderate	Much
☐ Material Needs (e.g., housing, food/clothing, income, employment, etc.)		☐	☐	☐	☐	☐	☐
☐ Substance Abuse (e.g., alcohol, prescription drugs, illicit drugs, etc.)		☐	☐	☐	☐	☐	☐
☐ Physical Health (e.g., adult or child disability, developmental delay, etc.)		☐	☐	☐	☐	☐	☐
☐ Mental Health		☐	☐	☐	☐	☐	☐
☐ Parenting Skills/Discipline		☐	☐	☐	☐	☐	☐
☐ Domestic Violence		☐	☐	☐	☐	☐	☐
☐ Education (e.g., school attendance, progress, etc.)		☐	☐	☐	☐	☐	☐
☐ Social Supports (e.g., extended family, friends, & neighbors, etc.)		☐	☐	☐	☐	☐	☐

6. Threats to Child Safety:

Check all safety threats present in this case first. Then for every threat checked, complete (2) and (3)	(2) Indicate whether level of safety threat was mild, moderate or severe.		(3) Was the safety threat addressed?									
			Yes, by:					No, because:				Don't know/ not sure
	At first contact	At Closure	DCFS staff	Private agency provider	Unpaid community resource	Family/ kin	Other	No funds available	Provider unavailable	Uncooperative family	Other	
☐ **Neglect or abandonment** (e.g., child lacked basic needs, the home was unsafe or unclean, medical or educational neglect, etc.)	☐ mild ☐ moderate ☐ severe	☐ mild ☐ moderate ☐ severe ☐ none	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ **Physical, sexual, emotional abuse** (e.g., excessive discipline, violence in the home, sexual or emotional maltreatment, etc.)	☐ mild ☐ moderate ☐ severe	☐ mild ☐ moderate ☐ severe ☐ none	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ **Lack of supervision or proper care** (e.g., child left unsupervised, burns, fractures, etc.)	☐ mild ☐ moderate ☐ severe	☐ mild ☐ moderate ☐ severe ☐ none	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ **Damaging adult-child relationship** (e.g., verbal or physical fights, rejection, etc.)	☐ mild ☐ moderate ☐ severe	☐ mild ☐ moderate ☐ severe ☐ none	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ **Other Threat** (specify)	☐ mild ☐ moderate ☐ severe	☐ mild ☐ moderate ☐ Severe ☐ none	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7a. Was information about or referral to services given to the family?

☐ yes ☐ no ☐ uncertain

7b. Were any services (traditional or non-traditional) or supports provided to this family?

☐ yes ☐ no ☐ uncertain whether family actually received services

7c. If yes, how soon after the initial report date did the family receive services?

☐ within one week ☐ within two weeks ☐ within three weeks
☐ within four or more weeks ☐ family was not offered services ☐ uncertain

If you answered yes to <u>either</u> 7a <u>or</u> 7b, complete SERVICES TO FAMILY CHART below.
If you answered no or uncertain to <u>both</u> of 7a and 7b, skip the SERVICES TO FAMILY CHART and continue to Question 8.

SERVICES TO FAMILY CHART

The following is a list of services that are sometimes provided to families.

1) **Place a check after any service to indicate:**
   (1) *<u>service provided during the case</u>* – direct services were provided by you or a member of your agency to a family member(s) while the case was open and had not been in place at the time of the first visit.
   (2) *<u>information/referral provided</u>* – service information was given or referrals to services were made.
   (3) *<u>service in place at start</u>* - services were already in place prior to the first visit.
2) **For any service received by the family, give us some idea of the level of service use from very little (1) to very much (5).**

For each service check **<u>all</u>** that apply	*(1)*	*(2)*	*(3)*	*Level of service use by family (check)*
	Service provided	*Info/ referral provided*	*Service in place at start*	*Very little < ---------- > Very much*
Services to address Material Needs (e.g., help with housing payments, emergency shelter or food, TANF, employment assistance, etc.)	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain
Substance Abuse Services (e.g., alcohol or drug abuse treatment)	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain
Health Services (e.g., medical or dental care, mental health/psychiatric services, etc.)	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain
Mental Health Services	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain
Parenting Classes	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain
Domestic Violence Services	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain
Educational Services	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain
Social Support Services (e.g., marital/family counseling, support groups, etc.)	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain
Other (specify)	☐	☐	☐	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ uncertain

8. Since the case opened, were relatives and friends outside the household involved in providing needed support and/or assistance to this family?

☐ not at all
☐ very little
☐ moderately
☐ extensively

9. Were no-cost neighborhood/community resources (i.e. churches) used to assist this family?

☐ not at all
☐ very little
☐ moderately
☐ extensively

10. Check any of the following reasons why the family may not have been fully served:

☐ size of worker caseload
☐ limited staff time to work with family
☐ other pressing cases on caseload
☐ problems beyond scope of CPS to remedy
☐ limited funds for needed services ☐ other_____

11. Rate the characteristics of the family members at the <u>first time</u> you met with them:	Very	Moderately	A Little	Not At All
Cooperative	☐	☐	☐	☐
Receptive to help	☐	☐	☐	☐
Engaged	☐	☐	☐	☐
Uncooperative	☐	☐	☐	☐
Difficult	☐	☐	☐	☐

12. If you met with members of the family more than one time, rate the characteristics the <u>last time</u> you met with them. ☐ met with family only once	Very	Moderately	A Little	Not At All
Cooperative	☐	☐	☐	☐
Receptive to help	☐	☐	☐	☐
Engaged	☐	☐	☐	☐
Uncooperative	☐	☐	☐	☐
Difficult	☐	☐	☐	☐

If you did not have to complete the SERVICES TO FAMILY CHART, stop here.

Otherwise, continue to Part Two.

Part Two

13. Did you help members of this family in obtaining services from any of the following? (*check all that apply)*

☐ school
☐ neighborhood organization
☐ mental health provider

☐ alcohol/drug rehab agency/program
☐ MR/DD provider
☐ youth organization

☐ health care provider
☐ job service/employment security
☐ employment & training agency

☐ legal services provider
☐ support group
☐ childcare/preschool provider/Head Start

☐ community action agency
☐ domestic violence shelter
☐ emergency food provider

☐ church or religious organization
☐ recreational facility (e.g. YMCA)
☐ neighbors/friends/extended family
☐ other

14. Overall, how well were the services that were actually provided <u>matched</u> to the service needs of the family?

☐ very well matched
☐ somewhat matched
☐ not very matched
☐ not at all matched

15. Overall, how <u>effective</u> were the services provided to the family in solving their problems or in producing needed changes?

☐ very effective
☐ somewhat effective
☐ not very effective
☐ not at all effective

Appendix C: Illinois Family Survey

CONFIDENTIAL

FAMILY SURVEY (DR)

*For office use only: CYCIS#*_____

Please fill in the following information so that we can send you your **GIFT CARD.**

If this is incorrect or blank, it could delay or stop delivery of your **GIFT CARD.**

Your Name _____

Street or PO Box _____

City _____

State _____ *Zip* _____

*Phone Number*__(_____)_____

As part of our study, we will be contacting some families again in the future to ask more questions. We understand that some people may not wish to be contacted, so please check a box to let us know. People who participate in the interviews will receive an additional gift card.

Can we contact you in the future about additional research opportunities?

❑ *YES* ❑ *NO*

CONFIDENTIAL

FAMILY SURVEY (DR)

A child welfare agency has contacted you in the past several months concerning one or more children in your home. Please answer the following questions about your experience with the child welfare agency and the caseworker who contacted you.

If more than one caseworker visited your home, please answer the questions about the person you saw **the most**.

SATISFACTION

1. How satisfied are you with the way you and your family were treated by the caseworker who visited your home?

❑ *Very satisfied* ❑ *Somewhat satisfied* ❑ *Not at all satisfied*

2. How satisfied are you with the help you and your family received from the caseworker?

❑ *Very satisfied* ❑ *Somewhat satisfied* ❑ *Not at all satisfied*

3. How likely would you be to call the caseworker or the child welfare agency if you or your family needed help in the future?

❑ *Very likely* ❑ *Somewhat likely* ❑ *Not at all likely*

RELATIONSHIP WITH CASEWORKER

4. How did you feel after the first time the caseworker came to your home?

Check all that apply:

❑ *Relieved*	❑ *Comforted*
❑ *Angry*	❑ *Disrespected*
❑ *Hopeful*	❑ *Encouraged*
❑ *Afraid*	❑ *Thankful*
❑ *Respected*	❑ *Stressed*
❑ *Worried*	❑ *Discouraged*

5. About how many times did you or other members of your family meet with the caseworker?

- ❑ *1*
- ❑ *2-5*
- ❑ *6-10*
- ❑ *more than 10*

6. Overall, how carefully did the caseworker listen to what you and other members of your family had to say?

- ❑ *Very carefully*
- ❑ *Somewhat carefully*
- ❑ *Not at all carefully*

7. Overall, how well do you feel the caseworker understood your and your family's needs?

- ❑ *Very well*
- ❑ *Somewhat well*
- ❑ *Not at all well*

8. Were there things that were important to you or your family that did not get talked about with the caseworker?

❑ *Yes* ❑ *No*

9. How often did the caseworker consider your opinions before making decisions that concerned you and your family?

❑ *Always* ❑ *Sometimes* ❑ *Never*

10. Did the caseworker recognize the things that you and your family do well?

❑ *Yes* ❑ *No*

11. How easy was it to contact the caseworker?

- ❑ *Very easy*
- ❑ *Somewhat easy*
- ❑ *Not at all easy*

CONFIDENTIAL

FAMILY SURVEY

We are interested in your feelings about your involvement with your caseworker and their agency. There are no right or wrong answers to any of the questions. Please answer as openly and honestly as you can.

Here are some ways that families may feel about having a caseworker involved in their lives. Some are positive and some are negative. You may have both positive and negative feelings at the same time. Please read each statement and think about how you feel right now about your involvement with your caseworker and their agency.

12. My family got the help we really need from the caseworker.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

13. I realize I needed some help to make sure my kids have what they need.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

14. I was fine before the caseworker got involved. The problem is theirs, not mine.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

15. I really made use of the services my caseworker gave me.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

16. It was hard for me to work with the caseworker.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

17. There was a good reason my caseworker was involved with my family.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

18. Working with my caseworker has given me more hope about how my life is going to be in the future.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

19. I think my caseworker and I respected each other.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

20. My worker and I agreed about what was best for my child(ren).
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

21. I felt like I could trust my caseworker to be fair and see my side of things.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

22. I think things are better because my caseworker was involved with my family.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

23. My caseworker wanted me to do the same things that I wanted to do.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

24. There were definitely some problems in my family that my caseworker saw.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

25. My caseworker did not understand where I was coming from at all.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

26. My caseworker helped me take care of some problems in my life.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

27. My caseworker helped make my family stronger.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

28. My caseworker was out to get me.
❑ *Strongly agree* ❑ *Agree* ❑ *Do not agree*

SERVICES AND NEEDS

29. Did you or your family get any of the following help or services during your experience with the child welfare agency?

❑ *We did not receive <u>any</u> services*

Check all services received:

❑ *Emergency shelter*
❑ *Car repair or transportation assistance*
❑ *Housing assistance*
❑ *Food or clothing for your family*
❑ *Money to pay your rent*
❑ *Appliances, furniture, or home repair*
❑ *Help paying utilities*
❑ *Welfare/public assistance services*
❑ *Medical or dental care for you or your family*
❑ *Any other financial help*
❑ *Help for a family member with a disability*
❑ *Legal services*
❑ *Assistance in your home, such as cooking or cleaning*
❑ *Help with child care or day care*
❑ *Help getting mental health services*
❑ *Respite care for time away from your children*
❑ *Help in getting alcohol or drug treatment*
❑ *Meetings with other parents about raising children*
❑ *Parenting classes*
❑ *Help in getting into educational classes*
❑ *Counseling services (individual, family, mental health)*
❑ *Help in looking for employment or in changing jobs*
❑ *Domestic violence services*
❑ *Job training or vocational training*
❑ *Education services*

30. If you received help or services from the case worker (or a referral they gave you), was it:

a. The kind of help you needed? ❑ *Yes* ❑ *No*
b. Enough to really help you? ❑ *Yes* ❑ *No*

31. Was there any help that you or your family needed but did not receive?

❑ *Yes* ❑ *No*

If yes, what?

_____

_____

_____

FAMILY OUTCOMES

32. Overall, are you and your family better off or worse off because of your experience with the child welfare agency?

❑ *We are better off*
❑ *We are the same*
❑ *We are worse off*

33. Are you a better parent because of your experience with the child welfare agency?

❑ *Yes* ❑ *No*

34. Are your children safer because of your experience with the child welfare agency?

❑ *Yes* ❑ *No*

35. Are you better able to provide necessities like food, clothing, shelter, or medical services because of your experience with the child welfare agency?

❑ *Yes* ❑ *No*

CONFIDENTIAL

FAMILY SURVEY

ABOUT YOU AND YOUR FAMILY

36. Is there anyone in your life that you:	*Yes, whenever I need it*	*Yes, occasionally*	*Yes, rarely*	*No, I have no one*
can turn to in times of stress?	❑	❑	❑	❑
can talk to about things going on in your life?	❑	❑	❑	❑
know will help you if you really need it?	❑	❑	❑	❑
ask to care for your children when needed?	❑	❑	❑	❑
ask to help you with transportation if needed?	❑	❑	❑	❑
can turn to for financial help if you need it?	❑	❑	❑	❑

37. What is your highest level of education?

- ❑ *Less than 8th grade*
- ❑ *8th – 11th grade*
- ❑ *High school diploma or GED*
- ❑ *Some college or trade school*
- ❑ *Two-year college degree*
- ❑ *Four-year college degree*
- ❑ *Some graduate school or graduate degree*

38. What was your total household income last year?

- ❑ *$0 - $9,999*
- ❑ *$10,000 – $19,999*
- ❑ *$20,000 – $29,999*
- ❑ *$30,000 – $39,999*
- ❑ *$40,000 – $49,999*
- ❑ *$50,000 – $59,999*
- ❑ *$60,000 or more*

39. What is your gender?

- ❑ *Male*
- ❑ *Female*

40. Are you of Hispanic, Latino, or Spanish Origin?

- ❑ *Yes (please specify)*

  _____

- ❑ *No*

41. What is your race?

Check all that apply:

- ❑ *Black or African American*
- ❑ *White*
- ❑ *Alaska Native*
- ❑ *American Indian*
- ❑ *Asian*
- ❑ *Native Hawaiian or other Pacific Islander*
- ❑ *Other (please specify)* _____

42. Were you offered services in your preferred language?

- ❑ *Yes- in English*
- ❑ *Yes- in another language*
- ❑ *No*

THANK YOU!

Children and Family Research Center
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN
SCHOOL OF SOCIAL WORK