

Panelists:

Brett Brown

Ida Drury

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

Brett Brown: Good morning everyone, welcome to session this morning, Evaluating Differential Response and Multiple Site RPG Approach. My name is Brett Brown, I am the organizer and I will give a little background on the session and DR and then we'll get started.

The National Quality Improvement Center on Differential Response was established by the Children's Bureau several years ago. It's the American Humane Associations to lead organization for the QIC-DR, Walter R. McDonald & Associates is a partner with them and it's overseeing the evaluation and also the Institute of Applied Research in St. Louis are our partners, so it's those three organizations. The goals of the QIC-DR are really two: one, to implement to DR in the US and to build cutting edge knowledge that can then be used, practical knowledge that can be used in the field and then to get that knowledge to those who are in the field to improve Differential Response implementation and results. The, I will say the primary effort or not the only effort of the QIC-DR is a randomized controlled trial in three sites in Colorado, Illinois and Ohio. We have representatives from each of the sites here this morning. They are going to tell you more about what's going on in those sites.

There is a special issue of the American Humane Associations journal protecting the children should be coming out in December of 2011 that will include four papers. These four papers that we are going to be presenting today, plus several additional papers on the control response and really the focus is on that list is also reporting further reports on what's been going on with the implementation and evaluation for the, for this DR project, all right.

We are going to lead off with two evaluation-focused presentations. One by myself on the, putting together the multi-site evaluation, second by Linda Newton-Curtis, who is the part of the Ohio Evaluation team and will be talking about challenges involved in implementing an RCT for DR, then Ida Drury, the Project Director for the Colorado site will be presenting on their screening practices and how they, how that really sets the table for the Differential Response. And going to an operational definition this is how we are thinking about Differential Response and defining it for the evaluation and for this part of effort as some involving two or more discrete pathways for screened report. So after the initial screening is done and state determines that a case needs to go forward and the family contacted, you have two pathways at least one in the traditional investigation pathway and two, the non-investigation pathway, where there is no formal finding of

maltreatment and where the emphasis is more, very much on a partnership with family service orientation and prevention. It's not that one that doesn't do that in investigation, but that really putting it on a more non-investigative partnership-oriented, giving it that framework makes it the ideas that it makes it easier to provide services and have a positive impact on family's function. And also that the pathways are formalized in statute policy or protocols, so this is a, you know, formal the, there is also a Pathway Assignment process where it's clear who it is that is appropriate for DR and who is not. So we will have a specific list of criteria and list of which are risk-related. Where all DR is designed for lower risk families although as it's implemented around the country, there could be a substantial differentiation in how the risk is defined, see anywhere from 10% of the cases to over 50% of the cases depending on whose DR you're looking at.

Cases can be reassigned, if there, out of the non-investigation to investigation if there are safety concerns and services are voluntary in the non-investigation pathway. In practice somehow that becomes, it's a little squishier, it's not always strictly voluntary. I think that there are states where if they, if the caseworkers decide that a family must have certain services for the safety of the family and they can take, they may decide to reassign this to investigations. But spirit of it is that is to be voluntary kind of activity.

All right, and I will move on specifically to my presentation. I am the coordinator for the cross-site evaluation, so we have, we work to coordinate the activities, the designs, the core instrumentation across three sites, okay to make sure that they are, that there is a great deal of comparability. The comparability is desirable because it helps build up the knowledge base in more systematic way. We got three sites to do that in with. So our first evaluation task is really is developing a common design and instrumentation across the sites and second one was approval from our various Institutional Review Boards and most of you have probably had experience with the institutional review boards. And when you have a multi-site, when you have mostly site evaluation, in our case there were multiple organizations involved at each site. You can have, well, we have four Institutional Review Boards, actually five review processes and it could have been up to seven Institutional Review Boards within the organizations. I am trying to coordinate all those and make sure, essentially pass at least a complementary set of IRB protocols, is a really challenge and talks about coordination preemptively.

The challenges that we faced included, well, integrate the insights and interests of the key actors include both cross-sites for the small comparability. The local site evaluators just focuses, is more on the questions of particular concern to the locality and also just the doing of their data collection *[indiscernible]* *[00:07:29]* practical orientation to prove to and there is also the, you know, the implementers and the evaluators, there is also, there is another, I think that's the project directors get on the sight and the evaluators who all having to pull mistake in design and the instrumentation how the data are going to be collected and so on. That effort really calls for a very conclusive design process to be successful. But there are some practical elements that having to do with time, conclusive design processes can be very time consuming from staff and so we have those pressures and we also have the pressures of the county. Once we got started the RCT's will be

launched by December 1, so we have a lot of work ahead of this and put some constraints.

The research, and we will start with talking about how we'll do the research and so on and that's just identifying the core research questions, the data collection strategies, what are the analysis, certainly really a lot of fairly wonky, you know, kind of concerns. And the process that we use really was started with the cross-site team doing an initial gleaming from the, from both our designs and the proposals of local site designs and also previous evaluation work that was for the Institute of Applied Research who's a very important partner in this because they had done several previous evaluations and we are able to use a lot of their, you know, the questions and the instruments is starting point for our own. How we went about it probably is not something we have to focus on. Well, here is a lot of initial in-person, you know, in-person to the meeting, well the brainstorming and the semi-weekly teleconferences. Most of that of which, are the evaluators who are playing the primary role and we also, once we had kind of achieved some unanimity on what interest we want to go forward with. They also sort out local stakeholder requirement and see that it made sense to the people and we are actually collecting the data from and who would be using it in, you know, in this.

One of the limitations or one of the other things we've learned and everyone tends to have their own little narrow focus. But one of the gifts of having a, of keeping all these various groups involved is that you are constantly being pulled out of your own little frame, you know, you were doing and if you do it right then the designs and the effort attributes is all stronger for, I think that the evaluators in the beginning, were a little too focused on the technique of this and the project directors at one point said, "This is great, but we have a lot to say about what kind of questions we want answered, how the data are going to be collecting because that involves our staff, and we want to make sure that that goes well. So we need to be more involved in the process," and so we did respond to the best we could and I think that it did in the end result in a good common framework, that had buy-in from all groups. But that was something I think that needed to be realized as part of the process and that we use that going forward to make our future work more efficient, yes.

Participant: Well you said that you report in the local stakeholders so people will be using this order bill. Did you just bring in, well, did you bring in those individuals or their program managers or their managers? Did you bring in the actual workers who are going to be...

Brett Brown: *[Overlapping conversation] [00:11:25]*

Participant: ...utilizing the tool or their managers or corporate managers. You know I ask that, we're smack in DC we're implementing this now so on the evaluation team we're trying to figure out those certain parts that we bring in.

Brett Brown: The example that comes to mind is in Colorado where there were, the caseworkers were, did have a chance to review this and discuss these with the evaluation team is that, some family.

Participant: And families.

Brett Brown: And families.

Participant: We did some work administering the family survey to some parent partners who gave us some feedback about the link and the time it took and how to fill things out. That was really key I think for them.

Brett Brown: Yeah. That's one thing and then it also helps build up, you know, you make sure that the questions sort of resonate with them. So that when you go back and actually either ask them to collect data or ask them to provide data, there is going to be a lot less, why are you asking this or why aren't you asking that, you know, I mean there are few things sort of and it is a good way to make sure that what you are thinking has been translated properly into and sort of terms or little concern to, I mean the people understand and that you haven't, and there are four, I mean, sets of researchers involved here and they are brilliant people being project directors and we still miss some stuff. I mean, everyone has something to contribute to that. It's like it's one of my teams for, how to do this, right, all right.

So moving on to the instrument development, one thing at sort of our research frameworks and our research questions, we are going to build on that in order to develop the surveyed instruments and we had two sets of instruments. One we're surveyed, really the survey instruments well we are talking of getting the question, information from the families as they exit DR. Also the caseworker, there were separate caseworker surveys in each of the sites and there are of course the administrative data pulled from their SACWIS Systems and SACWIS like systems and they are supplemented with case reports from each of the caseworkers. So that's really know a lot of information on the family and the services that were rendered allowing us to put that in a consistent format and so those who've dealt with the child welfare administrative data in various states and I think there are a lot of wayside compatibilities and incompatibilities. I mean they in fact also can exist within states, so it's, yeah that was just important to move for us.

The second set of instruments was semi-structured interviews with Focus Groups and different site visits first time which is just completing. We are interviewing administrators, caseworkers, screeners, community stakeholders. These are the instruments for the, the survey instruments and the administrative, those are actually available on the QIC-DR website and so if you are all doing work in that area, you want to see what kinds of questions we were asking, maybe good. I don't think we have the semi-structured interview questions up there yet, but we will. All right, the challenge in creating these instruments, all right... I think that moving forward into this phase, we did have people, the right people there at the right time providing, you know, their input in

place and so that was good. In fact, it is, it proved to be a very time consuming process to get everybody moving forward in onboard. It just, it always is.

There was also a push for field testing. We have the basic questions and local sites were also add their own questions because I don't, I mean we didn't want to restrict what they did as long as we had a common forum, which is also called for a lot of time. So the solution to this where we were, we really didn't seem to have the time to do this kind as a group was, just split up the work and this is something that the local variables had proposed. It's good in each site. Each site took one of the three instruments and the case reports, family survey, caseworkers surveys and did field tests to finalize it and then brought those, brought there what they had found and suggested changes to the instruments back to the group. So we were so *[indiscernible]* [00:15:59] on the month. This was I think it was possible because of the experience of the previous, our previous experience in working out the research design because there has been a level of trust and a sort of understanding of how everyone thinks about these things and level of common agreement that allowed us to be able to delegate work to particular groups, understanding that they understood where the larger vision was and to produce results that everyone could usually depend on.

All right, the other issue I want to talk about quickly is just this IRB process and as I said there was actually five IRB applications and four IRB's themselves and we used one for two groups. It's a very challenging to coordinate all four of these IRB's, are there for the protection of research subjects, to protect their safety and their dignity and the long history. But they can be very tricky also because although there are some common standards developed for IRB's that every IRB is going to have a little different idea of how one best protects, can best protect the respondents or subjects of research and you want to sort of flush those out early so that you can avoid conflicts at the end. So what we did is, we did a lot of, I mean each group did a lot of early reconnaissance, talking informally with IRB, their own IRB staff to see how they, what kind of feelings they have especially around issues of consent and whether you need a active consent versus passive consent, as no consent when that was required and in what form and it was a particular issue.

The cross-site IRB which is sort of the IRB for the whole project, you know, and that's where you hand in, this is how we are going to, this is the research designs I do it here the instruments, here is how we are going to get consent and folks. Then the package we built in flexibility wherever we could that allowed the local sites to do, as long as it didn't interfere with the comparability across the sites and we built into that flexibility, into that tier to allow the local IRB's some freedom to make requirements of different levels for especially for consent. We also staged the submission process so that the cross-site IRB application was approved before the locals were submitted. That way we know that at least the main IRB has said this is okay, we need to go forward and also other IRB's if they see that a respected IRB has gone ahead and approved to the design, that makes them you know feel more comfortable with it. So that is just a practical and the result was we got, we did get approval for all of our applications that were not, it was not without some exciting moments. We did have one of the local IRB's who at one point

had called into question one of the core design features of the evaluations which had not been surfaced earlier on. Fortunately the evaluators were able, working with the IRB to convince them that the design was adequate to the test so that we are able to get past that and get approval. So like I say, it's not, you can minimize the chances for things going if you can't, get rid of them completely, but I think because we were so prepared and we done a lot of advanced thinking of preparation that we were able to do deal with them.

All right, what are the conclusions? One, is that fairly inclusive designs processes payoff having everybody at the table, at the right times to make sure that they are heard and they are able to contribute. They are also very time consuming and there are limits to that and one of our, and I think the keys to our success to date is that we were, we did have really successes that built through the levels of familiarity and trust that allowed the group as a whole to come more efficient as we tackled the new design efforts or new stages of the evaluation together and the final conclusion just is that planning had to stay and advanced planning since it is just extremely important when you are coordinating so many different groups and so many different approval processes, okay.

Where we are going to, we've organized this as that we are going to allow sometime between each paper for questions and we probably have at least five minutes, so we are going to open the floor for questions about this before we move on.

Participant: So how long did it take you to perform your field tests that you *[indiscernible]* [00:21:28].

Brett Brown: I think we were able to get results back within a month from the time we started, contacting people to the time and we were able to report that.

Linda Newton-Curtis: Definitely, yeah.

Brett Brown: Would you rather had six weeks probably, maybe. I don't know.

Womazetta Jones: I think it could go on forever.

Brett Brown: Well, yeah.

Participant: And then you implemented everything, the *[indiscernible]* [00:21:53].

Brett Brown: Well let's see now. Those field testing that we finalized the instruments in last late summer at which point we handed in the Institutional Review Board applications because there has to be part of that and those were the, the cross-site was reviewed and approved within two weeks, three weeks. And then the other three, the local site IRB's went down, but every IRB has a different rhythm. University IRB's often are state department keep monthly and it require that you have the application in for more than a month before the next meeting so that you will have adequate time. American Humane Associations Institutional Review Board was able to be more flexible within that, but you know you want to contact them well ahead and make sure that that's okay. You know the

work that you don't want to alienate the IRB chair that whole process. They are partnering and you want to make sure that you are not pressing, you are not making them review applications on the weekend. You know, you just want to make sure that you are in their schedule and they are in yours, okay. I am pleased to move on, all right so. Our next presenter will be Linda Newton-Curtis of HSRI and she's the part of the evaluation team for the Ohio project and will be telling us about what are some of the practical challenges of actually collecting a data. Linda?

Linda Newton-Curtis: Okay. So I guess I put this on to the...

Brett Brown: You can minimize that.

Linda Newton-Curtis: Okay, good morning. Sorry about that. So I am one of the evaluation or I am on the evaluation team for Differential Response in Ohio. What I am hoping to give you this morning is the most kind of like the down to earth exposé of our experience in implementing an RCT. And also some of the challenges, lessons learnt, not just from our own perspective as evaluators, but also from the perspective, to some degree of the counties, what they experienced and some of the challenges that they went through. So what I want to do first of all is give you some context and background in terms of what Ohio has experienced. As you can see on the top right, you can see that there has been three rounds. Round 1, we are doing a replication at an extension of a study that was already done previously in Ohio. 10 counties were previously involved in an RCT around Differential Response and that study started in 2007. We are known as Round 2. We have six counties, six sites, one of whom was also previously involved in the Round 1 study. As you can see DR is continuing to rollout across the state, across our state. So Round 3 has just rolled out as another 10 sites and Ohio was just put out another RFP for an additional round.

So there is lots of things that come as a result of that. First of all, it causes some complications for us as evaluators, making sure that we only have those people or those families that haven't had previous exposure to DR going into our study and that's caused some complications in terms of our own counties that are collecting data. One of the things that they have to contend with is the fact that they are asking their caseworkers to collect data when about half the state are going to be doing DR and then not going to have to collect data. So it's causing some added complications that perhaps aren't occurring in the other sites in Colorado and Illinois.

One of the things about Ohio is that there is 88 counties and it's a county-administered state, which means that they have their own ways of doing things, their own ways of sequencing things. Different people have responsibilities for decisions within the different counties, but they are different people. So we had to ask our six counties to come up with some kind of generic case flow so that we can understand or could understand, you know, exactly what the sequence of a case coming into the pipeline of child welfare was, where decisions were made at each point and who specifically made those decisions and of course the criteria for making those decisions, because they could change little between counties. Once we got all our counties to come up with this kind of

generic case flow, then what we could do as evaluators was kind of overlay on top of that what our evaluation plan would be and whether decisions would be made within our evaluation. So as you can see when a call comes in, the initial thing is that the call is screened by the screening supervisor or by the screeners. And at that point they make a determination about whether or not this case is worthy of further look by CPS. The only cases that are potentially eligible for our study are those that are screened in as a abuse or neglect case. There are other cases that are screened in, but they are not eligible for our study. At that point a Pathway Assignment Tool, and I talk a little bit about the Pathway Assignment Tool, is implemented. And what this is Pathway Assignment Tool is going to do, is give the screener a mechanism upon which to determine whether or not the case is within our risk threshold for being within our study. High risk cases are not eligible for Differential Response of tracking to be done.

One of the things about this Pathway Assignment Tool is as I said previously, it's a county administered system, so there are certain state rules that determine this, that certain cases absolutely are over and above the threshold of risk that we can say, you know, this case can go to Differential Response. But because it's a county administered system, different counties had their own ideas about, well, what would be eligible for Differential Response beyond that. I mean would domestic violence, for example, would be eligible, would families where there were drug affected babies, would that be eligible, would some types of drugs be eligible and others not, for example. So what we try to do is bring all counties together so that they could come up with a common understanding of which families would be eligible and if they couldn't come to an agreement upon that then how to document those differences between cases. So laying the foundation and of course that was a part of laying the foundation.

One of the things that was so important was training. As Brett said, we are collecting state administrative data. We are also collecting these family surveys, the caseworker's surveys and so on and so forth. So we went out to each county and we did day long trainings at each county. Some of the counties are very far as you could see from the previous map, some are closer together. So what we've really encouraged counties to do was if their workers couldn't come to the training at their own county, to go to other counties to complete training there, because we really, really felt that it was so necessary for this training to occur because the tracking of these families was going to be so complicated. I think one of the surprising things, one of the things that really hit us in the face, we've had so much contact with our counties. We really had established some, I think some really good buying from our county coordinators. We've had coordinators within each county. Well, one of the things that really struck us was we went up to or we were discussing the training that was going to be going on at one of the counties and the county coordinator just couldn't understand. "Well, why do you need the traditional workers?" I mean this is a Differential Response study. You know, over the previous months they had been at least, I know, nine months leading time to this. We've been having constant meetings with our counties both face-to-face and over the phone, lots of emails going back and forth. But it was only at the time that we went out to do training that we suddenly realized this one coordinator just didn't understand despite the nodding of the head overtime that, "Oh, yeah I understand, I understand," she didn't understand

that we were collecting data on both sides of the track to make the comparison. I guess the lesson learned there is that, you know, sometimes even when people are saying, “Yeah we understand,” over extended periods of time, random assignment seems kind of intuitive as an evaluator is not necessarily so intuitive to people in the field, because that’s not what they deal with on a day-to-day basis.

Following on from that when we went out to do some training, we were training in the various counties as I said and we had both traditional workers and Differential Response workers coming in. And as we were talking about in one of the counties, the data that needed to be tracked, the caseworker, the families that needed to be tracked overtime and the type of information that we were going to be collecting, one of the traditional workers said, “Well I thought this was voluntary.” Again communication had been an issue this time between the county coordinators and getting that communication down to their workers. They were seeing this very much as Differential Response project and not as something, again, that the traditional workers were going to implement, implicated in.

Random really does mean random. At the beginning of the study, because this is a whole different approach their counties wanted to, have dedicated Alternative Response from caseworkers and so towards the beginning of the study, they wanted to clear the caseloads of those Alternative Response workers so that they wouldn’t have to kind of jump back and forth between the traditional approach and this differential approach, this alternative approach. Well, we worked with the different counties to think about different ratios. What you probably didn’t see in the map is that we have a couple of metro counties, they are really huge counties, they did dedicated whole units to Alternative Response whereas in our smaller rural counties that have maybe just, oh, I don’t know, eight or nine people in total in their CPS workforce, they just dedicated one person to the workforce. Well, if you decide even to do a 50/50 ratio of families going to IR or DR, it doesn’t mean to say that they come in, in a constant one-one flow. We knew this. I don’t know that we communicated this as efficiently to our counties as we should have. It caused some friction between workers in some places. Traditional workers thought that Differential Response workers were getting easier cases. They thought that they weren’t, you know, getting so many cases that, “Well, everyone is paying so much attention to the Differential Response workers, what about us, aren’t we important?” You know. And hey, if this isn’t a good, if Differential Response is so good, then why isn’t everybody getting it, you know. So all these different issues came up, yeah Beth?

Beth: I was just wondering did they get to pick which case workers were going to be their Differential Response caseworkers?

Linda Newton-Curtis: Yeah. What, and this is another thing. What happened was in some counties, in one county the casework or the managers picked a unit that they thought would be a good unit to do this work. In another counties people volunteered to be Differential Response workers and then they were interviewed and chosen out of those interviews, but yeah they were sub-selected, absolutely perhaps causing some other issues as well. County solutions, what did they do? Well in terms of trying to even out caseloads they came across to adjust ratios and we had to kind of be very careful about

that because we didn't want to create this kind of oscillation effect overtime where they will be overwhelmed and then have nothing, overwhelmed, have nothing. In some counties workers were given non-AR cases, but cases that were comfortable, they had the same type of approach as an AR case. But, then again, you know sometimes workers suddenly became overwhelmed and then we found out that in one county they had totally bypassed the randomizer and I had just assigned a couple of cases to Differential Response. The good thing was we found out this in a group meeting and we could say, "No, no, you can't do this." I mean, undermine is the whole thing of randomization and therefore undermine the integrity of the whole research and we explained again this idea of what it means to randomize and why it's so important. And I am happy to say that the person that did this was very chagrined and said, "Oh no, I am out of compliance." Again we had to say, "Come out, it's not a case of compliance, it's, just, you know, this is what the research needs." So those are some of the issues that propped up with randomization.

Technology was another issue that it was really helpful, but really, really, really, sorry, caused some problems now and again. We had an electronic randomizer. It was going to be screeners or the screening decision makers, those that actually use that Pathway Assignment Tool that said whether or not this case was eligible for our study. Those were going to be the people that would put the intake number into the electronic randomizer. This is a really kind of, something that was very, very kind of difficult for them to grasp before they actually started doing it and actual fact it's a really easy process. We had a website and a little kind of data entry path within the website where they can just simply enter the intake number, hit the submit button and pops back you know randomized Differential Response, Traditional Response so they know, so they...

A main problem with a randomizer was when it went down and it went down quite a bit at the beginning of the study and we couldn't figure out why. I am happy to say we really do have a good partnership with our counties and at this point we knew our screeners and our screening decisions makers pretty well. They had our cell phone numbers, they had, I mean they had everything and so it didn't matter when this randomizer went down, we'd get call, one of us would get a call. At the beginning it happened, like I said, quite a lot, in fact, so much that we were concerned that this was going to undermine the study, because we didn't want people to come so frustrated that they would think you know what, randomizer, I am not going to do it. So what we did initially was said okay, we'll just flip a coin, we will go to that good old-fashioned coin toss and heads it's Differential Response, tails it's the traditional track and so on for the survey. We would document it, they would document it and we would keep a log. Overtime we figured out what the problem was and we've changed the randomizer to a different server and we've gotten rid of most of those problems. It still happens on occasion, but once again I think we got such a good relationship with our counties that we can work with that.

SACWIS was undergoing some major changes at the time, the State Administrative Data System and really couldn't accommodate the types of information that we needed to keep track of, for our study. And so what we did was develop our own system for tracking.

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We coded SODs for reasons, I won't go into, but it make sense to our counties. It's developed overtime into an amazing data system. We can give reports to the counties out of it. They can look into the system and see certain aspects of it, we can look into the system and see everything. It keeps our Pathway Assignment Tool, the family characteristics in there, we have the dates and that's just the reality in terms of intake numbers and so on being a skew.

So some of the lessons learned, buy-in is absolutely huge. I mean I cannot stress heavily enough the degree to which it's necessary to have buy-in between the evaluators and the county representatives, but also the caseworkers, you know, at every level that has to be buy-in. And so it means not just one training, but additional training, refresher trainings, individualized trainings for new workers coming in, I mean are constant with training. There has to be this idea of a shared vision that comes from the buy-in, you know. I don't think anybody can think that we are doing this to you. It has to be a partnership and I think for that partnership to occur, there really has to be open communication. But, first we would have semi-monthly conference calls with our counties and as I said before so many phone calls, emails, face-to-face visits, visits between the counties to give each other social support. As I said previously, one of our previous counties, one of our counties that had been involved in a previous study, they have been immense mentors to the other five counties, not just in terms of practice, which of course is the most important thing, but also in terms of the evaluation, how to kind of streamline some of the processes.

And then final slide, the pilot period. I cannot emphasize enough and strongly enough how important this pilot period was. It gave us an opportunity for kind of like this no fault period of time where everybody could make mistakes and, you know, it gave everybody an opportunity to feel that they were allowed to make mistakes and they wouldn't be penalized for it. It gave us an opportunity to make sure that that Pathway Assignment Tool was working and not too many families needed to switch from the differential response to the traditional response because suddenly they were found out, oops, sorry, this family is too high risk. It gave us an opportunity to monitor the data. Our original pilot had been just a two-month period. We actually extended it for a three-month period because we figured out that two months it's just not enough time to really understand the processes as these families travel through the pipeline. They just went through enough, you know, we didn't have enough families in the system. We need to be able to see, you know, what was going wrong as these families struggled through. Our study ends in 2013. We will be doing our final analyzes then. We've already started to look at some of our data and we'll be going forward from there. Questions, yeah.

Participant: Correct me if I'm wrong, but it sounds like your Differential Response was in place before it arrived in the process, correct?

Linda Newton-Curtis: Yes, it was. And so as I said previously one of our problems has been maintaining the integrity of only having, you know, having new families coming in. That's one of the reasons why we setup our SOD system. So the county that previously been a part of the 10 site study, the 10-county study could tell us which families, their id

numbers basically, had been involved before. So at least our counties can do a search through the SOD system to make sure those families don't come back in again. One of the problems is the SACWIS back then wasn't configured in such a way that we can positively in all cases go into SOD's and be assured that some of these families haven't been involved in Differential Response previously and that's just one of the problems and we can't necessarily get that information from the other nine counties. This is the problem. Yeah.

Brett Brown: Last question.

Linda Newton-Curtis: Last question.

Participant: Okay. For, what's your attrition right now, overall difference? How you can handle siblings in sites?

Linda Newton-Curtis: Well, we don't randomize siblings. We randomize the family. There was a lot of debate over what it means and what is a family. I mean, and there is still debate over that. So as to siblings per se, no problem, really what is a family is more of a problem and what do you do when two families in the same house are involved in, you know, with CPS and one has been randomized and then the other has an report. So I mean we can talk more about that afterwards if you want to. In terms of attrition, what do you mean by attrition? I mean in terms of families not completing surveys...

Questioner-5: Well it sounds like *[overlapping conversation]* *[00:48:08]* go to the traditional paths if something is found, just you know when they go out of the...

Linda Newton-Curtis: Oh! Okay, the number of families that have transferred from Differential Response to the traditional trend?

Participant: Or moved or whatever.

Linda Newton-Curtis: Yeah. I think we are getting about a 4% at this point, yeah.

Participant: Okay. Thank you very much Linda.

Linda Newton-Curtis: Sure. In fact, I know we are getting a 4% because I checked it the other day.

Participant: 4 or 4.0?

Linda Newton-Curtis: Well, it's not 4.0, but it's only about 4.1.

Brett Brown: All right. Next, thank you. Our next, was gonna say, contestant. Our next presenter is Ida Drury and she is the Project Director for the Colorado Consortium on Differential Response.

Ida Drury: *[Indiscernible]* [00:49:03] okay. Hello, and to create that early buy-in as a project we had initially thought about getting T-shirts for all of our caseworker supervisors that said, I (heart) randomizer, so that we haven't actually done that. We have no copyright on it. So if anyone is interested, I am thinking now actually just after listening to Linda and reminiscing on some of these times and discussions and trainings that I think we all deserved T-shirts that say, "I participated in a random-controlled trial in child welfare services and we have to tell the tale." It's a little less simple, but I think it really gets to the heart of what we've been through, a bit of a trauma bond I think between the three sites, our cross-site evaluator and American Humane. And so I am going to bring the discussion down a little bit to the practice level and talk a little bit about some of the adjustments that we made prior to implementation at the Colorado the site. One is I am just going to talk a bit about adjustments, problems and lessons learnt, overall as a state administered-system. I live in Colorado which is a county-administered-state-supervised system, so the challenges are a touch different by the same also.

One of the first challenges that we encountered had to do in the area of screening which is, of course our front door, right, to child welfare services. It's also often not an examined part of child welfare services and so one of the reasons we initially focused on this was that it had become an examined part of child welfare services because of some political and social action that it occurred in our state. We had been evaluated by our governors, our governor appointed Child Welfare Action Committee. They had taken a look in particular at our screening system and I had run into some problems and some inconsistencies. And so screening had really, at the time I came to work as project director and to begin implementation of Differential Response, screening was sitting on the stage already as something that needed to change. And in the counties that came together, we have five county consortium, two metro counties and one larger midsize county and two smaller midsize counties. I had already identified that as a need for change in practice in their agencies as well and so not only was this a need that had been identified for us, but it was a self-identified need of the counties back in our consortium. How was, we could begin the improvements in the pre-implementation stage. Now, I don't know how often all of you interact with caseworker supervisors, but when we learn about something new in the field, a new way of doing things, a different way of practicing, a different sort of attitude we want to start yesterday, because it really, there was a lot of resonance with the principles of DR on behalf of the folks that were going to be involved in our study, they were excited, they were chomping at bit, and they wanted to get started probably tomorrow.

Now, as Linda pointed out there were lot of things that needed to be figured out from what the caseloads would look like to what the SACWIS System would look like. So we identified screening as a way that in pre-implementation we could begin thinking about the principles of Differential Response and begin implementing changes that were going to improve our screening system. Plus, one of the things that our counties found very important was integrating practice change across the entire agency. So, again, as Linda pointed out there was, we didn't want the kind of situation where people are appointed to the folks who are doing the non-investigative pathway and said they are the ones who are

doing this different kind of practice and I am going to continue doing business as usual. So we really focused a lot on offering folks opportunities for training for both pathways. We offered chances to understand how the implementation of a Differential Response model would influence their work, whether they were in the investigation response and might be receiving some track changes or if they were in ongoing and might encounter a family that had been through initially a Differential Response. So we really wanted to incorporate all those caseworkers, but the screeners are often left out of many of our training practices and especially in metro counties where folks have the primary role of screening. These were folks who hadn't been to training in forever and kind of just joined to talk about what it is that they do and talk about that specifically. And so we offered the chance for those folks to get together again because we felt that this really created a foundation.

So we talked a little bit about the Pathway Assignment, how that decision is made in this model of Differential Response about whether something goes investigated pathway or non-investigated pathway right at the time of screening. So following the call from a mandated or a voluntary reporter we are making that decision, is this lower moderate risk or is this high risk. And we already had a bit of a, sort of a tiered system in Colorado for deciding the level of risk. So we had some response times that we would assign to different types of maltreatment that were coming in, so this was familiar for folks. But one of the things that we realized early on when we examined some of the reports that were coming in is that they generally didn't have a lot of information that would help our teams and folks make a decision about whether or not they qualify for Family Assessment Response. And so to minimize that track changing as much as humanly possible without crystal balls, those are still on backwater for our projects and I've written them into my grant twice and it's nothing so far.

We needed to really make sure that we were starting in the very best manner with our first outline. So we made some changes right off with that. We changed our referral guide. Prior to this there had not been a statewide standard referral guide at all. There was some rule that talked about how you needed to get folks' address and the general age and social security number of the child and a bit of information about what was alleged to have occurred. We found that if we were going to be approaching families differently, we may be like some additional information and so we added not only information that went into a bit of detail about the type of maltreatment that was being alleged and a description of that maltreatment, but we also added the request for our tangible supports for families child characteristics that might give us some hints about child vulnerability or the level of risk inherent in the report. Knowing, just for example, a lack of supervision call looks very different with a 13-year-old who is developmentally delayed or say that a 13-year-old who is pretty high functioning and has even baby sat for her cousins before. Do you know what I am saying, so really kind of determining the level of risk by gathering additional information, not just about the bad stuff that happened, but also the strengths of the family that were coming into the system.

So we added, we developed a four-page referral guide with a ton of questions on it in all kinds of different categories. And screeners initially were like, okay, this is a good idea,

but this is ridiculous, but there is no way and if I ask all these questions that I am not going to be on the phone for about three hours for every call and I just don't have time for that in my work. And so we did quite a bit of training related to that and we'll talk about that a little bit too. The other thing that we did was we made a structured agency response guide that guided folks through the decision and you will see that a RED team is named in this decision point as well. So what we did was we implemented RED teams, RED stands for Review, Evaluate and Direct. It's concept developed by Sue Lohrbach, who was a Practitioner in Olmsted County, Minnesota. There is an article about if folks need references. But essentially it's a group of folks sitting down and making the decision about what gets assigned and what doesn't, and what the level of risk is. And they do it by standing forever it seems at a white board and really mapping that each and every referral that comes into the agency to make this decision, laying strengths, risk factors, really talking about what is the danger, harm here, what are we worried about with this family.

And just to provide some context for that, the way this used, this decision used to be made in Colorado and, I know, other jurisdictions as well, is really, either a singular supervisor or a group of supervisors sitting in a circle, passing papers around and reading the referrals that came in: yes/no, yes/no/stacks. I went to the first one at Arapahoe County when I first began and I thought like I was getting covered in paper and just had caused some kind of like disconnect in there, very efficient system. The problem with efficient systems, of course, especially when you are dealing with very complex family situations, is that the likelihood of something getting missed in that type of silo decision making process is probably much greater. An example I like to bring up is, I was sitting in a RED team and someone had made a phone call about a child having a mark on her back from something that had occurred over the summer, a scar from a situation with a parent and the line in the referral said there was no mark on, oh no, the reporting party did not see a mark on the child's back. And so half of people heard that as she looked and couldn't see a mark and half the people heard that as she didn't look, like she couldn't look or was prohibited so she didn't see it. And so we actually from the RED team called the reporter back right in the middle of that to ask for clarification. And so in situations like that the nuances of these types of referrals that can really get sorted out in that RED team. But in order the RED team something, you need additional information. Oh, there I go. And then of course there was the eligibility decision which we implemented post-implementation of Differential Response.

So as I said, we developed our process, we trained on it, we spent time talking with practitioners. They were allowed six months of practice. I have never seen so many creative ways. I am trying to make sure that these questions get asked. Flip charts, these things called Sherpas and so they flip through and they become very skilled that they're like flipping back and forth between groups of questions and to ask. We then wanted to see six months post-practice, whether or not this had made any difference in the quality of reports. So our paper really describes this process in great detail, but I will give you just the overview as a teaser, very exciting stuff. So we took a random sample of all the referrals that have been received in those past six months and documented by our screeners. We then engaged in a systematic peer review, so I sat with supervisors and

screeners and they reviewed referrals that had come in from other counties and they really just took a look at whether or not information was present or missing and then made comments related to each and every referral. Following that peer review, we did an immediate guided discussion which really was just a processing event; we social workers who like to process so we did. We talked about what we felt, well, we talked about based on the referrals that each of us had reviewed, what we were worried about and things that we felt needed to change and then we came up with some action stuffs actually from each county about how we might improve our screening practice. We also did some quantitative evaluation of results. This is where a good relationship with an evaluator comes into play and for a project director. So the more that folks can work together I think to get some good information, I think the better.

And then we really hope to improve our screening practice and the project based on the data that we received and some things immediately. I had supervisors saying, “You know, I am going to leave this particular meeting and I am going to directly put on the agenda, the fact that we are not asking for good strengths-based questions from every single report or that we are not writing it when we do.” Okay. And so there was some immediate things that happened. Folks said overall that they had confidence in screening decisions that came out of referrals that had a lot of information, but we identified another problem in the fact that we were gathering more information in a blank textbox is that, I love this piece, that someone said that the narrative piece will sound like a logic problem. You know, those on the GRE where you are trying like, “One train left at...” and, you know, and you’re really figure it out. And I really have to concentrate on where they are going with the story. And so that really pointed to some, hopefully some improvements in our SACWIS system that can better guide screeners through this call, maybe lesson the need for the flipping of the flip chart and more readily guide them. Currently we just don’t have a good system for that in SACWIS.

Quantitatively we got some interesting feedback. We found out that pretty consistently folks were getting really good general information, the stuff that’s required in statute, the stuff that they were used to getting in the beginning on the type of maltreatment, et cetera. Where things sort of dropped off was, excuse me, information about those supports, the things that we had added: child information functioning, special needs and vulnerability, family coping, strengths and intervention. We also added a scaling question at the end which took a, took our mandated reporters by surprise in particular based on narrative therapy, but we started asking folks you know based on a scale of one to 10 with one being, not safe at all and 10 being, totally safe. If we were to not intervene in this situation, where do you feel like the safety of the child would land on that scale and so really causing folks to step back and take a look at what it was that they were alleging as it related to child safety. Not that there is a right or wrong answer to that, I mean that’s the beauty of therapy, right, but really kind of getting a sense of where the reporting party was coming from. What we found really points to some, not just improvement in our screening process and having our screeners ask the question, but some education with our mandated reporters so that they can anticipate that some of these questions are going to be asked. They can have a better idea of that. It’s not that we don’t care about the maltreatment that’s being alleged, but we are going to be asking for a

whole host of other bits of information that might help us intervene in the lives of families appropriately.

Overall, there are some implementation or implications for Colorado. We are hoping to integrate this with current change initiatives so that the learning from these five DR counties and spread DR statewide. You don't have to be doing DR to improve your screening practices. We certainly use that as a first step for us, but I think that screening is a key part of the work that we do and you can improve that no matter where you are at, especially in a county administered system where there are so many ways of doing things like Linda pointed out. Again I mentioned mandatory reporter outreach, some adjustments to our training and then overall we hope to provide some statewide technical assistance as state program staff.

So I do want to let people know that if they are interested in copies of our tools or Pathway Assignment that you can, I'll be more than happy to send those to you if you email me and I would entertain any questions that people have for me.

Participant: I am just curious in terms of the proceed level of the safety of the family, if you look at that data and people tend to see people at sort of imminent risk or a similar range?

Ida Drury: I would love to do some analysis of that. Right now that the scaling is in the body of the referrals, so it would be pretty tedious do that. But one of the things for that reason that we've talked about doing exact was is putting that scaling question directly into the SACWIS System so that we can draw that data, because it varies from person-to-person, yeah. All right, thank you.

Brett Brown: Okay, thank you very much. All right, our final presenter is Womazetta Jones, the Project Director for the Illinois Differential Response prior to, *[indiscernible]* *[01:08:08]*. I am sending you only these questions too.

Participant: Sure.

Womazetta Jones: Oh, I'll talk about it if you want me to.

Brett Brown: *[Indiscernible]* *[01:08:40]* want me to and I didn't know that some had, all right give me just a second. Thank you. Hmm...okay.

Womazetta Jones: And that's it?

Brett Brown: Up there.

Womazetta Jones: Hmm...mm.

Womazetta Jones: Good morning everybody. So I am going to rap us up. Let's see how well I do. I am Womazetta Jones. I am a Project Director for DR in Illinois and we put

the articles, putting it altogether, lessons learned from the planning and development phases of implementing DR in Illinois.

Now what I really love is that each of the three sites in this research study, this project is very different. We have baseline similarities on things that Brett ensures that we do the same, but we are very different. One being Illinois implemented DR in all one 102 of its counties on the same day. We are a state system, so I don't, the piece of the county administered no, but it does not mean that because we are a state system and we have one way of doing things that it was easy. But we implemented in all 102 counties on November 1st and pretty much what Brett already covered. DR is an alternative means of responding to report the child maltreatment. Now within Illinois, specifically neglect. In, currently 17 states are using DR, some statewide, others within counties and within their states like Ohio.

Now, I tell you the young people in my office did the graphics. I have to pull some out because they got me really, so I did not do that arrow *[laughing]* [01:10:23], couldn't take it out without this. What we deal was we started looking at DR prior to the grant, any of that in terms of do, should we do DR in Illinois. And we have a visionary Director, I mean a very innovative Director McEwen. He had started reading about Alternative Responses. So he had read a lot, but he has the Children and Family Research Center at the University of Illinois, School of Social Work in Urbana if they can just pull it altogether into one report for him. But you know, honestly he had read every article already. But he just wanted one comprehensive document to share with various individuals to look at, should we do DR Illinois, because since 1975 in Illinois when a report was made to our hotline, we don't have RED teams, we have one place that all reports go into. We have one choice. If it met the criteria set for the statute, it had to be investigated. So he brought all of the critical stakeholders together in one place to discuss that lit review - critical stakeholders meaning, besides personnel that DCFS. We are highly privatized state, so the private agency major players are guardian Guardian ad litem's Office. We are a union state, there you go all the effort. So representatives from the union, representatives from the inspector general's office, a whole lot of people who don't typically all sit together in one time to really talk necessary, let's say peacefully, sometimes it's a bit heated. But he was like, "Let's look at this because if we decide to do it, all of us are going to make that decision."

So when we look, when they all looked at it, they said. "Okay, we would like to DR; it's going to require a legislative change, because statute is clear." They only go one way if it's accepted. So we did get legislation, start getting interacted in '08. So we moved on to '09 and at that time we continued to have other interactions with other states such as a peer-to-peer with Minnesota because they were the most similar to how we are set up. And we want to hear, although we didn't know if we were going to do it we had statute put in to place to allow for Differential Response if indeed we decided to indeed do DR. We looked at what type of model should we develop, which I am going to go through in a minute in more detail in order to do DR, because investigations is very clear, setups in seven to five-ish, I mean, a lot of us had lived it, done it. But we knew DR could not be the same way, otherwise we will have a alternative pathway to investigations. That was

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one thing we knew for sure, but there was also one of the pieces that had a lot of people worried, because investigations has a hammer. You know, you go in, you do, if you don't do this, we are going to take your kids. If you don't do this, we are going to do, so there are consequences, so how do we structure it? And being there, a wonderful happened, we heard about an RFP about Differential Response and we did submit our proposal to the one of the research and demonstration sites which had began in the 2010. We were informed that we were one of the selected sites.

So with that, this is about the time that I came back to the department, because I had left for about three years. I have had a little mental health break, slowed down the pace, because all of time at the Illinois Department Children and Family Services was in the vision of child protection. An investigator, an investigator supervisor, a manager over a lot of investigative teams and a statewide manager over investigations and I dealt with sex abuse serious harms, that type of stuff. So I just needed a little break. So Director McEwen asked me to come back because he wanted someone who fully understood the world of child protection within our state in order to figure out how can we do something very different than that to help a certain category of families, mainly those low risk families who needed help. You know, inadequate food, shelter, clothing, housing, not torture sex abuse, cuts, well to bruises, you know, death cases, but those other cases. So you needed someone who fully understood that world to make sure the new one did not mirror that in terms of practice.

We had to look at our SACWIS System and how we would situate that, the memorandum of understanding with our union because over 90% are going to say, well let me, I'll make it easier, only a 145 people at the Illinois Department of Children and Family Services are not in the union. Everyone else, worker, supervisor, manager, even the person above the manager are all in the union. So we had to work with the union and we had to look at where they might be coming from was. Of course they have to protect their membership, how might that affect them and I will talk about that in a moment. And being our contracts with our private sector community and selection of workers and train them.

So one of the thing, one of the pieces we had to put together was what was going to be the criteria for DR in the state of Illinois. Now we had our statue, we had to have our rule approved which you know interpret statue, but more specific, it gets more specifics. We only had to develop our procedures in terms of what would be criteria, the criteria for DR, how would we do it. So it's a state system, but it's very complex and we have a lot of pieces. You have to be approved by a lot of folks to do things. But we really rolled with this very quickly. The criteria for DR Illinois was we have to know the names and addresses of the families we are going to work with. In investigations we did cases unknown, unknown, everybody on a corner of a particular street. But DR we had to know that information. The ledge offenders and of course as Brett knows we don't call them offenders, but just for the purpose of this slide we had, in terms of what defines a family and the parents, legal guardians are the responsible relative. We got a loser with it, because there are lot of kids being raised by aunts, uncles, cousins, godparents and they don't have legal on them, but they are raising them. We could have no indicative

reports on our system meaning that we had indicated them for maltreatment or if we had, they had now been expunged or even no longer in our system. No currently pending child protection reports. Every, you know, everyone in the house they could not have been the ward of the State of Illinois or getting ready to be a ward meaning we needed to take custody and then our allegations, as I mentioned, is inadequate food, shelter, clothing, supervision, environmental neglect, medical neglect, mental and emotional impairment due to neglect and risk of harm due to neglect.

Now, our flowchart as I mentioned, we don't have RED teams. We have a centralized location that all reports go to and to be on a DR, to get involved with DR it had to come in as a hotline call that was accepted. So someone's calling our 1800 number, it's been reviewed by our hotline worker, they found that it met the criteria for an investigation and right there is when our randomizer kicks in. Our randomizer is everything for us is within the SACWIS System and I had to laugh and I finally realized it stood for State Automated Child Welfare Information System. You know, I am oldie, I go by acronyms. But we built that randomizer to then extrapolate out the cases that met the criteria for DR and into further extrapolate out what will go to the control group, the DR group, the experimental group and we had, so no person is making that decision within are same. And we chose to do that to ensure that certain kind of families were not being given this opportunity.

Now, staffing, there are two types of workers that work within Differential Response. There is our DCFS worker, their role is to assess safety and DNR Private Agency workers which we call, their title is the Strengthening and Supporting Families Worker, SSF. They are the change agent. They are the service to that family. They provide the family with everything that they need.

Now with the DCFS staff, again we had to reach an understanding with the union and we staffed it relatively small because their role is minimum, it's to assess safety. That was the one piece that no one would give one. They said the state had to do that part, that component. So we have right now 30 workers throughout the state that pairs with the private agencies to do this and five supervisors statewide to handle that. Then with the private agencies, we have 14 private agencies with DR contracts, so of course that's 14 supervisors, 52 workers and their ratio for caseloads is 12 to one.

Now to select our agencies, there were variables we use. They had to have, they had to know the area they were going be servicing. They had to know it. It wasn't an entitlement contract because you've been around since my great, great grandmother, you get a contract, no. You had to demonstrate, we had to, they had to have demonstrated to us that they truly knew how to engage families because, guess what, they don't all know how. They know how to tell somebody what to do, but not engage them. They had to be financially stable and then the staff, all the staff on both sides, public and private, must have a COA Acceptable Bachelor's Degree and all supervisors must have an MSW. And experience of working with youths, families, knowledge about the system and they have to successfully complete all of the required trainings for DR.

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Now, with the private agency workers or the way we have it structured is everything we do is based on engaging the family and their strengths and using the recovery called home visiting model because they are the service. This is not a referral and linkage program. You don't get to refer them to a homemaker to teach them how to clean your house. You show them how to clean your toilet. You don't get to refer down to someone to help them understand the school system, you go with them and you advocate for them and show them that system. So it's not referral and linkage. It's short-term intensive. 90 days, a 120 if absolutely necessary, but the worker is the service.

Now, we had a series of trainings. We had a control group training for the DR staff that, oops sorry. A control group training for the DR staff which is four weeks long, so we, very different than the other sites. Our staff sit in a room together for four consecutive weeks. I am sorry, I did, that was experimental group I am talking about now, I want to, try to go pretty quick, three or four weeks move by and we go of all of that and being some, the biggy being engagement and there you may have another week and check this out, one week flashback, they did and not me and its one week at the office going through all of these additional pieces.

Now going back to that other group, the control group, that's the investigation side. We have a webinar training for them to ensure that they understand their role in this research project, okay. But we also have supervision coaching and evaluation because training alone is not sufficient. Now, some people were shocked that Illinois, they had people sitting in a room for four weeks. But this is a huge paradigm shift and for us, our logic not responding to Ohio and Colorado, one day wasn't going to make it for us. We did, so we did four weeks. We, I mean, one of the other pieces of course is this formal supervision, the coaching and the evaluation piece. So we have ongoing pieces for the workers and the staff. I mean the workers and the supervisory staff in DR and it's not optional, it's mandatory.

The staff for DR, again, addressing the needs, identified by the family. So all of those trainings in being some are needed because we are used to telling people what to do, so we've had to retrain ourselves not to do that and to be willing to transport people, watch their kids while everybody is doing 16 loads of laundry, show them how to do laundry, clean a toilet all the day. You have to, you know, that's a whole big cultural shift for us. We have a monitoring and quality assurance piece. We monitored the contracts in terms of our private agencies in compliance with what they signed they want to do. They may also have a review by my office to monitor the practice where we review the cases and then we also, we of course have a QA and pit division within the department because we are part of a pit plan in terms of what we have to be in compliance with.

Challenges, the families perception of DCFS, they don't have a good perception of us and why should they? So that's a challenge to help them know when we knock on their door, we really are there just to help. It would, then the department, we've had a huge struggle, the adaptive challenge huge for the Child Protection Division and their, their not having an issue with DR. DR does not fall into the Child Protection Division at DCFS in Illinois. It's a separate division because if we would have had it fall under that umbrella

they would have changed DR to fit their method of practice and not seeing that they needed to change their method of practice to fit the new innovation. So DR is separate.

And the technical challenge we've been very fortunate. I have an, our SACWIS, I mean our Colorado, Ohio, I always feel for them because Brett knows that was definitely not one of my challenges. They read the table from day-1. They helped design actually some of the practice pieces in terms of, because some of our SACWIS team they are former workers, former supervise direct service, so they know how it works. So our SACWIS team, technical, the technical challenges for us really have not been anything worthy of talking about. It's been going wonderfully well. So I am very fortunate with that. But why I do this, the reason I do this, the reason I chose to come back to DCFS to do this was when I realized I was going to get a chance to truly help families. I was going to really get that opportunity and not just reach a finding and give them a referral or maybe take their kids or maybe do a safety plan, but actually be able to help. That's why I am doing this and that's why we are doing it within the community what they are saying with DR, have people now calling my office direct to say, "Can we just refer down to DR? We don't want them to have an investigation. We want DR to help them." And unfortunately right now no, because this is a research and demonstration project and within the department what we are seeing obviously it's impact on caseloads, because for, up through June, the end of June over 2,400 cases had been randomized to DR, so it is 2,400 cases that didn't go to investigations. So the workers are beginning to see it with the biggest, the workers in child protection they are much more with DR than upper administration and child protection. So it's not that, it's not a battle with the workers, it's more of a battle with longtime administrators looking at what that might mean to them if DR is successful.

So that is it. I know I rushed through it, but I wanted to meet my time frame.

Brett Brown: Most excellent.

Womazetta Jones: Thank you.

Brett Brown: Are there, are there, is there a couple of questions before we end?

Participant: Within our website we can locate some of your documentation?

Womazetta Jones: Yes.

Brett Brown: Yes.

Womazetta Jones: Most definitely. If you go into the, just Google Illinois Department of Children and Family Services and you go on there and look, and just go on to instruments or tools, you will be able to pull up instruments and tools. Brett may know better than I do.

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Brett Brown: If you go QIC Differential Response in Google, you will get our, you will get the link to our website.

Participant: QIC?

Brett Brown: Just QIC and Differential Response in Google and you will get the....

Womazetta Jones: And all the instruments for DR, we developed all new instruments for DR in Illinois. We did not use any of the existing instruments except for the safety instruments.

Participant: Hmm...mm..

Brett Brown: All right. If you have particular questions you would like to follow up with one of the speakers feel, please feel free to come up with. Thank you very much for coming and thank you all.