
Minnesota Alternative Response Evaluation

Final Report

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Preface and Acknowledgements

Classic assessments of child protection in the United States describe a system able to provide services only to the most severely abused and neglected children. This is the “residual approach” to child protection described by Duncan Lindsey. This approach, he writes, “demands that aid should be invoked only after the family is in crisis. From this perspective the child welfare agency becomes the site of triage, a battlefield hospital where casualties are sorted and only the most seriously wounded receive attention.” The problem with this approach, he contends, is that “because the damage to children is so great by the time they enter the system, the number who survive and benefit is minimal.”¹

Given the limited public resources made available, this residual approach “is certainly understandable,” Sheila Kamerman and Alfred Kahn write, “but it is not a sufficient societal response to the needs of children.” They continue: “If (less critically maltreated) children are not identified and helped, their problems will become acute. We must not intervene coercively with families where there is no statutory mandate to do so. Neither, however, should we overlook people truly in need of services.”²

The Minnesota Alternative Response is an attempt to find a way out of the dilemma described by Lindsey, Kamerman and Kahn. It represents the beginning of a new approach, one that emphasizes intervening earlier, more intensively and in a non-coercive manner in less serious cases, not waiting for the damage to be so great that the prospects of improvement are unlikely.

The Alternative Response project would not have been possible in Minnesota without the support of the McKnight Foundation along with federal, state and county funding. The role of the McKnight Foundation in this project should be particularly noted. It is unlikely the project could have been undertaken without significant support from this source. The foundation provided funds for participating counties to defray some of the new costs associated with the project, which helped, for example, to pay the costs of additional staff. McKnight Foundation funds also allowed counties to address serious needs identified during child protection assessments, provided incentive stipends to families who participated in interviews and surveys, allowed the Department of Human Services to train county staffs, and funded the evaluation. Participating counties provided certain matching funds and took the risks associated with beginning a new initiative within a service system context of limited resources and extensive demands on human and fiscal assets. The Department of Human Services, supported by the state legislature, provided an exceptional level of organizational support and provided counties on-going technical assistance and training through the designation of special administrators to guide and monitor the project. Whatever improvements have been made in child protection services in Minnesota through the Alternative Response project could not have been achieved without the individual and coordinated efforts of this

¹ *The Welfare of Children*, Oxford University Press, 1994, p. 4-5.

² Kamerman, S. B., and Kahn, A.J. (1990), If CPS is Driving Child Welfare—Where Do We Go from Here? *Public Welfare*, Winter: 1990.

quartette, the McKnight Foundation, county human services agencies, the state Department of Human Services, and the state legislature.

Within the Department of Human Services, a special acknowledgement is due to Erin Sullivan Sutton, Child Safety and Permanency Director, Children and Family Services, whose efforts and judgment provided the foundation and an administrative framework for the project and evaluation. Recognition should also go to David Thompson and Carole Johnson, DHS special consultants, who provided ongoing technical assistance to counties and guidance and support to the evaluation. Acknowledgement and thanks must also go to all the professionals within DHS who assisted in the tasks of data collection and transferal.

A special acknowledgement should also go to the state legislators who supported the project since its inception and, in many cases, who championed its cause during prior years of planning and consensus building.

Recognition and acknowledgement must go also to those individuals who served on the research advisory committee for their guidance: Noa Staryk, of the McKnight Foundation; Byran Egelund, Esther Wattenberg, and Samuel Myers, of the University of Minnesota; Patricia Schene, Child Welfare Consultant; Ying-Ying Yuan, of Walter R. McDonald & Associates; Michael Weber, of Volunteers of America; and Claudia Fercello, Research Consultant and part of the original DHS management team for the project.

The evaluators would like to take this opportunity to express our appreciation to the administrators, supervisors, social workers, data technicians, researchers and bookkeepers in all the counties that participated in the project. They are too numerous to mention here but without their help, patience and feedback the study would not have been possible. Two individuals from their ranks deserve a special acknowledgement because of their contributions: Rob Sawyer, Olmsted County Children and Family Services Director, and Patrick Coyne, Dakota County Social Services Director.

We would also like to extend our thanks to the many persons who consented to be interviewed and surveyed, and who gave their time and views during this project. This includes a wide variety of community stakeholders and community agency administrators.

A special word of appreciation is due to the many family members whose contributions were essential to the evaluation. They share the desire of all families to nurture and care for their children and the need to be given the opportunity and resources to do so.

Neither the project or its evaluation could have been done without any of these individuals. But one other person must be recognized and thanked, Nancy Latimer of the McKnight Foundation. She has been a guiding and steady hand throughout the course of this project. The children of Minnesota are in her debt.

Study Highlights

Among the many study findings of this evaluation, five stand out:

1. Child safety was not compromised by the Alternative Response (AR) to child protection. No evidence was found that this approach led to a decrease in the safety of children. On the contrary, there was evidence that the safety status of children improved during cases in which AR was used and that this was related to increased service provision.
2. Families who received the AR approach were less likely to have new child maltreatment reports than control families that received a traditional investigation.
3. While the initial cost of AR in services provided and worker time was greater than in traditional CPS interventions, it was less costly and more cost effective in the longer term.
4. Most families liked the AR approach and responded more positively to workers who used it. Under AR, families more often reported that they were treated in a friendly and fair manner, were listened to by workers, were involved in decision making and case planning, and benefited from the CPS intervention.
5. Most CPS workers also liked AR and saw it as a more effective way of approaching families with reports of child maltreatment. These attitudes strengthened among social workers as they gained experience using it.

Executive Summary

The Alternative Response (AR) demonstration began in the beginning of 2001 in 20 Minnesota counties. This is a summary of major findings of an independent longitudinal evaluation conducted by the Institute of Applied Research completed in 2004. The evaluation includes an impact and outcome study, a process analysis and a study of cost effectiveness. Tracking of families and costs will continue an additional two years.

The impact study was restricted to 14 counties and involved the random assignment of 5,049 families screened to be appropriate for AR into experimental (AR) and control groups that received traditional investigations (TR). System data was received on all Child Protection Services (CPS) families in the 20 counties throughout the evaluation. Feedback was obtained from 1,184 families through interviews and mail surveys. Interviews and surveys were also conducted of CPS county staffs and community stakeholders. The following is a list of current evaluation findings that were statistically significant.

Practice Shift/Model Fidelity. Feedback from families and workers indicated that CPS practice changed consistent with the model during the demonstration. Compared with control families, AR families were more likely to report:

- That they were treated in a friendly and fair manner.
- That workers met with them when their whole family was present.
- That CPS workers listened to them and tried to understand their situation and needs.
- That all matters important to them were discussed.
- That they were more involved in decision making.
- That workers helped them obtain services as well as providing direct assistance to them.
- That workers connected them to other community resources.

Family Response. AR families were more likely than control families to report:

- Greater satisfaction with the way they were treated by child protection workers.
- Greater satisfaction with the help they received.
- That they had an increase in positive feelings following the initial CPS visit from workers, more often reporting that they were relieved, reassured, hopeful, and optimistic.
- That they had a reduction in negative feelings following the initial CPS visit, less often reporting that they were worried, afraid, angry, confused, or pessimistic.
- That the entire family was better off because of the experience.

Worker Response

- With few exceptions, CPS workers involved in utilizing AR held very positive attitudes towards it. Overall, these attitudes strengthened among workers as they gained experience using it.
- CPS workers were more likely to report that AR families were cooperative and actively involved in case planning and decision making than TR families.

Services

- 54 percent of AR families received some specific services other than case management vs. 36 percent of control families.
- Among families that received services the mean number of services received was higher for AR (1.6) than control (0.9) families.
- AR families who received services compared to control families who received services were more likely to report satisfaction with the way they were treated and that the services they received were the kinds they needed.
- AR families who received services were more likely to be poorer and more likely to receive assistance to meet basic needs such as food, clothing, home repairs, help paying utilities, and help in finding a job.

Child Safety

- Local offices differed in the types of families screened as appropriate for AR. More liberal interpretations of screening criteria resulted in higher proportions of families with child safety problems entering the AR caseload.
- No evidence has been found—in analyses of case data, feedback from families, reports of workers or responses of community stakeholders—that the AR approach placed the safety of children in greater jeopardy than traditional investigations.
- Based on worker reports of changes in child safety, safety did not decline while families were receiving an alternative response, relative to control families that received a traditional investigation. On the contrary, workers in AR cases reported more improvements in child safety problems that had been found at the time of the first home visit.
- Service responses were distributed to a broader array of families under AR—both families with and without child safety problems. Most of the areas of increased services to experimental families were the type that addressed basic family needs related to low income and other financial stresses. Some evidence was found that delivery of such services was related to improvements in the safety status of children in families while being served by AR compared to those in families that received a traditional response.

Risk of Future Child Maltreatment

- Each experimental and control family was assessed using the SDM Family Risk Assessment instrument. Worker ratings of caregivers in experimental AR families indicated that they were substantially more cooperative and motivated than those in control families with traditional investigations. The immediate improvement in such attitudinal and behavioral risk factors is evidence of a reduction in risk apart from differences in the level of services later offered to families.

Recurrence

- Overall, AR families were less likely to have new maltreatment reports than control families. A survival analysis showed that this difference was consistent even though families were tracked for varying lengths of time.
- AR better assisted families not previously active in CPS than the minority of AR-appropriate families had had previous CPS cases.
- AR families were provided with formal service cases over twice as often as control families. Regarding services:
 - The AR approach reduced maltreatment recurrence whether or not services were offered.
 - Yet, AR families who received services were less likely to have new maltreatment reports than control families who received services.
- No relationship was found between the level of worker activity, as measured by the number of logged direct and collateral contacts of workers, and recurrence of child maltreatment reports. This finding may be due to absence of specific information about the nature of worker activities.
- On average, AR workers expended more time on cases overall than traditional workers during the initial activities with families. As families were tracked for longer periods, this difference was reversed because control families returned to the system significantly more often. This finding is reflected in differences in cost, discussed below.
- Among the three largest racial groups, Caucasian, African-American and American Indian families, the rates of recurrence during the follow-up period were lower for experimental families—those that received AR. The effects of AR were evident among families in each of these sub-populations. The positive effects of AR cannot be attributed to differential treatment of racial or ethnic minorities.
- Most families with recurring reports, regardless of their initial screening, were later screened into traditional investigation. Although fewer experimental families had recurring reports, among those that did, about the same proportions were later screened for the AR and traditional tracks as families in the control group.

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- Looking *only* at families with later maltreatment reports, no difference was found in the level of findings of child maltreatment or in the level of formal case openings (case management workgroups). However, the following was also true:
 - Because fewer experimental families had later reports, overall they had fewer later findings of maltreatment (but not statistically significant).
 - Because fewer experimental families had later reports, the proportion of new CM workgroups for all experimental families was lower than for all control families (statistical trend).
 - Examining patterns of presented problems in recurring reports, the following was found:
 - Positive long-term outcomes of AR were not limited to families with particular types of initial presenting problems but were distributed among all types of problems and families in the experimental group. This finding is consistent with the broader approach embodied in AR, in which the focus is the full array of family needs rather than addressing only the immediate child maltreatment threat.
 - Fewer experimental families had children later removed and placed in out-of-home care than control families. This appeared to occur among families in which children were removed for shorter periods of time.

Family Well-Being

- A year after their last contact with CPS, AR families were less likely to report drug abuse and domestic violence problems within their households.
- Two years following their last contact with CPS, AR families were more likely to report that their family and children were better off because of the intervention.
- AR families were less likely to report feelings of stress related to their relationship with other adults in their family and less stress related to their home in general in each of the 3 annual follow-ups
- The mean income of AR families who received services increased during the first through the third year following case closing. This was not the case for AR families who did not receive services nor control families whether or not they received services.
- Control families more often reported serious problems obtaining health care for their children through the third year of the follow-up.

Cost Findings

- Costs related to case management and other services during the time the initial case was open were greater for AR than control cases. Costs for case management and other services following the closing of the initial case through the end of the follow-up period (mean of 452 days) was greater for control cases.

Total costs for case management and other services, both separately and combined, were less for AR cases than control cases.

- Combining impact findings on recurrence (that positive outcomes were achieved more often for AR cases) and cost findings (that the long-term costs of AR were less than were control-group costs) produced a positive cost-effectiveness ratio. The mean cost of achieving the goal of recurrence avoidance with AR was \$398 less than with the traditional approach.

Chapter 1. Introduction

As states seek ways to make child protection systems more effective, a new paradigm has emerged with potential to be a major system reform within child protection. Sometimes referred to as Differential Response, it is based on the idea that since child maltreatment comes in many forms there should be flexibility in responding to it. In Minnesota the model is called Alternative Response, and it provides a more flexible approach for addressing child maltreatment reports that do not meet state statutory requirements for a mandated investigation.³

The Alternative Response (AR) was introduced in Minnesota as a demonstration project in 20 counties during the latter half of 2000. The AR demonstration was built on the work of prior initiatives within the state and in other states that sought to find better ways of applying a family-centered and family-friendly approach for resolving issues that bring families to the attention of the child protection system.

A three-part evaluation of the project began in February 2001 that included an impact and outcome study, a process analysis of the project's implementation and operations, and a study of its cost-effectiveness. Based on interim results of the evaluation and on feedback from families and child protection professionals in participating counties, the Alternative Response Model has been implemented statewide, a process that began in 2003. This document is the final report of the initial phase of the evaluation. Outcomes and costs associated with AR families in the 20 demonstration counties will continue to be tracked for an additional two years.

What is Alternative Response?

A traditional response (TR) to a report of child maltreatment typically involves an investigation that focuses on a specific report of child abuse or neglect and determines whether or not maltreatment occurred and can be substantiated. The Alternative Response, which is only undertaken when a traditional investigation is not statutorily required, does not focus on the reported incident other than by way of explaining to the family what precipitated the interest of the child protection agency and as a guide to establishing the immediate safety of the child. Compared to the relatively narrow focus of a traditional investigation, the alternative response:

³ See Minnesota Statutes, Section 626.5551.

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- 1) Approaches families more broadly from the first encounter, focusing on their situation, problems and needs, and in a manner that is positive and non-confrontational, supportive of family stability, strength-based and safety focused, holistic and, overall, more “family friendly.”
 - 2) Meets with family members, parents and children, as a unit beginning on the first visit if possible.
 - 3) Involves family members in decision making about what to do and, consonant with the safety needs of the children, allows family members to choose whether to continue a relationship with the agency.
 - 4) Provides services and assistance that fit the broader needs and situations of families, linking them to other community resources when possible.

Through this shift in the manner in which child protection intervention is done, the goal of AR is to provide an opportunity to minimize the confrontational experience, enhance cooperation, and strengthen the family’s ability to take care of itself.

The adoption of the AR approach for certain types of reports was not meant as an indictment of the traditional investigative approach which, in Minnesota, attempts to incorporate a family-centered and strength-based approach to CPS interventions. Rather it was an attempt to improve the child protection system by increasing the likelihood that family-centered practice occurred and was effective through social work practice that was overtly friendly, respectful, and supportive and that sought to facilitate the involvement of the family in what happens next.

Screening. The determination of whether a report of child maltreatment is appropriate for a Traditional or Alternative Response is the initial responsibility of a county’s intake unit. This unit receives incoming reports made by mandated reporters, such as police departments and schools, as well as from the general public.

The first step in intake is to determine whether to accept a report of child maltreatment. An accepted maltreatment report is one that is determined to meet the minimal criteria established by the state requiring an official response and assessment.⁴

Once a report is accepted as an indication of possible child maltreatment it is screened for the type of response it will receive, traditional or alternative. The first job of child protection is to safeguard children. Accordingly, if new concerns arise during the initial assessment of a report, or at any later point, the response can be changed from AR to a traditional investigation. Figure 1.1 shows the basic decision points in the system with the two response options.

⁴ Throughout this report, unless otherwise indicated, the term maltreatment report should be taken to mean an accepted report.

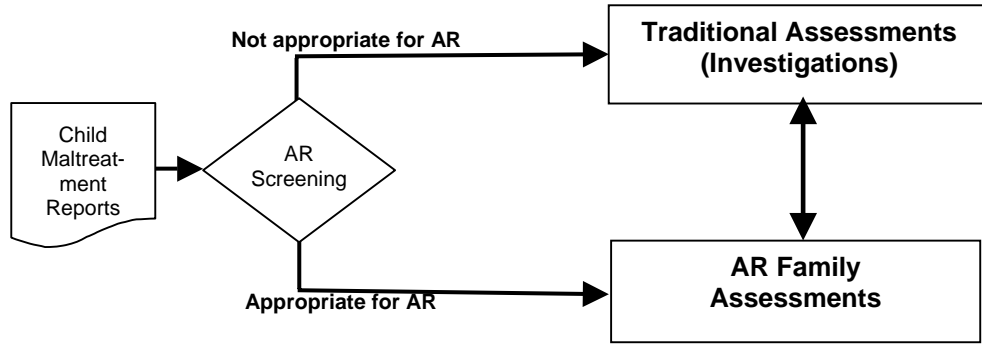


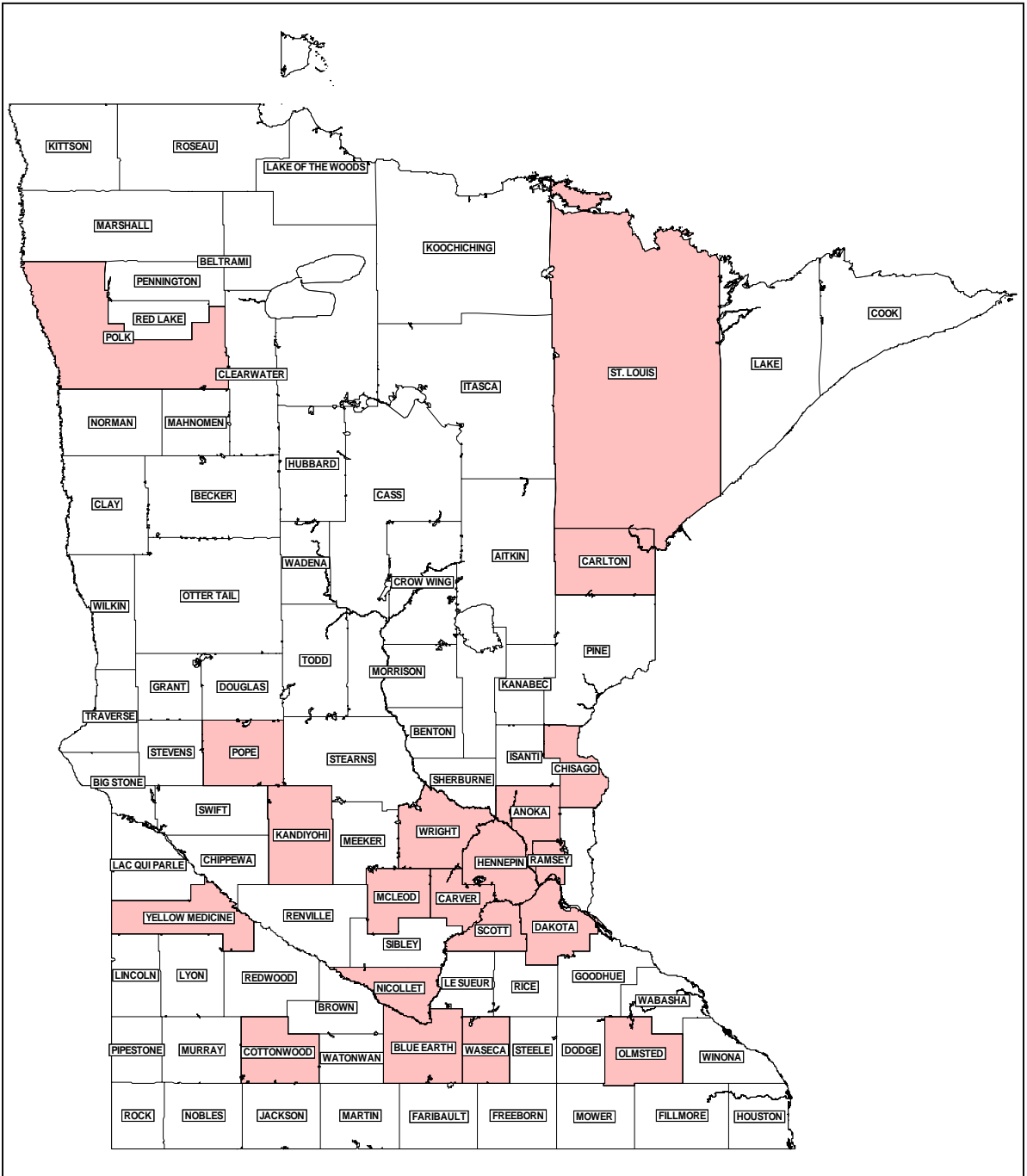
Figure 1.1. Screening Child Maltreatment Reports for Appropriate Response

Participating Counties

The 20 counties participating in Minnesota’s Alternative Response Demonstration can be seen on the map on the following page. The counties are representative of the diversity of the state. Included in the demonstration are the two large metropolitan counties of the Twin Cities, fast growing suburban counties adjacent to the metro area, counties with mid-sized cities that are major economic centers, and more rural counties in different parts of greater Minnesota. The counties represent the cultural and ethnic diversity of the state and include a number of recent immigrant groups from widely different parts of the world along with Native American reservation communities.

Outline of Report

The evaluation had three central parts: a process study, an impact study and a cost analysis. The process study examined how the AR demonstration was implemented and provides feedback on the new approach from families, workers and community stakeholders. The results of the process study are presented in Chapters 3 through 7. The impact study examined whether the project achieved the outcomes that were hoped for when it was originally planned, improvements in the child protective system and in the lives of families and children. The impact study findings are presented in Chapters 8 through 11. The cost analysis in this evaluation was a cost-effectiveness study that examined the financial consequences of investing in the new approach. The results of the cost analysis are presented in Chapter 12. There is a brief overview of the study design and methodology in the next chapter with fuller and more technical discussions provided in the following chapters and in the appendix.



Minnesota Counties Participating in the Alternative Response Demonstration

Chapter 2. Research Design and Methodology

This chapter presents a brief overview of the research design and methodology. It is meant as basic outline of the research activities described in the report. Research methods associated with the impact and cost-effectiveness analyses are presented in greater detail in Chapters 8 and 12. Other survey methods are also described in Chapter 5 through 7. Additional and more technical details of design and sampling are presented in Technical Appendix.

As noted in the previous chapter, the AR evaluation involved several different approaches. First, there was a *process study* of project implementation as manifested in organizational and practice changes. The perspective of practitioners, community stakeholders and families were considered in this analysis. Certain intermediate service outcomes were also considered in the process analysis. Second, an *impact study* was conducted that measured outcomes for families and for the CPS system and determined whether those outcomes could be attributed to the approach to families embodied in AR. Third, the impact study was extended to include a *cost study with a cost-effectiveness analysis* that sought to determine whether AR was in the long term more or less costly than the traditional approach to child protection intervention and whether there were cost savings associated with the outcomes of the demonstration.

Research Design

Process Study. The AR demonstration took place in 20 Minnesota counties. The process study was designed as a longitudinal study of CPS offices and personnel, families in contact with these agencies over the course of the study, and community stakeholders. Surveys were conducted to collect data during the early phases of the demonstration and again near the end of the evaluation period. These were analogous to before-after measures, asking the same questions of administrators, workers and community representatives at these two points in time. Interviews of workers, supervisors and administrators were ongoing throughout the demonstration. Most of the 20 county offices were contacted and visited on a yearly basis. In addition, data from local information systems (collected in the Minnesota Social Services Information System, SSIS) were tracked and analyzed on an ongoing basis. This approach and these data sources provided a basis for analyses of organizational, behavioral and attitude change during the demonstration.

Impact Study. The impact study (IS) was designed as a field experiment and was conducted in 14 of the 20 demonstration counties that agreed to permit a control

group to be selected. Families that were screened as appropriate for an alternative response were randomly assigned either to an experimental or a control condition. Experimental families were provided with the AR approach and services. Control families were treated in the traditional fashion. Random assignment continued from February 2001 through December 2002. This process is discussed in Chapter 3 and described in detail in Chapter 8. Variables centered on outcomes for families and children, such as improvements in child safety, reductions in child abuse and neglect report recurrence, and reductions in out-of-home placement. Data were assembled from the SSIS as experimental and control families were tracked. Many relevant outcomes were measured through this source, but certain detailed information was missing from SSIS. For this reason, other outcomes were measured through more detailed data collection on samples of experimental and control families.

Cost Study. The cost study was both a cost-tracking study and a cost-effectiveness study. The design of the study was also experimental. Samples of families were randomly selected from the experimental and the control groups assembled for the impact study. All direct and indirect costs associated with child protection were assembled for these families from the beginning of their contact with the agency (and assignment to the study) until the end of data collection.

Data Sources and Data Collection

The distinction of process, impact and cost studies is conceptual and is based on different evaluation goals. They are indeed different kinds of studies, each of which could be conducted separately. In a proper evaluation, however, they will be integrated in various ways, including data collection. Many of the data sources and methods described below fed into all three part of the study.

Social Services Information System (SSIS). Throughout the evaluation monthly extracts of SSIS data were provided to IAR to permit tracking of families in the 20 counties participating in the project. Tracking involved longitudinal monitoring of outcomes associated with families who received AR and control families assigned to traditional investigations. SSIS data were used in all three parts of the evaluation.

SSIS data consisted of all relevant data records on all families in each of the study counties. State personnel assembled county files on a monthly basis and extracted data on the 20 files for the evaluators. Tables were merged and a county identifier added to permit county level data to be distinguished. Data were cumulative and included system tables associated with reporting and intake, screening, assessment and case-management, worker time records, personal characteristics of families and family members, child removal and placement, assessments of safety and risk, and other related files. Evaluators received monthly uploads of tables and added them to a research database. From the research database, analysis files were constructed.

The SSIS incorporated the random assignment procedure through which families were assigned to experimental or control group status. This change in SSIS occurred several months after the evaluation began. Before that, an internet-based system of random assignment designed by the evaluators was employed. Thus, families entered the experimental and control groups continuously during the assignment period (2/2001 through 12/2002).

Case-Specific Worker Survey. The case-specific (CS) survey was Internet-based. Workers were contacted via email and then completed the survey through their Internet browser. The purpose was to collect information on families and worker activities that was unavailable through SSIS. Workers were asked in this survey to respond concerning a specific case in which they had been involved. Workers were surveyed after the agency's last contact with the family. In some cases, last contact occurred at the end of the investigation or family assessment. In others, it was after the end of a service case. If more than one worker was involved with the family all were contacted. The CS survey was designed to collect information on child safety, services delivered to families and family needs. The final *case-specific sample of families* consisted of 690 families.

Cost Data Survey. Cost data were not available through SSIS and could only be collected through local bookkeepers and accountants in the 20 offices participating the study. Consequently, a second *cost-effectiveness sample* was selected from among study families. Cost data were used almost exclusively in the cost analysis, although, because of the experimental design, the cost analysis was effectively an extension of the impact analysis. Cost data consisted of all expenditures recorded in the local accounting systems as well as indirect costs calculated on the basis of worker time records. Cost information was obtained in part through an Internet-based survey but primarily from local personnel during visits or through telephone contacts. State sources provided data relevant to indirect costs. The final cost-effectiveness sample consisted of 649 families.

Family Surveys. A third sample of study families was selected. This was the *family-feedback sample*. The sample consisted of experimental and control families as well as family from the NIS counties. Families in this sample were surveyed on a continuing basis throughout the study to obtain their feedback—in some cases, through interviews, and in others, through written questionnaires. Like the CS survey, families were only contacted after their last contact with the agency. Data from families were utilized in both the process study, and because experimental and control families responded, data were also analyzed for the impact study. In the surveys, caregivers were asked to respond concerning a wide variety of issues, such as their reactions to and experiences with the agency, feeling and attitudes about workers who contacted them, services needed and received, evaluation of their own children on a number of dimensions, and various family welfare variables. In the first survey 3,866 families were contacted, of which 1,184 responded with feedback via an interview or written questionnaire; 678 of these responded to a second survey; and, 413 to a third survey.

Early and Late Worker Surveys. Data from these worker surveys were used primarily in the process analysis. They were collected through a series of questions directed at workers and supervisors in the 20 demonstration offices to determine their perceptions, attitudes and appraisals of the AR approach generally and in their particular office, family responses to AR versus traditional CPS, changes that had occurred, and any problems that had developed. The surveys were also Internet-based. The first was conducted mid-2001. Responses were received from 115 of 201 workers contacted. The last survey was conducted in early 2004. Responses were received from 106 of 262 workers contacted.

Early and Late Community Surveys. At about the same time as the general worker surveys just described, surveys of community stakeholders were conducted. These consisted of key-informants from the community, such as school counselors and social workers, law enforcement personnel, community attorneys and court personnel, health and mental health professionals, community agencies that provide services to children and families, groups involved in meeting basic human needs, child advocates, as well as members of minority and immigrant-group organizations. Surveys measured familiarity with and opinions about AR, concerns regarding child safety and community perceptions of local CPS staff. There were 362 respondents to the 2001 survey and 364 to the 2004 survey; 151 individuals responded to both surveys. Data from these surveys were used in the process analysis.

Office Visits and Interviews. Regular site visits were made to CPS offices in counties participating in the AR demonstration. Between 2001 and 2004, 82 separate site visits were made to these offices and on nearly all of these occasions multiple individuals were interviewed, nearly always administrators, supervisors and front line social workers. Often interviews were held in a group setting but one-on-one interviews were also conducted. Through this means a large majority of all CPS social workers involved in the AR Demonstration were interviewed, many on an annual basis. In addition, 8 site visits were made to community agencies in the Twin Cities that provided AR services under contract with Hennepin or Ramsey counties. Two multiple-agency focus groups sessions were also held. Regular meetings were held with DHS administrators charged with managing and monitoring the AR project. And a variety of other meetings were held with SSIS personnel and individuals responsible for other data that was needed for the evaluation.

Chapter 3. AR Implementation

The Alternative Response demonstration project was a joint initiative of the Department of Human Services and participating counties. In this, the project mirrors the way the human services system and, within it, the child protection system are organized and operated in Minnesota. The human services system in the state is highly decentralized, and it is administered and operated by counties. While this leads to less statewide homogenization and cohesion among the same types of programs (such as child protection) than is found in states with more hierarchical administrative structures, at the county level it creates greater opportunities for collaboration and promotes close working relationships among human services programs (such as between child protection and child and family welfare, mental health, MRDD, public health, juvenile probation, etc.). The dissimilarities among county child protection programs are offset by state agency staff that act as facilitators of best practice as well as by a tradition of cross-county connections and communication. The result tends to be networks of county-level agencies that more often operate like social and organizational systems at the community level than is often the case elsewhere. Community Child Protection Teams are an example of this. Many states and counties in other parts of the country have similar inter-agency groups, but rarely do they operate as effectively as work groups and planning units as some of those we have learned about and witnessed in action in this project.

Demographic Context of the AR Project

The 20 counties that participated in the Alternative Response represent the diversity of the state in most demographic categories. The counties vary greatly in population and population density as well as in socio-economic and sub-cultural characteristics. Such characteristics shape the context within which all child protection programs operate and variability in them should be taken into account when program outcomes are evaluated.

Table 3.1 shows the population of the counties that participated in the AR project. The populations of the counties are given in the table in order to provide the reader some perspective on their relative size that may be helpful in interpreting the implications of county-specific data presented in the report. Project counties included the Twin City counties of Hennepin and Ramsey with their large urban populations, a number of suburban metro counties, which also have relatively large populations, and counties in greater Minnesota some of which have medium sized cities, such as Duluth (St. Louis County) and Rochester (Olmsted County), and others which are quite rural with relatively small populations.

Table 3.1. Selected Population and Demographic Data

<i>County</i>	<i>Population</i>	<i>Number of children under 18 years</i>	<i>Percent of households with children under 18</i>	<i>Median household income (dollars)</i>	<i>Percent of households headed by single women</i>	<i>Percent of the population below the poverty level</i>	<i>Percent of children in poverty</i>
Anoka	298,084	73,059	53.5	40,076	9.8	5.3	7.3
Blue Earth	55,941	12,140	48.6	25,366	7.8	18.5	14.8
Carlton	31,671	8,069	46.8	24,900	9.0	12.3	15.2
Carver	70,205	14,359	58.7	39,188	7.3	4.9	4.9
Chisago	41,101	9,275	53.4	31,281	8.0	7.8	9.3
Cottonwood	12,167	3,249	42.1	21,661	6.9	13.7	17.9
Dakota	355,904	81,392	55.8	42,218	9.1	4.3	5.4
Hennepin	1,116,200	233,992	49.1	35,659	9.9	9.2	13.2
Kandiyohi	41,203	10,841	48.1	25,368	7.5	13.7	15.1
McLeod	34,898	9,181	49.8	29,549	7.3	7.5	7.2
Nicollet	29,771	7,248	51.4	30,491	7.9	8.9	8.9
Olmsted	124,277	29,204	52.0	35,789	8.0	6.9	7.3
Polk	31,369	9,019	48.5	22,559	8.5	14.4	16.3
Pope	11,236	2,943	43.7	20,131	5.9	13.8	17.5
Ramsey	511,035	117,853	50.0	32,043	11.9	11.4	17.2
St. Louis	200,528	47,216	44.4	24,093	9.4	14.2	15.7
Scott	89,498	17,751	58.2	40,798	7.4	4.1	4.3
Waseca	19,526	5,150	49.1	26,992	7.4	9.4	11.3
Wright	89,986	22,053	55.3	33,456	7.7	6.8	7.7
Yellow Medicine	11,080	3,125	45.3	21,537	5.7	14.8	15.6
Total	3,175,680	717,119	51.0	34,241	9.6	9.1	11.7

The table also includes other selected demographic data that have often been found to be associated with the relative number of child maltreatment reports. The table includes the number of children under 18 in the population, the percentage of households with children under 18, the median household income, the percentage of households headed by single women, the percentage of the population below the poverty level and the percentage of children living in poverty. These data show some of the variability that is found among the AR counties and are included to suggest caution at the outset about drawing conclusions about program outcomes found in different locations.

Operational Issues

There was a great deal of similarity in the manner in which the 20 counties implemented the Alternative Response project, just as there are many similarities in their general approach to child protection. In both AR and traditional interventions, for example, all counties relied on service vendors to provide a variety of funded services, such as therapeutic interventions. Secondly, all counties sometimes changed the track of a report based on the results of the assessment. This was more often the case with a report screened appropriate for AR that was judged to involve greater risk to the child than originally believed when the screening was done or if new and serious safety concerns emerged. Third, at various points during the process, referrals were sometimes made to other county and community programs, such as child welfare, mental health, MRDD, law enforcement, etc. Such referrals might be made at initial intake, following assessment, or once an ongoing CPS case had been opened.

But beyond these similarities there were also differences in the way counties implemented AR. The three main differences involved: 1) continuity or discontinuity between the assessment and service phases of a case; 2) separate units of AR and TR workers dedicated to one approach or the other versus combined work teams in which workers were involved in both approaches; and 3) case management and service delivery provided by county social workers versus community agencies. The manner in which the AR approach was implemented in specific counties was primarily affected by two factors, the size of the county staff and the pre-existing organizational structure. Overall, counties with small staffs were more constrained in the manner in which they implemented the new program and were less likely to have separate workers dedicated only to the alternative or traditional approach.

The most common approach to AR was one in which there was direct continuity between assessment and any subsequent case management, that is, the social worker who did the initial assessment retained the case if it was opened for case management and/or ongoing services. Some variation in this was found in 16 of the counties. Variation tended to happen in one of two ways. 1) In some of the counties AR social workers were dedicated only to AR, while in others they were sometimes also involved in traditional interventions. 2) In certain counties the original AR workers retained the case if

placement occurred and if the track was changed to a traditional intervention, while in other counties the case would be eventually shifted to another worker in these instances.

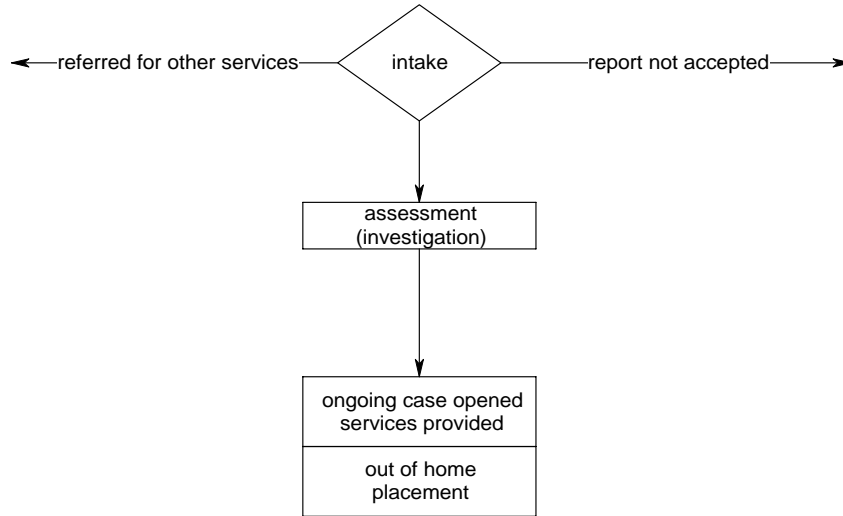
In both Hennepin and Ramsey counties, extensive use was made of community agencies in the provision of services including case management. All counties utilized contracted service vendors in their communities to provide special therapeutic services and other assistance to families with specific needs. However, in most counties, county social workers acted as case managers and helped families in locating and arranging needed services on a case-by-case basis. Hennepin and Ramsey counties involved community agencies at an earlier stage in the planning process and contracted with them to work directly with families without a county social worker as an ongoing intermediary.

Once underway, the most significant operational changes in the manner in which the AR program was operated were made in Ramsey and Hennepin Counties. In Ramsey County, AR experimental reports were initially assigned to a separate AR worker team for assessment. This was changed mid-way through the first project year when all social workers involved in assessment began to do both the Alternative and Traditional Response. However, it was later decided to revert back to the original design that utilized a separate AR unit and this change was undertaken at the beginning of the 2003 calendar year. In terms of the effect on the evaluation, most of the study population in Ramsey County experienced the full staff model and not the special team model.

The exact opposite occurred in Hennepin County. Initially in Hennepin County, a special unit was responsible for meeting with and conducting the assessment of families screened for AR. This was changed in 2003 and AR was dispersed to all assessment workers. As this change happened after 12/31/02 it did not impact the study population who experienced AR through the special unit.

Traditional Child Protection Intervention. Before discussing in more detail how AR was implemented it may be useful to look at the principal organizational features of traditional child protection intervention in the 20 counties. The prevailing approach to child protection in the counties at the start of the demonstration is depicted in the first flow chart. The intake unit would receive a maltreatment report. This unit decided whether the report reached the threshold for child protection (CP). Even if the report was not accepted for child protection, it could be referred to another county service unit—such as mental health, child welfare or developmental disabilities. If the report was accepted for child protection it was referred to the county’s assessment unit where it was assigned to a CP specialist or social worker for a traditional investigation. If, based upon the level of risk to a child, it was determined that an ongoing case should be opened for case management and/or mandated CP services, a referral was made to a different worker who was usually in a different unit. (In very small counties where all CP social workers conducted assessments, the case might simply be switched to a different social worker. This happened, for instance, in Pope County.) If it was necessary to place the child outside the home, the case was retained and managed by the same ongoing CP social worker.

Traditional Child Protection Intervention



This flow chart represents the way traditional child protection intervention was done in 15 of the 20 AR counties (Blue Earth, Carlton, Carver, Chisago, Dakota, Kandiyohi, McLeod, Nicollet, Olmsted, Polk, Pope, Ramsey, St. Louis, Scott and Wright). In a variation on this model, found in Anoka and Hennepin, responsibility for out-of-home placement cases was given to a permanency-planning worker in a separate unit. (And placement might occur immediately during the assessment phase or subsequently after an ongoing case has been opened.) Finally, in three counties (Cottonwood, Waseca, and Yellow Medicine), the worker who conducted the assessment retained the case if opened for ongoing services and/or placement.

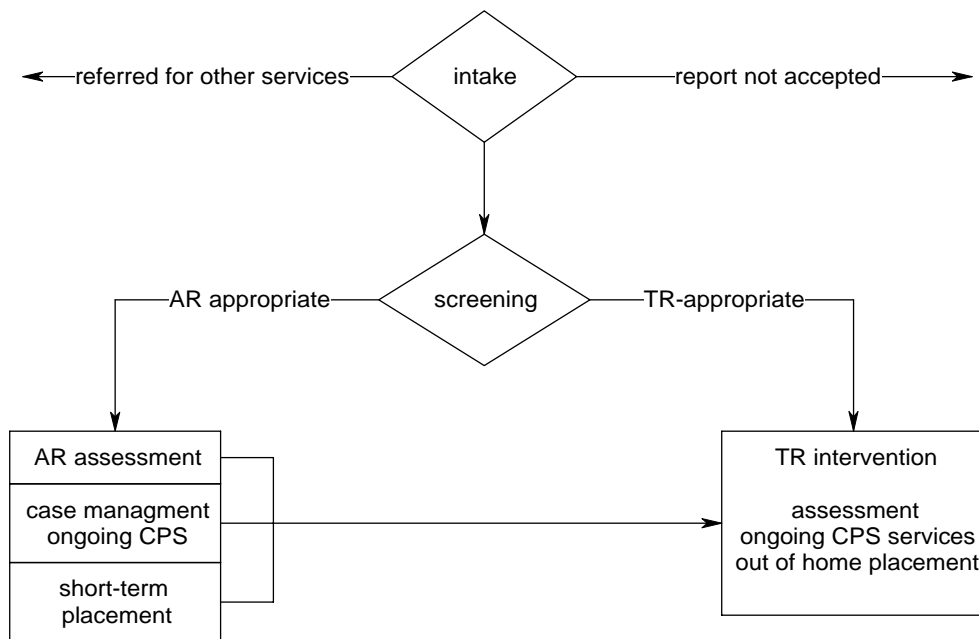
Alternative-Response Models. Each of the approaches described above was employed in the implementation of AR in project counties, but with additional variations. And of course, with the introduction of AR came a second level of screening. Once a maltreatment report was accepted it was passed to one or more screeners (individuals, units or teams) to determine whether it was appropriate for the Traditional Response or the Alternative Response. An AR-appropriate report was assigned to an assessment worker for an AR assessment while a report determined to be appropriate for a traditional intervention was assigned to an assessment worker for that purpose.

The most common approach to AR was one in which there was direct continuity between assessment and any subsequent case management, that is, the social worker who did the initial assessment retained the case if it was opened for case management and/or ongoing services. Some variation of this approach was present in 16 of the counties. Variation tended to happen in one of two ways. 1) In some counties AR social workers were dedicated only to AR, while in others they were also involved in traditional interventions. 2) In some counties the original AR workers kept the case if placement occurred and if the track was changed to traditional intervention, while in other counties the case would eventually be shifted to another worker in these instances.

In the most common AR model (shown below), the dedicated AR worker originally assigned to the case kept it as long as it remained in the AR track and was not switched to a traditional intervention. This meant that even if short-term placement outside the home occurred, particularly if it was voluntary and with no new safety risks to the child, the case typically remained in the AR track with the original worker. At the same time, the case could be switched to the TR tack at any point if warranted by safety risks to the child. This might occur as a result of the assessment process or if new safety issues arose while an ongoing case was open. Long-term placement requiring permanency planning would also involve a track switch.

This AR model (Generic AR Model 1) was found with some variation in 9 counties—Anoka, Carlton, Carver, Chisago, Dakota, Kandiyohi, Olmsted, St. Louis, Scott and Waseca. In one of them, St. Louis County, the case would be transferred if it stayed open beyond 120 days and if ongoing services continued to be needed. In the others, only a change in child safety or the prospect of long-term placement would prompt a track change. (It should be noted that the traditional intervention model varied in these counties.)

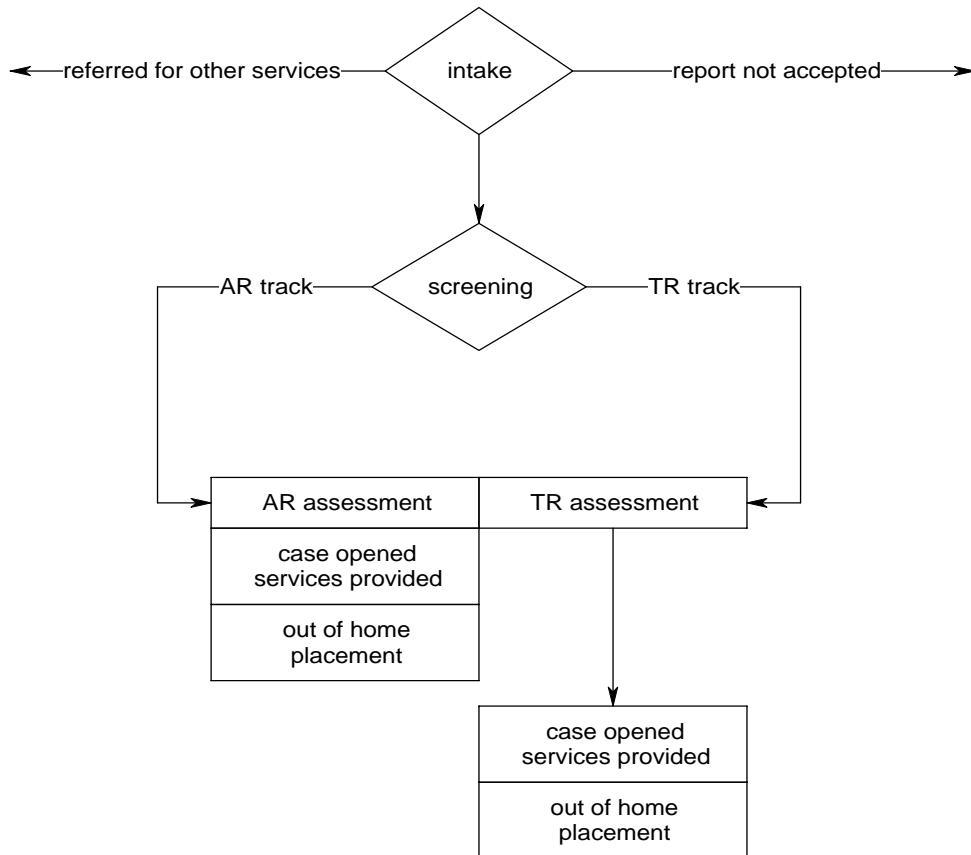
Generic AR Model 1



In seven counties, workers who conducted the AR assessment retained the case if it was opened for ongoing services and/or placement, but they were not dedicated AR workers and were also involved in traditional interventions. In five of these counties (Cottonwood, Nicollet, Polk, Pope, and Yellow Medicine) child protection social workers did both AR and TR assessments. These workers also did traditional CPS case management and permanency planning. The next flow chart (AR Model 2) shows the

version of this AR model found in Pope County where workers did both AR and TR assessments and then retained an AR case if opened for ongoing services and/or placement, but handed off a TR case to an ongoing unit if a case management workgroup were opened.

AR Model 2: example of Pope County

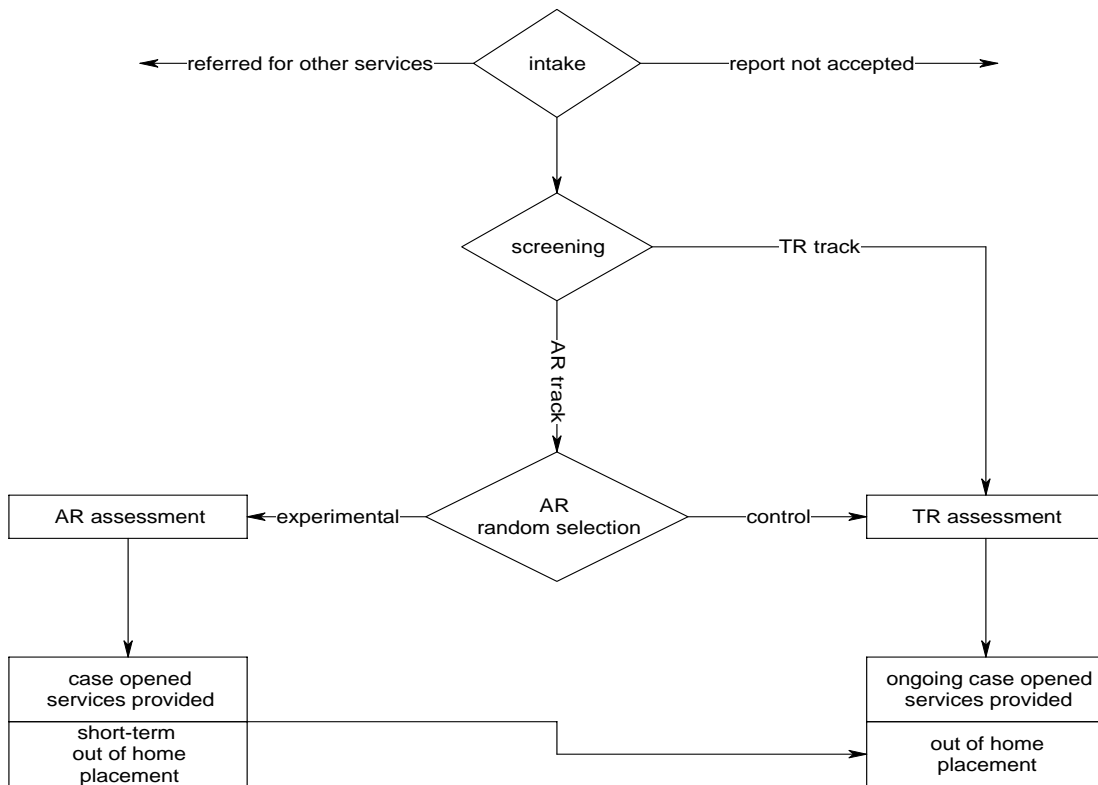


There were other variations of this model. In its simplest form (such as in Yellow Medicine), a single set of workers did everything, and kept the family from beginning to end, from assessment through any case management opening and/or placement through to the closing of the case, whether either AR or TR approach was used. In another variation (found in McLeod and Wright), the original AR assessment worker would retain the case if opened for ongoing services and/or placement. However, in these counties workers who conducted AR assessment also carried traditional ongoing services and placement cases of families who received a traditional investigation conducted by a separate unit.

In three counties (Blue Earth, Hennepin, and Ramsey), there was discontinuity between the assessment and service phases—social workers who conducted AR assessments did not retain the case if it was opened for ongoing services, case management or placement (with some exceptions in Ramsey County). The following flow chart (AR Model 3) shows this model as it was found in Blue Earth. Here, after

screening, AR cases were assigned to AR staff for assessment. Staff who did assessments did not do ongoing case management. If families accepted services and an ongoing case was opened, the AR assessment worker and a case manager did a hand-off visit with the family during which the case plan is finalized. Some AR cases were opened a short time only in order to provide immediate help and pay for services, while some were opened for monitoring only without services being provided. If short-term (less than 90 days) out-of-home placement occurred, the case manager retained the case. If placement was longer term, the case was transferred to the traditional on-going child protection unit.

AR Model 3: example of Blue Earth



In both Hennepin and Ramsey counties extensive use was made of community agencies in the provision of services including case management (in function if not always in name). In Hennepin County, county assessment workers (initially only those in a special unit but later all assessment workers) conducted the assessment and then handed the family over to a community agency for any ongoing services that might be provided. In most instances, an AR specialist from one of the contracted community agencies accompanied the county worker on the first family visit when the assessment was done. At this point the original county assessment worker ceased to have any contact with the family. If the family needed and agreed to services, the community agency (which also carried out the strength and needs portion of the assessment) would provide them during the post-assessment period of up to 90 days from the conclusion of the assessment. At

this point the original county assessment worker ceased to have any contact with the family. If the case remained open longer than 90 days for reasons related to the safety of the child, particularly if a second maltreatment event occurred or if the child was placed outside the home, the case was transferred to the county's ongoing CPS or permanency planning unit.

In Ramsey County, when post-assessment intervention/services occurred county workers had the option of handing off the family to a community agency (selected by the family) for ongoing and case management services or of keeping the ongoing case himself/herself. If a community agency was to be involved the county worker returned to the family with a worker from the vendor agency for a "hand-off" meeting. In this instance, the ongoing case would become the primary responsibility of the vendor agency. If out-of-home placement occurred, the case was transferred to the county's ongoing child protection unit.

AR Families and the Study Population

The study population for the evaluation consisted of families who were screened as appropriate for AR between February 1, 2001 and December 31, 2002. February 1, 2001 marks the beginning of data collection for the evaluation. Some counties had implemented AR programs during the previous year. Notable among these was Olmsted County, which has a reputation in the state as an early implementer of best practices and often influences the practice in other parts of the state. A majority of the counties began their AR programs in January and February 2001. The two largest counties in the state, the metro counties of Hennepin and Ramsey, began the program in March 2001. Some counties that had implemented AR prior to the beginning of the evaluation chose not to participate in the controlled, impact experiment, which involved the random selection of reports screened appropriate for AR into experimental and control groups. They tended to view the selection of certain families for the control group as policy retrenchment and removing services from families who would have received them without the introduction of the evaluation. Fortunately for the evaluation, 14 counties who were newly implementing the AR program at the beginning of 2001 agreed to have a control group, thus permitting a full experimental design in a majority of project counties.

The process of randomly selecting experimental and control cases, which began February 1, 2001, continued until December 31, 2002, a 23-month period. At that point, the 14 counties participating in the experimental impact study were free to provide AR in all situations where they judged it to be appropriate. The study population of experimental and control families from this 23-month period continued to be tracked throughout 2003 and into 2004 through data available from the state Social Services Information System and through interviews and surveys of families and CPS workers. In the 6 counties not participating in the impact study, outcomes associated with families who received the Alternative Response were also monitored in order to more fully understand factors that influenced the effectiveness of the differential approach. This report includes tracking data on AR and control in all project families through March 31,

2004 (and for some data through 6/30/04). As noted earlier, however, outcomes as well as costs associated with these families will continue to be tracked an additional two years.

Accepted Maltreatment Reports. Table 3.2 shows the number of reports accepted by each county and their percent of the total for all demonstration counties combined during the initial study period, February 1, 2001 through December 31, 2002. It also shows the rate of accepted reports per 1000 children (ages 18 and under) in the population. This rate will be higher if one of two things is the case: either there are more reports received per unit of population or the county accepts more of the reports it receives as rising to the threshold of child protection.⁵

Table 3.2. Number of Accepted CA/N Reports by County From February 2001 through December 2002, and the Rate of Accepted Reports per 1000 Children in the Population

<i>County</i>	<i>Number</i>	<i>Percent</i>	<i>Accepted reports per 1,000 children</i>
Anoka	1,770	6.9%	24.2
Blue Earth	467	1.8%	38.5
Carlton	185	0.7%	22.9
Carver	462	1.8%	32.2
Chisago	478	1.9%	51.5
Cottonwood	195	0.8%	60.0
Dakota	2,282	9.0%	28.0
Hennepin	10,532	41.3%	45.0
Kandiyohi	481	1.9%	44.4
McLeod	390	1.5%	42.5
Nicollet	291	1.1%	40.1
Olmsted	1,543	6.1%	52.8
Polk	593	2.3%	65.8
Pope	129	0.5%	43.8
Ramsey	2,861	11.2%	24.3
St. Louis	1,352	5.3%	28.6
Scott	652	2.6%	36.7
Waseca	186	0.7%	36.1
Wright	514	2.0%	23.3
Yellow Medicine	117	0.5%	37.4
Total	25,480	100.0%	35.5

There was a general recognition within the CPS system that counties vary in their acceptance of reports. Some of this variation, of course, is due to the nature of a county's

⁵ It should be kept in mind in reading any of the tables in this report that percentages involving smaller numbers are more sensitive to small changes. This will typically be found in counties with smaller caseloads.

population. For example, counties with a higher incidence of children in poverty, everything else being equal, often experience a higher number of reports. But variation may also be affected by differences in policies and traditions within county child protection offices. Moreover, traditions and demographics may be expected to interact—a population more likely to yield a larger number of reports places increased stress on a system’s ability to respond, and systems and staff adjust formally and informally to such stresses.

Study Population Size and Group Assignment by County. The study population for the evaluation consisted of 7,784 families. This was the number of families with accepted child maltreatment reports during the initial study period in the 20 project counties that were considered appropriate for the Alternative Response. Among these families, 5,733 were in the 14 counties participating in the impact portion of the study. Of these, in turn, 3,177 (55.4 percent) were randomly assigned to the experimental group and received the Alternative Response, and 2,211 (38.6 percent) were assigned to the control group and received the Traditional Response.⁶ In Hennepin and Ramsey counties, a ceiling was placed on the number of cases that could be assigned to the AR group, a precaution taken because the workload implications of the new approach were not fully known. This meant that, by default, a ceiling was placed on assignment to the control group and this left a set of unassigned cases in a residual or “other” group. During the random assignment period, there were 345 (6.0 percent of all families screened for AR) placed in the residual group in the two metro counties. The counties were permitted to approach these families as they chose, and 49 received AR while 296 received a traditional investigation. (See Table 3.3.)

Additional service dollars were provided to counties for AR cases. Counties received specially designated service dollars from the McKnight Foundation (which counties matched with one dollar for every four received) to pay costs associated with services provided to “experimental” families. In the 14 impact study counties these dollars were available for AR cases selected in the experimental study group. In the 6 non-impact study counties funds were available for an equal proportion of families who satisfied AR screening criteria; these families were selected randomly in a process that mirrored the selection of experimental cases in impact counties. The non-impact study counties were expected to use AR on any families selected in this manner, and, in these counties, there were a total of 2,051 families deemed appropriate for AR through the end of December, 2002. Of these, 1,476 were randomly selected to receive additional service funding through DHS (and listed under the “experimental” column in Table 3.2), while 575 families were classified as “other.” Although not required to, non-impact counties used AR when approaching families screened appropriate for AR even when outside funds were not available. Services determined to be needed by these families were provided through regular county funds and no operational differences were ever be found in the treatment of AR families whether selected for McKnight funds or not.

⁶ The proportion of total families assigned to the control group was smaller. This occurred because weights were applied to random selection to permit local offices to maximize McKnight service funds. This process and an analysis of potential distortions of weighting are discussed in Chapter 8.

Table 3.3. Study Population Size and Group Assignment by County

County Name	Families	AR/ Experi- mental	Control	Other AR	Other TR
Anoka	703	533	170	0	0
Blue Earth	122	92	30	0	0
Carver	198	155	43	0	0
Chisago	213	109	104	0	0
Cottonwood	63	44	19	0	0
Hennepin	1914	577	1067	3	267
Kandiyohi	149	128	21	0	0
Nicollet	73	63	10	0	0
Polk	216	140	76	0	0
Ramsey	1066	716	275	46	29
St. Louis	591	365	226	0	0
Scott	301	164	137	0	0
Waseca	75	51	24	0	0
Yellow Medicine	49	40	9	0	0
Total (impact counties)	5733	3177	2211	49	296
Carlton	87	36	0	51	0
Dakota	902	781	0	121	0
McLeod	133	87	0	46	0
Olmsted	654	380	0	274	0
Pope	59	52	0	7	0
Wright	216	140	0	76	0
Total (other counties)	2051	1476	0	575	0
Total	7784	4653	2211	624	296

Screening

Criteria for determining whether an AR or TR response was appropriate in a specific instance were provided to counties by DHS. Actual screening of accepted reports was conducted by county personnel. In most counties, intake personnel screened reports, sometimes with oversight or active involvement of a CPS supervisor or administrator. A few counties used intake teams to finalize the screening decision. The biggest change in the way screening was done was in Hennepin where during the last year of the evaluation it was decided not to finalize the response track until the assessment was completed. This was done partly to facilitate the hand-off of AR cases to community agencies for ongoing case management when families were cooperative and sought assistance in modifying conditions that had led to problems implicated in the maltreatment report or other safety or risk conditions. However, such a decision also affected an underlying feature that distinguishes AR from traditional investigations—that

families are approached differently from the beginning of contact. For the purposes of the impact study this change did not present a problem since it occurred after the initial intervention with the study population had already occurred.

Screening the Study Population. Figure 3.1 shows the percent of maltreatment reports that were screened as appropriate for AR by each county during the initial study period. For the 20 counties as a whole, 36.4 percent of reports were screened for AR, leaving the other 63.6 percent to receive a traditional investigation.

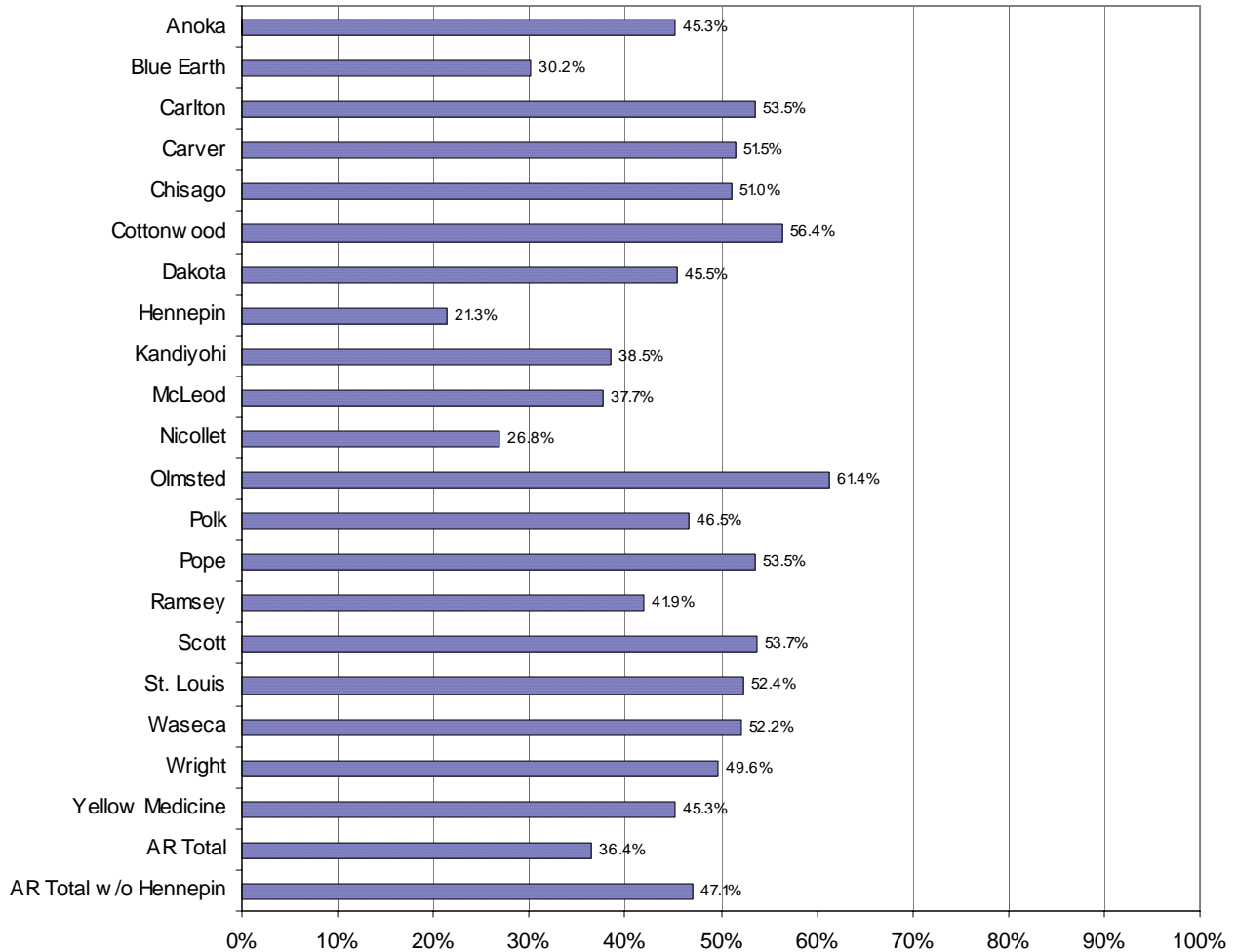


Figure 3.1. Percent of Reports Screened for Alternative Response Between February 1, 2001 and December 31, 2002.

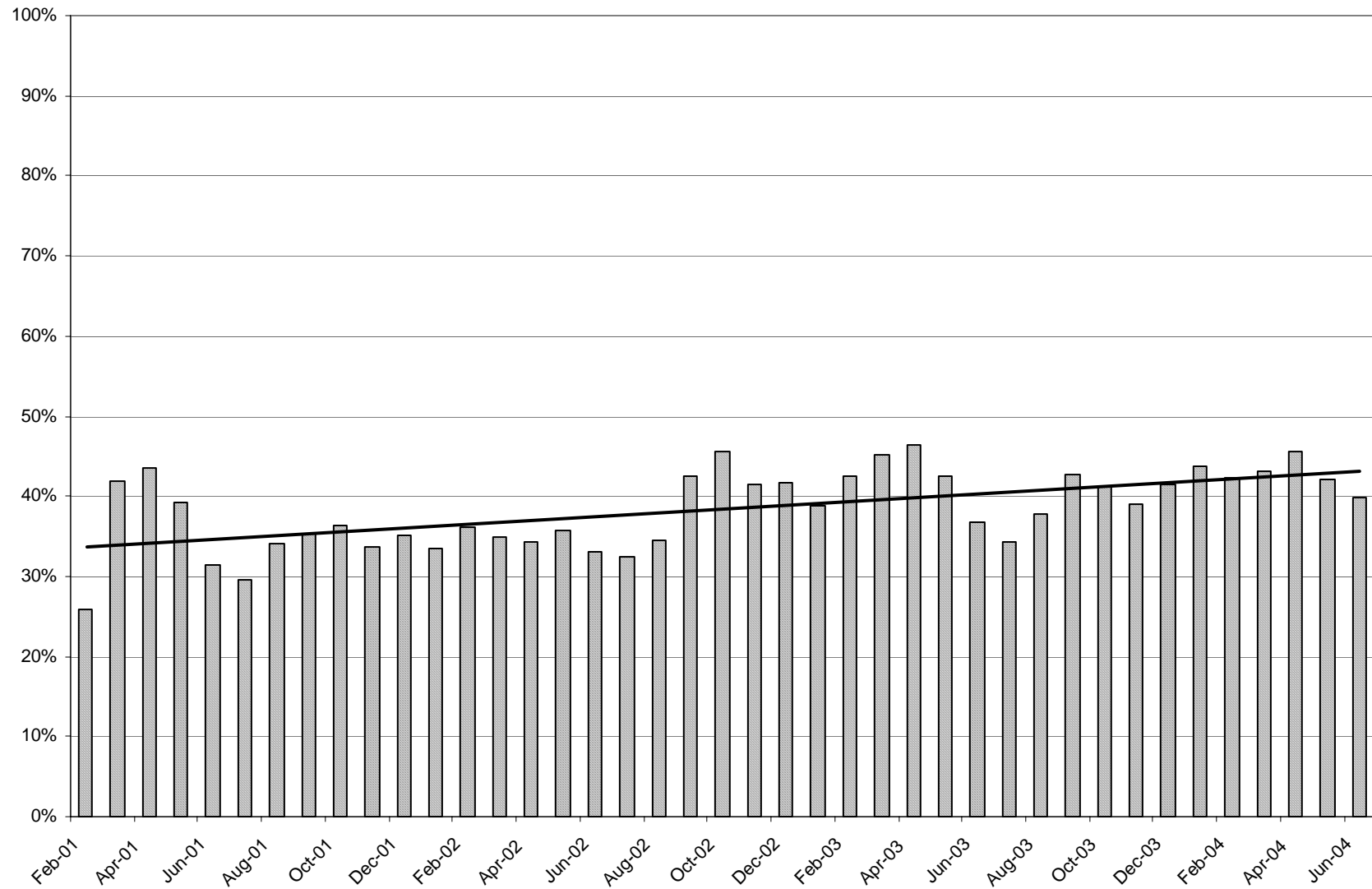
The percentage of reports screened for AR varied considerably from county to county. Hennepin County, the largest in the state, screened the lowest percent, 21.3, and Olmsted County, the county with the most experience with AR, screened the highest, 61.4 percent. If Hennepin County is removed, the percent screened for AR by the other

19 counties combined rises to nearly half of all reports, 47.1 percent. It is unlikely that differences in screening percentage can be attributed solely or even primarily to differences in the nature of reports received. Ramsey County, the other half of the Twin Cities, screened 41.9 percent of accepted reports for AR, nearly twice as many as Hennepin County. Large differences can also be seen among the counties in the southern part of the state where Blue Earth, which screened 30.2 percent for AR, and Nicollet, which screened 26.8 percent, were well below Olmsted's figure. Differences in screening decisions reflect the decentralized, county-based nature of the child protection system in Minnesota, where policies and practices can be advised by DHS but by and large cannot be required.

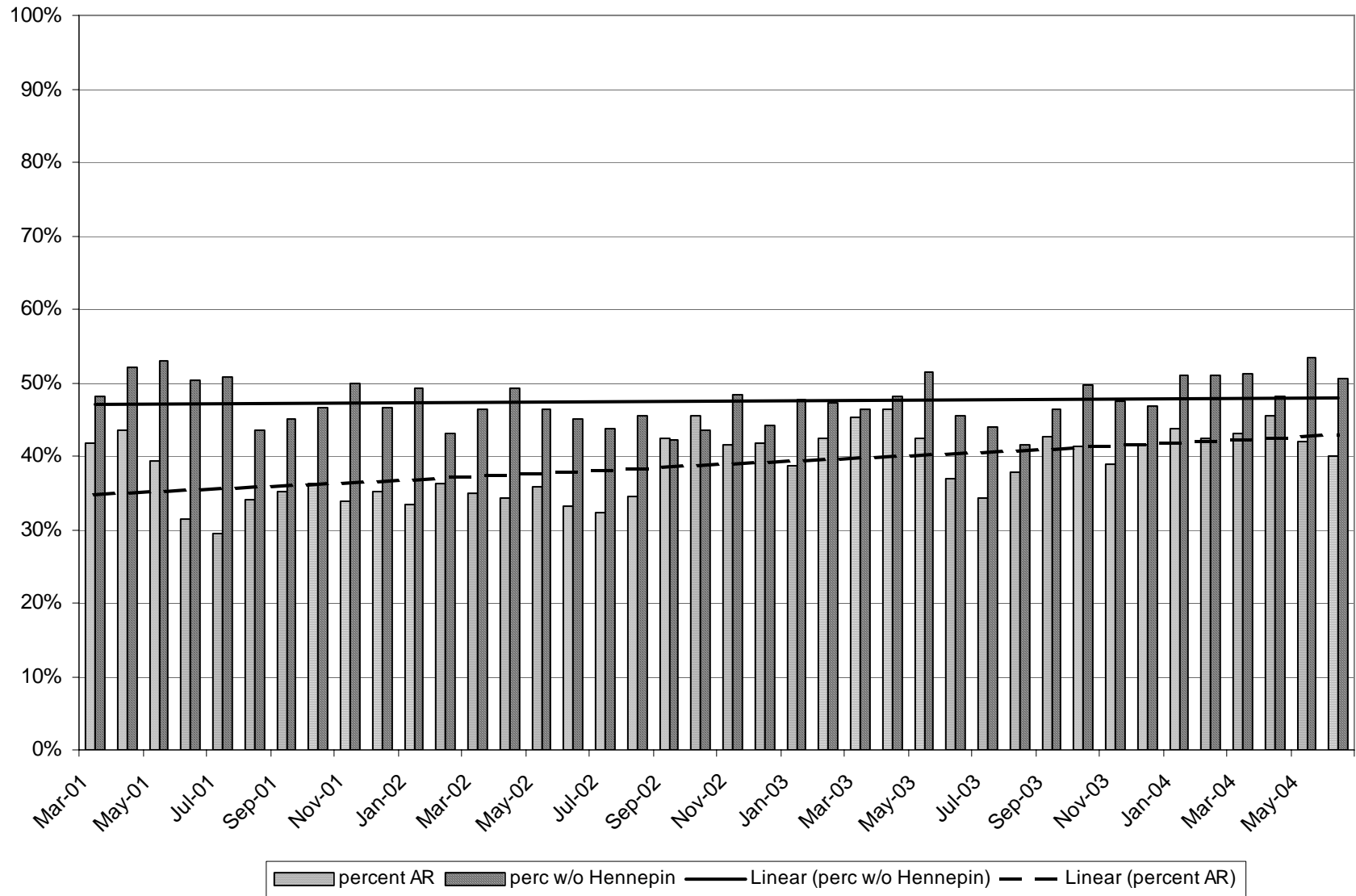
This means that there were real differences in which families received AR. A family screened for AR in Olmsted County may have been screened for TR in Nicollet or Hennepin counties. It was expected early on, therefore, that we would find differences in the risk levels within the study population from county to county. Given Olmsted's relatively high AR screening percentage vis-à-vis Nicollet, for example, we can assume that Olmsted compared to Nicollet was using the AR approach with families with more intense child-safety threats—the main criteria of the screening process. As a consequence, Olmsted also accepted more high-risk and moderate-risk families into AR. This, in turn, can be expected to affect outcomes in at least two ways. If everything else is even, we might expect that 1) among families screened into AR, Nicollet would achieve positive outcomes with greater frequency than Olmsted since Olmsted was using AR with a greater proportion of higher risk cases. On the other hand, to the extent that utilization of AR increases positive outcomes across the full spectrum of cases, we might expect that 2) Olmsted would produce better outcomes than Nicollet when their entire caseloads are considered. The consequences of screening differences are considered in subsequent analyses of outcomes in Chapters 3, 9 and 11.

Ongoing Screening of Reports. The following three figures show how counties screened reports throughout the period covered by the evaluation. Figure 3.2 gives the percent screened for AR for all 20 counties combined for each month from the beginning of the project in February 2001 through June 2004. A trend line has been added to the figure that shows a gradual increase in the proportion of AR screenings over the period of the evaluation.

As it turned out, a large part of the increase in AR screenings was due to an increase in AR screenings in Hennepin County. Figure 3.3 again gives the percent of reports screened for AR for all counties combined, but it also shows the percentage for the other 19 counties combined when Hennepin is excluded. The screening percentage without Hennepin varied from 43 to 53 percent. With trend lines superimposed on these bar graphs we can see that when Hennepin is excluded, the percentage screened for AR did not show a marked increase over time, although there were cyclical variations throughout each year. The total number of reports tended to be lower during the summer months--June, July, August—and higher during the spring—March, April, and May. Paralleling this, the percent of reports that were screened for AR also tended to be lower



**Figure 3.2. Percent of Reports Screened Appropriate for AR by Month (with Trend Line)
All Counties**



**Figure 3.3. Percent of Reports Screened Appropriate for AR by Month (with Trend Line)
All Counties – Including and Excluding Hennepin**

in the summer (averaging 34.3 percent with Hennepin and 44.7 percent without Hennepin) and higher in March and April (averaging 41.8 percent with Hennepin and 50.3 percent without Hennepin).

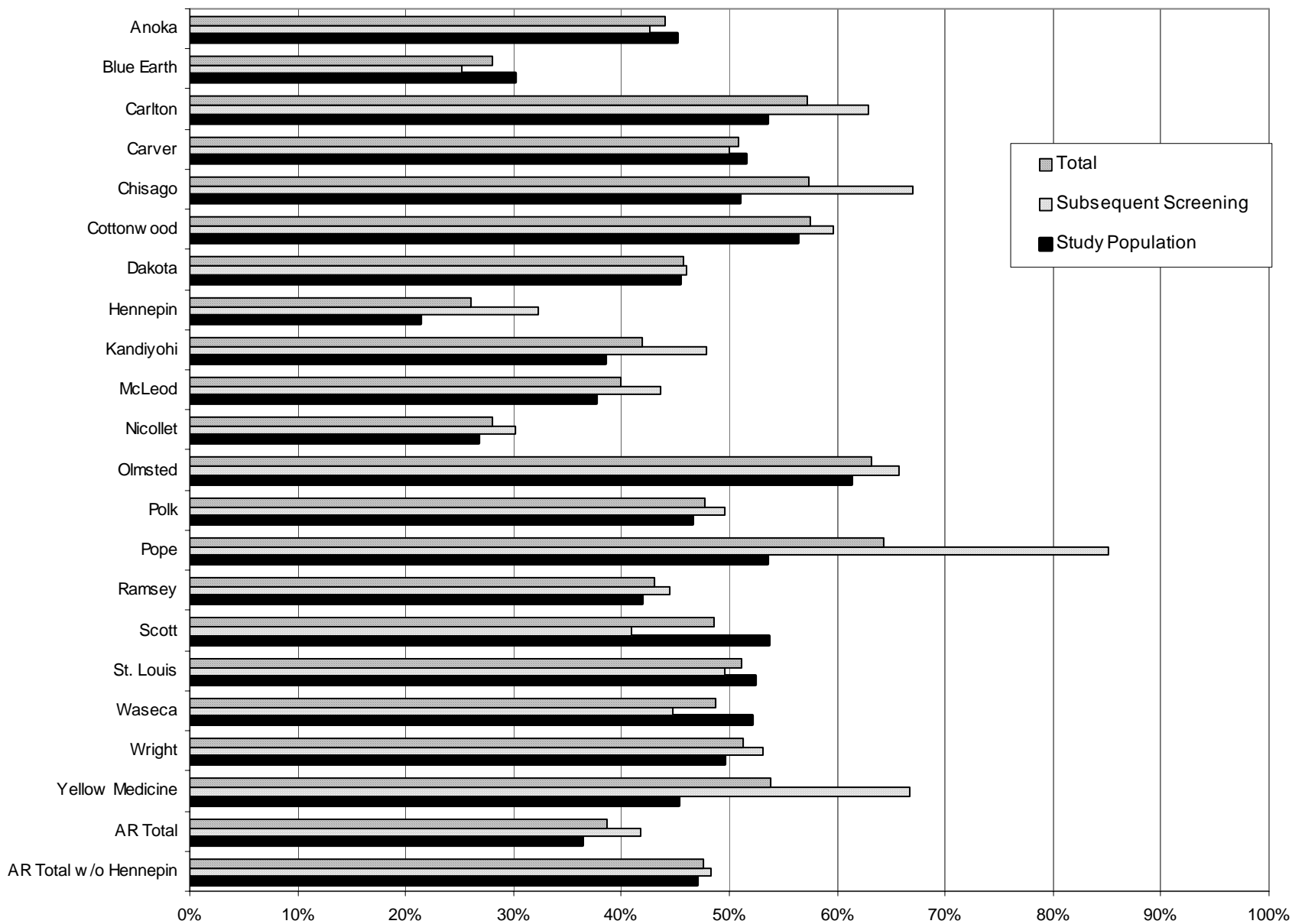
In addition to Hennepin, a number of other counties also increased the percent of reports screened for AR as time went on. This can be seen in Figure 3.4 which shows the percent of AR screened reports for three points in time: during the initial 23 month study period (2/1/01-12/31/02); during the subsequent 18 months (1/1/03-6/30/04), and throughout the entire evaluation period (2/1/01-6/30/04). Fourteen counties had higher AR screening percentages during the subsequent period than during the initial study period. The largest increases were in smaller counties, such as Pope (with a 31.6 percent increase from 53.5 to 85.1 percent), Yellow Medicine (21.4 percent increase to 66.7 percent), and Chisago (15.9 percent increase to 67.0 percent). There were also increases of note in Carlton (9.4 percent increase up to 62.9) and Kandiyohi (9.4 percent increase to 47.8 percent). Among counties with decreases in the percent screened for AR over time, the largest drop was in Scott County (down 12.8 percent to 40.9 percent), followed by Waseca County (down 7.4 percent to 44.7 percent), and Blue Earth County (down 5.0 percent to 25.1 percent; this latter figure was the lowest among project counties).

Track Changes

To ensure the safety of children was not placed in jeopardy by the introduction of AR, counties were able to switch families from the AR approach to the traditional CPS approach at any point. In most instances such track changes were done during the assessment phase when additional information came to light about the family, the reported incident or the situation of children. Over the course of the evaluation, switches from AR to TR were done on about 5 percent of the reports initially screened for AR. At the same time it was possible for counties to switch from TR to AR, but this was not done very often--less than 1 percent of reports initially screened TR were ever switched to AR.

Maltreatment Reports

Before proceeding to the next section, we want to briefly present data on the number of maltreatment reports made in the 20 AR counties and in the state as a whole while the demonstration and the evaluation were underway. The numbers of maltreatment reports in the state are charted by month in Figure 3.5 from the beginning of the demonstration in February 2001 through June 2004. The graph shows the number of reports per month for the state as a whole as well as the number for the 20 counties in the AR project and the other 67 counties in the state. As can be seen in the graph, while the counties in the demonstration represent a minority in the state, they accounted for a majority of the CA/N reports in the state (just as they account for a substantial majority of



**Figure 3.4. Percent of Reports Screened Appropriate for AR by County
For the Study Population (2/1/01-12/31/02), Subsequently (1/1/03-6/30/04), and Total (2/1/01-6/30/04)**

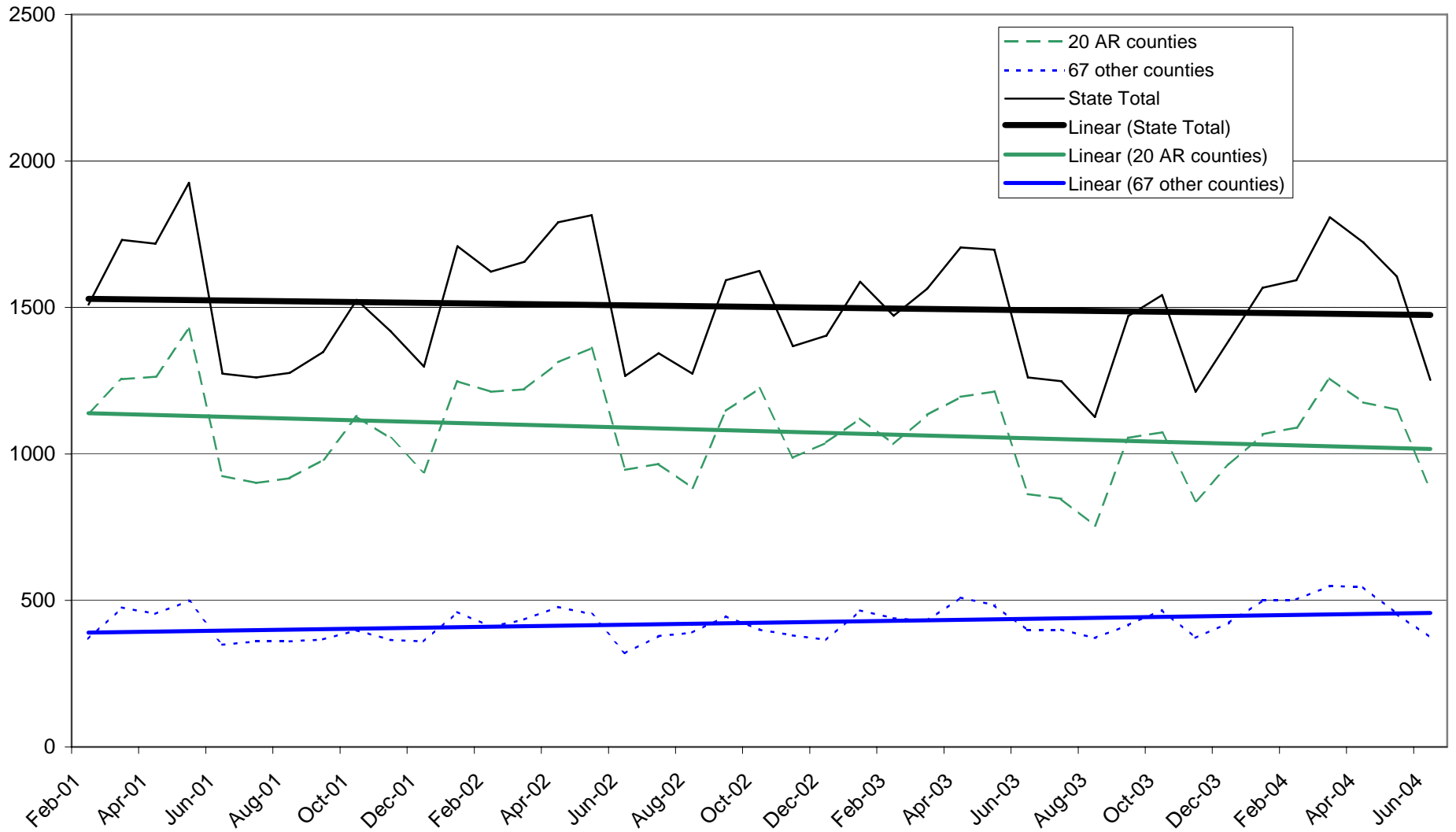


Figure 3. Maltreatment reports by month

the state's population). The graph plots actual numbers of reports and also shows a linear trend line for each group. What is noticeable is that the trend line for the state is on a downward slant. This is also true for the AR county group. But it is not true for the other 67 counties in the state, although the differences in trends are modest.

Figure 3.6 shows similar data in another form. In this graph, maltreatment reports within the two sets of counties are shown as percentages of all state reports and are listed by quarter. The trend lines of the previous figure can be seen here as the proportion of state reports in the 67 counties increases somewhat during this period and the proportion in the 20 AR counties decreases correspondingly.

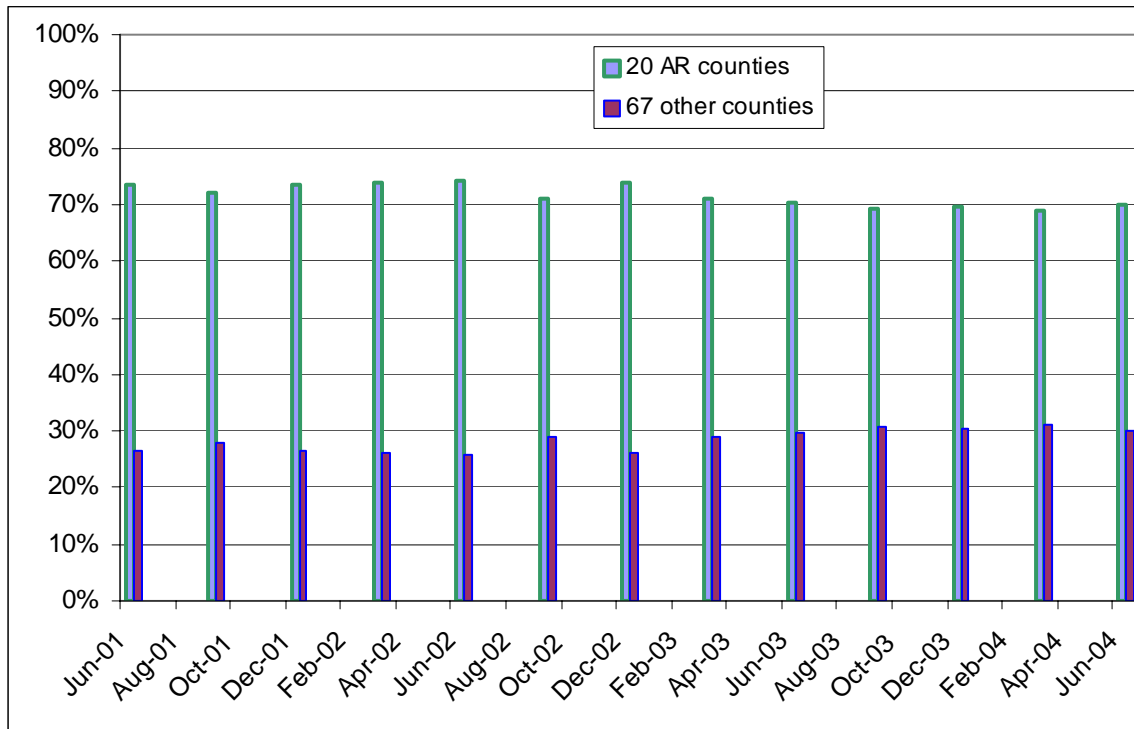


Figure 3.6. Percent of maltreatment reports that are in 20 AR counties and percent in other counties by quarter

The general pattern of slight decline in maltreatment reports was found in many of the AR counties across this approximate 3-year period. In the metro Twin Cities, it appeared in Hennepin County but not in Ramsey. The trend was weakest in suburban counties around the Twin Cities, but could be seen in Anoka and Scott (although in Wright County the trend line rose across this period). The trend was also apparent in Olmsted County. It is in the smaller rural counties as a group where the trend was most interesting since these counties are similar in many ways to the 67 non-AR counties around the state. See Figure 3.7

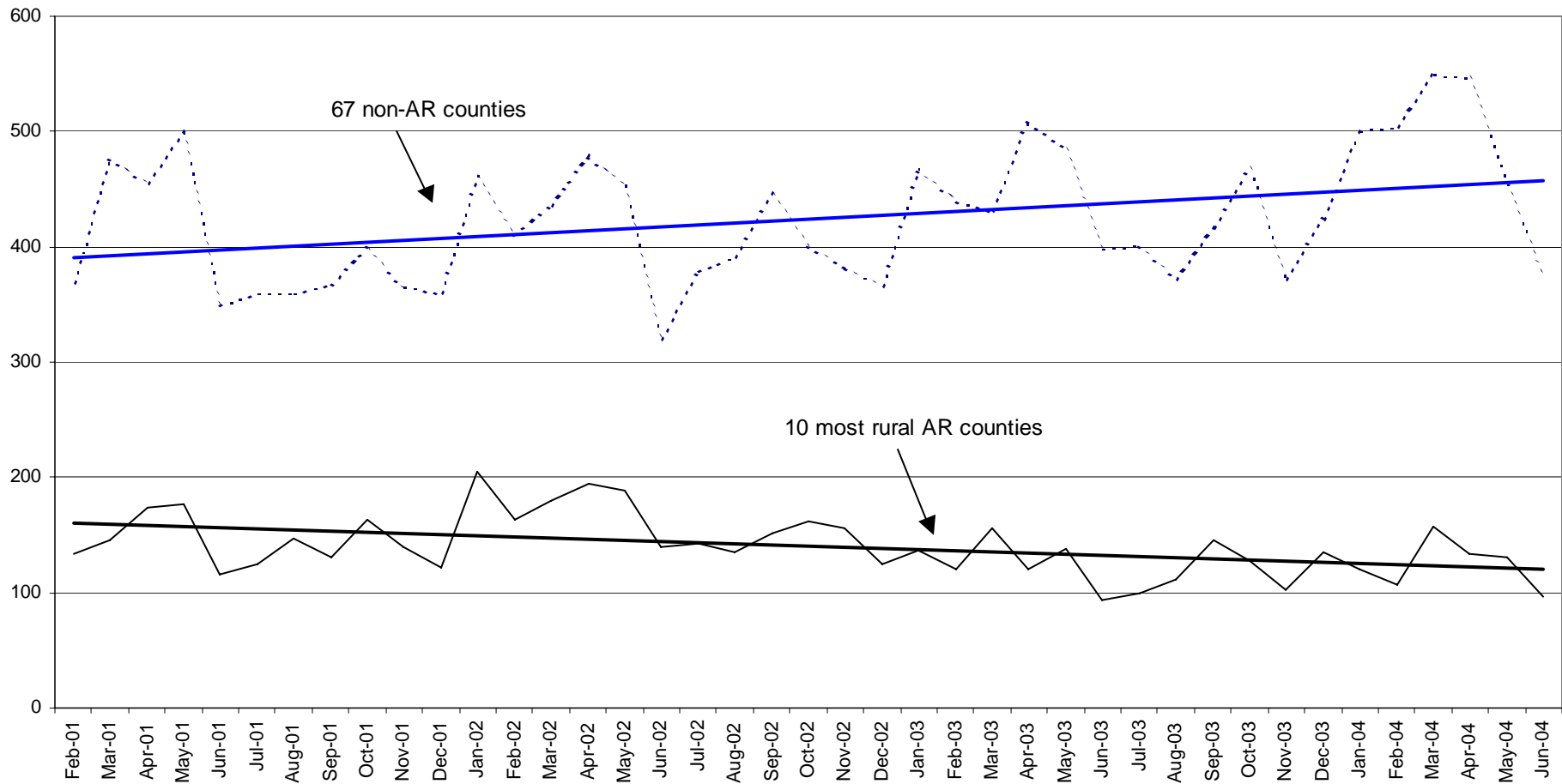


Figure 3.7. Maltreatment reports in the 67 non-AR counties and the 10 most rural AR counties since February 2001

Chapter 4. Practice Shift and Model Fidelity

In human service systems reform, change in outcomes is predicated on change in practice. A change in treatment or the nature of intervention is the precondition for improved outcomes. Therefore, before asking whether a new project has achieved its goals, the question that must be asked and answered is: How is the new practice or the new treatment different from the old? That is, was there a shift in practice and, importantly, was this shift faithful to the new treatment model?

The Alternative Response model of child protection in Minnesota has two major elements that distinguish it from the traditional model:

1) The first element involves the manner in which families are approached following a report of child maltreatment. With AR, families are to be approached (a) as a unit, (b) in a positive manner that is consistent with family-centered practice and focusing on problems and needs that are likely to affect child well-being beyond those implicated in the specific report that was received, and (c) in a manner that involves family members in decision making about what to do.

2) The second element of the model involves providing services and assistance that (a) build on existing strengths within the family, (b) are perceived by family members as most needed for family and child well-being, and (c) may or may not have been provided in a traditional intervention. At the same time, the AR model is designed through child safety assessment and planning to preserve the emphasis on immediate child protection that was central to traditional investigations.

Questions about CPS practice were put to:

- A large sample of families in interviews and surveys of the primary caregiver, including 473 experimental and 376 control families in the 14 counties participating in the impact study and 309 families in the 6 other counties, and
- 105 CPS workers in all projects counties in interviews and surveys.

Family members and workers were asked to explain what occurred during the CPS intervention and to describe their attitudes about it.

Part 1. Practice Shift

Response of Families to AR

Satisfaction. A relatively large percentage of all families contacted reported general satisfaction with the way they were treated by CPS workers who visited their homes. The level of family satisfaction increased with the AR approach, as can be seen in Figure 4.1. The figure contrasts responses of experimental families who received AR with control families who received a traditional investigative assessment.

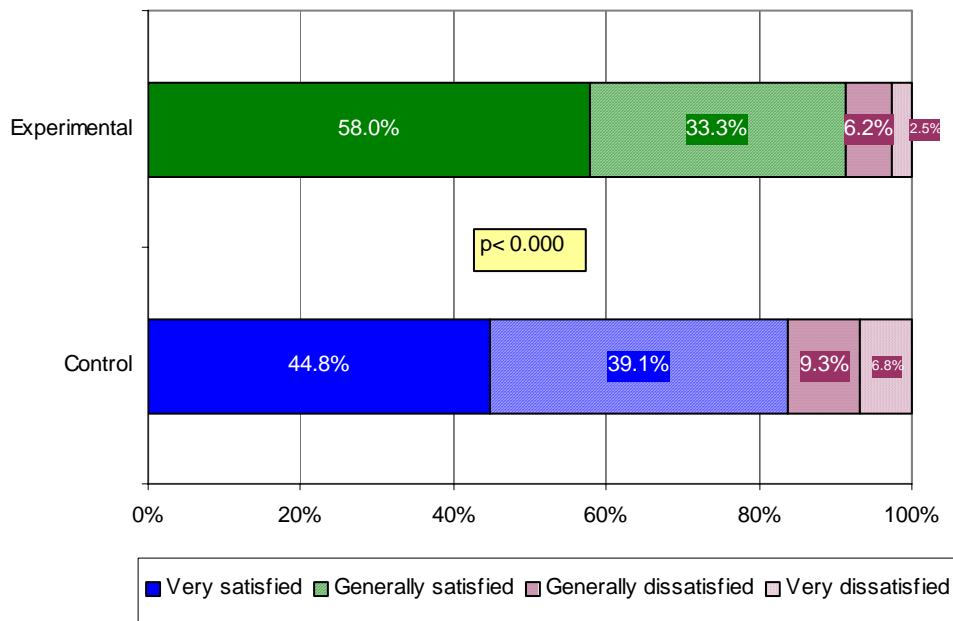


Figure 4.1. Level of satisfaction among families the way they were treated by the worker(s) that visited their home?

The pattern of increased satisfaction among AR families was generally repeated across the counties participating in the project. This can be seen in Figure 4.2 where the level of satisfaction has been simplified into either satisfied (whether “very” or “generally”) or dissatisfied (“very” or “generally”). The top 14 counties in the figure are those that participated in the full experimental design and had control groups. The last 6 counties listed in the figure are those without control groups. Some of the counties are quite small and there were too few responding families in them to yield a valid indication of reaction. This is why Cottonwood and Pope counties are not found in the chart and why there are no control-group figures for Kandiyohi, Waseca and Yellow Medicine. Where experimental and control group figures are available, the response of AR families was more positive in all but one county. And in this county, as in nearly all counties, AR families reported a very high level of satisfaction. Counties with the highest percentage of families reported they were “very satisfied” were Carlton (80 percent), Anoka (70.3

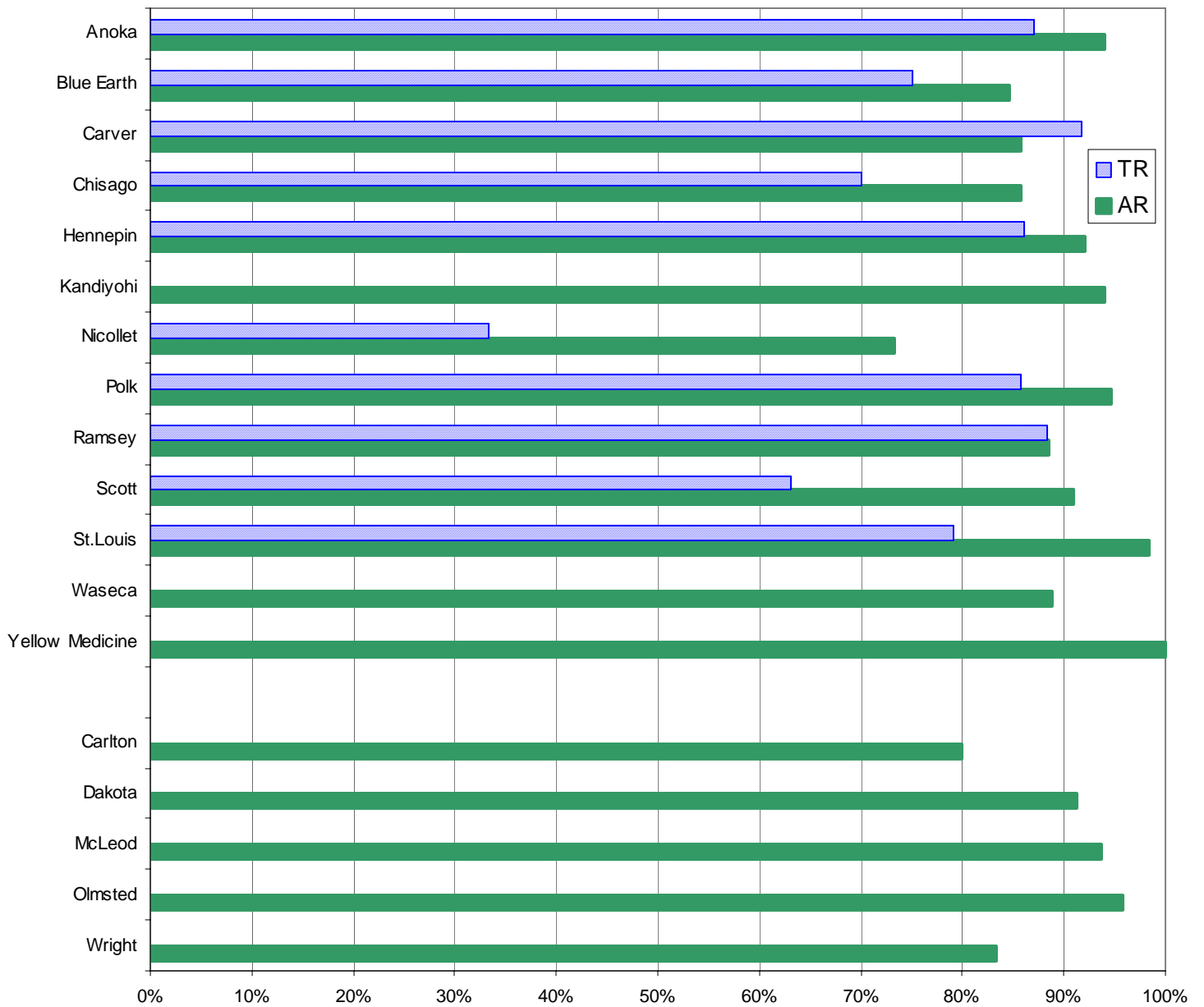


Figure 4.2. Satisfaction reported by families by county

percent), and Kandiyohi (69.7 percent). Carver County had the highest percentage of control families (75.0 percent) reporting they were “very satisfied” with how they were treated by CPS workers.

Across all 14 experimental counties, AR families, compared with control families, were more likely to report that they were satisfied not just with how they were treated but

with the help they received or were offered ($p < .003$). AR experimental families were also more likely to say that their family was better off because of the experience ($p < .01$).

Friendliness. Although families in the traditional group frequently reported that child protection workers treated them in a friendly manner, families receiving the Alternative Response were more likely to do so ($p < .003$). Whereas 41.4 percent of the control/traditional approach families described the manner in which they were treated as “very friendly,” this figure rose to 53.3 percent for experimental/AR families. (See Figure 4.3).

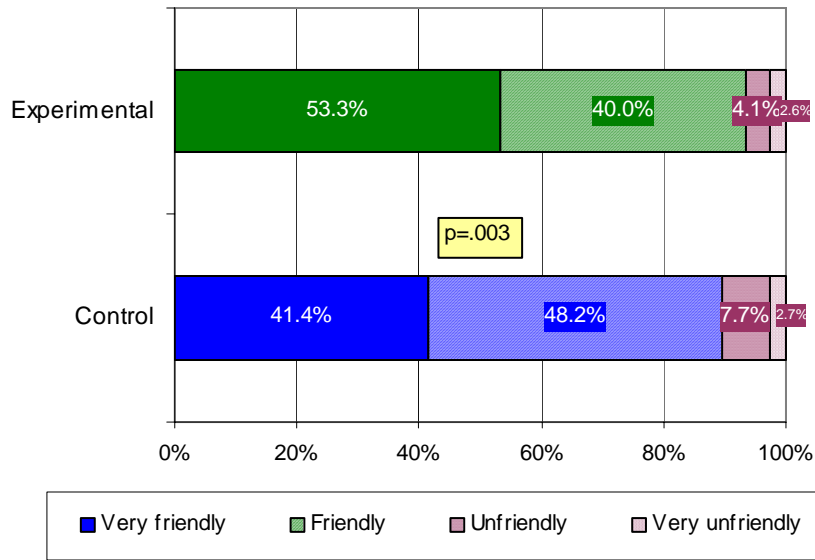


Figure 4.3. Percent of experimental and control families who described the way they were treated as friendly or unfriendly

One factor that can influence the atmosphere of an assessment meeting and affect the reaction of families is the presence of law enforcement personnel. In the types of maltreatment reports that were screened appropriate for AR the frequency of law enforcement involvement in assessments was already quite low in the project counties. Nonetheless, AR lowered the frequency of police presence during assessment from 7.4 percent of the time in traditional assessments to 3.0 percent according to the reports of family respondents.

Listening and Decision Making. AR families were more likely to report that they had been involved in decisions made about what would be done to address the problem areas and family needs discussed with workers ($p < .0001$). While 45.1 percent of the families who received the traditional approach said they had been involved “a great deal” in such decision making, this figure rose to 68.2 percent among AR families. (See Figure 4.4). On the other hand, nearly one in five (19.7 percent) control respondents said they had

no involvement at all in decisions that were made; among AR families this figure was 8.4 percent.

AR families were also more likely to report that CPS workers who met with them listened to what they and their family members had to say ($p < .02$) and tried to understand their family’s situation and needs ($p < .0001$). AR families were also more likely to say that they had been treated fairly by county CPS workers ($p < .0001$) and that all matters important to them were discussed during the assessment interview ($p < .001$).

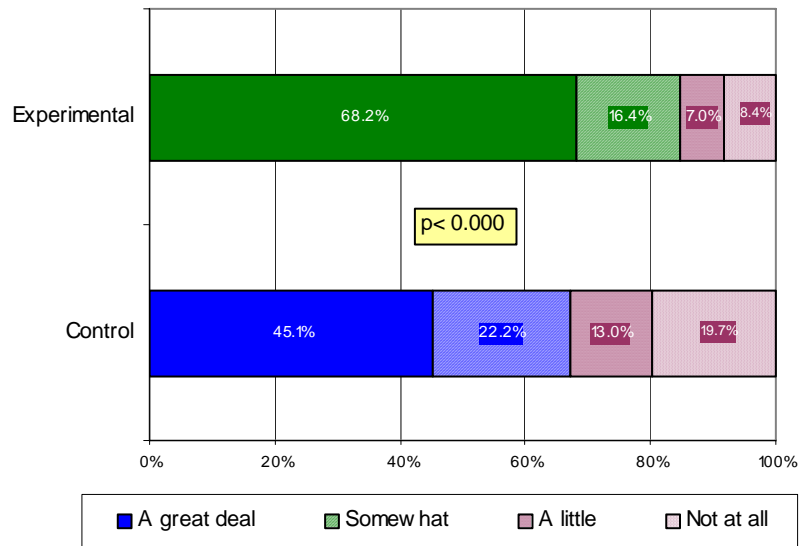


Figure 4.4. Were you involved in the decisions that were made about your family and child (ren)?

Emotional Response. In an attempt to understand better how families responded to the two approaches, caregivers were asked to describe their feelings at the end of the first visit from the county child protection worker to their home. They were specifically asked about a set of 24 emotions, 12 positive and 12 negative.

The AR approach led to a significant reduction in negative feelings generally, as can be seen in Figure 4.5-Part A. AR families were less likely to say they felt angry, afraid, irritated, dissatisfied, worried, negative, pessimistic, or discouraged. At the same time, AR families were more likely to report positive feelings following their first meeting with a child protection worker. They were more likely than control families to say that they felt relieved, hopeful, helped, reassured, and encouraged, as can be seen in Figure 4.5-Part B.

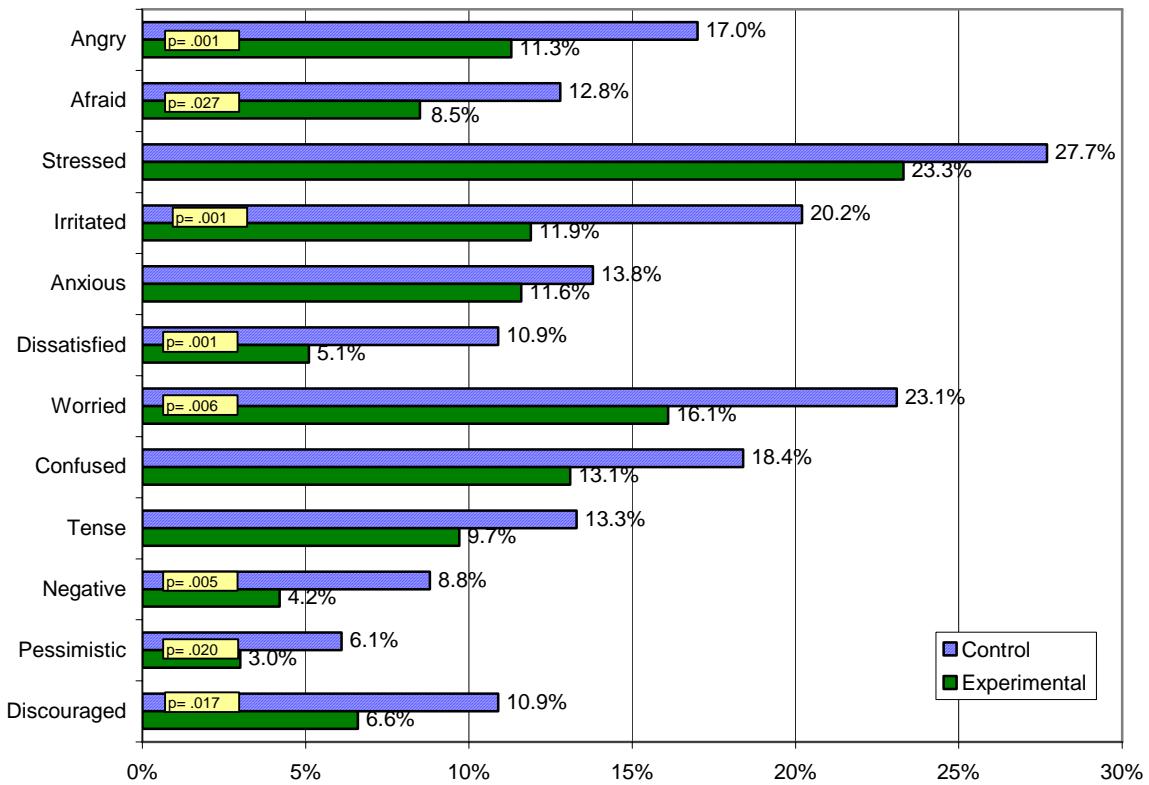


Figure 4.5-Part A. How family respondents described their emotions following the initial visit from workers (chart of negative emotions)

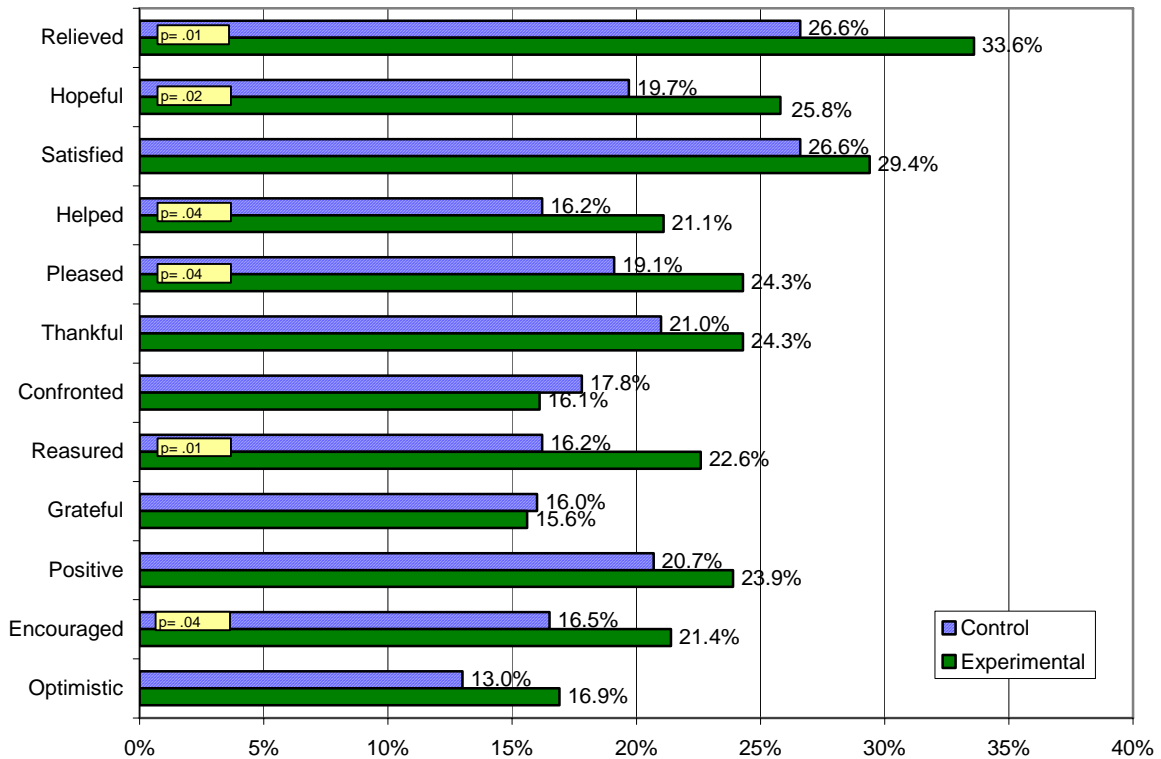


Figure 4.5-Part B. How family respondents described their emotions following the initial visit from workers (chart of positive emotions)

Family Unit. One of the objectives of AR is to meet with the family as a unit whenever possible and whenever the safety of children does not dictate otherwise. Judged in terms of the presence of children and spouses, AR assessments tended to be more inclusive. Respondents who had received AR reported one or more children were present during the initial assessment visit over two-thirds (68.2 percent) of the time compared with a little over half (54.7 percent) of control families who received a traditional investigation. Among those who were married, 82.2 percent of the AR respondents said their spouse had been present during the assessment versus 65.4 percent among the TR control group.

AR Families in Non-Experimental Counties. With respect to each of the issues discussed above, the responses of AR families in the 6 non-experimental counties were similar in all essential ways to experimental families in the other 14 counties. There were no significant differences between the two groups of AR families.

Race and Family Responses. Among AR families from different ethnic or racial groups, no significant differences were found in the application of the protocol based on feedback from families. This included no differences in any of the following:

- Level of satisfaction with the way families were treated by CPS worker.
- Level of satisfaction with help families received.
- Whether families were treated in a friendly manner.
- Whether families perceived they were better or worse off because of their CPS experience.
- Extent to which families were involved in decisions that were made.
- Whether the CPS worker tried to understand the situation and needs of families.
- The extent of positive or negative feelings of family members following CPS home visits.

Comments of Family Members. Throughout our interviews with families we asked them to tell us why they felt the way they did and to give us examples that explained what they said. The following two frames are representative comments from families we interviewed. The first frame contains comments from families who received the alternative response and the second frame contains comments from families who received a traditional assessment.

AR Families

When asked in interviews why they were satisfied or dissatisfied, families that received AR were more likely to say things like:

- “She listened to what my concerns were and was there to help.”
- “She wasn’t quick to judge.”
- “She was nice, non-judgmental. She heard the whole story.”
- “She was a good listener. I was comfortable with her.”
- “She was polite, not rude.”
- “She told me why she was there and tried to help.”
- “He was really nice, really understood. Rather than automatically assuming I’m a bad person.”
- “I was grateful she didn’t think that we were bad people.”
- “She informed me of my options and was respectful.”
- “She made me feel comfortable, answered everything we asked and explained everything.”
- “He worked with us, understood everything that was going on.”
- “She met with us together and took time with each member of the family.”
- “She gave me information that helped.”
- “They wanted to make sure things were OK with (son) and gave me information that helped.”
- “They were helpful and opened doors. Provided other eyes. It was good to see what others see that you don’t.”
- He gave us a lot of ideas and the kids liked him.
- “She taught us parenting techniques. I had trouble with my three year old. I know better now how to discipline her and her behavior has changed.”

Not all families that received AR were satisfied with the way they were treated. Those who were not, tended to report worker behavior that, at face value, was not consistent with the AR intervention model; such as:

- “It was uncomfortable. She didn’t do very much listening. She did most of the talking.”
- “She was hostile and made too many accusations without any basis.”
- “They upset the kids and then just left.”
- “I am still stressed because of the accusations.”
- “I felt like somebody was interrupting my life and I did not have any power.”

TR Families

Many families who received a traditional response reported satisfaction with the way they were treated during the assessment:

- “She was real nice and understanding.”
- “She handled things well. I didn’t feel threatened.”
- “She was nice, pleasant and explained things thoroughly.”
- “I was treated fairly—no racism.”
- “She was a professional. She talked to my daughter and let her know she’s lucky to be in a good family.”
- “I learned a lot about my daughter.”
- “We talked about different disciplinary measures and I took a lot out of what she was saying.”
- “They were very thorough, accurate. I could express myself to them.”

On the other hand, families who received the traditional response were more likely to report negative experiences, such as:

- “He didn’t explain why he came.”
- “She came accusing. I was not given a chance. I was disrespected and labeled and treated like a bad person.”
- “My husband and I were treated very rudely.”
- “They had no business coming to my house and treating me like an animal. They made a tape of the whole thing.”
- “The lady never told us she was coming and was a little threatening.”
- “It caused so much stress in our family.”
- “Things are the same. Still no help with what I need, like child care. No help.”
- “Things were discussed but not followed through on.”
- “The worker acted like he had power over me. I am extremely dissatisfied.”
- “Workers need to assess situations individually.”

Worker’s Perception of Family Cooperation

The effect of the Alternative Response on practice as seen through the eyes of family members is consistent in all substantial aspects with what child protection workers told researchers in interviews during site visits. Moreover, it is consistent with certain data obtained through the case-specific survey in which workers provided detailed information on a random sample of AR and TR cases.

In the case-specific sample, workers were asked to rate the cooperation of the families during their first visit and during their last. Their rating was on a 11-point scale from -5, very uncooperative, to +5, very cooperative. The ratings given AR experimentals for the first visit was 2.5 and for controls, 1.8, a difference that was significant ($p = .02$). The difference was greater on the last visit, rated 2.9 for AR families and 1.6 for TR families. (See Figure 4.6.) Moreover, workers were more likely to report that TR parents were hostile throughout the case (6.3 percent) compared with AR parents (3.3 percent).

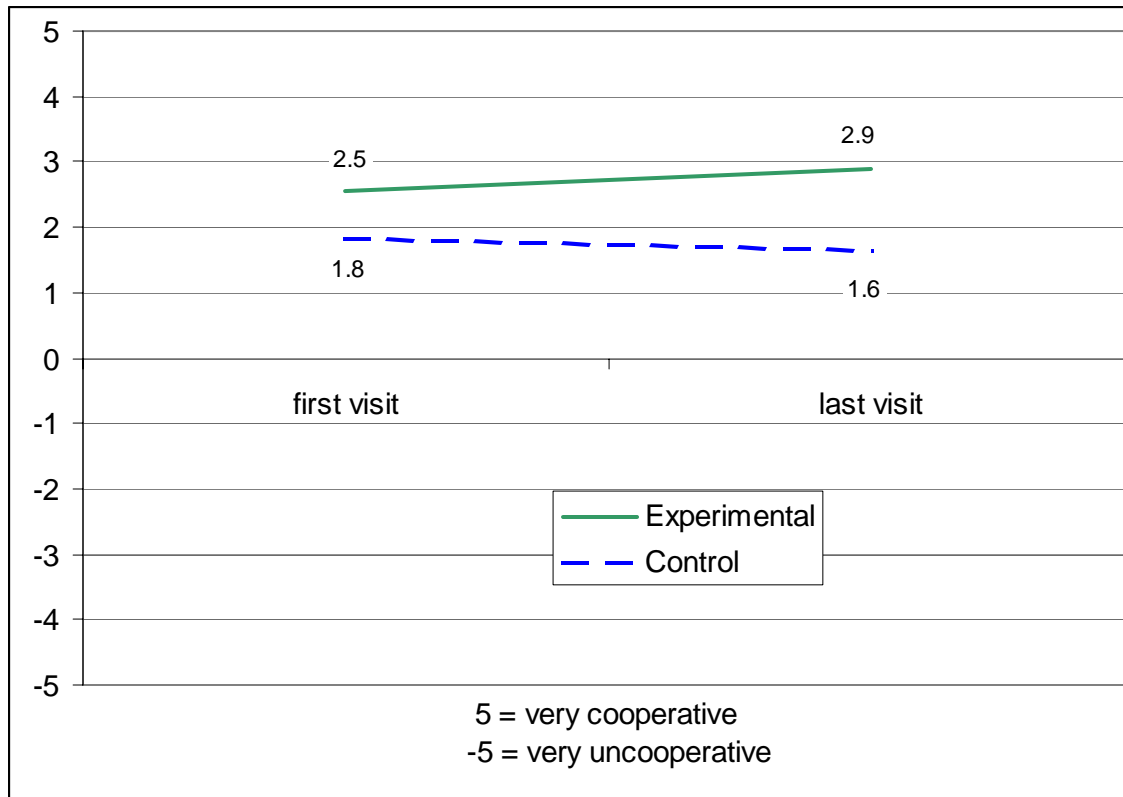


Figure 4.6. Level of cooperation during first and last visit with families, according to workers

During interviews, many county workers spoke of the improved cooperation of families with AR. One said: “Cooperation of families is better with AR because we don’t have to make determinations. Especially with middle class families who want privacy—which is important really to all families.” Another said, “a family’s willingness to change is the key factor in whether a family will change. This is one of the main reasons I prefer AR, because families are more likely to cooperate with you and be willing to do what they need to do.”

Worker-Family Contact

With AR the pattern of contact between workers and family changed. AR workers had a single face-to-face meeting with a smaller percentage of families than did TR workers (26.5 percent vs. 41.2 percent). For those visited more than one time, the average number of total meetings was higher for AR (5.4) than TR (2.9) families. This difference, in part, would seem to reflect the relative roles played by families and workers in these encounters. With TR, the worker has the primary responsibility to make a determination about the maltreatment report, can it be substantiated or not. This may take more than one visit to establish whether or not the family agrees to the visit. With AR, families have much more control over the process. They may accept assistance that has been offered or not and, if they do it is likely that subsequent meetings will occur. In addition, workers may have concerns about the safety of children. Under AR it is easier for the worker to remain in contact since continued intervention does not hinge on whether or not a finding could be established. The result, in any event, is increased contact in a more targeted set of cases. This suggests a kind of second level screening in which intervention is dictated by family need and child safety directly and does not depend on whether a report can be substantiated.

In terms of overall workload, workers had a greater mean number of contacts with AR families than they did with TR families. This included more face-to-face meetings (3.6 on average compared to 2.4), more telephone contacts between the worker and the family (6.1 vs. 3.4), more contacts involving people other than the primary social worker such as community service providers (2.4 vs. .8), and more contacts of all types overall (12.5 vs. 7.0; $p < .0001$). AR workers were also more likely to conduct interim or follow-up assessments while the case was open (27.7 percent vs. 15.0 percent) as well as final assessments at case closure (46.2 percent vs. 21.3 percent; $p < .0001$).

Risk Assessment and AR

When conducting risk assessments in response to reports of child maltreatment, CPS workers utilized the Structured Decision Making (SDM) Family Risk Assessment instrument. There is a discussion of the effects of AR on scores produced by this tool in Chapter 6. But one point should be made here. While the SDM tool is meant to produce an objective indicator of future recurrence, certain items on the instrument reflect the dynamic environment in which information on families is gathered. Primarily, these are items that call for workers to make judgments about families. When item scores of experimental and control families were compared, the scores of AR families were more likely to reflect that families were more cooperative, motivated, and realistic and have higher self-esteem. There were statistically significant differences between the scores of experimental and control families on these items, while the two groups were nearly identical on such objective factors as number of children in the family and the age of caregivers. This is strong evidence that the interpersonal dynamics between workers and families in AR assessments is not only different from that in traditional investigations,

but that the difference in practice reflects the kind of change that was the goal of the underlying policy.

This may be the place to note another item on the assessment tool on which a difference was found between AR and TR families. This has to do with identifying families in which a caregiver has a history of domestic violence. This was more likely to be found in TR families, and it suggests that meeting with the family as a unit (another practice objective of AR) may inhibit some victims of spouse abuse from revealing this fact to the worker. To the extent such information is considered important or potentially important information that will be factored into worker judgments and decisions about the case, AR workers may need to consider ways to ensure they find out about the possible presence of domestic violence in the family.

Part 2. Services

There were three sources of information about services provided to families. Data was available on all families in the study population in the state data system, SSIS. We also had the reports of families who participated in the study and provided feedback. And, there was information from workers on assistance offered and provided to families selected in the case-specific sample. We shall look at these one at a time.

SSIS

The usefulness of SSIS data is that it was available on every family in the study population. However, because the database was designed for administrative and programmatic purposes, and not with evaluation in mind, its utility was somewhat limited. Nevertheless, it was possible to see whenever a worker determined there was a need to provide case management or other ongoing services following completion of the initial assessment. In such instances, workers would open a “case management workgroup.” It is called a workgroup because it identifies all the individuals involved in the case, including family members and CPS professionals. The composition of the workgroup may change and evolve over time if there are changes within the family or if new workers become involved for new activities, such as adoption.

When a case management workgroup is opened, it is an indication that some post-assessment services or assistance are to be provided to the family. In a few cases, the services may not extend beyond case management and, possibly, referral to community resources. In a large majority of cases, however, the new workgroup is an indication that funded services are to be provided through a vendor agency. Opening the workgroup, besides identifying group membership, is a practical device for linking the service decision to the county’s fiscal payment system. Opening a case management workgroup is a major decision, and it sometimes involved shifting the family to the caseload of other workers in an ongoing CPS services unit and frequently signals the need to expend service dollars to ensure the well being of a child. At the same time, it is possible for workers to refer families to community resources during the assessment without opening

the new CM workgroup. In some counties it is also possible to draw on some funding sources to pay the costs of certain safety-related items needed by the family without opening a CM workgroup. With all of this in mind by way of qualification, the presence of a case management (CM) workgroup in a family’s record can be taken as a rough proxy for service delivery beyond the initial assessment.

We examined the presence of CM workgroups in the study population. Table 4.1 shows the percent of families in each county with CM workgroups. Looking first at families in the 14 impact study counties we see that families in the experimental (AR) group were more likely than control (TR) families to have a CM workgroup open. The difference was not small. Experimental families had CM workgroups opened 31.1 percent of the time following assessment compared with 13.8 percent of control families. In the 6 non-impact study counties, the percent of AR families with an opened CM workgroup was 36.7 percent. This is a strong indication that services were more likely to be provided in AR situations than in traditional investigations, a practice feature consistent with the model.

Table 4.1. Percent of Families an opened Case Management Workgroup By County and Study Population Group

County Name	Experi- mental AR	Control TR	Other AR	Other TR
Anoka	34.5%	18.8%		
Blue Earth	25.0%	10.0%		
Carver	22.6%	4.7%		
Chisago	45.9%	20.2%		
Cottonwood	22.7%	47.4%		
Hennepin	46.3%	9.7%	33.3%	6.4%
Kandiyohi	40.6%	14.3%		
Nicollet	30.2%	20.0%		
Polk	20.7%	14.5%		
Ramsey	20.4%	26.2%	19.6%	41.4%
St. Louis	23.8%	11.5%		
Scott	26.8%	11.7%		
Waseca	52.9%	16.7%		
Yellow Medicine	40.0%	0.0%		
Total (impact counties)	31.1%	13.8%	20.4%	9.8%
Carlton			78.2%	
Dakota			35.1%	
McLeod			45.9%	
Olmsted			32.3%	
Pope			28.8%	
Wright			37.5%	
Total (other counties)			36.8%	

Looking at individual counties, we can see that this pattern was found in 12 of the 14 counties. One of the exceptions was Cottonwood, a very small county where percentages can vary considerably with a change in a few cases. Ramsey County, the second largest county in the study, was the other exception. In Ramsey County, 26.2 percent of control families in the study population had case management workgroups opened versus 20.4 percent of experimental families. This pattern was also found among families in Ramsey that fell outside the experimental study. As we can see, other AR families were less likely than other TR families to have CM workgroups. Compared with other counties, generally, Ramsey was somewhat more likely to open a CM workgroup in traditional investigations and somewhat less likely to open a CM workgroup in the Alternative Response. If we remove Ramsey County from the analysis, the difference between experimental and control group increases. Among the 13 other counties the percent of experimental AR families with a CM workgroup was 34.3 and among control TR families it was 12.0 percent.

As discussed in the previous section, Ramsey County changed the way it operationalized the AR model during the first year of the project. This resulted, in part, from a lack of full acceptance of the project by some workers. It may be that worker reaction was partly responsible for the relatively low use of CM workgroups in Ramsey County among AR families. Some workers, in fact, referred to AR as “TR-light.” This may have led to a less than full implementation of the model affecting, among other things, the manner in which it was presented to families. If this accounts for the relatively low number of case openings among AR families, what accounts for the relatively high number among TR families? As it turns out, for whatever reasons, Ramsey County had the highest substantiation rate among families in the control group among the 20 project counties, 55 percent. Among TR families, those with substantiated reports are the pool from which case openings come. The higher the proportion of substantiations the higher the proportion of case openings can be expected to be, all else being equal. Hennepin County had the next highest substantiation rate among control families (43 percent), followed by Anoka (42 percent) and Carver (37 percent) counties.

Although the percentage of AR families with case openings was significantly higher across all impact counties than was the percentage of TR families, the percentages shown in the table are under-representations of the number of families who received services. This is partly to do with what was mentioned above, that families sometimes received services without a case being opened. But it is also the result of how we were able to extract data from the SSIS system. It is sometimes difficult to distinguish the beginning and ending of cases and to separate out cases that overlap. And there are some inconsistencies among counties in how they handle new reports on a family with an already open and active case. The data in the table above are figures based only on the report that brought the family into our study population and any case opening that resulted from the initial assessment that was done. If there was an ongoing CM workgroup open in such a case and a new one was not indicated, it is not represented in the figures in the table. The objective of using CM workgroups as a proxy for services was not to determine precisely how many families received services, but to use this source of data as an indicator of possible differences between experimental and control

families. Two better sources of data exist for determining how many families received services, the families who received them and the workers who provided them. We will turn to these two sources now.

Family Response

In surveys and interviews, families members were asked whether the CPS worker(s) they met with helped them obtain any services. Over half (54.3 percent) of the AR experimental respondents answered “yes” compared with 35.6 percent of TR control families. (See Figure 4.7.) Among AR families in the other 6 counties, 48.5 percent reported they had received services by or through a CPS worker.

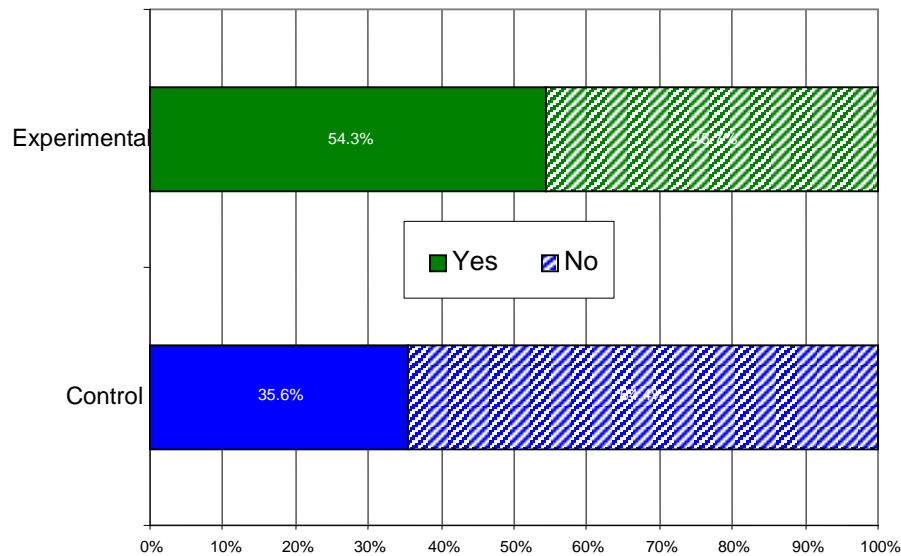


Figure 4.7. Percent of experimental (AR) and control (TR) families that reported receiving services.

Among families who reported receiving services, experimental families were significantly more likely to say that the services were the kind they needed ($p < .0001$) and to say that the services were enough to really help them ($p < .0001$).

There were other significant differences in what experimental and control families said about services. Experimental families, for instance, were more likely to report that the CPS worker provided direct assistance to the family and more often put them in touch with a community agency or initiated contact with a community service resource on their behalf. Experimental families were also more likely to report that they were offered services that they turned down. Control families, on the other hand, more often said there was help they needed and wanted but did not get. (See Figure 4.8.)

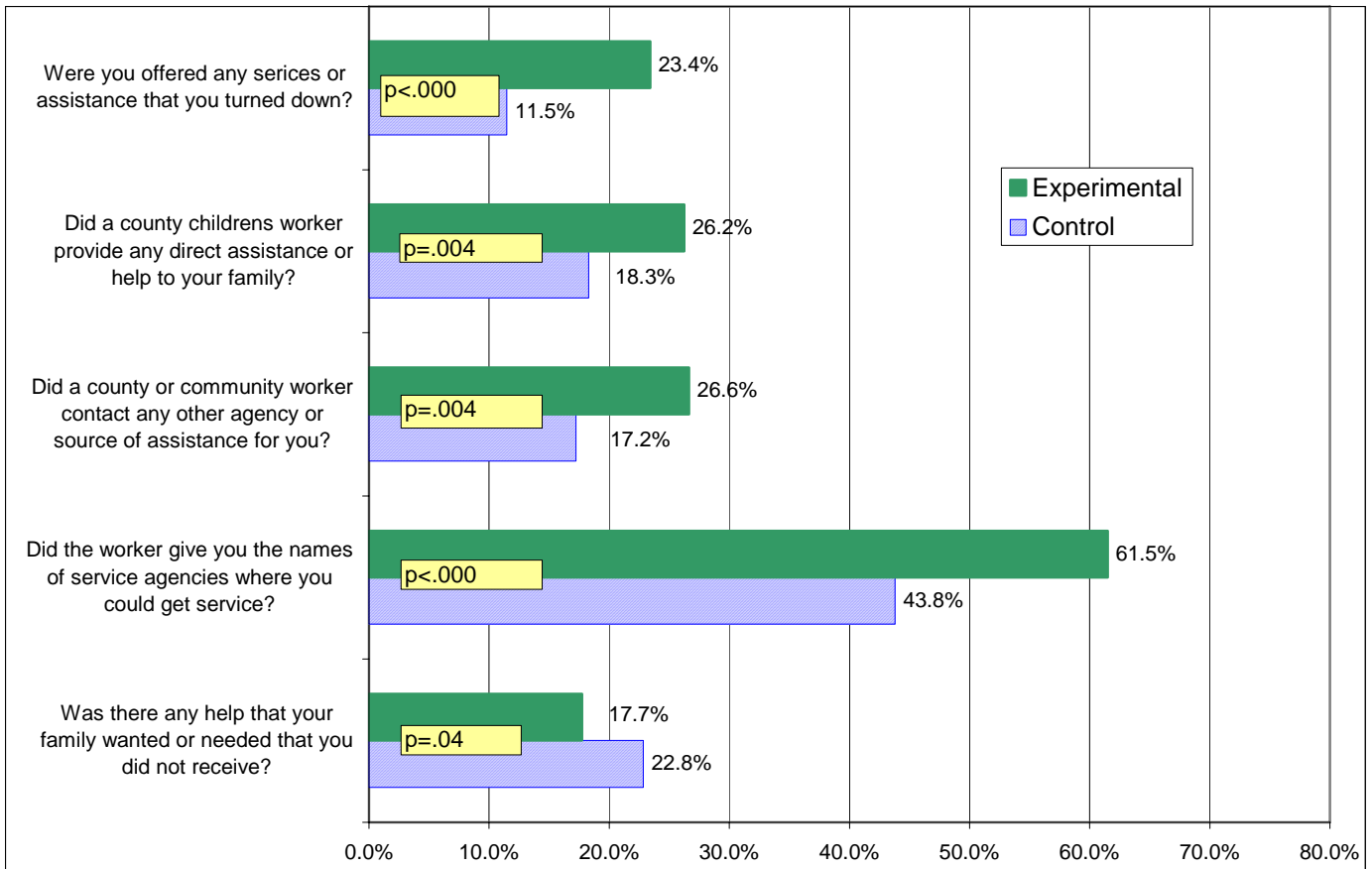


Figure 4.8. Reports of experimental and control families about services offered and received.

Ethnicity. Among AR families of different ethnic or racial groups there were no significant differences in any of the following:

- Whether or not they had received any services
- The mean number of specific services received
- Whether they received the kind of assistance they needed
- Whether they received enough assistance to really help them
- Whether or not there was any assistance they wanted or needed but did not receive
- Whether the CPS worker helped them receive services from another agency
- Whether they were offered any services they turned down

Workers

In responses to the case-specific survey, workers were more likely to report that they provided services to AR experimental families than to TR control families (59.2 percent vs. 37.6 percent).

Data from workers (cited here) and from families (reported above) came from different samples of the study population. The sample of families (n=1,158) consisted only of families who chose to participate in the study and voluntarily provided responses to questions asked by evaluators in interviews and questionnaires. The sample of case-specific worker responses (n=612) was a randomly drawn set of families about which workers were asked to provide certain information.

What is most remarkable is the consistency in responses across the two groups. The reports of families and workers validated each other and reinforced the integrity of the findings. This can be seen graphically in Figure 4.9, which shows the percentages of families and workers that reported services were provided by workers to families.

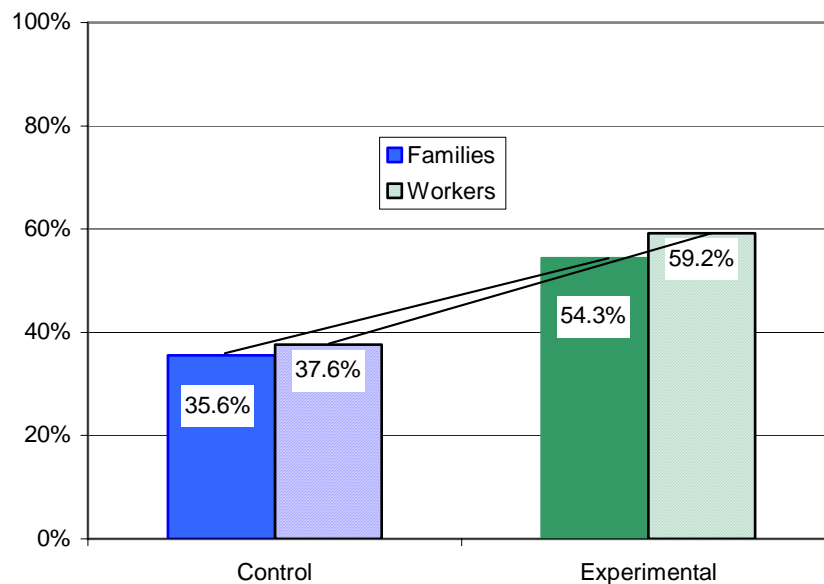


Figure 4.9. Percent of experimental and control families that received services according to families and workers.

In addition to the direct provision of services, many families were given information about where services they needed could be obtained in the community. Such information was provided to a majority of all families in the case-specific sample. However, workers were more likely to report they provided such information to experimental families than to control families (78.4 percent vs. 66.2 percent). Moreover,

workers were more likely to report that they had knowledge that AR families acted on the service information they were given. (See Figure 4.10)

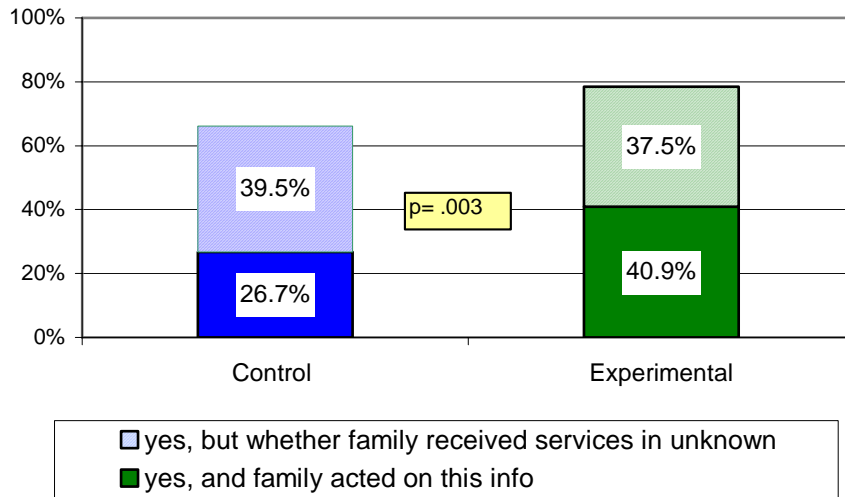


Figure 4.10. Percent of workers who reported they gave service information to families and knew whether or not families acted on this information

Part 3. Worker Perception of Their Own Practice

In evaluating public services programs, it is not uncommon for researchers to be confronted with workers who describe a new initiative as the “same old” things wrapped up in new terminology. Not infrequently workers will insist that they have really been engaged in such activities before the demonstration came along. Even in new projects found to be effective, this reaction may be found, and it may be true. It is probable that some workers at least, informed by knowledge of best practice or committed to family – centered practice, have been attempting to do most of what a new initiative has focused on. New initiatives usually do not proceed from a belief that all or even most existing practice is bad. Rather, most new programs seek to build on good practice and extend it and, through various structural, training, or funding adjustments to facilitate its use by as many workers and offices as possible. However, to the extent that a new initiative is truly “new,” and represents some substantial departure from existing practice, the following axiom applies: It is unlikely that a new initiative is actually being implemented if workers insist they are essentially doing the same things they have always done, whatever that might have been.

As part of the evaluation of the AR project, workers in the 20 counties were surveyed during the first half-year of the project in 2001 and again during 2004, the year of this report. While most of the results of this survey will be discussed in another section, one question is apropos here. Workers were asked: “If you worked in child protection before the start of AR, has the Alternative Response affected how you approach families or perform your work (that is, are you doing anything differently from

before)?” They were asked to respond either by saying “not at all,” “in small ways,” “in a few important ways,” or “a great deal.”

Figure 4.11 shows how workers responded to this question during the first year of the project (2001) and in the last follow-up (2004). As can be seen, beginning from the first year of the project, workers responded strongly that AR had impacted their practice. This was true among workers who did AR, whether exclusively or in combination with traditional assessments. Among workers who used AR only, the response was stronger, with 50 percent saying AR had affected their approach to families a great deal and another 32 percent saying it had affected their work in a few important ways. Three years later, the response of these AR workers was stronger still, with 69 percent saying it affected their CPS practice a great deal. The finding is strong evidence that a practice shift has occurred in these counties.

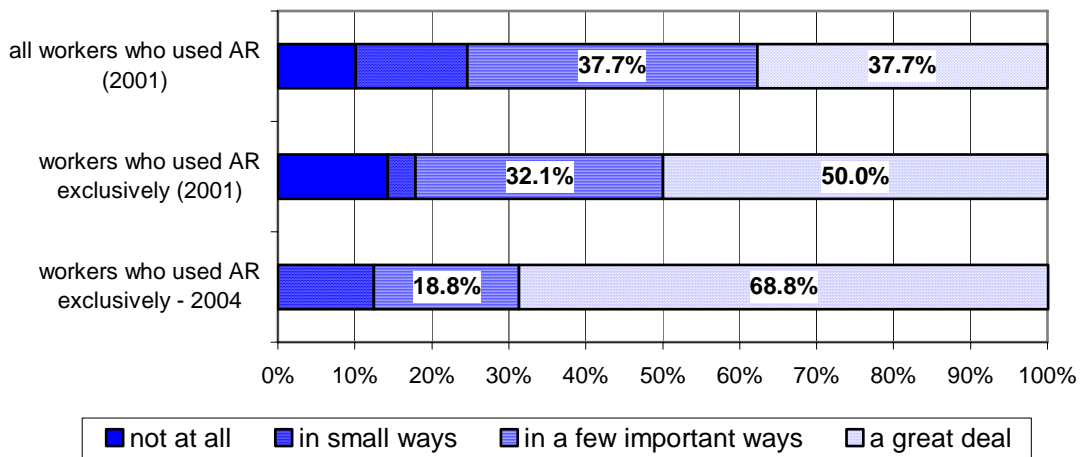


Figure 4.11. Workers responses to the question: Has the Alternative Response affected how you approach families or perform your work?

These survey data reinforce accounts given by workers during interviews and comments made in surveys. Some workers saw the new approach as institutionalizing practice they had always tried to do, such as one who said: “I have always used a holistic, family-friendly approach.” But, she added, “With AR I am more intentional about being holistic and recognizing family strengths.” Only a very few described AR as “nothing really new.” Partially because of specific new tools and objectives that were different in conducting an AR assessment compared with a traditional investigation, most described their AR assessments as different from traditional ones and as consistent with prescribed practice.

In describing their practice under AR, most CPS workers described not just changes in actions but in attitudes as well. The following worker comments were typical and representative of the large majority.

"Prior to doing Alternative Response, I had worked as an ongoing case manager in this county. Alternative Response has allowed me to do some things

differently. The grant allowed us to be able to meet some financial needs that the families were struggling with (rent, utility bills, food, school supplies, etc.) things that we would not have been able to do previously. We were able to approach families with more of a ‘How can we help you?’ approach than if we might have done with an investigation—no tape recording, meeting as a family, no determination made, offer to provide services and/or provide information as to resources, support services, etc. Although families were sometimes upset initially about our involvement, they were usually cooperative with the process, and in some cases, appreciative of our involvement.”

“We discuss safety of the children with families instead of trying to determine whether maltreatment occurred or not. And we approach families as a whole instead of interviewing each family member separately. With AR, families are more involved in the decision making.”

“Families are approached as a unit (not split up to interview), each person is heard by the rest, children's feelings are revealed, families hear what they are doing well, the approach does not focus on blame and wrong doing.”

“With AR we identify strengths, don't focus an incident that brought family to CP, work with the family to identify needs, interview family as a unit rather than individually, support and work cooperatively with the family, and there is less court involvement.”

There is a broader discussion of worker response to the implementation of AR practice in Chapter 6.

Summary of Major Findings

Across all major dimensions, the responses of family members and CPS social workers indicated that a major practice change occurred and that the change was consistent with the AR model as designed by policy makers. Although experimental-control group differences on individual issues were not always great in absolute terms, differences on all major dimensions were, nonetheless, statistically significant ($p < .05$). And, on the other hand, no area was found in which responses from control families who received the traditional approach were more positive than experimental AR families. On nearly every issue, responses of AR families in the 6 counties that did not participate in the experimental design were very similar to AR families in the 14 impact study counties. The following is an outline summary of major findings related to the change in CPS practice:

Families. Compared with control families that received the traditional approach, experimental AR families were more likely to report:

- Greater satisfaction with the way they were treated by child protection workers.
- Greater satisfaction with the help they received or were offered.
- That their family is better off because of this experience.

-
- That they were treated in a friendly manner.
 - That they were more involved in decision making.
 - That the county CPS workers they met with listened to what they and their family members had to say.
 - That CPS workers tried to understand their situation and needs.
 - That CPS workers treated them and their family fairly.
 - That all matters important to them were discussed.
 - That they had a reduction in negative feelings and increase in positive feelings following the first assessment meeting.
 - That workers met with them more often.
 - That workers met with them on subsequent occasions in which their children or whole family were present.
 - That workers helped them obtain services.
 - That workers provided direct assistance themselves to families.
 - That workers connected them to other community resources.

CPS Workers. Correspondingly, compared with the traditional approach to child protection, CPS workers that utilized AR were significantly more likely to report:

- That they had more contact with families.
- That they conducted interim and final assessments.
- That families were cooperative.
- That services and support were provided to the families.
- That the services provided were effective and matched to the needs of families.
- That services were provided across a broader spectrum of service areas.
- That families were linked to a broader set of community resources.
- That extended families were involved in providing support to the families.

Finally, and significantly, social workers themselves recognized a substantial change in CPS practice with the introduction of the Alternative Response. They accepted the policy and enacted it, but beyond this, most of them believed in it and committed themselves to making it work.

Why Change Happens

Changing human services systems is more difficult than most people outside these systems generally realize. As the saying goes: Change is easy to talk about, but hard to do. Like ocean liners, public bureaucracies and governmental agencies and even human services systems have their own momentum. The most likely thing to happen is what has always happened. As a result, change cannot be done without great effort, sound planning and tenacious follow-along. Ultimately, it will only occur if those in the field

believe in it and commit themselves to it. And this will only happen if they are supported, encouraged and well guided by their supervisors and immediate administrators. And local administrators themselves operate within larger systems that can facilitate or impede their best efforts and intentions.

In seeking to ensure consistency in practice across participating counties as well as faithfulness to the AR model, the state agency, DHS, dedicated two administrators to this project, something almost unheard of in days of constriction and a general pulling back of support for public programs. Through these individuals, who were responsible for the day to day overarching management and monitoring of the project, support was provided to county administrators and training was given to county child protection staffs. This training was begun prior to the implementation of the project and on a regular basis thereafter, with support provided to counties individually and through group workshops. An all-sites, lessons-learned conference was organized and held after the first year of the project and annual video-conferences were held in which evaluators were asked to share interim findings to county staffs. After the second year of the project, DHS organized a national forum that addressed differential response intervention in general and Alternative Response in particular, and in which AR county social workers who had been living and breathing the new approach participated actively. On their own initiative, county field staff organized quarterly meetings in which they exchanged information and provided practical technical assistance and support to one another. Some CPS supervisors followed the lead of their workers and began to meet among themselves and with this larger group of social workers. These efforts were successful in modifying CPS practice and gave AR a chance to work.

Chapter 5. Services

Services provision is an important part of the AR model. As was seen in the previous section, evidence from the state information system, from county workers and from families themselves confirmed that counties participating in the project implemented this aspect of the model in their CPS practice. The effects of services on outcomes related to families and children will be explored in some detail in Chapter 8 where impact findings are presented. But because the provision of services was expected to be an important intermediate variable in the achievement of project goals, we want to review some key findings concerning services provided through the Alternative Response.

There are three questions examined in this section:

1. What services did families receive because of AR that they might not have received otherwise?
2. Which families received services?
3. What did the families think about the services they received?

Types of Services Provided

Family Reports. The percent of families who reported receiving specific services is shown in Figure 5.1. The services are varied and include therapeutic interventions, medical and health care, social support, childcare and a variety of services related to basic needs. In the figure, the services are ranked in order most provided to experimental families, from food or clothing for the family (which 11.2 percent of these families said they received) to assistance in the home (which 0.8 percent reported receiving). Because relatively few families received services listed nearer the bottom of the graph, the y-axis was stopped at 25 percent so that differences between the two groups could be viewed more clearly.

The graph lists 22 services, and, simply in terms of raw percentages, a larger percentage of AR families said they received 16 of them while a larger percentage of TR families said they received 6 of them. The difference between the two groups was statistically significant with respect to 7 services and each time it was the experimental

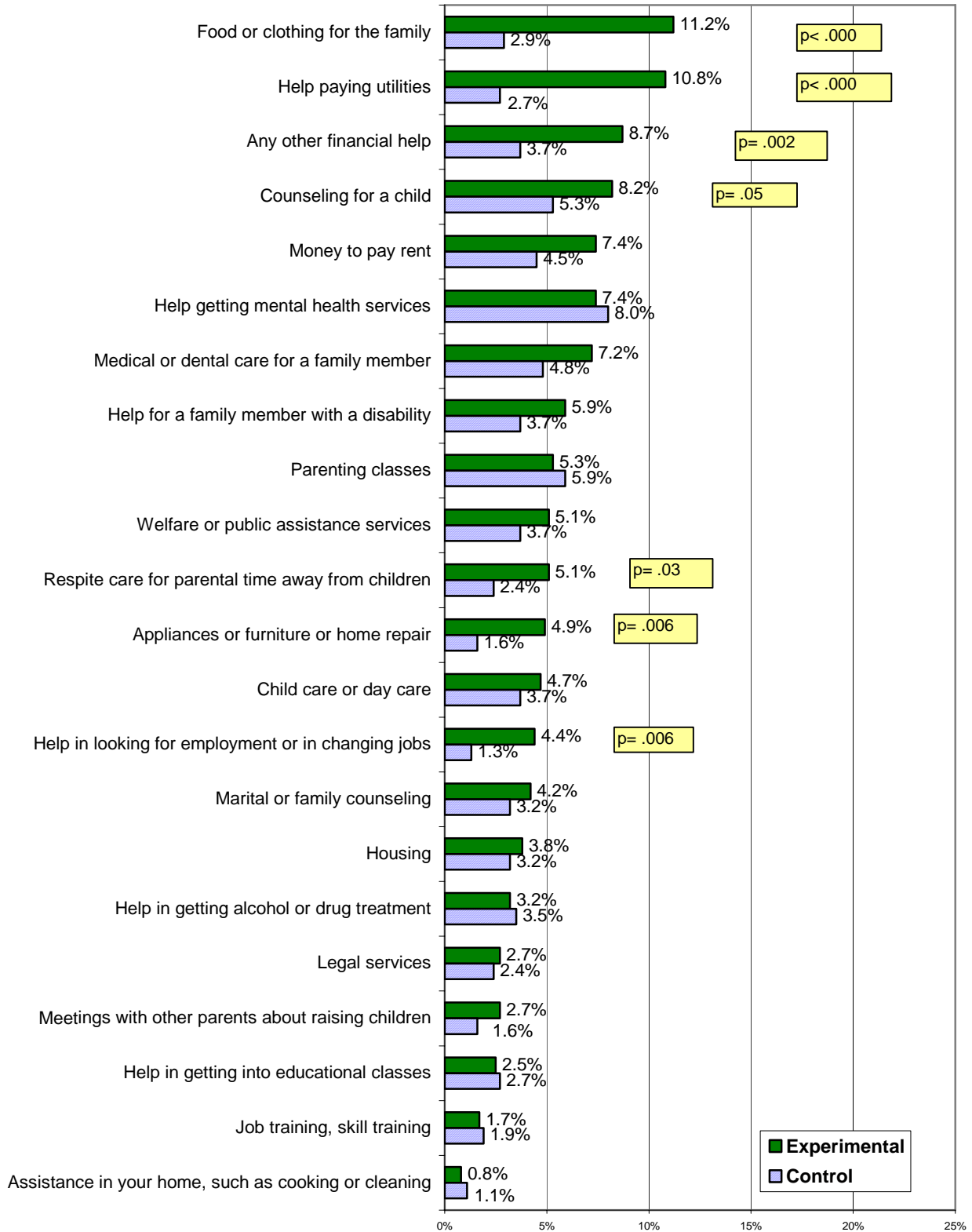


Figure 5.1. Percent of experimental (AR) and control (TR) families who reported receiving specific services.

group that more frequently reported receiving the service. AR families were more likely to report that they received the following services:

- Food or clothing for their family
- Help paying utilities
- Help paying rent
- Other financial help
- Home repair, appliances, or furniture
- Respite care
- Help in looking for employment or in changing jobs

Four of these six services address basic needs more likely to be present in low-income families: food and clothing, help with utility bills, help paying rent, and help obtaining appliances and home repair. Help with employment is something families in any socioeconomic strata might need, but could be expected to be a larger need among poorer families. Respite care is the one service in the group whose need is least likely to be connected to social class.

The increase in the provision of services provided to AR families generally, the breadth of services provided, and the increased frequency of services that address basic needs are all factors consistent with the social work model of the AR approach.

The most frequent services provided to control families were mental health services, parenting instruction, and counseling. These are consistent with a more focused medical model in which a specific problem is assessed and therapeutic intervention provided.

Worker Reports. Workers who were surveyed about families in the case-specific sample were asked to indicate what specific services had been provided to these families. Figure 5.2 shows the percent of families in the case-specific sample that were provided specific services according to their CPS workers.

The services listed are very similar to those in the previous figure although not identical. As before, the services are ranked in order most provided to experimental families. In this chart, counseling and parenting services occupy the top three spots. The scale again extends from 0 to 25 percent.

Figure 5.2 lists 27 services and the raw percentages show a larger percentage of experimental families receiving 24 of them. The difference was statistically significant for 13 services.

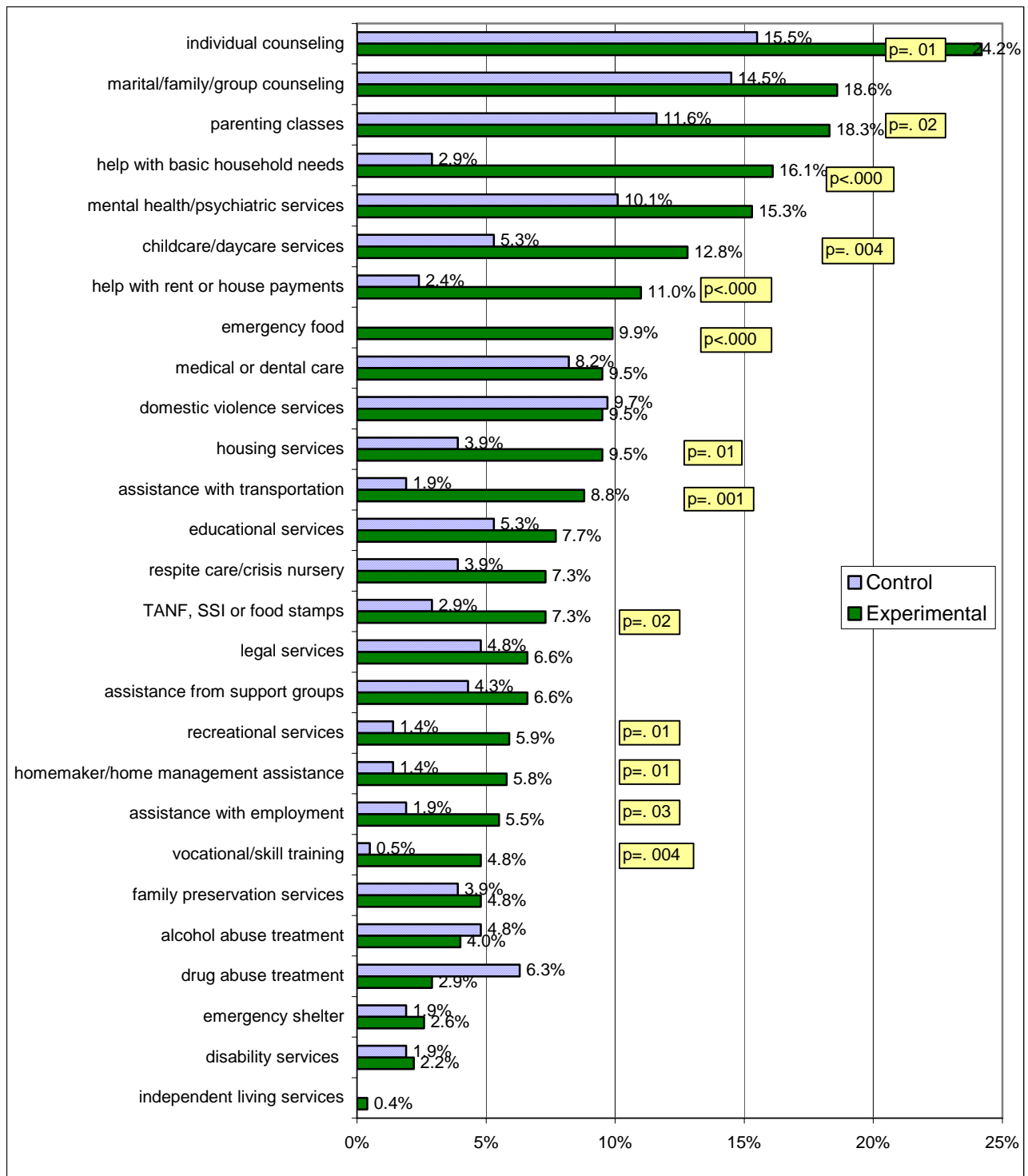


Figure 5.2. Percent of experimental and control families reported by workers to have received specific services.

Workers were more likely to report that they provided the following services to AR experimental families:

- Individual counseling
- Parenting instruction
- Help with basic household needs
- Childcare
- Help with rent or house payments
- Emergency food
- Housing services
- Transportation
- Obtaining public assistance
- Recreational services
- Home management
- Employment assistance
- Vocational training

In the case-specific survey, the most frequent services workers said they provided to control families were individual and family counseling, parenting instruction, domestic violence services, health care, and drug abuse treatment. These represent typical service responses to reports of child maltreatment. Most fall into the general category of therapeutic interventions and most often involve vendors with contracts with the county agency to whom family members are referred.

While workers also indicated that such services were provided to experimental families (and sometimes to more of them), major differences occur in increased services that are practical and that address basic needs. Six of the services where the difference between the groups was significant involve efforts to address basic needs: help with household needs, help with rent or house payments, emergency food, housing services, help obtaining public assistance, home management assistance. And five of the services involve practical help: help getting childcare, help with transportation, help obtaining recreational services, employment-related assistance and help getting vocational training. Although needs or problems in these practical areas may extend across socioeconomic boundaries, they are more likely to represent needs of lower-income families.

When CPS workers were asked during interviews about the kinds of services they provided to AR families, they tended to focus on those that were different from what was often provided to TR families. A number of workers said that AR had made them think differently about services to CPS families, and more creatively. One county worker said:

“We can provide many types of services now we wouldn’t have before: electricity, lamps, refrigerators, rent, utilities—things that take the stress off. We also provide the kinds of things we do with traditional families, but AR allows us to be more creative in working with families.”

During interviews with workers it was clear that many had begun to think creatively about how best to help families. It was also possible to see how their thinking had been influenced by the perspectives of the families themselves and the need many had for basic assistance. One worker said:

“We can help AR families maintain employment with day care, transportation, gas money, tools and alarm clocks. And help them with some pretty basic things they need for their homes and their children, like blankets, pillows, cribs, vacuums, safety gates, electrical plugs.”

Other assistance provided by workers included the repair of a floor in a trailer, a secure front door, dumpsters. Much of it was described as “services to meet immediate needs” and “concrete assistance.” “Services to eliminate stress—door alarms, car repairs, food, prescription co-pays.” One worker noted that “family-based services are key. Such as day care which impacts ability to work, cleaning assistance—rodent control.”

While the percentages for similar types of services varied between the reports of families and workers (cf Figures 5.1 and 5.2), a general pattern emerged. The introduction of AR led to an increase in practical and basic services to families. While the percentage of AR families who received certain specific services was not large, the percentage of TR families who received them was often very small and, in a couple of cases, none. For certain services the difference was dramatic (emergency food: 8.8 percent vs. 0.0 percent; help with rent: 11.0 percent vs. 2.4 percent; help with basic household needs: 16.1 percent vs. 2.9 percent).

Some workers interviewed noted how the availability of additional funds for concrete assistance had help them think about other ways of helping families. One said that “the majority of services we provide are unfunded. And this would not have been the case as often with TR. We are giving AR families a lot of referrals, and we advocate for our clients and seek out resources for them.” Another said that “some of this concrete help might have been offered before with county funds, but no one here thought of it before.”

Amount and Source of Assistance Provided. The number of services and service referrals provided by workers was greater for AR experimental families than control families. For the entire sample, the mean number of services and service referrals provided to experimental families was 2.7 compared with 1.6 for control families. Among AR families in the 6 non-experimental counties (“other AR”), the mean number was 3.1. (See Figure 5.3.) The mean number among families who received any services was 3.5 for experimental families and 2.7 for control families.

When workers reported that services and service referrals were provided to families they were asked to indicate the primary provider of the services—the workers themselves, a paid service vendor, an unfounded community resource, or a resource of the family such as a relative or friend. Figure 5.4 shows what workers said. The full length of the bars in this graph represents the mean number of services received by the family sample (2.7 for experimental families and 1.6 for control families). As can be

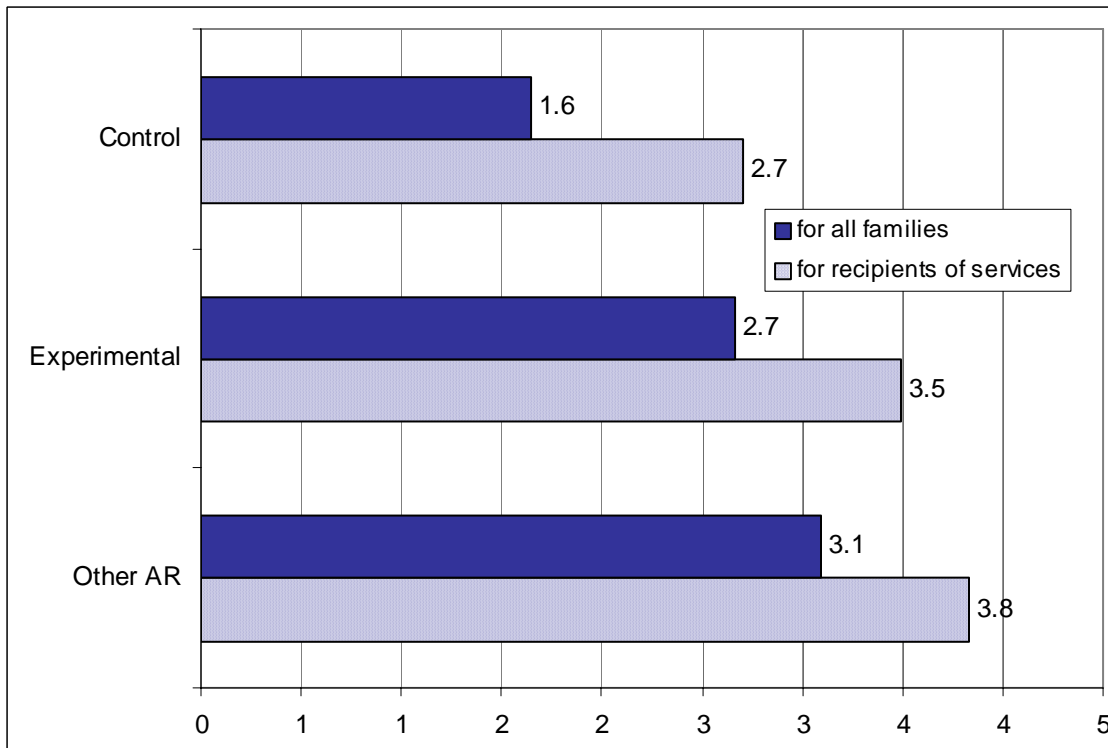


Figure 5.3. Mean number of services and service referrals for all families and among families who received any services by study group.

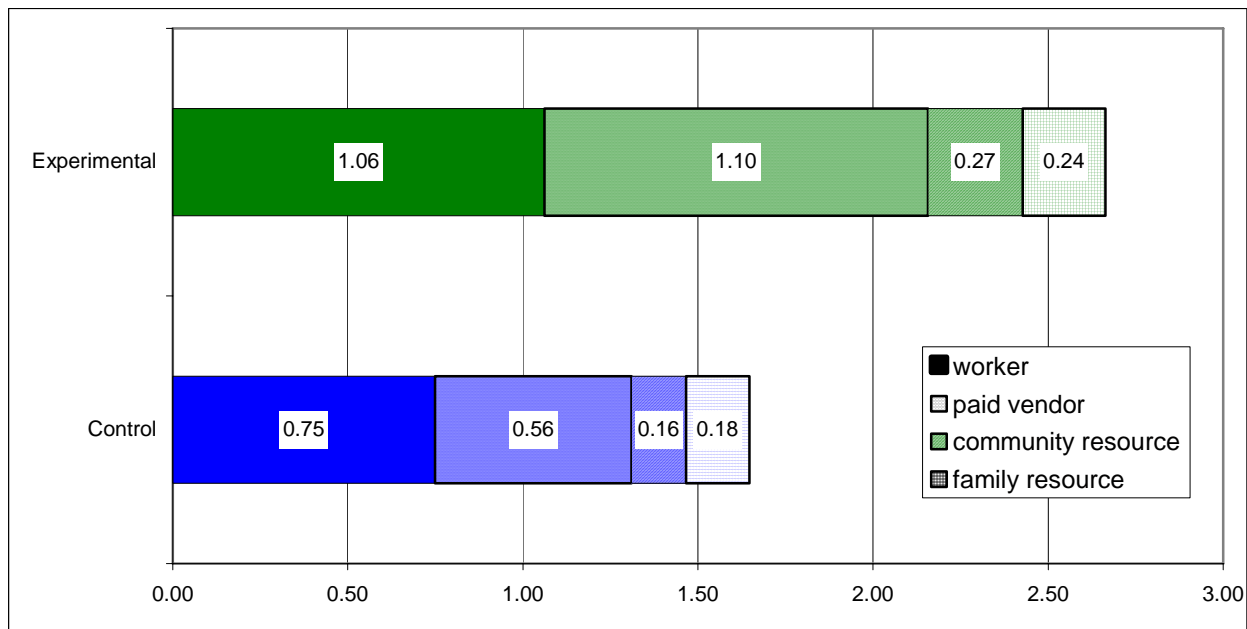


Figure 5.4. Mean number of services and service referrals reported by worker by type of service resource for experimental and control families

seen, AR expands the mean number for each provider group, indicating that: AR families receive more direct assistance from workers than do control families, more services from paid vendors, more assistance from unpaid community resources, and more assistance from the families own support system. The difference between the groups was greatest for services provided through vendors and smallest for assistance from the family system.

Another way to look at these data is by the percent of families who received assistance from these different sources. This can be seen in Figure 5.5. The graph shows that, according to workers, 46 percent of the experimental families received some services or service referrals from the CPS worker, 40 percent received services from a vendor, 17 percent from a community resource and 17 percent from a resource within the family support network. In each case, these are larger percentages than was the case among control families.

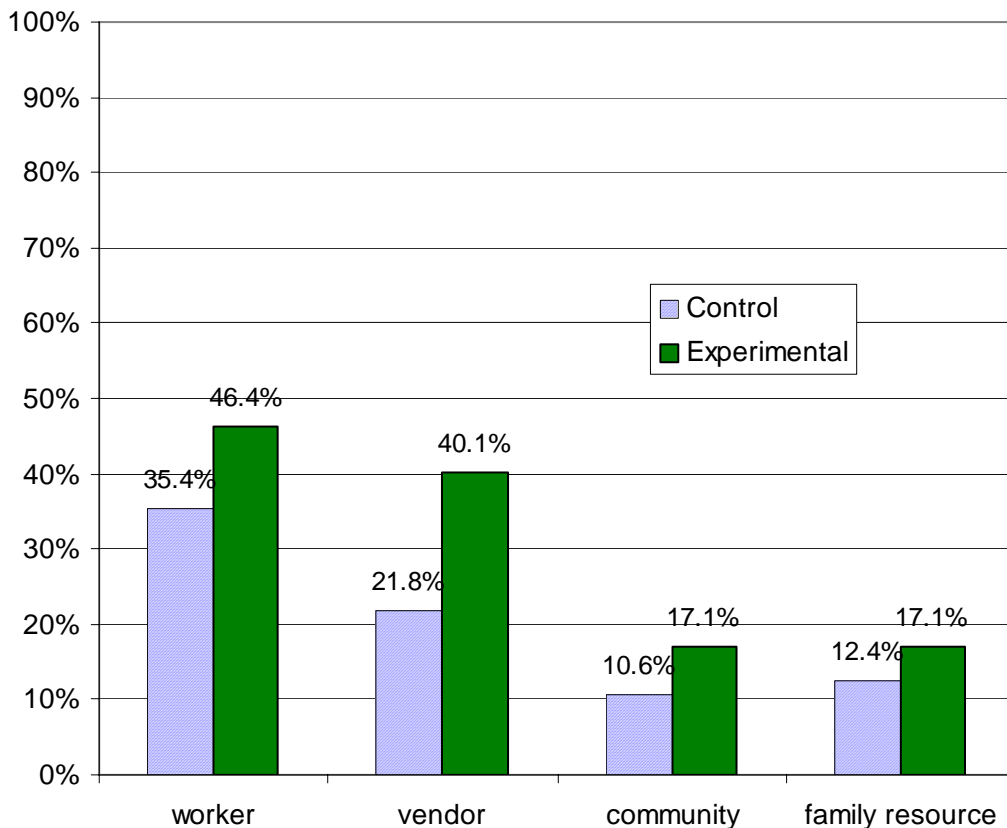


Figure 5.5. Percent of families who received assistance from different sources according to workers

Workers were asked whether they helped connect members of families in the case-specific sample to specific, local service resources. Figure 5.6 summarizes their responses, and it shows when the percentage of experimental families exceeds that of controls to a statistically significant extent.

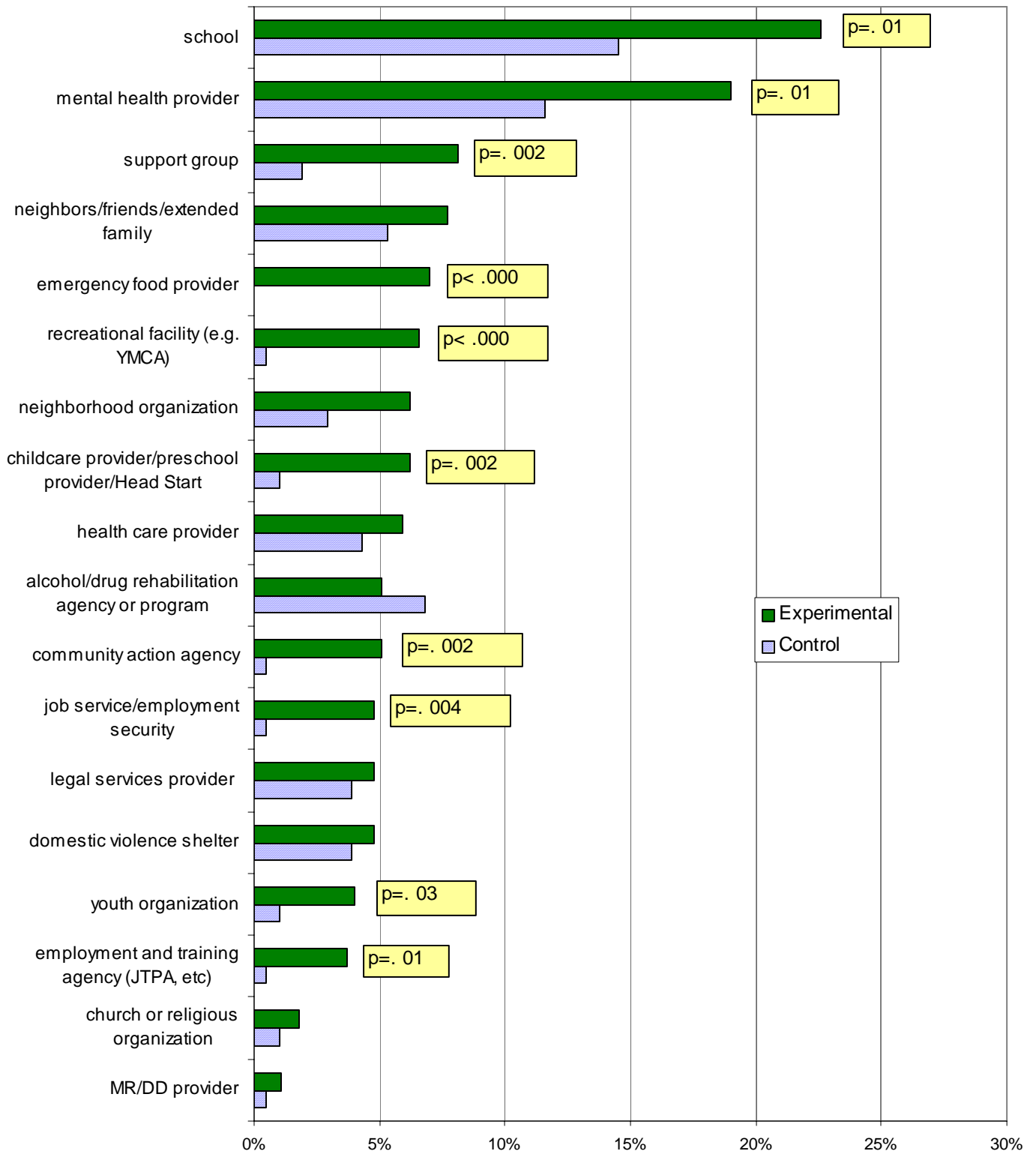


Figure 5.6. Percent of experimental and control families connected to local service resources according to workers.

Who Received Services?

Feedback received from families provided a picture of the kinds of families, AR and TR, who received services. Whether they received the alternative or traditional response to a report of child maltreatment, families that were more likely to have received services were those that reported ($p < .02$):

- More stress in their relationships with their children.
- More stress in their relationship with other adults in their lives.
- Concern about the general well-being of their family
- Concern about the general well-being of their children

Everything else being equal, AR families with certain problems were more likely to receive services than TR families with such problems. This included ($p < .02$):

- Having children with serious illnesses or who complained of being ill or missed school often because they were sick
- Having children with a developmental disability or a learning disability
- Experiencing stress associated with other adults in their lives

Within the group of families who received the Alternative Response, those in greater distress were more likely to receive services. AR families most likely to receive services were those who reported ($p < .03$):

- That their children complained frequently about feeling unwell, and about having headaches and stomachaches.
- That their children acted as if they were depressed, anxious or unsafe.
- That their children more often refused to go to school and had trouble learning in school and getting along with other students.
- That they had a harder time controlling the behavior of their children.
- A higher level of stress with regards to relationships to their children.
- That their children had ADD/HD.
- More stress associated with their financial and economic situation and their current job or job prospects.
- That their house was overcrowded.
- That they did not have any relatives or friends to turn to for financial help.
- A lower level of educational attainment.
- A lower household income.

Considering control families only: those that received services were more likely to report that their children ($p < .03$):

- Were difficult for them to control.
- Acted out to get their attention.
- Engaged in occasional delinquent behavior.

Overall, families who were under greater stress, especially stress related to their household relationships and their children, were more likely to receive services. This was true for AR and TR families, except that more such AR families received some assistance. In addition, families in both groups tended to see services received as more useful if they helped them address basic needs generally—for example, if they received food, clothing, or home- or employment-related assistance. And since more AR families got these kinds of services, more responded positively. Families responded positively not just to concrete services they received but to direct assistance provided by workers and to worker initiatives to link families up to resources in their communities. Among AR families, it is clear from what they told us, that those in greater distress were more often the targets of intervention assistance.

The findings reported above, which derive from feedback received from families, document efforts by CPS workers to provide services needed by the families they encountered. While the services might have been therapeutic or they might have been of a practical nature, they were provided to address underlying problems affecting family and child well being. And the weight of the evidence is that AR is more often effective in allowing workers to do this.

Ethnicity of Families. Based on feedback from families, those in the AR-experimental group who were in ethnic or minority communities were more likely to receive services than were white AR families. (See Figure 5.7.)

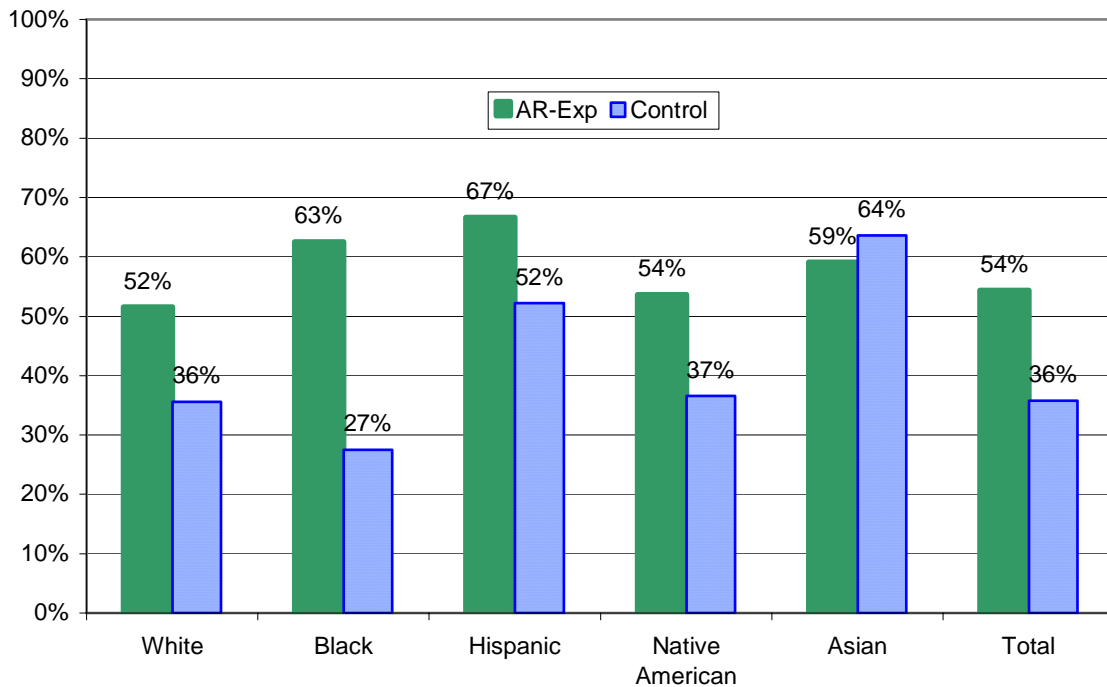


Figure 5.7. Percent of families of different ethnicity who reported receiving services

For example, while 51.6 percent of white families reported that they received some services, 62.5 percent of black families said they received services as did 66.7 percent of Hispanic families. On the other hand, in the control group, white families were more likely than black families to receive services (35.6 percent vs. 27.5 percent). The most logical explanation for this has to do with the nature of reports more likely to lead to service provision under AR than TR. Another factor may involve sub-cultural differences in willingness to accept assistance voluntarily, an aspect of AR but not TR. This may explain the figures for Asian families among whom services were more likely to be provided to control than experimental families.

A somewhat similar pattern can be seen when we look at the mean number of services provided to families. (See Figure 5.8.) The average number of services received by experimental Hispanic and black families was greater than the number received on average by white families. (2.6 and 2.2 vs. 1.5).

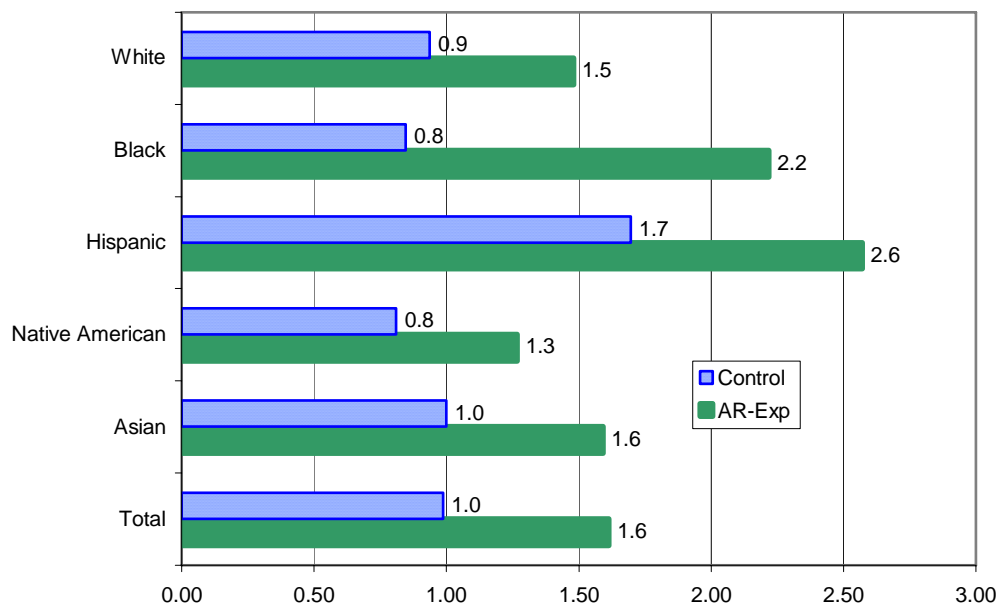


Figure 5.8. Mean number of services received by families of different ethnicity

Services and Income. Under AR, overall, services were more likely to be targeted to families of lesser means—families who were poorer and had lower incomes. This was not the case with control families. (See Figure 5.9.) Sixty percent of AR families who received services were families whose income was below the mean for the group. On the other hand, among control families who received services, 52.3 percent, much closer to half, had incomes below the mean.

In traditional investigations, the provision of services is more directly related to the report of maltreatment and the formal finding of abuse or neglect. However with AR,

while issues relating to the present risk and safety of children are the first priority, services may address more tangential factors that are preventative in the longer term.

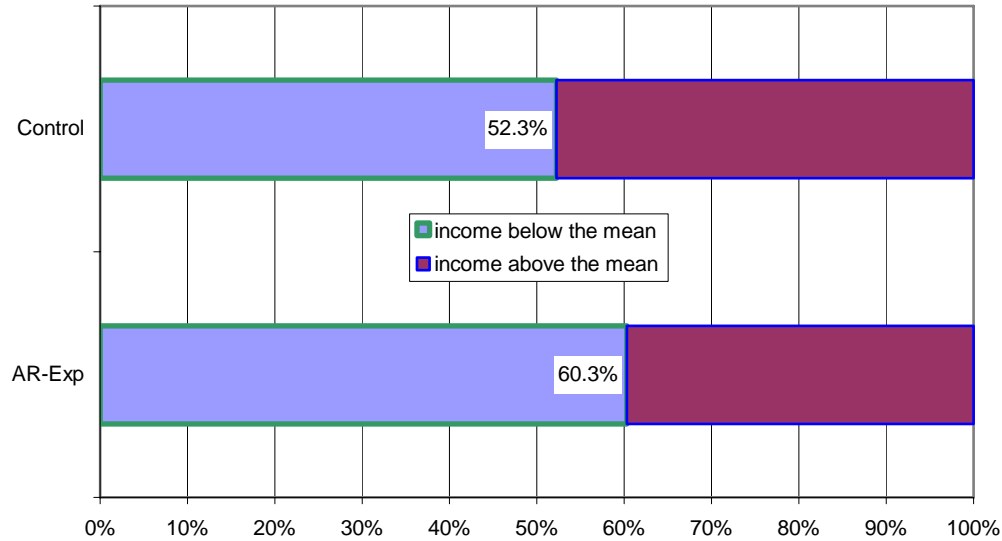


Figure 5.9. Percent of families with incomes below the group mean that receive services

This relationship between service provision and income is more understandable when one recalls the difference in specific services provided to the two groups of families. AR families were more likely to receive assistance related to basic needs than were TR families, and such needs were more likely to be present among poorer families. This relationship between services, income and need is consistent with family responses to the two approaches reported in the previous chapter and in this one.

The Relation between Services and Family Response

What did families think of the services they received? It was noted in the last chapter that AR-experimental families were more likely than TR-control families to report that services they received were the kind they needed and enough to really help them. AR families who reported that the assistance they received was the kind they needed were more likely to have received services to address basic needs, such as food and clothing ($p = .03$). AR families who said that the services they received were enough to really help them were more likely to receive money to pay their rent, food or clothing for their family, appliance or furniture or home repair, and respite care ($p < .04$). The relationship between these specific services and the perception that they were sufficient and relevant to meet the needs of families was a statistical trend among control families.

Overall, families who received services as a result of a CPS intervention responded more positively to the experience than families who did not. This was generally true both for AR families and for families who received a traditional investigation. For example, compared with AR and TR families who did not receive services, those of both groups who did were more likely to report that their family was better off because of the CPS experience ($p < .0001$). They were also more likely to say that after the first visit with the county worker they felt hopeful, helped and encouraged ($p < .03$). Perhaps naturally, they also reported that they were more involved in decision making about what would happen next ($p < .001$) and that they met with workers on subsequent occasions in which their children and other family members were present ($p < .01$).

Among AR and TR families who received services, AR families were more likely than TR families to report that workers treated them and all family members fairly ($p = .008$) and with more understanding of their family needs and problems than were families who did not receive services ($p = .002$); AR families were also more likely to report that all important issues were brought up for discussion during the worker's visit ($p = .01$). Additionally, TR families who received services, were more likely than AR families to report certain negative emotions following the CPS worker visit; they were more likely to describe themselves as confused, wary, tense, pessimistic and discouraged ($p < .001$). And, perhaps most importantly, AR families were more likely to report that the services they got were the kind they needed as well as enough to really help them ($p < .001$).

The responses were most critical from families, whether AR or TR, who felt there were services they needed but did not get. Such families were most likely to express dissatisfaction with the way they were treated by the visiting worker ($p < .0001$) and with the help they received or were offered ($p < .0001$). These were the families who most often said they were worse off because of the experience ($p < .0001$), reported that they were treated in a less friendly manner ($p < .0001$), and more often said the worker did not listen to what they had to say nor understand their family situation and needs ($p < .0001$). These families were those likely to express stronger negative feelings following the CPS assessment. They more often said they were angry, stressed, irritated, anxious and dissatisfied.

Comparing the reactions of AR and TR families who did not receive services provides a useful insight into the effects of the AR approach itself. In this subset of cases, AR families reported a higher level of satisfaction than did TR families ($p < .0001$) and were more likely to say they were treated fairly and that workers had a greater understanding of their family problems and needs ($p = .03$). TR families were more likely to report that they felt irritated and wary during the assessment visit ($p = .007$). AR families were more likely to say they had been offered services and assistance that they turned down ($p < .0001$) and that the workers gave them specific information about where they could get services ($p < .0001$).

AR and Services

It can be argued, and it has been, that it is not possible to increase services to families simply through the introduction of a differential response to child maltreatment reports; there is a finite amount of funds available in the service system and certain families will receive more only if others receive less. It is a common view within child protection, and the normative reality of CPS service funding, that limited resources should be reserved for the most critical cases.

The AR project benefited greatly from the infusion of new funds for services from the McKnight Foundation, which stimulated, in turn, additional resources from the state and participating counties. Some McKnight dollars were specifically earmarked to pay for services that addressed very basic and practical needs.

There is a second way to increase services and assistance to families in need, and that is through the wider use of unfunded community resources that include a variety of community organizations and support networks, faith-based sources, and extended families of the case families in question. The evidence presented in this chapter suggests that this occurred in the AR project. Moreover, it appears that the emphasis placed on using some of the McKnight funds for “hard goods” to meet practical, concrete needs of families touched the social work inclination of CPS workers and expanded the way many of them thought about services. The new funds, in effect, leveraged a different way of acting and helping.

Chapter 6. Worker Perspective

Just as it is important to gain the perspectives of family members who are affected by a change in policy and practice, it is also important to learn what CPS workers think about it. County social workers are the ones who are charged with implementing any such change within the child protection system and they have much to do with the extent to which a new program's goals are achieved or, even, whether these goals are given a chance to be achieved. In an elemental way, an agency's policies are to be found in the day-to-day actions of workers and their interactions with families. In Chapter 4, we saw that what workers did when they encountered families screened for AR was consistent with what policy makers hoped they would do. Here we take a closer look at what workers think about the new approach, something that can be expected to affect what they continue to do.

Throughout the evaluation, the opinions of county CPS workers about AR were solicited during on-site interviews and in a survey conducted in the spring of 2004. A similar survey was carried out in spring 2001 as the AR project was beginning and results were included in the first annual report of the evaluation. Both interviews and surveys provide useful qualitative information on worker attitudes and perceptions related to the new approach. The information collected through interviews is anecdotal in nature, while that provided in surveys is more systematic. This section provides a summary of major findings from the spring 2004 survey, augmented with information from interviews. Where differences were found between the first (2001) and second (2004) surveys they are pointed out, as are similarities and differences among workers in different counties.

There were 105 workers who participated in the 2004 survey across the 20 project counties. Most of them (97) had had some direct involvement with Alternative Response families, either as front-line workers or as supervisors, and the survey data reported here involves the responses of these workers.

Perception of the Reactions of Families. Overall, workers have tended to report that AR families responded more positively than TR families to their efforts to help them. Among other things, for example, workers reported that AR families more often viewed their agency as a source of support and assistance compared with TR families ($p < .000$). Workers also reported that AR families were more likely to think they were better off because of the involvement of the CPS agency than were other families ($p < .000$). (In the survey, workers were asked to assess the reaction of families on a 10-point scale, from very negative to very positive. Figure 6.1 shows how workers rated the reaction of AR and TR families to CPS intervention.)

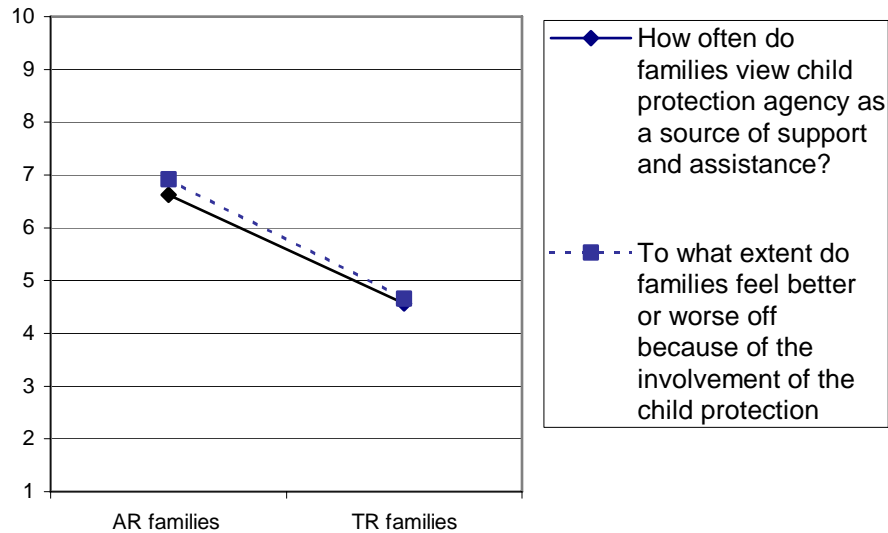


Figure 6.1. Worker perceptions of attitudes of AR and TR families towards child protection (1=very negative and 10=very positive)

During an interview a worker remarked, “I have never heard someone say ‘thank you’ after a child protection report before AR. Now I have.” Another said, “Families respond more positively to AR. They are not so threatened. And they are more likely to reach out to us for help.”

Perception of their own Effectiveness. Workers saw themselves as more often able to help AR families receive services they needed than TR families ($p=.008$). (See Figure 6.2.) They were somewhat more likely ($p=.07$, a statistical trend) to view their intervention with AR families as more effective than with other families.

Workers were asked during interviews whether there were certain types of reports or families that were least likely to benefit from AR. The most common response to this question was cases involving chemical dependency. One worker noted, “I’ve had zero luck with meth cases. Because they lie and mislead, play you along. They are into passive non-cooperation.” Another noted such cases were particularly difficult “if it is not the reason for the report.” Reports involving custody disputes were mentioned by a number of workers as especially difficult. Some workers added educational neglect cases to this list. Workers were of two minds on this problem, some seeing a need for greater leverage that comes with traditional assessments, while others thought, as one said, “TR offers these families nothing. At least with AR we can do something for them.”

While the pattern represented in Figures 6.1 and 6.2 extends across the entire project, workers in counties in greater Minnesota were generally more positive in their view of AR and its effects than workers in the two metro area counties. This relates both to worker perception of the attitudes of families about AR and to their own effectiveness. (See Figure 6.3.) Among the individual counties, workers in Carlton County as a group

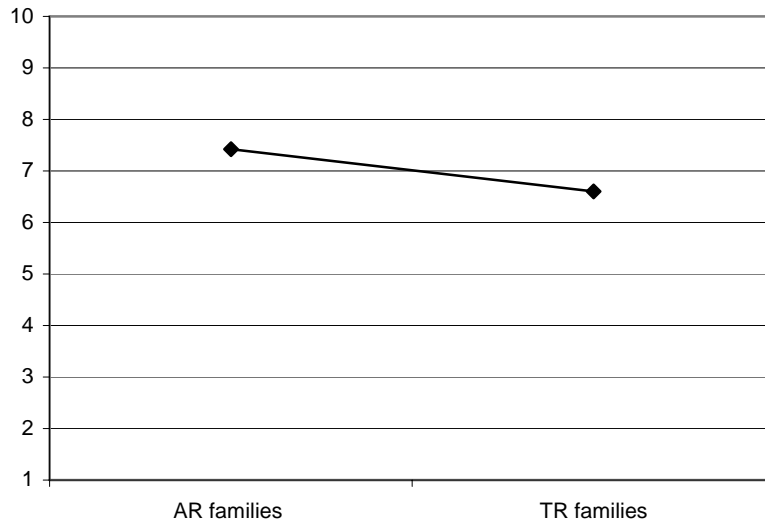


Figure 6.2. Worker's ability to help families and children obtain needed services. (1=very poor; 10=excellent)

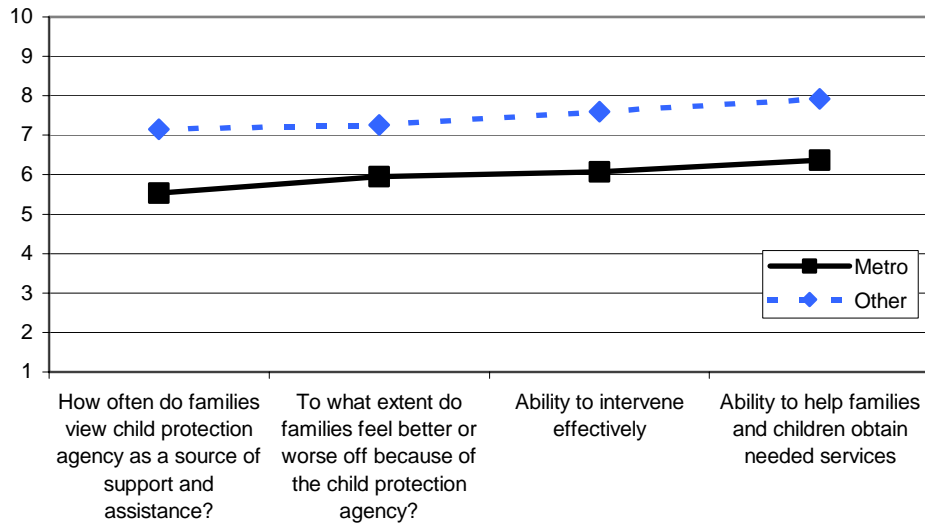


Figure 6.3. Perception of workers in metro and non-metro counties.

were the most positive in their assessment of AR regarding these issues, although workers in many other counties were not far behind in their positive assessment of AR. The least positive assessments were made by workers in Hennepin County.

Considering the relative difference in the perception of the reaction of AR and TR families, workers in Wright, Polk and Carlton saw the most gained by implementing AR.

Workers in Dakota and Scott expressed the largest relative gain in their own effectiveness with the introduction of AR compared with TR. Compared with workers in other counties, those in Olmsted tended to rate the reaction of both AR and TR families as quite high, as well as their own ability to intervene effectively with both groups of families.

AR and Child Safety. Child safety is the single most important issue for child protection. Any change in CPS must insure it is not compromised. Child safety was assessed through various means in this evaluation and is discussed in the impact study portion of this report. But workers were asked for their judgment of this issue. In the survey they were asked: “How successful do you believe AR has been in keeping children safe?” Across all counties, 77.3 percent of workers described AR as very or mostly successful in keeping children safe; 4.1 percent said it was not successful. Workers outside the two metro counties were significantly more positive ($p < .0001$) in their assessment, with 93.9 percent describing AR as very or mostly successful and none saying it was not successful. (See Figure 6.4.) Much of the concerns about safety were found among workers in Hennepin County, as can be seen in Figure 6.5, which shows how workers in each county responded to the question of safety on the four-point scale.

During interviews, some workers expressed a degree of unease with AR over the safety of children. One said, “Yes, we have some safety concerns. We’re pushing a lot of cases through AR.” Another spoke of issues that “might remain hidden because we’re seeing children with their parents and not by themselves.” One metro county supervisor

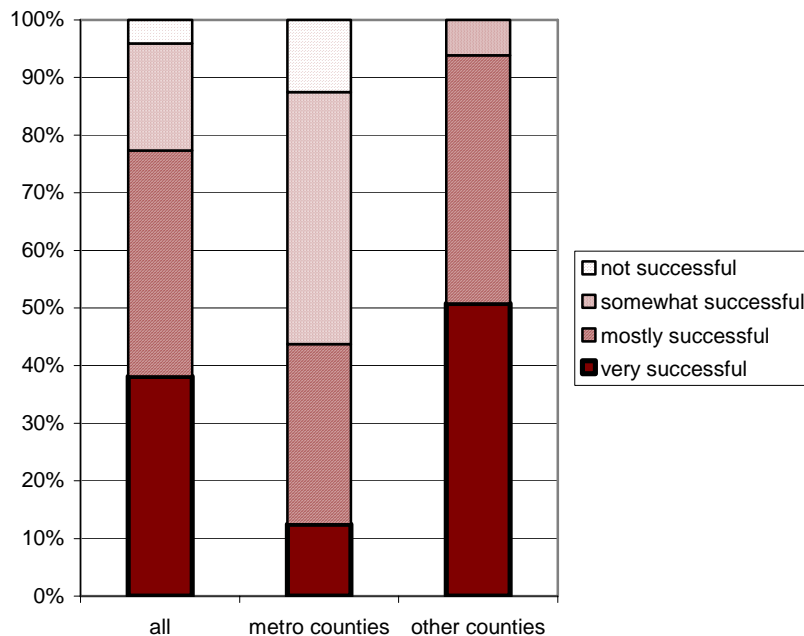


Figure 6.4. Extent to which workers perceive AR as successful in ensuring child safety (all workers and metro vs. non-metro workers)

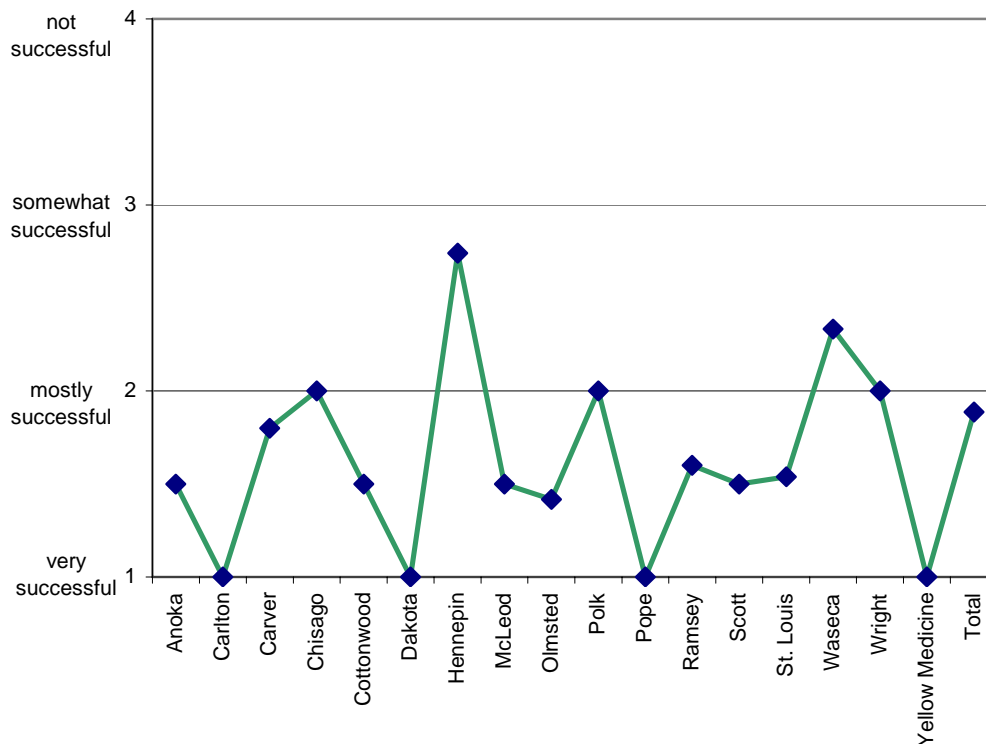


Figure 6.5. Extent to which workers in different counties see AR as ensuring child safety.

continued to see “traditional investigations as more thorough about what’s going on in the family.” But this was not a view shared by most experienced AR workers. One said, “AR hasn’t created safety problems. We can always see kids separately if we have a concern about them.” A majority of workers interviewed would agree with the worker who said, “We have no more concern with safety than with TR. If anything, we close AR cases knowing more about the cases and doing more for them, and the family is not angry.”

With some exceptions, workers did not report concerns about safety with AR in their communities. Counties that had active child protection teams or who had conducted any significant community outreach regarding AR reported few safety concerns among key stakeholders. Overall, safety concerns by workers and stakeholders have decreased as experience with AR has increased. (Chapter 7 includes a more detailed discussion of child safety and AR from the perspective of community stakeholders.)

Relationship between County CP Office and Key Agencies. Workers were asked to assess the working relationship between their office and a set of key community agencies and institutions. The specific agencies and institutions included: local law enforcement authorities, juvenile court, prosecuting/county attorney, schools, hospitals

and health services, mental health providers, employment services such as Job Service and JTPA, churches and other religious organizations. Their mean responses on a 10-point scale are shown in Figure 6.6. In general, their assessment of the relationship with most of these organizations was high. Employment services and churches being an exception to this. Among the others, the mean score was highest with law enforcement and lowest among schools.

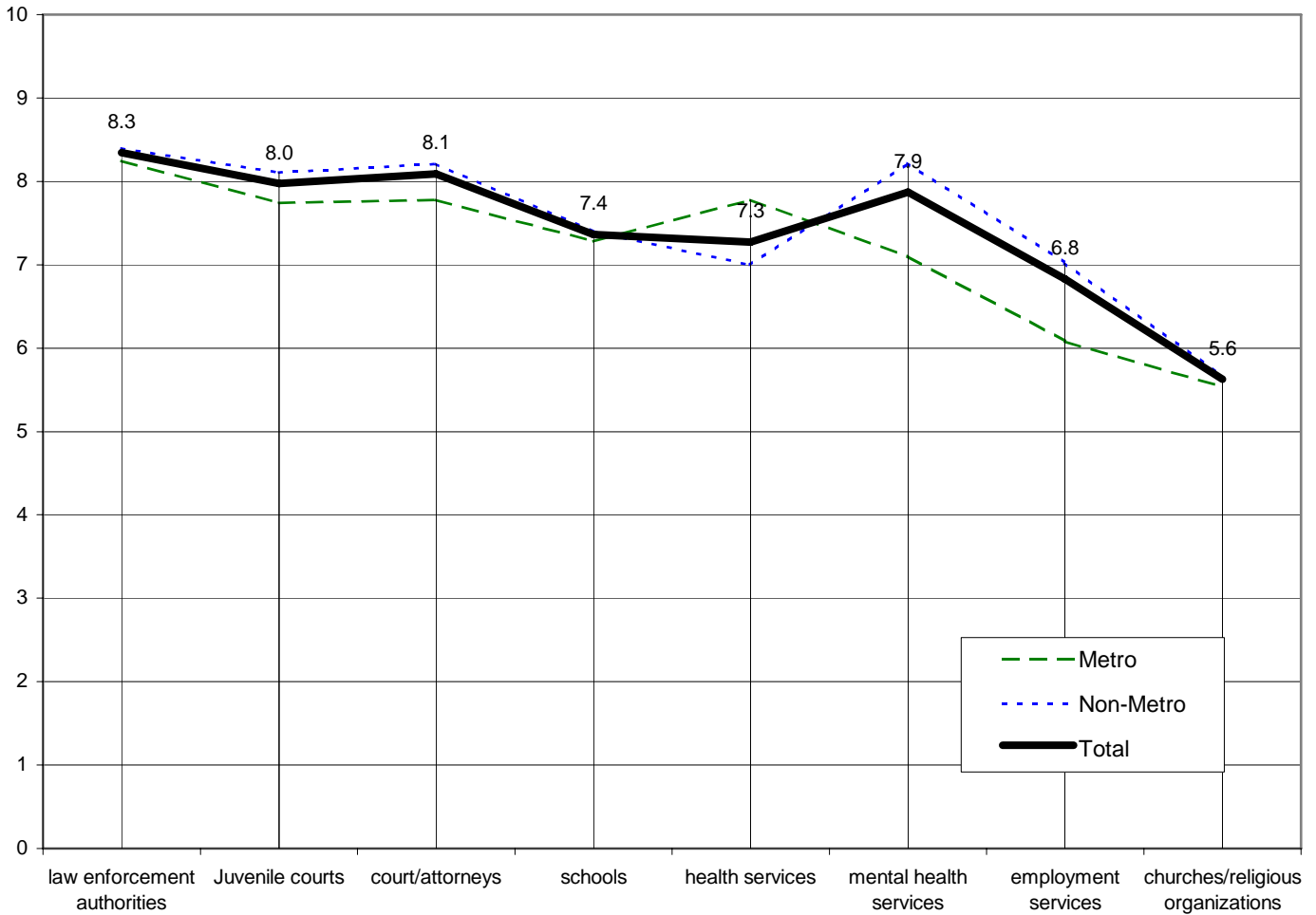


Figure 6.6. Working relationship with county CPS and key agencies.

During interviews, most workers described community attitudes towards AR as having improved greatly since the start of the project, especially the attitudes of court personnel, prosecutors and the police, and, to a somewhat lesser extent, schools. Although community response is seen as mixed in most counties. One worker said, “There is still a lot of misunderstanding about AR in the community.” In two counties with large reservation communities, workers described a positive response to AR from tribal leaders. One worker said, “Tribes see it as a traditional value piece, because it respects families and doesn’t involve police.” A worker in another county said,

“Tribal reps like AR and work together with us and for the first time they see the county agency as a resource and see us finally doing something good and are more comfortable contacting us.”

AR Protocol vs. Service Funding. As described at the beginning of this report, there are two underlying elements of the AR approach: the protocol (the manner in which families are approached) and additional funding for services families need but might otherwise not receive. Workers were asked their view on the relative importance of these two elements. The question that was put to them was: When AR is successful with families, how much of this tends to result from a) the protocol or b) the additional funding for services?

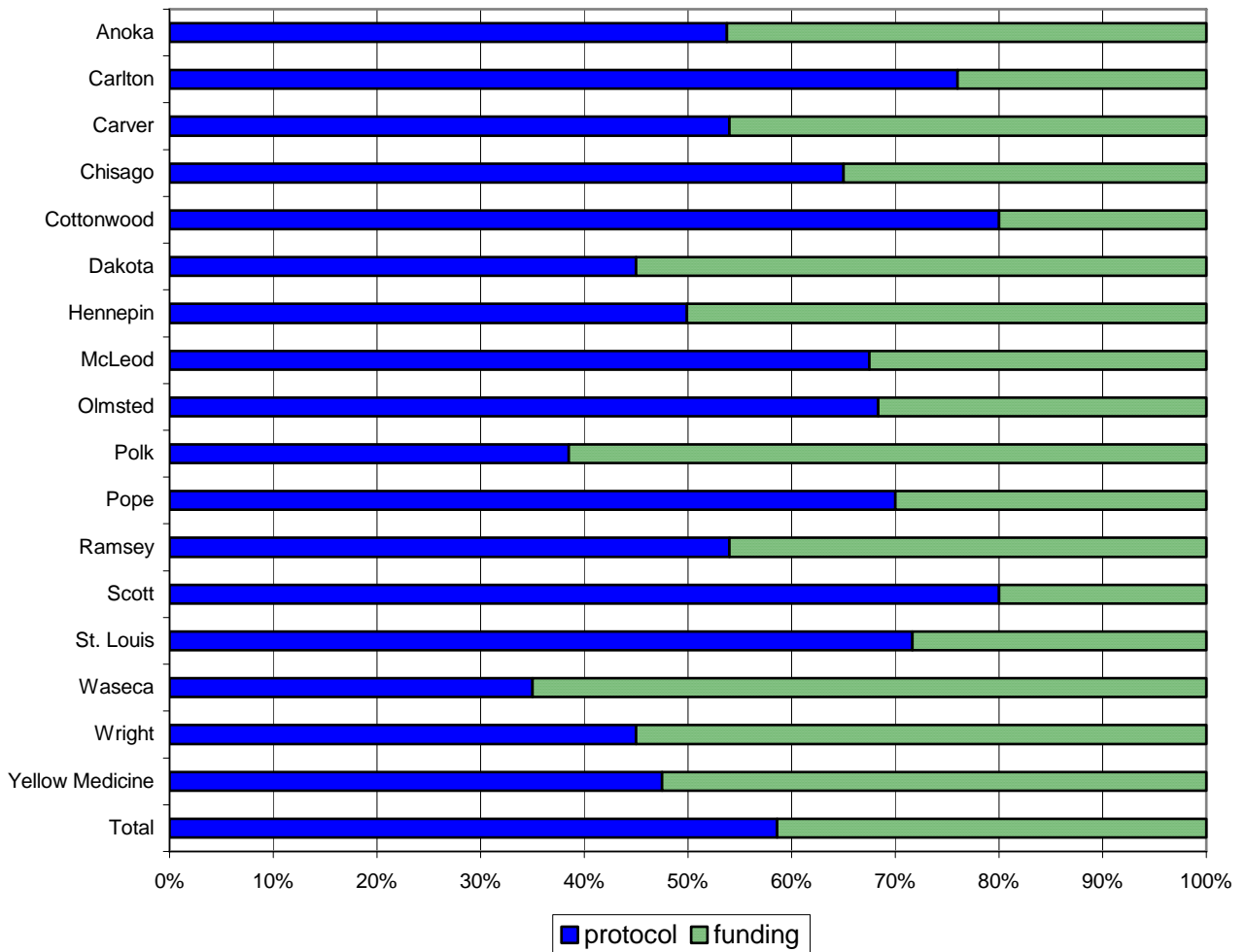


Figure 6.7. Relative importance of AR protocol and additional funding for services according to workers in project counties.

Among all workers in the 20 project counties, the mean percent indicated for the protocol (58.6 percent) was higher than the mean percent for additional service dollars

(41.4 percent). Just two workers attributed all AR's success to only one of the two: one saying 100 percent of the success of AR was due to the protocol and the other saying 100 percent was due to service funding. All others saw both factors playing a role, only varying in how much to attribute to one or the other. The overall mean percentages indicate a view that the two elements are important counterpoints that provide balance to the new approach. Workers in non-metro counties put more emphasis on the protocol (62.5 percent) than workers in the two metro counties (50.5 percent). Workers in metro counties saw the two elements as of essentially equal importance. Across all 20 counties, however, there was considerable variation, with workers in 5 counties seeing funding for services the more important factor

The survey question about the relative importance of the protocol and service funding presented workers with a forced choice and required them to indicate a percentage for each element. And during interviews it was clear that some workers had a clear choice concerning the primary importance of one or the other. During one interview with three AR workers, the following exchange occurred:

Question: "What is the relative importance of: the new way of approaching families in AR versus being able to provide services to meet their needs?"

Worker 1: "By far the approach is the more important factor. It allows us to keep it positive."

Worker 2: "But many families work with us because of the service dollars. The funds help remove stressors—we can help them with rent payments, payments for moving expenses, transportation, a lot of things that really make a difference."

Worker 3: "The bottom line is that AR helps to relax the family. Makes them more cooperative. The emphasis is on what's good for the family-- what's helpful, informative, and supportive. Families respond better because of the approach but also because we can really help them with specific needs they have. It makes our job easier and more effective."

A number of workers noted that the approach was more important and the primary element because there would always be families who did not need services or who would not accept them but could be helped nonetheless through the supportive, strength-based and participatory approach that marked AR. But for many workers the question about the relative importance of the two AR elements was not an easy choice, and some saw it as a false choice. One said, "You can't separate the two because why would we find out about needs if we couldn't address them."

Most workers saw both elements as indispensable, even when allocating greater or lesser importance to one or the other as they were asked to do. For most, however, the two elements were two sides of one coin, and some could not envision one succeeding

independent of the other. In addition to providing concrete assistance families needed to ensure the well-being of their children, the availability of funds was generally seen as reinforcing workers efforts of convincing families that they cared about them and wanted to help them deal with issues that confront them. The positive and participative approach (“families now drive the case plan”) made it more likely that families would be cooperative and accept help in the form of services they needed, and by giving them a vested interest in the process, increased the likelihood that services offered would be accepted and would make a difference.

In the survey, workers were also asked whether they thought the AR approach would be effective if there were no additional funds for services; that is, if it consisted only of the protocol and efforts to find additional unfounded service resources to assist families in their communities.⁷ A small percent (15.6 percent) of workers answered “yes” without qualifications that the AR approach would be effective. The majority (62.5 percent) answered “yes, but not as much,” indicating their belief that some additional funding for services was integral to the effectiveness of AR. A second minority (15.6 percent) said simply “no” – AR would not be effective without additional service funds. And a few were unsure. Workers in the two metro counties placed a greater weight on the importance of additional funds for services than did workers in the other counties (see Figure 6.8). The response of the workers in the non-metro counties particularly shows a strong conviction that the AR approach itself has great merit in working with CPS families.

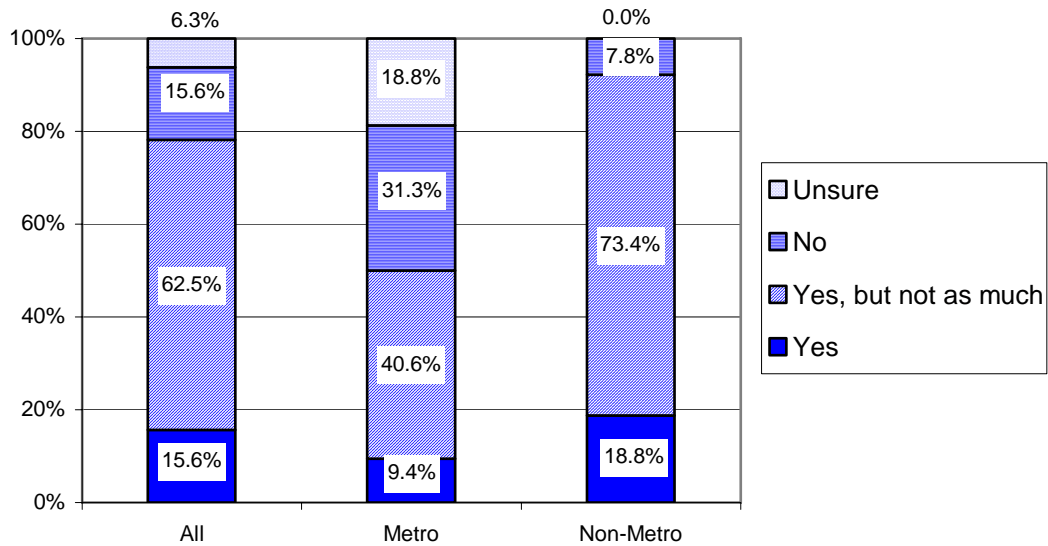


Figure 6.8 Would the AR approach be effective if there were no funds available for additional services?

⁷ This was the approach in the State of Missouri in 1994 when a differential response was introduced into a set of test counties and, while a change in approach was permitted, no funds were authorized for services.

Level of Understanding. It is fundamental to the correct implementation of a new program that workers understand the goals and program philosophy on which it is based. In the first worker survey conducted in 2001 and again in 2004 workers were asked how well they understood the goals and philosophy of the alternative response approach being implemented in the demonstration. The responses of different groups of workers are shown in Figure 6.9. The first set of bars at the top of the graph shows the responses of all workers engaged in AR, fully or partially, in 2001 and 2004. The second set of bars shows the responses of workers involved in AR only and the third set are those of workers involved in both AR and TR. The bottom set of bars shows the responses of workers involved in TR only. As can be seen those in the AR-only group have the greatest confidence in their understanding of AR, and, as might be expected, those in the TR-only group are the least confident of the workers. In each set of bars, workers in 2004 indicated a more thorough understanding of AR. While it is essential that workers engaged in AR have a clear understanding of the AR approach, there are benefits to all CPS workers being fully grounded in the approach. Beyond helping to make the child protection system more coherent, it facilitates the switching of cases from TR to AR when this is appropriate and beneficial to families. Moreover, it is unlikely that many key stakeholders in the community will understand AR as fully as might be desired while some CPS staff remain less than fully informed about it.

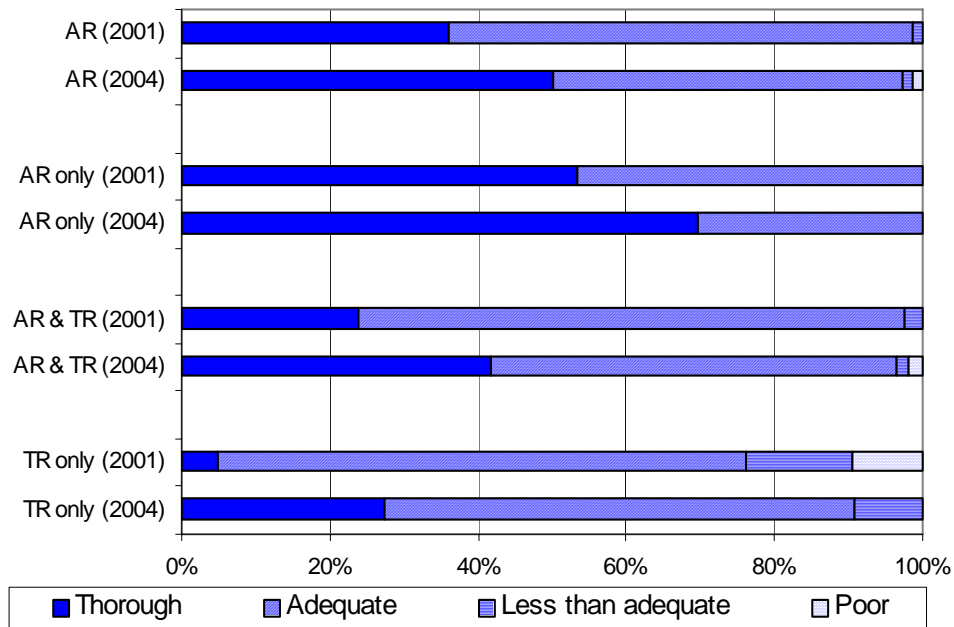


Figure 6.9. Workers' ratings of their knowledge of the goals and program philosophy of the AR approach.

Training. Workers were asked if they felt they needed more training related to Alternative Response. A minority (42.6 percent) indicated they did, but just 4.6 percent said they felt they needed “a lot” of training while 38.0 said they could benefit from “a

little.” Half of the workers (49.1 percent) said they did not need additional training while the rest (8.3 percent) said there were unsure. The percent indicating the need for training dropped in the 2004 survey from the 2001 survey, as we would expect, when 61.1 percent said they needed additional training in AR

In interviews during site visits, county CPS staffs frequently referred to the helpfulness of training provided by DHS administrators. Social workers found the training helpful in understanding the program generally, in implementing the AR protocol, and in utilizing assessment tools. Workers “appreciated” training that provided “practical examples and practical theory.” Only an occasional worker complained mildly of “too much theory.” A number specifically mentioned the helpfulness of training on strength and solution-based approaches as well as strength-based interview techniques. The helpfulness of skill trainings on crisis intervention and understanding safety signs was also commented on.

Asked about additional training, if any, they would like, a variety of general things were mentioned, such as the need for ongoing support and periodic updates on AR, refreshing knowledge of AR philosophy and principles. Some asked for additional clarification for distinguishing AR and TR cases in screening and for additional guidelines on aspects of the protocol, such as under what circumstances children in AR families could be approached separately. Some workers also asked for more skill training on using assessment tools, dealing with uncooperative families, and approaching families where there were domestic violence and substance abuse issues. Some asked for training to be extended to included professionals of key community agencies and institutions, such as the police, schools and courts.

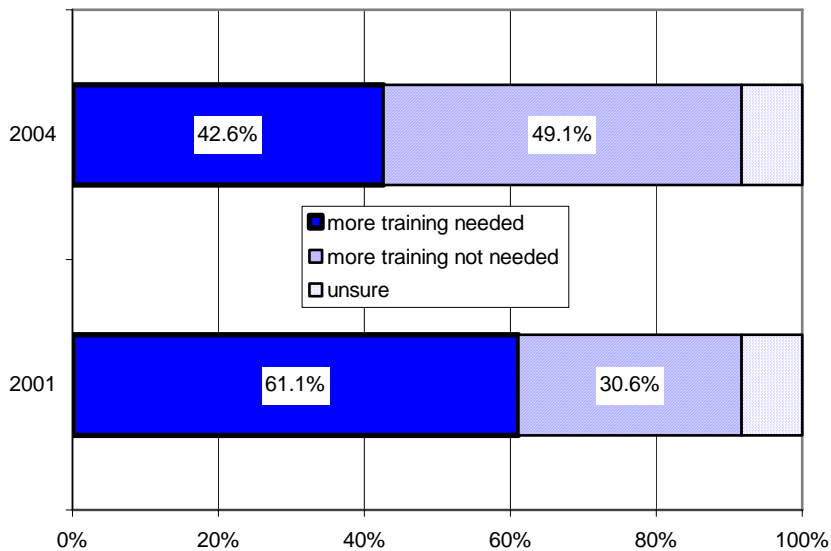


Figure 6.10. Percent of workers who indicated the need for more training.

Worker Job Satisfaction and Workload. Workers were asked about their level of satisfaction with the child protection system in place in their county and about their job and workload. In the survey, workers were asked these four questions:

1. How satisfied are you with the Child Protection System in place in your county?
2. How satisfied are you with your child protection job?
3. How satisfied are you with your workload and duties?
4. To what extent do you feel “burned out” by the demands of the job.

They were asked to respond on a 10-point scale. For the first three questions, the scale went from “very dissatisfied” (1) to “very satisfied” (10); so a higher number indicated greater satisfaction. For the last question, the scale went from “not at all” burned out (1) to “completely” burned out (10); so a higher number indicated greater job stress. The mean responses of workers in 2001 and 2004 to these questions can be seen in Figure 6.11.

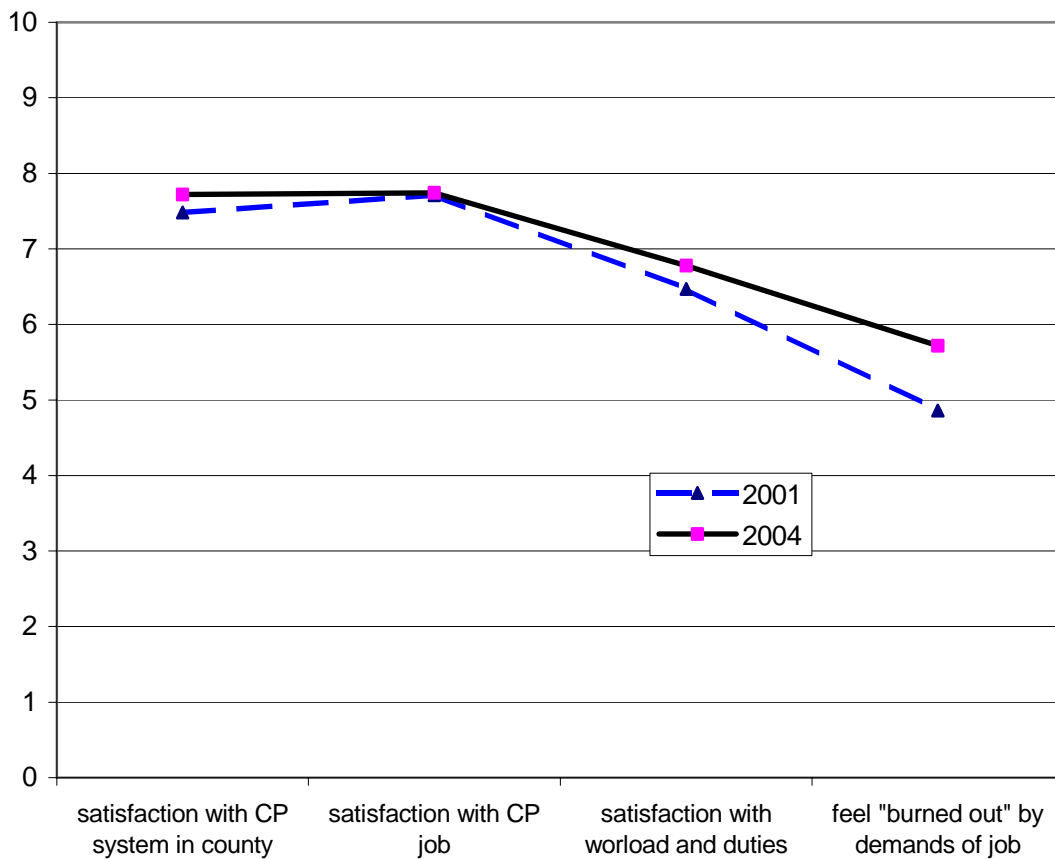


Figure 6.11. Worker ratings on job satisfaction and workload questions (1= very dissatisfied; 10= very satisfied)

Responses between the years were not significantly different on questions about level of satisfaction. Overall, worker satisfaction with the CPS in their county and with their jobs was relatively high. Satisfaction with workload and duty was not rated as high but still on the positive end of the scale. Responses about “burn out” were mixed, with the mean falling closer to the middle of the scale indicating some level of stress, although not high on average. The reported level of stress was higher in 2004 than 2001 ($p = .02$) for all responding workers and for the same set of workers who responded to both surveys.

In Figure 6.12 the responses of workers from metro and non-metro counties from the 2004 survey are distinguished. Workers in outstate counties were somewhat more positive in their assessment of the CPS in their counties than metro workers ($p = .03$). There were no differences, however, in their assessment of their own job or workload or in reported feelings of burnout.

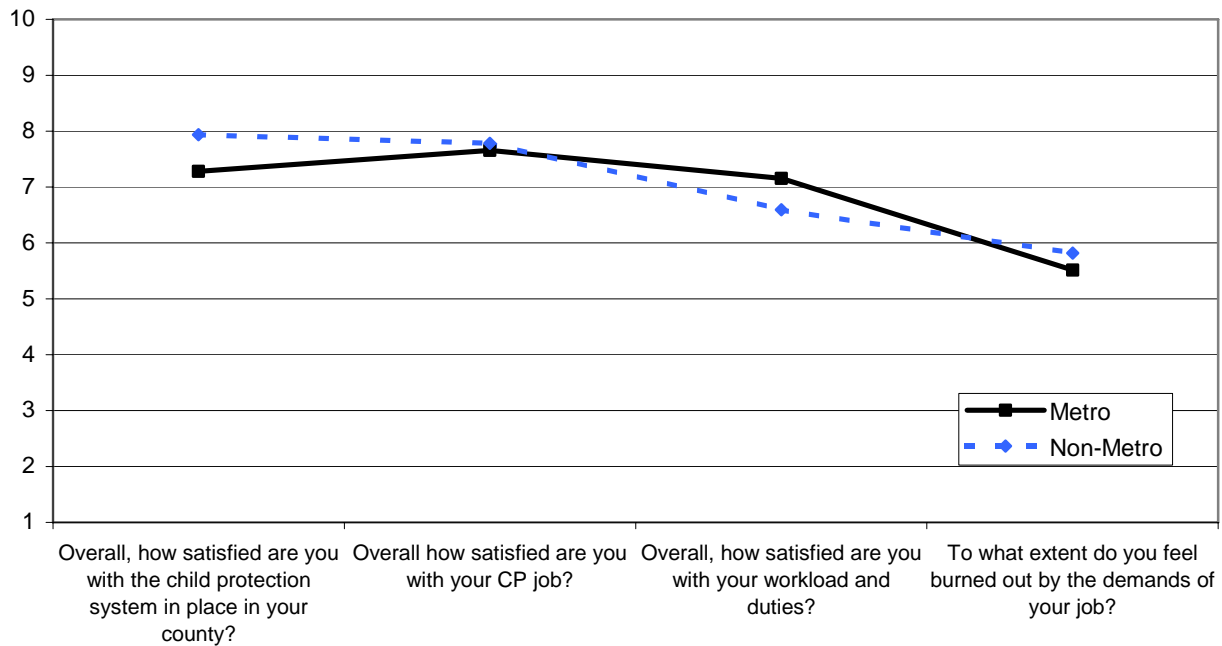


Figure 6.12. Metro and non-metro worker ratings on job satisfaction and workload questions: (1= very dissatisfied; 10= very satisfied)

In the survey, 4 in 10 workers (41.6 percent) involved in AR reported that their caseload had increased due to AR, half of these saying the increase had been large. A larger percent (52 percent) said there had been no change in the size of their caseload and a few said their caseload had decreased. Nearly half (48.8 percent) said that AR had increased their workload; most (41.9 percent) of the rest said AR had not impacted their workload. Half (50.6 percent) of the workers said AR had increased their paperwork.

Finally, about 3 in 10 said AR had increased their job-related stress, including 1 in 10 who described the increase as large. On the other hand, a slightly larger percent (34.4) said their stress level had diminished and about as many (35.2 percent) said AR had not affected their job stress one way or the other. (See figure 6.13.)

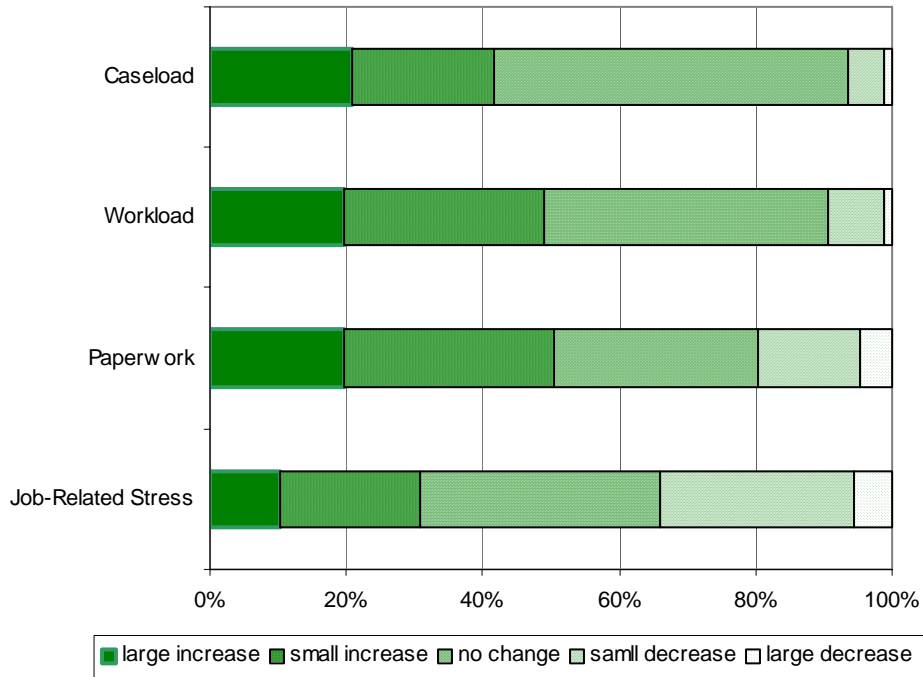


Figure 6.13 Impact of AR on workload and job stress according to workers.

A sizeable minority (44.4 percent) of the workers surveyed said that the introduction of AR made it either a little more or much more likely that they would remain in this field of work. Only a few (5.6 percent) said it was a little less likely they would not remain in child protection and none said it was much less likely they would stay in the field. Half of the workers said AR would make no difference in any such decision. (See Figure 6.14)

Looking at the difference between workers in metro and non-metro counties (Table 6.1), we can see that in neither group did many workers report that AR was a disincentive to remain in the profession. At the same time, more metro county workers tended to say that AR has had no effect on any such decision, while workers in outstate counties were more likely to say AR was an added incentive for them to remain in child protection. This difference reflects an overall higher level of enthusiasm for AR among workers in outstate counties.

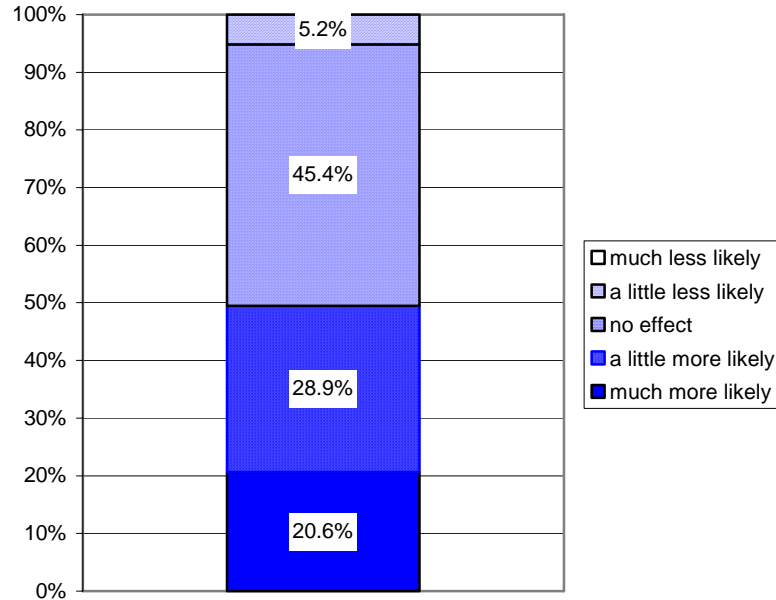


Figure 6.14. Impact of AR on likelihood that workers will remain in CPS field.

Table 6.1. Likelihood that workers will remain in CPS field because of AR

	metro-area workers	non-metro area workers
much more likely	6.3%	27.7%
a little more likely	21.9%	32.3%
no effect	65.6%	35.4%
a little less likely	6.3%	4.6%
much less	0.0%	0.0%

Worker Attitudes toward AR. A large majority of workers in both interviews and comments made in surveys expressed a positive attitude toward AR. A majority indicated that non-judgmental, strength-based and empowering approach to families fostered by Alternative Response had a positive effect on their practice. Workers also indicated that AR allowed them to focus on the family as a whole and provide support, advocacy as well as more immediate help and referrals to community services and resources.

Generally, according to workers, AR builds more positive relationships between families and themselves as well as changes adversarial view of child protection system. Workers tended to like the fact that AR is not as “punitive,” “intrusive,” “threatening,”

“labeling,” “blaming,” “shaming or antagonistic” as the traditional approach, which focuses on investigation, documenting incidents and making determinations.

As one worker said, AR “takes pressure off of the family and lets them take more responsibility in their actions by learning to work with Social Services in remedying a problem other than being court-ordered and getting defensive at the start.” Another said the AR approach is “more respectful and cooperative with the families’ own boundaries and privacy”.

Many of the workers spoke of the benefit of a holistic approach to families rather than meeting all family members separately. This is perceived by families as being very family friendly and encourages more collaboration and involvement of families in creative thinking, decision-making, and goal planning. It allowed families “to take a good look at their family dynamics and how it operates as a system” and focuses on “looking forward with the family rather than looking back at an incident”. As one worker commented, “family-driven goals seem more effective than the agency determining the goals” and asking parents about their ideas makes the new approach more “social work oriented, rather than authority oriented.” Thus families avoid becoming “dependent on the system” or “becoming ‘caught’ in the system”.

A number of workers also indicated the importance of immediate assistance and flexible money provided through the AR budget. These funds helped families address some financial needs and made significant difference especially when, according to one worker “about 99 percent of the families I see are poverty stricken” and “AR money can alleviate a problem which may be the very source as to why families is involved with Social Services”.

There were also workers who indicated that the AR approach worked better with their personalities and belief systems. With AR workers felt more connected with families and able to establish “better rapport” and to offer help instead of offering a “threatening, investigative, police-based intervention.” One said, “I wouldn’t do this job without AR. Our job is child safety, not prosecution.” Workers reported that that they preferred the role of “helping professional rather than investigator” and felt able “to form more trusting relationships with the families” which was “more rewarding” for them as professionals. In addition, workers felt “happy to be able to offer an approach that is not blaming and shaming.”

Workers also reported that due to the AR approach they became more aware of services and resources available in the community and “expanded their practices.” One said, “AR has made me examine community resources. Not every family is the same—one size doesn’t fit all.” Another noted that immigrant families were among those most helped by AR “because we can help them access the service system. Many of our most successful cases are with non-English speaking families who aren’t as aware of the resources that can be found in the community.”

At the same time there were workers who spoke of an increased workload that included additional paperwork as well as time and effort for building relationships with families. A couple expressed dissatisfaction with the lack of a feedback mechanism to find out about treatment outcomes for families who had contacted community agencies to which the worker had referred them. A number of workers expressed disagreement with the voluntary nature of AR participation, suggesting that this requirement was awkward to present to families and not always the best path to pursue in situations in which there were no other reasons to switch to the TR approach but in which some additional intervention or assistance was advisable.

Observations. The most striking thing noticed when talking to workers about AR was how much most had bought into the approach over the course of the demonstration. With few exceptions, attitudes towards Alternative Response strengthened among workers as they have gained experience using it.

These attitudes generally are much stronger in counties outside the metropolitan area of the Twin Cities than they were in Hennepin and Ramsey counties. The two urban counties are different in many ways, of course, from the other counties that participated in the AR demonstration. They have a greater number of cases overall, even as a percent of the population, and, the data suggests, a greater proportion of particularly difficult cases. Beyond this, however, the two metro counties differed structurally in the manner in which they implemented AR. Both counties made greater use of community agencies in the delivery of services to AR families and this is both a strength and a potential problem for them. It is a strength because the community agencies on which they rely bring a wealth of experience and community-connectedness to the people they serve. Some of these agencies specialize in providing services to particular ethnic and immigrant groups and they have forged especially strong ties to these groups. At the same time, the use of community agencies has meant that county workers themselves are not as intimately involved with AR families as are workers in other counties. In Hennepin County, once the initial assessment is completed and an AR family accepts further assistance, the county worker backs off and hands the family over entirely to a worker from a community agency. In Ramsey County this is not done all of the time, but it is done much of the time. The result is that county workers do not have the opportunity to see how AR may make a difference for a family across the course of the entire case. Their contact with AR is more limited and only at the front end of the process where families are most likely to be at their most defensive and cautious.

Evidence collected in the evaluation suggests that CPS workers are more likely to have an accurate understanding and appreciation of AR, whether or not they specialize in it or also do TR, and whether they or community agency workers are responsible for case management, if they are given the opportunity to witness the AR dynamic through all phases of more than a few cases.

Chapter 7. Community Stakeholders

CPS does not operate in a vacuum, but intersects on a regular basis with an array of community agencies and institutions. These include family and juvenile courts, county attorneys or prosecutors, police and sheriffs departments, schools, health and mental health agencies in addition to various community organizations and service providers. The relationship between CPS and these entities is fundamentally dynamic and integrative. Any significant modification to the child protection system will in some way affect the work of professionals in these organizations and will be impacted in return by their understanding and acceptance of it. Such individuals are sometimes referred to as “key informants” by researchers. Professionals within human services systems are likely to refer to them as community stakeholders.

Surveys of community stakeholders were conducted in the project counties in the first and last year of the evaluation, 2001 and 2004. The surveys targeted individuals who were mandated reporters of child abuse/neglect, providers of services to children and families and other persons knowledgeable of the child protection system in place in the counties. Among those surveyed were school counselors and social workers, law enforcement personnel, community attorneys and court personnel, health and mental health professionals, community agencies that provide services to children and families, groups involved in meeting basic human needs, child advocates, as well as members of minority and immigrant-group organizations. These individuals provide an important third-party perspective on the CPS system and the AR approach. There were 362 respondents to the 2001 survey and 364 to the 2004 survey (with response rates of 47.0 percent and 45.6 percent respectively); 151 individuals responded to both surveys.

Figure 7.1 provides a breakdown of the types of individuals responding to the survey across the 20 pilot counties. It shows the types of services respondents said they or their agency provided. There is some duplication across the categories due to respondents in agencies that provided a range of services to children and families. In the 2004 survey, about half (48.4 percent) indicated that they were involved in some way with programs and/or services for children. Over half (52.7 percent) provided counseling or some other aspect of mental health or health services. A little over a third (36.8 percent) were law enforcement or court personnel and about 4 in 10 (43.1 percent) were in education, most often as school counselors or administrators.

In addition to the general service areas listed in the figure, a little under 1 in 4 respondents in each survey were with organizations that specialized in services to minority communities, including recent immigrants. About 10 percent were involved in

Native American service groups and smaller percentages were in organizations that provided services to other groups.

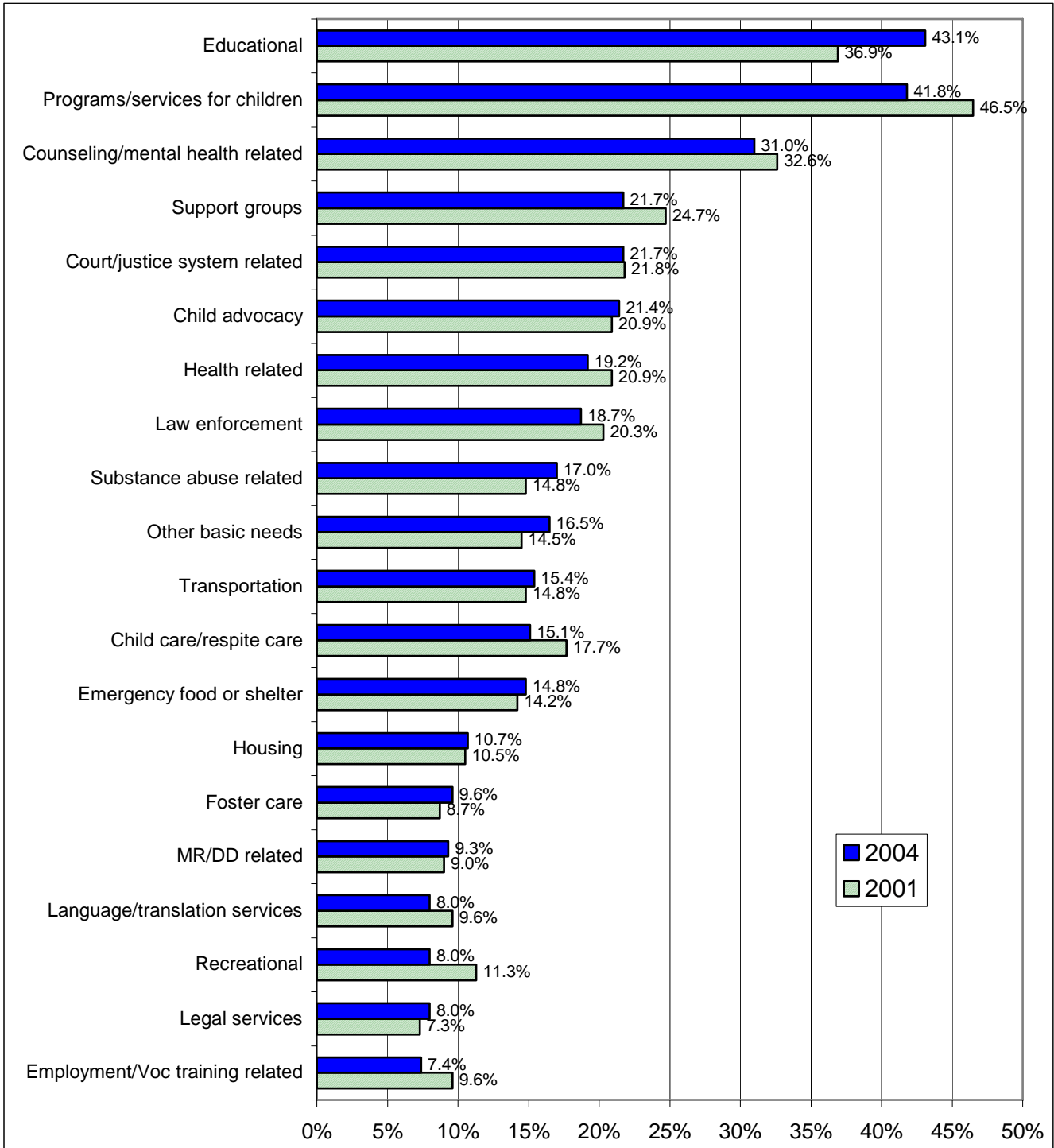


Figure 7.1. Types of stakeholders responding to surveys (percent who said they provided specific services)

Familiarity with AR

A high percentage of respondents reported having some direct contact with child protection social workers (92.5 percent in 2001 and 96.4 percent in 2004). Over half (55.8 percent) of the 2004 respondents said their last contact was within the previous week, and another one-fifth (19.8 percent) said it had been within the last month. Not all of these individuals, however, were aware of AR.

In the 2004 survey, 70.2 percent of responding stakeholders said they were familiar with the Alternative Response approach, up from 55.7 percent in 2001. Much of the increase involved respondents who said they were now “very” familiar with AR, as can be seen in Figure 7.2. Just over half of the stakeholders (52.8 percent) reported in the 2004 survey that they had attended at least one meeting related to AR in which their involvement or assistance was requested; in 2001 this figure had been 44.8 percent.

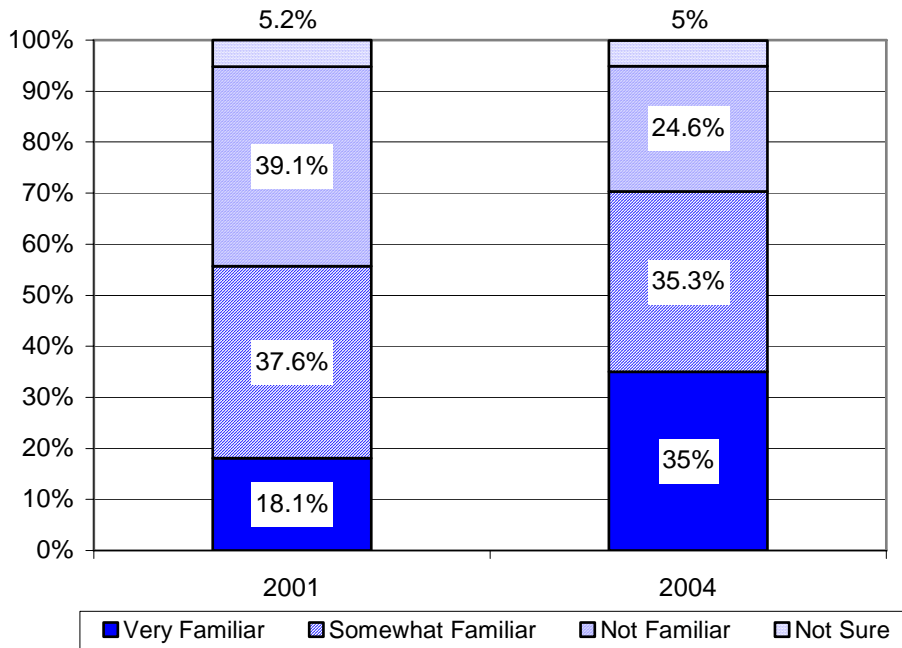


Figure 7.2. Level of familiarity with AR approach reported in 2001 and 2004 surveys.

In general, the level of familiarity was inversely related to the population density of the county of the stakeholder. Stakeholders in the most rural counties reported the highest level of familiarity, followed by those in counties with midsize cities, such as St. Louis County (with the city of Duluth) and Olmsted County (Rochester). This was followed by the suburban counties around the Twin Cities and, finally, Hennepin and Ramsey counties. (See Figure 7.3.) The increase in familiarity reported by stakeholders was found across all major stakeholder groups--all service groups representing 15 percent or more in Figure 7.1. Among these larger clusters (including children’s service

providers, court and law enforcement personnel, health and mental health professionals), educators reported less familiarity than the others.

A number of respondents said they would welcome additional information about AR. Some said they did not understand the criteria used to distinguish families who were appropriate for AR instead of a traditional investigation.

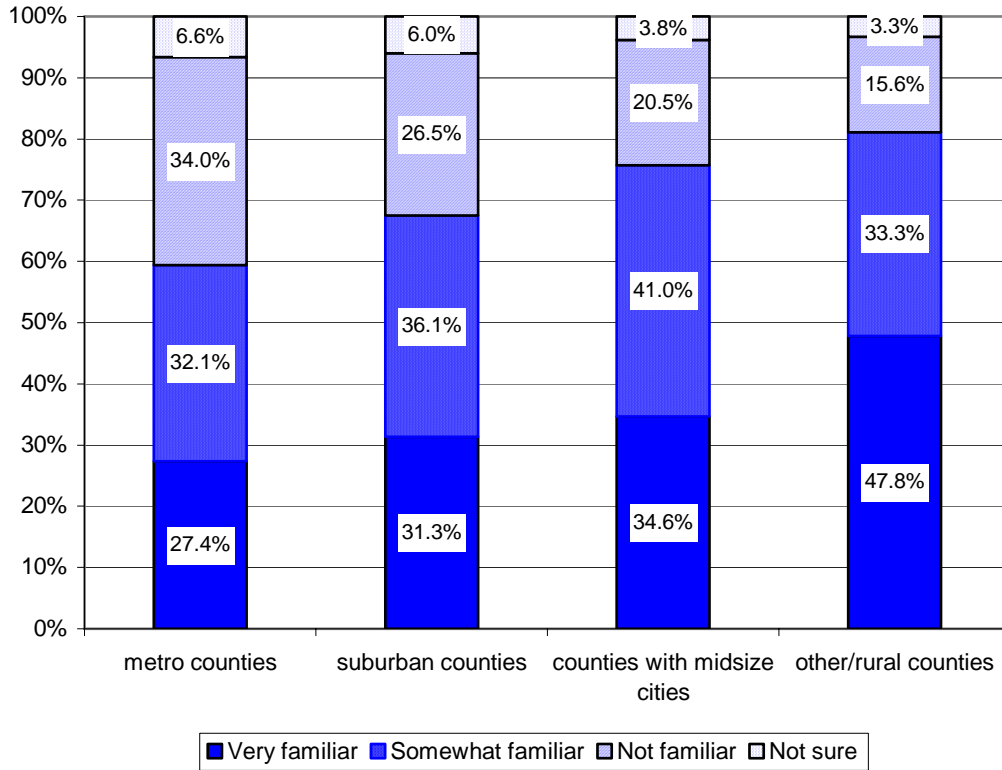


Figure 7.3. Level of familiarity with AR by region reported in 2004 survey

Opinion of AR. The large majority of respondents who knew about AR said that their overall opinion of it was positive. In general, as stakeholders gained knowledge of the approach their assessment grew more favorable. This can be seen in Figure 7.4 which shows the mean favorability rating of stakeholders in 2001 and 2004. The largest increase in positive opinion ($p = .02$) was found among stakeholders in the more rural counties where there was also the highest level of familiarity with the approach. Across all counties, opinion about AR grew more positive among all major stakeholder groups between 2001 and 2004. This included educators, the group with the least positive opinion in the first year of the project. (See Figure 7.5.)

A number of respondents to the 2004 survey explained what they liked about AR. Some focused on its “strength-based approach” that was “less intimidating” and “less threatening” than traditional investigations, and “more oriented on prevention.” Others appreciated “decreasing the adversarial approach to child protection to low and moderate risk families” and “reducing the guilt and shame” of such families. A couple of

respondents commented on how AR can benefit both children and families in “reducing factors that lead to violence.”

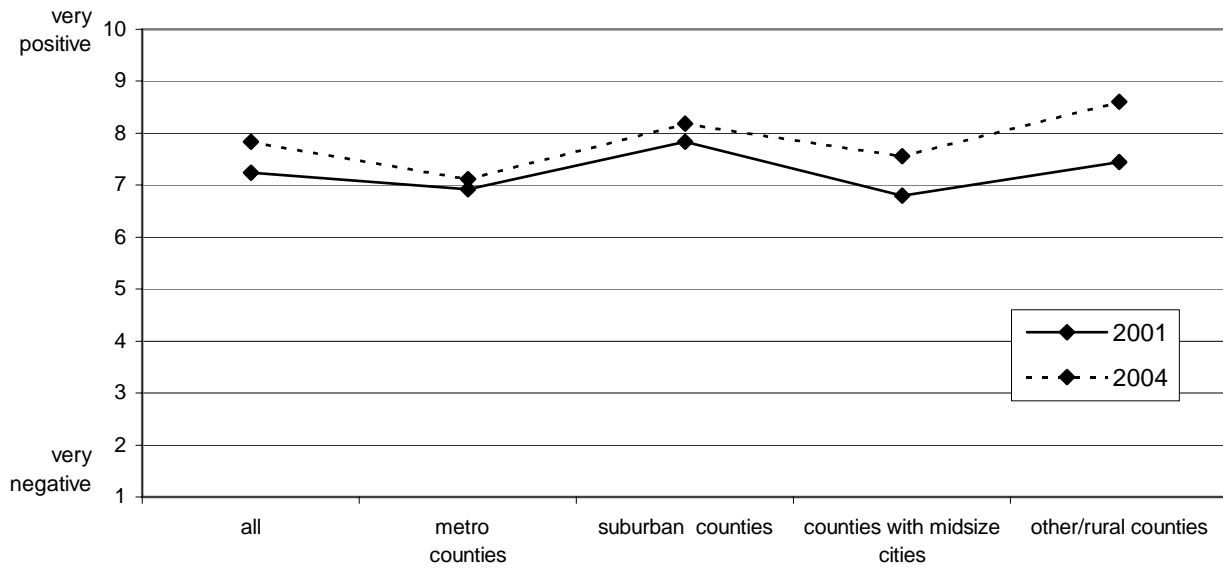


Figure 7.4. Overall opinion of AR by those familiar with it (for all respondents and by county group)

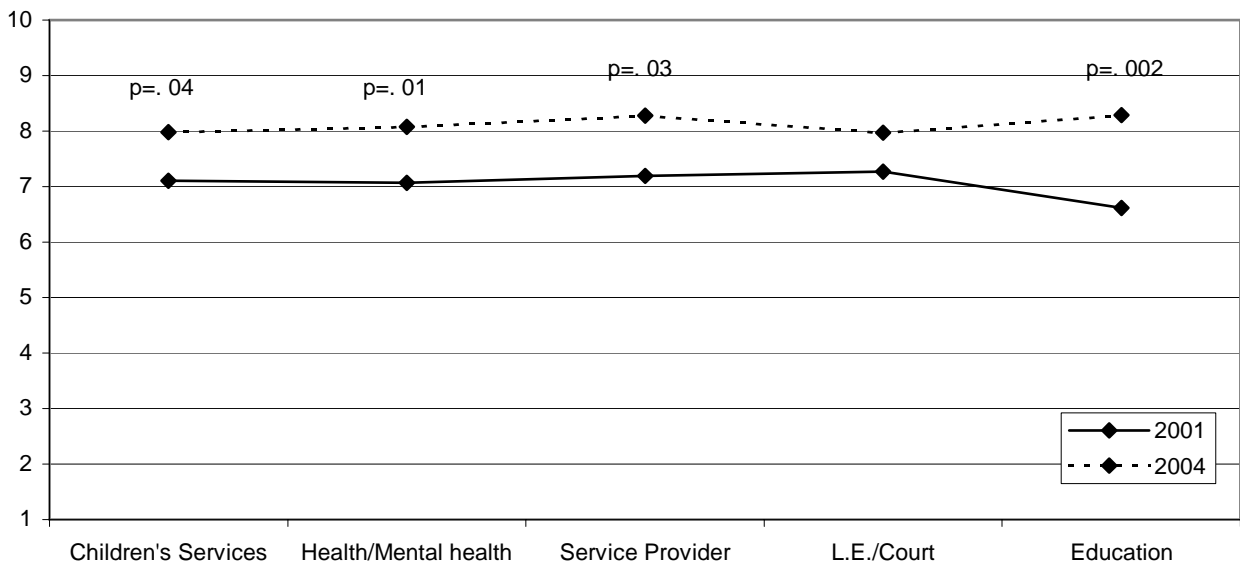


Figure 7.5. Overall opinion of AR by major stakeholder groups

Most comments reflected an accurate understanding of AR and how it differed from traditional investigation. Most of these, in turn, were quite positive, even enthusiastic, in support of the new approach. Such as these:

“AR’s strengths-based approach can help some families really make changes, when parents are can be willing and open to being helped and when the anger and shame are removed. It can be a fine line for workers between protecting kids and assisting parents. It’s a tough challenge, but a worthy one. I hope AR can continue.”

“This is a very positive approach. It is less intimidating for families. The flexibility of funds allows for basic needs to be met, which are critical barriers to many of our families.”

“AR is absolutely necessary. It provides help to families when proof of child abuse and neglect is hard to verify. It provides families with the opportunity to receive help and to help themselves before catastrophe occurs.”

“AR is an excellent concept and a great way to provide efficient, needed services. But it is a process for the family that could take time and immediate results should not be expected in all cases. When accepted by a family and used appropriately it has the potential to lead to lifelong change.”

Respondents with less positive opinions of AR sometimes expressed concerns that AR was a way to save money. One saw AR as “a legal tool to screen out cases so they (counties) don’t have to deal with them and save money.” “It appears,” another said, “that this is nothing more than an ineffective attempt to save money.”

At the same time there were respondents with a highly positive view of AR who also expressed funding concerns. (“It’s a very good program. I’m worried the money will go away.”) Typically, these stakeholders were aware that additional funds had been made available to AR families for services that might not otherwise have been provided. One said:

“I love the approach and feel it is smart, progressive, effective and child centered IF it is adequately funded. I fear the potential of the model may be sabotaged by reducing services available due to funding cuts. That would be tragic as it is an excellent investment for children and families in _____ County.”

Some stakeholders expressed concerns that AR was “not tough enough.” As one said: “I’m concerned that investigations lose their ‘punch’ when AR is used. Families sometimes don’t feel the seriousness.” And a couple expressed concerns about the “voluntary” aspect of AR, believing “families can just refuse services and do whatever to get by, but not change.” Another said in a critical comment:

“I think it (AR) has decreased the adversarial view of child protection services. However, I think many at risk families can ‘game’ this system as well as or better than the traditional response, and it hasn’t decreased the amount of child abuse/

neglect in this county. It probably has made life easier for the social workers, and saved some money.”

But other respondents saw AR differently. One school social worker commented: “AR assists me greatly with families resistant to do what is necessary for their child's success’. And court and law enforcement personnel, as shown in Figure 7.5, were largely supportive of AR. Some of the positive comments of such persons addressed the effectiveness of AR in keeping families out of court. One assistant county attorney said:

“AR is extremely beneficial--it helps serve families who don't need the court's involvement and saves court time for those who do. This program has helped my caseload. At the same time, those (AR) families are getting served and the children protected! WONDERFUL! Some parents have tried to say the county has only one way to respond to maltreatment...NOT TRUE!”

Some law enforcement officials also mentioned that AR had, as one put it, “helped reduced the case load of L.E.” Another said:

“As a Law Enforcement officer, the A.R. approach frees up our time for other things. If the social workers encounters something criminal in nature, we can then be contacted and become involved at that time. I am very happy with the A.R. approach.”

The majority of respondents simply expressed brief, positive comments about AR, with some wanting to see the approach expanded. Others liked the two-tiered approach to CPS.

“I think AR is a positive program. I have not heard any negative comments about it.”

“It's great to give some low-incidence families a much less threatening option. AR is a great program.”

“AR appears to be a very effective way to address child protection concerns. Families respond very positively to the AR social workers!”

“I think it is a good tool which should be expanded.”

“I would like to see this service be available to more families. Families where neglect is the issue we could use some more preventive intervention. Many families ask for assistance but do not receive it because they are considered lower risk.”

“Think that having both a traditional and an alternative response to child protection issues is important. Many families will respond very favorably to the strengths based AR approach, where they are assisted with their problems, not made to feel guilty or threatened.”

“I think AR is GREAT. If it doesn't work it can always be switched to traditional CPS.”

Child Safety. In the 2004 survey, stakeholders were asked if they had any concerns that the AR approach might put the safety of children in jeopardy. A little under half (45.0 percent) said they had “no concerns” (16.9 percent) or “very little concern” (28.1 percent). A little under a third (30.5 percent) said they had “some, but not major concerns.” A small percentage (8.4) said they had “major concerns” that AR might jeopardize child safety. While the others (16.1 percent) said they were “unsure.” As can be seen in Figure 7.6, stakeholders in the two metro counties were more likely to have safety concerns than those in outstate counties.

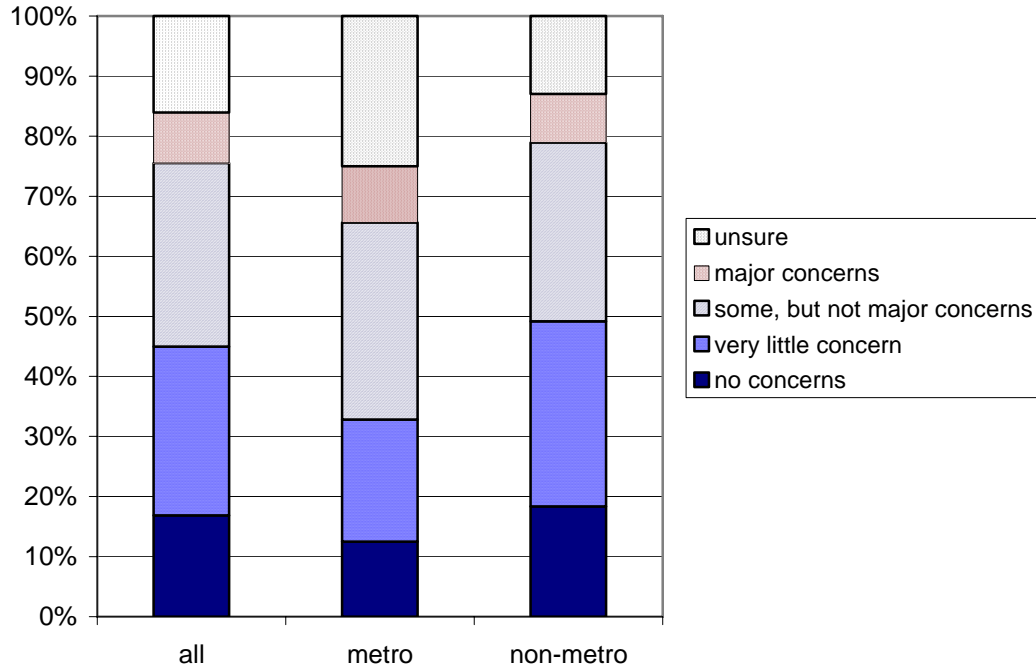


Figure 7.6. Level of concern among stakeholders that AR puts child safety in jeopardy.

Asked whether they had any direct knowledge that the AR approach had put the safety of children in jeopardy, only a few respondents said they had. Nearly 9 in 10 (88.1 percent) said they had no such direct knowledge. Four percent (4.0) said they had knowledge about one such case, while 6.7 percent said they knew of a few cases. Three of the respondents (1.2 percent) said they were aware of “many times” in which child safety had been jeopardized by AR. As before, those voicing safety concerns tended to come from the metro counties. (See Figure 7.7)

Perception of Child Protection Staffs. Stakeholders were asked questions about child protection social workers in their counties. The questions were not meant as an evaluation of the work of social workers. However, because social workers are the point of contact between the child protection system of a county and the rest of the community, the views of stakeholders about CPS workers are important. Their responses

to the questions in the surveys were an indication of how county child protection programs were perceived in their communities across an important set of dimensions.

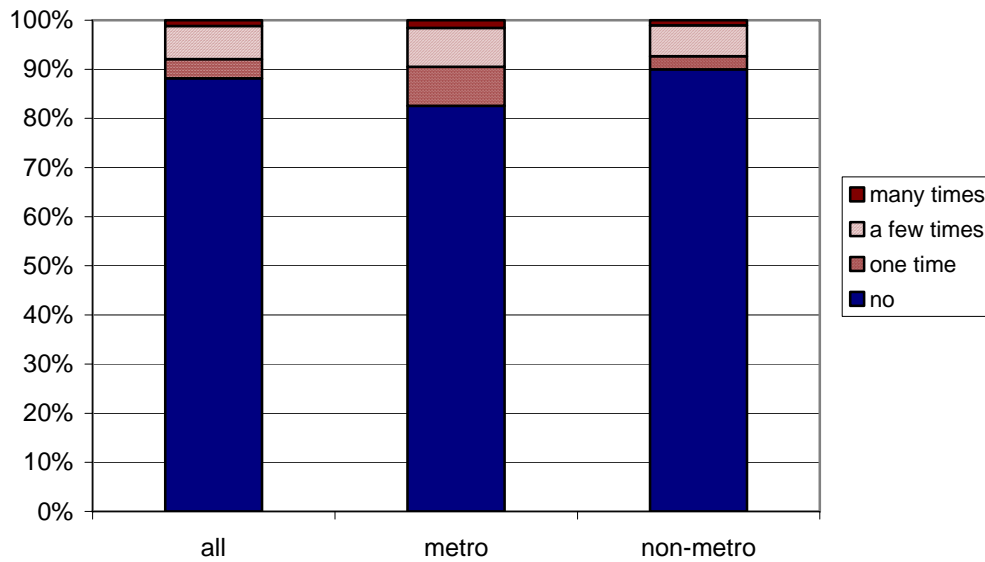


Figure 7.7. Percent of stakeholders with any direct knowledge that AR had placed child safety in jeopardy.

Respondents were asked to indicate their assessments on 10-point scales on which 1 represented the most negative assessment and 10 the most positive. The questions were:

- a. How much do county CPS workers know about the services you (your agency) provides and the type of people you serve?
- b. How effective are county CPS in making use of the resources available in your region?
- c. To what extent do you view CPS social workers as a source of services and assistance to families in your community?
- d. What do you perceive to be the level of satisfaction with count CPS workers among families they serve?
- e. How adversarial or supportive is the relationship between CPS workers and the families with which they work?
- f. How would you rate the level of job satisfaction among the CPS workers you know?

Figure 7.8 shows the mean response of stakeholders on each of seven questions. Respondents sometimes commented that the answer to some of the questions depended on individual workers. Some workers were viewed as more knowledgeable than others, some more likely to make better use of available resources in the community than others, and so forth.

The same questions were asked in the 2001 and 2004 surveys. As can be seen in the figure, the mean responses of stakeholders were more positive on each question in 2004 than they had been in 2001. Among the various stakeholder groups, the most positive responses on each question were those of law enforcement and court personnel, critical elements in the broader child protection system. Stakeholders outside the metro Twin Cities area were more positive on all questions in both surveys than their counterparts in Hennepin and Ramsey counties.

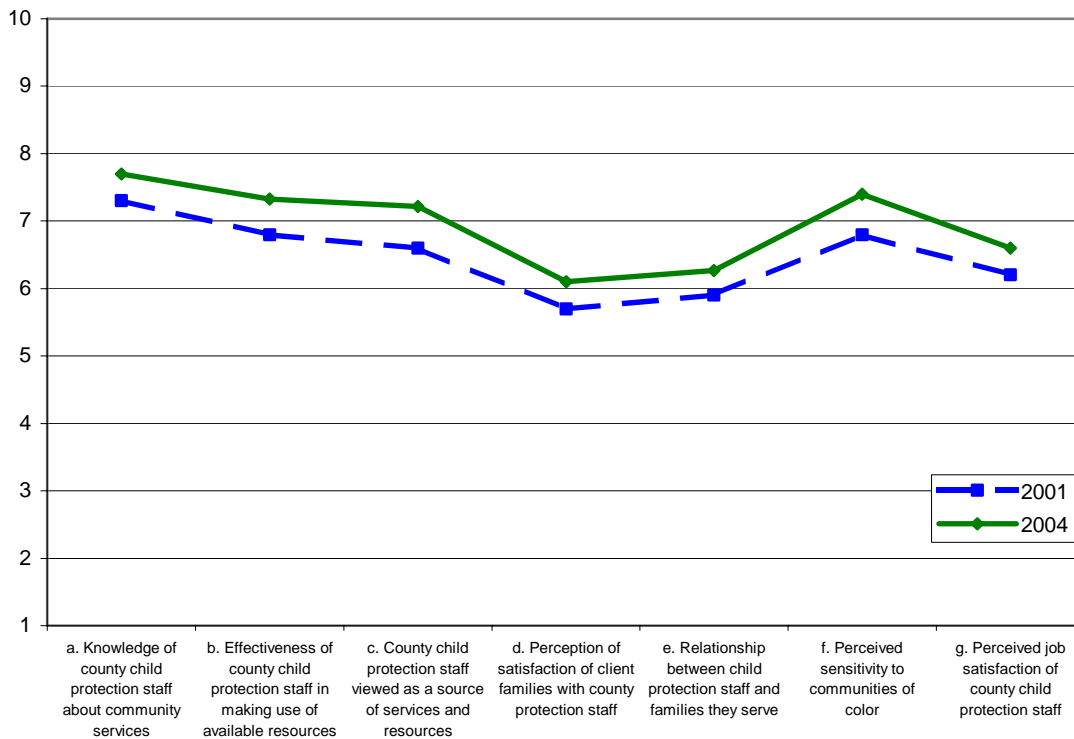


Figure 7.8. Community Stakeholder Perceptions of County Child Protection Staffs (1 represents the negative end of the scale and 10 represents the positive end.)

Among all respondents, the largest increase between 2001 and 2004 was in viewing CPS workers as a source of services and resources for families with which they worked ($p < .000$). Significant improvements were also found in the perceived sensitivity of workers to communities of color ($p = .001$) and in the knowledge of CPS staff of community services ($p = .002$).

Conclusion. It is clear from the responses of stakeholders who were surveyed that a majority of these key community representatives support AR and view it as a positive development in their county’s child protection system. At the same time a relatively small minority of such persons remains unconvinced. At the end of the demonstration period, these individuals remained skeptical that a family-friendly approach was tough enough to get some parents to change their behavior towards their children and some were concerned for the safety of children in certain situations. Overall

it appears that increased familiarity with the approach increases the comfort level of the community with it. The response of stakeholders tended to parallel the views of county CPS workers. In counties in which workers had a strong positive view of AR, this was reflected in the views of stakeholders. Whereas in counties in which workers were more ambivalent many stakeholders remained either less informed or more skeptical about AR.

Chapter 8. The Impact of Alternative Response: Background and Methods

Introduction

The object of the impact evaluation was to determine whether real differences in outcomes occurred for families that participated in the AR program and whether those differences can be attributed to the introduction of the new approach embodied in AR. The outcomes of primary concern were child safety, family risk of future child maltreatment, recurrence of reports and cases of maltreatment, future removal of children from families because of maltreatment, and family reports and views of their own well being.

The primary goal of traditional CPS is assuring child safety. Child safety threats refer to conditions that will, with high probability, result in child maltreatment in a short timeframe. At the same time, there is the recognition that CPS also has the responsibility to address the causes of safety threats and child maltreatment. The causes may not themselves be safety threats but may, along with other factors, directly or indirectly lead to situations in which safety problems and child maltreatment emerge.

At a simpler level, certain characteristics have been shown to be correlated with child maltreatment. Child safety problems and child maltreatment tend to occur more often in families with certain characteristics than in families without those characteristics. Variables correlated with the emergence of child safety threats or child maltreatment are referred to as “risk” factors.

Risk factors include past incidents of child maltreatment, but most risk factors are characteristics that we would identify as child and family *welfare* deficits. Correlates are *predictors* of maltreatment. But saying that risk factors—poverty, unemployment, mental illness, substance abuse, deficits in parenting knowledge and skills, developmental disabilities of children, and others—predict safety/maltreatment implies that child safety treats and child maltreatment occur *because these conditions exist in families* and, therefore, addressing them should reduce future child maltreatment. As we have noted, one of the emphases of the AR approach is to assess the strengths and needs of families more broadly from the very first encounter and to address needs with services. In Chapters 4 and 5, we demonstrated that significant changes in provision of services took place under AR.

We have also noted that AR was designed to change the traditional investigative protocol. AR family assessments continue the investigative emphasis on child safety while moving away from concerns of identifying perpetrators and victims and proving maltreatment. The emphasis of AR is family engagement, family participation in decision making, and voluntary participation in services. In the previous chapters, we have also demonstrated, based on responses of families, workers and community stakeholders, that various dramatic changes occurred in these areas as well.

Substantive changes in practice, the preconditions to change in outcomes for families, occurred, and they occurred because AR was introduced. In the following chapters, we consider the ultimate “so what?”—whether these changes made any differences in the lives of families and children.

The Impact Research Design

As noted, the goal of the impact evaluation was to determine whether different outcomes transpired in the lives of families that participated in the AR program and whether those differences can be attributed to the introduction of the new approach embodied in AR. An impact study requires some form of comparative method to evaluate the significance of observed changes—ideally a control group. The Minnesota AR impact evaluation was designed as a *field experiment* utilizing random assignment. Groups generated through random assignment are similar on most major dimensions.

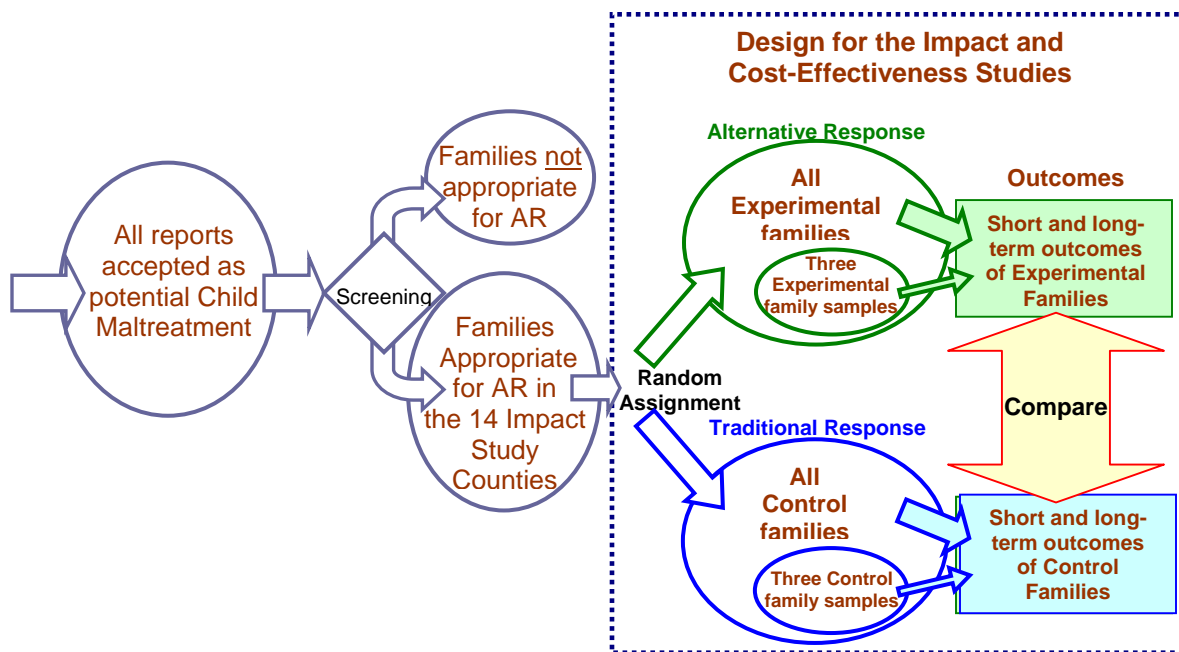
Experimental and control families are the main focus of the analyses described in the following pages. Because of the centrality of the experimental design to the impact study, we want to reiterate here certain points made in Chapter 3. Of the 20 Minnesota counties participating in the study, 6 chose not to permit control cases. These counties could not be included in the impact portion of the study and below are referred to as the **non-impact-study (NIS) counties**. Impact-study families were selected from the 14 Minnesota counties in the demonstration that agreed to permit control group assignment. They are referred to as the **impact-study (IS) counties**. Maltreatment reports on all families, whether experimental or control, had been screened as appropriate for an Alternative Response. Through the random assignment process, a family had as much chance becoming a control case as an experimental case. Workers and supervisors had no influence on assignment. The process is diagrammed in the chart on the next page.

Because all the families in the study were appropriate for AR, the families assigned to the experimental condition were very similar, as a group, to the families assigned to the control condition. The one difference between them was that the experimental families all received an Alternative Response while the control families all received a Traditional Response. The AR families received a family assessment and became eligible for special AR funding, while the TR families received a traditional CPS investigation.

Several thousand families were assigned to the experimental and control groups. They are represented by the larger circles in the diagram labeled “all experimental families” and “all control families.” As can be seen, random samples of experimental and control families were also selected. Samples were selected to permit fuller information to be obtained on representative groups of experimental and control families. Although the diagram shows only one circle for sample experimental families and one for sample control, there were actually three samples of each, two of which have been discussed in earlier chapters—the case-specific sample, experimental and control families on which workers provided fuller information and the family feedback sample, experimental and control families that were contacted to provide feedback—and one that will be discussed in Chapter 12, experimental and control families selected for the cost study.

The outcome boxes in the diagram represent a variety of different information obtained from the Social Services Information System (SSIS), from workers about the case-specific sample, from families about their own situation and experiences, and from bookkeepers and accountants about agency spending on families and children. The heart of the impact study is a comparison of the outcomes for experimental and control families after they were subjected to the traditional or alternative responses.

The experimental assumption is that major differences in outcomes can be attributed to differences in the way the families were treated.



Comparability of the Full Experimental and Control Groups

While random assignment can yield sets of families that are, as groups, very similar to one another, this is much easier to accomplish in an experimental laboratory than in a field experiment, like the present study. The following is a short description of the process of random assignment, possible sources of bias and how the experimental and control groups were prepared for analysis.

Weighted Assignment. Each of the 14 IS counties permitted random assignment of reports that had been screened as appropriate for AR to the experimental group for an alternative response or to the control group for a traditional response. At the same time, each county in the program was assigned a quota of cases for which they could receive financial reimbursement. It was imperative that counties reach their quota to maximize reimbursement to their program. It was necessary, therefore, to manage *both random assignment and quota targeting* through the assignment process. This was accomplished by assigning weights to experimental and control assignment. The assignment to experimental or control status remained random but was disproportionate. For example, a county might have a control weight of .30 and an experimental weight of .70 so that for every 100 cases approximately 30 would be randomly assigned to the control group and 70 to the experimental. These weights were determined by looking at the pattern of cases during the preceding year but also involved a certain amount of guesswork. Thus, the weighting was occasionally changed if intakes decreased or increased beyond expectations and it appeared that the county would undershoot or overshoot its quota. This created the possibility of two peculiar kinds of biases.

First, the distributions of experimental and control cases over the year were different in some counties. If the types of the child abuse and neglect reports vary with the seasons then the experimental and control groups could differ from one another on this basis. For example, a decrease in control cases in the fall after school has started when there is an increase of neglect of basic needs or education neglect reports would lead to an overrepresentation of these kinds of reports in the experimental group. The hope was that such variations would balance each other out across the 14 counties.

Second, the weighting procedure as a whole could lead to a higher concentration of experimental or control cases from particular counties. We know that the AR screening process varied from county to county. Consequently, some counties had greater proportions of more serious safety problems in the AR program than others. Too great an imbalance of experimental and control cases among counties might lead to a mismatch between the experimental and control group overall.

Track Switches. AR or TR status after screening was not necessarily a permanent condition. Screening was made on the basis of information in the maltreatment report and other information on the family that was known to the agency. *Random assignment occurred immediately after the initial screening.* After telephone contacts and visits with family members, other information sometimes came to light that suggested that the original screening was incorrect. For instance, all sexual abuse cases

were screened for TR. If upon visiting a family an assessment worker of a report assigned to AR found evidence of sexual abuse he or she would switch the cases to TR. This was an expected procedure and occurred in a small minority of cases. However, this meant that an experimental case would not receive AR, the experimental treatment, and could not be included in analyses of the effects of the AR approach. Such families retained their original experimental designation but were set aside in analyses. A very small number of control cases were also switched to AR. This procedure was actually prohibited during the first two years but they nonetheless occurred and represented errors in the process. These families were set aside as well.

The Final Group of Experimental and Control Cases for the Impact Study.

Through December 2002, 3,177 were assigned to the experimental condition in the 14 IS counties. Another 2,211 families were assigned to a control group. The impact study was limited to families for whom agency contacts stemming from the initiating report had ended as of March 31, 2004 (the end of data collection for this phase of the impact study). The date of the end of agency contacts represented the close date of the research *treatment phase*.⁸ These amounted to 3,044 (95.8 percent) of experimental cases and 2,103 (95.1 percent) of control cases. Nearly all the closed cases had ended several months prior to the end of data collection. For example, all had closed by December 2003 and only 13 experimental and 20 control cases were still open on October 1, 2003.

Of the 3,044 experimental cases, 170 (3.3 percent) were switched from AR to TR because of findings of workers and supervisors after the family was contacted. As indicated, 35 control cases (.7 percent) were erroneously switched to AR as well. Analysis indicated that the loss of these cases did not influence the overall distributions within the experimental and control groups on demographic and case variables. (The variables included in this analysis were the number of children and adults in the family and their gender, the major types of presenting problems, and racial identification of the family.) The cases were set aside in the impact analysis, therefore, leaving 2,874 experimental and 2,068 control cases.

Problems arising from weighted assignment were analyzed by breaking the experimental and control groups into groups corresponding to the eight calendar quarters (during 2001 and 2002) in which they were assigned. Some variation was observed within individual counties, particularly very small counties, but such variations in the experimental and control population appeared to cancel each other out resulting in highly comparable experimental and control groups. In 13 of the IS counties, no serious experimental-control variation could be found. The exception was Hennepin County (Minneapolis) in which assignment had occurred differently. Weights were assigned to experimental and control cases equally (50/50) for certain periods but more often weighted more heavily toward the experimental, for the reasons described above.⁹

⁸ The “initiating report,” the distinction between CPS “case” and research case, the treatment phase, and the interpretation of the case “closure” are explained in greater detail below.

⁹ In the larger counties, a third residual category was created to which reports were also randomly assigned. This was necessary to insure that the number of AR cases did not exceed the capacity of the AR staff. Counties were permitted to offer either AR or TR to such cases.

During the early months of the project, assignment in Hennepin resembled the other counties in the study. In anticipation of an increase in the number of cases that could be handled in Hennepin, however, a much larger percentage of total reports was later opened for assignment to the experimental or control group, heavily weighted toward the control side with the anticipation that this would quickly be shifted back to at 50/50 weighting. However, Hennepin did not achieve its goal of AR utilization during the two-year period. The consequence was that the control group had become twice as large as the experimental group by December 2002. This led to a vast *overrepresentation* of Hennepin control cases in the study, that is, to an excess of urban inner-city families in the control group. This problem could be solved in several ways, but the simplest was to randomly sample Hennepin control cases.¹⁰ A 25 percent sample reduced the Hennepin control group to a size comparable to the control group in the other 13 IS counties, permitting Hennepin to be included in the impact analysis without jeopardizing experimental and control group comparability.

Finally, in a handful of research cases, workgroups had been erroneously interrelated in SSIS resulting in errors in the construction of families in the research database (see below for an explanation of this process). These cases were set aside as well.

The final study groups for IS study included 2,860 experimental families and 1,305 control families. These groups are compared in the following chart (Figure 8.1). Some of the differences were statistically significant. For example, there were significantly more neglect of basic needs (food, clothing and shelter) and educational neglect cases among the experimentals. These presenting problem categories, however, are not mutually exclusive and may represent different judgments by intake workers about the most important among two or more presenting problems.

There was no significant difference between the proportions of African American and Caucasian families in the experimental and control groups. However, there were significantly more other minorities in the experimental group, a difference that appeared to result from an imbalance in Ramsey County (St. Paul). The largest absolute difference was in the number of caregivers in the family. Whether this difference is real or not is debatable because data on number of caregivers in the family was missing in 6.2 percent of experimental cases and 4.6 percent of control cases due to missing relationship codes in SSIS.¹¹ More control cases had a case opened prior to the initiating report. These data are based on listings of case management workgroups in SSIS prior to 2001, and might be affected by the date of adoption of SSIS (a SACWIS system), which varied from county to county, and the completeness of data transfer from the earlier data systems utilized in the counties. There is, however, no reason to believe this would have varied

¹⁰ An alternative method would have been to apply a .25 percent weight to Hennepin control cases in analyses. This is a more cumbersome procedure that results in essentially no difference in analytic results.

¹¹ This is family level data and reflects adults listed in multiple workgroups that were opened after the initiating report that led the family into the study. An increase of adults is found when family structure changes: for example, when a single parent in a first workgroup has married at the time of a second workgroup. Adults accumulate in families as they are identified in this study. As we will see, fewer subsequent reports and workgroups were opened for experimental families.

systematically for control as compared to experimental cases. The significance of past history in the child welfare system is discussed below in the section in which maltreatment report recurrence and family risk are analyzed and this variable was controlled statistically in the principal impact analyses.

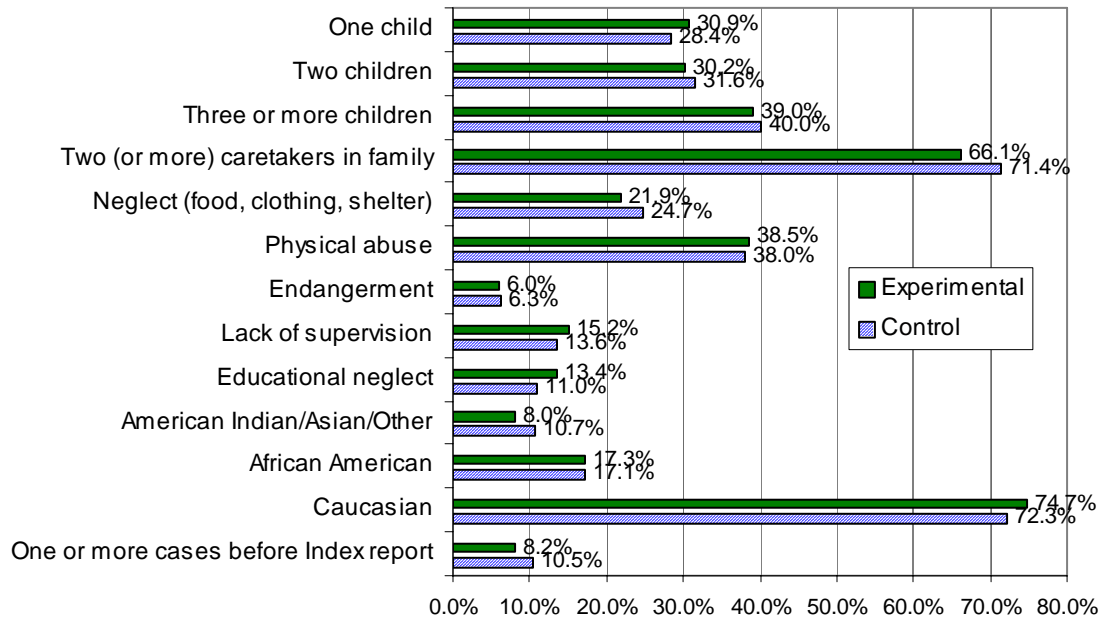


Figure 8.1. Experimental and Control Group Comparison on Select Demographic and Case-related Variables

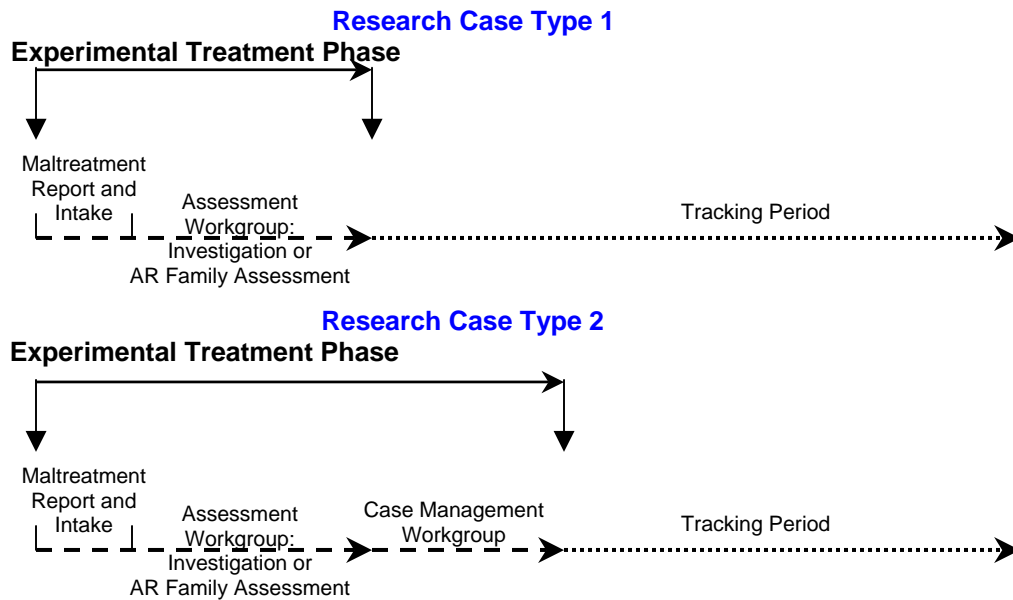
Overall, the final experimental and control groups were very similar. The differences were small, but with numbers of families in this range (1,000 to 2,000) even small difference will be statistically significant. Nevertheless, the differences point to the need to statistical controls, when possible, in analyses of long-term outcomes.

Research Cases and Tracking of Families. The term “case” has a special meaning in the impact study. Cases refer to *research cases*. This does not always mean that a CPS case (called a *case management workgroup* in Minnesota) was opened on the family. Rather it refers to the activities from the time of assignment of the family to the experimental or control condition that are related to the initial child maltreatment report (the *initiating report*) until the end of the evaluation. The early part of the case from the initiating report until the final contact with the family will be called the *treatment phase*. The term does *not refer to social work*. It is a research term and refers to the *experimental treatment*—in this case the difference in approach to experimental families embodied in AR compared to TR.

Two types of research cases are illustrated in the following diagram. In a Type-1 case, the treatment ended after assessment workgroup was closed, representing the end of the initial contacts with the family. A Type-2 research case involved a further opening of

a case-management workgroup. For this type, the research treatment ended after that workgroup has been closed. During the period following the close of the treatment phase we tracked families in SSIS. If new maltreatment reports or new case openings occurred during this tracking period they were recorded in the research database. Other events recorded in SSIS, such as removal and placement of children, were also captured and recorded in the research database.)

Tracking periods varied for each family. In addition, research cases began at various times from the beginning of the evaluation in February 2001 through the end of experimental and control group selection in December 2002. They lasted from a few days to many months. After the end of the research case families were tracked.



The SSIS is county-specific—an amalgam of separate county databases with the same structure but with county-specific identification codes for each case and individual. We received essentially separate databases from AR-project counties each month and semi-annually on all other Minnesota counties. We combined individual county databases into a single research database with research identifiers associated with each family. This permitted us to track families that moved from county to county and to identify new maltreatment reports without regard to the county of the initiating report.

Each research case represented a family. The term *family* refers here to an assembly of children, caregivers and other adults identified in SSIS workgroup records. Workgroups tables contain references to individuals in some way associated with the assessment or case. Data on persons, including demographics and family relationships

were stored in the SSIS person file.¹² Each research case began with an assessment workgroup. In TR cases (the control group), the assessment workgroup consisted of a traditional CPS investigation. In AR cases (the experimental group) the assessment workgroup was an AR family assessment. In most cases, all family members could be identified in the assessment workgroup. However, as *new* case management and assessment workgroups were identified, a check was made for children (e.g., a newborn, a child who was living with relatives earlier, children of a new spouse) and adults (e.g., new adult partner, relatives living in the home) not previously identified. When these individuals were discovered they were added to families. Family members accumulated in this way but were not removed from families.

Assembling families in this way has important implications for variables associated with child maltreatment recurrence. In this study recurrence is not simply recurrence of a child or adult in a new report or case but the recurrence of a new report or case for the entire family. In this way, new reports may or may not refer to the alleged victims, perpetrators or caregivers of past reports, and the maltreatment alleged is more likely to vary compared to studies that focus on individuals rather than entire families.

¹² As alluded to earlier, relationship codes were sometime missing in SSIS for adults along with dates of birth and other critical information. Whether this meant that the individual was only peripherally related to the family or that the worker simply failed to enter the data was difficult to determine.

Chapter 9. Improving Immediate Child Safety and Family Risk

A child is safe when the likelihood of instances of CA/N is low. Children are unsafe when they are highly likely to experience any of the following:

- Lack of food or inadequate nutrition
- Inadequate clothing
- Lack of hygiene considered health threatening
- Unsafe shelter
- Unhygienic living situation
- Inadequate health care and medications
- Lack of proper supervision
- Abandonment or locking out of home
- Abuse arising from physical violence
- Inappropriate or overly severe physical discipline
- Emotional abuse arising from degrading statements, emotional rejection of the child or threats of these or of physical abuse
- Sexual abuse

These categories are not necessarily exhaustive and each includes a range of safety threats from mild to extreme. Furthermore, the categories may include very different kinds of maltreatment. For example, sexual abuse might range from inappropriate touching through sexual intercourse but it could also include using a child for prostitution. The situations in which any one of these types of abuse was threatened might vary considerably. So, we should not assume that situations of children are the same simply because it is possible to categorize them in the same way. Categories like these tend to hide variability among families and group together cases that on more detailed examination would be separated.

Short-Term and Long-Term Safety Protection. Child safety in this section refers to immediate threats that are likely to result in harm if not removed. Within the context of initial family assessment and subsequent service cases, the question is whether the threats are removed or controlled so that children are immediately protected. Safety threats can reemerge or new threats can arise at a later time after cases are closed. This is related to the mission of CPS to address the underlying causes of child abuse and neglect. Child safety may be assured in the short-term while workers visit and monitor families or

during the period a child is placed in substitute care, but may nonetheless recur at a later time after contact between the family and the agency has been terminated.

Initial Child Safety Status as Measured by the SDM Safety Assessment Instrument

Minnesota adopted the Structured Decision Making (SDM) Safety Assessment Instrument as a tool for workers to use in safety planning. This tool had been adopted in certain Minnesota counties at the time the AR evaluation began in 2001. A requirement of participation of the 20 counties in the study was utilization of the tool with each family screened as appropriate for AR. Formal safety assessments were conducted for all reports, including most experimental and control cases of this evaluation.

The SDM safety tool was not designed as a research instrument. Its primary purpose was to assist workers in determining safety problems and developing a safety response. However, it includes the following questions which workers complete with a yes or no response:

1. Caregiver's current behavior is violent or out of control.
2. Caregiver describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.
3. Caregiver caused serious physical harm to the child or has made a plausible threat to cause serious physical harm.
4. The family refuses access to the child, there is reason to believe that the family is about to flee, and/or the child's whereabouts cannot be ascertained.
5. Caregiver has not, or will not, provide supervision necessary to protect child from potentially serious harm.
6. Caregiver is unwilling, or is unable, to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care.
7. Caregiver has previously maltreated a child and the severity of the maltreatment, or the caregiver's response to the previous incident(s), suggests that child safety may be an immediate concern.
8. Child is fearful of caregiver(s), other family members, or other people living in or having access to the home.
9. The child's physical living conditions are hazardous and immediately threatening.
10. Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.
11. Caregiver's drug or alcohol use seriously affects his/her ability to supervise, protect, or care for the child.
12. Other (open-ended, to be completed by worker).

The items cover a variety of circumstances and behaviors that are associated with immediate safety threats to children. The responses of assessment workers to these items reflect the point in time that the safety assessment was completed. In some instances,

workers completed the safety tool soon after the first contact with the family but more often they were completed at the end of the family assessment or investigation. In any event, the SDM safety tool could not be used as an outcome measure because follow-up safety assessments were not conducted at the conclusion of cases. However, the tool could be used descriptively and to illustrate the basic equivalence of experimental and control families.

Using the SDM safety items as a kind of index in which 0 = no item checked and 1 = one or more items checked, counties and study groups can be examined for differences. In Table 9.1, the proportion of families are shown for the experimental and control families in the 14 IS (impact study) counties and the AR families in the 6 NIS (non-impact study) counties. The first finding is, consistent with random assignment, that there was no statistically significant difference between experimental and control families. Experimental-control comparisons for each of the 12 items showed no statistically significant differences except for Item 8. In this instance a child in slightly more control families (1.8 percent) than experimental families (1.1 percent) was found to be fearful ($p = .024$). We attached little importance to this since such a finding for one item out of 12 could itself have been due to chance variations.

Table 9.1. Any Item Checked in The SDM Safety Assessment of Initiating Child Abuse and Neglect Reports (All Study Families 2/2001 through 12/2002)

Study Group	No safety item checked	At least one safety item checked	Families
Experimental - 14 impact study counties	84.2%	15.8%	2,874
Control - 14 impact study counties	84.7%	15.3%	2,068
AR - 6 non-impact study counties	77.6%	22.4%	1,941
Total	82.5%	17.5%	6,883

However, utilization of the 12 safety items varied significantly between the IS and NIS counties. This finding could mean that the safety assessment is used differently but the more likely explanation, consistent with other evidence in this study, is that differences existed in AR screening practices in the NIS counties. Olmsted County (with 26.0 percent of AR cases with checked safety problems) among these six accounted for most of the difference, and Olmsted also had the longest running AR program, predating the AR demonstration by over a year. In Olmsted, more difficult cases tended to be screened into the AR track.

This relationship between the percentage of reports screened as appropriate for AR and the proportion of families with at least one SDM safety item indicated can be seen in the following graph (Figure 9.1). The relationship is not perfect because the numbers of families in some counties were relatively small. Generally, the chart shows that the higher the proportion of reports screened as appropriate for AR, the higher the

proportion of families in those reports with a safety problem indicated. The correlation was moderate to high ($r = .55$). The only large county in the graph that did not fit this pattern was Ramsey County. *This figure provides both validation of the SDM tool as a general indicator of safety status as well as a confirmation that more liberal interpretations of screening criteria result in higher proportions of families with child safety problems entering the AR caseload. At the same time, as indicated, the similarity of the proportions of families with safety problems indicated in the experimental and the control groups supports the validity of the random assignment process across the 14 IS counties.*

Finally, the relatively low overall proportion of families (17.5 percent) with a safety item checked may be an indication of any or all of the following: 1) that families screened as appropriate for AR are more likely to include families with relatively mild safety problems and no safety issues at all, 2) that the 12 items in the scale do not represent a comprehensive list of child safety threats, and 3) that the SDM tool is completed in some cases after safety issues have been addressed and resolved.

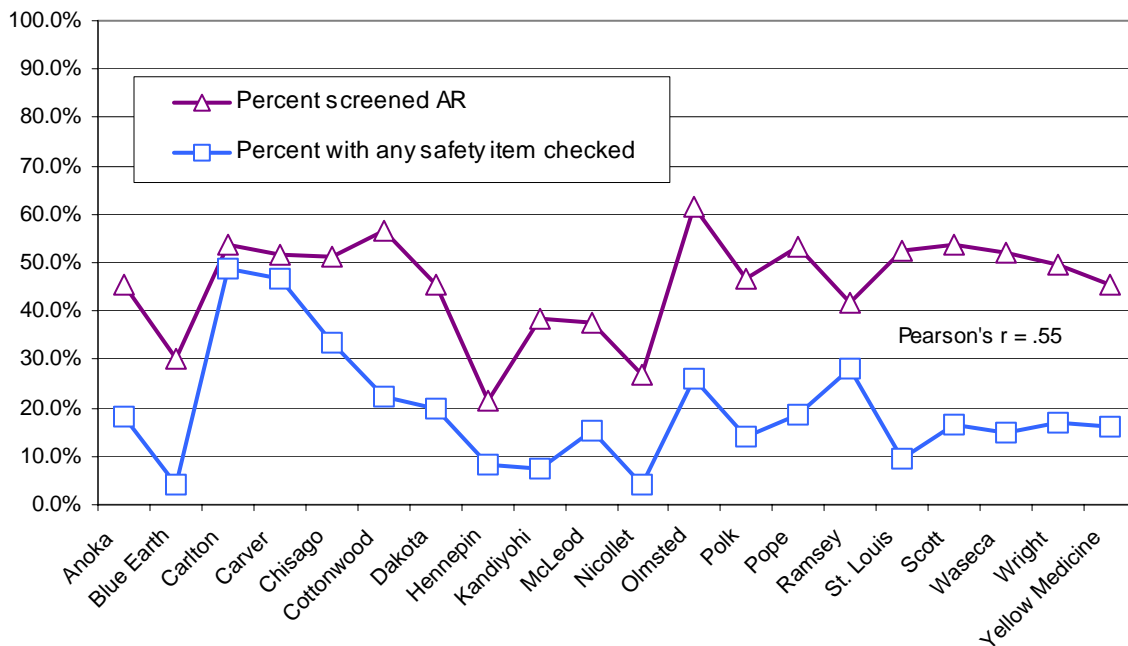


Figure 9.1. Comparison of Percent of all Families Screened as Appropriate for AR with Percent of AR-Appropriate Families with a SDM Safety Item Indicated (February 2001 through December 2002)

Worker Reports of Changes in Safety Status

As previously noted, a case-specific survey was conducted in which workers were asked to respond concerning a representative sample of study families. In each instance, a worker responded concerning a family about which he or she had direct knowledge.

Workers were contacted after the final contact of the agency with the family. Workers were asked to respond in three general areas: 1) changes in safety and 2) changes in family strengths and needs and 3) services provided to families.

Child safety change was measured by asking workers about safety problems at their first contact with the families and again at closure. Rather than focusing on the reasons for any threats to safety workers were asked about specific areas of safety concern. These included the following:

- Child lacked basic needs (food, clothes, hygiene)
- Home unsafe or unclean
- Homeless or potential homelessness
- Abandonment or locking in or out
- Caretaker neglected medical/health care of child
- Educational neglect or truancy
- Other neglect
- Violence to child by caretaker (non-disciplinary)
- Excessive discipline
- Emotional maltreatment
- Child witnessed...violence in the home
- Sexual maltreatment
- Other abuse
- Child 6 yrs or younger unsupervised
- Child 7-12 yrs unsupervised
- Other harm through lack of supervision
- Verbal or physical fights
- Rejection of child by parent
- Rejection of parent by child

Some Methodological Issues. Some initial differences were found among study families that may have been attributable to sampling methods. Among all the families in the sample (n = 690), at least one safety issue from the above list was indicated by workers at first contact in 57.5 percent of control families compared to 45.4 percent of experimental families in the IS counties. AR families in NIS counties resembled control families with 59.3 percent with at least one of the safety issues. Considering the population wide analysis of the SDM safety assessment instrument presented in the

previous section, this difference was most likely due to uncontrolled sampling errors.¹³ A possible source of this error may have arisen from the distribution of presenting problems (i.e., problems reported to the intake worker during the initial telephone report) within the three study groups. There were 207 control families, 271 experimental families, and 212 AR families in the NIS counties. There were 15 presenting problem categories in the SSIS system. Among these, the most frequent were: neglect (food, clothing, shelter), physical abuse, endangerment, inadequate supervision and education neglect. Only 5.1 percent of experimental families in this sample were reported for child endangerment compared to 18.8 percent of control families and 15.7 percent of AR families in other counties. This and other similar variations could easily explain the differences in levels of families with unsafe children at intake.

Another difference of importance concerns the lack of knowledge in some cases of safety status at the conclusion of the case. Among families in the sample, the safety status was known both at first and last contact with the family in 49.3 percent of control cases, 42.3 percent of experimental cases, and 56.9 percent of AR NIS cases. (Compare these percentages to those at the beginning of the previous paragraph to see the decline in cases.) These percentages represent the proportion of families in each study group with safety problem at the beginning of the case in which the safety status (of at least one problem) was known at the final contact with the family. Worker's ignorance in most cases was due to cases being passed to ongoing service workers and loss of contact with the family. The evaluators contacted such workers and obtained their responses in many cases but only when the original worker provided reliable contact information and only when the second worker was willing to take the time to respond to the case-specific survey.

Difference in Safety Status at Last Contact. It might be thought that workers would be a biased source of information about how well families fared and whether children were made safer while they worked with families. They were, no doubt, biased in many ways, but not to the extent that they always indicated positive change in families. With this in mind we may compare families and safety problems in the three groups. The following analyses are based on the subset of families with at least one initial child safety problem indicated and on which the safety status was reported as of the last contact with the family

Looking first at the family level, the number of distinct safety problems (from the bulleted list above) per family did not vary significantly across the three groups. IS experimental families averaged 1.8 safety problems per family compared to 1.6 for IS control families and 1.9 for AR NIS families. The most general level of safety change

¹³ County offices were sampled disproportionately. Consequently, weights were developed to increase the representation of counties that were under-sampled and to decrease the representation of those that were over-sampled. It was necessary to monitor and exclude certain cases of workers who had been previously surveyed concerning two or more cases. This procedure was necessary to control the burden of completing the survey for workers, so that no worker completed more than two surveys. It also introduced a bias in the sample, under-representing the responses of workers in smaller offices who had served many study families.

consisted of a difference score between safety status at the first and last contact with the family. These were scored as follows:

- First Contact
 - 3 = severe
 - 2 = moderate
 - 1 = mild
- Last Contact
 - 3 = severe
 - 2 = moderate
 - 1 = mild
 - 0 = not present

These are admittedly crude numeric values. However, by using them difference scores (safety at last contact minus safety at first contact) were derived that could range from -3 to +3. Not surprisingly there were very few negative scores of any kind but there were a relatively large number of zero scores (0 = no change in safety status), which indicates no decline but also indicates no improvement. Because several safety problems were indicated in some families and only one in others, the next step was to produce an average (mean) safety change score. This amounted to .87 for the entire set of families in the analysis. Differences between study groups are shown in Table 9.2. The experimental-control difference in this table was statistically significant ($p = .02$), indicating that AR workers believed more positive child safety changes occurred during the time they were in contact with the family compared to TR workers. (We should reiterate that in some counties the same workers handled both AR and TR cases while in other counties these functions were specialized.)

Table 9.2. Average Change in Safety Status in Experimental, Control, and AR-NIS Families

Study Group	Average safety change	Number of families (weighted)
Experimental - 14 Impact-Study counties	.99	102
Control - 14 Impact-Study counties	.76	116
AR - 6 Non-Impact-Study counties	.86	116

Whether this positive change is considered programmatically significant or not depends on the weight we attach to the measures of safety change. However, the more important finding for the AR program is that, *relative to control families, safety did not decline while families were receiving an alternative response.*

Looking at safety problems in greater detail, the following two charts (Figure 9.2) show the *number* of experimental and control families with various outcomes for *each safety problem area*. As can be seen the number of families in each safety category was

relative small, and for this reason, the variations between the two tables are all within chance ranges. Safety outcomes are grouped into three categories of *no change in safety status* and *positive change in safety status*. These six categories can be seen in the legends of the two charts. They represent simplifications of the following:

Safety Change Category	Beginning Safety Status	Ending Safety Status
1 Severe, no change	Severe	Severe
2 Moderate, no change	Moderate	Moderate
3 Mild, no change	Mild	Moderate
4 Mild, improved	Mild	None
5 Moderate, improved	Moderate	Mild or none
6 Severe, improved	Severe	Moderate, mild or none

A line is superimposed on each chart in Figure 9.2 dividing the first three categories from the last three. By inspecting the portions of each bar that fall on either side of the dividing line it is possible to see the sources of the difference between the summary measures of safety change in Table 9.2. In a greater proportion of experimental cases workers indicated that positive improvements (bars to the right of the dividing line) had occurred in the safety status of the children between the beginning and their last contact with the family. *Summing across all the categories, the percentage of safety problems among experimental families that ended with safety improvements totaled 47.7 percent compared to 31.8 percent for control families.*

Workers made safety assessments of each family in the sample independently. While it might be assumed that workers would judge improvement in their own cases more positively, this analysis is based on the *relative difference in safety assessments* of workers in experimental cases where AR was provided and control cases where the traditional approach was taken.

Why was the outcome “no change” for some safety problems? In each case workers were asked, “Was the safety issue addressed?” In many cases they answered yes and provided information about how. In the large majority of these they indicated that county staff dealt with the problem. The next largest category was that vendor agencies or paid providers took responsibility. In some cases they answered no, that the safety issue was not addressed. The number of times that workers, particularly traditional workers, admitted that the issue was not addressed was relatively small. However, when workers did answer in this way, they nearly always responded that the “family was uncooperative.” Focusing again on the three “no change in safety status” categories in Figure 9.2, in experimental cases 24.2 percent of instances workers indicated that the family was uncooperative; in control cases the corresponding proportion was 5.6 percent. However, there are reasons why, in the larger view, this finding may be deceptive.

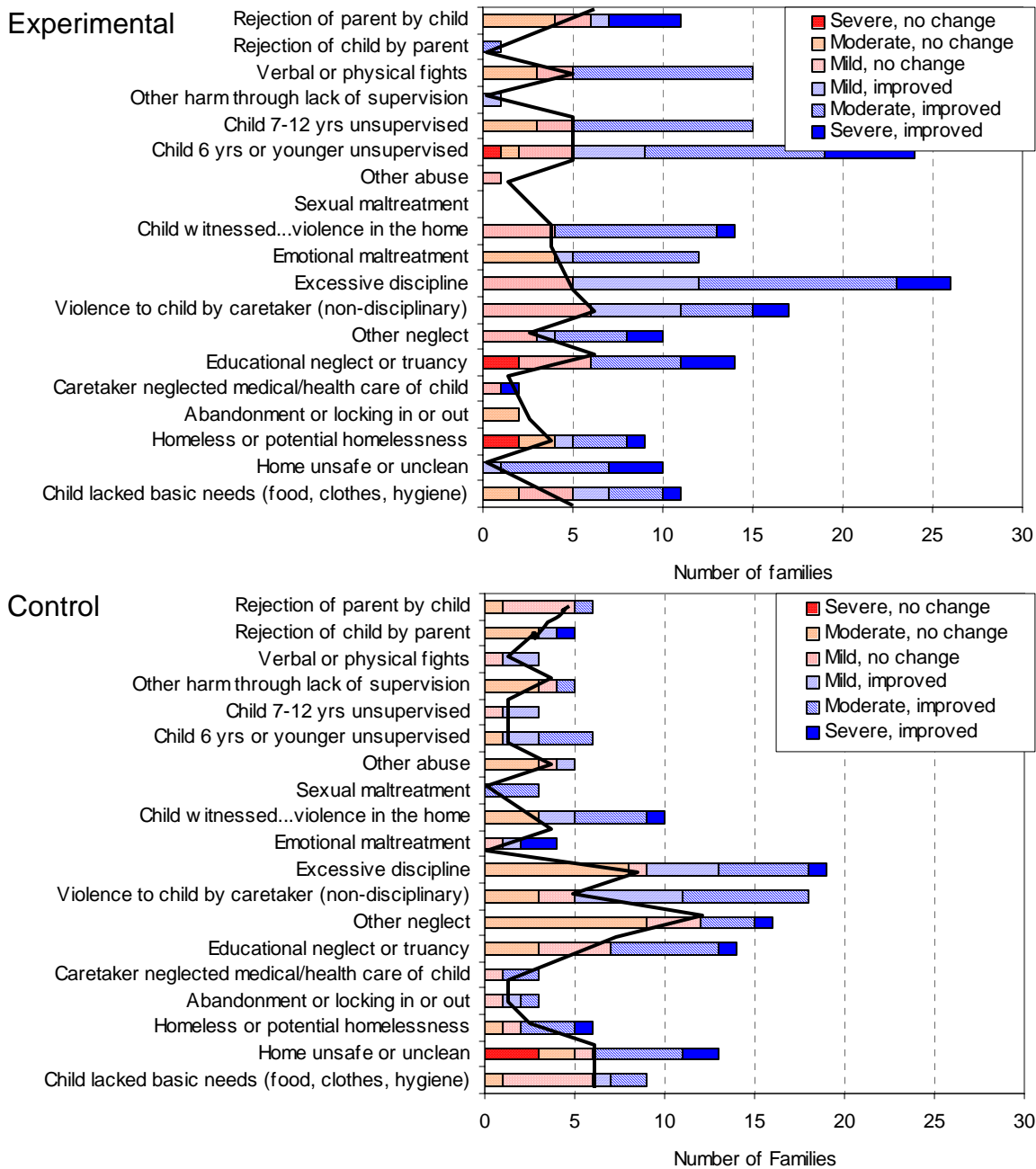


Figure 9.2. Number of Safety Problems by Outcome

In the same case-specific survey, workers were also asked to identify whether there were extenuating circumstances that made work with each family very difficult, impossible or unnecessary. This question was asked of all families including those with and without identifiable child safety problems. Workers cited many different reasons for these problems. A major difference between the responses of workers in control group cases and workers in experimental cases (and in AR cases in the six NIS counties) arose from the nature of investigations. Traditionally, the agency has taken no further action with families when investigations failed to substantiate child maltreatment, the primary

focus of investigations. In control cases, therefore, all of which were investigated, workers reported that further work was unnecessary in 21.6 percent of families because the traditional assessment (investigation) found no maltreatment and in another 22.5 percent of cases in which substantiation occurred but the family was considered low risk and no case was opened.

When these families were removed from the analysis, a different picture emerged of the problems that hindered work with families (Table 9.3). The proportion of families in which lack of cooperation was the primary difficulty with the family ranged from about 44 percent of AR families (both experimental and AR families in the six NIS counties) to about 56 percent among control families. Although the percentage was higher, the difference between experimental and control was not statistically significant. The higher percentage among control cases may be attributable to the elimination of cases in which no maltreatment could be proven and lower risk cases. These were not necessarily eliminated under AR and would likely have been families that were served in other ways. Other barriers to working with families occurred at about the same levels in all three groups.

Table 9.3. Reasons Work with Families was Difficult, Impossible or Unnecessary (Case-Specific Sample)

<i>Study Group</i>	<i>Uncooperative¹</i>	<i>Perpetrator no longer present²</i>	<i>Other reason³</i>	<i>Number of Families (weighted)</i>
Experimental - 14 Impact-Study counties	44.7%	8.8%	14.0%	114
Control - 14 Impact-Study counties (eliminating unsubstantiated and substantiated low-risk cases)	56.1%	14.0%	10.5%	57
AR - 6 Non-Impact-Study counties	44.1%	13.9%	7.8%	115
1. Uncooperative included: family fled or moved out of county, caregiver otherwise uncooperative, child was uncooperative, caregiver denied allegations, caregiver hostile throughout case, caregiver often missed appointments, and other similar comments. 2. Perpetrator no longer present included: perpetrator left family, perpetrator separated by court, perpetrator was imprisoned, perpetrator no longer present for other reasons. 3. Other reasons included: language barriers, another agency responsible for case, extreme poverty, caregiver mental illness and drug abuse.				

If it is true that traditional CPS investigations end by not serving a larger set of families reported for maltreatment than the AR approach two other things should also be true: 1) low-risk AR families should receive more services than similar TR families and 2) AR families with no safety problems should receive more services than similar TR families. Said another way, services should be distributed more evenly across the full distribution of AR families. This is based on the assumption that the amount of services provided is an index of the level of agency response to the family. And, we should add, to make such a comparison the screening process must be the same overall for AR and TR families and the groups must be effectively equivalent. The latter condition holds fairly well for experimental and control families, which were screened and then randomly assigned. It is not true for the AR families in the six NIS counties, where we know that

screening processes admitted a greater proportion of higher risk families and families with more severe safety problems into the AR track.

Looking at (sample) experimental and control families, 28.8 percent of low risk experimental families received one or more services (beyond information and referral) compared to 14.8 percent of low-risk control families. Similarly, 28.5 percent of AR families with no safety problems received such services compared to 7.6 percent of similar control families. *Service responses were distributed to a broader array of all families under AR, especially lower-risk families and families with no immediate threats to child safety.*

What about experimental and control families in which there were child safety problems? Did the service response vary among these families? These represent a smaller proportion--somewhat less than half of the families in the sample. When these families were examined the same pattern was found. Service levels tended to increase with the intensity and multiplicity of safety problems in both the experimental and control group, that is, families with more severe threats to child safety received a more intense service response. However, over all the families in the experimental group, 38.3 percent received a service response compared to 25.5 percent of similar control families. Correspondingly, experimental families with at least one safety problem received more services regardless of risk level (35.3 percent for low risk, 41.4 percent for moderate risk and 35.0 percent for high risk) compared to control families (28.1 percent for low risk, 24.4 percent for moderate risk and 20.8 percent for high risk). *Service responses were distributed to a broader array of families under AR with child safety problems.*¹⁴

Services and Changes in Child Safety

The average safety change shown in Table 9.2 is a gross measure of safety improvement, indicating somewhat better performance among experimental families. This difference was reflected in and to some extent validated by the safety improvement across many different types of safety threats (Figure 9.2). We have also seen that services were delivered to a broader array of families under AR. The next question that arises is whether the experimental-control differences in safety improvement are related to the level of services delivered.

Service Responses to Experimental and Control Families with Safety Problems. Workers were asked about the nature of services provided to each sample family. They responded concerning 27 separate categories of services in relation to each family in the case-specific sample. When they responded positively about a particular type of service they were asked whether 1) only information and referral to the service was provided, or 2) the service was actually provided to the family, or 3) the service was already in place at the start of the case. The last of these three occurred in only a small

¹⁴ As noted, this analysis was based on the case-specific survey. Services for these families were discussed in the Chapter 5. For the present analysis definitions of services received were modified slightly to include a small percentage of families in which services were already in place at the time of the initiating report.

minority of cases, and for this reason, was combined with the second category in the present analysis.

The 25 most frequently provided services are shown in the following list (Table 9.4). They have been grouped into three general logical categories: services addressing basic family needs, counseling and therapy services, and services addressing special problems of family members. This arrangement is based on an intercorrelational analysis. The services in each category co-occur in the same cases more frequently than they co-occur with services in the other two categories. For example, a family that received housing services was more likely to receive emergency food than, say, individual counseling.¹⁵

Table 9.4. Types of Services Delivered to Families with Safety Problems and Services Offered Significantly ($p < .05$) more Frequently to Experimental (AR) Families (in Bold)

Services Addressing Basic Family Needs	
Childcare/daycare services	Emergency food
Respite care/crisis nursery	TANF, SSI or Food Stamps
Medical or dental care	Assistance with transportation
Help with rent or house payments	Assistance with employment
Housing services	Vocational/skill training
Help with basic household needs	Educational services
Counseling and Therapy Services	
Marital/family/group counseling	Domestic violence service
Individual counseling	Assistance from support groups
Mental health/psychiatric services	Disability services
Services for Other Special Needs	
Drug abuse treatment	Recreational services
Alcohol abuse treatment	Family preservation services
Parenting classes	Independent living services
Homemaker/home management asst.	

Each separate service in Table 9.4 was received by a small number of families. The most frequent service, individual counseling, was received by a little over 12 percent of the families with safety problems. The average across all services was about 5 percent of families. However, larger proportions of families received one or more services within a category: 38.0 percent of families with services addressing basic needs, 40.3 percent with counseling or therapy services and 23.0 percent with services for special needs.

In most categories, experimental families were provided more services than control families. This was true of the entire experimental and control sample as well as families with child safety problems, the segment considered here. None of the services were offered more frequently to control families. The types of services offered significantly more frequently to experimental families are shown in bold in Table 9.4. Most of the areas of increased services to experimental families were the type that

¹⁵ The three categories themselves, however, are also intercorrelated. A subset of multi-problem families received services across all three categories.

addressed basic family needs. Most such needs are economically related, that is, they are associated with low income and other financial stresses. This change is one of the hallmarks of the AR approach: the shift in emphasis beyond traditional therapeutic services to services that meet basic family and household needs. Counseling, therapy and similar services were not offered less often to AR families but basic needs were addressed more often.

Our original question is whether this increase in delivered services was related to higher rates of improvement in safety status among AR experimental families.

- 1) The dependent variable: average change in safety status (described in Table 9.2).
- 2) Independent and control variables:
 - a. Experimental or control group membership.
 - b. Presence or absence of one or more services in each of the three categories.
 - c. Level of risk assigned to the family at the time of the family assessment or investigation using the Structured Decision Making Family Risk Assessment tool.

Looking at the variables separately, there were several findings:

- *Disregarding services and risk, experimental families had more positive changes in safety than control families, as reported above (see Table 9.2).*
- *Disregarding whether families were experimental or control, neither counseling/therapy nor services for special needs were related to changes in safety status. This does not mean that such services had no consequences for families. Rather it means that such services were distributed across both families with safety improvement as well as no change in safety (as judged by workers). On the other hand, delivery of services to address basic needs of families may have been related to safety change. Generally, the more basic services delivered to the family the higher the measure of safety improvement. Average safety improvement was .79 for no services of this kind, .90 for families with one service from any of the 12 types of services (Table 9.4), and 1.1 for families with two or more services ($p = .017$). However, because only small proportions of control families received such services, this cannot be stated with certainty (see discussion below).*
- *Again, disregarding whether families were experimental or control, the level of risk was unrelated to safety change. This finding is not surprising because risk is a measure of the probability of recurrence of child maltreatment while safety concerns immediate*

threats to children.¹⁶ They are not the same concept, although risk, as well, might have been reduced by the conclusion of contact with the family. We had no independent measure of *change* in risk level over the entire course of a case. There also was *no significant difference between the average risk levels of the experimental and control group families* (Experimental: 6.9; Control: 7.5, $p = .26$), suggesting the two groups were similar on this dimension. Finally, *no significant difference was found in the average risk of families that did or did not receive services*.

Limiting services to those addressing basic needs, these variables were considered together in a factorial analysis (see Technical Appendix). Risk level was measured by summing the *weighted numeric totals* for neglect and abuse on the SDM Family Risk Assessment instrument. Risk was used as a covariate in the analysis, effectively controlling for variations in risk level among families. Risk had no effects in this analysis. Indeed the analysis is unchanged whether risk levels of families are considered or not. Experimental families continued to show greater safety improvement in the analysis, but *the effect of basic-needs services on safety change disappeared in the analysis*. The reason for this was the small proportion of control families that received such services. Only 14.7 percent of control families with a safety problem received any services of this kind compared to 41.5 percent of similar experimental families. The difference is evident in the following graph (Figure 9.3) that shows how experimental and control group membership and services were related in combination to safety change.

The interaction between services and experimental-control membership in Figure 9.4 *was not* statistically significant. The figure is shown here because it illustrates a pattern relationships and because services were found to be implicated in child maltreatment recurrence (see next chapter). It suggests further study that focuses on a larger sample of cases. In the figure, child safety increased among experimental families as more basic services were offered (on the right-hand side of the graph). No differences are apparent by level of these kinds of services for control cases. This should not be interpreted to mean that such services make no difference under conditions of traditional investigations. Rather, that question remains open. The number of control families with safety problems that received these types of services was so low (less than 15 percent) that the analysis was unable to demonstrate any effects for these families. The analysis suggests, but does not prove, that delivery of basic services has an effect on removal of safety threats within the context of open child welfare cases. This has an intuitive appeal because many of the threats themselves are directly related to these services. For example, repairing rotten boards in a floor makes the floor safer, that is, an unsafe home can be made safer by assistance in purchasing basic household items related to safety threat. But the difference shown in Figure 9.3 could also be explained in more complex way: AR is a more effective approach to reducing child safety because AR families are engaged more fully than their traditional counterparts. Families that are engaged more fully are also more amenable to help with basic needs. The AR demonstration included

¹⁶ Remember that all experimental and control families were screened as appropriate for AR in the 14 IS counties. When the entire CPS population is considered, families screened as *not appropriate for AR* tend to be higher risk families as well as families with more severe child safety problems. Risk and safety are different concepts but are correlated when the full range of safety threats are considered.

an increase in funds to purchase such services. Thus, the observed change in safety might be due to either factor separately or to a combination of these factors.

An analogous approach is taken in the examination of child maltreatment report recurrence below. That analysis supports that notion idea that both the approach and the increase in services lead to improvements in the long-term safety and welfare of children.

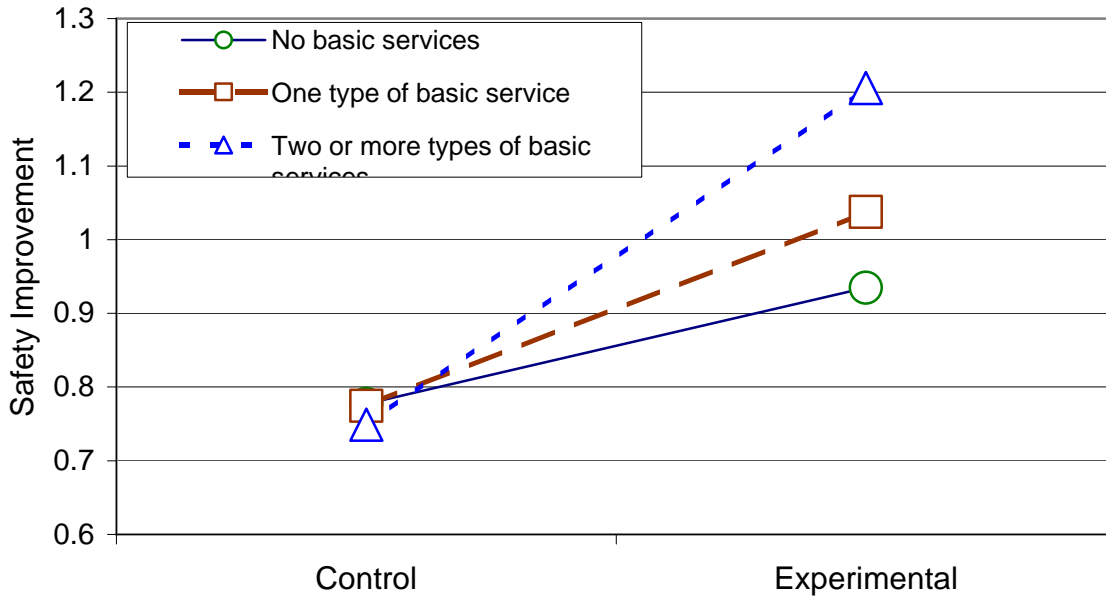


Figure 9.3. Estimated Marginal Means of Safety Change for Experimental and Control Families for Differing Levels of Deliver of Services Addressing Basic Family and Household Needs

Changes in Family Risk: Effects of AR Before Services are Offered

Risk factors are the characteristics of families, family members and the situations of families that are correlated with newly accepted reports of child maltreatment. While some risk factors can be found in SSIS, such as family size, age of caregiver, cases opened in the past, and others, we did not make a systematic effort to collect risk data. The reason for this was that the Structured Decision Making (SDM) Family Risk Assessment was completed for experimental and control families.¹⁷ Risk Assessment data associated with initiating reports were available for 97.9 percent of the experimental and control cases.

The research plan called for utilizing risk assessment findings to distinguish and control for pre-existing risk levels among experimental and control families. This

¹⁷ Several months after the evaluation had begun the SDM Family Risk Assessment instrument was integrated into SSIS. These data were provided to the evaluators. Risk data were back entered into SSIS for several hundred AR and control cases assigned to the evaluation before this change, except in Hennepin and Dakota counties where automated systems predated the evaluation. Hennepin and Dakota data were provided to the evaluators were converted and integrated into the research database.

procedure assumes that the risk assessment is independent of (that is, not influenced by) the difference in approach to experimental and control families. We will show, however, that this was not the case. *We, therefore, adopted an alternative approach—using the SDM risk assessment items as dependent variables. That is, as measures of outcome differences between AR and TR.*

The SDM Family Risk Assessment instrument is primarily a tool for child welfare *practice*. It was not designed as a research tool. Nonetheless it is a scale that has been validated for CPS cases in several states. Our analysis indicated that as a general rule higher risk scores on this instrument do indeed predict new CPS reports and cases. Families with high-risk scores are significantly more likely to be named in subsequent child maltreatment reports than families with low-risk scores. There are, however, large number of false positive and negatives—high-risk families that are never seen again and low-risk families that return to the system. A good risk tool will minimize these errors, but this is a difficult task for a phenomenon as multi-faceted as child abuse and neglect.

The SDM instrument is composed of discrete items, each of which is given a weighted score. There are 11 neglect-related items that compose an neglect-risk subscale and 12 abuse-related items composing an abuse-risk subscale. Neglect scores can range from 0 to 20; abuse scores from 0 to 16. The overall risk level is determined by the highest score on either of these scales and is rated as low, moderate, high or intensive. The overall risk level can be overridden by a supervisor because of the presence of other serious safety threats to the child, although this happens in only a small minority of cases.

Some of the risk items are more “objective” than others, such as the number of children in the home, the age of the caregivers, abuse and neglect of caregivers when they were children, or the financial situation of families. Variation in these items will depend on the effort and skills of assessment workers to uncover them. Other items require more interpretation and judgment on the part of workers, such as parenting skills of caregivers, cooperation and motivation. It is these types of items that are the primary focus of this analysis.

The Family Risk Assessment instrument is typically completed toward the end of the assessment workgroup when workers have more information on families. Very few workers reported that they completed the instrument at the time of the first visit with the family, unless there was only one visit and no further contact with the family. But whether the assessment is short or lengthy the scoring of the Family Risk Assessment in part depends on interchanges between assessment workers and family members.

Assessments are situations of social interaction—often of a rather intense and emotional nature. TR assessments, that is, traditional CPS investigations are more adversarial in nature with a focus on discovery of abuse and neglect, identifying a perpetrator and determining maltreatment status. They are more likely to evoke negative emotions such as fear, anger and hostility in caregivers. AR family assessments, by contrast, are less adversarial and more family-friendly with an emphasis on participation of all family members as a group. The voluntary nature of further work with the family is

a critical feature of the AR approach. The AR approach is more likely to evoke cooperation of family members and sets up a situation in which family members can demonstrate their motivation. Other evidence in this evaluation supports this view and confirms that AR families on the whole respond more positively to this approach. Because the Family Risk Assessment focuses in part on caregiver responses to the entrance of CPS into their homes, it is logical to assume that differences in approach that elicit more or less positive family responses will lead to variation in worker assessments of risk.

To determine this we examined how experimental and control families compared on the individual items that composed the scale (Figure 9.4). For most items the absolute differences were not great, that is, about the same proportions of experimental families as control families received scores on the items. *In general, the SDM tool appears to be reliable across TR investigations and AR family assessments.* However, certain differences between ratings of experimental and control were more extreme.

The greatest difference in Figure 9.4 can be seen in three sets of items that are highlighted by the boxes in the chart. *AR assessment workers tended to regard caregivers as more cooperative, more motivated and realistic, less apathetic and hopeless, with higher self-esteem and parenting skills.* These differences are consistent with an approach that from the time of the first contact with the family 1) replaces the adversarial and accusatory approach of traditional investigations with one that emphasizes assistance and building on family strengths and 2) engages families by actively seeking their participation in decision-making. Family responses (see below) are significantly more positive under AR. It is not surprising, therefore, that the risk assessment items rating cooperation, motivation, attitudes and dispositions of caregivers are rated more positively under AR.

These kinds of attitudinal and behavioral factors were included in the SDM tool because they indeed are predictive of recurring child maltreatment. *We concluded that the variations in the method of approaching families embodied in AR (the AR Protocol) improves family attitudes and reduces the risk of future maltreatment.* The implication is that approaching families differently reduces attitudinal risk factors *apart from differences in the level of services later offered to families.* Put another way, we might say that *changes in risk (as measured by SDM) were already occurring very early in the AR process.* This conclusion should be no more controversial than including such factors in the Family Risk Assessment tool. They are included in that tool based on empirical studies that show that poor family attitudes (for example, lack of cooperation) are indicators of risk of future child maltreatment. It follows with equal force that approaches that lead to improved attitudes of family members reduce risk of future reports. *We interpret these findings as support for the assertion that the AR protocol produces effects in families apart from provision of services,* as most AR workers also believe (see section on AR Protocol versus Service Funding in Chapter 6).

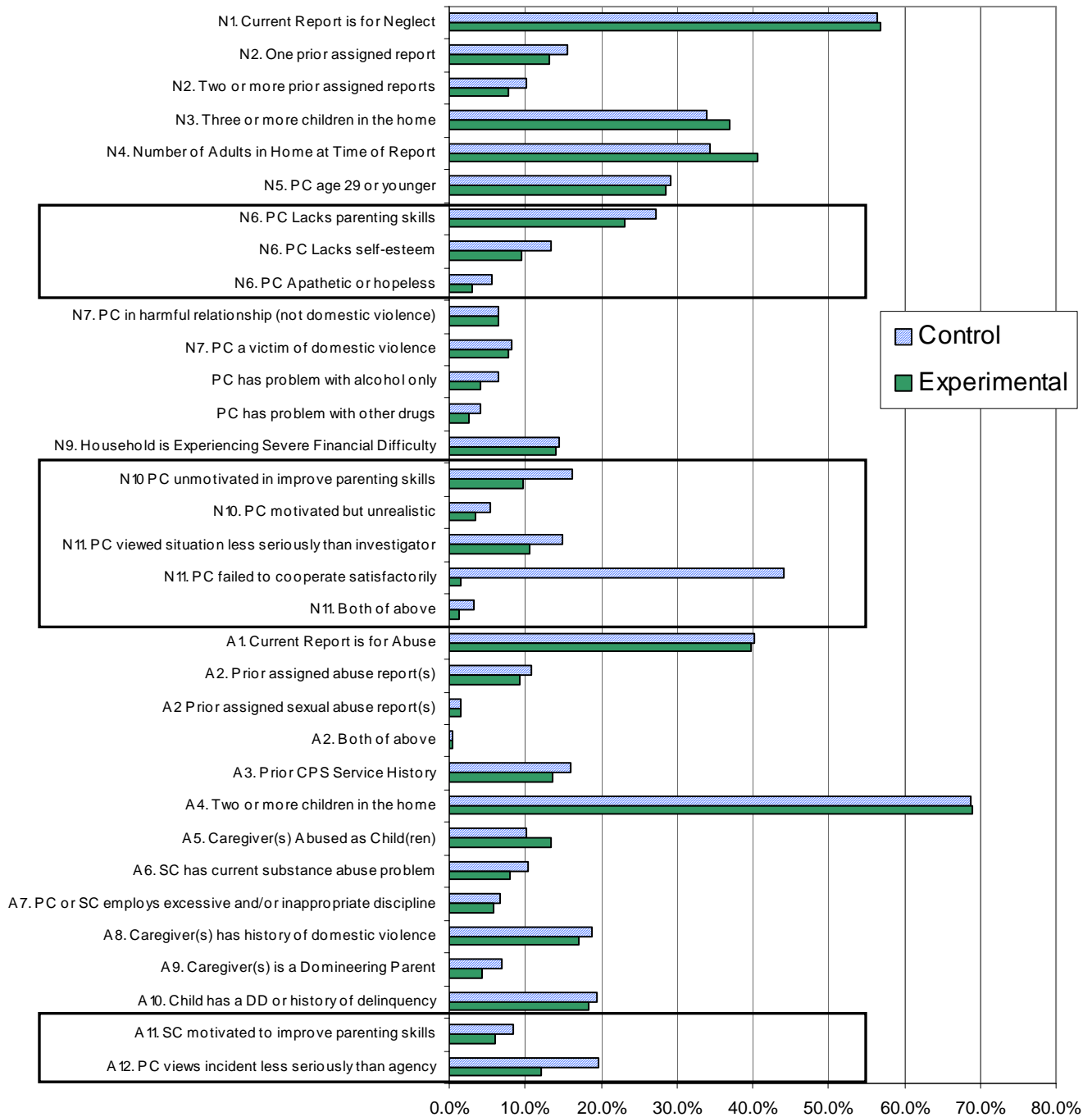


Figure 9.4. Proportions of Individual Risk Assessment Items Answered Affirmatively for Experimental and Control Families

Chapter 10. Maltreatment Recurrence and Family and Child Well-Being

Recurrence of Accepted Reports of Child Abuse and Neglect

In this section we ask whether the AR approach reduced new reports of child abuse and neglect. All study cases began with a report and intake that we have termed the *initiating report*. Some families also had one or more new reports during the assessment or case management phases of their cases. In the control group, 2.9 percent had a new report during the research treatment phase compared to 3.4 percent of experimental families. This difference was not statistically significant. These reports are not included in the analysis of recurrence. Recurrence of accepted CA/N reports refers to new intakes *after the close of the research treatment phase*. The research treatment phase, as noted earlier, in some cases included only an assessment (type-1 cases) and in others an assessment plus other case management activities (type-2 cases). Taken together assessment and subsequent service cases are considered as the *experimental treatment*. The treatment is concluded at the end of the research treatment phase, and it was from that point that tracking for recurrence was considered.

The simplest measure of recurrence is the proportion of experimental and control families with new reports of child maltreatment. *A statistically significant difference was found: 27.2 percent of experimental families had new accepted incident reports compared to 30.3 percent of control families ($p = .019$).* These percentages do not take into account differences, however, in the number of days that cases were tracked.

Time Difference among Cases. After the research treatment phase was closed, families were tracked in SSIS until the end of the data collection for this analysis: March 31, 2004. The tracking period for experimental cases varied from 128 to 1,143 days compared to 142 to 1,146 days for control cases. The mean number of days was 689 for experimental families and 706 for control families. The gap between these averages was only 17 days but was large enough to be statistically significant. The question that arises is whether the longer average follow-up period afforded control cases greater opportunity for new child abuse and neglect reports and might account for the increases proportions of new reports for control families.

Families entered the study over a two-year period, experienced cases of varying lengths, and presented different lengths of time for follow-up. A collection of statistical techniques exists for addressing differences of these kinds called survival analysis. The simplest type of survival analysis is referred to as life table analysis.

Survival Analysis through Life Tables

Survival analysis as applied to the reoccurrence of reports of child abuse and neglect is concerned with the period of time until a new report occurs. The method considers both *whether* new reports occur and *how long it was* before they occurred. This time period is referred to as *survival time*, how long the family “survives” until a terminal event—in this case, a new accepted report—occurs. The main problem that arises in most evaluations of time-to-a-terminal-event is that tracking of cases is cutoff at the end of the study. Cases that do not experience the event before the study ends are called *censored cases* in survival analysis. We assume that some of the censored cases would have been observed to experience a report had data collection continued, but we cannot know which. Nonetheless, all cases, both censored and uncensored are used in computing life tables. Life tables use a particular technique to determine the number of cases *exposed to risk* of the terminal event while at the same time taking into account the censored cases. In this study, we will determine how many families were exposed to the risk of new CA/N reports while also considering families tracked to the very end of data collection with no new reports.

In constructing a life table the tracking time is divided into fixed intervals. For example, 90-day intervals might be chosen. If the maximum tracking time were two years, then there would be approximately eight such intervals to consider. The first interval, 0-90 days, would include all cases. If any cases had tracking periods of less than 90 days with no new terminal events (reports), they would be considered censored. In the life-table approach each of these censored cases is counted as a half case. For example, if the total sample was 100, of which 10 have been tracked for less than 90 days, these 10 would be treated as censored in the 0-90 day interval. The 10 cases would be counted as 5 cases and the total number of cases would be considered to be 95. Effectively this counts the tracking period for these 10 cases as 45 days each while the other 90 cases would each have tracking periods of 90 days. If terminal events (new reports) occurred for, say, 20 cases during the 0-90 day interval, the rate would be counted as 20 events/95 cases or .211 (rather than $20/100 = .20$). The same technique would be used for each of the other 90-day intervals.

The rate of new reports in each interval can be thought of as a probability, with a value ranging from 0 (no terminal events) to 1 (every case experienced a terminal event). The probabilities can be accumulated until at the end of the last time interval to give a total probability.

Finally, in an experimental study, separate life tables can be constructed for the experimental and control groups. Then the survival times of cases in the experimental group can be compared to those in the control group to see if, as a whole, they are different. If the overall difference is great enough to be unlikely to have occurred by chance, we can assert that the experiment was a success.

In Chapter 8, we argued that the experimental and control groups were essentially similar to one another. However, it was also evident that a slightly greater proportion of control cases had had a previous case under Child Protection Services (a case management workgroup opening) before the initiating report in this study. One of the strongest predictors of new reports and new cases in the CPS system is previous cases in the system. Previous experience in the system is an indicator of risk. Considering the entire study sample of experimental and control families, only about one out of ten (9.8 percent) had been involved in a case with the agency before the AR demonstration began. Looking forward to new CA/N reports after the research treatment phase had closed, 48.5 percent of these families experienced a new report before the end of data collection, compared to 26.2 percent of families who did not have a previous case ($p < .0001$). Having had a previous case in the system is, indeed, a risk factor for new child maltreatment reports. Because the experimental and control groups had different proportions of such families (experimental: 8.2 percent; control: 10.5 percent), the first analysis based on life tables was segregated on that basis.

The segment of the survival analysis corresponding to experimental and control families with no previous history as active CPS cases (about 90 percent of all cases) is shown in Figure 10.1.

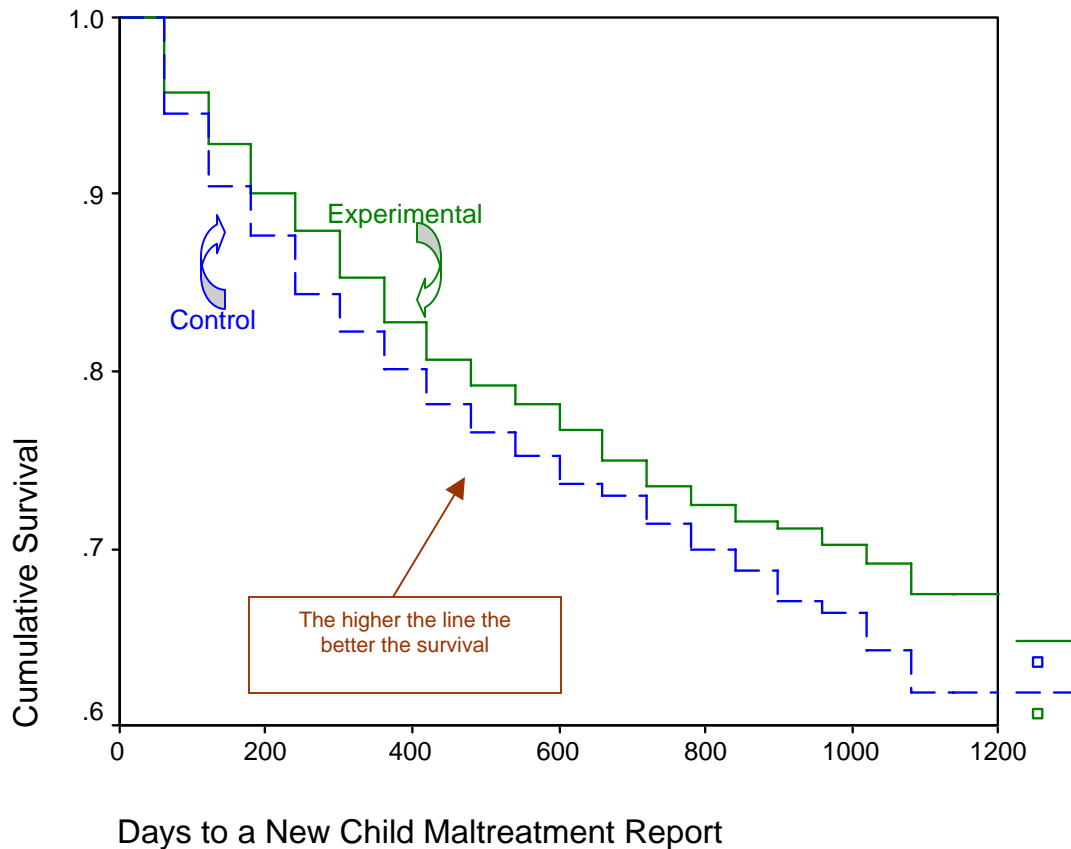


Figure 10.1. Survival of Experimental and Control Families from the Close of the Research Treatment until a new Accepted Child Maltreatment Report: Families with no Previous CPS Cases (60-Day Intervals)

The cases underlying Figure 10.1 can be described as *low to moderate-risk cases* that would generally correspond to the low and moderate-risk categories in SDM risk assessment scheme. We already know from the previous discussion that families in the experimental group were less likely overall to have a new accepted report during the follow-up period. *The survival analysis shows that this difference was distributed evenly over the follow-up period, that is, it was a consistent difference between families that received an alternative response compared to families that received an investigation during the research treatment phase.* In the graph, the lower the line, the poorer the survival: control families experienced new reports sooner and, therefore, more reports during the follow-up period. The difference between survival rates of experimentals and controls was statistically significant ($p = .04$). On the other hand, no differences were found for the minority of higher-risk families ($p = .37$). *This difference shows that families that were not previously active in CPS were better assisted by the AR approach*

than by the traditional approach. (Details of the statistical results can be found in the Technical Appendix to this report.)

Effects of Services on Recurrence

In the Introduction to the impact analysis we distinguished between Type-1 and Type-2 cases. The distinction hinged on whether a service case was opened. In Minnesota these are referred to as case-management (CM) workgroups. Records of specific services delivered were not available through SSIS, and this was the reason that we sought information on services through workers, families and local bookkeepers for samples of families. However, as a general rule services are not delivered unless a CM workgroup is opened.¹⁸ Not all families with a CM workgroup received formal purchased services (for example, financial assistance, counseling or childcare), but some do. In addition, in virtually all cases the contacts between agency representatives and families were more extensive when formal cases were opened. Worker contacts included various forms of informal assistance (for example, transportation assistance and providing information and referrals to community services or other county departments other than CPS).

The traditional approach to services in CPS has been the “squeaky wheel gets the grease.” Families in crisis in which the safety and future welfare of children are most threatened have received the bulk of the services offered and have occupied the majority of worker time. This has a curious effect from the research perspective. The *riskiest families* typically receive services. Recurrence is more likely to occur in such families when compared to lower-risk families that receive no services, *apart from how effective the services may have been in solving problems*. Thus, it may appear that families that are provided with services reappear in the system *more rather than less often* than families that are not given services, making service provision seem less effective than no services at all.

Since this study involves a randomly assigned control group, it affords the opportunity to deal with this problem to a certain extent. The experimental design controls for many variables that make families more or less risky. However, we did not and could not control which families received services, and this variable differed significantly between the AR and TR groups, as has been noted earlier in this report.

Looking at the families in the impact study, over twice as many families in the experimental group had case management workgroups opened. Overall, 15.1 percent of control families had such a workgroup opened compared to 36.2 percent of experimental families (Figure 10.2).¹⁹

¹⁸ Exceptions to this rule were found in some study counties where assessment workers were able to provide immediate services. Even in these counties, however, most longer-term services were offered via the CM workgroup as noted in Chapter 5.

¹⁹ The proportions differ slightly from those presented in Chapter 5 because the experimental and control group considered for the impact analysis was reduced, as discussed in Chapter 8.

One of the effects of AR, as services are offered to a wider variety of families, was to nudge the agency away from child protection toward prevention of child maltreatment. Indeed, using the SDM Family Risk Assessment as a rough measure of risk, CM workgroups were opened for 28.1 percent of low-risk experimental families and 40.8 percent of moderate risk families compared to 3.0 percent and 9.2 percent respectively of control families. Among high and intensive risk families in the study, the difference was not as extreme, but nonetheless, CM workgroups were opened for 64.2 percent of experimental families in this risk category versus 57.3 percent of control families. *From this it is clear that most of the difference in CM workgroup openings between experimental and control families was attributable to an increased emphasis under AR for working with lower-risk families.*

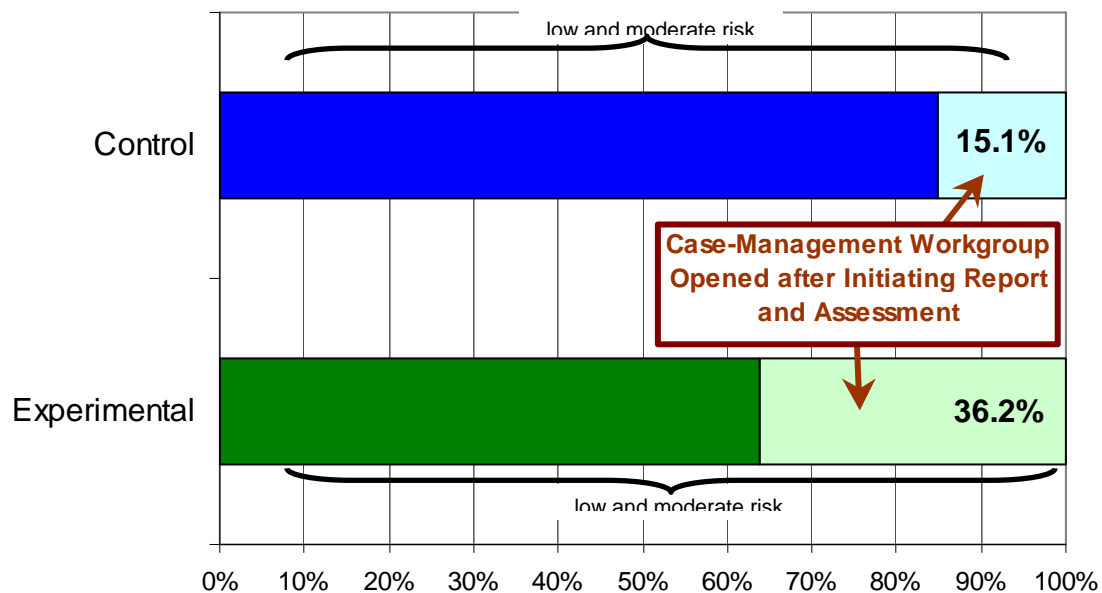


Figure 10.2. Case-Management Workgroup Openings after the Initiating Report for Experimental and Control Families in the Impact Study

This finding also tells us that control families for which no CM workgroups were opened were different from experimental families in this same category. Control families with no services were, on average, lower-risk families than experimental families with no services. And control families with services were, on average, higher risk families than experimental families with services. This is also shown in Figure 10.2, where the brackets correspond to the approximate distribution of the low and moderate risk families combined. Most families in both the experimental and control groups fell into these categories but many more experimentals had a CM workgroup opened.

The most straightforward way to show the effects of services on report recurrence is through cross tabulations (Table 10.1). After looking at cross tabulations, we use a

more powerful statistical analysis of the same data. First, it is apparent that under both conditions experimental families experienced lower recurrence of reports: 27.6 percent experimental versus 29.7 percent control when a CM workgroup was *not* opened, and correspondingly, 26.4 versus 34.0 when a CM workgroup was opened. The first difference amounted to only 2.1 percent and was not statistically significant in this elementary analysis, while the second amounted to 7.6 percent and was significant ($p = .02$). This is not as important, however, as the pattern of differences. Among control families, those for which *a service case was opened* appeared to do worse than families for which no case was opened (34.0 percent compared to 29.7 percent). This is the pattern described above in which service cases appear to do worse than non-service cases because they are the highest risk cases. On the experimental side, service cases appear to do slightly better (26.4 percent compared to 27.6 percent). This is due, in part, to the inclusion of more low- and moderate-risk families in the portion of the experimental group that was offered services, as was illustrated in Figure 10.2

**Table 10.1. Rate of New Reports
by Case-Management Workgroup Opening
(All Control and Experimental Families)**

	<i>Control</i>	<i>Experimental</i>
<i>Type 1: Assessment workgroup only</i>		
No new reports	70.3%	72.4%
One or more new reports	29.7%	27.6%
<i>Type 2: Case-management workgroup opened</i>		
No new reports	66.0%	73.6%
One or more new reports	34.0%	26.4%

The last conclusion suggests the analysis shown in Table 10.2. In this case the high-risk experimental and control cases that had had CPS cases before the demonstration were removed from the tabulation. When these families are removed from the analysis, the same pattern holds.²⁰ This analysis shows that when the highest-risk families are removed from consideration, the reduction in recurrence among AR families who received services as well as the increases in recurrence among TR families who received services were still evident. If the difference in patterns between experimentals and controls in Table 10.1 was simply a reflection of increased services to lower risk families and not to the effects of services, per se, then we might have expected the pattern to disappear in Table 10.2. Instead, the pattern remains at about the same intensity. *This supports the hypothesis that service cases among lower risk AR families led to family*

²⁰ We made the point in the previous analysis of risk and change in family attitudes that the SDM Family Risk Assessment instrument was not independent of the difference in approach, that is, that risk levels of families and risk scores were reduced by the family friendly approach embodied in AR. For this reason, the risk scale cannot be used as a control variable. Two individual items in the scale, however, refer to past child abuse and neglect reports (see items N2 and A2 in Figure 9.4). These items are less susceptible to the influence of the way the worker approaches the family. An index was created using these items (0 = no previous reports; 1 = one or more previous reports). When families with no previous reports were analyzed, the results were similar to those in Table 10.2, and for that reason, are not shown here.

improvement, increases in child safety and lower recurrence rates. Like so much in evaluations of this kind, the results suggest but do not prove this to be the case.

**Table 10.2. Rate of New Reports
by Case-Management Workgroup Opening
(Only Control and Experimental Families
with no Previous CPS Case Openings)**

	<i>Control</i>	<i>Experimental</i>
<i>Type 1: Assessment workgroup only</i>		
No new reports	65.2%	69.0%
One or more new reports	25.1%	23.7%
<i>Type 2: Case-management workgroup opened</i>		
No new reports	56.3%	68.4%
One or more new reports	28.9%	21.7%

The same pattern holds in a survival analysis. In this case, a more sophisticated type of survival analysis was utilized (Cox Proportional Hazards Regression). The model that corresponds most closely to Table 10.2 is shown in the following table (Table 10.3). (Details of the analysis can be found in the Technical Appendix.) In this analysis, the more powerful regression model demonstrates the reality of differences that were only suggested in cross tabulations.

The Cox Regression allows us to examine the relative influence of the AR program on report recurrence while at the same time considering service case openings. In summary the table shows the following:

1. Families that had been in earlier open cases before they were selected for the experimental or control group were significantly more likely to experience a new report later, whether or not they received AR or other services ($p < .0001$). *This supports the conclusion that, other things being equal, families previously served by CPS are at higher risk of subsequent new reports.*
2. AR produced reductions in recurrence, whether or not families received services during the original case or had a case opened before being assigned to the demonstration ($p = .008$). The Cox analysis yields survival charts similar to those shown in Figure 10.1, even though the analysis controls for both previous and current case-management workgroup openings (see Technical Appendix). *This adds further support to the conclusion we reached upon examining differences in the SDM risk assessment—that the AR approach improves outcomes whether or not service cases are opened on families.*
3. The effects of services on recurrence during the case are not found in whether a case management workgroup was opened ($p = .301$) but in the interaction between the AR approach and service openings ($p = .052$). This corresponds to the pattern of differences in Table 10.2. *This supports the hypothesis that the relative reduction in*

recurrence among experimental families compared to control families was associated with services. Expanding the population of families that can be and are served will improve long-term outcomes of families screened as appropriate for AR.²¹ This focus on the interaction of AR vs. TR and opening vs. not opening CM workgroups addresses the general questions: 1) Are later child welfare outcomes improved if, regardless of risk level, a family has a case management workgroup opened? and 2) Are results better under the AR than under the TR approach? *The tentative answer is yes to both questions, but to answer these questions definitively an analysis would be necessary that linked specific family service needs with services actually offered.*²²

Table 10.3. Cox Regression Results
Dependent Variable: Time to First New Accepted Report of Child Maltreatment
after the Research Treatment was Concluded

Variable	B	Wald Statistic	Signifi- cance	R	Exp(B)
A. Previous CPS case before demonstration	-0.84	105.5	0.000	-0.07	0.43
B. CM workgroup opening after initiating report	-0.08	1.0	0.301	0	0.93
C. Experimental-Control group membership	0.36	7.1	0.008	0.02	1.44
D. Interaction of B and C	-0.30	3.8	0.052	-0.01	0.74

Effects of the Level of Worker Activity with Families on Recurrence

The data system (SSIS) permits workers to log the types of activities and the length of time expended on the activity for each case. Worker time logs permit 22 separate types of activities to be coded, but the large majority of activities actually recorded fall into three categories: assessment/investigation, client contacts and collateral contacts. *We could find no relationship between child maltreatment report recurrence and the quantity of activities of workers in experimental and control cases.* It is possible that there is a relationship but that the measure is too crude to show it. Collateral contacts, for instance, refers to a wide variety of activities.

Judging from total logged minutes, experimental workers on average spent more time on cases than control workers. When all activities were considered without regard to the type of activity, this difference was not statistically significant. However, when the type of activity was limited to “client contacts,” the difference was statistically significant. The average (mean) number of logged minutes of client contacts in control cases was 87.8 minutes compared to 98.0 minutes for experimental cases. AR workers

²¹ This particular model is analogous to the interaction shown in Figure 9.3. In this analysis, however, the group of control cases in which the service variable (CM workgroups) was positive was large enough to reveal a statistically significant difference. The same effects might have occurred in the safety analysis if a larger sample of cases had been available.

²² For example, a question might be: Are later child welfare outcomes improved if a family in need of childcare is actually assisted with childcare and does this service have better effects under AR than under TR? Questions like this cannot be answered directly at this level of analysis because SSIS contains no data on specific services offered to families.

had significantly more client contacts in family assessments. The average number of minutes spent in client contacts for cases in which a CM workgroup was opened, however, was somewhat lower for AR than TR, but this is attributable to the smaller proportion of TR cases of this type. In the present analysis, this amounted to a mean of 124 logged client-contact minutes for 1,036 AR cases with a case management workgroup opened out of 2,060 total cases (50.3 percent) compared to a mean of 163 logged client-contact minutes for 197 similar TR cases out of a total of 1,305 cases (19.0 percent). The net effect was more time with clients and more time overall logged by AR workers for experimental families. *This finding corresponds to the findings of the cost study considered in Chapter 12 showing that AR involves higher costs during the initial AR case.*

Worker time logs were also examined during the follow-up period on each experimental and control case. *During the follow-up period the situation was reversed: more worker activity was logged for TR cases.* This also corresponds to the work in Chapter 12. Again, the total difference in hours across the entire set of experimental and control families was not statistically significant. These hours occurred, of course, when report recurrence and ensuing events, such as case openings, occurred. The average amount of time spent on recurring cases was about equal for the experimental and control families. *The difference arose because recurrence and the worker time associated with recurrence occurred for a smaller proportion of experimental families than control families, as demonstrated above.*

Effects of Race on Family Recurrence

We are generally reticent to introduce variables based on racial and ethnic identity into analyses like those in this section, primarily because race and ethnic identity in American society are strongly associated with measures of social class: income, wealth, educational level and other related variables. Individuals in minority families, on the whole, are poorer and less educated than those in the majority white population. Differences that are discovered in analyses that compare families based on racial and ethnic identity may be due to racial discrimination, social class differences or a combination of the two. If complete data were available on income, earnings and education of each family in this study, it might be possible to determine whether racial discrimination was operating in AR. Unfortunately, this kind of information is not consistently recorded in SSIS.²³ Nevertheless, the following material is presented because we were requested to include such analyses. We note that without social class information the analyses are of limited value.

To determine the race of families, we examined the racial designation within SSIS of the caregivers of the family. In a small number of cases (2.7 percent), this information was missing from the file. These were coded as missing data in analyses. A five-

²³ The SDM Family Strengths and Needs assessment instrument is a potential source of comparative data of this kind. Unfortunately, this instrument was added to SSIS some months after this evaluation began and was not available for early cases.

category system was utilized: Caucasian, African-American, American Indian, Asian and Pacific Islander. Only a handful of the latter category was in the experimental or control group. Hispanic is a separate designation in SSIS that potentially cuts across the other racial groups. In about 90 percent of families that were considered Hispanic, however, the racial designation was Caucasian. Only 368 Hispanic families were found in the experimental and control groups combined.

Looking at all experimental and control subjects, 74.1 percent were Caucasian, 17.2 percent were African-American, 4.6 percent were American Indians and 4.1 percent were Asian. The latter two groups amounted to 183 and 162 families respectively, numbers that were generally too small for meaningful comparisons. African Americans are underrepresented in the study population compared to the CPS population of Minnesota as a whole, in part because Hennepin County with its large African-American population was slow to adopt and implement AR and in part because several other moderate sized counties in the study had small populations of African-American. American Indians were found in Counties that were near to or that incorporated portions of Indian reservations and in the urban population St. Paul (Ramsey County) and Minneapolis (Hennepin County).

The proportions of families with report recurrence in each of these four groups are shown in Table 10.4, without regard to experimental or control group membership. This table shows the percentages of families with at least one report during the follow-up period. Recurrence was substantially higher among African American and American Indian families.

Table 10.4. Maltreatment Report Recurrence by Race

	<i>Percent Report Recurrence</i>
<i>Caucasian</i>	26.4%
<i>African American</i>	36.1%
<i>American Indian</i>	42.6%
<i>Asian</i>	19.9%
<i>Hispanic</i>	29.5%

The question is whether difference could be observed when experimental and control groups were compared. In other words, were the effects of AR observed for the entire study population also discernable *within* these subpopulations? This is shown in Table 10.5. *Among the three largest groups, Caucasian, African-American and American Indian families, the pattern previously demonstrated for AR was preserved. The rates of recurrence during the follow-up period were lower for experimental families—those that received AR.* However, tabular analyses like these are sensitive to the size of sample, and of these three, only the difference in Caucasian families (the largest group) was statistically significant ($p = .037$). The difference with the American-

Indian category showed a statistical trend ($p = .097$). The proportions among Asians can be discounted due to the small number of families in this category.

Table 10.5. Maltreatment Report Recurrence in Experimental and Control Families by Race

	<i>Control</i>		<i>Experimental</i>	
	n	%	n	%
<i>Caucasian</i>	261	29.0%	522	25.7%
<i>African American</i>	78	36.6%	162	34.5%
<i>American Indian</i>	33	47.1%	41	36.3%
<i>Asian</i>	7	11.5%	17	16.8%
<i>Hispanic</i>	22	23%	86	31%

Hispanic families showed a reversal, with families under the traditional approach actually doing significantly better than AR families. We know of no explanation for this difference, except that this racial designation was over-represented on the experimental side of the study making the number of Hispanic control families overall quite small (95). It should be remembered that 9 out of 10 of these families were also included in the Caucasian analysis, because the Hispanic category cuts across the other racial groups. We are inclined to discount this finding.²⁴

A survival analysis similar to the analysis reported above for the effects of CM workgroup openings was also conducted (Table 10.6). The racial/ethnic variable was simplified to a binary form: white versus minority families. In this case the question was whether the differences apparent in recurrence between Caucasian and minority group families as a whole (see Table 10.5) would continue to exist when we controlled for previous case openings, case openings during the initial case and experimental versus control group memberships (see the Technical Appendix for full tables). *The analysis suggests that the variables underlying higher recurrence among minority families (of any kind) are independent of the other variables, including the AR program. It also shows that the differences produced through AR are robust when racial variables are considered, that is, the positive outcomes due to AR cannot be attributed to differential treatment of racial or ethnic minorities.*

²⁴ Hispanic designation was the most difficult to determine through SSIS data. Many cases were found in which one or more children were designated as Hispanic but adults were not. Whether this reflects adoptions or entry errors could not be determined. These cases were not included among Hispanic families. Among families that we did designate as Hispanic, some had one Hispanic caregiver and others had two. Differences in outcome were found when these two subsets were compared. This illustrates the messy problems that arise when simple categorizations are forced on families with diverse racial and ethnic structures.

Table 10.6. Cox Regression Results
Dependent Variable: Time to First New Accepted Report of Child Maltreatment
after the Research Treatment was Concluded

<i>Variable</i>	<i>B</i>	<i>Wald Statistic</i>	<i>Signifi- cance</i>	<i>R</i>	<i>Exp(B)</i>
A. Previous CPS case before demonstration	-.82	100.9	.000	-.08	.49
B. CM workgroup opening after initiating report	-.14	4.2	.040	-.01	.87
C. Experimental-Control group membership	.12	3.7	.055	.01	1.13
D. Caucasian versus minority families	.18	8.0	.005	.02	1.19

Screening of Recurring Reports

All experimental cases received an alternative response (a family assessment) after the initiating report and all control families received a traditional response (a CPS investigation). When families experienced later reports, the hope was that control families would *not* be offered AR, even if they were later screened as appropriate for AR. While this was mentioned to local office representatives during preparations for the evaluation several months before the evaluation began, after evaluators examined the data system (SSIS) it became apparent that it would be impossible to control track assignment of later reports. As new reports were screened, the SSIS exhibited no information on how previous reports had been screened (i.e., whether that had been AR or TR) and more importantly, on whether families had been assigned to the experimental or control group. In addition, all but the very smallest offices received large numbers of reports—too many for intake workers to remember previous screening decisions. Also, numerous staff representatives in local offices were responsible for screening decisions. It was unlikely that the impact evaluation played an important role in screening. This became more likely as the evaluation proceeded, particularly after December 2002, when assignment to experimental and control groups ceased.

Table 10.7 shows percentages of *families* with different combinations of AR and TR recurring reports. The percentages for all study families reflect recurrence rates discussed above (control: 30.3 percent; experimental 27.2 percent). The bases of the percentages in each column are experimental and control families with at least one new report. Under this condition, the control and experimental percentages are roughly similar. For example, about 63 percent of each group had one or more reports screened TR but none screened AR (bottom two percentage rows of table).

This means that 37.1 percent of control families that experienced a recurring report had at least one of those reports screened as AR. This crossover had minimal effects on the results of the survival analyses presented above because those analyses were keyed to the reception of the *first* recurring report. Screening and AR/TR-track assignment occurred after the report was received.

Table 10.7. Pattern of Screening of Recurring Reports for All Families and for Families with at Least One Recurring Report after Closure of the Initial Treatment Case

<i>Patterns of recurring reports</i>			<i>All study families</i>		<i>Only families with recurring reports</i>	
<i>Number</i>	<i>Screened AR</i>	<i>Screened TR</i>	<i>Control*</i>	<i>Experimental*</i>	<i>Control</i>	<i>Experimental</i>
<i>None</i>			69.7%	72.8%		
<i>One</i>	<i>One</i>		7.4%	5.7%	24.7%	21.3%
<i>Two or more</i>	<i>Two or more</i>		0.6%	0.8%	2.0%	3.1%
<i>Two</i>	<i>One</i>	<i>One</i>	2.2%	2.0%	7.4%	7.3%
<i>Three or more</i>	<i>Two or more</i>	<i>One</i>	0.2%	0.2%	0.5%	0.9%
<i>Three or more</i>	<i>One</i>	<i>Two or more</i>	0.5%	1.1%	1.5%	4.2%
<i>Four or more</i>	<i>Two or more</i>	<i>Two or more</i>	0.3%	0.1%	1.0%	0.5%
<i>One</i>		<i>One</i>	13.0%	11.5%	43.1%	42.9%
<i>Two or more</i>		<i>Two or more</i>	5.9%	5.3%	19.6%	19.9%
<i>Total Number</i>			1,305	2,860	392	770

* 0.3 percent experimental and control cases with missing screening information for recurring reports

The primary import of Table 10.7 is that the agency reaction to experimental and control families with new reports was, overall, the same. The reaction was the same because the experimental and control groups were very similar. This suggests that recurrence was not limited to one particular type of family or type of alleged child maltreatment, that is, that families that returned to the system were a reflection of the diversity of the original group of families. And if this is true it suggests *the effects of AR demonstrated above were not confined to particular types of initial child maltreatment*—a finding that is demonstrated in the following section where patterns of presenting problems are considered.

A second point to emphasize in Table 10.7 is that most experimental and control families (nearly two thirds) that returned were never offered AR. Instead they were screened as traditional. Traditional investigations are chosen more often when reports are believe to involve serious threats to the safety of children. This occurred in part because serious safety threats are indeed present in families with second, third and fourth reports. For example, the original screening before random assignment excluded sexual abuse reports from AR, but some of the new reports were sexual abuse reports and, therefore, were mandatory TR. On the other hand, screeners may also have been approaching AR more conservatively than necessary. To illustrate this point, families in the six NIS counties are shown in Table 10.8 along with experimental and control families. This table contains percents only for families in which recurrence occurred (see rightmost columns of Table 10.8).

Table 10.8 illustrates the difference in approach in the NIS counties that had fully adopted AR from the beginning of the demonstration, and for that reason, were unwilling to permit any families to be assigned to a control group.

Table 10.8. Pattern of Screening of Recurring Reports for Families with at Least One Recurring Report after Closure of the Initial Treatment Case

<i>Patterns of recurring reports</i>			<i>Families in the 14 IS counties*</i>		<i>Families in the 6 NIS counties</i>
<i>Number</i>	<i>Screened AR</i>	<i>Screened TR</i>	<i>Control</i>	<i>Experimental</i>	
<i>None</i>					
<i>One</i>	<i>One</i>		24.7%	21.3%	32.6%
<i>Two or more</i>	<i>Two or more</i>		2.0%	3.1%	9.3%
<i>Two</i>	<i>One</i>	<i>One</i>	7.4%	7.3%	6.0%
<i>Three or more</i>	<i>Two or more</i>	<i>One</i>	0.5%	0.9%	1.7%
<i>Three or more</i>	<i>One</i>	<i>Two or more</i>	1.5%	4.2%	4.1%
<i>Four or more</i>	<i>Two or more</i>	<i>Two or more</i>	1.0%	0.5%	1.2%
<i>One</i>		<i>One</i>	43.1%	42.9%	31.0%
<i>Two or more</i>		<i>Two or more</i>	19.6%	19.9%	14.0%
<i>Total Number</i>			392	770	484

* Duplicates columns from Table 10.7 above.

In Table 10.8, it can be seen that the response to recurring reports in these counties was more heavily shifted to AR and away from TR. These counties, led by Olmsted with the oldest fully functioning AR program in the state, screened more reports into AR from the start, as had been shown in earlier analyses in this report. Generally they trusted the AR approach for a wider array of families, many of which would have been screened as inappropriate in other counties. Yet, the recurrence rate (25.0 percent) was lower than either the experimental (27.2 percent) or control group (30.3 percent) in 14 IS counties. And among those families with new reports the pattern of assigning more families to AR was continued.

Findings of Maltreatment. Because the recurrence rate was lower among experimental families, rates of both new AR and TR screenings were also lower. This will be apparent from an inspection of the middle experimental and control columns in Table 10.7. These differences were not statistically significant. Similarly, the rates of substantiation or findings of maltreatment were also lower for experimental families but the difference was not large enough to be statistically significant.

New Case Management Workgroups. We have seen that significantly and substantially more case management workgroups were opened to provide post-assessment services for experimental families in response to initiating reports. The reasons for this have also been discussed. Having now seen that the pattern of screening associated with recurring reports was similar for experimental and control families, it might be expected that services after assessment would be about equal for both groups. This was indeed the finding. Looking only at families for whom a new report was received, new case management workgroups were opened for virtually the same proportions: 49.7 percent of control families compared to 48.9 percent of experimental

families ($p = .42$).²⁵ However, *because fewer new reports were received for experimental families overall, the proportion of new CM workgroups for all experimental families was lower than for all control families (statistical trend)*. New cases were opened for 17.7 percent of all control families compared to 15.8 percent of all experimental families ($p = .069$).

We also asked whether this difference was related to case openings after the initiating report. The results were informative. As pointed out previously, these groups are not strictly comparable because a substantially larger number and, thus, a much wider variety of experimental than control families were given post-assessment services (by having a CM workgroup opened), and we would, therefore, expect lower rates of new reports and cases. Looking at families with a CM workgroup after the initiating assessment, 182 of 1,086 experimental families (17.6 percent) had a new CM workgroup opened compared to 39 of 158 control families (19.8 percent). The probability associated with this (.26) indicates that the difference observed is not reliable, primarily because of the small number of control families. The same pattern can be observed among families that had *no CM workgroup after the initiating assessment*. These were the Type-1 cases referred to earlier that experienced *only a traditional investigation or family assessment*. Among these, 270 of 1,824 experimental families (14.8 percent) had a new CM workgroup opened compared to 192 of 1,108 control families (17.3 percent). This difference was statistically significant ($p = .039$). *This finding adds weight to the assertion that the AR approach has long-term effects apart from service case openings.*

These findings are also consistent with the cost-effectiveness analysis in Chapter 12. Smaller proportions of new reports and new assessments reduce the need for additional post-assessment services. Together these outcomes reduce the later costs of associated with CPS.

Patterns of Presenting Problems in Recurring Reports

The analysis of patterns of screening moves us away from a binary view of recurrence of CA/N reports—as events that either happen or do not happen. This approach can be developed further by coupling two variables: 1) the categories used by intake workers to characterize presenting problems and 2) sequences of CA/N reports in the same family over time. Each of these has limitations.

Presenting problems recorded by intake workers reflect reporters' descriptions of child maltreatment. Categories of presenting problems in SSIS include:

- Neglect (food, clothing, shelter)
- Physical abuse
- Threatened physical abuse

²⁵ New case management workgroups were counted for *any* subsequent contact with CPS. For example, a family with three new reports/assessments that had a CM workgroup opened for only the third of these three would be counted as 1 in this analysis.

-
- Sexual abuse
 - Threatened sexual abuse
 - Mental injury
 - Prenatal exposure
 - Infant medical neglect
 - Endangerment
 - Inadequate supervision
 - Educational neglect
 - Medical neglect
 - Emotional neglect
 - Chronic and severe use of alcohol or controlled substance
 - Abandonment

The principal limitation on these is that intake workers typically enter only one type into the data system. Our assumption was that this represented the primary emphasis of the reporter or the most dangerous types of abuse or neglect being reported. It was clear from narratives entered in SSIS by intake workers, however, that reports often included multiple types of child abuse and neglect.²⁶ SSIS data, therefore, represent a simplification of the types and quantities of maltreatment being reported.

No comparable categories exist for assessment workers to complete after the first visit with families. When an investigation is conducted and child maltreatment is determined, assessment workers, of course, enter the type(s) of maltreatment into SSIS. This is limited to the minority of substantiated investigations, and because none of the families in experimental cases in this evaluation were investigated, types of maltreatment were known for only a small portion of control group families.

On the other hand, it should be remembered that the majority of reporters are mandated, that is, professionals who are required under law to report possible child maltreatment. Most reporters, whether mandated or not, call because they have real concerns about the welfare and safety of children. False reports (e.g., harassment reports) constitute only a tiny minority of total reports to CPS. It is true that in the traditional CPS system most investigations were unsubstantiated. But unsubstantiated meant unable to be proven, not that the reports were false, and when reports were substantiated, the type of maltreatment indicated was nearly always in the same general category as the type of maltreatment reported.²⁷ In the traditional system, a child maltreatment report

²⁶ Intake workers create a narrative summarizing the reporter's allegations. Narratives are informative to assessment workers and provide a starting point for conversations with family members. But the type and extent of information included varies significantly—partly because of differences in emphasis of intake workers but primarily because of limitations on what reporters know about families. Some reports are rich in family history and circumstances and details of threats to children; others are not. For this reason we decided not to use intake narratives for quantitative research purposes. However, we did conduct a systematic analysis of narratives to examine the question of multiple presenting problems. We found that the majority of intake narratives contain two or more alleged types of maltreatment.

²⁷ This was confirmed for Minnesota data by comparing the presenting problem with the type of maltreatment when substantiation occurred. Confirmed maltreatment and presenting problem were virtually always in the same general category of child abuse and neglect.

represented the opinion of one person (usually a professional) that a child was being maltreated or in danger. A substantiated report represented the opinions of two people, the reporter and the investigator, that a child was being maltreated or in danger. Problems presented in reports to CPS should not be disregarded.

For the present analysis, all reports were assembled for each experimental and control family during the data period from February 2001 through March 2004. Each family had an initiating report during the period of assignment (February 2001 through December 2002). Reports before the initiating report were set aside in this analysis. The primary presenting problem was available for each report. Unlike our previous recurrence analyses, all reports were considered, whether during or after the initial “research treatment period.” Using this information, contingency tables were constructed for the experimental and control groups (the two sub-tables in Table 10.9).

Before discussing these, some underlying characteristics should be reiterated. Like all the analyses to this point, recurrence is tied to families, not simply to children, parents or perpetrators. Families in this analysis may increase in size as they are tracked, if new children and adults appear, as discussed in the introduction to the impact analysis. This occurs in only a minority of families but when new children appear (though births or marriage), the likelihood of new reports increases accordingly. New reports then refers to new reports on any child in the family whether that child or the adult perpetrator was or was not a member of the family at the time of the initiating report, when the family entered the evaluation. Also, unlike county level SSIS data, this analysis tracked families throughout the state. In this way new reports were captured on families that moved to other Minnesota counties. This occurred in a substantial portion of families because so many counties in the study were adjacent to one another (e.g., counties in the Minneapolis-St. Paul area, Blue Earth and Nicollet, Carlton and St. Louis). This should be born in mind when comparing statistics in this study with others used in the state or generated in other states because both these procedures tend to bring (report) recurrence nearer to actual levels than more restricted procedures that do not consider families or family relocation.

The categories of presenting problems in Table 10.9 are shown on the left side of the table. Each row represents a presenting problem *in the initiating report*, that is, in the report at the time the family was assigned to the experimental or control group.²⁸ The central columns of the table also represent presenting problem categories (see abbreviations at the end of each row title). The columns contain counts of *later reports on families*. For example, there were 321 control families with an initiating report of neglect (food, clothing or shelter). Looking across this row, there were 60 subsequent neglect reports on these families and 29 subsequent physical abuse reports, and so on. These 321 families had a total of 180 later reports after the initiating report, and these reports were received on 97 of the 321 families, a little less than two per family.

²⁸ The initiating report is not, of course, the first report *ever* received on families and should not be interpreted in that way. Some families have a past history with the agency as we have seen. Rather, this approach takes a static snap shot of each family at the time of the initiating report and then observes the family for new events over time.

Moving down the left side of the table to the Total row for control families, we see that there were 1,305 families with initiating reports. Looking across, we see that there were 767 later reports on 416 families. These 416 represented 32 percent of all control families. By arranging data on sequential reports in this way, informative patterns emerge that remain hidden when maltreatment reports are considered in a static fashion.

It is clear that *variability in the types of presenting problems in later child maltreatment is not the exception but the rule*. In the body of the table, any cell that represents 10 percent or more reports in that row is printed in bold typeface.²⁹ In the previous example, the 60 later reports of neglect constituted 33.3 percent of all later reports on those 321 families, and the number **60** is printed in bold. We might expect that the majority of later reports on families that were initially reported for child neglect would also be child neglect. But while neglect is the largest category of later reports, two-thirds of later reports were of other kinds. The other big categories were physical abuse, endangerment, and lack of supervision. This is the pattern of the table for both the control and the experimental group. *The primary presenting problems of the majority later reports were different from the presenting problem of the initiating report.*

A striking example of this appears in the sexual abuse column (labels SA in Table 10.9). About 6 to 7 percent of new reports were sexual abuse reports and those reports are scattered uniformly across the different categories of presenting problems. We would be hard pressed to predict, based on an initial presenting problems, which families would later present as sexual abuse.³⁰

This pattern suggests that a broader approach is needed to families reported for child abuse and neglect. In certain cases, a set of underlying factors were present in the family at the time of the initiating report that led to child maltreatment at a later time. The question in these cases is whether the family was dealt with in a comprehensive fashion with a concentration on the full array of family strengths and needs or whether the focus was on the particular type of child abuse and neglect and only those factors thought to be directly related to it. In other cases, new conditions emerge in families or family circumstances change leading to new instances of child maltreatment. The CPS system cannot be expected to deal with such unforeseen problems, but even in these cases we can ask what could have been done to assist families and children to cope when new problems arose.

²⁹ Because some rows contained small numbers of reports, this procedure was limited to cells with 5 or more reports.

³⁰ We are not saying that sexual abuse or any other kind of child abuse and neglect do not have unique etiologies. Indeed sexual abuse would probably be found in these cases to have arisen because of changes in family circumstances in which children were exposed to potential sexual perpetrators. We are saying that families cannot be “characterized,” that is they should be stereotyped based on a single kind of child maltreatment report.

Table 10.9. Presenting Problems of Initial and Later Reports of Experimental and Control Families

Presenting problem Control Families	Families		Number of later reports by presenting problem															Later reports		Families	
	No.	%	NG	PA	TPA	SA	TSA	MI	PE	IMN	END	SUP	EDN	MN	EMN	ASA	ABN	No.	%	No.	%
Neglect (fd, cltg, shlt) NG	321	25%	60	29	2	11			3		29	21	15	3		2	5	180	23%	97	30%
Physical abuse PA	496	38%	37	112	6	15	3	1		1	24	21	7	1		2	2	232	30%	146	29%
Threatened phy abuse TPA	32	2%	3	1		3					3	4	1			1		16	2%	12	38%
Sexual abuse SA		<1%																			
Threatened sexl abuse TSA	2	<1%	1								3							4	1%	0	0%
Mental injury MI	4	<1%	1			1						1						3	<1%	3	75%
Prenatal exposure PE	3	<1%	1			3			1				1					6	1%	3	100%
Infant medical neg IMN	1	<1%																	<1%	0	0%
Endangerment END	82	6%	6	17	1	2			1		11	10	5				1	54	7%	22	27%
Inadequate superv. SUP	178	14%	22	30	3	6				1	12	31	15	4	1	1	1	127	17%	61	34%
Educ. neglect EDN	143	11%	6	16		9			1	1	22	7	40	3				105	14%	50	35%
Medical neglect MN	26	2%	3	10	2	1		1			3	1	2	1				24	3%	12	46%
Emot. Neglect EMN	5	<1%	2									1			1		1	5	1%	3	60%
Alcohol/Subst. Abuse ASA	6	<1%	2									2	1			1		6	1%	4	67%
Abandonment ABN	6	<1%	2	1								1					1	5	1%	3	50%
Total	1305	100%	146	216	14	51	3	2	6	3	107	100	87	12	2	7	11	767	100%	416	32%
% each type later report			19%	28%	2%	7%	0%	0%	1%	0%	14%	13%	11%	2%	0%	1%	1%	100%			
Presenting problem Experimental Families	Families		Number of later reports by presenting problem															Later reports		Families	
	No.	%	NG	PA	TPA	SA	TSA	MI	PE	IMN	END	SUP	EDN	MN	EMN	ASA	ABN	No.	%	No.	%
Neglect (fd, cltg, shlt) NG	627	22%	169	72	6	23	2		2		32	68	30	9	2	7	3	425	25%	191	30%
Physical abuse PA	1102	39%	79	222	16	49	4	3	2		46	41	25	8	8	6	7	516	31%	279	25%
Threatened phy abuse TPA	71	2%	5	12	3	1					2	3	1	1	1		1	30	2%	20	28%
Sexual abuse SA	1	<1%																	<1%	0	0%
Threatened sexl abuse TSA	2	<1%	3	1			1					1						6	<1%	1	50%
Mental injury MI	7	<1%	2			2		1				1						6	<1%	2	29%
Prenatal exposure PE	6	<1%	1	1								1						3	<1%	3	50%
Infant medical neg IMN	3	<1%	1								1			2				4	<1%	2	67%
Endangerment END	171	6%	20	24	2	5			2		25	4	4		1	8	3	98	6%	49	29%
Inadequate superv. SUP	436	15%	53	56				2	2	1	33	80	15	6		9	2	270	16%	129	30%
Educ. neglect EDN	385	13%	32	50	1	7	1		2		48	28	98	1			5	273	16%	128	33%
Medical neglect MN	27	1%	5	7		2					3	1	4	4				26	2%	10	37%
Emot. Neglect EMN	7	<1%	1								2	1						4	<1%	0	0%
Alcohol/Subst. Abuse ASA	8	<1%	3	1	1						1							6	<1%	4	50%
Abandonment ABN	7	<1%	2	2													1	6	<1%	4	57%
Total	2860	100%	376	448	29	101	8	6	10	1	193	229	178	31	12	30	21	1673	100%	822	29%
% each type later report			22%	27%	2%	6%	0%	0%	1%	0%	12%	14%	11%	2%	1%	2%	1%	100%			

Are any differences evident between experimental and control families in the patterns of subsequent reports? We know that the AR approach is designed to engage families and to offer services on a broader basis. This has been confirmed in the analyses presented to this point and is further supported by analyses below:

- The level of services as measured through case-management workgroup openings was significantly and substantially greater
- Families were more cooperative and had a greater sense of participation
- The types of services offered to families were broader, with significantly more services addressing basic household and financial needs of families

Inspection of the body of the control and experimental sub-tables in Table 10.9 shows little that is different. The cells printed in bold are essentially the same between the two sets of families. *The patterns of recurrence do not change substantially, even though the level of service cases in experimental families (36.2 percent) was over twice as high as control families (15.1 percent).* This is also evident in the column percentages at the bottom of each sub-table (“% each type later report”), which divide up the kinds of later reports for experimental and control families. The percents are quite similar for both groups.

The effects of the AR approach (both improved family engagement and increased service levels) are evident in comparing the rightmost columns of the experimental and control sub-tables. There it is possible to see that a slight reduction in recurrence occurred for experimental families in many different areas of presenting problems. Among families with original neglect reports the report recurrence levels were the same and was higher for endangerment cases among experimentals but lower for experimental families with initial reports of physical abuse, threatened physical abuse, lack of supervision, educational neglect and medical neglect. *This suggests that the positive outcomes outlined in previous sections and especially in the survival analyses were not limited to particular types of initial presenting problems but were scattered among all types of problems and families in the experimental group. This finding is consistent with the broader approach embodied in AR, in which the focus is the full array of family needs rather than addressing a particular child maltreatment threat.*

A final note is in order on the levels of recurrence. This analysis indicates the recurrence of child abuse *reports recurs for about one in every three families* screened as appropriate for AR. As it turns out, AR-appropriate families are lower-risk in general, although screening for AR is focused more on child safety issues rather than on the variables associated with risk of future child maltreatment. Nonetheless, this rate of family recurrence (one out of three) is low for several reasons. The longest tracking period for any family in the table is about three years and many families were tracked for less than two years. The rate of recurrence would be certain to increase were these families tracked for a longer period. Our experience elsewhere is that the statewide *family-report* recurrence rates for the entire CPS population approaches 65 percent over

periods of eight years. Families once reported have at least 65 percent chance of being reported again. The rates will be slightly lower among the families in this study because those that were inappropriate for AR were not included and they tend to have the highest recurrence. *However, it is inaccurate to say that low-risk and moderate-risk families seldom return to the system. It depends on how recurrence is defined and how long families are tracked.*

Later Removal and Placement of Children

We have seen that a portion of families previously reported to the CPS system returned with new reports and new assessments. In some of these cases child maltreatment was determined that was serious enough to warrant the removal and out-of-home placement of children. Among the 1,305 control families, there were 3,360 children with 263 removed and placed for some period of time during the follow-up period. Among the 2,860 experimental families, there were 7,174 children with 514 removed for some period of time during the follow-up period. This amounted to 7.8 percent of children in control families compared to 7.2 percent of children in experimental families. Families in which children were removed had more children on average than families in which children were not removed. In some cases, SSIS placement records showed simultaneous removals of all children in the family but in a significant number of both experimental and control families, placement records were found for only one child in the families during the period. Consistent with the emphasis of this evaluation on entire families rather than individuals within families, the dependent variable for this analysis was *removal of any child in the family* during the period in question.

Among experimental families the percentage amounted to 10.9 percent while among control families it was 13.1 percent, a difference that was statistically significant ($p = .02$). These percentages may seem large for families that qualified for AR after the initiating report, although the variety of new presenting problems suggests that serious safety issues arose in some families during the follow-up period. The length of child removals, however, casts the percentages in a different light. Looking at the longest period of removal of any child in a family, removals of less than thirty days were found in 19.9 percent of control and 18.6 percent of experimental families in which a child was removed. Another 11.1 percent of controls and 9.0 percent of experimentals were removed for periods of 30 to 89 days. So about one of every three families had a child in placement during the follow-up period for less than 90 days. In the control group a child was placed from 90 days to one year in 43.9 percent of families while in the experimental group the comparable figure was 39.9 percent. This distributions of days when broken into intervals in this way were roughly comparable for experimental and control families ($p = .64$). Experimentals had children in placement for slightly longer periods: the average number of days in placement was 244 days for control and 285 for experimentals and this represented a statistical trend ($p = .07$).³¹ *These data support the concept that*

³¹ The periods of placement were *cut off with the end of data collection* for this analysis: March 31, 2004. The mean days in placement of children will increase as families are tracked for longer periods.

experimental children had longer average placements because children that would have been placed for shorter periods were not removed.

Like report recurrence, follow-up periods varied for study families. A survival analysis was conducted similar to those considered earlier, except in this instance we moved directly to a regression analysis that permitted the introduction of control variables. Table 10.10 shows that the differences between experimental and control families. The difference demonstrated in the simple cross-tabulation presented above (control: 13.1 percent; experimental: 10.9 percent) was still evident in this analysis.

Table 10.10. Cox Regression Results
Dependent Variable: Time to New Removal and Placement of a Child
after the Research Treatment was Concluded

Variable	B	Wald Statistic	Significance	R	Exp(B)
A. Previous CPS case before demonstration	-1.15	105.6	.0000	-.117	.32
B. CM workgroup opening after initiating report	-.39	14.9	.0001	-.041	.67
C. Experimental-Control group membership	.25	6.6	.0102	.025	1.28

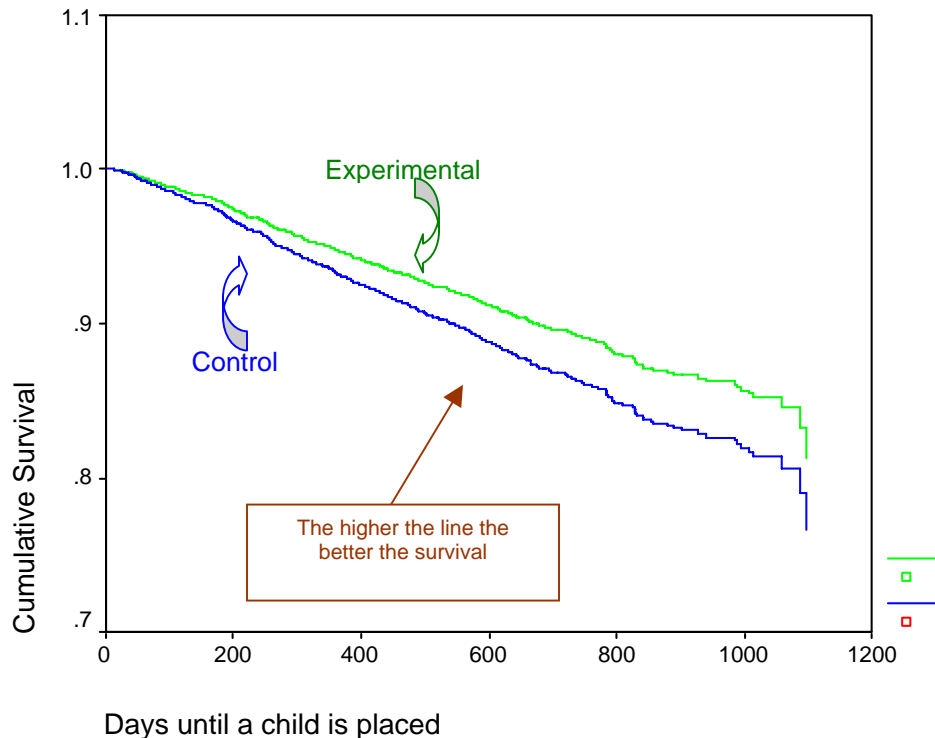


Figure 10.3. Cumulative Survival of Experimental and Control Families until a Child is Removed and Placed Outside the Home

The survival analysis takes into account the time from the close of the research treatment until a removal and placement occurs or data collection ended. Previous CPS

cases (CM workgroup) before the demonstration and CPS cases as a consequence of initiating report were both highly predictive of later removal and placement of children. *Families with a previous case during either period were more likely to experience a child removal during the follow-up period.* However, the analysis also shows that *reduced out-of-home placement associated with the AR program continued to be statistically significant even when the two variables showing previous case openings were controlled.* The difference under these conditions is shown in the comparisons of the survival functions for the experimental and control groups in Figure 10.3.

Family and Child Well-Being Based on Reports from Families

Random samples of families were contacted at nine-month intervals following the end of the CPS intervention that brought them into the study population. The following is a summary of the major findings from the reports of these families. Unless otherwise stated, all references to AR and TR families should be understood to apply to experimental and control families in the 14 impact-study counties. (All findings included here were found to be statistically significant at $p < .05$ or better.)

1. First Follow-up. (n = 849; including 473 experimental families and 376 control families). Among all experimental and control families contacted at the first follow-up, approximately nine months after last contact with CPS, experimental families were more likely ($p = .04$) to report that their family was better off because of the experience. In addition, parents in AR families were likely to report that they felt less stress about their relationships with other adults in their family than they had a year earlier. This finding held up whether or not the families had received services ($p < .04$). AR families were also less likely to report that someone in their household had a drug abuse problem (3.4 percent vs. 6.5 percent; $p = .02$). AR families were also less likely to report that there was a domestic violence problem within their family (5.2 percent vs. 11.2 percent; $p = .014$).

Compared with control families, AR families were also more likely to report that their household income (from work-related sources) had increased from one year ago (36.8 percent vs. 28.1 percent; $p = .018$). AR families were also more likely to indicate that they had some relatives or friends that they could turn to for financial help should they need to ($p = .007$).

When AR families who did not receive services are compared to TR control families who likewise did not receive services, families who received a traditional investigation were more likely to report having much more stress over their economic and financial outlook now in comparison to a year before (30.1 percent of TR families vs. 17.4 percent of AR families). Reported household income was lower for TR families who did not receive services compared with AR families who did not receive services ($p = .001$).

2. Second Follow-up. (n = 458; 252 experimental families and 206 control families). Among families contacted for the second follow-up, approximately 18 months from the end of their initial CPS involvement, 18.3 percent of experimental families reported that they had been in contact with a county child protection worker on some issue related to the well-being of a child, compared to 20.7 percent of control families; the difference was not statistically significant. Control families were more likely to report that one of their children had been involved in some delinquent behavior (28.4 percent vs. 20.8 percent; $p = .04$).

At this follow-up, AR experimental families were more likely to report that their families and their children were better off for the initial CPS experience ($p = .05$). And AR respondents were more likely to report that they had been employed more during the previous 12 months ($p = .04$) and continued to report that they had relatives or friends they could count on for financial help ($p = .008$). There was also a significant difference in reported household income (\$27,752 for experimental families and \$23,166 for control families; $p = .015$).

Comparing AR who received services with control families who received services, control families were more likely to report that their children were not affectionate ($p = .03$) and in poorer health ($p = .02$). By comparison, such control families were also more likely to report that their children had a hard time getting along with other students in school ($p = .04$).

Comparing the responses of AR families who received services with AR families who did not, we can see that those who received services continued to have many of the problems that separated them from other AR families. Their household income remained lower ($p = .01$) and they continued to experience greater economic stress ($p = .02$). They were more likely to live in crowded housing situations ($p = .02$) and less often had relatives to turn to for help ($p = .02$). Moreover, they continued to experience many problems with their children not reported as often as AR families who did not receive services originally. For example, their children were more often sick ($p = .02$) and depressed ($p = .02$); they tended to have more problems in school ($p = .004$) and more often refused to go to school ($p = .01$); they more often were affected by AD/HD ($p = .01$); and were more likely to be a source of stress for their parents ($p = .03$).

3. Third Follow-up. (n = 301; 158 experimentals and 143 controls). Among families contacted for the third follow-up, approximately 2 and a half years from the end of their initial CPS involvement, 16.4 percent of experimental families reported that they had been in contact with a county child protection worker on some issue related to the well-being of a child, compared to 17.5 percent of control families. AR respondents continued to report less stress due to relationships with other adults in their lives ($p = .035$) and less stress about their home in general ($p = .046$). Control families continued to report more frequent problems obtaining health care for their children when this was needed ($p = .015$). And AR families continued to report a higher household income (\$30,252 vs. \$24,724).

When we compared AR families who received services originally and those who did not, we continued to find many of the problems cited in the 2nd follow-up among families who had originally been assessed to need services. These differences within the AR group of families strongly suggests the probability that families assessed initially as in need of assistance are likely to continue to have more problems than other families and to be in greater need of ongoing or at least periodic assistance.

An indication both of how AR has helped families in greater need as well as how they remain different from other AR families can be seen in Figure 10.4. This graph plots reported income of families across the 3 follow-ups. It distinguishes four groups of families: AR families who did and did not receive services at the time of the original intervention, and TR families who did and did not receive services at that time.

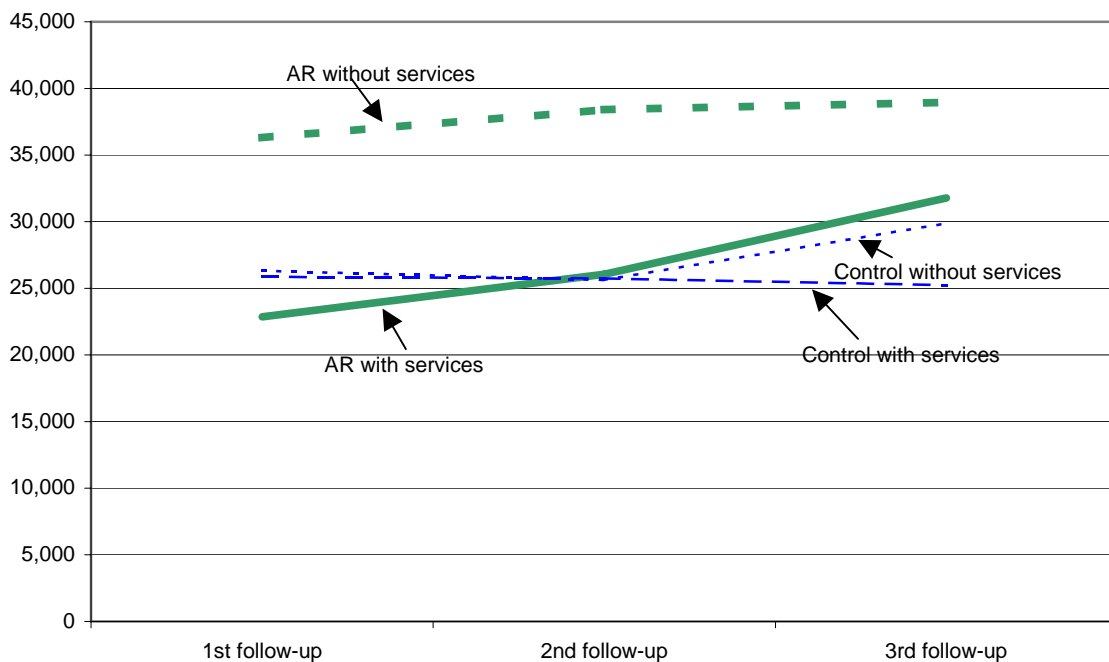


Figure 10.4. Mean income of AR and control families that received and did not receive services for each of the three follow-up periods

As noted in Chapter 5, one of the differences separating AR families who did and did not receive services as opposed to TR families who did and did not was their relative income. (And in this context, income may be seen as standing as a proxy for a whole host of conditions experienced by families.) As can be seen in this figure, there is very little difference in the income of TR (control) families who did and did not receive services at the first follow-up. Poverty and economic well-being was not a primary factor separating which of these families received services. Rather, services came into play based upon the nature of the official finding of maltreatment and often, although certainly not always, were therapeutic in nature. Over the next two follow-ups, as can be seen in the graph, the income of TR families who received some services remained essentially unchanged. The income of other TR families improved somewhat; this category includes

many families where the original report may not have been substantiated or situations in which the risk to the child was not considered grave.

AR families who did not receive services, as can be seen in the figure, averaged higher income throughout the follow-up period. Because AR services more often went to families in poverty and with multiple and often intense problems, this is an expected result. Of all families, those who received AR and also received services are the most interesting. Using income as a proxy, these families would appear to have clearly benefited from their AR experience. At the same time, as noted above, many continue to struggle and face major difficulties, including problems related to their children.

Chapter 11. AR Across the Entire CPS Population: Olmsted County

The primary impact analyses were focused on the 14 IS counties in which experimental and control groups were randomly selected *only from among* families screened as appropriate for an alternative response. The experimental design purposely excluded from consideration families that were screened as *not appropriate* for AR. All the impact questions to this point were addressed by comparing families that were appropriate for AR—some given the traditional CPS approach (the control group) and others given the AR approach (the experimental group).

Another analysis was conducted, limited to cases in Olmsted County, that involved a comparison of families screened as appropriate and provided with AR with families screened as not appropriate and provided with TR.³² Traditional CPS investigations, therefore, were conducted only for families screened as *inappropriate* for AR, while all families screened as AR-appropriate received an alternative response. The primary objective of the special analysis of Olmsted data was to identify possible reasons for recurrence among families that were, at one point in time, screened for and provided with AR in comparison to families that were screened for TR and investigated. **The presentation in the section is intended to illustrate certain aspects of the analytic approach and conclusions, not as a complete summary of the Olmsted analysis.**

Some of the 19 other counties in the study began accepting families into AR during the second half of 2000 before the demonstration began in 2001, but Olmsted began AR a year earlier and had a fully functioning AR program by the time the demonstration began. Olmsted representatives declined to permit families to be assigned to a control group because that procedure was viewed as a step back from an approach to which the county was already committed. We have also seen that Olmsted, as a more mature program, screened greater proportions of families into AR from the very start of the demonstration than most of the other 19 counties. The consequence was that many families with more serious safety allegations, and coincidentally more families with moderate to high-risk conditions, that were screened out of AR in other counties were accepted for AR in Olmsted. In this sense, the Olmsted AR population is more representative of the AR population later in the demonstration as other counties became more comfortable with the approach and screened more families into AR.

Olmsted Study Families. Data were available on Olmsted families who were in active cases or had a CA/N report on or after January 2001. A set of 832 families was

³² This section summarizes select analyses and findings from a report prepared for the Olmsted County.

found in SSIS data that had at least one intake and assessment workgroup during the period from January 2001 through June 2002. These families were selected *without regard to screening* and represented all families with a new report identified in SSIS files made available to evaluators. Each family was tracked for a standard 18-month period from the date of the initial intake.³³ As noted above, we refer to the first report, intake, and AR or TR assessment as the *initiating* report and assessment.

Report Recurrence and Assignment to AR or TR in Olmsted County

As noted in previous sections, repeated reports of child maltreatment on a family are indications, at the very least, of continuing concern of threats to the safety of the children by friends, neighbors and relatives or, more often, by mandated reporters. After a report has been received in a system utilizing alternative response, the choice of a TR investigation is an indication either that the nature of the report implies criminal activities under Minnesota law or that other characteristics of the family warranted a more adversarial approach. *Screenings for TR, therefore, can be interpreted as an indication of the most serious threats to child safety.* This suggests that a more informative measure of recurrence might be obtained by combining screening outcomes with counts of new reports.³⁴

Looking at recurrence and screening outcomes, seven patterns were defined:

1. Only one report (the initiating report) was received during the 18-month period and was screened AR.
2. Several reports on a family were screened AR with no TR screenings.
3. Families with one or more reports screened AR were subsequently shifted to one or more TR reports.
4. Responses in sequences of reports jumped back and forth from AR to TR and vice versa.
5. Families with one or more reports screened TR were subsequently shifted to one or more AR reports.
6. Several reports on a family were screened TR with no AR screenings.
7. Only one report (the initiating report) was received during the 18-month period and was screened TR.

³³ Standardized tracking simplifies comparisons. It also means that tracking periods are not coterminous. For example, a family that was first identified with an intake on February 15, 2001 would have been tracked for 548 days through August 17, 2002, but a family with a first intake on May 15, 2002 would have been tracked through December 14, 2003.

³⁴ This combination was carried out in a simpler way in a previous chapter (see Table 10.8) for experimental and control cases in the IS counties. The difference in the case of Olmsted was that none of the problems associated with the “artificial” assignment of AR-appropriate cases to traditional investigations in a control group were present. Workers and supervisors assigned all reports to AR and TR solely on the basis of their interpretation of screening criteria.

Only the initiating report was received for the majority (61.3 percent) of the 832 families (categories 1 and 7). The remainder had at least one other report during the follow-up period. The proportions of each type are shown in Figure 11.1.

Families with a single AR report constitute the largest category (42 percent). Another 13 percent of families had several AR reports within the 18-month period and 8 percent that began with one or more AR reports transitioned to one or more TR reports within the same period. On the other side, 20 percent of families screened for TR had no other reports, while 11 percent of families had several TR reports and another 4 percent with one or more TR reports transitioned to one or more AR reports.

A little over half of the families (51 percent) were never removed from the AR track compared to a little under a third (31 percent) who remained in the TR track. Switching between tracks, therefore, was confined to a minority of families with 8 percent changes from AR to TR, 4 percent changing from TR to AR, and 2 percent moving from AR to TR to AR or TR to AR to TR.

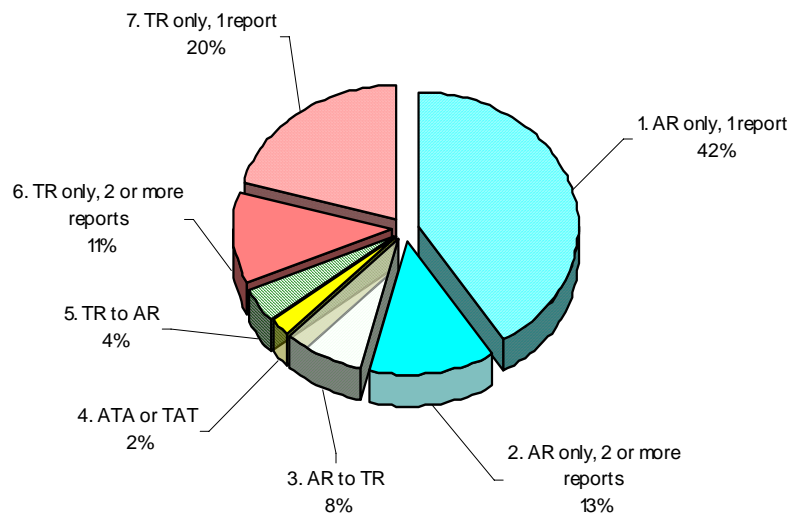


Figure 11.1. Screening Patterns of Sequences of Child Abuse and Neglect Reports of 832 Olmsted County Families during an 18-Month Period

The chart confirms that *Olmsted County maintains a relatively high consistency in the way families are approached across multiple reports. Most of the TR families were screened as TR again when new reports were received. Similarly families that were AR in the initiating report were usually screened AR later. However, minorities of families on both sides were switched between tracks when new reports were received. The shift from TR to AR meant that after one or more TR reports the family was shifted to and remained in the in the AR track for all subsequent reports (e.g., TR-TR-AR-AR or TR-AR-AR). Similarly, families that shifted from AR to TR remained in the TR track (e.g. AR-AR-AR-TR or AR-TR-TR). Very little oscillation such as AR-TR-AR or TR-AR-TR was found. Only 18 families out of 832 (2.2 percent) oscillated back and forth*

between the AR and TR tracks. However, all three of these categories would likely increase were families tracked for a longer period of time (see discussion of Table 11.1).

The shift from AR to TR can be interpreted both as recurrence and as a decline in safety status across two or more reports. On the other hand, the shift from TR to AR can be interpreted as recurrence and as an improvement in safety status across two or more reports.

A sense of the relative rates of recurrence of families initially screened AR versus families initially screened TR can be had by comparing pie slices 2 and 3 with slice 1 for AR and then pie slices 5 and 6 with slice 7 for TR. *Recurrence rates were higher for families screened initially into TR.* There were 527 families with an initiating report screened for an alternative response with 187 (35.5 percent) receiving at least one new report. By contrast, there were 305 families with a traditional response to the initiating report and of these 135 (44.3 percent) received at least one new report. Part of the explanation for this difference is that greater proportions of lower risk families were initially screened into AR. Families screened for AR tend to be at slightly lower risk of new reports of child maltreatment.³⁵ Lower overall risk means lower overall recurrence. *Although the screening tool is focused primarily on safety issues, it is also, to a lesser extent, indirectly sensitive to risk factors.*

Correlates of Recurring Sequences of Reports and Track Assignment

Level of Recurrence by Patterns of Screening. One possible explanation of the grouping seen in Figure 11.1 is simply the frequency of new reports. The more reports and consequent screenings that a family has, the more likely that one of those reports will lead to a change in tracks. Table 11.1 supports this idea.

Table 11.1. Screening Patterns by Mean Number of Total Reports

Screening Pattern	Number of families	Mean number of reports per family*		
		All	AR	TR
1. AR only, 1 report	340	1.0	1.0	
2. AR only, 2 or more reports	109	2.6	2.6	
3. AR to TR	67	3.4	1.7	1.8
4a. AR to TR to AR	11	4.7	3.4	1.3
4b. TR to AR to TR	7	3.7	1.1	2.6
5. TR to AR	35	3.1	1.5	1.6
6. TR only, 2 or more reports	93	2.7		2.7
7. TR only, 1 report	170	1.0		1.0

* Means based on all reports, including the initiating report

³⁵ SDM Family Risk Assessment scores associated with the initiating assessment were available only for about two-thirds of the 832 families and could not be used for the following analyses. Among these, however, risk assessment scores were lower for families screened into AR than for families screened into TR.

It is evident that families involved in changes of track over time have, on average, 3 to 4 reports over an 18-month period. Among families with the TR to AR and AR to TR patterns, the averages are evenly split between the two tracks. But even if it is true that transitions between tracks are more likely to occur as more reports are received on a family, what are the differences that might lead to this?

As a first step, we asked whether the kinds of presenting problems varied among the groups. The bottom two rows of Table 11.2 show the average number of reports within each presenting problem category for families that began as AR and those that began as TR. Families that began as AR had slightly higher averages in the categories of physical abuse and endangerment. Families that began as TR had higher averages in sexual abuse (a type of CA/N that mandates TR) and parental alcohol or substance abuse. Except for sexual abuse, however, the differences were not great. Looking inside the table at families that exhibited different patterns of screening some differences are apparent. The means that are in bold are those that exceed the mean for the entire group (in bottom two rows).

Table 11.2. Screening Patterns by Mean Number of Reports in Presenting Problem Categories

Screening Pattern	Mean reports for Presenting Problem*								
	NG	PA	SA	EMN	MN	END	SUP	ED N	ASA
1. AR only, 1 report	.07	.36	.00	.01	.00	.36	.14	.03	.01
2. AR only, 2 or more reports	.28	.70	.01	.02	.02	.83	.37	.17	.05
3. AR to TR	.31	.82	.21	.00	.03	1.09	.46	.22	.12
4a. AR to TR to AR	.73	.00	.36	.00	.09	1.36	.73	.09	.00
4b. TR to AR to TR	.57	.00	.00	.00	.00	.71	.29	.57	.29
5. TR to AR	.26	1.06	.09	.00	.00	.57	.71	.29	.00
6. TR only, 2 or more reports	.27	.35	.44	.01	.03	.83	.29	.06	.19
7. TR only, 1 report	.09	.26	.26	.01	.01	.22	.06	.02	.02
Total Initial AR	.16	.50	.04	.01	.01	.57	.24	.08	.03
Total Initial TR	.17	.40	.29	.01	.01	.46	.21	.08	.08

* Means based on all reports, including the initiating report

NG Neglect (food, clothing, shelter)

PA Physical abuse

SA Sexual abuse

EMN Emotional Neglect

MN Medical Neglect

END Endangerment

SUP Inadequate supervision

ED N Educational neglect

ASA Alcohol/Substance Abuse

The patterns of means in the table may be interpreted as follows:

- Neglect of food, clothing and shelter (NG) was implicated in increased number of reports as well as in track change, but at about the same levels for initial AR and TR families. This may indicate that chronic neglect families are found in both groups. Lack of supervision (SUP) resembles the category of neglect of basic needs (NG). The two categories are interrelated, often appearing in the same reports.
- Likewise physical abuse (PA) reports overall were higher for families that began as AR and remained AR. But physical abuse was implicated in changes in both

directions as well. Unfortunately, severity of physical abuse, a variable relevant to these changes, cannot be determined from this general designation.

- Under sexual abuse (SA), it is apparent that a primary reason for changes to TR among initial AR families was the emergence of new reports of sexual abuse. Other reasons were new reports of medical neglect (MN) and endangerment (END).
- The pattern for educational neglect (ED N) may suggest that that type of presenting problem is associated with remaining in AR and with transitioning from TR to AR. Parental alcohol or substance abuse (ASA) appears to be related to the opposite: continuation in TR and transition from AR to TR.

Problems of Family Members and Family History in CPS. Olmsted workers diligently entered information into SSIS concerning mental health problems and disabilities of children and adults.³⁶ An analysis of report recurrence and track change is summarized in Figure 11.2 for one of these problems: Adult alcohol or substance abuse (A/SA). AR and TR in the chart refer to the track assignment after the initiating report. Likewise, A/SA refers to characteristics discovered during the family assessment or investigation following the initiating incident. This permits an analysis *from the viewpoint of the agency at the time of the initiating incident.*

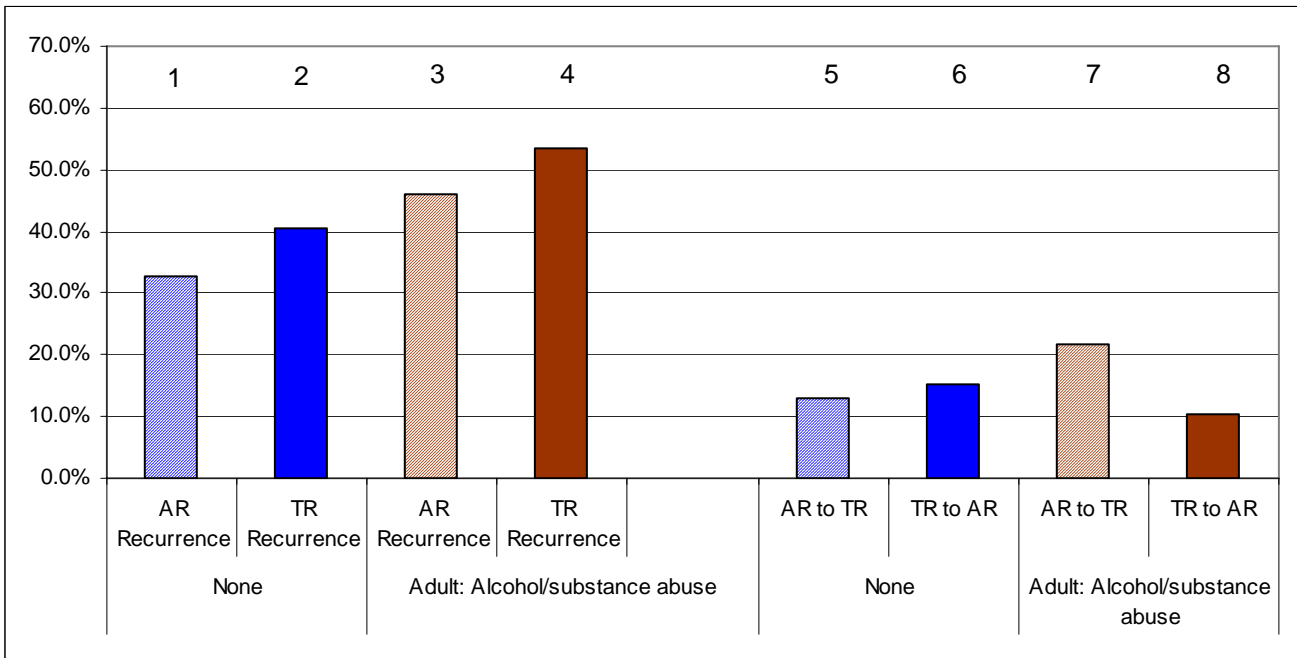


Figure 11.2. Percent of Families with Recurrence and Track Change by Initial Track Assessment (AR or TR) and Presence of Adult Alcohol or Substance Abuse during Initial Assessment

³⁶ Workers in several of the 20 demonstration counties entered this data as well but in some counties little or no use was made of these categories. This inconsistency precluded the use of these variables in the analyses comparing experimental and control families.

The question was: Knowing that the family was assigned to alternative response or a traditional investigation and that adults in some families in both groups had A/SA problems, what would be predicted concerning future report recurrence and future track change?³⁷ In fact, A/SA was discovered during later assessments in some the non-A/SA families in Figure 11.2. This could be explained by newly emergent problems, entry of new caregivers into families or by problems that existed but were not entered in the initial assessment. When these families were taken into account, the bars in the chart representing A/SA recurrence increase *but the pattern of differences among the bars did not change*. The four bars on the left hand side (1-4) represent the percentages of families with at least one new report (of any kind) during the follow-up period. The bars on the right (5-8) are a *subset of 1-4* and represent the percentages of families with recurrence *and* with the track changes indicated.

Several comparisons are possible. Some were statistically significant while others were not. Our interest in this case is less on significance and more on the variations that appear in the chart. First, comparing bars 1 and 3 as well as 2 and 4, it can be seen that the presence of A/SA is associated with increased report recurrence. Second, comparing 1 and 3 taken together with 2 and 4 taken together, we can see that being initially assigned to TR is associated with increased report recurrence. These differences appear to be additive: the tallest recurrence bar occurs for the combined conditions of initial TR and A/SA presence. *Families with an initially dangerous report and with an adult abusing alcohol or drug had the highest overall recurrence.*

Third, comparing bars 5 and 7, it can be seen that when A/SA is present among families that were initially in AR track, they are more likely to be screened for TR as later reports are received. The difference was nearly 9 percent and was statistically significant, indicating sharp declines in child safety among some initial-AR-A/SA families. Fourth, comparing 6 and 8, initial TR families with A/SA seemed to be slightly more likely to switch to AR, a reduction in safety threats, later but the difference in this case was smaller (5 percent) and was not statistically significant.

These comparisons support the following conclusions: 1) an initial TR screening is a risk factor for future reports, 2) A/SA is a risk factor for future reports, 3) a TR screening and A/SA together increase the risk, and 4) A/SA is also associated with an increase in later reports in which child safety is threatened. *Regarding the question of recurrence among families assigned to AR, adult alcohol and substance abuse when found among AR families are predictive of new reports and new reports that require investigations.* These findings regarding A/SA determination by workers dovetail with the findings regarding a primary presenting problem of alcohol or substance abuse. The conclusion for practice should be: *When alcohol or substance abuse problems are observed in a caregiver, regardless of the type of initial child maltreatment report or the initial track (AR or TR) assignment, the future safety and welfare of children are*

³⁷ The reader should not forget that assignment to the TR group occurred because they were determined to be *inappropriate for AR and not because of random assignment*. This analysis compares the AR and TR segments across the entire agency caseload.

threatened by the continuation of the A/SA condition. A/SA treatment should be a priority whether the condition was or was not judged to be related to the alleged child maltreatment.

Figure 11.2 is shown and discussed to illustrate the analytic approach for this type of variable. As noted at the start, this section is not intended as a complete summary of the Olmsted data analysis. However, the following table (Table 11.3) summarizes similar findings for several other variables of this kind. The final category in the table refers not to characteristics of family members but to the history of the family in the CPS system *before the initiating report*. Each is an indicator of risk and some are indicators of declines in safety over time.

Table 11.3. Results of Analyses of Problems of Family Members and Family History in CPS

<i>Characteristic</i>	<i>Report Recurrence</i>	<i>Future Track Change</i>
Initial screening for AR or TR	TR screening predicted more recurrence than AR screening regardless of the other problem areas considered.	AR to TR and TR to AR about equivalent: initial screening does not appear to be related to future track change.
Adult alcohol and substance abuse (A/SA)	A/SA associated with later report recurrence for both initial AR and TR families.	A/SA associated with later shifts of initial AR families to TR.
Adult mental illness (AMI)	AMI associated with later report recurrence for both initial AR and TR families.	AMI is not associated with later track change.
Child emotional problems or mental illness (EP/MI)	EP/MI weakly associated with later report recurrence for both initial AR and TR families.	EP/MI is not associated with later track change.
Child developmental disabilities, mental retardation or physical disabilities (MR/DD/PD)	MR/DD/PD associated with later report recurrence for both initial AR and TR families.	MR/DD/PD is <u>negatively</u> associated with later track change. AR families had more later AR screenings and TR more later TR— less track switching.
Case-management workgroup (CMWG) during a period preceding the initiating report	CMWG associated with later report recurrence for both initial AR and TR families.	CMWG is not associated with later track change.

We now turn to the type of tabular analysis that previously illustrated in Table 10.9 in our comparison of experimental and control families in IS counties. The same type of analysis is possible in comparing initial-AR with initial-TR families across the entire CPS caseload. In Table 11.4 the categories of presenting problems have been collapsed and rather than frequencies of reports row percentages are shown in each cell. To make the table easier to read, percentages in cells with frequencies of less than 3 are not printed.

Table 11.4. Presenting Problems of Initial and Later Reports of Initial-AR versus Initial-TR Families

<i>Initial AR Presenting Problem</i>	<i>% of all families (column)</i>	<i>% NG</i>	<i>% PA</i>	<i>% SA</i>	<i>% EMN</i>	<i>% MN</i>	<i>% END</i>	<i>% SUP</i>	<i>% ED N</i>	<i>% ASA</i>	<i>% later reports (column)</i>	<i>% families with new reports</i>
Neglect (food, clothing, shelter) NG	8.1%	31.8%	22.7%				15.9%	20.5%			11.1%	39.5%
Physical abuse (& threatened) PA	34.0%	3.1%	38.8%	8.2%			24.5%	19.4%			24.6%	29.3%
Sexual abuse (& threatened) SA	0.2%										0.3%	100.0%
Emotional Neglect & Mental injury EMN	0.8%										0.5%	25.0%
Medical Neglect & Prenatal exposure MN	0.4%										0.8%	100.0%
Endangerment END	35.6%	7.0%	26.6%	4.9%			44.1%	9.8%	3.5%	2.8%	35.9%	30.5%
Inadequate supervision (& abandonment) SUP	12.8%	15.4%	10.3%				28.2%	30.8%			9.8%	25.0%
Educational neglect ED N	3.9%	16.7%	10.0%				13.3%	20.0%	30.0%		7.5%	33.3%
Alcohol/Substance Abuse ASA	0.9%										0.5%	20.0%
Unknown	3.4%	11.1%	8.3%				33.3%	19.4%	13.9%		9.0%	83.3%
% total new reports	100%	10.6%	25.1%	5.3%	0.8%	1.5%	30.9%	17.1%	5.8%	3.0%	100%	32.3%
<i>Initial TR Presenting Problem</i>	<i>% of all families (column)</i>	<i>% NG</i>	<i>% PA</i>	<i>% SA</i>	<i>% EMN</i>	<i>% MN</i>	<i>% END</i>	<i>% SUP</i>	<i>% ED N</i>	<i>% ASA</i>	<i>% later reports (column)</i>	<i>% families with new reports</i>
Neglect (food, clothing, shelter) NG	9.0%	28.6%	21.4%	21.4%			14.3%	10.7%			9.2%	43.3%
Physical abuse (& threatened) PA	32.8%	12.3%	32.1%	7.5%			17.9%	24.5%		4.7%	34.9%	34.9%
Sexual abuse (& threatened) SA	18.7%			42.3%			11.5%	23.1%			8.6%	30.6%
Emotional Neglect & Mental injury EMN	0.9%										0.7%	66.7%
Medical Neglect & Prenatal exposure MN	1.5%										1.3%	60.0%
Endangerment END	22.3%	9.2%	6.2%	4.6%			49.2%	15.4%	7.7%	4.6%	21.4%	45.9%
Inadequate supervision (& abandonment) SUP	3.6%		15.8%				21.1%		31.6%		6.3%	66.7%
Educational neglect ED N	3.3%						22.2%		33.3%		5.9%	63.6%
Alcohol/Substance Abuse ASA	2.7%						44.4%			33.3%	3.0%	66.7%
Unknown	5.1%			11.1%			29.6%	33.3%			8.9%	82.4%
% total new reports	100%	11.5%	18.4%	10.2%	0.0%	2.0%	26.3%	19.4%	6.6%	5.6%	100%	43.4%

Our discussion of Table 11.4 will be brief. More detailed discussion of this and other similar tables are included in the fuller report.

The primary differences between the two groups of families (Initial AR versus Initial TR) can be seen by comparing the first data column (“% of all families”). Initial-TR families were, of course, reported for (SA) sexual abuse (18.7 percent compared to .2 percent), a mandatory screening criterion. They were also reported for A/SA more often and for medical neglect (MN). Initial-AR families were accused of inadequate supervision (SUP) and endangerment (END) substantially more often. The two groups were roughly comparable in the areas of neglect of basic needs (NG) and physical abuse (PA) and educational neglect (ED N).

Looking in the lower right corner of each sub-table, the percentage of total report recurrence for each group can be seen (32.3 percent for initial AR and 43.4 for initial TR). The column percents in each sub-table (see rows labeled “% total new reports”) are revealing. The interesting comparison is not between the percentages for initial AR versus initial TR but the change in percentages between the first report and later reports. Sexual abuse reports among initial TR families were virtually zero in the beginning but were 5.3 percent in recurring reports—an increase. Sexual abuse reports among initial TR families actually declined from 18.7 percent to 10.2 percent. Endangerment and inadequate supervision showed changes in the opposite direction—a slight relative decline for AR and a relative increase for TR. Overall, the patterns indicate that the initial differences in percentages in the first data column (“% of all families”) tended to flatten out for recurring reports (“% total new reports”). (Notice that this finding is quite different than that associated with experimental and control cases in Table 10.9.) Our conclusion is: *While the types of maltreatment in the first report for initial AR and initial TR families were different in several ways, the types of maltreatment appeared to be more similar when judged across multiple later reports.* This supports our earlier contention that as families are tracked over several years, diversity of child maltreatment is the rule rather than the exception. As we have noted, this does not preclude unique etiologies for different types of child abuse and neglect but it does suggest *underlying similarities among families that are, at one point in time, accused of very different kinds of child maltreatment. From the standpoint of child welfare practice, this supports the idea of broader approach to families that looks beyond the maltreatment report of the moment to the entire array of family needs and strengths. Ideally, therefore, contacts with families for child protection purposes should be used an occasion to initiate assistance with the broader array of child and family welfare needs.*

Other interesting patterns are present in Table 11.4 but we leave them for the fuller report on Olmsted County.

Chapter 12. Cost Analysis

The cost analysis in this evaluation sought to determine the financial effects of public investments in the types of cases targeted in the Alternative Response. Often these types of cases within CPS receive minimal services if any at all and the costs incurred to the child protection system are limited. Indeed, conventional wisdom advises that within the context of severely restricted resources, funds should be spared and used only for the most severe cases. The Alternative Response approach itself rows against the tide of CPS convention. The hope behind the initiative was that intervening more substantially in less severe cases would have longer-term preventative consequences. To the extent some prevention might be realized, however, the question that still remains is at what cost were any such outcomes achieved? The underlying question is: How much is a society willing to pay for a reduction in future harm to its children? This analysis sought to provide data and analysis that would allow that question to be answered within an informed and rational frame of reference.

Design. This study sought to determine the relationship between the initial financial investment in AR cases and longer-term CPS costs that might be associated with them. It distinguished two periods of time: period 1 involved the time of initial contact with the family following a maltreatment report until CPS intervention was discontinued. Period 2 began the day after period 1 ended and extended throughout the follow-up period. Costs associated with period 1 at a minimum included CPS staff time involved in conducting a family assessment. Additional costs might have been incurred if a case was opened for case management and services. Costs associated with period 2 were incurred only if there was a subsequent maltreatment report made on the family during the follow-up period and the county CPS again became involved with the family.

The design for the study, which involved the aggregation of costs for a sample of experimental and control cases during the two periods, can be easily understood with reference to the following matrix.

	Period 1	Period 2	Total
experimental families	<i>a</i>	<i>b</i>	<i>c</i>
control families	<i>x</i>	<i>y</i>	<i>z</i>
<i>difference</i>			<i>z-c</i>

Mean costs associated with the sample of experimental families are represented by “*a*” for period 1 and “*b*” for period 2. The total of these costs is represented by “*c*”.

Similarly, mean costs associated with the sample of control families are represented by “x” for period 1 and “y” for period 2. The total of these costs is represented by “z”. The final cell contains the bottom line: the difference between total mean costs incurred by experimental families and control families.

Sample. A sample of cases³⁸ was drawn from the study population that mirrored the sample design used in the impact study. That is, the same proportions were drawn of experimental and control cases in the 14 impact-study counties. Costs associated with these cases represented the core data for the study. In addition, a random set of cases was also drawn from the 6 non-impact study counties for comparison purposes only.

A total of 752 sample cases were drawn. This included 299 AR experimental cases from the 14 impact study counties and 299 TR control cases from these counties. An additional 154 cases were drawn from the six other counties.

	AR/exp	TR/con	Total
14 impact counties	299	299	598
6 other counties	154		
<i>Total</i>	<i>453</i>	<i>299</i>	<i>752</i>

Time Period for Selection of Cases. The sample was selected from cases that opened between July 1, 2001 and December 31, 2002, and that closed by June 30, 2002. (In this context, “open” refers to the initiation of CPS contact with a family following a maltreatment report and “closed” refers to the last contact between the family and CPS related to that report.) The open dates ranged from a minimum of 4 months after the demonstration began (judged to be a fairer test of the approach than beginning on the first day of the demonstration) through the date when selection of control cases stopped (12/31/02). That is, only cases that opened during that period were included in the sample. The closed date of 6/30/02 meant that the follow-up time period ranged from a minimum of 16 months to a maximum of 26 months. The minimum time period involved cases in which there was essentially a single contact between the family and CPS; the maximum involved cases that remained opened through the end of the follow-up period.

Relevant dates associated with each case in the sample were obtained from SSIS. Each case in the sample had a unique set of dates—the initial contact date that was the beginning of its period 1, the last contact date in period 1, and the first date in period 2. All of the cases shared the end date of period 2, the date follow-up data was cut off. These dates, along with necessary identifying information on each case that was also obtained from SSIS, were entered into a research database that was constructed for the analysis.

³⁸ The term “case” here refers only to a family unit that forms part of the study population. It does not refer to the CPS designation of case status which, in Minnesota, means that a case management workgroup has been opened. As used here, therefore, a case may involve any family on whom a CPS assessment is completed whether or not a subsequent case opening occurs.

Across all cases in the study sample, the mean length of period 1 was 85 days and the mean length of period 2 was 453 days. Statistical adjustments were made to ensure these “cost opportunity” days were identical for the experimental and control groups.

Data Types and Sources. There were two types of costs that entered the analysis: costs of purchased services and costs associated with CPS staff time including case management.

1. Costs of Services. Beginning in the fall of 2003, county bookkeepers were sent lists of experimental and control cases that had been selected in the sample. The lists contained various information on the cases to enable bookkeepers to identify them accurately and locate them within their accounting systems. Bookkeepers were asked to supply three types of data for each case: a) a list with the cost of any and all service(s) provided between 7/1/01 and 9/30/03; b) the BRASS (service) code associated with each service; and c) the date(s) when each service was provided.

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

The dates attached to service provision for each cost item for each case that was provided by bookkeepers were melded into the research data base. Cost and date data from bookkeepers, when combined with SSIS data on CPS activity, permitted the separation of costs on individual cases into the appropriate study period, 1 or 2.

The service codes attached to the bookkeeper cost data permitted researchers to compare data submitted by bookkeepers with certain data in SSIS for quality assurance purposes. For example, if SSIS indicated that out-of-home placement had occurred for a child in a sample case, but data provided by a bookkeeper did not include costs for any such placements over the same dates, bookkeepers were queried about the lack of consistency. This back and forth continued with each county bookkeeper until researchers were satisfied that all inconsistencies were accounted for or explained.

2. Costs of Staff Time. Costs associated with staff time were obtained by combining data from two sources. The first was the amount of time CPS workers spent with specific families. Workers log this time into SSIS and conversations with counties indicated that they believed these data were reliably accurate. Through this source we were able to determine the number of staff hours by case and period.

Costs associated with staff time were obtained through quarterly SEAGR rate reports that counties submit to DHS. These hourly rates, which vary from county to county, and, within counties, from one quarter to another, are typically used in cost allocation analyses across programs.

By combining the hourly log data and the county SEAGR rates for specific periods, we were able to calculate the cost of staff time for each case in the sample for periods 1 and 2.

Cost Data

14 Impact Study Counties. Table 12.1 shows the cost data for the 14 impact study counties. It may be useful in this first table to go through each cell individually.

Table 12.1. Mean cost data associated with sample cases in 14 impact study counties combined

Service Costs			
Group	Period 1	Period 2	Total
Experimental	\$492.60	\$562.62	\$1,055.23
Control	\$152.28	\$1,209.97	\$1,362.24
Staff Costs			
Group	Period 1	Period 2	Total
Experimental	\$639.19	\$241.82	\$881.01
Control	\$441.18	\$327.71	\$768.89
Total Costs			
Group	Period 1	Period 2	Total
Experimental	\$1,131.80	\$804.44	\$1,936.24
Control	\$593.45	\$1,537.68	\$2,131.13

Period 1. The figure shows that mean service costs for period 1 were \$492.60 for experimental families and \$152.28 for control families. This is what would be expected since a major component of the AR approach was the provision of services to families who might otherwise not receive them through additional funds made available for the project. It further shows that mean staff costs during period 1 were \$639.19 for experimental families and \$441.18 for control families. This indicates that, on average, CPS workers spent more hours working with AR families during this initial period, verifying what many workers told researchers during interviews. Total period 1 costs for experimental families averaged \$1,131.80 compared to \$593.45 for control families.

Period 2. Mean CPS-related service costs incurred experimental families during period 2, however, were less than those sustained by control families (\$562.62 vs. \$1,209.97). Period 2 service costs could only be incurred if there was a subsequent maltreatment report after period 1 ended and some services were needed and purchased. These lower mean costs for experimental families supports impact study findings on recurrence. Mean staff costs for experimental families during period 2 were also less

than for control families, although the difference was not as great (\$241.82 vs. \$327.71). Total period 2 costs for experimental families averaged \$804.44 compared with \$1,537.68 for control families.

Total Costs. When costs for both periods are combined and all costs aggregated, the bottom line is that costs for experimental families averaged \$1,936.24 while total mean costs for control families was \$2,131.13. The major finding of the cost analysis, therefore, can be stated as follows:

- Savings achieved by experimental families during the follow-up period more than offset investment costs incurred during the initial contact period.

However, any follow-up period is arbitrary in length. And so, the question arises: If the follow-up period were longer would this savings be maintained or even continue to grow, or would the effects of AR eventually be nullified without future assistance to families. This question will be answered in an extended follow-up of outcomes and costs that will be the next phase of this evaluation.

With and Without Ramsey County Data. Compared with cost data from other counties, that from Ramsey County was anomalous. (See Table 12.2.)

Table 12.2. Ramsey County cost data

Service Costs			
Group	Period 1	Period 2	Total
Experimental	\$972.60	\$1,417.86	\$2,390.46
Control	\$210.50	\$1,291.95	\$1,502.45
Staff Costs			
Group	Period 1	Period 2	Total
Experimental	\$773.26	\$287.70	\$1,060.95
Control	\$596.45	\$720.88	\$1,317.33
Total Costs			
Group	Period 1	Period 2	Total
Experimental	\$1,745.86	\$1,705.56	\$3,451.42
Control	\$806.95	\$2,012.83	\$2,819.78

The amount spent on both experimental and control families was higher in Ramsey County than the combined means of the other 13 impact study counties and higher than mean costs in Hennepin County separately. The total mean cost incurred by Ramsey County experimental families was particularly high (and in this case higher than equivalent control families). The mean of \$3,451 was considerably higher than the combined mean for the other 13 impact counties, which was \$1,460, and higher than the

combined mean spent on AR families in the 6 other counties in the demonstration (\$1,412).

Table 12.3 shows the cost data matrix for the other 13 impact study counties. The difference in total mean costs (control less experimentals) for these counties as a group was \$611 compared with -\$632 for Ramsey County. Table 12.4 shows the cost matrix for the 12 outstate impact study counties, that is, without either Ramsey or Hennepin counties. The bottom line difference (control less experimentals) for these 12 counties was \$528. (That the \$528 was less than \$611 when Hennepin was included shows the positive influence of that county on the group mean.)

Table 12.3. Mean cost data for 13 impact counties (excludes Ramsey)

Service Costs			
Group	Period 1	Period 2	Total
Experimental	\$341.81	\$293.94	\$635.75
Control	\$147.19	\$1,202.81	\$1,350.01
Staff Costs			
Group	Period 1	Period 2	Total
Experimental	\$597.08	\$227.40	\$824.48
Control	\$427.63	\$293.39	\$721.02
Total Costs			
Group	Period 1	Period 2	Total
Experimental	\$938.89	\$521.34	\$1,460.23
Control	\$574.82	\$1,496.21	\$2,071.03

Table 12.4. Mean cost data for the 12 outstate impact counties (that is, all except Hennepin and Ramsey)

Service Costs			
Group	Period 1	Period 2	Total
Experimental	\$299.30	\$329.65	\$628.95
Control	\$205.67	\$905.00	\$1,110.67
Staff Costs			
Group	Period 1	Period 2	Total
Experimental	\$675.81	\$258.03	\$933.85
Control	\$606.37	\$373.45	\$979.83
Total Costs			
Group	Period 1	Period 2	Total
Experimental	\$975.12	\$587.68	\$1,562.80
Control	\$812.04	\$1,278.46	\$2,090.50

The reasons why Ramsey County’s cost data are so different from the others is not apparent. The data from this county proved most difficult to obtain because of the splintered nature of the accounting system. And there were some high-end cases that accounted for considerable costs by themselves. But each county had some cases that tended to account for a large amount of the total cost. It may be that the sample in Ramsey County was skewed and not representative; this can occur when the overall sample essentially consists of 20 sub-samples each drawn separately. At the same time, there may well be organizational factors endemic to Ramsey County that accounted for at least some of this seeming anomaly. As noted in the implementation section (Chapter 3), Ramsey County switched from a small team approach half way through the evaluation to the distribution of AR cases across all social workers. This was done, in part, because of negative attitudes on the part of some staff about AR (and was subsequently changed back to a team approach). To the extent that this personnel factor may be at play we might expect that it had a corresponding dampening effect on impact results. To the extent this might have been a factor, it only reinforces the importance of individual social workers in the successful conduct of effective child protection policy.

Cost Data for 6 Non-Impact Study Counties. Total mean cost of the 6 non-impact study counties was mentioned above. Below (Table 12.5) is the full cost matrix for these counties as a group, showing mean service and staff costs for both periods. While the total mean costs are remarkably similar to those of the other 12 outstate counties, there are interesting differences. For example, as a group these counties invested more heavily in upfront service expenditure (the mean during period 1 was \$522 compared with \$299 for the 12 outstate impact counties), but seem to have gotten a good return on their dollars—with lower mean service expenditures (\$173) and total costs (\$351) during period 2 than was the case for the 12 outstate impact counties (where service costs averaged \$330 and total costs averaged \$588).

Table 12.5. Mean cost data for the 6 outstate non-impact counties

Service Costs			
Group	Period 1	Period 2	Total
Experimental	\$522.16	\$173.22	\$695.38
Staff Costs			
Group	Period 1	Period 2	Total
Experimental	\$539.34	\$177.55	\$716.89
Total Costs			
Group	Period 1	Period 2	Total
Experimental	\$1,061.49	\$350.78	\$1,412.27

Cost Effectiveness

The issue for cost effectiveness is not simply the relative cost of doing things differently, but the cost of achieving desired outcomes using different approaches to CPS. One of the key goals of CPS is to reduce recidivism or the recurrence of future maltreatment reports. We know from the impact study that the Alternative Response has been somewhat more successful at doing this. The recurrence of new reports of maltreatment after contact with CPS has ceased was found to be 30.3 percent for control families and 27.2 percent among experimental families. Stated positively we can say that for every 100 cases the goal of recurrence avoidance was achieved in 72.8 of the AR cases compared with 69.7 of the control cases through our current follow-up period. Given the costs expended on the two sets of cases (Table 12.1), we can calculate that the mean cost of achieving the goal of recurrence avoidance with AR has been \$2,660 compared with \$3,058 for the control group, a difference of \$398. This is the average difference across our follow-up period. The cost of achieving this outcome for 1,000 families would be \$398,000 less using AR than it would have been with the traditional approach. (And this should probably be considered a conservative figure. Were Ramsey County excluded from the analysis the average difference would be \$966.)

Conclusion

The potential impact of any improvement in cost effectiveness can be understood by keeping in mind the size of the challenge confronting county child protection professionals in Minnesota. In the 12 months between July 1, 2003 and June 30, 2004, there were 17,536 maltreatment reports statewide.

The cost-effectiveness figures reported above represent positive economic benefits to the state, to counties and to the public at large whose tax moneys fund CPS. However, based on information from families about employment and income differences between experimental and control families, AR must be considered to have positive cost benefits to CPS families as well.

In the first paragraph at the beginning of this chapter, the question was asked: How much is a society willing to pay for a reduction in future harm to its children? The findings of this analysis suggest that, if done smartly and with the commitment of social workers, without whose hard work and faithfulness to the AR model none of this would be remotely feasible, it may be possible to achieve CPS goals at a long term reduction in public costs, but only if upfront investments are made.