

**Session 5.03 - The Challenges and Successes of Random Assignment in
Child Welfare Program Evaluation**

Panelists:

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Please note: The following is a direct transcription and has not been edited.

Leslie Cohen: Hi. I'm Leslie Cohen. I am a Senior Research Associate at James Bell Associates and welcome to the Successes and Challenges of Random Assignment in Child Welfare Program Evaluation. Before we get started, I just want to remind everybody that the audio session for this will be digitally recorded. I am going to read it word to word because it seems very legal and once formatted, for accessibility standards will be made available in the summit website and move it for written consent participants who ask questions or provide comments during the session will be given their permission or consent to this recording. If you have any questions about this recording, please feel free to talk with one of the Summit support staff. So, I think what they mean to say is speak at your own risk.

Okay. So, today's agenda is going to start with a brief overview of Random Assignment, what is it, why do it and how do you do it. And even though I think we know that Random Assignment is often considered the goal standard and evaluation that there is lots of challenges that often foil our efforts and crush our enthusiasm as we try to do it, but, the challenges are not insurmountable. So, you are going to be inspired today by Cheryl Smithgall, who is a Research Fellow at Chapin Hall at the University of Chicago, Diane DePanfilis, and she is a Professor and Associate Dean for Research as well as the Director of the Ruth H. Young Center for Families and Children at the University of Maryland, School of Social Work and you are also going to be inspired by Tara DeJohn, who is an Assistant Professor at the University of Arkansas at Little Rock their School of Social Work and if you actually go into your booklet and you look her up, you are going to see there that it says that she was a Ph. D candidate, but, she has since graduated and gotten a job so that's exciting as well as Patricia Washington, who is Louisiana KISS Grant Manager and that's the program that she and Tara are going to be talking about.

So, we're going to start with a brief overview, whats and the whys and the how of Random Assignment. Random Assignment is the use of chance procedures and experiments to ensure that each participant has a same opportunity to be assigned any given group. It's different than a quasi-experiment design where subjects are select into an intervention or the comparison group or and there by non end up there by non-random means. We do it because it's simply the best way to determine causal connections between interventions and outcomes. Really when testing an intervention, the idea would be to be able to look at the same group of children simultaneously, one getting the

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intervention and one getting the comparison. Obviously, in the world that we currently live in that is impossibility. You cannot look at the same group of children under two conditions. So, we do Random Assignment, because Random Assignment to an intervention is the best approximation to the desired comparison, because what it does is it removes all of the selection bias on both measured and unmeasured characteristics of the population. And it ensures that the groups have similar qualities and therefore any differences between the experimental or the intervention and the control group can then be attributed to the intervention rather than the characteristics or the differences in the characteristics of the group.

So, this Random Assignment how to do it list is very simplified, but, I think for the purposes of our discussion it will make sense and my colleagues will go into more detail about how to address some of these issues. You need to define the selection criteria for membership in the sample. You need to define the number of control conditions to which the members will be assigned. You have to determine the level of which randomization will occur, are you assigning at the child level, are you assigning at the agency level, I mean you have to determine the size of the samples so that you can actually detect differences and the ratio which members will be assigned to each group. Maybe you don't need as many participants in the control group as you do in the intervention group. You have to determine the frequency of assignment. You're going to assign every day every month once a quarter. And then you got to figure out how you are actually going to do your approach, what's your systematic approach. And you know interestingly enough, does not have to be complicated, you could actually flip a coin. You could throw darts although I'm pretty sure it's probably hard to get darts into many of your office buildings or a little more sophisticated might be a computer program that actually will do the random assignment for you.

I am going to illustrate random assignment using the Tennessee subsidized guardianship waiver demonstration as my example. Some of you may remember waivers. Any of you familiar with waivers in the room? There is like some grin on your face. I don't know what that means, but, the Congress authorized states to use Federal dollars and ways that they weren't otherwise allowed to use them to test innovative child welfare programming. And one of those programs was subsidized guardianship and so they were testing whether paying a subsidy to a caregiver to take guardianship would have positive impact on the outcome. Welcome. For children that were in foster care. And the Federal government required sort of in return for those dollars, the use of those dollars, they said you have to evaluate your programs. There were 11 states that had subsidized guardianship waivers, seven of the states used random assignment with varying degrees of success, Tennessee was very successful in utilizing random assignment.

So, what Tennessee? How to do it? They started with their sample and defining their sample and the eligibility criteria and it was children between the ages of zero and 17. 75 were eligible for group assignment when he or she was in the foster care system for nine out of the last 12 months, was living with an approved relative caregiver or kin for six months and they entered care in three particular locations within the state, it was not a statewide program when they started, Shelby, Upper Cumberland and Davidson, many of

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you are familiar with Tennessee. And when the child eligibility was in that they were randomly assigned to either the experimental or the control group. We assigned in a one-to-one ratio. And we did that assignment quarterly. So, the first stage of each quarter of the fiscal year, we would collect all the kids or pull all the kids in the system that met the eligibility criteria and they will be assigned in a one-to-one ratio to the experimental or the control group. And you're experimental, condition was that they they had available to them all of the permanency tools in the tool box, plus they had the availability of subsidized permanent guardianship. And the control group was eligible for all of the traditional permanency options that were available to children in foster care in the State of Tennessee, which included permanent guardianship without a subsidy.

So we got everybody assigned throughout the life of the waiver and as you can see we were successful in balancing the characteristics of both the caregivers and the children. If you look at the highlighted column in yellow, you will see that the difference between the characteristics of the intervention and comparison group are negligible, randomization was successful, so we could confidently say that any outcomes, any differences in outcomes between the intervention and the comparison group were attributable to the availability of subsidized guardianship. And any time I'm doing evaluation, I'm always looking for a rule of thumb. I don't know if anyone here likes a rule of thumb, but, with random assignment, a good time to sort of raise your red flag is if the difference between the two groups is at about 5%. It doesn't mean you have to throw it out or it didn't work, you just want to start paying attention and considering whether there might be sort of factors that were that are messing up the random assignment process.

One of the really great things about random assignment is that it really gives you a context in which to discuss the successes and the shortcomings of an intervention. So in Tennessee, if we only had the group that was receiving the intervention, we would have been able to say, okay, you know there were 649 kids who got subsidized guardianship or offered subsidized guardianship, 496 of them attained permanence, 88 of those permanencies were reunification, 176 were adoption and so on and so forth, which is interesting, but, we don't have any idea what would have happened if we didn't offer guardianship. I mean maybe we would have had pretty similar results, but, what we can say, because we did random assignment is the results would not have been similar and in fact, there was 11. 21% increase in permanence for the group that had subsidized guardianship available so that was really positive, but, it also showed some other interesting issues and it might be a little hard to read from your seat, but, one of the things that we found was even though permanence went up, there were fewer adoptions in the intervention group than there were in the control group.

So, it did rise some issues about sort of the pros and cons of offering subsidized guardianship and really allowed for a rich discussion about whether this was a program that we wanted to offer nationally and obviously the Federal government had that discussion and included subsidized guardianship in the foster connections to success still and act in 2008. So, there are lots of challenges to random assignment. I think I probably made it sound very easy like one, two, three, magic. Now works out beautifully. It is its really rewarding. The results are really beneficial and useful. And

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so, we're going to start with Cheryl and we're going to jump into case specific examples of how do we address some of those challenges.

Cheryl Smithgall: All right. Thank you, Leslie. So, as Leslie said I'm going to do more of a case study approach rather than sort of lessons learned across and I think it's because I really want to kind of dig into the nuts and bolts of doing random assignment and this is a study that has been the random assignment has been underway for a year. And there are certainly things that I've learned along the way that I wish I knew you know before we started the process, but, at least I can share them along the way and not wait for the end. So, little bit about the outline. There is only 10 slides, so I won't dwell on this, but, I'll give a little bit of context for the project at least for specifics that are relevant to talking about the random assignment. And then I selected three challenges to really talk about and I'm really pulling these out in the interest of engaging in a conversation about how much we can adapt the design or put in place a process that minimizes the inconvenience for the field and the resistance in the field and still adheres to what Leslie talked about in terms of having the comparison group that we want. So, what I am talking about is pulled from an evaluation that we're doing for Comprehensive Family Assessment, which is a grant that Illinois Department of Children Family Services has from the Children's Bureau. The program was launched in 2005 with placement cases and as part of the grant, the proposal was to take this program and do it with intact family cases and use a randomized experimental design.

So, I think it's key to point out we're adapting an existing model at the same time as implementing the random assignment. That's not necessarily ideally would have been nice to sort of pilot test the model and make sure we understood the changes first before we jumped into the random assignment. It's also challenging to move from placement cases to intact. Intact has a different process in the child welfare system in Illinois, so we have to get up to speed on what that process was. So, how would I describe what the treatment is, selected intact family service teams are participating in the project, so we did identify teams across the state that would be representative of different geographies. When fully staffed, these teams have 48 workers. Teams are usually maybe five or six workers to a team. These teams receive a range of cases that, but, mostly I'd say 80% of their cases are called level four, which are high risk intact family cases. And these those level four cases are being assigned to one of the following conditions: Either the worker the case worker who is assigned to intact family services is doing the assessment on their own or that worker is paired with a licensed clinician and doing the initial assessment as part of this IA program that Illinois has.

You know we debated about whether this was an intervention with the case or this was an intervention with the worker. And we ran over what the theory was and how you know the theory related to the outcomes what outcomes they were looking at and really they were articulating outcomes at the case level about the family engagement and this quote from Berlin kind of address that out a little bit that it's not just about finding things about the client, but, it's the process of doing it with the client and they thought that a licensed clinician being there with the worker would somehow change that process and engage the family more as well as yield more information. So, the next challenge that we had was

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you know where to insert the Random Assignment Process in the normal case flow for the child welfare system, because this wasn't really a matter of just identifying cases and referring them out to an external program. We were really inserting an intervention into the child welfare you know existing process. So, let me just get this all up. So, there were couple things that we had to pay attention to. There were mandated timeframes for the case flow. So, this shows that in Illinois the process is that an investigating worker goes out when they have substantiated the case and decided that it is appropriate for intact services, they make a referral to an intact manager. That manager confirms okay, this is you know what I would confirm is the level of risk and it is going to go to one of these teams. The supervisor for that team accepts it and then assigns it to a worker and as soon as that worker assignment is made, there is 24 hours for them to do it hand off and transfer the information about the case from the investigating worker to the intact worker and there is 48 hours to get out to the family. And we couldn't interfere with that. So, we had to figure out how do randomly assign in that process and then how to do it so that there wasn't a possibility of sort of gaming the system. In other words, we didn't want them to know whether a clinician was going to be involved at the point of assigning it to a worker. We didn't want them to be able to assign all the treatment cases to certain workers and not to other workers. So, we did by a computer program. There is an external person with the integrated assessment program who enters an ID for a case into a website and then that feeds back a decision based on the computer date and timestamp and some equation that it goes through and it turns back a decision to them and then they report that to the supervisor. We then have a feed of those cases, those identifiers, and we go and verify that it went to a worker on one of these teams and that we can actually locate the case in the information system. And this has been really helpful in providing information that will allows to really interpret the results whether there is an effect or a lack of effect.

We've identified some lags in that time although that's the policy of 24 hours and 48 hours. It doesn't actually happen that way and it's important for us to understand where it did and didn't happen that way across the sites. We are able to we have a pretty good information flow with the program staff for the integrated assessment program and they keep us informed as possible, but, there are times where we find out, there is a name we haven't seen, did you guys get a new worker? They're like, oh, yeah, forgot to tell you. There is another worker on that team. So, it's just helpful in terms of understanding. Are we talking about the same 48 workers over the entire year and a half of random assignment or are there some who are coming in coming out and would we want to look at that sort of worker variability as well. We have an understanding then of why cases are getting closed, transferred things like that and what you know that will mean when we do the intent to treat analysis. So, one of the challenges when we started this was getting IRB approval and consent to randomly assign.

How are we going to do this in a 24-hour timeframe and to not so to not interfere with the intervention and the timeline and also because we really wanted to know a question of how this would be applied for the eligible population of cases in the child welfare system rather than a sort of filtered target population that accepted or that the worker decided to refer. We were able to get consent, a waiver of consent to be randomly assigned. Now

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the family still consents to the treatment. So, when the screener comes out with the case worker, there is still a consent process and the family can say, no, I don't want that person involved, but, at least we are able to measure that now. We are able to say, okay how often did a family decide they wouldn't take this up at all or how often and we really are able to get a little bit more at the involuntary nature of the population with intact services. So, there were three factors that were key in that justification and that put the regulation reference up there as well, but, it was you know and these are spelled out in the regulations, it was For Public Service Program and there was minimum risk. The worker was going to be doing an assessment anyway. It's a matter of having a licensed clinician along and to change to require consent would have changed the intervention and the timeline. So, a second challenge right after that was that the program staff couldn't tell me what the flow of cases was to the intact teams. They monitor things according to case loads of workers. So, they can tell me point and time how many cases a certain worker has, but, they couldn't tell me what the flow was coming in so that we could think about what that meant for random assignment and what that flow would then mean to the licensed clinicians. So, there is only two licensed clinicians for like two or three teams of workers. So, you've got you know two clinicians and 15 workers and the caseloads for clinicians are different from workers. So, we had to align all of that and figure out what kind of random assignment ratio would work.

There was a lot of concern on the program that on the not the IA program, but, the field staff wanted to make sure that having this clinician involved would not delay their timelines, not just the 24 and 48 hours at the beginning, but, they are required to complete the assessment by day 45 and have it filed with the courts and everything. And they were insisting that if they were depending on this clinician to be involved in writing the report and getting it back to them, they could not be late for those. So, we so collectively the decision was made to air on the side of a lower workload for the clinicians until we could see how this works. So, we started with a 20% treatment, 80% control random assignment ratio. And then in six months, they decided that they had the capacity to increase that. So, we went up to 40% and 60%. Now, on the analytic side, we're going to have to wait the data to adjust for that, but, it is possible.

Third challenge that I put out is the tolerance for long strings of cases. So, they were worried especially with this 24 and 48 hour timeline, you know how would we deal if six or more cases in a row come in and we only have these two clinicians to deal with those teams and they've got to get out to all of these homes in 24 hours. So, again that was factored into their erring on the side of a low percentage going to the treatment group at first. Now, it turns out as soon as we started. One of the sites was really eager and they were really disappointed that the first 13 cases went to the control group. Well, when 80% of your cases are steered to control, you know if you carry out the probability that's actually not that surprising. So, we've had many, many conversations with them. I will occasionally get emails and they say, are you sure that thing is working, we haven't had a case you know assigned to treatment in the last eight ones, eight cases that have gone through and we always check it and then we respond back and say, yes it's working and you know sometimes we've explained the math behind it and they've you know politely listened, but, you know they just want to know is it working.

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So, where are the opportunities in this? You know as I said this is a study of an eligible population rather than a consenting participating population that gives us some interesting information. And I think one of the other things that you know is really good for the field to discuss is sort of the value of random assignment in looking at professional judgment that's involved in case decision-making. So as we went as we were in the field for six or eight months, we went back out and we talked with the sites and we heard a lot of workers in different areas saying, you know, I really like this program, but, that random assignment really annoys me, because I had this other case that I really wanted to go and not this one. So, we're trying to capitalize on that and sit down and talk with them. So, tell me about the one that didn't go, why would you've really wanted it on that case, what was it about that case that you thought it would be useful for, because we are picking up in the conversations that while it's a valuable program, they're not sure it's needed for all of the level four intact cases that come through and there is really probably a subgroup analysis here. I don't think we'll have the power to do a quantitative subgroup model and detect those findings we may, but, you know drawing on the qualitative data, getting them to talk about, which cases they had go to the treatment where it was effective and they understand what the value was as well as the ones where it didn't go and they really thought they could have used that clinician on that particular case. And then if you pull up the slides, there are links to the we are sure about the program that DCFS has on their site and some reports from Illinois and those are the project team members. I will pass it on.

Diane DePanfilis: Okay. Hi, I decided to do something a little different, because I knew most of us on the panel were going to be giving example after example after example and so what I've done instead is come up with a list of what I what are my personal lessons learned having done this multiple times. It doesn't mean necessarily that even when you know and you can anticipate the barriers that you will be successful, because sometimes the rules change which might have permitted certain things in the past, but, might not in the current environment. So, but, just to give you the context I started to implement randomized control research designs when the family connections program that I was part of developing in Baltimore was first being demonstrated and funded by the Children's Bureau. So that was in 1996. So, since then there have been multiple iterations of tests or tests of modifications of that program both outside of public child welfare and inside public child welfare. So, some of the examples will come from that, from those experiences and then also there separately I've been involved in leading randomized trials of interventions that are exclusively and public child welfare including one that I'm involved in right now with Washoe County Department of Social Services, which is part of the PII initiative, which as I already even mentioned several times today.

So, but, these are some of the things and I was trying to take some notes, because I think some of the examples that you've already heard about hopefully I can sort of bring them back to why it's important for us during this session and in other sessions I think is to really talk about the practicality and the feasibility of making the choice. I mean we heard in our plenary that this should not be the only way we structure evaluations of innovations in trying to reform public child welfare services systems policy practice. So,

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but, I still firmly believe for the reasons that have already been introduced here that it is it definitely should be among the stages of our practice with putting in place evaluations to understand whether the what that we hope to see some different impact does truly have that impact. But, having also lived through some of the trials and tribulations and the challenges of implementing successfully, we can't also ignore the equal weight that has to be given with make ensuring that the implementation of the intervention does really get done as intended. So, the more complex the intervention the harder it is also to manage or to really control the differences between what somebody is supposed to get in the treatment group versus the control group.

So, anyway first, number one, whether your community is the stakeholders within a public child welfare agency or the community at large, engaging everyone to understand and be committed and to respect why we're doing this and I think we've already heard a couple examples Cheryl talked about how workers would love to see ex-family get the opportunity for a much more comprehensive assessment process to sort of guide what happens in terms of the services that might be available to them. There are also other challenges. We had serious issues in trying to recruit referrals from the community for different interventions when why would you make a referral when you can't guarantee that someone is going to "get" what they perceive to be the better intervention.

So, when there is treatment as usual, which you saw in the two examples previously presented, it's easier to sell the point that we don't know whether the new way of working is better, but, when you are talking about a preventive intervention which was the case in our family connections work and it's now being implemented with kinship care providers in Maryland within public agency. Most of the time those potential participants don't have an alternative. So, if there is no community alternative, they are getting nothing or very minimal information of flier versus the opportunity to get something that at least on paper sounds like it's better than what they are they currently have available. So, I think different types of settings make it more possible to do the sell, to really engage people in that process. And so you really can't we can't overlook the importance of that understanding and I think it's come out a couple of times both in the first session that I went to earlier in the day about implementing evidence based practices as well as in the plenary how important it is for the message to be clear and for everyone to understand and sort of be on the same page. And you just because you are on the same page when we joined together at the beginning doesn't necessarily mean we're always going to stay on the same page as time goes on.

So, the amount of time and resources need to continue to be put in place for those that ongoing conversation, because even when the implementation of the Random Assignment begins to seem to work in those situations sometimes the as you are monitoring the actual flow of cases which is really important with even knowing how to set up your computer program, you need to know what the potential pull is going to be if you've missed the mark with that potential pull in terms of the numbers then your random assignment might not work anymore, because you might end up with 20 cases at the end who are supposed to be assigned one way or the other, but, they're not, because you don't achieve that target. So, anyway that's important. The direct practitioners also

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in understanding why Random Assignment is necessary there needs to be a lot of commitment and being still billing being willing to implement current practice as usual, if you happen to be one of the workers that's assigned to practice with standard practice versus the new practice and so that we don't have the tension within an organization of you are special, you get special treatment, you get all these extra things, but, I am just supposed to carry this full caseload and not have the opportunity to practice the way I might want to. So, and these dynamics the whole importance of the organizational culture and climate in the context of things are really something that can't be overlooked and need to be considered carefully.

The coaching and I've already mentioned this that part of it in terms of the role of the direct practitioner being who is being randomly assigned versus the families versus, but, the whole importance of building in the implementation coaching and technical assistance to assure that the intervention is being implemented with fidelity, there are a lot of other sessions at the Summit that are focusing on those aspects and I believe those are essential for any kind of intervention that is you know more than just a simple kind of strategy. Then there is the whole issue of maintaining control over the randomization procedures you've already heard how well that was managed in the two examples previously. One of my first implementations of a Random Assignment study you know large urban public child welfare agency had many challenges even though we controlled which family got assigned to which intervention, the intake supervisor program manager was less likely to tell us about families who truly met the eligibility criteria, because he wasn't convinced we should be going through this. He just thought everybody should get this opportunity for the new intervention. So, really took lots of discussion and agreement at the top to make that commitment and to convey the importance that this was really something that the agency wanted to do.

I mean I think the administrator from Minnesota talked about that. She obviously was on board. What we know about the dynamics of public child welfare agencies is that frequently we begin initiatives and all of a sudden there is a new administration and we might not always have the same people on board at the middle of the study or at the end of the study that might have been part of it. So, getting things in writing, making sure you got sort of everything ready to tell the next cast of leaders on why we were doing things the way that we aren't. Then there is the whole issue of the timing of the randomization, which was also illustrated in the first two examples in terms of intent to treat, means truly it's done prior to when the intervention is absolutely going to be delivered and you saw how tricky it was in Cheryl's example of that 24-hour window. That becomes much more complicated when you add in the human subject factor which I'm going to discuss that has had a different experience than what has been illustrated before. So, in the in sort of number four and I'll get back to that. I moved that one down on the list, because I knew there were lots of other examples that would sort of make it an easier sort of straight forward conversation.

In Cheryl's example and also in the eligible participants for the for a guardianship waiver, you know how many people who are likely to be eligible either at the beginning or based on the case flow, you've been you are able to monitor that right along. So, when

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you set up your randomization procedures, you know you're going to have 1,000 cases that meet eligibility criteria over the set period of time, you can do your computerized formula based on that number and unless some major disaster occurs or the agency gets a 50% cut and staff which then would might reduce the capacity, you are in pretty good shape, but, when you're recruiting from the community, you make the best estimate you can based on needs assessments, based on understanding who would likely be eligible, but, you can't you are in lot much less control of the flow of recruitment at the level that you hope to accomplish. And that impacted us in our first study of family connections.

So, the second time around we did randomization by blocks. So, even though we projected and I forgot 250 families that we had hoped to recruit during this period of time, we did not do the computerized table in terms of the Random Assignment of all 250 at one time. We put them into smaller blocks, so would be maybe within 50, the first 50 they were randomly assigned their place, and then the next 50, as you could add block after block, you still project it for the full thing, but, it accounted for since it wasn't going to be a toss the coin one this way, one this way, one this way, one this way, was going to be random. That may not be back and forth. You don't want everybody at the end who never gets assigned to know their numbers not to be up and then you end up with a different proportion than you might have predicted needed based on your power analysis and your analysis plan, which all of course has to be done before you can establish these procedures.

So, the other thing around that is the management of the staff who in most cases these are large scale implementation efforts and it's usually not one of us being able to personally manage all of the pieces that might be required. So, planning ahead with implementation research manuals and all of those things and needing to recover from turnover of your own staff that might occur in that process, maybe the first group we're completely on board, but, maybe you don't think about some of the assumptions you might make in recruitment of similarly qualified research staff may be incorrect in terms of their absolute commitment. And I've had lots of experience with HR in the last however many years. So, now let's talk about human subjects procedures. In Cheryl's examples, I am glad she gave you the citation, so you can go to for those of you who are in the process who use these things all the time in developing your IRB protocols, what a new interpretation that has come out and affected us pretty recently is that the whole exemption and one of the criteria for waiver of consent is evaluation of a governmental program. It's been recently interpreted to us that that must be a federally Federal government program rather than a State government program. So, I am not sure today whether that would apply or perhaps her IRB wouldn't raise the question, but, the University of Maryland IRB has raised the question when it got up to Federal interpretation, Federal interpretation came back saying, yeah, no that does not apply, so, anyway.

One of the things that we do because we have obtained human subject consent for all of the studies that we've been involved in is obtain certificates of confidentiality, which is everybody familiar with what those are. They are not hard to get as long as you have an IRB approved protocol and what you are able to say to participants is the that they are

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what they might disclose to you in the context of research interviews will be held in confidence with a couple of exceptions. And one of the key ones in our field of work is suspicion of child abuse and neglect or that there is they somebody may be a danger to themselves and others for other reasons so it could be a suicide or whatever. But having that conversation it does seem to make because many times these are folks who are involved in core processes. They are worried about being honest in the process and whether or not the Certificate of Confidentiality would truly prevent us from having to show our records or produce our records from the court, at least it's the highest assurance we can provide that as a routine we would not be required to do that.

Then the other issue that I have been challenged about and I think and I put it under human subjects is the whole notion of vulnerable population. So, children are definitely a vulnerable population. Even though our studies are always separate in my very beginning they were classified as more than minimal risk, but, then that's been changed to the interpretation was changed. They're currently at least in my experience classified as less than minimal risk. So, it doesn't mean that you have to say there will be a potential benefit around the risk benefit ratio. However with children the notion of assent and consent gets complicated unless you do have an exemption for waiver especially when you are talking about children who are in the formal or informal public child welfare system. So, either they are if they're in their home, their parents are their guardian, their legal guardian, their legal parent, if they are in foster care, it's pretty complex who has the right to sign on their behalf and then obviously if they're 11, 12 or older, they also have to provide assent. So, another tricky thing that's happened on in our campus recently and it came out of a pediatric study not in social work was the issue of a teen mom whether the teen mom can who might be in care with her child, whether she has the right to give consent for data about her infant things shared. And this particular case went up to the attorney general's office, University Counsel and right now I think there is a study that is not going to be approved in allowing a study of teen parent, because of that complexities.

So, all of this is when you're working in particular areas, I think you learn how important it is to be a continually educated and to try to educate your IRB personnel about the kinds of studies we do so that these kinds of things don't start to spiral out of context. I know of another faculty member at the University of Maryland who has stopped doing studies of children in group care for the very same reason, because of the complexity of who has the right to give consent so. We, each have the responsibility to operate under the same Federal rules in terms of human subject protection, but, each IRB sometimes has a little differences in terms of their interpretation and in my experience ours is very strict and difficult. I am sorry that this is being delayed and we try to work through. I know.

And we try to work through that educational process, because these are so different than in FDA approved study that's testing a new drug or whatever, but, another vulnerable population is employees, because of you know if you go back to those early slides in terms of equal opportunity to be part of a process, there is a current study that I am working on where the proposal is to randomly assign not only the families to that new intervention or the control, but, to also randomly assign workers. And the proposal is to

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randomly assign workers without asking for human subject consent. That is still the resolution of that is still to be determined, but, I think that that is probably not going to be accepted by the Institutional Review Board, which unfortunately is not at Maryland I had said another institution, because of the right for employees to decide whether or not they will consent to research to information about them being used as part of the evaluation, because there is the whole issue of you have the intervention being implemented and is intended and then you have the variable around the practitioners confidence, attitudes and skill to deliver the intervention is intended and you certainly want to be able to understand those dynamics as part of your evaluation plan. So, hopefully we can have more discussion about this at the end. Our work has also always had in our logic models of measuring change over time and proximal as well as distal outcome. So, with the proximal level, we're looking we're asking participants to be part of completing instruments, standardized assessment instruments, which we do through a CASI, Computer Assisted Self Interviewing program and most of the time those interviews are home-based. So, the challenge I think sometimes of implementing that component for both the treatment and the control groups make up more complicated to get all of your access in the right columns at the right point in time for all of your groups depending on what your large your numbers are and so anyway the whole issue around different levels of retention both with the intervention as well as in the research itself, when you have the need to get direct information from participants at intervals over time to measure the degree to which the intervention has been successful in helping families achieve whatever your targeted outcomes are that also makes some of the management or the controlling of the implementation of the evaluation more difficult and that was particularly the case when we did the replication of family connections with grandparent

Informal grandparent caregivers, that I know these were grandparents who are getting no intervention or getting the supportive intervention, which was again tested the treatment intervention, retaining the folks who were getting nothing into those data points was particularly challenging, because even though you know we give participant gifts for their participation that those gifts were insufficient to ensure and then even just tracking and finding people over time is difficult. I think some of the study there is some great information out there about all of the creative things that you need to do to sort of retain connections with your participants over time, birthday cards, all sorts of things to make sure you're sort of remembering where they are, getting three names of other people who will know where you are, and that's all part of your consent process. Telephones change every other day. So, those are necessarily the reliable method for tracking people over time, but, monitoring those administrations if you are the principal investigator is something you just definitely don't want to wait until the end, you know monitoring how well you're doing with getting the data collected at the right points in time over time so that the tracking system is really important and making adjustments both with the equipment side as well as the management over time.

And then it's already been brought up and I think it's going to be illustrated further in the rest of the panel is the importance of the best design study using only quantitative methods probably will still not tell the story at the end of the day. So, when you can conceptualize and mix method study, I think you have a better way to answer the

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question what if any better off people are at the end of the day and if so what are the other factors that might have contributed to that in terms of the participation, the retention the their satisfaction, how would they tell what changed about their life and their circumstances from the beginning to the end as might be really important to answer questions that can't be answered by standardized assessment instruments or by administrative data. And there is the issue also with certain types of assessment instruments automatically have it's not the instruments. It's the condition have cycles like depression for example. And so knowing that people who have tendency to have depressive symptoms at different intervals in time, they may always have the ups and lows. And so understanding that a little bit in terms of when you talk about the administration of the timing of when instruments will be implemented, you could artificially inflate or the alternative and which might misevaluate whether or not there really is change at the that could be attributed to the intervention itself. So, I'll pause here and hopefully we can come back to some of these examples as we move forward.

Tara DeJohn: I'm Tara and this is Patricia and our other colleagues Shewayn apologizes she wasn't able to make it and her flight actually did get rerouted and messed up so that she couldn't get in. And we are going to talk about how we used Random Assignment and with some overlap with what's been presented already, but, in the context of a pilot grant initiative called the Louisiana kinship integrated service system. So, just Patricia and I were going to kind of go back and forth with different pieces of it and set the context of the overall grant initiative and then how we were able to use Random Assignment in a piece of that project and some of the lessons we learnt from it the gifts that came with it and some of the struggles as well.

Patricia Washington: Thank you, Tara. Well, the kid's grants purpose was actually to demonstrate how enhanced collaboration between the TANF and child welfare could improve overall outcomes for Kinship Care Placement Children. The program started in 2007 that's when the staff payments existence. I mean it was myself I originally started within the program as a care manager from the TANF side and another co-worker Karen Martin, a care manager from the child welfare side. It was a very, very interesting and tedious start to the project, because part of our initial plan was just set in place referrals. Randoms randomization was not our original method of assignment. The person who was acting somewhat in a program management capacity at that time was a person who had also written and obtained the grant for the project, Carol Rose we were all strongly, strongly opposed to using this method of assignment in our honesty.

[Indiscernible] [00:53:56] Office of Social Work and Social Development was acting as our program evaluator and at that time a person who had talked to us about using random assignments and we were all strongly opposed. Karen and I being the old staff and knowing the need that existed for the workers for the staff to refer cases to the project, we figured that that would be a much better way of handling the program and the evaluators talked to us time and time and time again and we were all vehemently opposed Random Assignments. However we had no choice in the matter. This was the method that they chose to use. We figured we would get more input from the staff in using referrals. We knew that the need was out there and if we did this, we would definitely have a very large

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base to pull fund in order to get our programs started. We were talking a few days ago about the Summit and what we would talk about and Carol mentioned she had no idea that random assignment would make us famous. So, it's a little inside joke that we have about it and we found that it truly has worked. I believe we've gotten some very pertinent data to what our program was set out to establish and we've established that and Tara is going to take us on to the next phase within our presentation.

Tara DeJohn: Just to give you a broad picture of the grant it was a mix method research design and that we are using that quantitative and qualitative methods in the overall project evaluation and we are looking at both organizational system factors as well as client system factors. On the organizational level, we were measuring and assessing collaboration readiness between child welfare and TANF workers. We assess their intra and interdivision kinship knowledge about how what their level of understanding about their own agency's policies and definitions of kinship caregivers was and each others and the Louisiana Child Welfare and TANF serving agencies are under a broad umbrella agency that's now called Department of Children and Family Services. From the time that the grant projects started to now not only has major administration change in form of governors, department secretaries, we've also changed department names, we've changed division program names. We've had all kinds of changes even and a hurricane all in our five-year project, so that really has shaken some things up. And then develop across trainings from the pretest and are just now completing our post test measures. But, at that organizational system, we did not use Random Assignment. It was convenient samples and staff personnel. It's at the client system where the random assignment was implemented and in that there is pre and post test for client satisfaction. There is pre and post test measures for well being using a clinical depression inventory, CDI, the both the caregiver and the child complete if the child is age appropriate.

And then we had a self developed client data form that collected information for us to measure safety, permanency and economics sufficiency. And then we also had some care managers, Patricia, Karen and two other care managers that originated from either child welfare or TANF that served as the either treatment or observation care managers for the project and then using in all of those components evaluate from the Random Assignment of the clients and client in this case was child driven based by child cases. So, as Patricia mentioned, some of the initial factors in the Random Assignment, the biggest part was garnering that support, getting all the partners and stakeholders, getting the different leaders from the Steering Committee to agree that Random Assignment was okay, getting the direct field workers to agree that Random Assignment was okay, part of the biggest way that we were able to accomplish that was one to convince them that clients will not be withheld from services. When we decided to do Random Assignment, those cases that were set into the observation group continued services as usual so that the treatment group was going to receive the LA KISS Care Management and it was defined as more of a brokerage of services by the cross-train care managers. It wasn't direct service itself.

The care managers worked with the treatment group and linking either serving as advocates back to the child welfare TANF workers or in the community linking them to resources, but, they weren't like providing counseling to the agency. So, the fact that

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they weren't the treatment group wasn't getting what was perceived as an intensive direct service helped get the buying. The fact that both the observation and treatment group that the observation group was going to get treatment as usual helped to buy in. We did give incentives for participation in the program and the incentives were given to both treatment and observation caregivers. So, that was another thing that helped gives some equity to both groups and because these are groups where the majority of caregivers are impoverished knowing that each caregiver was going to get a little economic token helped the buying and then because there is such a strong push for evidence-based or evidence-driven models in both child welfare, especially child welfare, and just being introduced at least in the Louisiana that notion being introduced into welfare programs saying that we could be on the forefront for Louisiana in contributing to that knowledge base and you have to have Random Assignment to say that you are doing anything that's evidence-driven or evidence-based was another caveat that helped give the buy into that that we were giving some record. We were establishing some objectivity that would help promote maybe hopefully some more funding and more support from higher up administration to add to a program that everybody at the table agreed was necessary and needed. I think I will add to that okay. And then the next part came and it took, we spent a full year in the beginning of the project just in planning and really setting up the design and we really think that was probably the best thing we could have done that if we would not have really taken our time in defining the criteria, getting everybody on the table, setting up protocols, bring on our measures and setting up the defining the timing several of the other panelists already mentioned you know to deciding, how are you going to decide who is the eligible for the program, we set up all of those parameters in advance.

We decided that draws would be made from the state database and that Random Assignment would be made through a computer software program that the evaluation team would do so the clients not only were assigned randomly treatment or observation, but, because we had three care managers in the treatment group, because there would be more work there and we had one in observation, because there was less per se work there that they were also randomly assigned care managers, so, was another level of objectivity to control for any kind of worker effect. All of those things were ironed out in advance. We decided we would do draws on a quarterly basis to give all the care managers time to recruit to go through confidentiality with the families that agreed to participate, to get their consents, to do all the initial assessment, setup the charts, all of that, so that cases were added incrementally over the next three and a half years of the life of the project.

And eligibility to become into the program was decided by policy whichever whatever the policy was for a child to be in a kinship placement and how that was defined by child welfare or how that was designed by the TANF program stayed in place and then we were able to evaluate the impacts of that. With the implementation, with recruitment, one of the gifts I think that we had was that we were targeting in a very specific region of the state and that not only were first letters were sent out to clients as they were generated from the computer for Random Assignment, but, then if they didn't respond to the letters, which wasn't all that uncommon, you know why is the state contacting me, that the care managers actually made home visits and I think that that made a tremendous impact maybe you want to speak to that.

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Patricia Washington: Yeah, I think that made a great impact on our program, because the persons we were the families that we were working with were not used to us coming to them. They were used to coming to us. They were very eager some of them to participate in the program after they found out what it was all about, because they felt that finally here is a program that really, really, really has our self interest at hand. They were about trying to help the family meet some of the needs that they have within their families or even recognizing that there is needs that they have within the families. So, I think that really helped a lot with us going to them as opposed to having them come to us.

Tara DeJohn: And with the participant retention whether the families were in observation or treatment groups, they were contacted a minimum of every six months and that kind of fit in with the flow of contact that they were used to. What happens then it turned out that the majority of our participants came from TANF only. We don't know why that just those that agreed to participate, we had a greater number of families that became eligible. I have my professional guesses, because this probably isn't the appropriate venue for me to state that, but, why there were more TANF only kinship families than child welfare kinship families, but, I think if you read the literature about what's happening in child welfare and kinship, those of you that are seeing about that literature probably have an idea of why that so.

And the Louisiana is one of the leading states in utilizing kinship placements and has been for many, many years. And so in that a lot of kinship families tend to have contact every six months with their TANF worker by phone to renew their eligibility for their kinship care subsidy and it takes several years before they get on in annual renewal. So, they were kind of used to somebody calling them and say, hey, how is it going, what's new, the child is still with you and checking on them so that that flow of update fit with kind of what their normal routine actually was. And so they were used to kind of always keeping in contact so that helped with our retention and then those that were in the treatment were having more active contact anyway with the care managers.

And in the follow up what's going to the post test and that included a second satisfaction interview and kind of as Diane mentioned with the qualitative piece I think one of the unique gifts that we got here was that I did most of the qualitative interviews for the caregivers and I cannot tell you how many times they said they were so amazed that somebody cared about what they had to say about their experiences with the agencies. And even if they weren't getting an incentive that they were small incentives, it was \$10 at pre \$20 at post. So, we can barely buy Meal McDonald's anymore for that. But, the opportunity to say this is how reenrollment is affecting me, this is the kind of services I really wish I had to better sustain the family that I am trying to raise. To them, by they are in words was invaluable.

And so that opportunity if we just had Likert scales of approve or agree to disagree that wouldn't have worked and I don't think they would as many would have participated as did, because they had that opportunity to really talk about how they were treated, what would they like to see for policies that would better help their family, what kind of

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resources would they like to be linked with that would better help them in their families. They had been taking many of them have been taking care of children that they didn't give birth to for seven to 10 years often times without any kind of assistance and nobody would ever ask them that before. And so it was a very enriching rewarding aspect that just kind of as a caveat. Anything on that, apart from that?

Patricia Washington: Well, just one comment I wanted to make on the participant retention I think part of the reason for the numbers being much higher on the TANF side than child welfare was because TANF has been eligibility driven for so long. Those of us that have worked in that area your main concern when the family sit before you is determining their eligibility, not really meeting any other needs that the family has other than financial and you're really not meeting the need, you are I'm going to leave that alone as a whole another issue, but, it's eligibility driven. You're not really looking at any other criteria in the family what other than do they meet the eligibility criteria for whatever programs that they are applying for. And having worked in that field knowing that the families had needs aside from just eligibility wasn't just about money, the children has tremendous issues that needed to be dealt with. And I think that's why many of the TANF clients so really welcomed this program in becoming a part of it. Initially it was very difficult getting the families to participate until we put the incentive in place. I think for those who would not have become involved with the program, the incentive really helped them to make the decision to do so.

Tara DeJohn: So, some of the lessons learned, one of the big hurdles that we had initially was we were involving LSU, TANF and child welfare divisions all functioned on different technology systems. We all had different you know even just of Microsoft we were one was 2003, one was 2007, one was 2010, none of our systems communicated. And trying to find a common technical language that would work just and not even anticipating that we would all be so disparate in what our software and technology resources would be and so having to work with and bring to the table IT people. Initially, the people that came to the table were program people. And so, we recognized we have to get IT people on board and then have them involved and that was kind of an early lesson learned and then realizing to make sure that I think someone mentioned about how turnover happens. That turnover in IT people too not just workers and they service because sometimes they will write things in languages that they're expert in, but, when they leave, it turns out nobody else uses that language and then you have to start all over again. And so, we had some data issues and some data that was lost, because in the beginning certain things were captured in one software that was written in apache code that turned out nobody else knew apache code once this person left and we had to start over from scratch.

Fortunately, but, wonderful care managers that have been in this system for a long time that know they will caveat if they didn't have it's not documented it didn't happen and still had the paper documentation. So, we learned and emailing things back and forth that sometimes in this computer age, we think what we put it in cyberspace it will stay there, learning that's not necessarily so. You're going to make sure that how our cyber languages is the same and compatible and has a long shelf life. So, that what was a major

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hurdle and with tight resources, it's not always feasible to get everybody in the same language and having to be creative with that aspect of doing that and then too with communicating and doing random assignment. We wouldn't have been able to keep the participants engaged if we wouldn't have been able to do home visits. Many of the clients that we worked with if they had a phone, they just had a cell phone and often times they had restrictions on minutes. So, we had to be very mindful of that and we tried to be very culturally responsive to what their day to day realities were like and to meet them where they were at to keep them engaged in their process and not just make them fit our model. But, we tried to make the model adjust to meet their needs so doing home visits. Not if we had the option of doing some surveys on a computer asking them first are they comfortable if we do this on the computer and letting them look at it, some were, some weren't, but, we let them help drive. So, those things that they could have input in to help give some control so that they weren't treated like a case, but, in other words humanization to the process and then that still didn't compromise the integrity of the data and then communication. We had active work groups throughout the whole time that met monthly. And then we've really kind of had a participatory action type philosophy to the evaluation. As evaluators, we were in constant communication with the direct team that was doing the work. If they had issues that we tried this that you want us to do, we can't get it to work, we were always figuring out how can we make this work and constantly talking to each other. So, there was never this I don't think perception of it's us and them as evaluators and project workers. We were a cohesive team constantly and then we always brought people into the work group any time the work group got somebody is not at the table. That's so that all the groups were represented. We tried to bring caregivers in the beginning and focus groups to participate to help setup what do you think needs to be involved in this project. So, it was a very collaborative effort to get all the bases to be covered and that communication was kept open at all times and everybody's opinion and input was perceived as valuable and welcomed.

Patricia Washington: I think one of the really important factors was the closeness of the evaluation team with our project. It was like they were their hands on. I think we spoke to them and communicated back and forth with them more often than we did with each other sometimes. It was have you talked to Shewayn or have you talked to Tara, it was just a really great relationship that was established with the evaluation team and they truly felt like they were a part of us. It wasn't in us and them as she said a few minutes ago. Another really important thing that I found in communication is that we were involved on several different committees, partnerships that we'd established within the community and communicating the information back and forth about what we were doing.

One of the disadvantages I saw and the one this was the only disadvantage that I saw in the random assignments was that whenever we would go out and present our programs to other people within the community, everybody wanted to know how do we become a part of that, how do I get a client involved in this, how and it was I'm sorry we're doing random assignment. So, that was the only negative part that I saw in this whole Random Assignment method. And I think that's it.

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Tara DeJohn: I think we are out of time.

Leslie Cohen: It shows everybody inspired, all fired up to go do Random Assignment and tackle the challenges. Are there any questions for the panelists? Oh, we were that clear?

Female Speaker 1: I was wondering whether you can talk more about up from by you from your partners, from your agencies as you guys mentioned sometimes your partners may think this random assignment takes time or is it a group program let's get it running, how do you convince them or tell them this the beauty of this random assignment and so what some strategies to communicate among the *[Indiscernible] [01:17:02]*

Leslie Cohen: You want to talk about the strategies for promoting buying...

Patricia Washington: Yeah.

Leslie Cohen: With their stakeholders. Cheryl go ahead.

Cheryl Smithgall: A lot of field time, you know Illinois is a pretty big state. We drive five or six hours to do field meetings simply to address you know the buying of Random Assignment and that face to face conversation is really critical rather than by phone and stuff like that. The other thing that I don't think we've touched much on here is you know there is more and more information coming out about adapted designs of randomized trials and you know it doesn't just have to be this case goes, this case doesn't kind of a rolling random...

Leslie Cohen: Yeah.

Cheryl Smithgall: Roll out a Random Assignment that kind of stuff. There is a paper by Hendricks Brown and colleagues, I think it's 2009 I think give the citation of anybody once he emailed me, but, the talks about in particular public health settings where they've used different kinds of designs that really relate to that buying. So, there is you know medical trials where every time there is a success on a case that goes to treatment, it stacks the Random Assignment ratio toward the treatment group rather than keeping it same and that was more comfortable to the field. So, I think it's also about exploring ways in which you can you know adhere to what Leslie first introduced and having that comparison group, but, may get feasible for the field.

Female Speaker 2: Well, when you were doing your field about why this was good, what did you say?

Cheryl Smithgall: I guess for our project it was we had the benefit of fact that this program had existed for workers on placement side. So, we actually drew on qualitative interviews from those field staff and some of them were very open as Patricia was saying that I was against this from the beginning and they were talking about the actual sort of program dynamics not just the Random Assignment, but, who said, I really didn't want

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this and I will come around kind of things. So, we drew on and we had field staff talk about fields like Ruben are part of the program talk about it. So, they could explain you know did it interfere with any of the other case for responsibilities or you know what benefits they felt they got out of it or what. They just took all challenges they had that they want to talk to.

Diane DePanfilis: You know I think a frame that we have to have as evaluators is also not I am really guarding against the tendency of discussing the treatment intervention as being better, because we really don't know. And so agencies have to everyday make decisions around how much they are going to invest in the way they deliver services. And so being really committed to that is important, but, I think that's why it's harder for the community to understand especially for if your target populations won't get anything. If they'll either get this or not either nothing or very little and I think those are harder sells to understand. I mean you can go do information referral, but, they have information referral now.

So, I think in the context of a public agency where we don't know whether this much more intensive probably more costly intervention is going to make a difference significantly enough of a difference to make it worthy investment of the added cost and skill level or whatever that will be needed that I think that compelling case does help. As long as we don't like go start the PR for the project, look how exciting this is, our agency got this new initiative, we're going to do X, Y and Z and then to discover later, oh, well why is that better than current practice or whatever you know so that's sort of the attitude. I was going to make a note Cheryl's point about that paper was actually presented in one of the sessions today so it was in the afterwards when you go to get that oh, that's from...

Cheryl Smithgall: 9'O clock.

Diane DePanfilis: 9'O clock, yeah. So, it was on the implementing evidence based practices. I can't find the number. I am still on Monday. I'll find it. If anybody needs me I'll look it up for them, visit during the 9'O clock and you'll finally in with the first moderator that organizer of it, so if you go to that session later you'll get the complete citation for the paper. Very interesting idea, so it's the timing, the staging of everybody is going to get the intervention. They're just not all going to get it in the first phase. They might get it in phase two or phase three that if you are doing an intervention and in discussion to the community might be one of the things that you would add to that list.

Cheryl Smithgall: And feasibility I mean....

Diane DePanfilis: Yeah.

Cheryl Smithgall: For public social services since they often don't have the resources to launch something state wide or county wide or you know whoever, so you know I staggered well. The paper I think that I was looking at is actually from 2009 so it's a little bit older, but,....

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Diane DePanfilis: Yes.

Cheryl Smithgall: He did draw on the same referral model....

Diane DePanfilis: Right, yes, right.

Cheryl Smithgall: But, it actually presents the number of other ideas too so it's a good one to look at. And I also want to say for guardianship in Illinois and in Tennessee without Random Assignment the state would not have gotten the waiver authority to spend those dollars. So, receipt of that money or the use of federal funds was contingent upon doing Random Assignment. So, it was really in a state's best interest to at least have some kids getting to trying to benefit from this alternative I mean using Random Assignment versus having nobody have guardianship and not being able to test out its effectiveness. And so that was compelling to get people to jump on board and ultimately it was the fact that enough states did Random Assignment did randomized control trials that persuaded the Federal government to say, hey this program really works.

And I think without that level of rigor, without that level of evidence it would have been very hard for the Federal government to say this is a change that we want to make through the social security act and the program that we want to make available to everybody. So, I think there was sort of this some ethical pain that to get to what Diane was talking about I mean everybody wants to think it's like this for intervention yet we don't really know and we kind of need to I think clinicians would say they kind of suffer through, practitioners suffer through that period so that we can say it with confidence that it's really effective and we are working you know investing limited resources out there.

Tara DeJohn: And for us the users it help to give increased objectivity to what you are going to be able to say about the program and it removes the burden on the workers to have to refer and our workers are already overtaxed with what they have to do anyway and so it removed that element from them having that burden and for anybody having to go back and track of this as everybody referring who could kind of do that, but, it took that out of the picture so that the burden of the implementation of the program being on a workers back wasn't there by putting it in a Random Assignment process.

Cheryl Smithgall: Well, just one another topic I'd love someone just speak to in that crossover, sometimes you have this great Random Assignment plan and it works, but, your folks assignment control groups sneak over the intervention group and can you talk about ways that you to employ this practices to avoid that?

Diane DePanfilis: I've never had it happen, but, I think it has to do with what kind of intervention is being implemented and who is responsible of making sure they are assigned to the right people. I don't know if other people have had that experience. I mean I think it happens maybe more often in you know like in a group care setting when there is a greater likelihood that you will be exposed to the intervention even if you are not a direct participant, but, I think most of the interventions we are talking about are

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home based kind of intervention, so it's harder to imagine it would the practitioner themselves if the practitioners trying to deliver more than one intervention well then it could happen there.

Cheryl Smithgall: Right.

Diane DePanfilis: If they are trained to do services as usual plus the new innovation, then they could go ahead with the people being aware of that.

Cheryl Smithgall: It includes a family preservation evaluation and that may no more than I do use on the federal side. It was about gate keeping on the program, right, so having good monitoring in the program, but, there are also in the negotiation of the buying. There were a certain a number of allowable exceptions for certain cases and that was part of you know getting the program side comfortable that...

Diane DePanfilis: That's another technique...

Cheryl Smithgall: There could be a couple of...

Male Speaker 1: It's always it's important to them right.

Cheryl Smithgall: Yes, right.

Male Speaker 1: You feel very passionate *[Indiscernible]* *[01:26:27]*

Diane DePanfilis: They're not part of the research.

Cheryl Smithgall: Right.

Diane DePanfilis: Right, yeah.

Male Speaker 1: You did have significant problem there, so *[Indiscernible]* *[01:26:46]*....

Diane DePanfilis: Yeah.

Male Speaker 1: Couple of slides, and part of that is again it is a whole issue and the evaluation versus issues *[Indiscernible]* *[01:26:59]*.

Diane DePanfilis: Right, right.

Female Speaker 3: *[Indiscernible]* *[01:27:39]*.

Cheryl Smithgall: Why would be okay to or where we would allow exceptions. So, we allowed one exception in the current study that I was talking about, because and it's sure nature of the case flow, you know there is an investigating worker who has this case and

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they are passing it off to the intact case worker. Well, what happened was two cases came through and I am sorry, one case came through from the investigating worker. It was actually two families. They were literally living in two residences, but, they were related and so investigations had treated them as all one case with everybody there. When it came to intact, the intact manager said this doesn't make sense. These are actually two different families with two different residents. They live across the street from each other and the perpetrator was involved in both families. And so he split the case and entered it twice, entered it separately for Random Assignment and then one went one didn't and they called me up and said now what do we do. And that was after the point of random assignment though so intended treat analysis will keep them separate, but, we allowed the crossover I guess basically more so than the exception you said.

Male Speaker 1: And in family preservation a lot of problem was with the judges.

Cheryl Smithgall: Yeah, okay.

Male Speaker 1: Judges have the same problem that you just talking about it. There is some unique thing out there reorganization I've been asking to.

Diane DePanfilis: Right, right.

Male Speaker 1: They are used to telling the people what to do...

Diane DePanfilis: Yeah.

Cheryl Smithgall: It's not right, but, that let me tell...

Male Speaker 1: *[Indiscernible] [01:29:15]*

Diane DePanfilis: All, right

Male Speaker 1: *[Indiscernible] [01:29:18]*

Cheryl Smithgall: And working with the courts with a whole another fashion and reporting session. But, we do need to end because I know the next scrutiny just to set up. So, thank you all for participating. It was wonderful.